Chronic pain management in dermatology

Pharmacotherapy and therapeutic monitoring with opioid analgesia

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Learning objectives
Describe the clinical settings in which it may be appropriate to initiate opioid therapy for the management of chronic pain, in particular for pain states that manifest in dermatologic conditions, and discuss appropriate therapeutic goals; assess patients' pain to select an appropriate opioid agent and dosing regimen, with close attention to minimizing treatment-related side effects; discuss the safe and effective titration of analgesic dosing after initiating opioid therapy, including the consideration of opioid rotation, referral to a specialist in pain management, and/or discontinuation of therapy as indicated and describe components of routine therapeutic monitoring and discuss the signs of aberrant drug-related behavior.

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A number of chronic dermatologic conditions may necessitate long-term adjunctive pain management in addition to treatment of the primary skin disease, such as hidradenitis suppurativa, lichen planus, and other systemic diseases associated with significant pain. Adequate management of chronic pain can represent a unique challenge, but remains an integral component of clinical treatment in relevant contexts. For nociceptive pain of moderate to severe intensity, opioid analgesics can be beneficial when other pain management strategies have failed to produce adequate relief. The decision to initiate long-term opioid therapy must be carefully weighed, and individualized treatment plans are often necessary to effectively treat pain while minimizing adverse effects. Part II of this 2-part continuing medical education article will describe the appropriate settings for initiation of opioid analgesia for dermatology patients and detail therapeutic strategies and patient monitoring guidelines. (J Am Acad Dermatol 2015;73:575-82.)

Key words: nonsteroidal antiinflammatory drugs; opioid analgesia; pain; postherpetic neuralgia.

Chronic pain is extremely common, and by definition is persistent and often difficult to treat. In the dermatologic context, pain in addition to primary disease burden can confer

Abbreviations used:

FDA: US Food and Drug Administration
NSAID: nonsteroidal antiinflammatory drug

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significant quality of life impairment and morbidity for affected patients. For centuries, opioid analgesia has remained a mainstay of pain management, and its efficacy is well-established. For nociceptive pain of moderate to severe intensity, opioids can be useful when other analgesics fail to produce adequate relief. In the appropriate clinical context, with reasonable precautions and monitoring in place, opioid analgesia can be an effective and safe tool to treat refractory pain.

The use of opioid therapy has increased substantially in recent decades, particularly in the treatment of non–cancer-related chronic pain. Global data reveal that the average opioid (morphine equivalent) consumption increased from 1.82 mg per person in 1980 to 61.66 mg per person in 2011.[1] Along with this expansion in opioid-prescribing practice, there have been corresponding increases in opioid-related abuse and death.[2] Long-term opioid therapy does remain controversial for a number of reasons. There is limited availability of scientific evidence in the setting of chronic noncancer pain to guide pain management. In addition, opioid therapy is vulnerable to misuse and/or abuse given its psychotropic and potentially addictive effects.

Despite these legitimate concerns, pain management experts recommend that patients suffering from chronic nonmalignant pain should not be denied opioid therapy, despite hesitation surrounding their long-term use (related to adverse effects, long-term tolerance, and the potential for misuse and/or addiction).[1,3,4]

The decision to initiate long-term opioid therapy must be carefully weighed. After a comprehensive medical history and physical examination, physicians can clearly establish that nonopioid therapy has failed. Informed consent procedures should include a discussion of treatment goals, potential risks, and adverse effects.[4] It is also important to remind patients to lock their medications to prevent drug theft and diversion.

Many practitioners have developed "opioid contracts" to facilitate informed consent and mandatory follow-up. The value of these treatment agreements, however, has yet to be demonstrated by high-quality evidence. Controversy surrounds their use, particularly because of the impact of the substantial legal ramifications after inappropriate prescription of opioid analgesics.[4] When possible, it is optimal to involve a single clinician and pharmacy for patient safety and monitoring. In addition, individualized treatment strategies are often necessary. To adequately treat pain and minimize adverse side effects, the counsel of a specialist with expertise in pain management may be required.[5]

SELECTING OPTIMAL AGENTS AND DOSING SCHEDULES

Key points

- **In general, for the management of chronic pain, pure μ-opioid agonists are chosen**
- **Chronic pain treatment with opioids is largely based on the intensity of pain, patients' previous and current analgesic regimens, and comorbid medical illnesses**

Opioid agonists bind to and activate endogenous μ receptors in the brainstem to produce analgesia. Opioid analgesic effects are complex, and a given opioid may function with different potencies as an agonist, partial agonist, or antagonist at >1 receptor class or subtype. It is therefore unsurprising that these agents are capable of diverse pharmacologic effects.[6] The American Pain Society and American Academy of Pain Medicine outlined recommendations for the management of chronic pain (Table I). Generally, chronic pain treatment should begin with regular administration of shorter-acting opioids (every 4 to 6 hours for most oral agents) until adequate analgesia is achieved. After a short-term initial trial of opioid treatment, patients and clinicians may choose to proceed with longer-term therapy.[4] Low-dose short-acting agents continue to be recommended in this setting because of the reduced risk of inadvertent overdose.

For treatment of sustained pain, around the clock dosing or transition to a longer-acting opioid is reasonable. Longer-acting formulations permit superior, prolonged relief without rebound pain caused by a rapid fall in plasma opioid concentrations.[5] Although it remains controversial, they are potentially associated with improved adherence profiles and a decreased potential for abuse. To dose a long-acting opioid, clinicians may first prescribe and titrate short-acting agents. The 24-hour short-acting drug requirement may then be converted to a sustained release preparation to be dosed 2 to 3 times daily around the clock. Conventionally, two-thirds of the daily requirement is prescribed as a long-acting formulation, with doses of immediate-acting drug to be taken on an as-needed basis (calculated as 5-15% of the total daily opioid dose).[7] Low-risk patients on stable as-needed doses of short-acting agents need not switch to a different regimen if clinically unnecessary.[4] When patients develop tolerance, they may require an increase dose of opioid to achieve a given analgesic effect. Clinicians may then use the following approaches: