



## Review Article

DOI: 10.36959/377/353

# Opioid Pseudoaddiction in a Patient with Long-Term Oxycodone Use for Chronic Pain

Lakshmi Priya<sup>1</sup>, Fei Cao<sup>2,3\*</sup>, Jaskirat Sidhu<sup>2</sup>, Jeffery Metzner<sup>2</sup> and Muhammad Farhan<sup>2,3</sup>

<sup>1</sup>Medical Student at University of Missouri, Kansas City, MO, USA

<sup>2</sup>Department of Psychiatry, University of Missouri, Kansas City, MO, USA

<sup>3</sup>University Health Pain Management Center, Kansas City, MO, USA



## Abstract

Pseudoaddiction is a term to describe drug-seeking behaviors in a patient that has inadequate pain control. It is the result of the medical undertreatment of pain, which poses iatrogenic harm to patients by withholding analgesic treatment [1]. The case presented is of a 26-year-old female with chronic back pain from a motor vehicle accident who was unable to find a physician to prescribe opioids after leaving the care of her primary care physician. She resulted to drug-seeking behaviors and alcohol use to relieve her severe pain. While she was diagnosed with opioid misuse disorder, her behaviors align with the concept of pseudoaddiction. When evaluating patients with drug-seeking behaviors, physicians should be aware of the concept of pseudoaddiction and ensure they are not misinterpreting the CDC guidelines for prescribing opioids.

## Introduction

The 2015 National Survey on Drug Use and Health reports that around 38% of U.S. adults use prescription opioids, and of those people 13% reported opioid misuse and 2% reported opioid use disorder [2]. The opioid epidemic has led physicians to enforce strict regulations and careful prescribing practices to mitigate the growing opioid crisis. The Centers for Disease Control (CDC) issued the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain in order to de-prescribe opioids and reduce addiction [3]. However, misapplication of the guideline prevents patients with chronic pain from getting adequate pain control, leading them to suffer from untreated pain, depression, and suicide [3]. The CDC released a statement highlighting the misapplication of the guideline and the risks they could pose to patients. For example, the guideline is meant for patients 18 years and older with chronic pain but could be misapplied to patients receiving active cancer treatment or patients with post-surgical pain. The CDC also warns that the guideline does not advise hard limits or discontinuing opioids already prescribed at a higher dose [4]. Abrupt tapering and sudden discontinuation of opioids can lead to harmful opioid withdrawal symptoms and severe distress [4]. In response to the misapplication of the guideline and inadequate pain control practices, the term “pseudoaddiction” has re-emerged.

The concept of pseudoaddiction can be defined as poorly treated pain that leads to behaviors that resemble addiction but resolve with improved pain control [4]. Without adequate pain control, many people may result to substance abuse and

drug-seeking behaviors in order to get pain relief. These behaviors may lead physicians to diagnose their patients with opioid misuse or opioid use disorder when they actually have inadequate pain control. Physicians must realize that poorly controlled pain can make people take desperate measures and they should always remember to be thoughtful when addressing their patient’s pain [5].

## Case

The patient is a 26-year-old Caucasian female who presented to the emergency department with complaints of heavy drinking and alcohol withdrawal symptoms, including nausea, vomiting, palpitations, and shaking. The patient has a past psychiatric history of PTSD, generalized anxiety disorder, major depressive disorder, alcohol use disorder and a past medical history of chronic back pain due to a motor vehicle accident (MVA). Upon arrival vitals were significant for a heart rate at 107, positive urine drug screen for oxycodone, the blood alcohol level of 344 and sinus tachycardia on EKG.

**\*Corresponding author:** Fei Cao, Department of Psychiatry, University of Missouri, Kansas City; University Health Pain Management Center, Kansas City, MO, 64108, USA

**Accepted:** February 10, 2021

**Published online:** February 12, 2021

**Citation:** Priya L, Cao F, Sidhu J, et al. (2021) Opioid Pseudoaddiction in a Patient with Long-Term Oxycodone Use for Chronic Pain. *J Clin Anesth Pain Manag* 5(1):196-197

She was admitted to the medical floor for safe alcohol detoxification and psychiatry was consulted to manage her opioid dependence. CIWA protocol, seizure/fall precautions, and ondansetron PRN for nausea were initiated. Cyclobenzaprine, lidocaine patch, and acetaminophen PRN were started for chronic back pain. Narcotics were held and psychiatry was consulted.

During the psychiatric evaluation, the patient reported she had a motor vehicle accident 10 years ago. She underwent spinal fusion and was prescribed oxycodone 10 mg Q8H PRN for chronic back pain by her primary care physician (PCP). Her PCP controlled her oxycodone use by requesting leftover oxycodone at each visit, ordering random UDS tests, and not allowing early refills. Pt reported her chronic back pain was stabilized on oxycodone without dosing escalation for almost 9 years. A year prior to the emergency room visit, her PCP had moved to another hospital and she was unable to receive oxycodone. At this point patient had 75 oxycodone tablets left and she took 1-2 10 mg tablets as needed per week for severe breakthrough pain. The patient attempted to find another physician to continue her prescribed oxycodone but without any success. As a result, she turned to drinking alcohol to “detoxicate” herself from chronic opioid use. She started drinking occasionally at the age of 17-years-old and in the past year had been drinking at least a fifth of liquor almost every day to “detoxicate” herself from opioid use. She denied any legal troubles due to alcohol use but reported it affected her relationship with her partner. One month prior to her current presentation, she first experienced alcohol withdrawal symptoms and reported her symptoms included anxiety, nausea, headache, sweating, and tremors. The mental status exam was significant for mild tremors in the patient’s right hand and she reported her mood as “sad.” The psychiatry team did not diagnose the patient with opioid use disorder as the patient denied using prescription opiates in an amount larger than what was prescribed and denied abusing her prescription opiates or misusing opiates from non-prescription resources. The team diagnosed the patient with opioid misuse disorder due to concurrent alcohol use, which did not satisfy the diagnosis of opioid use disorder. Since she did not have a diagnosis of an opioid use disorder, the psychiatry team also recommended that the medicine or pain team prescribe opioids for the patient’s chronic back pain.

After discharge, unfortunately, no physician was willing to prescribe the patient opioids. Several months later, she went to habitation and started buprenorphine and naloxone (Suboxone). She was also prescribed naloxone nasal spray for potential opioid overdosing. Then her chronic pain was stabilized by chronic Suboxone administration.

## Discussion

Pseudoaddiction should be considered in patients with chronic pain who start exhibiting drug-seeking behaviors. While their presentation may reflect opioid misuse or opioid use disorder, it could be attributed to inadequate pain control. Although differentiating between pseudoaddiction and opioid use disorder can be difficult, the cessation of drug-seeking behavior after adequate pain control could be a distinguishable factor [6]. In addition, physicians should ensure they are reviewing the latest CDC guidelines and aware of common misapplications of the guideline to ensure their patients with chronic pain are getting adequate treatment. For patients already on long term high dose opioid treatment, physicians should review the risks of continuing high dose opioids, collaborate with patients who agree to taper their doses and taper slowly to minimize withdrawal symptoms, and refer patients to multi-disciplines [4]. Failure to achieve adequate pain control in patients with chronic pain can lead to significant patient harm and psychological distress.

## References

1. Weissman DE, Haddox JD (1989) Opioid pseudoaddiction--an iatrogenic syndrome. *Pain* 36: 363-366.
2. Han B, Compton WM, Blanco C, et al. (2018) Prescription opioid use, misuse, and use disorders in U.S. adults. *Ann Intern Med* 168: 383-384.
3. Darnall BD (2020) The national imperative to align practice and policy with the actual CDC opioid guideline. *Pain Med* 21: 229-231.
4. CDC (2019) CDC advises against misapplication of the guideline for prescribing opioids for chronic pain.
5. Passik SD, Kirsh KL, Webster L (2011) Pseudoaddiction revisited: A commentary on clinical and historical considerations. *Pain Manag* 1: 239-248.
6. Greene MS, Chambers RA (2015) Pseudoaddiction: Fact or fiction? An investigation of the medical literature. *Curr Addict Rep* 2: 310-317.

**DOI: 10.36959/377/353**