Opioid Therapy in Chronic Pain

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KEYWORDS

• Opioid dependence • Addiction • Pain management • Dependence

KEY POINTS

- Not all patients with pain are suitable candidates for chronic opioid therapy (COT).
- Short-term opioid therapy has different goals and purposes and should not progress to COT without reconsideration of goals and purposes.
- Opioid dependence develops in all patients receiving COT, may have a strong psychological component, and is not always easily reversible.
- COT should be goal oriented and discontinued if goals are not met.
- There are significant safety issues that need consideration during COT.

INTRODUCTION

Opioids have a long history of use for the treatment of pain, and despite efforts to find alternatives, they remain the strongest and most effective analgesics available. The downside is that they are addictive and potentially dangerous, especially when used not as prescribed, and there are many complex reasons why opioids used to treat pain in outpatients, who control their own use, may not be taken strictly as prescribed. Throughout history, although recognizing the value of opioids in treating serious pain, especially acute pain and pain at the end of life, there has been caution about using opioids to treat chronic pain. This caution existed because of the perceived increased risk of addiction when opioids are used long term and at home. There has been a surge in prescribing of opioids for chronic pain, especially in the United States, and this surge has been produced by a combination of increased availability, production of new opioids and new formulations that have been aggressively marketed, and changed beliefs about whether the risk of addiction for some should preclude use when it might help the many who do not become addicted.[1] The surge in prescribing for chronic pain has produced a parallel increase in cases of opioid abuse and related deaths,[1–3] and despite what is now more than 2 decades of experience, it is still unclear whether, and under what conditions, opioids can be used to treat chronic

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pain safely and effectively. Many questions remain, but what this article presents is how opioids should be used to treat chronic pain considering recent concerns about their efficacy and safety.

PATIENT SELECTION

Not all patients are suitable candidates for opioids. In fact, proper selection of candidates for the treatment can do more to improve efficacy and safety than any other aspect of managing the treatment. It is tempting to think that a patient's complaint of severe pain is enough to warrant use of strong pain medications. Recent teaching has been that a report of severe pain warrants treatment with opioids if all efforts to use alternative treatments have failed. But recent evidence shows that for some pain conditions, opioids not only may not work well but also may hinder the progress toward recovery that can be achieved by other means.[4–9] It is becoming clear that this is true for several pain conditions and is particularly true for musculoskeletal pain. Opioids allow people to rest comfortably and are useful for providing comfort.[10] They are also useful during acute onset or acute exacerbations of pain when they can reduce pain enough to start the process of active rehabilitation. With long-term usage, however, they may have a different role. Analgesia is not always maintained long term, and the numbing effect of opioids tends to make people less inclined to move even when exercise, or at least maintained activity, is the intervention most likely to achieve recovery. There are many musculoskeletal conditions and so-called centralized pain states such as nonstructural low back pain or fibromyalgia, where the numbing effects of opioids can actually lessen the likelihood of recovery.[11–15] At the same time, when there is significant damage due to disease, trauma, or surgery, and normal activity is not a realistic goal, the numbing effect of opioids can be helpful and may even improve function in patients with serious functional incapacity. Opioids at low doses can also be helpful in low-risk patients who are intolerant of alternative treatments and cannot realistically be active, for example, the elderly. Choosing candidates for opioid therapy based on their disease state and not on their reported pain severity has several advantages. It allows one to exclude cases that are more likely to recover without opioids. It allows one to target opioids only toward cases that can be improved. It removes the need to make judgments about pain severity and what a report of pain suggests. Past teaching was that because pain is a subjective experience, "pain is what the reporting person says it is." Although this is indisputable, severe pain that would be better managed without opioids should not be treated with opioids simply because of a report of severe pain. Decisions about the suitability of opioid treatment must always be made on an individual patient basis, but **Table 1** attempts to summarize some of the broad categories of suitability for long-term opioid treatment.

BASIC PRINCIPLES OF CHRONIC OPIOID MANAGEMENT

- Decisions about opioid treatment always take place after a full history and physical examination and after reaching and documenting a pain diagnosis.
- Continuous treatment with an opioid for 90 days or longer is COT.[16]
- At 90 days, or preferably sooner, a process of shared decision making needs to occur concerning whether COT is a good choice.[17–21]
- Before offering COT[21]
  - Patient completes a screening instrument for addiction risk.
  - Baseline urine drug toxicology screen is done.
  - If available, active or prior usage is checked in prescription monitoring system.