Care of the Patient with Co-Morbid Pain and Anxiety

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CASE 1

Anxiety, sedative hypnotics and alcohol use disorder

- 42-year-old single male treated by his PCP for 10 years for chronic anxiety and episodic panic attacks.
- Diagnosed with social anxiety disorder and panic disorder with agoraphobia, maintained on Fluoxetine (Prozac) 80 mg daily and Trazodone 150 mg for sleep.
- At the time of diagnosis averaging six-pack per day, more on weekends, with episodes of binging and blackouts.
- Failed repeated attempts to reduce his drinking and several detox admissions, 4 years ago he became active in AA and has not had not a drink since.
- Continued anxiety - started on clonazepam .5 mg bid 3 years ago

- Continued complaints of anxiety lead to gradual increase in clonazepam dosage to 1mg qid
- Continued complaints of anxiety and sleeplessness and increased isolation, work-related difficulties
- No return to use of alcohol, confirmed with family
- Increasing numbers and severity of panic attacks and requests for additional medication (requests prn alprazolam)
- Rejects PCPs suggested referral to Psychiatrist

- Visits a walk-in clinic and obtains prescription for Xanax at 1 mg three times a day.
- Next visit his PCP queried the CSRS. Alprazolam listed from another provider.
- Informed this was potentially harmful and outside treatment agreement; referral for evaluation of his benzodiazepine use was a condition of his continued care.
- His PCP has now initiated referral to you!

1. What psychosocial or pharmacological treatment is appropriate given the degree of alcohol use upon presentation 10 years ago?

A. All pharmacotherapy high risk in patients with active alcohol use disorder. Treatment of anxiety primarily with AA, counseling and lifestyle management.

B. Use of sedative-hypnotics might be useful but should be considered a short-term. Continue alcohol focused now on sedative misuse.

C. Use of benzodiazepines useful in reducing symptomatic anxiety, may assist with reducing harms of alcohol use.

D. Various non-scheduled medications such as SSRIs preferred in managing anxiety symptoms rather than drugs with reinforcing effects .

2. With stable sobriety what risks are involved in use of benzodiazepines for exacerbation of anxiety disorder? How would you respond to increasing complaints?

A. Benzodiazepines effective agents in treatment of anxiety disorder. Little evidence to support risk of alcohol relapse in this situation.

B. Benzodiazepines should be used with caution in patients with alcohol use disorder in remission; increased risk of relapse.

C. Use of any agent with reinforcing qualities is contraindicated for all patients with addictive disorders.

D. While generally considered risky, use in this circumstance is justified by the degree to which anxiety interferes with functioning.

3. Is use of increasing dosages of benzodiazepines within prescriptive parameters due to an underlying addictive process or inadequate treatment of the anxiety disorder?

A. Increased dosing of clonazepam was necessary and appropriate given continued anxiety. Pseudo-addiction.

B. Personal and family history suggests vulnerability to addictive substances and high risk for addiction to benzodiazepines. Offer enhanced monitoring while continuing use of benzodiazepines.

C. RR clearly addicted to benzodiazepines; using despite harmful consequences.

D. Benzodiazepines should not ever be used in patients with a history of addiction. Pharmacotherapy with non-scheduled agents might supplement counseling and support of AA.

4. What would you now recommend to this patient and his PCP?

A. This is a difficult situation but your management is optimal. Carry on.

B. Education about risk factors common to all addictions. Explain continued use of benzodiazepines only justified by attempts at non-drug treatment enabling discontinuation over the short term. Suggest return to AA; call his former sponsor.

C. Aggressive treatment of disabling anxiety is indicated and benzodiazepines should be continued.

D. The cycle of addiction is likely to progress and inpatient rehabilitative treatment indicated.

CASE 2

Chronic Pain, Depression, Opioid and Sedative hypnotics and alcohol use disorder

History

- Psych hx
  - Depression in his 20's follow first divorce, tx fluoxetine successfully for 3 years
  - Anxiety with occasional panic attacks in late 30's with work stressors, resolved
  - Mixed anxiety and depression following surgery and disability, some benefit from duloxetine 60mg per day currently
  - Currently poor concentration, energy, and lack of interests. Tends to be tired, sleeping 10 hrs per day "Kind of depressed I think. I am even crying with the stupid commercials. Hate it when I can't remember stuff". No active SI.
- SUD hx
  - ETOH heavily 17-28 y/o, 2 DUI, stopped with divorce, rare ETOH since then.
  - MRJ rare, tends to make him PI
  - Cocaine (powder) for 2 months in early 20's "liked it too much, won't use it"
  - Smoking half PPD, moved to "vape" last year

Medications

Currently

- MS contin 30mg bid
  - "Helps my pain but makes me tired some times"
- MSIR 15mg 4-5 per day
- Duloxetine 60mg
  - "Helps my mood, only bit of pain"
- Carisoprodol tid prn
- Alprazolam 1mg tid prn
  - Taking 1.5 to 2mg most days

Previous Trials

- Gabapentin
  - "too tired"
- Fluoxetine
  - "helped "
- Hydrocodone
  - "made me sick"
- Oxycodone/APAP
  - "worked for my pain when I was first hurt"
- Hydromorphone
  - "I was way tired"
- Paroxetine
  - "can't remember"

Next steps

- What do you want? What is in your way the most?
  - “I want to be able to do more and I can’t. My pain is too much and I am tired all the time.”
  - ASSESSMENT… opioid sedating and not working well enough for him. Consider rotation. Oxycodone has helped in the past.
  - PLAN.... Replace MS contin with 20mg oxycontin bid and MSIR with oxycodone 10mg qid prn
- On Recheck….
  - “I think my pain is maybe a bit better but I really feel jittery now. Last week I had a panic attack and I can’t sleep like I used to.”
  - ASSESSMENT... Stimulated by oxy, promoting anxiety and sleep reduction.
  - PLAN....Replace oxy with methadone 5-10mg bid and oxymorphone IR 5mg qid

- A month later
  - ”My back pain is better, not out of control as much, but my leg is acting up. I don’t have near as much anxiety, just some, and my sleep is better.”
  - ASSESSMENT…partial anxiety resolution, continued pain. Ongoing concern about opioid and benzo.
  - PLAN....replace xanax with Lyrica 75mg tid and consider increase in cymbalta to 90-120mg
- Further depression? Increase cymbalta vs wellbutrin vs savella vs lamictal
- Further anxiety? Increase lyrica vs cymbalta

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