

## OPIOID TREATMENT PROTOCOL

Reprint from: Anthony F. Kirkpatrick, MD, PhD, Manjul Derasari, MD, Peter L. Kovacs, MD, Bruce D. Lamb, JD, Robert Miller, PhD, Anthony Reading, MD. A Protocol-Contract for Opioid Use in Patients with Chronic Pain Not Due to Malignancy. *J. Clin. Anesth.* 1998;10:441-443.

Patient's Name: \_\_\_\_\_

The use of opioids (also called narcotics) to treat patients dying from cancer is well-established. However, the use of opioids to treat non-cancer patients suffering from chronic pain is controversial. The opioid you will be taking is called \_\_\_\_\_. This opioid is designated as a controlled substance by the U.S. Drug Enforcement Agency (which means the drug has the potential for abuse, addiction, and illegal diversion).

The purpose of this contract is to summarize an agreement among all parties involved in the care of the above named patient. The ultimate responsibility for management of the patient's chronic pain is placed upon the patient. Our responsibility is to help the patient to become as effective a manager of the pain experience as possible. The patient agrees to decrease reliance on opioid use as much as possible and to focus more on issues of minimizing suffering, changing attitudes and lifestyle, reducing disability, and accepting responsibility for one's own health destiny.

The patient will agree to the following (as indicated by the signature to this contract):

1. The patient will visit and be re-evaluated by the prescribing physician and the patient's psychologist (or psychiatrist) at least once every month during the initial trial period, unless notified by the physician involved. After the initial trial period, the patient will be re-evaluated at least once every 3 months. All re-evaluations will be scheduled appointments, not walk-in appointments.
2. There will be no change in the patient's prescriptions by telephone. The patient must appear in person and will not be allowed to change the dosing without prior authorization. One physician will assume responsibility for all pain medication, and no other physician(s) will prescribe them.
3. The patient will keep a daily record of all opioid tablets taken. This information will be provided to the prescribing physician and psychologist (or psychiatrist) in a summarized form, by the patient, at each office visit. In addition, at each visit, the patient will provide a list of all opioids in his or her possession to ensure that all opioids are accounted for.
4. The patient has agreed not to take the opioid tablets unless the pain limits the patient's function significantly or if the pain is severe. It is not appropriate for the patient to attempt total relief of the pain with opioid. To do so places the patient at increased risk of respiratory depression, sedation, nausea, constipation, and tolerance. A 50% reduction in pain is a realistic goal.
5. The patient must report significant side effects due to opioid; for example, over sedation, nausea, vomiting, constipation, confusion, euphoria (high feelings), and dysphoria (down feelings). There are other side effects which are very rare. These side effects, which may be related to opioid use, include nausea, vomiting, dizziness, sweating, respiratory depression, gastrointestinal upset, involuntary movements, jerks or tremors, headaches, weakness, seizures, bad dreams, muscle rigidity, transient hallucinations and disorientation, visual disturbances, insomnia,

- dry mouth, diarrhea, stomach cramps, taste alterations, flushing of face, decreased blood pressure, difficulty with urination, itching, skin rashes, and swelling of skin.
6. The goal in prescribing pain medications is to reduce the need for them in a reasonable amount of time. For example, the underlying pain may decrease over time, and the patient should attempt to learn safer ways to manage his or her pain (e.g., relaxation techniques, self hypnosis, biofeedback, etc.). Approximately every 6 months, the need for this medication will be re-evaluated and the patient agrees to attempt to reduce or discontinue the pain medication altogether.
  7. The patient understands that:
    - a. Patients who take opioids can potentially develop psychological and/or physical dependence and/or tolerance.
    - b. Opioids may impair mental and/or physical ability required for the performance of potentially hazardous tasks (e.g., driving, operating a machine).
    - c. Opioids should not be taken with alcohol or other CNS (central nervous system) depressants (sleep aids, tranquilizers) because addictive effects, including CNS depression, may occur. The physician prescribing the opioid should be consulted if other medications are currently being used or are prescribed for future use. Failure to report the use of any pain medications, other than those prescribed by this physician, shall be a breach of contract by the patient and constitutes sufficient cause for termination of this contract.
    - d. The patient understands that sometimes abrupt cessation or a sudden reduction in a dose of opioid after prolonged use may result in withdrawal symptoms (initial symptoms including sweating, gooseflesh, tearing of eyes, runny nose, yawning, restless sleep, and enlarged pupils). After 24 to 72 hours, the symptoms may include irritability, anxiety, weakness, twitching and spasm of muscle, diarrhea, kicking movements, severe backache, stomach (abdominal) and leg pain and cramps, hot and cold flashes, insomnia, nausea, loss of appetite, vomiting, increased body temperature, increased breathing rate, blood pressure, heart rate, and sneezing. Excessive loss of fluid from increased sweating, diarrhea, and vomiting may lead to severe dehydration. Death may occur. Without treatment, most symptoms from opioid withdrawal disappear in 5 to 14 days; Some symptoms such as insomnia, irritability and muscle aches, may last 2 to 6 months. After 72 hours of withdrawal, it is unlikely that withdrawal symptoms will worsen.
    - e. Tablets must be taken whole, and are not to be broken, chewed, or crushed. Otherwise, the opioid could be rapidly absorbed causing toxicity.
    - f. If the patient fails to comply with the requirements of this treatment protocol, the physician prescribing the opioid may discontinue the opioid at an appropriate rate (detoxification from opioid) and discontinue the doctor-patient relationship with the patient. Similarly, any unethical behavior by the patient will be grounds to discontinue the care of the patient (e.g., diversion or selling opioids to others or taking opioids for emotional reasons). The patient understands that he or she already has a chronic pain problem, and that we do not want to add a drug problem. The patient understands that successful treatment of the chronic pain will require more than pain medication; it will require learning new pain management strategies, increasing activity, and becoming as healthy as possible. One of the treatment goals for many patients is the eventual discontinuation of all opioids and other pain medications where advisable.
    - g. If the patient becomes stabilized on an effective dose of opioids, a primary care physician may assume the responsibility for the patient's care, including the writing of prescriptions for opioids. The patient will

follow the requirements dictated by the new physician who is prescribing the opioids.

- h. The patient agrees to the use of periodic drug screens to assure appropriate use of medications.

Treatment Protocol:

1. The patient will undergo a therapeutic trial with opioids to determine if he/she is a candidate for continued use.
2. Prescription of opioid will only be renewed on a monthly basis.
3. Confusion caused by the opioid, which cannot be controlled by adjustments of dosage, will be a basis for discontinuing its use and considering an alternative treatment.
4. Sedation without confusion may be treated by decreasing the dose of opioid.
5. It may be necessary to treat nausea and vomiting with Reglan 10 mg q6h or Compazine 10 mg q6h, by oral or rectal routes.
6. The patient may be treated for constipation by adjustment of diet or with:
  - a. Colace 200 mg b.i.d
  - b. Concurrent administration of Senokot, two tablets b.i.d. This may be increased to four tablets b.i.d. In addition, the patient may take Dulcolax suppositories, 1 PRN q daily.
7. The patient will actively pursue and document other non-medication methods of managing pain. These other methods may include relaxation training, self hypnosis, biofeedback, meditation, pool exercises, and/or any other modalities that may be helpful in reducing pain, increasing pain tolerance, or increasing levels of life-enhancing activities.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I, (the patient), have read, understood, and agreed to abide by the contents of this document.

\_\_\_\_\_

Prescribing Physician

\_\_\_\_\_

Psychologist (or Psychiatrist)