PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #69
PSEUDOADDICTION
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Introduction: The term *pseudoaddiction* was first used in 1989 to describe an iatrogenic syndrome resulting from poorly treated cancer pain. The index case was a 17-year-old man with chest wall pain from leukemia. The patient displayed behaviors (moaning, grimacing, increasing requests for analgesics) wrongly interpreted by the clinicians as indicators of opioid use disorder (OUD), rather than of inadequately treated pain. The term *pseudoaddiction* is not a diagnosis nor is there any empirical evidence it is a validated condition or that it adds value to clinical decision-making. In fact, it is a historically fraught term that has been misapplied in the published medical literature and opioid marketing campaigns in ways that may have contributed to the opioid epidemic in the US. While at its core the term was intended to be a way for clinicians to broaden their diagnosis and consider whether concerning behaviors regarding opioid use may be an indication of poorly treated cancer pain, it remains controversial. Regardless, clinicians who care for patients with serious illness may encounter the term in the published medical literature and elsewhere. Therefore, it can be helpful to be aware of its history and controversy.

Controversies: Experts in the pain and substance use disorder community have argued the concept has contributed to binary thinking in which clinicians are led to conclude whether the clinical issue underlying observed aberrant opioid behaviors is either pain (implying pseudoaddiction) or not pain (implying addiction). However, concerning opioid use behaviors and pain commonly overlap and coexist (see *Fast Fact* #68). As a result, critics are concerned the term has contributed to liberal opioid prescribing practices especially for patients with chronic pain conditions and doing so has indirectly harmed them.

Features of pseudoaddiction as described in early case reports

- Concerning behaviors that suggest to the clinician of the possibility of unsafe opioid use or psychological dependence (opioid use disorder) (not a comprehensive list):
  - 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.
  - Patient self-titrates the prescribed opioid dose to try to achieve better analgesic effectiveness
- Inadequately prescribed and titrated opioids in a patient with tissue destruction from advanced cancer; typically, the opioid regimen is of inadequate potency and/or an excessive dosing interval (e.g., acetaminophen with codeine (Tylenol #3) one pill by mouth every 6 hours PRN).
- The concerning behaviors diminish or resolve after a better analgesic plan is adopted.

Assessment and management If you are concerned the prevailing clinical issue is under-treated pain that is leading to concerning behaviors:

1. Perform a complete pain assessment: Is further medical work-up needed (e.g., CT imaging in cancer) needed to assess the cause of the pain? Is the a pain syndrome one that typically responds to opioids? Is the current opioid dose, route, and schedule pharmacologically appropriate? Does the patient have a history of a substance use disorder? (See *Fast Facts* #311-312)
2. Establish trust. A common fundamental issue is the breakdown of trust between the patient and clinical team. Clinicians should meet to discuss how they will restore a trusting therapeutic relationship. Outside assistance from a pain or palliative care service can be helpful. Then meet with the patient and discuss the events leading up to the current problem with transparency. Engage the patient in the analgesic decision-making process and make sure to elicit the patient’s perspective.
3. Consider whether the analgesic medications (opioids and non-opioid adjuvants) can be safely adjusted to improve analgesic effectiveness. See *Fast Facts* #18, 20, 36. Frequently re-evaluate progress in pain management and ask for consultation assistance as appropriate.
4. Incorporate non-pharmacologic analgesic strategies such as physical therapy, occupational therapy, cognitive behavioral therapy, etc as appropriate to the clinical situation.

5. Avoid stigmatizing patients who are requesting opioids or higher doses of opioids for uncontrolled pain for example by labeling them "addicts." See *Fast Fact* #429 for further information about stigmatizing language in pain management.
6. Since uncontrolled pain and OUD often coexist, clinicians need to perform continuous benefit: risk analyses about opioid therapy and dosing. Even when clinicians feel "*pseudoaddiction*" is a factor, they should maintain appropriate and standardized opioid monitoring which prioritize the patient's safety and function (see *Fast Fact* #68 for further discussion about this).

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.
3. Greene MS and Chambers A. Pseudoaddiction: Fact or Fiction? An Investigation of the Medical Literature Current Addiction Reports December 2015, Volume 2, Issue 4, pp. 310-317.
4. Keefe PR. The family that built an empire of pain. The New Yorker. 2017 Oct 30;30.
5. Higgins C. *Comorbid opioid dependence and chronic pain: Clinical implications*. 2018 Doctoral dissertation, University of Dundee). Available at: https://discovery.dundee.ac.uk/ws/portalfiles/portal/29634094/PhD_thesis_Higgins_.pdf Last accessed February 3, 2022.
6. Passik SD, Kirsh KL, Webster L. Pseudoaddiction revisited: a commentary on clinical and historical considerations. Pain Management 2011; 1(3)
7. Bottiger BA, Orme DC, Gordin V. Acute Management of the Opioid-Dependent Patient. InTreatment of Chronic Pain by Medical Approaches 2015 (pp. 119-132). Springer, New York, NY.

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