発表抄録(英文)

Case report: Cognitive-behavioral therapy for IBS exacerbated by inappropriate opioid use.

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Scientific Streams: Addiction

Abstracts

IBS is a functional disease mainly caused by abnormalities in the large intestine's motor, sensory, and secretory functions. It is associated with intestinal dysbiosis, mucosal inflammation, stress, and psychosocial factors.

In this study, we report two cases of patients with chronic IBS who had worsened and prolonged symptoms due to an easy and inappropriate prescription of opioid analgesics and who successfully responded to multidisciplinary treatment, including cognitive-behavioral therapy.

Case 1, 66-year-old female, housewife

She had a history of several emergency visits for anxiety disorder and suicide attempts. She regularly visited a psychiatric clinic and was prescribed Bz sleeping pills and SSRIs for a sleep disorder. She had chronic constipation and used laxatives daily. Three years ago, she visited the emergency room due to sudden severe lower abdominal pain, but gastrointestinal endoscopy revealed no abnormality. Six months later, at another hospital, she was found to have internal hemorrhoids and underwent resection. Her pain worsened after the surgery, and her use of analgesics and anticholinergics increased. Her physician started her on intravenous opioid analgesics, but the opioids had a transient and limited effect, and her symptoms persisted.

The physician then prescribed buprenorphine suppositories instead of intravenous morphine, which he began to use frequently. After being diagnosed with IBS with anxiety at the University Hospital Gastroenterology Center, she was referred to our multidisciplinary pain center and visited the outpatient clinic with her husband. She was able to perform household chores and daily activities generally in the morning. However, in the afternoon, her anxiety gradually increased. At 7:00 p.m., she suddenly developed severe lower abdominal pain and used buprenorphine suppositories twice a day and then went back to bed. She was anxious and fearful of pain attacks and was obsessed with the thought, "Opioids only have a temporary effect, but I cannot live without opioid suppositories," and her quality of life was

deteriorating due to a vicious cycle of somnolence, abdominal pain, and constipation. Our chronic pain team conducted a 10-week group cognitive-behavioral therapy intervention once a week. We provided a multidisciplinary approach that included pain neuroeducation, psycho-education, life monitoring, autonomy training, mindfulness meditation, exercise, cognitive reframing, and behavioral activation. At the end of the program, her pain was still persistent, but opioid suppository use decreased to once a day, and her self-efficacy improved. We continued monthly follow-up medication adjustments, outpatient psycho-education, and mindfulness sessions with the couple. One year after our intervention, like a sudden miracle grace, the pain disappeared, and she was free from opioid use.

Case 2, male, about 70 years old. Pharmacist.

Six years ago, he had rectal cancer and underwent a laparoscopic low anterior resection. A small bowel stoma was constructed for complications of suture failure the day after surgery.

Two years later, he got the stoma closure and balloon dilation for anastomotic stricture. One year ago, lower abdominal pain appeared, but endoscopy, CT, and PET showed no recurrence. An internal medicine physician prescribed opioids at a university hospital for the pain without improvement.

At another hospital, he was diagnosed with functional abdominal pain. Amitriptyline and Chinese herbal medicine did not show improvement. He suffered from anorexia, weight loss of 10 kg, and worsened fatigue. He came to our pain center. He was obsessed with the fear that a pain attack might occur at any moment, and he used his judgment to adjust the dosage of opioid medication despite the lack of efficacy of the drugs. We presented a case report of case 1 and recommended tapering off opioids and a multidisciplinary approach. We provided approximately one month for individualized treatment. At discharge, his appetite improved, and he quit opioid use. After one year of outpatient follow-up, his symptoms of pain and constipation resolved, and he returned to a healthy lifestyle.

Discussion: Anticholinergics and opioids were inappropriately and continuously used by the physician to treat the pain of an anxious IBS patient, forming a vicious cycle of bowel dysfunction-physical and psychological dependence.

Although they did not show a high degree of improvement immediately after the cognitive-behavioral therapy program, their behavior was changed, and they became free from opioid dependence, leading to a

complete recovery.
The relationship strengthening through psycho-education with the couple, behavior change, and discovering a new purpose in life and social role increased resilience and led to complete recovery.
Conclusion: Appropriate psychological and pharmacological support, a multidisciplinary approach with cognitive-behavioral therapy, and ongoing follow-up are considered vital to IBS. Education on the proper use of analgesics and pain education for the general public and healthcare professionals is essential.

Opioids for abdominal pain create a vicious cycle, trapping individuals in its grip. CBT can help with opioid tapering and RECLAIM ONE'S LIFE.

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Ms. A
female 60s homemaker

Diagnosed with Severe Chronic Constipation 4 years ago. Thereafter, started using Buprenorphine suppositories frequently for abdominal pain. The difficulty in bowel movements further worsened.

CBT Classes for chronic pain

Once per week 10 times with 3 months FU.
It is is operated by a multi-disciplinary team including anesthesiologists, psychologists, nurses, rehabilitation therapists, health fitness programmer, and nutritionists.
components :
Psychological education, exercise, relaxation technique, autogenic training, time-based pacing, cognitive restructuring, self-monitoring, and mindfulness.

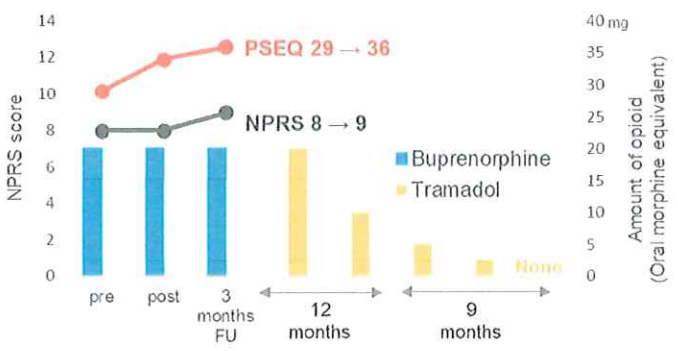
Skill maintenance phase

Self-monitoring , exercise, and pleasant activity had became ingrained.
Psychological education and mindfulness guidance by The anesthesia doctor were continued during the examinations.

Tapering-off phase

夏の暑さが和らぎ過ごしやすくなった秋の午後の日、痛みがなくなっている自分に突然気づきました

"One day, as the summer heat subsided and a gentle autumn arrived, the pain suddenly vanished."
Afterward, successful gradual tapering of opioids was achieved.



Mr. B
male 70s pharmacist

Diagnosed with rectal cancer and underwent surgery five years ago, he had four years of remission. However, six months ago, he started experiencing pain in the surgical area. Various examinations showing no abnormalities. opioids were administered for pain relief, but with limited improvement. He dmitted to our hospital for further pain management.

Session 1 - Session 5 (hospitalization)

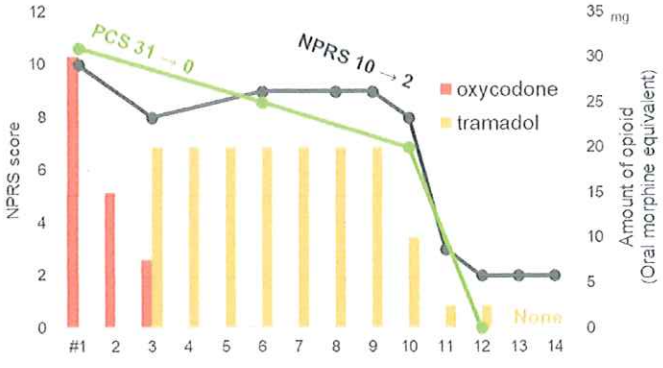
The anesthesia doctor swiftly adjusted the opioids.
Attention training technique, mindfulness training were provided by a psychologist.
Despite being overwhelmed by intense pain, he remained actively committed to his training.

Session 6 - Session 9

As part of outpatient treatment, medical consultations and CBT sessions were continued. He maintained mindfulness practice and resumed activities he used to enjoy, such as walking and music appreciation. However, he said, *"I do them just for any slight relief from the pain."* He solely concerned with the ups and downs of pain and was unable to experience the pure joy of those activities.
The psychologist felt the need to share Creative Hopelessness and intentionally asked, "How did those activities affect the pain?" He thought for a while and quietly said, *"It's still the same, huh..."* After that, there was a moment of silence for about 1 to 2 minutes.

Session 10 - Session 14

Two months after Creative Hopelessness session, he said, *"The pain itself hasn't changed, but it doesn't bother me as much."* He also mentioned, *"Even with the pain, I was consciously focusing on reclaiming my life."*
Afterwards, he became more active, found greater enjoyment, returned to work, and successfully reduced medication.



発表概要報告書

（日本語 1200 字以内）

腹痛に対するオピオイド鎮痛剤の使用は、副作用による腸の機能不全からさらなる腹痛を生じる危険性がある。この状態に陥ると、オピオイド鎮静薬は腹痛の長期的な増悪要因であると同時に、本人にとっては一時的にでも痛みを和らげる"唯一の救い"の機能を持つため、悪循環を抜け出すのが難しくなってしまう。本ポスター発表では、オピオイド鎮痛剤の不適切使用により悪化した過敏性腸症候群患者に対して認知行動療法を実施し、減薬計画を補助することで改善した2症例を報告した。

症例A:60代　女性　専業主婦
4年前に重度の慢性便秘と診断。それ以降、腹痛のため頻繁にオピオイド坐薬を使用し、便通がさらに悪化していた。当院のペイン外来へ来院され、慢性疼痛チームによるグループ認知行動療法クラスへ週1回、10週間にわたり参加した。プログラムの内容には、疼痛の神経学的な教育、心理教育、エクササイズ、リラクセーション技法、自律訓練法、時間基準のペーシング、認知再構成法、セルフモニタリング、マインドフルネスなど、多面的アプローチが含まれた。さらにプログラムの3ヶ月後にもフォローアップセッションを実施。医師の診察内でも心理教育、マインドフルネス、セルフモニタリングに関する指導が継続された。スキルが定着した頃、「痛みがなくなる日が突然やって来ました」と手紙に綴っておられた。そこから急激な改善を見せ、オピオイドの減薬に成功し痛みも落ち着いた状態で安定した。

症例B:70代　男性　薬剤師
5年前に直腸がんの手術後、4年間再発なく経過。しかし、6か月前から手術部位が強く痛みだし、検査に異常なくオピオイドが投与されたが効果は限定的。さらなる疼痛管理のため当院に入院となった。麻酔科医によりオピオイドが調整されたが、痛みが強く十分な減薬に至らなかった。入院期間中、心理士よりマインドフルネストレーニングが提供された。
外来通院へ移行し、麻酔科医の診察と心理士によるCBTセッションが継続された。彼はマインドフルネスの練習を続け、散歩や音楽鑑賞などの趣味も再開していたが「苦痛を少しでも軽減するためにやっている」と痛みの上下に執着しており、活動の純粋な喜びからは遠ざかっていた。痛みをコントロールしようとする体験の回避を手放すために、その非機能性を確認する"創造的絶望"のセッションが実施された。次回来院時、彼は「痛み自体はあまり変わらないが気にならなくなった」、「痛みがあっても、自分の生活を取り戻すことに意識を向けていたよ」と話した。その後、彼はより活動的になり、楽しみを見つけ、仕事に復帰した。ほどなくして痛みも落ち着き、オピオイドの減薬・終了に至った。

結論:腹痛とオピオイド鎮痛剤の悪循環に陥った患者・クライエントに対して、CBTを用いた心理介入は、痛みのマネジメント・オピオイドの減量をサポートし人生を取り戻す手助けとなりうる。

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