

Long-term Opioid Treatment of Nonmalignant Pain

A Believer Loses His Faith

AS A PATIENT-CENTERED INTERNIST, I HAVE never wanted a patient of mine to suffer needless pain. During my residency in the 1980s, I was influenced by studies showing that physicians undertreated pain, and I vowed that I would not practice in that way. Although many physicians I knew refused to enroll with the federal Drug Enforcement Agency for the right to prescribe controlled substances because they wanted an easy excuse to say they could not write prescriptions for opioids, I got my "triplicate pad" as soon as I finished internship and had my license.

Since the mid-1980s, I have cared for countless patients dying of AIDS and other types of cancers and have prided myself on not letting them die in pain. During this time, I have also cared for patients with other types of pain, especially musculoskeletal pain, and have applied the same lessons of pain management that I was taught in residency and that were reinforced by my state-mandated continuing medical education credits on pain management: Pain is a subjective experience, and so a patient's report of pain is the only way of gauging the need and the response to therapy; when the condition cannot

and diversion of medication (sale to others).^{1,4} Fourth, although it is clear that opioids relieve short-term pain, there is no evidence from randomized controlled studies indicating that they are effective in the long-term treatment of chronic pain.⁵

Suddenly, I find myself to be a believer who has lost his faith. At the county hospital where I practice and oversee the care of all the patients as director of the county health department, there are many patients receiving long-term treatment (including by me) with high-dose opioids for nonmalignant pain. As was found by Braden et al⁶ in this issue of the *Archives*, common diagnoses for opioid-prescribed patients are musculoskeletal problems (joint pain, back pain, neck pain, extremity pain), and opioid doses are frighteningly high. Braden et al identified almost 50 000 people without a malignant neoplasm who were not in hospice programs and who had used opioids continuously for at least 90 days. The median opioid dose was a morphine equivalent of 120 mg/d. For patients taking both long- and short-acting opioids, the mean (SD) doses were 217 (314) mg/d in one sample and 192 (199) mg/d in the other, the high standard deviations indicating that some patients were taking much higher doses. Other researchers have reported patients taking doses as high as 1 g/d morphine equivalent.⁴

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be alleviated with definitive treatments (eg, medications, surgery, radiation) or minor pain relievers, it is appropriate to use opioids; if the opioid does not result in complete pain relief, titrate the dose up until the patient is comfortable; a mental illness or history of substance use is not a reason for denying needed pain medication.

Although I am still convinced that the principles of pain management that I have followed are correct for patients with cancer or other painful life-threatening diseases, and for the short-term management of painful conditions (eg, sickle cell crisis, kidney stones), I have come to question whether the long-term treatment of nonmalignant pain is causing more harm than good. Four things can be said with certainty. First, the use of opioid treatment for nonmalignant conditions has grown during the last 2 decades.¹ Second, with the increase in the use of opioid treatment for nonmalignant pain, there has also been an increase in the number of deaths due to opioid overdose.^{2,3} Third, long-term opioid use is associated with a number of adverse consequences in addition to overdose, including decreased cognitive function, constipation, hyperesthesias (increased pain due to the use of opioids), immune suppression, hormonal changes, addiction,

WHY WOULD PHYSICIANS PRESCRIBE SUCH HIGH OPIOID DOSES?

If readers wonder how patients without malignant conditions can so commonly reach such high doses of opioids, consider the following scenario that has happened in my practice many times: The patient complains of pain. You perform the appropriate examination, and more often than not you find the pain to be musculoskeletal and without treatable cause. You prescribe a nonsteroidal anti-inflammatory drug (NSAID) and urge gentle mobilization—as much exercise as the person can achieve without hurting himself. Some patients will already be asking for opioids at this point, telling you that a friend or family member got better by taking a particular pain medicine, and could they have that one. They may already have "borrowed" some of it and attest that it works very well. Nonetheless, you send them out with just the NSAID on this visit.

A certain number of patients get better with NSAIDs and time; a certain number do not. For those still complaining of pain, you next prescribe a short-acting opioid with a relatively low potency, such as acetaminophen with codeine. You know shorter-acting agents are

Consensus guidelines that establish a maximum recommended dose for long-term treatment of nonmalignant pain with opiates could help. It is not reasonable or fair to expect practicing clinicians to hold the line on opioid prescriptions, given that consensus guidelines fail to define any upper limit on dosing. The existence of a formal maximum recommended opioid dose for patients with nonmalignant pain would reduce the harm from these medications by eliminating the highest doses that have been associated with the highest likelihood of overdose.² It would also decrease the unhealthy patient-physician negotiation that often occurs when patients seek higher doses. We would simply tell patients that they are already receiving the highest recommended dose. Instead of fearing being accused of failing to address a patient's pain in accordance with community standards, physicians who prescribed above the recommended dose would take extra care to be certain that the circumstances truly warranted exceeding the recommended dose. For many patients, knowing that there is a firm ceiling on the dose saves them from having to press for higher doses. Perhaps most importantly pain guidelines should explicitly acknowledge that not all chronic pain can be eliminated. Learning how to cope with pain can be more empowering for patients than trying to find a pill to completely eliminate it.

FOR CHRONIC PAIN ESTABLISH A MAXIMUM OPIOID DOSE

Our therapeutic alliance. Uptake drug testing, in my mind, poses a different problem. Requiring drug testing tells my patients that I do not believe them. This is not a message that I want to give to my patients. Some patients sell their prescribed pain medicines—and we should all be concerned about this because prescription drugs purchased on the street lead to overdoses, including among teenagers with little experience using these drugs. However, to base my physician-patient relationships on the idea that my patients are lying to me is against my values and interferes with

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RECOMMENDED STRATEGIES FOR LONG-TERM OPIOID TREATMENT

Readers who are expert in modern pain management may think that I have ignored some key pain treatment guidelines: medication contracts, evaluation for mental health and substance abuse issues, referrals to pain specialists, and urine testing. However, I can say from the front line that while all of these measures have value, none solves the problem. Medication contracts are an excellent way of clarifying responsibilities of both the patient and the physician with regard to pain control.^{3,7} But when you create a contract, and the patients do not follow their part of the bargain, what do you do next? For example, a very common and sensible provision in a contract is that the patient should not receive pain medications from any other physician. What do you do if they tell you that they were in such great pain that they went to the emergency department the prior night and received a small number of additional opioid pills? Are you going to wean them from their opioids? But what about their pain? What if they live in a homeless shelter and tell you that their prescription was stolen? What if it happens a second time 4 months later? These are difficult and common occurrences. Patients receiving pain medicines for nonmalignant conditions have a high incidence of underlying mental health and substance abuse disorders,⁸ and we should evaluate and treat these disorders. Indeed, most of my patients who are receiving opioids for nonmalignant pain are also taking psychotropic medications and have been through multiple substance abuse programs. Should I therefore refuse to treat their pain? Certainly people with mental health and substance abuse problems are not immune to pain, and I am not prepared to tell my patients that I will not treat their pain because of their underlying mental illness or substance addiction. Referral to pain clinics is particularly helpful when patients have pain that could be alleviated by a nerve block. These patients are, however, the minority. Sending pa-

tients to a pain specialist to help with outpatient opioid medication can ease the burden of the primary care physician, and many clinics have interdisciplinary staff to help manage underlying mental health and substance use problems. However, such referrals undermine the relationship between patients and their primary care physicians and suggests that the pain, which is very much a global problem, is in some way separable from physical and mental health. Furthermore, from a practical point of view, pain clinics might not be an option for uninsured low-income patients.