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Case Report

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Pluri Psychopathology and Risk of Opioid Use Disorder

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Abstract

Background: *Psychiatric comorbidty is an important risk factor when predicting risk of opioid use disorder in chronic non-cancer pain. We present a case with gender dysphoria, in wich psychiatric comorbidity was not taken into account for de prescription of pharmacological treatment for pain.*

Case presentation: *We report the case of a 51-year-old man with gender dysphoria, personality disorder, chronic pain disorder and opioid use disorder. For the last 9 years he has taken continuousy transdermal fentanyl prescribed by chronic non-cancer pain. Despite of presenting a pluripathology that discouraged the use of opioids in this patient, throughout his evolution, he has gone to different non-psychiatrists and has shown himself with a querulous, confictive and demanding attitude, so that he managed to keep on raising his dose of prescribed opioids.*

Conclusions: *This case shows the importance of knowing the risk factors of consumption due to the use of opioids patients with chronic non-cancer pain, the importance of psychiatric comorbidity associated with prognosis and the neeed to know exactly how opioids are managed by some prescribers, as well as to carry out an interdisciplinary therapeutic plan to avoid risks.*

Keywords: Chronic Non-Cancer Pain, Buprenorphine, Gender Dysphoria, Opioid Use Disorder, Risk Factors.

Abbreviations

ABU: Addictive Behavior Unit
ADPD: abuse or depend on prescription drugs
BUP/NAL: Buprenorfina/Naloxona
CNCP: Chronic Non-Cancer Pain
COMM, current Opioid Misuse Measure
DIRE: Diagnosis, Intractability, Risk, Efficacy score
FM: fibromialgia
SOAPP: Screening goes Opioid Assessment for Patients with Pain
ORT: Opioid Risk Tool
OWS: Opioid Withdrawal Syndrome
PU: Pain Unit
VAS: Visual Analog Scale.

Background

The prescription of opioids in chronic non-cancer pain is not always correct. Usually we find prescribed opioids in patients with FM or somatoform disorders and, it is also usual for a specialist to prescribe opioids, but that the follow-up is done in the health care center. That's why there are several prescribers. Plus, there are clinicians who prioritize pain as "the fifth vital sign". Above comorbid psychopathology, partly justified by the high prevalence of psychopathology in patients with Chronic Non-Cancer Pain (CNCP). In the case of our area, given the increase in fentanyl prescription in CNCP, the Pain Unit (PU) works together with the Department of Psychiatry to detect possible cases of opioid consumption disorder and treat them. We show an example.

Case Presentation

A 51-year-old Spanish man who presented gender dysphoria, mood disorder, personality disorder and opioid use disorder, because of hist 9 year of continuous intake of transdermal fentanyl prescribed by Rheumatology. He was referred to the psychiatry clinic, because he had no follow-up at that time for Mental Health (he had left the follow-up) and was being treated by the PU, when he presented CNCP, not responding to treatment. The reason for the referral was to perform psychopathological assessment, treatment if needed, and assess a possible rotation of fentanyl to buprenorphine / naloxone (BUP/NAL).

The patient personal history goes as follow

Allergic to metamizole, acetylsalicylic acid and pyrazolones
Bronchial hype-reactivity syndrome
Contact with Tuberculosis at 10 years with chemoprophylaxis
Recurrent urinary tract infections
Hiatus hernia; polyarthralgia; calcific tendinitis of the left shoulder
Chronic left cervico-brachialgia; herniated disc C4-C5 and C5-C6
Fibromyalgia (FM)
Arthroscopy of both knees by meniscopathy twice

Right knee arthroplasty in 2015 that required rehabilitation with poor functional outcome
Ligamentoplasty in the right knee
Transsexuality surgery
Bilateral mastectomy in 1997 and hysterectomy in 2001. (Treatment with hormone therapy since 1997).

He had psychiatric follow-up since 2008, according to previous reports he had dysfunctional personality traits and Dysthymia, with poor therapeutic adherence and conflicts with different physicians. Attempt of autolysis through autointoxication and venolysis in the youth that relates with bad acceptance by his father of his sexual condition.

Nicotine smoker of 8 cigarettes / day from 17 years; Cannabis use at 17 years (does not specify quantity), abstaining for 10 years.

No family history of interest

He came to me accompanied by his wife, with a two-hour delay. He doesn't have any children. He is the oldest of 3 brothers. Unemployed for more than 5 years, (he made an effort to demonstrate his functional limitations). He has a subsidy for physical disability.

He reported onset of affective discomfort at age 22. The relationship with the moment is that he assumed his identity and sexual condition. Likewise, he describes problems with the family for this reason. He had previously started cannabis use at age 17. Throughout his biography he had presented conflicting behaviors with the environment, a tendency to externalize guilt, he did not assume or assume responsibility for his actions, having a feeling of emptiness, low tolerance for frustration and stagnation in the role of victim. In his early years of youth, he justified this victimization due to his process of sex change and in later years, he justifies it with a belligerent and querulous attitude towards the health environment, blaming the pain suffered in recent years.

He referred the onset of pain at 23 years, with focus on lumbar at that time and subsequent diffuse involvement, being at the present time a generalized complaint, without focus.

Diagnosed 7 years ago from FM, he referred VAS: 9/10 (Visual Analog Scale) in the scan. At that time taking transdermal fentanyl 200mcg /72h. He reported opioid use more than 9 years ago, based on Rheumatology and PU.

He reported that he had moderate opioid withdrawal syndrome (OWS) at 40 hours after the administration of the fentanyl patch, with tolerance phenomena and associated hyperalgesia.

Results of the scales made in consultation: COMM >9, DIRE <7. The patient was diagnosed with: Gender Dysphoria, Borderline Personality Disorder, Opioid Use Disorder, Cannabis Use Disorder and Somatoform Disorder with persistent pain. As a therapeutic plan, referral to psychotherapy and inclusion in the program of rotation of opioids in CNCP with BUP / NAL was proposed, but the patient preferred to postpone the decision until further consultation.

He left again the follow-up consultations and, after 6 months, he requested by his own initiative to rotate opioids. After this and with previously signed informed consent as indicated, he had fentanyl suspended 200 mcg more than 12 hours ago, for induction with BUP / NAL on an outpatient basis in the Addictive Behavior Unit (ABU).

On examination, symptoms of withdrawal, anxiety, sweating, tremors, myalgias and spasms of the lower limbs appear. At the beginning, 0.4 mg of Buprenorphine was administered, giving rise to the symptoms of abstinence. Three hours later, he returned with withdrawal symptoms (tremors and anxiety), administering another 2 sublingual tablets (total 0.4 mg of Buprenorphine). One hour later, OWS persisted and was administered half a tablet of BUP / NAL (equivalent to 2mg of Buprenorphine), determining the following guideline: BUP / NAL 2 / 0.5mg half a tablet every 6 hours and total suspension of fentanyl. He was instructed to go to ABU daily until dose stabilization. The next day dose was adjusted, resulting in BUP / NAL 8 / 2mg half tablet every 8 hours. This pattern was maintained until its next revision in consultation. VAS 5/10 in that consultation, then, he again left the follow-up in Psychiatry. He has not returned to the Pain Unit either.

Discussion

Chronic pain and abuse of prescription opioids are extremely common worldwide [1]. Although no absolute contraindication has been established for the use of these drugs in the treatment of pain, there is evidence that in certain cases it is advisable to avoid their use [2]. As a general rule, for the treatment of non-oncological chronic pain, it is recommended to follow the analgesic scale with a progressive approach, elaborating an individualized treatment plan that includes, from the beginning, pharmacological and non-pharmacological measures [3]. Opioids should be considered as a chronic-based treatment only if there is a low risk of developing substance abuse disorder and the persistence of pain has not responded to treatment with non-opioid analgesics and antidepressants doses [4]. Opioids should only be maintained in continuation treatment when it has been well demonstrated that there is efficacy in terms of pain (after having made a therapeutic trial). When possible, opioids should be combined with non-pharmacological therapies and non-opioid drugs at the lowest dose that achieves effectiveness [3]. Before starting opioid treatment in chronic non-cancer pain, clinicians should expose patients to the risks of overdose and developing an opioid use disorder [5]. In addition, another of the important points of the therapy is to assess the risk / benefit of the prescription. Because it is difficult to predict who will abuse opioid medications, universal risk assessment is strongly recommended, which means that all patients, including patients without prior opioid treatment, should be evaluated for possible risk of abuse [6,7]. There are instruments to identify those patients with potential risk of misuse / abuse of opioids prescribed at the beginning of treatment: The Screening goes Opioid Assessment for Patients with Pain (SOAPP); The Opioid Risk Tool (ORT). These instruments are not diagnostic tools. In general, the questionnaires only have an indicative value. The clinical interview is the most sensitive when predicting risk [8,9].

Risk assessment tools during treatment are the current Opioid Misuse Measure (COMM) can help to identify patients who during long-term opioid treatment show aberrant behavior with misuse of mediation and the Diagnosis, Intractability, Risk, Efficacy (DIRE) store. DIRE was designed to predict analgesia and adherence during long-term treatment, but it can also be used during its continuation [10].

Risk factors associated with the development of prescribed opioid consumption disorder include factors such as age, sex, functionality in daily life, psychiatric comorbidity and personal history of

substance use. In addition, the low pain tolerance in patients with active or past addictions also seems to be related to opioid misuse. It is not known if the low pain threshold increases the risk of addiction or the addiction itself decreases pain thresholds. Regardless of the reason, treating pain is a challenge in these patients. Previous studies indicate that people who are younger; single; unemployed; have a lower level of education; have bad/good health; and consuming tobacco, alcohol and illicit drugs are more likely to participate in the abuse or depend on prescription drugs (ADPD) [1].

Combinig these variables (age, depression, psychotropic medications and pain deterioration) the risk for opioid dependence increases, compared to individuals without these factors (OR = 8.01, P <0.001) [11]. Also, presenting chronic physical conditions (arteriosclerosis or hypertension, cardiovascular disease, arthritis, and any evaluated medical condition) were associated with the onset of opioid abuse / dependence, even after controlling for sociodemographic factors and mental disorders of the Axis I and II, emphasizing the need for careful screening practices when prescribing opioids [12]. In the same way, the use of tobacco was associated with an increased risk of ADPD as demonstrated by multiple studies [13-15]. A history of mood disorders, psychological problems and psychosocial stressors increases the risk of misuse of prescription opioids. Multiple studies [16-18] have reported a consistent association between psychiatric morbidity and the misuse of prescription opioids in patients with chronic pain.

The most consistent variable that has been associated with the misuse of prescription opiates is a history of substance use disorders (SUD) [19]. Patients with chronic pain have high rates of comorbid SUD. Up to one third of patients with chronic pain seen in primary care, and 8-35% in pain clinics, have a current TUS [20]. Interestingly, patients at increased risk of misuse of prescription opioids reported more pain and deterioration, symptoms of depression and were more likely to have current SUD, compared to patients with lower risk of misuse of prescription opiates.

Although prescribed opioid use disorders are approximately four times more frequent than Heroin use disorders, research on the results of specific treatment for the use of prescription opioids disorders are limited, and the extent to which treatments developed for the use of opioids are limited. Heroin dependence can be successfully generalized to prescription opioid dependence is unclear [21]. In the absence of specific protocols for prescribed opioid use disorders, most treatment facilities differ from the accumulated evidence base with respect to treatment options for opioid use disorders more widely. Treatment for opioid use disorders generally involves medically supervised detoxification followed by maintenance with opioid substitution therapies [22]. Opioid replacement therapy involves the administration of controlled amounts of longer acting opioids with less euphoric effects in an effort to reduce cravings and prevent withdrawal symptoms.

Substitution therapy often involves the use of long-term medications, or even for life [23]. The two most common substitution therapies are methadone and buprenorphine. In 2002, the FDA approved the administration of buprenorphine in the office, and in 2012, 51% of the opioid treatment programs (www.buprenorphine.samhsa.gov) offered buprenorphine [24]. Because it is a partial mu agonist, buprenorphine is associated with less euphoria and sedative effects than methadone and has been shown to decrease abstinence, hospital admissions, morbidity and mortality among patients with opioid use disorders [25]. Studies suggest that the results of buprenorphine (at 8 mg / day sublingually) are superior to placebo, and similar to daily doses of 50-60 mg per day of methadone [26]. Similar to methadone maintenance therapy, buprenorphine therapy can be maintained for years.

Conclusion

This clinical case shows the importance of knowing the risk factors of consumption due to the use of opioids in patients with chronic non-cancer pain, the importance of the psychiatric comorbidity associated with the prognosis and the need to know exactly how opioids are managed by prescribers, as well as to carry out an interdisciplinary therapeutic plan to avoid risks.

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