

Urine Drug Testing In Pain Management

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Decade of Pain Management

- 2000-2010
- Increased awareness of undertreated pain
- Educational efforts
- Opioid-phobia coined
- APS/AAPM developed position statements regarding chronic opioid therapy (COT)
- Resulted increased availability of opioids

Percentage of US consumption of world's opioid production

hydrocodone	99
oxycodone	80
methadone	58
hydromorphone	54
fentanyl	49
merperidine	43

Unanticipated Consequences

- National epidemic of non-medical opioid use
- Economic burden from prescription opioid abuse to be a minimum of \$9.5 billion in 2005 (Birnbaum 2006)

Unanticipated Consequences

- 18.9% of opioid deaths from prescriptions
- 12.6% for heroin
- 3 fold increase abuse
- 2/3 of abused opioids from a valid Rx
- 1/5 obtained from multiple MDs (doctor shopping)
- 50-60% entering opioid treatment got opioids from their physician
 - Failure to exhaust conservative care prior to COT, poor risk assessment and monitoring once COT are started

Unanticipated Consequences

- 1992-2003 number of people admitting opioid abuse increase 94% while population grew 14%
- Opioid abuse growth in ages 12-17 years old age group grew by 542%

NCASA

Unanticipated Consequences

- 70% psychosocial comorbidities in chronic pain population (Manchiknti 2004)
- COT is growing faster in patients with mental health disorders and histories of substance abuse (Deyo 2009)
- Unstable psychosocial comorbidities are risk for non-medical use of controlled substances
- Prevalence of addiction 3-16% (general population) Savage

COT

- Pain is subjective
- Must rely on self-report
- Addicted individual will not provide reliable information if it will result in discontinuation of their drug of choice
- Self-report of drug use in pain population is unreliable (Katz 2002)

COT

- Must rely on subjective and objective report
- Objective observations are:
 - Pill counts
 - Prescription monitoring programs
 - UDT
 - Aberrant behaviors

Aberrant Behaviors

- Self-escalation
- Lost or stolen controlled medications
- Treatment non-compliance
- Behavioral monitoring alone is inadequate
- Aberrant UDT
 - Illicit substances
 - Non-prescribed controlled substances
 - Absence of prescribed controlled substance(s)

Differential Diagnoses of Aberrant Drug Taking Behavior

Addiction

Pseudoaddiction

Chemical coping

Organic mental syndrome

Personality disorder

Self-medicating comorbid psychosocial condition
depression, anxiety, stressors

Criminal intent

Incidence of Aberrant UDT

• Cook RF,	1995	50%
• Fishbain DA,	1999	46.5%
• Hariharin J,	2007	38%
• Ives TJ,	2006	32%
• Berndt S,	1993	32%
• Katz NP,	2003	29%
• Michna E,	2007	45%
• West R ,	2010	9-33%
• Manchikanti L,	2006b	16%

COT

- Controversial treatment
- No long term data
- Available data typically uses inadequate metrics
- Prescription abuse at epidemic levels
- COT must be used cautiously

COT Risk Assessment

- Texas Medical Board (TMB) rule 170.3(a)(1)(B)(v)

Known Risk Factors:

- Personal/family history of substance abuse or ETOH
- Age <45
- Nicotine dependency
- Impulse control problems
 - ADD, OCD, Bipolar, Schizophrenia, Personality Disorders
- Hypervigilance states
 - PTSD, Preadolescent sexual abuse
- Somatoform disorders
- Organic mental syndrome
- Pain after a motor vehicle accident
- Pain involving more than three regions of the body
 - Webster 2005, Manchikanti 2006a

Risk Assessment Tools

- ORT (Opioid Risk Tool),
- PMQ (Pain Medication Questionnaire),
- DIRE (Diagnosis, Intractability, Risk, Efficacy Score)
- SOAPP-R (revised Screener and Opioid Assessment for Patients with Pain)
- Formal psychological assessment
- Risk divided into high, moderate, and low

Risk Assessment Tools

- Behavioral monitoring alone is inadequate
- Risk assessment tools (best sensitivity is 77%)
- Patient self-report is unreliable
- Incidence of aberrant UDT involves significant minority
- UDT is essential tool
- How should UDT be applied?

Instrument Sensitivity

	Low Risk	High Risk
SOAPP-R	30 (23%)	102 (77%)
Psychologist	40 (30%)	92 (70%)
PMQ	74 (56%)	58 (44%)
ORT	94 (71%)	38 (29%)

Application of UDT

- Recommended Risk Tool is SOAPP-R
- Point of care testing
 - Problematic
 - Abused
 - Requires confirmatory testing
 - Reserve use for rare
- Confirmatory testing
 - Use experienced lab
 - Mass spectroscopy
 - Low cut off levels
 - Not same test as employment testing



"You're fired, Jack. The lab results just came back, and you tested positive for Coke."

Application of UDT

- Low Risk 1 to 2 UDT per year
- Moderate Risk 3 to 4 UDT per year
- High Risk 4 to every visit or refill
 - Obtain baseline UDT
 - Random UDT based on risk profile
 - Risk profile may be changed

Corrective Action

- Repeat UDT
- Counseling
- Interval dosing
- Limit opioid availability
- Psychological evaluation
- Addictionology evaluation
- Discontinuation of COT
 - Decision requires comprehensive documentation
 - Document, Document, Document

Conclusion

- COT is controversial and challenging
- Opioid abuse is common
- Patient self-report is unreliable, Truth bias
- Behavioral monitoring alone will miss many aberrant drug taking behaviors
- Many abused opioids come from legitimate RX
- We will be deceived on occasion
- UDT will help

Conclusion

- Risk stratification should help monitor for aberrant drug taking behaviors without being abusive to third party payers
- Other helpful strategies
 - Behavioral monitoring
 - Prescription monitoring program