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Current Concepts in Physiatric Pain Management

How to Maximize Patient Safety When Prescribing Opioids

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Abstract

Opioid prescribing and deaths in the United States have increased exponentially in the past couple of decades. This increase has occurred amidst growing awareness of the lack of long-term efficacy of opioids, as well as the significant long- and short-term risks associated with these medications. The scope of the opioid epidemic has led to the development of extensive clinical screening and monitoring tools recommended for health care providers who prescribe opioids to patients for chronic nonmalignant pain. The purpose of this review is to summarize the latest guidelines and evidence that will assist in maximizing patient safety while using chronic opioid therapy as part of pain management.

Introduction

Opioid prescribing in the United States for chronic nonmalignant pain has increased exponentially in the past couple of decades and has led to an epidemic of overdose and deaths. According to data from the Centers for Disease Control and Prevention, the rate of deaths involving opioid use (up to 16,235 deaths in 2013) parallels the 300% increase in opioid sales since 1999 (Figure 1) [1].

This increase in opioid prescribing has continued despite lack of good long-term evidence to support the use of opioids for chronic pain [2-4]. Furlan et al [2] conducted a meta-analysis of 41 randomized controlled trials in which opioids were more effective than placebo for pain and functional outcomes for nociceptive or neuropathic pain or fibromyalgia; however, none of these trials were longer than 3 months, the average study length was 5 weeks, and most were sponsored by the pharmaceutical industry. A 2010 Cochrane review evaluated longer-term studies, that is, greater than 6 months; however 25 of the 26 studies were either case series or uncontrolled trials, and the authors concluded the evidence supporting opioids for chronic pain was weak [3].

Opioids also are associated with short-term risks, including nausea, vomiting, constipation, drowsiness, and respiratory depression. Long-term risks include tolerance, dependence, addiction, hyperalgesia, hormonal, changes including hypogonadism, osteoporosis, depression, and cognitive impairment [4,5].

Given the limited evidence for long-term effectiveness, short- and long-term risks, and public health concerns of escalating overdoses and deaths, tools have been developed to more effectively screen and monitor patients who are taking opioids for chronic nonmalignant pain. This article will review the latest guidelines and evidence for maximizing opioid safety.

Screening

Proper patient assessment and selection is essential before the initiation of opioid therapy for chronic pain. Elements of an appropriate evaluation for chronic opioid therapy include conducting a thorough history and physical examination, appraisal of previous nonopioid treatments, psychological evaluation, addiction and opioid risk assessments, urine drug testing, and review of prescription drug monitoring program report.

History and Physical

The prescribing health care provider should conduct a thorough history and physical examination, including assessment of all painful areas; onset, nature, and intensity of pain; and impact on physical and psychological function. Previous patient medical records, including diagnostic workup and past treatments, should be reviewed if available. If the patient is currently being prescribed opioids for an established chronic pain condition, the provider evaluating the patient should

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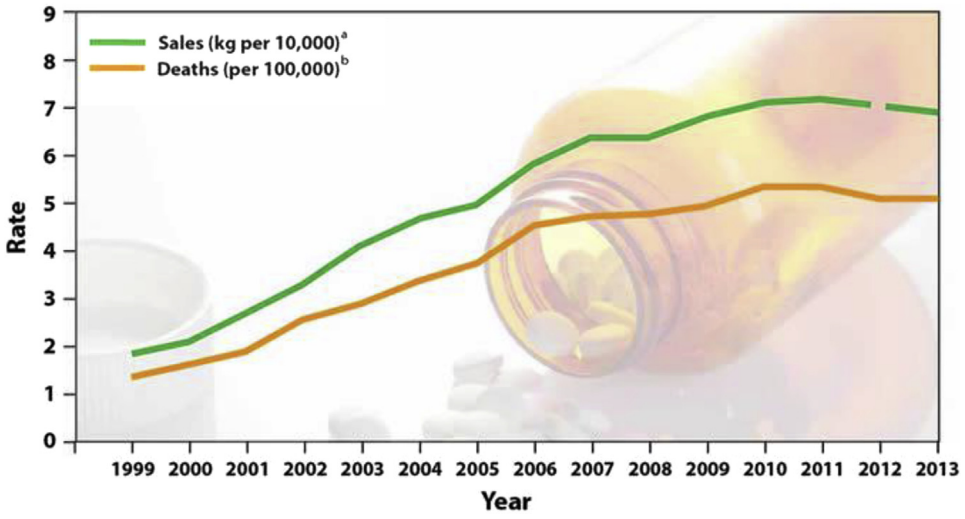

Figure 1. Prescription painkiller sales and deaths. Sources: [a]Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2012 data not available. [b]Centers for Disease Control and Prevention. National Vital Statistics System mortality data, 2015. Available at: http://www.cdc.gov/drugoverdose/data/.

attempt to review the records of the previous treating provider before continuing opioid therapy. The patient's medical history should be reviewed, especially for comorbid conditions that would pose an increased risk with opioid therapy (eg, chronic obstructive pulmonary disease, dementia). Social history should include employment or daily activity level and family or social support. Family history should screen for psychiatric conditions or addictive illness [6-10].

The physical examination should include assessment of cognitive abilities (eg, orientation, memory, insight, and judgment), gait and functional tests, neurologic examination, and appropriate examination specific to the painful area(s). For example if the patient's chronic pain is a musculoskeletal condition, the provider should perform standard inspection, palpation, range of motion, and special maneuvers (eg, straight leg raise test) for the particular body part(s) involved [11,12].

Assess Nonopioid Therapies

It is important to review the patient's past nonopioid treatments, such as adjuvant medications, physical therapy, interventional procedures (when applicable), and behavioral treatment (eg, cognitive behavioral therapy, mindfulness-based approaches). When appropriate, consultation with a specialist related to the patient's pain complaint should be pursued to evaluate for any treatable pathology. Consider delaying initiation of opioid therapy if the patient has not received adequate medical workup or trials of nonopioid treatments [7-9].

Psychological Evaluation

Psychological assessment should include screening for depression and other mood disorders, anxiety-related illnesses, sleep disturbance, and personality disorders. A useful tool for psychological screening is the Patient Health Questionnaire-9 (PHQ-9; Figure 2). The PHQ-9 contains 9 items, each scored 0-3, providing a 0-27 severity score. See Table 1 for summary of scoring.

If the patient appears to have an untreated or unstable psychological state, either from clinical judgment or abnormal scoring on a questionnaire (eg, moderate-to-severe depression on PHQ-9), evaluation and treatment by a mental health provider should be considered prior to initiating opioid therapy. The risk of opioid therapy likely outweighs the potential benefit in patients with uncontrolled psychological function, suicidality, and severe personality disorders [8-10].

Risk of Addiction

A history of substance use should be obtained, including current or past use of alcohol, tobacco, illicit drugs, and prescribed controlled narcotic medications. Family history of abnormal or inappropriate substance use is also important to elicit. Personal and/or family history of drug abuse and is a strong predictor of addictive or aberrant drug related behaviors after starting opioid therapy [6]. In this patient population, consultation with an addiction medicine specialist should be considered prior to initiating opioid therapy [8,9].

Assessment of Opioid Risk

Assessment tools such as Opioid Risk Tool (Figure 3) and the Revised Screener and Opioid Assessment of Patients with Pain have been developed to screen for the risk of addiction or aberrant drug related behaviors. Several society, state, and national guidelines