



Use of Opioids for the Treatment of Chronic Pain

A statement from the American Academy of Pain Medicine

Proper management of pain is a high priority in the United States.

According to the recent Institute of Medicine Report on Pain, 100 million Americans suffer from pain. Treatment of pain costs the United States more than half a trillion dollars per year. Pain is one of the most common reasons people consult a physician. Yet it frequently is inappropriately treated.

In the last several years, health-policymakers, health professionals, regulators, and the public have become increasingly interested in the provision of better pain therapy and in the reduction of drug diversion and addiction. However, there is currently no nationally accepted consensus for the treatment of chronic pain not due to cancer. Moreover, the economic and social costs of chronic pain are substantial.

Federal and State laws and policies about opioid use are currently undergoing revision. The trend is to adopt laws and guidelines that specifically recognize the use of opioids to treat intractable pain. These statements serve as indicators of increased public awareness of the sequelae of undertreated pain and help clarify that the use of opioids for the relief of chronic pain is a legitimate medical practice.

Due to concerns about drug misuse, diversion and addiction, and regulatory scrutiny, physicians may want guidance as to what principles should generally be followed when prescribing opioids for chronic or recurrent pain states. Regulators have also expressed a need for guidelines to help them to distinguish legitimate medical practice from questionable practice and to allow them to appropriately concentrate investigative, educational, and disciplinary efforts, while not interfering with legitimate medical care.

The American Academy of Pain Medicine offers these Statements on the Use of Opioids for the Treatment of Chronic Pain:

I. Legislation and Regulatory Policies Should Limit Inappropriate Prescribing But Should Not Discourage Or Prevent Prescription Of Opioids Where Medically Indicated And Appropriately Managed.

The United States is in a critical phase of national and state policy development with respect to the use of opioids in pain treatment. There has been recent interest in this issue in both the United States Senate and the House of Representatives. State legislatures have enacted laws intended to reduce the prevalence of “pill mills” which have led to overprescribing of opioids with little to no medical necessity.

AAPM supports legislative actions which limit inappropriate prescribing while, at the same time, allow access for patients who suffer from moderate to severe pain. The purpose of laws that govern controlled substances and professional conduct is to protect the public. Thus, we believe that federal and state policies should be directed at reducing the problem of improper drug diversion and abuse while, at the same time, allowing appropriate medical treatment.

AAPM does not advocate the imprudent use of opioids. However, if a practitioner responsibly decides to treat chronic pain with opioids, we offer this document as a guide to the judicious use of these drugs in the course of medical practice.

II. Prescription Of Opioids For Chronic, Intractable Pain Is Appropriate When More Conservative Methods Are Ineffective And The Treatment Plan Is Reasonably Designed To Avoid Diversion, Addiction, And Other Adverse Effects.

AAPM believes that pain should be diagnosed and treated in a comprehensive, systematic, collaborative, patient-centered fashion. Many strategies and options exist to treat and to manage chronic pain. Since chronic pain may have myriad causes and perpetuating factors, treatment strategies and options include interventional techniques, cognitive and behavioral methods, rehabilitation approaches, and the use of medications, including, where medically indicated, opioids.

In many cases, there is no cure for chronic pain. Therefore, treatment goals and clinical focus include pharmacologic and non-pharmacologic methods to improve the management of pain, improve quality of life, and decrease suffering. AAPM advocates a collaborative approach which includes biological, psychological, and social interventions in order to improve pain control and psychosocial functioning.

Chronic opioid therapy (COT) should be reserved for those who have intractable chronic pain that is not adequately managed with more conservative or interventional methods. AAPM does not advocate opioids as a first-line therapy, but we believe that these medications may be useful if prescribed in a judicious manner as part of a logical progression of treatment. Of course, the physician must prescribe in a manner calculated to avoid addiction, diversion, respiratory depression, dependence, and other adverse effects. We also believe that responsible prescription of opioids should not be inhibited by fear of criminal prosecution or regulatory action.

III. Physicians Should Be Sensitive To And Seek To Minimize The Risks Of Addiction, Respiratory Depression And Other Adverse Effects, Tolerance, And Diversion. However, Some Commonly Held Assumptions About These Issues Need To Be Reviewed.

Addiction: Addiction is a neurobiological, compulsive disorder in which an individual becomes preoccupied with obtaining and using a substance-- and experiences a lack of control over using that substance -- despite continued use that results in a decreased quality of life and significant adverse consequences. Addiction is a serious problem that should be considered as a possibility in all patients receiving opioids. Physicians should act responsibly to reduce the risks of addiction. However, misunderstanding of addiction and mislabeling of patients as addicts may result in unnecessary withholding of opioid medications. In all cases, the physician must balance the possibility of addiction against the benefits of the therapy – striving always to reduce the risk of the former. In some cases, however, treatment by an addiction medicine specialist may be indicated.

Respiratory depression and other adverse effects: Fear of inducing respiratory depression is often cited as a factor that limits the use of opioids in pain management. While respiratory depression can occur with patients taking opioids, this risk can generally be minimized if certain precautions are followed. For instance, concomitant use of other neuro-depressive drugs, such as benzodiazepines and alcohol, should be viewed with great caution, since the combination of these drugs has been shown to increase the risk of serious adverse events. In addition, caution with dosing and titrations is indicated for patients with underlying diagnoses such as sleep apnea or end-stage respiratory disease due to the increased risk of cardio-respiratory events. There is emerging data suggesting that COT can be associated with central sleep apnea, although the details of the association are not well understood. Finally, patients do not develop complete tolerance to the respiratory depressant effects of opioids and the risk of respiratory depression increases as dose increases, regardless of how long one is on opioids. Additionally, people on COT who develop respiratory infections or asthmatic attacks may be at risk of hypoxia. Dose decreases during these events should be considered.

Tolerance: It was previously thought that the development of analgesic tolerance limited the ability to use opioids effectively on a long-term basis for pain management. Tolerance, or decreasing pain relief with the same dosage over time, has not proven to be a significant impediment to long-term opioid use. Experience with treating cancer pain has shown that what initially appears to be tolerance is usually progression of the disease. In the noncancer patient, the failure to respond to increasing doses of opioids should be evaluated very carefully. The possibilities include tolerance, disease progression, non-opioid responsive pain syndromes, and opioid-induced hyperalgesia.

Diversion: Diversion of controlled substances should be a concern of every health professional. Attention to patterns of prescription requests and the prescribing of opioids as part of an ongoing relationship between a patient and a healthcare provider can decrease the risk of diversion. Urine and/or blood drug screening, frequent follow up and patient contact, and pill counts are some commonly used clinical interventions that may be helpful in ruling out the issue of diversion. Periodic review of state prescription monitoring program databases, where available, is also a useful tool to monitor compliance and adequacy of communication.

IV. **Opioids Should Be Prescribed Only After A Thorough Evaluation Of The Patient, Consideration Of Alternatives, Development Of A Treatment Plan Tailored To The Needs Of The Patient And Minimization of Adverse Effects, And On-Going Monitoring And Documentation.**

AAPM believes that guidelines for prescribing opioids should be an extension of the basic principles of good professional practice.

Evaluation of the patient: Evaluation should initially include a pain history and assessment of the impact of pain on the patient, a directed physical examination, a review of previous diagnostic studies, a review of previous treatments, a drug history, and an assessment of coexisting diseases or conditions. When appropriate, the patient should undergo a baseline drug screening exam.

Treatment plan: Treatment planning should be tailored to both the individual and the presenting problem. Consideration should be given to different treatment modalities, such as an

interventional approach, a formal pain rehabilitation program, the use of physical medicine and psychological and behavioral strategies, or the use of medications, depending upon the physical and psychosocial impairment related to the pain. Opioids should be prescribed only if the physician reasonably concludes that other treatment modalities will be inadequate to address the patient's pain. If a trial of opioids is selected, the physician should ensure that the patient or the patient's guardian is informed of the risks and benefits of COT and the conditions under which opioids will be prescribed. AAPM has recently updated its guidance for the proper consent for the use of opioids. A trial of opioids implies setting expectations that the medications will be prescribed for a short period of time. Continued use will be contingent upon demonstrated improvement in analgesia, physical function and quality of life – and absence of significant adverse events and maladaptive behaviors.

Consultation as needed: Consultation with a Pain Medicine or other specialist may be warranted, depending on the expertise of the practitioner and the complexity of the presenting problem. The management of pain in patients with a history of addiction or a comorbid psychiatric disorder requires special consideration.

Periodic review of treatment efficacy: Review of treatment efficacy should occur frequently to assess the functional status of the patient, continued analgesia, adverse effects, quality of life, and indications of medication misuse. Monitoring of compliance is a critical aspect of chronic opioid prescribing, using such tools as random urine drug screening, pill counts, and where available, review of prescription monitoring data base reports. Close follow-up and reexamination is warranted to assess the nature of the pain complaint and to ensure that opioid therapy is still indicated. Attention should be given to the possibility of a decrease in global function or quality of life as a result of opioid use.

Documentation: Documentation is essential for supporting the evaluation, the reason for opioid prescribing, the overall pain management treatment plan, any consultations received, and periodic review of the status of the patient.