PALLIATIVE CARE NETWORK OF WISCONSIN

Is it Pain or Addiction?

Background: "*Is it pain or addiction*?" is a question commonly asked in clinical practice when a patient on opioid therapy exhibits behaviors which worry the clinician. However, it is a flawed clinical question. Some seriously ill patients simultaneously have both significant pain and opioid use disorder (OUD). Some have high-risk opioid behaviors (e.g., taking more than prescribed, asking for dose increases without an obvious clinical indication) without having an OUD. Of course, patients with serious illness can also have changes in their underlying illness leading to worse analgesia. Thus, asking "*is it pain or addiction*?" is not a helpful framework as it encourages black-and-white thinking, and distracts clinicians from nuanced, patient-centered assessments focused on the benefit: risk analysis specific to chronic opioid therapy. This *Fast Fact* provides tips to clinicians in sorting these clinical dilemmas out.

Use a systematic approach in diagnosing OUDs: The DSM-5 criteria for OUD are widely available (1) and should be referenced by clinicians worried a patient's presentation could represent an OUD. The OUD criteria can be summarized as a patient taking opioids in larger amounts or for longer than intended (loss of control); unsuccessful efforts to reduce opioid use; a patient spending a great deal of time obtaining or recovering from the effects of opioids; opioid cravings; or use despite harms (which could be accidents, or medical/physical, social, vocational, legal, or interpersonal harms). The DSM-5 criteria stratify patients into mild-moderate-severe OUD based on the number of criteria a patient meets.

Recognize that OUD is a behavioral syndrome: While addiction undoubtedly has a biological basis, it is diagnosed based on observable or reportable *behaviors*, in part because biological events associated with chronic opioid use occur in both patients with OUDs and patients using opioids for analgesia without OUD. Tolerance – the need to increase a drug to achieve a certain effect – is common and expected with opioids, especially for central nervous system effects (sedation, dysphoria, euphoria). Physical dependence, defined by the development of a withdrawal syndrome when a drug is suddenly reduced/stopped, or an antagonist is administered, is also a normal and anticipated biological event with opioids. Importantly, the DSM-5 criteria specifically note the development of tolerance or physical dependence *should not be used* as criteria for deciding if a patient has an OUD. High opioid dose is not an OUD criterion either. The large population differences in opioid dose (which can vary by over two orders of magnitude) are poorly understood, even for cancer pain (2). Importantly, while high opioid dose does not in isolation imply a patient has OUD, it is a risk factor for harm-related events from opioids (e.g., falls, inadvertent polypharmacy overdose) and patients on high doses need careful monitoring and ongoing assessment to ensure any benefits of ongoing high dose opioid therapy outweigh risks.

Accept that it is going to be complicated: The benefit: risk analysis of chronic opioid therapy requires considerable clinical judgement balancing an array of factors including (but not limited to):

- Prolonged opioid use does not imply a patient has an OUD. A patient may dislike being on opioids (e.g., side effects, stigma, polypharmacy) but be unsuccessful with tapering due to disabling pain.
- Self-escalation of opioids and other risky behaviors should be viewed as concerning clinical data. A patient may self-escalate their opioid dose due to poorly controlled pain, not OUD. Note that while a single episode of self-escalation alone does not diagnose OUD, it still l represents *risky behavior,* and should prompt clinicians to intensify opioid safety discussions and monitoring. Additionally, an *ongoing pattern* of opioid self-escalation should prompt the clinician to suspect OUD, even if they also accept the patient has poorly controlled pain.

- OUD and pain commonly co-exist. OUD is largely defined by loss of control over use of opioids, *and this is true even if a patient uses opioids for pain*. Consider a patient who has chronic pain, who persistently cannot control the amount of opioids they take, and who describes the reason for that is uncontrolled pain. This is suggestive of an OUD. Patients without OUD who do not get good relief from opioids typically stop them, let alone repeatedly self-escalate them.
- Ongoing clinical assessment and analysis are crucial. A patient may persistently request an opioid dose increase. While this can be a sign of an OUD, it may be due to inadequately treated pain and/or disease progression. Clinicians must carefully assess if there is objective evidence or otherwise good reason to believe the patient's underlying pain syndrome is worsening (e.g., cancer progression). If not, the patient should be assessed for further reasons to prompt a desire for an increased opioid dose including a worsening mood disorder, tolerance to the opioid (which is usually not improved long-term by merely increasing the opioid), or an OUD.

Opioids for mood modification: A patient prescribed opioids for a painful metastatic cancer, may also use opioids for sedative effects (e.g., to help with sleep), or for mild euphoric effects (e.g., to reduce anxiety related to their terminal condition). Most clinicians accept these uses when patients are close to death, care goals are solely focused on relieving suffering, and it is clinically challenging to tell the difference between physical and emotional pain. For many in the final weeks of life, the benefits of ongoing opioid therapy typically far outweigh risks. For patients with longer prognoses, clinicians should educate patients about avoiding opioids for mood modification and offer safer alternatives including behavioral/mind-body interventions for anxiety, insomnia, and existential suffering. They should also consider OUD as a diagnosis if the patient continues to use opioids for mood-related reasons.

Patient safety and function should be a clinician's top priorities: For situations where a patient has pain and high-risk opioid features, but a diagnosis of OUD cannot clearly be made, it is less important to focus on that diagnosis than to step back, with the patient, and broadly examine whether opioids are safely improving/maintaining function and quality of life. Is the patient more engaged in key life activities because of the opioids, or not? Is the patient experiencing objective harm from the opioids (severe side effects, or engaging in risky use such as mixing opioids with alcohol or other drugs) – or are they thriving? Even for patients with otherwise 'strong' indications for opioid therapy (e.g., painful metastases), continuing opioids may not be safe or wise for some. It is critical for clinicians to examine their own biases towards OUD (e.g., reluctance to diagnose) and recognize that is a common, treatable illness that can be a tremendous source of preventable suffering if it is not correctly diagnosed and treated.

References

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