Opioid Use and Depression in Chronic Pelvic Pain

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KEYWORDS

• Chronic pelvic pain • Addiction • Opioid • Narcotic • Depression

KEY POINTS

- Opioid prescribing is a national epidemic, associated with high rates of diversion of prescription therapeutics.
- Opioid therapy should rarely be initiated for patients with chronic pelvic pain, even in the setting of a referring practice or emergency department.
- Screening tools can help predict and detect opioid addiction and diversion.
- Women on chronic opioid therapy for chronic noncancer pain should be weaned off their medication before attempted conception.
- Women with chronic pain should be screened for depression and treatment or referral provided when positive.

INTRODUCTION

Prescription medication abuse has become a national epidemic. In 2011, more than 238 million narcotic analgesic prescriptions were written, with more attributable deaths than heroin and cocaine combined.[1] According to data from the 2010 National Survey on Drug Use and Health,[2] the nonmedical misuse of prescription psychotherapeutics, including opioids, was the second leading type of illicit drug abuse, behind marijuana. Further data from the Survey found that almost one-third of people aged 12 and over who initiated illicit drug use for the first time began by using a prescription drug nonmedically. In addition, review articles on the use of opioids for chronic pain have found limited data supporting their long-term use in a variety of pain conditions.[3]

Women's health care providers are confronted with several chronic pain syndromes ranging from irritable bowel syndrome, interstitial cystitis and endometriosis, to musculoskeletal pain, vestibulitis, and pelvalgia. Often patients present to the consultant already having received long-term narcotic prescriptions, initiated from other providers. Volkow and McLellan[4] found that the main prescribers of opioids are primary care

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providers, followed by dentists and orthopedic surgeons, with the main prescribers for patients aged 10 to 19 being dentists. Emergency room visits also led to significant opioid prescribing. In one large insurance database, it was found that more than 400,000 narcotic prescriptions were written in 2009 through emergency departments for plan enrollees aged 18 to 64. More startling was that 10% of these patients who received narcotic prescriptions did so despite identifiable risk factors for opioid misuse.[5]

Primary care providers have reported unease at chronic opioid prescribing, while simultaneously noting the difficulty of referral to pain management centers.[6] In the author's practice, the patient's access to medication management by trained pain specialists is often limited by insurance considerations as well as the procedural focus (ie, injection therapy) of many pain management physicians.

THE PAIN EXPERIENCE

The experience of pain varies from patient to patient and is a factor of the patient's underlying coping skills, mental health, support, and potential secondary gain.[7] Furthermore, chronic pain and the medications used to treat pain lead to other complications, such as sleeplessness, job performance issues, and relationship issues (**Fig. 1**).

The perception of pain carries 2 components best summed in the legal term, "pain and suffering." The pain component, or sensory-discriminative component, is quantifiable and amenable to therapy. Suffering, or the affective-motivational component, is more difficult to quantify and treat with therapies targeted at the disease process.[7] Thus, one aspect of the physician-patient educational component is that therapy may, "fix your pain but not your suffering." It is important that alternative options for pain control are discussed with the patient. Physicians should be aware of resources in his or her community. Establishing collegial relationships with local counselors, acupuncturists, and pain management specialists allows the obstetrician/gynecologist (OB/GYN) to develop a multidisciplinary approach to the patient with chronic pelvic pain (CPP).

NARCOTIC ACTIONS

Nociceptive (pain) signals are transmitted to the superficial dorsal horn of the brain via sodium-dependent depolarization predominantly via A-δ and C fibers.[8] Opioids have

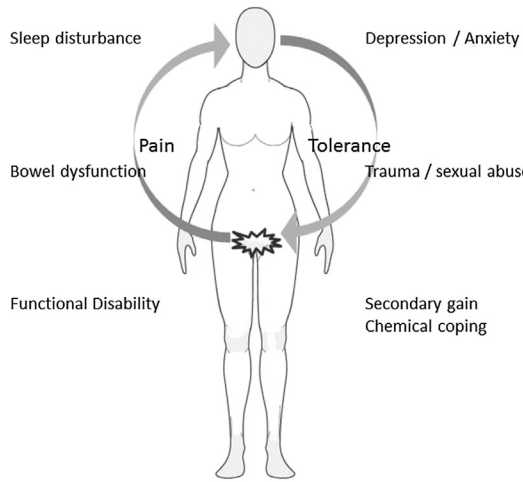

Fig. 1. The interaction of CPP with other psychosocial factors.