TREATMENT PLAN

The patient’s primary care physician prescribed oxycodone with acetaminophen 5 mg/325 mg 1 every 6 hours as needed, and a tricyclic antidepressant (TCA) amitriptyline 25 mg once every bedtime (most commonly seen TCA for pain) as an adjunctive agent. At the pharmacy, the patient asked to fill only the opioid prescription. After researching his medications at home using the Internet, he did not want to take the TCA because he “isn’t depressed and doesn’t need an antidepressant.” The pharmacist explained that the tricyclic has not been prescribed for depression, but to increase the efficacy of the pain reliever. By combining an opioid, a nonopioid analgesic (in this case, acetaminophen), and a TCA, the patient’s physician plans to suppress pain by several different mechanisms, which should result in greater pain relief with less risk of adverse effects.

The pharmacist reviewed the potential adverse effects of treatment with the patient, and noted that opioid-induced sedation and nausea usually decline soon after beginning treatment. The patient was instructed to reduce the frequency of dosing during the first 1 to 2 days if these effects were severe. The pharmacist also emphasized that the opioid is likely to cause constipation, and recommended a bowel regimen consisting of a combination tablet containing senna (a natural vegetable laxative) and docusate sodium (a stool softener), at a dose of 8.6 mg/50 mg taken 1 to 2 times daily depending on need. The patient was reminded to drink several 8-ounce glasses of water per day while using this product.

OUTCOME AND FOLLOW-UP

The patient attained generally good pain relief during the first 2 hours after each oxycodone/acetaminophen dose, but he experienced increasing pain at the end of each dose. His wife noticed increasing irritability and agitation while he waited for his next dose of medication. Both the patient and his wife became concerned that he was becoming addicted to his pain medication, and he scheduled another appointment with his physician. His physician assured him that his behavior was a normal response to pain that is only
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partially treated, and was not a sign of addiction. The patient’s oxycodone/acetaminophen dose was increased to 5 mg/325 mg, 1 to 2 tablets every 4 hours as needed for pain, in an attempt to eliminate end-of-dose failure (increased pain), while maintaining a dose that is below the 4 g per day maximum recommended for daily acetaminophen usage.

Two weeks later, the patient returned to the pharmacy to refill his prescription. His pharmacist performed a brief assessment of the patient’s pain relief and adverse effects with his new treatment regimen. This assessment includes both objective outcomes (eg, hours able to sleep without awakening and number of episodes of emesis) and subjective outcomes (eg, patient pain rating and complaints of nausea or sleepiness). The patient achieved good pain relief and reported few side effects. He was no longer troubled by nausea, vomiting, or dizziness, although he still experienced some mild sedation shortly after each dose.

He experienced significant constipation for a few days when he discontinued his bowel regimen, but his constipation resolved when he resumed treatment. His hip and back pain gradually improved over the next 2 weeks, and he was able to attain adequate pain relief with ibuprofen. His opioid dose was tapered (decreasing by 1–2 tablets each day) to prevent withdrawal symptoms, although this risk is generally low in patients using short-acting opioids for acute pain. After another week, his pain resolved completely.

DISCUSSION

Many individuals with pain first discuss their symptoms with a pharmacist. All patients should undergo a brief, focused assessment of the location, intensity, and character of the pain. Several rating scales and interviewing systems have been developed to assess pain, but the following questions should generally be included in all pain assessments:

- Where is the pain?
- When did the pain start?
- How often does the pain occur?
- What does the pain feel like?
- Has the pain intensity changed?
- What makes the pain better or worse?
- How does the pain affect your ability to function?
- What treatments have you tried in the past, and how well did they work?²

Thorough patient education is essential to attain the best possible outcomes for patients using opioids for acute pain. Many patients are treated with combinations of medications that act by different mechanisms, and it is essential that patients understand the role that each plays in the pain management strategy. Patients must also understand the expected adverse effects of opioid analgesics and any adjunctive therapies. Although tolerance to sedation, nausea, and respiratory depression usually develop quickly, constipation typically persists for as long as patients are taking opioids. A bowel regimen combining a stool softener and a stimulant laxative is required for all patients taking opioids.³

Although patients are often concerned about the risk of addiction with opioids, addiction is a primary neurobiological disease that is very unlikely to occur in individuals with no history of substance use problems who are using opioids for acute pain.³ Withdrawal symptoms may occur with the abrupt discontinuation of opioids, but this is not a symptom of addiction. Withdrawal symptoms may be avoided by gradually tapering the opioid dose before treatment is discontinued. Opioids given on a regular schedule over a period of time can easily cause an abstinence syndrome. For example, if the patient had been taking 2 hydrocodone tablets every 4 hours for 2 to 4 weeks, he probably would have experienced some withdrawal symptoms. It is important to discuss this syndrome when dispensing opioid pain relievers because patients who do not understand the potential for withdrawal symptoms may believe that they are becoming addicted. They often will not mention this to their healthcare providers and carry an unfortunate misperception of their “problem.” The distinction between dependence and addiction is not clearly understood by most patients, or even by many healthcare providers. Tapering an acute opioid treatment regimen is usually a natural process that occurs as the pain lessens and the patient takes less pain medication. Therefore, many patients do not notice that a dependence syndrome has developed.

Many opioids are available for the treatment of acute pain. With the exception of a small number of relatively high-risk agents (eg, meperidine or propoxyphene, which produce potentially dangerous active metabolites), there is little evidence that the different opioids vary significantly in their adverse event profiles. New treatment alternatives continue to
become available for patients with pain. For example, new formulations of established analgesics (eg, sublingual sufentanil and iontophoretic transdermal fentanyl) have been developed to improve pain relief for surgical patients. Tapentadol, an investigational analgesic that combines μ opioid receptor agonism with norepinephrine reuptake inhibition, may provide pain relief that is similar to morphine but with a lower incidence of adverse events. Ongoing randomized controlled clinical trials will continue to define the role of these new agents in the management of acute pain.

REFERENCES