PBLD: Give me OXY now!!

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Goals:

1. Review substance abuse terminology
2. Identify interviewing strategies to illicit information about substance use, particularly during an initial encounter with a non-cooperative or resistant patient
3. Review the role of urine toxicology in predicting withdrawal and substance abuse, both in the active or maintenance phases of disease
4. Participants will develop preoperative pain management strategies for the opioid-dependent patient with various clinical dilemmas common in the pediatric population.

Case introduction:

An 18 year-old girl with osteosarcoma of the right distal femur, now status post above the knee amputation, has chronic stump pain that prevents her from wearing a prosthesis. She is now admitted to the orthopedic service for a stump abscess that requires IV antibiotics and surgical drainage. It is Friday afternoon and an inpatient pain consult is requested for her right leg pain that she currently rates as "16/10". The team is trying to schedule a nuclear medicine study to rule out osteomyelitis and a possible I&D over the weekend. She is currently tolerating a regular diet.

- What is your differential for her leg pain?
- What is the difference between phantom pain and phantom sensation?

Case history, continued:

You review her bedside chart and learn that although initially prescribed oxycodone, her oncologist now manages her pain with Tylenol and NSAIDS only, due to multiple drug-related incarcerations and her own heroine use.

- What are your initial concerns?
- What other information would you gather before seeing this patient?
- Would you consider withholding opiates all together in this patient?

- How do you balance the need for proper analgesia versus concerns about active drug use, drug seeking behavior and withdrawal?
- What is pseudoaddiction and addiction?
- What is the difference between tolerance and dependence and tachyphylaxis?
- How will you evaluate for drug dependence?
- How would you evaluate for addiction?

Case history, continued:

As you are about to enter the room, her nurse tells you that the patient has been yelling insults to the staff and refuses to speak to her doctors unless she gets her "oxy". She adds, "By the way, her urine drug test from the ED is (+) for heroine and methamphetamine".

- Is this patient at risk for withdrawal?
- How will you evaluate this risk?
- How can urine toxicology help you predict withdrawal?
- How does urine toxicology work?

Case history, continued:

You enter the patient's room and try to your best to appear non-judgemental and nonthreatening but the patient hides under the covers and tells you to get out of the room.

- How will you avoid antagonizing this patient even further?
- How will you deal with this patient? How will you disclose the urine drug test results?
- Is there a place for a pain contract for such inpatients?

Case history, exciting conclusion:

You leave the room realizing that this patient is not going to engage. On your way out you tell the bedside nurse that you will touch base with the primary team. Feeling frustrated with the encounter, you head back to the anesthesia lounge to soothe yourself with some cookies. There, you run into one of your anesthesia colleagues who asks if you have been consulted on a "cancer patient with a positive Utox coming to the OR for a hip disarticulation". As he starts to give you more detail, you learn that her abscess is actually blocked lymphatics from cancer recurrence. "She is going to be your project" he teases. Later, you are called by the primary team to give recommendations for postoperative pain management.

- What is you perioperative pain plan for her upcoming surgery? Please consider preoperative, intraoperative, postoperative pain strategies
- Would you tell the team to send this patient home with an outpatient prescription of oxycodone?

Discussion:

The health care provider is ethically and legally bound to believe that pain is real when it is reported by a patient, err on the side of compassion, and treat the pain, unless evidence to the contrary exists. The same principles of pain management that guide care of the non-addicted should be applied to the addicted patient:

(1) Assess the pain and treat the underlying pathology,
(2) choose the appropriate analgesic therapy and individualize each patient's regimen,
(3) evaluate the response to the pain in an ongoing manner and change the drug, interval, dose, route, or modality as needed,
(4) choose the least invasive route of administration available, and
(5) the right dose is whatever it takes to relieve the pain with the fewest side effects.

Assessment, acute treatment and long-term management of acute on chronic pain is challenging. When patient's present with history and behavior consistent with substance abuse or dependence, the situation becomes especially complex. Part of the difficulty is in getting past societal (or personal) biases toward inappropriate use of medications. Much of the challenge, however, is pharmacologic in nature. We must balance the need for analgesia with avoidance of side effects—understandng also the real possibility of altered sensorium/ nerve function in the patient—and work to devise a plan that works for the patient, family, nursing staff, other providers, and will safely be executable within the care environment in which you are practicing. Ideally this will also come with a long-term follow-up plan to assist with transition of the patient to a stable regimen and addressing his or her long term needs with respect to substance use and pain.

In order to successfully navigate this challenging milieu, it is important for clinician's to be complete in their pain assessment, familiar with how to evaluate for substance abuse and dependence, accurate in their application of terminology related to altered nerve function/ pain sensation, facile with the selection and administration of various pain management modalities, and excellent communicators with the patient and all other parties along the way.

References:

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