



# Practice Dialogue

*The newsletter of the Newfoundland Medical Board*

A concise reference guide on treating chronic non-malignant pain

August 2004

## Accidental overdoses highlight problem

*Prescription drug misuse an ongoing issue for physicians*

Dr. Simon Avis, the province's Chief Medical Examiner, reports that since 1997, accidental drug overdoses were identified as the cause of 17 deaths in Newfoundland and Labrador.

Oxycodone was the primary cause of death in seven cases. Dr. Avis indicates that in six of those seven cases, OxyContin® was the form of oxycodone ingested. Percodan® was involved in the other case. As well, in six of the cases, other substances such as alcohol, marijuana and other drugs such as benzodiazepines were involved. In two recent accidental deaths, morphine overdose is suspected as being responsible for the deaths.

The OxyContin® Task Force final report included statistics on the increased use of oxycodone in the province since 2001. The number of prescriptions for OxyContin® (all strengths) increased 277% between 2001 and 2003, while the number of prescriptions for all other oxycodone products increased 214% in the same period.

The Newfoundland Pharmaceutical Association (NPhA), the province's pharmacy regulatory board, recently informed the Newfoundland Medical Board of an apparent tendency in this

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## Use of controlled substances for the treatment of pain

*Excerpt from NMB policy*

### Section II: Guidelines

The Medical Board has adopted the following administrative guidelines when evaluating the use of controlled substances for chronic pain control:

#### 1. Evaluation of the Patient

The medical record should reflect a detailed knowledge of the patient's medical history and physical status. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

#### 2. Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

#### 3. Informed Consent and Agreement for Treatment

The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the physician determines the patient is at high risk for medication abuse or has a history of substance abuse, the physician may employ the use of a

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## Accidental overdoses...

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province for physicians to prescribe OxyContin® more frequently than the recommended dosages in the *Compendium of Pharmaceuticals and Specialties (CPS)*.

NPhA says doctors are prescribing OxyContin® to be taken every five or six hours, compared to every 12 hours (q 12 h), as recommended by CPS. As CPS notes, “OxyContin administered q 12 h produced equivalent analgesia to Oxy-IR administered 4 times a day” in studies of OxyContin® and Oxy-IR®.

The OxyContin® task force final report is available on line: [www.gov.nl.ca/health/publications/oxyfinal/OxyContinFinalReport.pdf](http://www.gov.nl.ca/health/publications/oxyfinal/OxyContinFinalReport.pdf). Ω

## Use of controlled substances for the treatment of pain (cont'd) *Continued from page 1*

written agreement between physician and patient outlining patient responsibilities, including:

- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (i.e., violation of agreement).

### 4. Periodic Review

At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. The physician should recognize the entity of so called pseudo addiction (please see Section III: Definitions). Modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as improvement in patients' improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living, and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should re-evaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

### 5. Consultation

The physician should refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients.

### 6. Medical Records

The physician should keep accurate and complete records to include

- the medical history and physical examination;
- diagnostic, therapeutic, and laboratory results;
- evaluations and consultations;
- treatment objectives;
- discussion of risks and benefits;
- treatments;
- Medications (including date, type, dosage, and quantity prescribed);
- instructions and agreements; and
- periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

### 7. Compliance with Controlled Substances Laws and Regulations

To prescribe, dispense, or administer controlled substances, the physician must be licensed in the province and comply with the applicable legislation. For more information refer to the *Controlled Drugs and Substances Act* for the federal law governing controlled substances as well as the *Narcotic Control Regulations* and related regulations. Ω

(Note: Full text may be found at [www.nmb.ca/PolicyDocument.asp?ID=8](http://www.nmb.ca/PolicyDocument.asp?ID=8))

## A Reference Guide for Clinicians Treating Patients with Chronic Non- Malignant Pain

### Initial Assessment

1. **Perform a history and an appropriate physical examination and review relevant diagnostic imaging and other tests to document the mechanism of pain.** Be as accurate as possible. If possible obtain copies of consultant reports and hospital discharge summaries.
2. Also assess patients to determine if there is a history to suggest current or past addictions. Patients with an addiction history require careful consideration of the risks of addiction versus the benefits of opioid therapy.

### Patients with a History of Substance Abuse

3. **Consider a history of substance abuse as a relative contraindication for prescribing opioids for chronic non-malignant pain.** The management of pain in these circumstances requires extra care; more frequent assessment and monitoring; careful documentation; and consultation with experts in addiction and pain management.
4. **For more information** regarding this matter, physicians should **contact the Newfoundland Medical Board office**, or consult *Managing Pain: the Canadian Health Care Professional's Reference*. This book has been endorsed by the Canadian Pain Society.

### Treatment Plan

5. **Opioids are an important strategy for managing chronic pain.** However, careful consideration of other interventions such as exercise, physiotherapy, psychological assessment and support are essential to optimize treatment outcome.
6. **Together with the patient, establish appropriate goals of treatment:** e.g. reduction in pain, improvement in function, return to work, improved sleep, etc.

7. **Consider prescribing opioids for chronic non-malignant pain only after reasonable attempts using non-drug interventions and non-opioid analgesics have failed, and only as part of an overall pain management strategy.**
8. Non-opioid analgesics include acetaminophen, acetylsalicylic acid and non-steroidal anti-inflammatory drugs. Co-analgesics such as the tricyclic antidepressant amitriptyline and anticonvulsants such as carbamazepine and phenytoin may be effective in the treatment of chronic neuropathic pain.
9. **If a trial with a non-opioid analgesic is ineffective, consider trying medications with a fixed combination of an opioid and a non-opioid analgesic before prescribing long-acting opioids.**
10. **Remember: acetaminophen toxicity may occur if recommended daily doses are exceeded.**

### Opioid Therapy

11. **Titrate increasing opioid dosages carefully with an aim for functional improvement and enhanced quality of life as well as reduction of pain.** There may not necessarily be complete relief of pain.
12. **Failure to achieve at least partial pain relief with low dosage opioids may indicate that the pain syndrome is not responsive to opioids.** Such a situation should prompt review of the role of opioids in the patient's management as well as reconsideration of adjuvant medications and non-pharmacological measures.
13. **Slow release opioids should be prescribed in accordance with recommended frequencies** e.g. every 12 hours. The prescribing of slow release opioid preparations more frequently than recommended is almost invariably inappropriate and suggests a lack of knowledge regarding the pharmacokinetics of slow release opioid preparations.
14. **Prescribe breakthrough dosages of opioids sparingly;**

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## Follow-Up Assessments

15. **Assess the patient at appropriate intervals.** When titrating the opioid dose, patients should be seen at least every 1 to 2 weeks. When established on a maintenance dosage, intervals of no longer than 6 to 9 weeks between assessments are suggested.
16. **Use narcotic flow sheets and pain assessment sheets on each visit.** Samples are included in this bulletin.
17. **Follow-up assessments should routinely evaluate analgesia, functional status, quality of life, side effects, and any aberrant drug related behaviour** e.g. drug seeking (lost or stolen prescriptions or drugs, requests for early refills); unauthorized dosage increases; and double doctoring.
18. **Periodically review the management of all of your patients who are prescribed opioids for chronic non-malignant pain to determine if the opioid or the current dosage of the opioid is appropriate.** Consider whether a non-opioid analgesic or a fixed combination opioid/non-opioid analgesic might be effective.

## Contracts

19. **Establish a contract** with all patients for whom opioids are prescribed for chronic non-malignant pain. Specify only one prescriber; one pharmacy; no early refills; and the consequences of breaking the contract. If the contract is verbal, it should be documented in your office notes. If the patient is considered at risk for opioid abuse, have the patient sign a written contract which outlines patient responsibilities.

## Prescriptions

20. **Write prescriptions for opioids and other controlled drugs legibly.** Include the patient's name, address and MCP number as well as the date the prescription was written. Write the name of the drug, the dosage, the frequency and the amount to be dispensed clearly. The amount to be dispensed should be both written in script and numerically. All prescriptions should be documented accurately in the patient's file.

21. **Keep prescription pads and drug samples secure at all times.**

## Two Drugs with Abuse Potential

22. **Monitor patients carefully when prescribing two drugs with an abuse potential – opioids and benzodiazepines.** Such combination therapy should be avoided.

## Short Acting Opioids

23. **The long term use of short-acting opioids such as Demerol® and Dilaudid® in the management of chronic non-malignant pain should be avoided.** Short acting opioids may be used during the initial titration period, after which long acting opioids should be used. Demerol should not be used for the management of chronic pain because it has a very short duration of action. Furthermore, its active metabolites can accumulate causing generalized seizures.

## Threats

24. **If threatened or coerced by a drug seeker, notify CMPA and call the police. Ω**

**Note:** A sample narcotic flow sheet may be found at page 5, a sample pain scale and pain diary are on page 6 and a sample patient agreement letter is on page 7. They are also available on the Newfoundland Medical Board web site, [www.nmb.ca](http://www.nmb.ca).

These are designed to be copied for use by physicians. The flow sheet and pain diary contain spaces for fourteen entries, representing a two week interval between physician appointments.

For use by clinician

**Narcotic Flow Sheet**

Patient Name: \_\_\_\_\_

Chart Number: \_\_\_\_\_

Prescribing physician: \_\_\_\_\_

Date	Medication	Dose	Direction	Qty	Comments

Photocopy additional sheets as required

**Photocopy and provide to patient**

**Pain Scale and Pain Diary**

**Instructions**

- **Record your pain level at the same hour every day.**
- **Bring this record with you each time you visit your doctor.**
- In the box provided, record the number from the scale that matches the pain you felt at that time.
- To start, please circle the number on the pain scale that best describes the pain you feel right now.

**Pain scale**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
No Pain	Mild	Discomforting	Distressing	Severe	Excruciating

**Pain Diary**

<b>Date</b>	<b>Morning</b>	<b>Afternoon</b>	<b>Evening</b>	<b>If you get up at night</b>

## Patient Agreement Letter

1. I, \_\_\_\_\_Patient name\_\_\_\_\_, agree that \_\_\_\_\_Physician Name\_\_\_\_\_ will be the only physician prescribing opioid, also known as narcotic, pain medication for me and that I will obtain all of my prescriptions for opioids at one pharmacy. The only exception to this will be an emergency or the unlikely event that I run out of medication. I will inform my physician as soon as possible should such occasions occur.
2. I will take the medication as prescribed by my physician. I agree not to increase the dose without first discussing it with my physician.
3. I will attend all reasonable appointments, treatments and consultations as requested by my physician.
4. I understand that the common side effects of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing dosage. I agree to **refrain from driving any motorized vehicle** or operating dangerous machinery until drowsiness disappears and my doctor agrees I am fit to drive again.
5. I understand that using long-term opioids to treat chronic pain may result in development of a physical dependence on the medication and that sudden decreases or discontinuation of the medication will lead to withdrawal symptoms. I understand that opioid withdrawal is uncomfortable, but not life threatening.
6. I understand that there is a small risk that I may become addicted to the opioids I am being prescribed. As such, my physician may require I have additional blood, urine or hair testing and/or see a specialist in addiction medicine should a concern about addiction arise during my treatment.
7. I understand that the use of any mood-altering substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (like cannabis, cocaine, heroin or hallucinogens) can cause adverse effects or interfere with opioid therapy. I agree to refrain from using any of these substances without prior agreement with my physician.
8. I agree to be responsible for the secure storage of my medicine at all times. I agree not to give or sell my prescribed medicine to any other person. Depending on the circumstance, lost medicine may **not** be replaced until the next regular renewal date.
9. By signing this agreement, I waive my right to privacy and I give my doctor consent to contact any other health care provider, pharmacy, legal authority or regulatory agency to obtain or provide information related to my pain management or any misuse of my medications.
10. I understand that if I break this agreement, my physician reserves the right to stop prescribing opioid medication for me.

**Date:** \_\_\_\_\_

**Patient:** \_\_\_\_\_

**Physician:** \_\_\_\_\_

## Prescription Drug Diversion Physician Self-Check

Are you part of the problem?

If you answer “yes” to any of these questions, consider changing your practice.

**Prescription drug abuse and misuse is a health care issue.**

-  Do you prescribe on demand?
-  Do you accept the diagnosis made by a patient?
-  Do you comply with drug selection suggested by a patient?
-  Do you prescribe small quantities of medication to “get the patient out of your office”?
-  Do you prescribe any medication without first performing all the necessary examinations to make sure the patient is in actual medical need of the medication?
-  Do you prescribe before making every reasonable effort to make sure the patient is not obtaining prescription medication from other sources while under your care?
-  Do you practice in isolation, without maintaining a close professional relationship with pharmacists and other health practitioners in your area to facilitate early identification of drug-abuse problems?
-  Do you react in a negative manner when contacted by a pharmacist to confirm a prescription or discuss any other matter related to any of your prescriptions?
-  Do you permit your nurse/receptionist to authorize prescription renewals or to relay such information to pharmacists on your behalf?
-  Are your blank pads and drug samples kept in places easily accessible to unauthorized individuals?

**Photocopy and post this checklist in your practice.**

Source: Adapted from *The physician and psychoactive drugs*, published by Health Canada.

### Online resources

*Guidelines for the use of controlled substances in the treatment of pain*, Newfoundland Medical Board, [www.nmb.ca](http://www.nmb.ca).

*Evidence-based recommendations for medical management of chronic non-malignant pain: a reference guide for clinicians*, College of Physicians and Surgeons of Ontario, [www.cpso.on.ca/publications/pain.htm](http://www.cpso.on.ca/publications/pain.htm)

*Management of chronic non-malignant pain: CPSA Guideline*, College of Physician and Surgeons of Alberta, [www.cpsa.ab.ca/publicationsresources/attachments\\_policies/Management%20of%20Chronic%20Non-Malignant.pdf](http://www.cpsa.ab.ca/publicationsresources/attachments_policies/Management%20of%20Chronic%20Non-Malignant.pdf)