

Informed Choice: Information about Pain Management with Opioid Therapy ^{v1.1}

Michael Caruso PT

If you have ongoing pain (unrelated to cancer), you may be considering using, or you may currently be using, opioid medication treatment prescribed by your doctor.

The more you know and understand about any treatment can greatly alter effectiveness, your pain experience, and the results of treatment. The information provided below is intended to improve your decision making about your care.

Recent concerns about the risks, and uncertainty about benefits using opioid therapy, indicates the need for more careful consideration by both the individual patient and their doctor. Some alternatives that are patient-centered are noted below.

Questions you may have about using opioid medication:

How do I evaluate a treatment option recommended by my doctor?

All treatments have risks and benefits. “*What are the risks?*” and “*What are the likely benefits?*” are questions for your doctor.

Seek credible information that is not simple advertising. Unfortunately many doctor’s offices are littered with ads from companies that supply drugs and medical devices. Most of these do not come with solid evidence of effectiveness and risks are understated and safety implied -just based on where they are displayed.

In regard to opioid therapy: there is a pressing need, for scientific research that might help select individuals with chronic pain for opioid therapy. The current method of selection is a long process of trial and error that exposes many thousands of patients to long-term opioids needlessly (Turk D, 2009).

Other questions that may come to mind are:

What criteria will be used to determine if this is the best alternative for me?

Are there other alternatives to starting on an opioid now?

What are the alternatives in the future if this type of medication is no longer effective?

How will you help me get off these medications when I become dependent on them?

How effective is using opioid medication?

Opioids are not a magic bullet against chronic pain. Even when opioids are beneficial, they do not *cure* pain. Thus patients need to be aware that they will have to continue to function despite continuing pain. **Realistically the scientific evidence suggests that opioids may reduce pain by about 30% to 35%—but only among a minority of patients (about 40%).** This approach is not for everyone and many decide to abandon it as an option. In studies using opioid medication, about 40% of subject patients terminate treatment on their own. One explanation is that they just don’t find that the benefit is worth the cost (Turk D 2009). There is evidence to support the initial effectiveness of opioids for the treatment of chronic pain, but the effectiveness for long-term use is unknown (Ballantyne, 2008). And given the lack of evidence from long-term trials, it is not clear if any benefit is a short-term or sustained response (von Korff 2008).

Is it possible to identify patients with chronic pain who will respond well to opioid treatment?

No single tool exists to assess or predict characteristics or profiles for opioid efficacy (Riley 2008).

How do I find out if opioid treatment will be effective without taking on the risks?

Patients who do not find adequate pain relief in the first few weeks of opioid therapy are probably not good candidates for long-term therapy. Research has shown that if patients are not receiving reasonable improvement by three months, they are not likely to do so at some later point. It is important to craft an exit strategy—and suggest alternative treatment approaches—for patients who do not make sufficient progress (Turk D, 2009).

What are the risks of using opioids?

Although long-term opioid use is tolerated well by the body and toxicity is rare, there is the predictable development of tolerance to physical dependence on the drug (Kreek,1982). Current literature has raised concerns due to increasing awareness of adverse effects on the whole person. Increased sensitivity to pain, reduced cognition, and reduced coping ability (Hadler 2005). Other affects are substance abuse, overdose, falls and fractures, de-activation, reduced functional level (vonKorff 2008) Complicating factors common in many pain patients make opioid medication use less effective. “Ironically, patients with major depression and other psychiatric disorders are more likely than others to initiate and to continue opioid therapy, yet they are

also more likely to misuse medication, and may be less likely to experience analgesic benefit,” according to (Deyo, 2009).

Overdose: The trend data coming out of the Centers for Disease Control (CDC) on unintentional overdose death rates associated with opioids soared from 1999 to 2004 (from 2,900 in 1999 to at least 7,500 in 2004, an increase of 160% in just 5 years). “By 2004, opioid painkiller deaths numbered more than the total of deaths involving heroin and cocaine in this category (Paulozzi, 2008.)

A full understanding of side effects may not be possible because information concerning the side effects, adverse reactions, and toxicity of any drug is often fragmentary. “Addiction” would not be recognized unless treatment was discontinued. However, we have found that testosterone may remain decreased in around 20-30% of patients after one year of chronic treatment with methadone (Kreek, 1982).

Do I need more medical tests for a diagnosis?

All persistent pain states need a medical workup to rule out serious problems. Once cleared, most other efforts to pinpoint the cause of pain is a guess. It is often not possible to get a definitive diagnosis, and in some cases it can be harmful. For example, the diagnosis of fibromyalgia itself worsens the condition by encouraging people to think of themselves as sick and catalog their pain (Hadler 2008).

What are the alternatives to taking opioid medication?

The development of more reasonable, patient-centered approaches to address chronic pain is advocated (McClellan 2008). Learning about how pain actually works, and how movement and posture effect pain are supported by science as a means of managing your pain; they reduce the fear and the threat of your experience.

If you hurt when you move, treatment approaches that assess movement and posture are more effective than looking at an MRI or x-ray (Hadler 2008). If you already have an MRI try not to worry about it -focus on improving movement and posture. If you need, help, find a therapist to serve as a coach; that is informed of the evidence, that will listen and answer your questions, and guide you in better posture and movement. Learn to progress using graded exposure –rather than the “no pain, no gain” approach that is not helpful. A home program should start the first visit. Avoid therapists that sign you up for long treatment

courses, use specialized machines, or sell supplements. What works best is what you learn and do; the rest has poor scientific support (Hadler 2008).

Get to Know your Pain. The “Explain Pain” book and CD teaches ordinary people current concepts about how pain works.

It is now known that understanding more about why things hurt can actually help people to overcome their pain. Recent advances in fields such as neurophysiology, brain imaging, immunology, psychology and cellular biology have provided an explanation platform from which to explore pain (Butler and Moseley 2005).

Try the “Explain Pain” CD or book available at www.optp.com.

References:

- Ballantyne JC and Shin NS, *Efficacy of opioids for chronic pain*. Clinical Journal of Pain,2008; 24: 469–78.
- Butler D and Moseley L, *Explain Pain*. NoiGroup Pub. 2005 www.optp.com; NOIgroup.com
- Deyo RA et al., *Overtreating chronic back pain: Time to back off?*, Journal of the American Board of Family Medicine,2009; 22:62–8.
- Hadler N, *Worried Sick*. UNC Press 2008
- Hadler N, NewYorkTimes Jan 14, 2008 http://www.nytimes.com/2008/01/14/health/14pain.html?_r=1&oref=slogin (Dr. Nortin Hadler, a rheumatologist, eminent physician and scientist, renowned clinician and clinical educator, and professor of medicine at the University of North Carolina who has written extensively about fibromyalgia.
- Hudson TF et al., *Epidemiology of regular prescribed opioid use: Results from a national population-based survey*. Journal of Pain and Symptom Management,2008; 36:280–8.
- Kelly JP et al., *Prevalence and characteristics of opioid use in the US adult population*, Pain, 2008; 138:507–13.
- Kreek MJ and Hartmann N, *Chronic Use Of Opioids And Antipsychotic Drugs: Side Effects, Effects On Endogenous Opioids and Toxicity*. Annals New York Academy of Sciences 1982 pp151-172.
- McClellan AT and Turner B, *Prescription opioids, overdose deaths, and physician responsibility*. JAMA,2008; 9:2672–3.
- Paulozzi LJ, *Trends in unintentional drug overdose deaths*, Testimony to the U.S. Senate Committee on the Judiciary, March 12, 2008; http://judiciary.senate.gov/hearings/testimony.cfm?id=3199&wit_id=7036.
- Riley JL and Hastie BA, Individual differences in opioid efficacy for chronic noncancer pain, *Clinical Journal of Pain*,2008; 24: 509–20.
- Turk D, in The Back Letter. Lippincott Williams & Wilkins January & February 2009, (Dennis C. Turk, PhD, veteran pain researcher and president, American Pain Society, 2004-2005,
- Von Korff M et al., *Defacto long term opioid therapy for non-cancer pain*. Clinical Journal of Pain, 2008; 24:521-7. [bl_09-02] ed_IC_opioid_v1.1.doc