Beware of Relapse Risk When Treating Postsurgical Pain

ABSTRACT

Recovering addicts are susceptible to relapse after medical interventions for pain management, including surgery. In 2017, it was estimated that 26 to 36 million people worldwide abuse opiates.

Max Baker: Recovering heroin addict relapsed after undergoing surgery

A car accident resulted in injuries that required surgery. He informed the surgeon about his addiction, and that he was scared that medication used for anaesthesia and pain might cause a relapse.

The anaesthesiologist quoted research that shows that opioid-dependent patients who are on relapse prevention drugs (like buprenorphine/naloxone) do fine with anaesthesia and opioid painkillers afterward. But Max was no longer taking buprenorphine/naloxone — he'd been off that medication for a year.

The anaesthesiologist wound up using the normal drug cocktail to sedate Max for the surgery, a mix of drugs that included opioids. The surgery went well. To manage subsequent pain, the surgeon prescribed Max just a small amount of hydrocodone/paracetamol. Less than a month later, Max died of a heroin overdose. He was 23 years old.

There's no way of knowing what triggered the relapse. Had he come off the buprenorphine/naloxone treatment for his addiction too soon? Did the opioids give him a taste of the drugs he'd previously managed to kick, enough of a taste to relaunch the cravings? Or was he trying to self-medicate, to ease his physical pain from the car accident and surgery and simply took too much? Dr Shenko, the hand surgeon, has been asking himself those questions. He now thinks hospital surgeons and anaesthesiologists need to have ready access to addiction specialists, even before the surgery.

ABOUT THE AUTHORS

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Dheelan Naidoo: Over a year clean and sober before heart surgery

"On 27 November 2013, whilst I was on my way to work, I had my first heart attack. At the hospital the doctors started to treat me immediately. All I could gather was that my Heart Enzyme level was 2000 and that I was critical. I remember telling my wife to tell the doctors that I am in recovery and that I could not take mood-altering drugs. They brushed her aside and looking back now, I cannot say that I blame them. They were trying to save my life and that was all that mattered at that point in time.

A day later I experienced that proverbial "pink cloud" and I knew that I had already relapsed and I wanted more. The actual pain was doubled and tripled to get more and more drugs. Pethadine and morphine were like music to my ears. I underwent a quadruple heart bypass on 2 December 2013. The operation lasted seven hours and after a day I was in high care. In high care, I did not have to ask for anything because I was on a permanent high.

After two weeks I was discharged. All drugs were at my disposal and were justified because I was swimming in a pool of self-pity and now for the first time in addiction, people actually wanted to help me get the next fix. I loved every minute of it. Oxycodone became my drug of choice.

I was taking oxycodone until it almost killed me and all the pity soon turned into anger. Once again, I was a slave to the drug. I had it fixated in my head that if I did not have the drug I was surely going to die. Medical practitioners who once embraced me now threatened me with police action. The progressive nature of

this disease amazed me I was once again a person that nobody wanted around. I almost lost my family, my job and my life. Nobody cared about my 'pity party' and three months later I reached out for help. I was very fortunate to get help. I was re-admitted to Tranquility Home Rehab Clinic. I am now seven years clean and sober."

Opioids for chronic pain

Although opioids can reduce short-term pain and can effectively relieve pain for patients with active cancer or others in hospice or palliative care, studies have not been conducted to determine if opioids control chronic pain long-term. Opioids can have serious risks, and there is evidence that other treatments can be effective with less harm.

Successful pain management, while complicated by substance abuse activity or history, can generally be accomplished in primary care settings. Recognition and attention to withdrawal concerns, relapse triggers and comorbid conditions are essential, as is proactive support for long-term recovery.

The US CDC Guideline addresses patient-centred clinical practices including conducting thorough assessments, considering all possible treatments, closely monitoring risks and safely discontinuing opioids.

The Guideline is not intended for patients who are in active cancer treatment, palliative care or end-of-life care. The three main focus areas in the Guideline include:

Determining when to initiate or continue opioids for chronic pain

a. Opiates should not necessarily be the first line of therapy. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Nonpharmacologic therapies and nonopioid medications include:

- Nonopioid medications such as paracetamol, ibuprofen or certain medications that are also used for depression or seizures.
- Physical treatments (exercise therapy, weight loss, acupuncture, chiropractic, etc).
- Cognitive behavioural therapy.
- Interventional treatments (injections).

b. Establishment of treatment goals: Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

c. Discussion of risks and benefits of therapy with patients.

Considerations when prescribing opioids

a. Selection of immediate-release or extended-release and long-acting opioids.

a. Dosage considerations.

b. Duration of treatment.

c. Considerations for follow-up and discontinuation of opioid therapy.

Assessing risk and addressing harms of opioid use

a. Evaluation of risk factors for opioid-related harms and ways to mitigate patient risk.

b. Review of prescription drug monitoring programme data.

c. Use of urine drug testing.

d. Considerations for co-prescribing benzodiazepines.

e. Arrangement of treatment for opioid-use disorder.