

When patients present with suspicious complaints of pain, these seven steps can help you prevent the misuse of prescription drugs.

A SYSTEMATIC APPROACH TO IDENTIFYING Drug-Seeking Patients

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A request for pain medication came from a 23-year-old male from New York City who showed up at a rural emergency room. He complained of two days of continuous pain in his left flank that radiated into his groin and was getting worse. Although suggestive of renal colic, the pain did not follow the natural history of obstructive nephropathy: It was not spasmodic and was nonspecific except for its purported severity. His physical exam, too, showed inconsistencies including diffuse guarding and generalized – rather than localized – tenderness to even light palpation. Although his urinalysis report showed red blood cells too numerous to count on the microscopic exam, the physician had her doubts and asked to see the urine specimen. While the urine was an amber color, there were small clots of blood on the bottom of the cup, which were more consistent with droplets of fresh blood from a pricked finger than from the microscopic ooze from a ureteral mucosa irritated from an entrapped stone. After the patient declined a request for a urine specimen via an in-and-out catheterization, non-narcotic analgesics were administered. A follow-up renal ultrasound was scheduled for the next day, an appointment – not surprisingly – that the patient did not keep.

As the misuse of prescription medications has increased dramatically in the past few years, particularly for opiates, it has become increasingly important to identify drug-seeking behavior, such as that depicted above. Currently, up to 30 percent of prescription narcotics are diverted for illegal use by someone other than the person for whom it was prescribed.¹ Narcotics are not only shared with family and friends; they are often sold to strangers or exchanged for illegal substances.

This article describes the steps involved in a systematic approach to identifying drug-seeking patients.

1 **Involve your entire team.**

A team approach allows input from multiple health care professionals, which is critical since inconsistencies in a patient's symptoms and signs are often the first clues of malingering. A patient who is experiencing pain should have the same difficulty with movement in the parking lot, the waiting room, the hallway and the exam room. If a patient comes to the office with a complaint of pain, the office staff should observe the patient's level of function from the moment of his or her arrival. This information should be reported from the front office staff to the back office staff and then to the physician. Similarly, upon completing the clinical visit, the physician and office staff should observe the patient walking to the discharge window as well as exiting the office.

Family members who have accompanied the patient to the office visit can also provide input into the patient's level of function through the use of simple questions about daily activities (e.g., Can the patient walk up and down the stairs or bend over to tie his or her shoes?). It is relatively easy for a family member to report that the patient has had pain throughout the day. It is more difficult to describe a level of function that is anatomically consistent with the pain. This can be even more difficult if the family member does not know what the patient has said to the physician.

Previous physicians can also provide crucial information. Since drug-seeking patients switch physicians frequently, a prescription for narcotics should not be written at a first visit in most cases. Offices should first obtain a copy of the patient's records from the previous physician to verify diagnoses and treatments. In addition, a simple phone call to the previous physician's office can be invaluable in understanding a patient's behavioral pattern.

Pharmacists can be valuable allies as well. Many phar-

macies keep records about customers suspected of abusing the system. This includes patients who use multiple pharmacies, repeatedly submit refill requests too early, make excessive demands and offer to pay cash (to hide duplicate prescriptions from their insurance plans).

2 Recognize suspicious behavior.

Patients often reveal their drug habits through their behavior. They tend to be obsessive and impatient, calling repeatedly both during and after office hours. They manage to find physicians' home phone and pager numbers. They often do not keep follow-up appointments and then call for an immediate appointment. They may request medications that are adjuvants to pain management, such as carisoprodol and hydroxyzine, as many of these patients have polysubstance abuse.

Upon receiving prescriptions for narcotics, many drug-seeking patients are excessive in their flattery. They may hug the physician and say, "You are the best physician I have ever had." On the other hand, repeated entreaties for controlled medications will often suddenly cease when the physician clearly and calmly states the treatment plan and explains that the patient's condition does not warrant the prescribing of narcotics. Most patients who are fabricating a story sense not only when the physician is indecisive (and, therefore, they press forward) but also when the physician has made a decision (and further efforts are futile).

3 Obtain a thorough history of present illness.

In obtaining a history of an injury from a patient, it is important to determine the mechanism of injury. What force was exerted on the body? What part of the body sustained the force? Was the force compressive or rotational? How did the body accommodate the force? A drug-seeking patient will often try to impress the physician with the severity of the initial injury, often several years old. However, acute injuries are not chronic conditions. Injured tissues heal. Fractured bones knit together. The subjective and objective information regarding the mechanism of injury and subsequent tissue repair should be internally consistent.

A patient who sits stiffly with percussion tenderness along the length of the thoracic

or lumbar spine may be experiencing the sequelae of a torsional injury sustained a week ago, but almost certainly not from several years earlier. In the first two months following an acute injury, the rate of narcotic use is similar in all patients, regardless of prior history of addictions.² After two months, however, the rate of narcotic use falls quickly in patients without a history of addictions, whereas it falls very slowly in those with such a history.

Pain, although often portrayed by patients as constant, should follow the natural history of the injury. While re-injuries and other exacerbations can occur, the level of pain should parallel the degree of injury and subsequent healing over time. Even over the course of a single day, the diurnal cycle is not constant but should reflect changes in sleep, activity and cortisol levels. Here again, careful questioning by the physician can uncover inconsistencies in the patient's story. This should include altering pain questions so the patient has less opportunity to give a planned response and including several questions that are spurious from a medical perspective. Indirect and open-ended questions (e.g., "Tell me about your eating" and "How did your last meal agree with you?") can force the drug-seeking patient to give an unscripted reply.

4 Look for consistency in the exam.

All aspects of the physical exam should be internally consistent. Posture, point tenderness, percussion tenderness, passive and active range of motion as well as active resistance should tell the same story. Faking the injury in a consistent way is a relatively difficult task for most patients. This becomes even more difficult if the physician uses distraction techniques such as firmly palpating a non-injured extremity while gently palpating the injured extremity. The physician should move smoothly between the different components of the exam without

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■ Staff members, local physicians and pharmacists can provide valuable information and help you identify drug-seeking patients.

■ These patients often exhibit suspicious behavior, such as being obsessive and impatient.

■ Physicians should be on the lookout for inconsistencies in the patient's story during the history and exam.

giving the patient sufficient time to react to each one. While the physician should examine uninjured tissues first and avoid sudden movement, both essential for patient rapport, the exam of the injured tissue should not be scripted. Doing so would allow the malingering patient to plan out his or her responses.

Tissue injuries tend to be localized. Certain physical activities (but not all) will cause pain just as specific exam techniques (but not all) will produce tenderness. Patients who try to protect injured areas by tightening overlying muscles will have tenderness of the injured deeper tissue but not of the overlying muscle, a distinction that is rarely made by the feigning patient. Injured muscles that involuntarily spasm, on the other hand, will be tender while the voluntarily contracted muscle should not.

5 Conduct appropriate tests.

Just as a patient with asthma needs a peak flow reading, a patient taking narcotic medications needs regular urine toxicology testing. While this is one of the most effective tests for monitoring patient behavior, it is underutilized. An office protocol can help ensure that all staff follow a consistent approach. The medical assistant can automatically obtain a urine specimen prior to taking pain patients to an exam room, particularly if several months have elapsed since the last test. Alternatively, a patient can be required to give a urine specimen at the end of the visit just prior to checkout.

Radiological images should be obtained for a patient with a new complaint of pain to ensure there is not a concomitant problem such as a bony metastasis. While X-rays provide information about structure, they do not verify the legitimacy of pain, which is a phenomenon of function. If the history, physical exam and mechanism of injury do not correlate with each other, the X-ray cannot independently substantiate the diagnosis of pain.

6 Prescribe nonpharmacological treatment.

A patient genuinely seeking pain relief will understand that there is no “magic bullet” and be willing to use nonpharmacological treatment (physical therapy, home exercises, etc.) in conjunction with medications. A patient who is unwilling to try these therapies is unlikely to

desire an improved level of function. Before adding a narcotic to the patient’s treatment plan, the physician should verify that the patient is willing to try – and continue to try – at least five nonpharmacological lifestyle interventions, some of which can be very simple. In addition, the physician should prescribe nonopioid analgesics such as acetaminophen and NSAIDs and document their failure prior to placing a patient on an opioid. Most narcotic prescriptions should be for acute or intermittent use. If opioids are needed, a legitimate sufferer will generally seek to limit their dose and frequency, balancing the need to relieve pain with the desire to avoid unpleasant side effects.

Since all narcotics bind to opioid receptors, a patient who names a specific narcotic and claims only that narcotic works may be seeking the medication itself rather than relief from pain. This is particularly true in a patient who insists on receiving a brand-name medication. Similarly, patients who claim to be allergic to multiple narcotics except for one are not likely being honest.

7 Proceed cautiously.

If you decide to prescribe a controlled substance, it is wise to limit the quantity of medication and the number of refills. Make sure the prescription is legible with all information clearly filled in so the patient cannot modify it. Document clearly in the patient record that a narcotic was prescribed, perhaps using a different color of paper from the rest of the chart to ensure this information will not be overlooked.

Frequent office visits should be scheduled for close monitoring of these patients, and drug contracts outlining expectations can be helpful. Keeping a list of patients who are on opioids may also be helpful in tracking them.

Above all, office staff and physicians should be consistent and diligent, as drug-seeking patients are experts at exploiting weak links in the system. **FPM**

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1. Cicero TJ, Surratt H, Inciardi JA, Munoz A. Relationship between therapeutic use and abuse of opioid analgesics in rural, suburban, and urban locations in the United States. *Pharma Drug Safety*. 2007;16:827-840.

2. Massey GM, Dodds HN, Roberts CS, Servoss TJ, Blondell RD. Toxicology screening in orthopedic trauma patients predicting duration of prescription opioid use. *J Addictive Diseases*. 2005;24(4):31-41.

Regular urine toxicology testing is an underutilized but effective way of monitoring the behavior of patients taking narcotics.

Patients should be willing to try at least five non-pharmacological treatments before taking narcotics.

When prescribing a controlled substance, begin with a limited quantity and take steps to monitor the patient closely.