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FAST FACTS AND CONCEPTS #69

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Introduction The term pseudoaddiction was first used in 1989 to describe an iatrogenic syndrome resulting from poorly treated pain. The index case was a 17 year old man with leukemia, pneumonia, and chest wall pain. The patient displayed behaviors (moaning, grimacing, increasing requests for analgesics) wrongly interpreted by the physicians and nurses as indicators of addiction, rather than of inadequately treated pain. Put simply, pseudoaddiction is something that we do to patients, through our fears and mis-understanding of pain, pain treatment, and addiction (see also Fast Fact #68).

Diagnostic Features

- Behaviors that suggest to the health care provider the possibility of psychological dependence (addiction):
 - Moaning or other physical behaviors in which the patient is trying to demonstrate to the provider that they are in pain.
 - Clock-watching or repeated requests for medication prior to the prescribed interval.
 - Pain complaints that seem "excessive" to the given pain stimulus.
- Inadequately prescribed and titrated opioids analgesics; typically the use of an opioid of inadequate potency and/or at an excessive dosing interval (e.g. oral morphine q6 hours PRN – see Fast Fact #18).

Assessment Anytime there is a suggestion, because of escalating pain behaviors, that a patient on opioids may be "addicted," pseudoaddiction should be considered. Perform a complete pain assessment and review the recent analgesic history:

- Is this a pain syndrome that typically responds to opioids?
- Is the current opioid dose, route and schedule appropriate? If so, has a reasonable attempt at dose escalation been made?
- Is there any past medical history to suggest a substance abuse disorder? Complete a comprehensive addiction assessment if such a disorder is suspected.
- Pseudoaddiction improves with the provision of adequate analgesia, including opioids. In contrast, behaviors associated with a substance abuse disorder will not change.

Management If you believe the current problem is pseudoaddiction, there are two key management steps:

1. Establish trust. A primary issue in most cases is the loss of trust between the patient and the health care providers. The physician and nursing staff should meet to discuss how they will restore a trusting therapeutic relationship; outside assistance from a pain or palliative care service can be helpful. Plan to meet with the patient and openly discuss the events leading up to the current problem. Engage the patient in the decision-making process about the current and future use of analgesics.
2. Prescribe opioids at pharmacologically appropriate doses and schedules. Aggressively dose escalate until analgesia is achieved or toxicities develop (see Fast Facts #18, 20, 36). Frequently re-evaluate progress in pain management and ask for consultation assistance.

References

1. Weissman DE, Haddox JD. Opioid pseudoaddiction. *Pain*. 1989; 36:363-366.
2. Sees KL, Clark HW. Opioid use in the treatment of chronic pain: assessment of addiction. *J Pain Symptom Manage*. 1993; 8:257-264.

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