
Prescription Opioid (Narcotic) Drugs in the Injured Population- Part II. Treating Pain with Opioids

To array a man's will against his sickness is the supreme art of medicine.

-- Henry Ward Beecher

Disability has an estimated annual price tag of \$300 billion with the top two causes of disability being the pain-related conditions of arthritis and back problems.¹ Pain is a subjective experience that is unique to the individual and influenced by past experiences, environmental and societal factors. While short-acting opioids are prescribed for acute episodes of pain, chronic pain conditions often warrant the use of both a long- and short-acting opioid drug for optimal pain management.

Acute pain is common with injury and is necessary to alert us that something is wrong. However, pain can transform into a chronic condition when it persists beyond the normal healing time. One-hundred and sixteen million adults in the U.S. have chronic pain. This number is expected to rise with the aging population, prevalence of obesity, improved methods for saving lives after trauma, and an increased awareness of chronic pain.² Chronic pain is associated with depression, insomnia, and anxiety. Persistent pain can impact relationships and ultimately reduce a person's perceived quality of life.

Prescribing Chronic Opioid Therapy- It's About Goals and Expectations^{3,4,5,6}

Nowadays, there is more emphasis placed on appropriate patient selection and risk assessment for chronic opioid therapy. A good candidate for long-term opioid therapy is a person with moderate to severe pain, impacting the patient's ability to function and quality of life, with a low potential to misuse these drugs. Evaluation of opioid abuse can be done through the numerous tools available to providers, such as the Opioid Risk Tool (ORT). Even though a patient scores moderate-to-high for risk opioid abuse, this does not necessarily disqualify this individual from being treated with opioid medication. It just means more intense monitoring is performed, abuse-deterrent formulations are prescribed, and possibly an addiction specialist is involved in the care of the patient.

Once the physician has determined that the patient would benefit from chronic opioid therapy, an opioid agreement should be signed to define expectations. Patients need to understand that pain relievers will not "cure" them or remove 100% of their pain. A survey of patients with chronic, severe, non-cancer pain stated that the primary reason they changed doctors was because they "still had too much pain."⁷ If these patients had understood the expectations from therapy, possibly a change in physician care would not have been necessary.

Chronic pain management is also about setting and achieving goals. Creation of function-based treatment goals (e.g. go to the grocery store once a week) is an important step that is often overlooked. The goals should be realistic, meaningful to the patient, and verifiable. Patients often function better when they realize that they have some control over their pain and goals help them to realize that they

¹ IOM (Institute of Medicine). 2011. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington, DC: The National Academies Press.

² Ibid.

³ Chou R, Fanciullo GJ, Fine PG, Adler JA, Ballantyne JC, Davies P, Donovan MI, Fishbain DA, Foley KM, Fudin J, Gilson AM, Kelter A, Mauskop A, O'Connor PG, Passik SD, Pasternak GW, Portenoy RK, Rich BA, Roberts RG, Todd KH, Miaskowski C; American Pain Society-American Academy of Pain Medicine Opioids Guidelines Panel. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain*. 2009;10(2):113-30.

⁴ Manchikanti L, Benyamin R, Datta S, Vallejo R, Smith H. Opioids in chronic noncancer pain. *Expert Rev Neurother*. 2010;10(5):775-89.

⁵ Fishman SM. *Responsible opioid prescribing. A physician's guide*. Washington, DC: Waterford Life Sciences; 2007.

⁶ Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain*. 2009;10(2):113-130.

⁷ IOM (Institute of Medicine). 2011. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington, DC: The National Academies Press.

do.⁸ With goals and an understanding of treatment expectations, the provider-patient relationship and overall care of the patient is improved.

When the physician begins prescribing for chronic pain, the initial opioid therapy should be viewed as a short-term trial. The patient should receive other non-opioid medications (e.g. ibuprofen) and non-drug treatment modalities for a comprehensive treatment plan. Treatment should be aimed at improving pain and function and meeting the defined patient goals. Monitoring of adherence and misuse through random urine drug screens, medication dispensing histories, and state prescription drug monitoring programs provides a reliable risk management program.

Opioid Adverse Drug Effects⁹

A recent *Cochrane Review* reported that 22.9% of patients taking oral opioid medications and 5.8% using transdermal drug delivery (patch) stopped treatment due to the adverse effects.¹⁰ Adverse drug effects, which occur in over 10% of patients receiving opioids, must be monitored. The most frequently reported effects are nausea, constipation, somnolence, dizziness, vomiting, and pruritus (itching). Some of the less common side effects include delayed emptying of the stomach, hyperalgesia (opioids produce pain), hormonal dysfunction, muscle rigidity, and involuntary muscle contractions.

How Long Should Opioids be Used?

The evidence for long-term opioid use (> 6 months) is limited and weak. Early use and high dosages of prescription opioids have been associated with increased disability, increased medical costs, and continued opioid use.^{11,12,13,14,15} Opioid therapy is recommended to continue when it is benefiting the patient. This means less pain, better function (meeting established goals), tolerable drug side effects, or returning back to work. Discontinuation of treatment by tapering the opioid drug down is advised when therapy no longer benefits the patient or if there are issues with non-compliance, misuse, or abuse.



⁸ IOM (Institute of Medicine). 2011. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington, DC: The National Academies Press.

⁹ Benyamin R, Trescot AM, Datta S, Buenaventura R, Adlaka R, Sehgal N, Glaser SE, Vallejo R. Opioid complications and side effects. *Pain Physician*. 2008;11(2 Suppl):S105-20.

¹⁰ Noble M, Treadwell JR, Tregear SJ, Coates VH, Wiffen PJ, Akafofomo C, Schoelles KM. Long-term opioid management for chronic noncancer pain. *Cochrane Database Syst Rev*. 2010 Jan 20;(1):CD006605.

¹¹ Trescot AM, Glaser SE, Hansen H, Benyamin R, Patel S, Manchikanti L. Effectiveness of opioids in the treatment of chronic non-cancer pain. *Pain Physician*. 2008;11(2 Suppl):S181-200.

¹² Webster BS, Verma SK, Gatchel RJ. Relationship between early opioid prescribing for acute occupational low back pain and disability duration, medical costs, subsequent surgery, and late opioid use. *Spine (Phila Pa 1976)*. 2007; 32:2127-2132.

¹³ Mahmud MA, Webster BS, Courtney TK, Matz S, Tacci JA, Christiani DC. Clinical management and the duration of disability for work-related low back pain. *J Occup Environ Med*. 2000; 42:1178-1187.

¹⁴ Franklin GM, Stover BD, Turner JA, Fulton-Kehoe D, Wickizer TM; Disability Risk Identification Study Cohort. Early opioid prescription and subsequent disability among workers with back injuries: the Disability Risk Identification Study Cohort. *Spine (Phila Pa 1976)*. 2008;33(2):199-204.

¹⁵ Kidner CL, Mayer TG, Gatchel RJ. Higher opioid doses predict poorer functional outcome in patients with chronic disabling occupational musculoskeletal disorders. *J Bone Joint Surg Am*. 2009;91(4):919-27.