# The analgesia tango

## Chronic pain cases from a general practice

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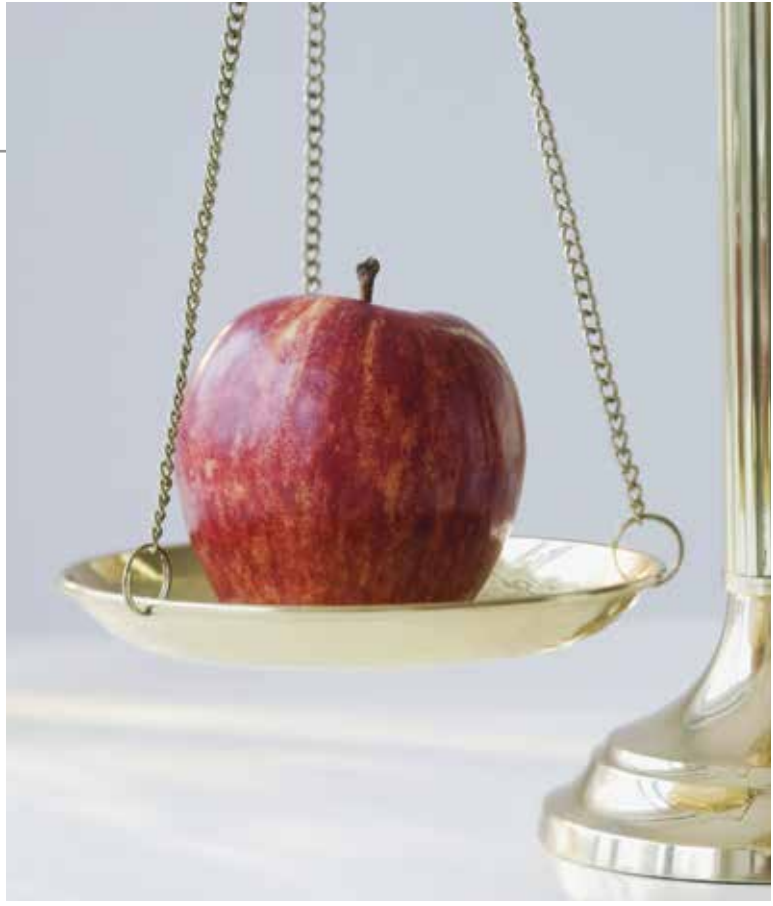
**Complex cases of patients with pain who have developed opioid dependence are often managed by GPs with a special interest and expertise in pain and addiction issues, with specialist advice as needed. Four complex cases of opioid dependence are discussed.**

### KEY POINTS

- **Opioids are indicated for acute analgesia, analgesia at the end of life and dependency management, and at times are prescribed for patients who have chronic pain resistant to other treatments.**
- **Opioid monotherapy for patients with chronic pain should not be relied on as the safety and efficacy of long-term use of opioids is not established. Other care for chronic pain should involve lifestyle and psychological management.**
- **The assessment and management of addictive behaviours requires a therapeutic, not a judgemental, approach.**
- **Addictive behaviours should determine how opioid analgesics are prescribed, rather than if they are prescribed. These behaviours determine the balance between usual prescribing and dispensing versus the structured approach of opioid substitution treatment.**
- **Training to become an authorised opioid substitution therapy prescriber may increase comfort about opioid management.**



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GPs face many clinical, ethical and regulatory challenges. These challenges often arise when treating patients with chronic nonmalignant pain. With the increasing use of pharmaceutical opioids, more patients are developing opioid dependence and need treatment for this as well as the condition for which they are taking the opioids. Opioid-dependent patients can be particularly demanding to treat, requiring quality time, and so may become our 'heartsink' patients. Becoming an authorised opioid substitution therapy (OST) prescriber should increase comfort about opioid management.

This article discusses several complex cases of patients with chronic pain who have developed dependence on their opioid analgesics. One author (SH) is a GP with expertise in the area of drugs and alcohol issues, and the other (WJ) is a GP with expertise in the medicolegal field. Here they reflect upon and discuss responses that ensure clinical safety and compliance with government regulations.

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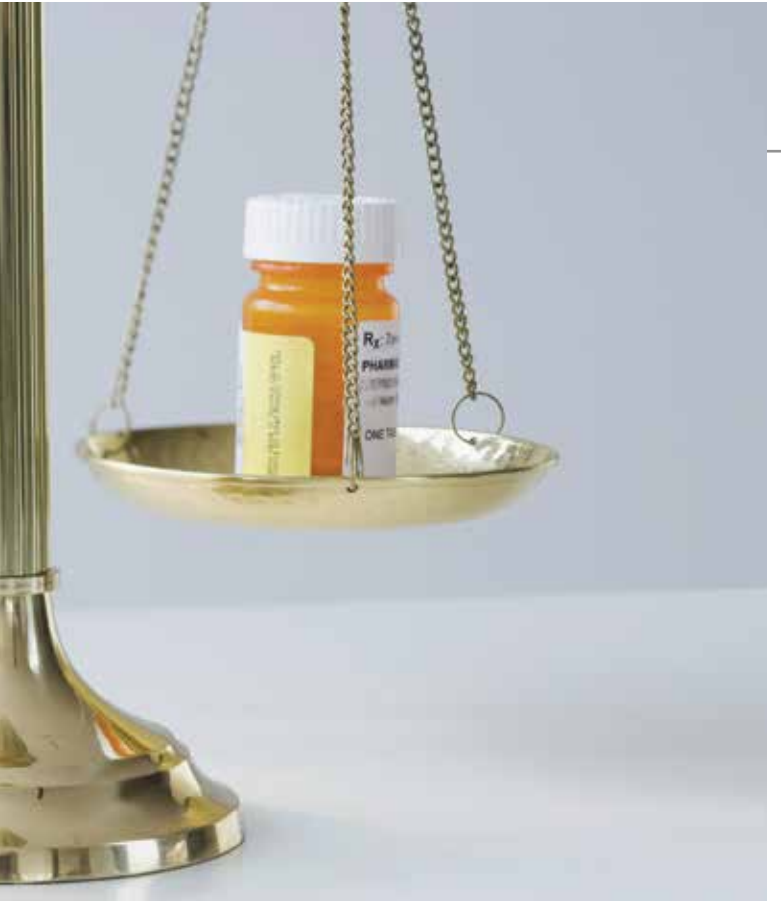

## Case 1

One Friday evening, before a long weekend, you are the only GP remaining in the surgery. A regular patient of a colleague telephoned reception late this afternoon and although there were no appointments she was told, as is the practice policy, that she would be seen if it was urgent.

The patient, 35-year-old Ms H, has now arrived in the surgery, with several of her very active children. She requests a prescription for her usual oxycodone tablets for her chronic neck and back pain, saying she needs it quickly, before the pharmacy closes. She explains that in response to leaving her violent partner, she prematurely ingested over the past few days a week's supply of the painkiller and the pharmacist would not dispense her next authority prescription. She says she is feeling dizzy and she is clearly distressed from her chronic pain.

### What would you do first?

Ask your receptionist to supervise the children in the waiting room so you can speak freely with Ms H.

First establish that Ms H has somewhere safe to stay with the children. If this is not the case, you must by law inform the police (given it is evening) or the Department of Community Services. The details of mandatory reporting requirements for domestic and family violence and child abuse vary between Australian states and territories. Are all the children with her now?

You then need to find out how Ms H is coping, especially with regard to her children. Could this ingestion of oxycodone be a cry for help, or even a failed suicide attempt? Is she significantly depressed? You need to explore her medical, psychiatric and drug and alcohol history, and then assess her chronic pain condition.

During the discussion you establish that Ms H's way of coping is to misuse her painkillers. Although you may suspect that this is 'drug-dependent' behaviour and that her dizziness may indicate oversedation, it could also quite reasonably be a cry for help. This needs to be discussed openly and empathetically with her.

### Assuming Ms H has somewhere safe to go and is coping, would you give her the script as requested?

Ms H is in a crisis situation. Saying 'no' to prescribing an opioid for a patient considered from their behaviour to be drug-dependent needs to be done with compassion and sensitivity and with an honest explanation. In such circumstances, saying 'yes' would be deemed unlawful. Unfortunately, compassion is no defence. In this situation you can explain to Ms H that you are concerned the opioids she has taken are making her dizzy and unwell and that she needs to be alert, given her home situation and the fact her young children depend on her. It is important to discuss with her other techniques for managing pain (e.g. heat, anti-inflammatories), as this emphasises that you understand her discomfort is genuine. If she insists on another prescription, you must tell her she needs to be assessed at the local hospital because it is not legal for you to prescribe opioids for her.

Ms H has many features that indicate problematic opioid use and there are multiple common factors associated with this, including concerns about domestic violence, possible homelessness, the welfare of her children and possible suicidality. A recent meta-analysis indicated that about one in four patients taking opioid analgesics long-term are misusers and one in 10 are addicted.[1] In the case of Ms H, there is clear misuse with her 'chemical coping' in the form of premature ingestion of her pills. Such behaviours would make it unlawful in all Australian states and territories to concede to her request for a prescription for oxycodone. Many doctors have been sanctioned for prescribing in such situations. You may feel more comfortable about refusing to prescribe opioids if a sign is placed in the waiting room stating no opioids are prescribed at a first consultation or without a comprehensive assessment.

This patient's need for an opioid prescription may seem compelling. However, it is safest for her and her children to see your colleague, who knows her well, as soon as possible. As this is an evening consultation there is little time for a detailed assessment and discussion about OST. Your colleague can also confirm Ms H's identity (if needed) and check for injection marks if you have not already done so, attempt to call any previous doctors and, if thought necessary, request a urine drug screen. He/she may also check the Prescription Shopping Information Service, although this is a delayed and limited service (http://www.humanservices.gov.au/health-professionals/services/prescription-shopping-information-service/). If you are in Tasmania, the Tasmanian Department of Health and Human Service's Electronic Recording and Reporting of Controlled Drugs service may be accessed.

Generally, it is not advisable to hand an opioid script to individuals at risk of dependency problems as some may forge an

**TABLE 1.** PHARMACEUTICAL SERVICES UNIT WEBSITES

| State | Useful websites |
|---|---|
| Australian Capital Territory | ACT Health: www.health.act.gov.au/public-information/businesses/pharmaceutical-services |
| New South Wales | NSW Ministry of Health: www.health.nsw.gov.au/pharmaceutical/doctors/Pages/default.aspx |
| Northern Territory | NT Department of Health: www.health.nt.gov.au/Environmental_Health/Medicines_and_Poisons_Control/index.aspx |
| Queensland | Queensland Health: www.health.qld.gov.au/clinical-practice/guidelines-procedures/medicines/default.asp |
| South Australia | SA Health: www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Clinical+resources |
| Tasmania | Tasmanian Department of Health and Human Services: www.dhhs.tas.gov.au/psbtas |
| Victoria | Victorian Department of Health & Human Services: www.health.vic.gov.au/dpcs/index.htm |
| Western Australia | Western Australia Department of Health: www.public.health.wa.gov.au/1/872/2/medicines_and_poisons.pm |

increased amount of the medication. Instead, telephone and then fax the managing pharmacy a one- or two-day script, contingent on daily doses being consumed at the pharmacy. Arrange a follow-up appointment for the patient in a day or so, allowing time for more detailed care. However, ask your staff to confirm on the day that the patient is still coming as they may only have wanted the script and not the supervision.

## 18 months later

Ms H had a car accident six months after your first consultation and her opioid doses have all increased since then. She is now, a year after her accident, taking paracetamol/codeine 500 mg/30 mg two tablets three times daily, oxycodone immediate-release 5 mg three times daily and oxycodone slow-release 20 mg twice daily. She has seen a rehabilitation specialist, who approved her opioid analgesics, and a neurosurgeon, who placed her on a surgical waiting list of several years' duration.

Ms H has been seeing all the doctors and locums at your practice and offers an impressive range of narratives requiring early scripts and preventing her from having blood tests, urine screens and routine health checks (including Pap smears) as requested. Today she sees you and states that all her Schedule 8 drugs were stolen from her house and so she needs the scripts repeated. You ask whether the crime has been reported to the police; she says she has done so and the police said they could do nothing as she had left a window open.

### *What would you do?*

You tell Ms H you want to support her by phoning the police yourself to add weight to her story but she interjects, claiming she meant to say she was going to contact the police. You invite her to go and report the crime to the police now, before continuing the consultation.

After her return, you tell Ms H that you are concerned about her apparent loss of control with her opiates. You advise her that a drug treatment program would be helpful. You explain the treatment and offer her methadone or buprenorphine–naloxone and she chooses the latter. You contact your state or territory health department pharmaceutical services unit and seek an authority/permit to prescribe her OST (Table 1; see Case 2 for discussion of dependency).

## The next few years

Over the next year, Ms H's presentations at the surgery decrease and become more orderly. Her care includes a Pap smear, serology for hepatitis B and C and vaccination for hepatitis B, and prescription of a range of coanalgesics. She is pleased to be more involved with her children.

After two and a half years of taking buprenorphine–naloxone, Ms H is generally stable and has no injection marks. Her pain and analgesia are now not dominating her life. This success is largely due to greater stability and support in her home life.

However, another year later Ms H reports increased domestic violence from her intermittently estranged de facto partner. On one occasion he accompanies her into the consulting room where he becomes demanding and belligerent before storming out of the surgery. You emphasise to him as he leaves that he is not to attend this surgery again, and that you will be forced to call the police if he does.

### *How would you manage this situation?*

You need to determine again whether Ms H or her children are in danger. She denies this and you tell her how to access a refuge or organise Apprehended Violence Orders if necessary.

## Missing appointments

At the next visit Ms H is very agitated about her oldest son who has been imprisoned recently. She is now repeatedly missing appointments, apparently to visit her son. You notice bruises on her left antecubital fossae, which she says are from being bitten by her pet lorikeet. You explain to her the bruises look as if the vein has been penetrated by a needle rather than by a bite from a bird, but she dismisses this. You now need to spend some time assessing her mental state and general coping skills. You need to ask her directly what medications (prescription and over-the-counter) and street drugs (if any) she is taking. You decrease the proportion of take-away doses of buprenorphine–naloxone she receives so she needs to

consume more under the supervision of the pharmacist.

The following month Ms H misses her appointment again. When she does present, she says her daughter's appendix had burst and while she was attending to this out of town she had to buy street buprenorphine–naloxone to stop withdrawal symptoms. You explain to her that, by law, she needs to obtain these medications only from you, as her registered prescriber, and that if she is ever again without these medications, she needs to present to a doctor or hospital and ask them to contact you. You remove all take-away privileges and shorten the duration of each script.

The pharmacist phones you a few days later to say Ms H refuses to dose correctly and keeps causing scenes, and that they believe she is doctor shopping again. A letter requesting a transfer of Ms H's notes then arrives from another practice. You notify your state's pharmaceutical services unit of her behaviour and of her transfer of care to the other practice.

### Re-presentation two years later

Ms H presents to you two years later, asking to be put on the buprenorphine–naloxone program again. She says she has been getting fentanyl patches regularly from her GP for her chronic pain, and has been injecting fentanyl extracted from these patches up to 30 times a day, topping up with street fentanyl and using heroin if there is no fentanyl available. She says she finds withdrawal from fentanyl far worse than from heroin. You note that she has many injection marks (Figure 1).

You contact Ms H's GP, who says Ms H has been doing well and expresses surprise that you believe she is opioid-dependent and needs treatment for this. The GP is unaware that Ms H has received OST before. Furthermore, the GP had checked with the Prescription Shopping Information Service, registered Ms H with the state health authority and had been reducing her fentanyl dose. The GP had not referred her to the local drug and alcohol services because of the long waiting time.

Ms H is commenced on buprenorphine–naloxone again.

## Case 2

Mr L, a 35-year-old chef, recently left a large city in the neighbouring state to be closer to his family after the breakdown of a long-term relationship. Seven years previously he had been sexually assaulted and had a lumbar disc prolapse. He has been taking 40 mg oxycodone twice daily since then. He has been trying to decrease this and has reduced the dose himself to 20 mg twice daily. He has now run out of tablets, has withdrawal symptoms and is distressed. He requests a script for more oxycodone.

Mr L has a history of childhood sexual abuse, depression and post-traumatic stress disorder following the assault. His drug and alcohol history includes cigarettes (tobacco), the consumption of 10 to 14 standard drinks over an evening approximately twice a month and the use, several years ago, of oral and intravenous amphetamines, 'ice' and ecstasy. Cessation of these stimulants has led to Mr L gaining weight. He has a family history of alcoholism and diabetes.

Mr L says that if he does not take oxycodone he has withdrawal symptoms of agitation, myalgia, cramps and diarrhoea. He used to rely on his ex-partner's buprenorphine–naloxone to treat his withdrawal symptoms. He denies injecting his painkillers apart from once about six years ago, and says otherwise he always uses the oxycodone as prescribed. His other medications are venlafaxine 300 mg daily and diazepam 5 mg half to one-tablet daily.

On examination, Mr L is overweight. He becomes teary when discussing the sexual assault. He is clammy with slightly dilated pupils, and has no injection marks. He moves slowly, maintaining a protective posture, and is mildly hypertensive.

### What would your care involve over the next few visits?

You provide Mr L with some educational resources (e.g. those available on the Hunter Integrated Pain Service website, www.hnehealth.nsw.gov.au/pain).

Figure 1. Ms H's injection marks at presentation two years later.

Regarding his medications, you advise Mr L to cease the diazepam. You provide him with a prescription for 28 tablets of oxycodone 10 mg (dosage, one tablet three times daily), with the daily dose to be dispensed from the pharmacy, and negotiate to wean this down to zero over the next three months. You also commence him on ibuprofen and fish oil.

You tell Mr L that you will discuss with him the exclusion of sexually transmitted infections at the next visit. Depending on where you are practising, you need to consider if you have a legal requirement to phone your state or territory health regulatory body for authority to prescribe opioid analgesics for Mr L (Table 2).

### Is Mr L opioid dependent, and what are the regulations on dependency?

Confusingly, the rules and definition of 'drug dependence' are different in each Australian state and territory; however, in each of these an authority (or permit) is required to prescribe opioids for drug-dependent patients. It is important to note that this requirement refers to the legal definition of dependence. This legal definition varies in its concordance to any clinical understanding of the meaning of dependence. As such, prescribers are obliged to practise in accordance with their local laws and regulations. These may change; the *NSW Poisons and Therapeutics Goods Act* for example is now undergoing review. More details are available at the

**TABLE 2.** A GUIDE TO THE REGULATORY REQUIREMENTS FOR PRESCRIBING SCHEDULE 8 DRUGS FOR NON-DRUG-DEPENDENT PATIENTS

| State | Requirements |
|---|---|
| Australian Capital Territory | Authority required if prescribing for longer than two months |
| New South Wales | Specific drugs require authority if prescribed more than two months. These are: alprazolam, injectable drugs of addiction, buprenorphine (except transdermal preparations), flunitrazepam, hydromorphone and methadone |
| Northern Territory | Notification may be required – complex rules apply (see NT pharmaceutical services unit website) |
| Queensland | Notification and treatment report required if prescribing for prescribing for longer than two months |
| South Australia | Authority required if prescribing for longer than two months |
| Tasmania | Authority is required if prescribing for longer than two months – note special requirements for alprazolam |
| Victoria | Permit required if prescribing for longer than two months |
| Western Australia | Authority is required if prescribing for longer than 60 days |

various state and territory pharmaceutical services unit websites (Table 1). Regulatory requirements for prescribing for nondrug-dependent patients are listed in Table 2.

### What would be the focus of Mr L's psychological care?

As Mr L initially presented distressed and in opioid withdrawal his mood requires reassessment after his opioid treatment is stabilised. You need to consider his current situation, past trauma, grief, depression, alcohol intake, benzodiazepine and opioid withdrawal symptoms and pain. Patients such as Mr L who have complex past histories often benefit from additional psychological or psychiatric care and may require medication for depression or anxiety.

### How would you provide psychological management of Mr L's pain?

A Cochrane review indicated that cognitive behavioural therapy has small to moderate effects on several chronic pain outcomes.[2]

Psychological management of patients with chronic pain, which the GP may carry out or refer for, includes:[3]

- pain education
- identifying goals and dividing these into achievable, concrete and measurable subgoals
- teaching skills to achieve the subgoals, e.g. activity pacing or planning daily specific exercises or tasks
- teaching active self-management skills, e.g. dealing with barriers in reaching goals, dealing with flare-ups and problem-solving
- identifying and challenging unhelpful thoughts, e.g. black and white thinking, catastrophising and fear of movement.

### Would you measure Mr L's pain outcomes?

You decide to measure Mr L's pain outcomes to assess his current pain and provide a benchmark for evaluating his therapy over time or with different providers. The simplest way to do this is by using the three-item PEG scale, which measures the pain outcomes of pain intensity, enjoyment of life and general activity (Figure 2).[4] This, and other useful resources and links, are available on the website of the National Drug and Alcohol Research Centre (NDARC) at the University of New South Wales (https://ndarc.med.unsw.edu.au/content/gp-toolkit). It usually takes less than a minute to score this test the first time, and subsequent scoring is even quicker.

### Would you address Mr L's smoking?

Mr L says smoking is his only vice and that it calms him down. You should discuss with him how he is coping overall and how he feels about continuing or ceasing smoking. Given that smoking has been consistently linked to pain/opioid outcomes,[5,6] you could discuss whether he would like to address his smoking. There have not been the neuropsychiatric adverse drug events reported with the use of nicotine replacement therapy as with the use of varenicline. However, a recent small trial indicated that varenicline may have a role in assisting with opioid analgesia detoxification independent of smoking status.[8]

## Case 3

Ms W, aged 28 years, presents for antenatal care when she is nine weeks' pregnant. She had been on a methadone program following a jugular vein thrombosis from injecting fentanyl extracted from patches. She withdrew from the program six months previously. She says this was because she and her partner had been doctor-shopping for fentanyl patches again and she was worried this would be discovered.

### How can you check what Ms W has been prescribed?

As well as the Prescription Shopping Information Service mentioned in Case 1, the PBS Third Party Information Service (http://www.humanservices.gov.au/customer/forms/2690) can also provide information on what has been prescribed to an individual. (A signed cover letter should be sent with the completed application form for this information request.)

### How would you manage Ms W's dependence?

You offer OST to Ms W and she accepts, saying she hated doctor shopping because it was stressful to lie to doctors and she detested the withdrawal symptoms.

While you prepare the paperwork required for the OST, Ms W tells you how she accessed the fentanyl patches. She would book to see five or six GPs a day and then she would provide each with a referral letter from her GP to a specialist stating she had vertebral fractures from a car accident. She would explain that she was getting some physiotherapy and had too much pain to be able to care for her sick grandmother. Once she has asked for the script, she would distract the GP by discussing her epilepsy until the consultation time was finished. These presentations led to her being given fentanyl patch scripts from about 80 to 90 doctors; only about a dozen refused to provide her with a script. She injected part of a patch six times a day in her feet or arms. She says a couple of doctors checked her blood pressure and potentially would have seen the multiple punctures on her arms. However, none ever asked her about them.

**Pain intensity, enjoyment of life, general activity (PEG) assessment tool**

1. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Figure 2. The PEG pain assessment scale, derived from the Brief Pain Inventory.[4]

### What prevents doctors being more cautious and structured in their opioid prescribing?

Several studies have addressed the questions 'What barriers prevent doctors using "Universal Precautions" when prescribing opioids?' and 'Why do doctors not actively offer structured opioid prescribing as per an OST program?'.[8,9]

The concept of Universal Precautions (UPs) was developed after the advent of HIV/AIDS to reduce the risk of the transmission of infection. It described minimum standards of care for all patients, regardless of their perceived or confirmed infectious status. Introducing UPs for chronic nonmalignant pain would systematise attention to the dimension of dependency when prescribing opioids. Rather than reserving harm minimisation strategies for those patients with confirmed dependency, doctors would systematically assess pain and addictive disorders along a continuum. They would manage the nuances of any behaviours suspicious of addiction as routinely as they currently manage cardiac risk factors. This would normalise flexibility in the degree of supervision and structuring for all opioid treatments.[10]

The barriers for GPs commencing OST for their patents involve stigma or fear about dealing with drug addicts. For opioid analgesia UPs, doctors struggle to determine the genuineness of a patient's pain and the truthfulness of the patient.[11] They describe apprehension about performing 'law enforcement' activities. For both strategies (OST and UP), doctors blamed limited time and resources. An important facilitating factor promoting UPs for both doctors and patients was the concept of better protection of patients from the potential harms of high-risk opioid medications.

Many doctors feel uncomfortable being forced into the position of a police officer or a judge and the action of trying to assess the genuineness of the pain or the truthfulness of the patient.[12] This approach can be contrasted with a patient-centred approach using a benefit-to-harm framework to make and communicate decisions about opioid treatments.[12]

Completing the training to become an authorised OST prescriber should increase comfort about opioid management as well as being associated with increased adherence to pain management guidelines.[8,13] OST training, which is provided by state and territory governments, involves attending face-to-face metropolitan and regional courses, although on-line training is offered in New South Wales and Victoria.

### What else would you do for Ms W?

For Ms W, given her partner is still injecting fentanyl, an additional harm minimisation strategy may be the prescribing of naloxone. This has been implemented systematically in some health systems in the USA and observational studies have described associations with reductions in fatal overdose rates.[14]

Ms W is referred to the local hospital for antenatal care. She is encouraged by the social worker to return to the addiction specialist who runs the methadone program and to discuss the best option for her and her baby.

## Case 4

Mr K, aged 53 years, has a massive cirrhotic liver from hepatitis C and alcohol abuse. When he reached the palliative phase of his illness, he had ceased his methadone program and had been commenced on fentanyl patches. He describes severe pain, tiredness and breathlessness, and is hardly able to walk due to his

massive ascites. His estranged partner, still on methadone, and their 9-year-old son have returned to live with him to care for him during his terminal illness.

Mr K invariably requires his scripts early, stating the patches fall off because of his heavy sweating.

### How would you manage Mr K's terminal care opioid analgesia?

With increasing numbers of people developing cancer and the palliative phases of illnesses becoming more prolonged, it is not surprising that doctors are seeing addictive-type behaviours among palliative care patients. Regardless of any concerns about Mr K's misuse, it would be unethical to suddenly terminate his opioid analgesia. However, the usual regulatory requirements of seeking authority would apply. As before, when concerned about aberrant opioid behaviours, prescribers can simply increase the opioid therapy structuring, as exemplified in an OST program. Due to the stigma associated with OST, there are particular barriers towards using this type of approach. Potentially, community nurses could be involved in the storage, application, removal and disposal of each patch. Another alternative that may be safe and effective in patients with hepatic failure is buprenorphine, as described in case reports.[15]

Mr K and his partner, incidentally, were widely known to be diverting most of the fentanyl patches onto the black market. A single 100 mcg patch may be cut into 10 portions and sold for the usual price of a cap of heroin (i.e. about $50 each).

## Whole-patient care

Opioids are essential medicines for acute and terminal analgesia and for dependency management, and may at times be prescribed for patients who have chronic pain resistant to other medications or treatments. However, the safety and efficacy of opioids for long-term use in chronic non-cancer pain lack the support of quality evidence of over 12 weeks' duration.[16] For this reason, as GPs, we need to be comfortable providing quality care to such patients without relying on opioid monotherapy. This care will involve active psychological management, encouraging active self-management and recognising the limitations of most medications in the treatment of patients with chronic nonmalignant pain.

## Conclusion

GPs should be familiar with the strategies of UPs and OST. Further information about assessment and management of opioid dependence is provided in other articles in this supplement.

With training, all interested GPs can develop the skills, knowledge and expertise to be able to prescribe methadone or buprenorphine–naloxone as OST. Such expertise will enable GPs to better manage pain and/or opioid dependency independently and in a positive manner, with advice from the local drug and alcohol clinic or the regional addiction medicine specialist. It is certainly in the interest of most patients with chronic pain who have become opioid-dependent to maintain continuity of care with their GP over the long term. After all, their chronic pain may well be incurable and their potential for opioid misuse is also long-term. MT

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### References

1. Vowles KE, McEntee ML, Julnes PS, Frohe T, Ney JP, van der Goes DN. Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis. Pain 2015; 156: 569-576.
2. Williams AC, Eccleston C, Morley S. Psychological therapies for the management of chronic pain (excluding headache) in adults. Cochrane Database Syst Rev 2012; 11: CD007407.
3. Nicholas MK. Expanding patients' access to help in managing their chronic pain. Pain: Clin Updates 2015; 23: 1-8.
4. Krebs EE, Lorenz KA, Bair MJ, et al. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. J Gen Intern Med 2009; 24: 733-738.
5. Mitchell MD, Mannino DM, Steinke DT, Kryscio RJ, Bush HM, Crofford LJ. Association of smoking and chronic pain syndromes in Kentucky women. J Pain 2011; 12: 892-899.
6. Pisinger C, Aadahl M, Toft U, Birke H, Zytphen-Adeler J, Jørgensen T. The association between active and passive smoking and frequent pain in a general population. Eur J Pain 2011; 15: 77-83.
7. Hooten WM, Warner DO. Varenicline for opioid withdrawal in patients with chronic pain: a randomized, single-blinded, placebo controlled pilot trial. Addict Behav 2015; 42: 69-72.
8. Holliday S, Magin P, Oldmeadow C, et al. An examination of the influences on New South Wales general practitioners regarding the provision of opioid substitution therapy. Drug Alcohol Rev 2013; 32: 495-503.
9. Krebs EE, Bergman AA, Coffing JM, Campbell SR, Frankel RM, Matthias MS. Barriers to guideline-concordant opioid management in primary care – a qualitative study. J Pain 2014; 15: 1148-1155.
10. Holliday SM. Managing the continuum between pain and dependency in general practice. Drug Alcohol Rev 2011; 30: 324-326.
11. Gourlay DL, Heit HA. Universal precautions revisited: managing the inherited pain patient. Pain Med 2009; 10(S2): S115-S123.
12. Nicolaidis C. Police officer, deal-maker, or health care provider? Moving to a patient-centered framework for chronic opioid management. Pain Med 2011; 12: 890-897.
13. Holliday S, Magin P, Dunbabin J, et al. An evaluation of the prescription of opioids for chronic nonmalignant pain by Australian general practitioners. Pain Med 2013; 14: 62-74.
14. Walley AY, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ 2013; 346: f174.
15. Ciccozzi A, Angeletti C, Baldascino G, et al. High dose of buprenorphine in terminally ill patient with liver failure: efficacy and tolerability. J Opioid Manag 2012; 8: 253-259.
16. Chou R, Deyo R, Devine B, et al. The effectiveness and risks of long-term opioid treatment of chronic pain. Evidence Report/Technology Assessment No. 218. (Prepared by the Pacific Northwest Evidence-based Practice Center). Agency for Healthcare Research and Quality (AHRQ) Publ No. 14-E005-EF. Rockville, MD: AHRQ; 2014. Available online at: www.effectivehealthcare.ahrq.gov/reports/final.cfm (accessed May 2015).

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