

# Clinical Watch

FROM CSAC, THE CLINICAL AND SCIENTIFIC AFFAIRS COUNCIL OF THE AAPA

## PAIN MANAGEMENT

### Opioid use in chronic pain

#### ›WHO SHOULD READ THIS?

Any physician assistant who provides care to patients with chronic non-cancer related pain.

#### ›WHY IS THIS IMPORTANT?

Fifty million Americans suffer from chronic pain each year, and chronic pain is the most common cause of long-term disability in the United States. Still, research suggests that three out of four chronic pain sufferers do not receive appropriate therapy.<sup>1</sup> Opioids offer effective pain control, and opioid use in the United States increased markedly between 1997 and 2006, especially for morphine (184%), fentanyl (450%), oxycodone (899%), and methadone (1,129%).<sup>2</sup> Despite this large increase, many providers continue to feel that pain in any form is undertreated.

#### ›HOW IS PAIN CLASSIFIED?

Pain can be classified into three general categories: acute, chronic, and cancer related. Acute pain is a normal response to tissue damage and usually resolves when the damage heals. Cancer-related pain is associated with tumor growth, metastatic disease, and side effects of treatment. Chronic pain is defined as pain that lasts longer than expected for healing, persistent pain not controlled by nonopioid methods, pain associated with nonmalignant disease, or pain where healing may never occur.<sup>3,4</sup> Pain may also be defined as *nociceptive* (resulting from tissue damage) or *neuropathic* (caused by damage or dysfunction of the central or peripheral nervous system).

#### ›WHAT GUIDELINES EXIST FOR OPIOID USE?

Despite growing evidence that opioids are useful in managing chronic pain, limited studies exist regarding ideal dosing regimens and duration of use.<sup>5,6</sup> Most studies are small, limited to a single study in the area, or limited to nonexperimental descriptive studies. Clearly, more studies need to be done in order to guide clinicians in prescribing opioid therapy for patients with chronic pain.

The American Pain Society and the American Academy of Pain Medicine has issued evidence-based guidelines for the management of chronic pain based on an expert review of the literature.<sup>7</sup> Another source of guidelines; assessment algorithms; recommendations based on type of pain; and multifactorial, comprehensive care plan management can be found at the National Guidelines Clearinghouse.<sup>8</sup>

Opioid therapy should be considered if other treatment modalities fail to provide effective analgesia and the benefit of using opioids exceeds the risks. The therapy, its side effects, and issues relating to tolerance and addiction should be discussed with the patient, and applicable regulations

should be reviewed.<sup>9</sup> The general recommendation is to start at the lowest dose possible and gradually increase until pain control is obtained.

#### ›WHAT ARE THE TREATMENT MODALITIES FOR CHRONIC PAIN?

Initial treatments for acute and chronic pain may include medications such as NSAIDs, acetaminophen, antidepressants, and anticonvulsants. Alternative therapies may also include core-strengthening activities, physical therapy, occupational therapy, psychiatry, counseling, dietary changes, and weight loss, as well as nontraditional therapies such as acupuncture, healing touch, massage, and other behavioral techniques.<sup>3</sup> Therapies should be selected as appropriate to the patient's needs, comorbidities, and physical ability.

#### ›HOW DO I INITIATE OPIOID THERAPY FOR CHRONIC PAIN?

When the patient and provider determine that opioid therapy could be beneficial, a standardized approach should be used that includes the following: an initial, comprehensive medical history and physical examination; establishment that nonopioid therapy has failed; establishment of agreed-on goals for treatment; discussion of the true benefits and risks of long-term opioid use and documentation of the discussion; limitation of prescribing to one provider and pharmacy (when possible); and a requirement for comprehensive follow-up. Screening for a history of

#### TAKE-HOME POINTS

- Limited evidence supports the use of opioid therapy in long-term (longer than 6 months) chronic pain.
- The best outcomes occur when the patient attends a multidisciplinary pain clinic.
- Before starting chronic opioid therapy, screen all patients for a personal and family history of substance use disorders.
- Clear documentation, such as controlled substance agreements, and specific ongoing follow-up policies can reduce the potential for opioid abuse and potential regulatory concerns.

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or risk for substance abuse should be done initially and during follow-up visits. During follow-up, there should also be regular review of the goals being achieved, monitoring for signs of abuse, assessment of side-effects, and drug screening if needed; adjunctive therapies and the end of opioid treatment should be considered if goals are not being met.<sup>10</sup>

PAs should also use a controlled substance agreement, which outline patients' and clinicians' responsibilities and the treatment limitations.<sup>3,4,6</sup> A sample agreement is provided with the online version of this article. Potential items to include in the agreement are limitation to one prescribing clinician and designated pharmacy, drug screening for at-risk patients (including a screening schedule and responsibility for cost), a refill policy, and a therapy discontinuation policy.

## ▶WHAT ARE THE BEST OUTCOMES?

Patients with chronic pain do best when they participate in interdisciplinary pain management programs where the team may include a pain management clinician, psychologist, nurse specialist, physical therapist, vocational counselor, and pharmacist. Such team support provides patients not only with medication therapy but also with additional strategies for coping with their condition.<sup>3</sup> A written plan of treatment is tailored to fit the patient's abilities and expectations, and it includes measurable treatment goals and requirements for continued treatment. Such agreements might require continued use of counseling, traditional and nontraditional therapies, and other active coping practices. Early referral to a pain clinic for interdisciplinary pain management is recommended for patients with difficult to treat acute or chronic pain. Patients who have significant comorbid psychological conditions such as depression or substance abuse or who have complicated medical conditions may

benefit most from early consultation with pain medicine specialists.

## ▶WHAT ARE THE MOST COMMON CONCERNS?

Practitioners, patients, and others are very concerned about the potential for addiction and its consequences, drug-seeking behaviors, escalating drug doses, and drug diversion. Practitioners are concerned about regulation of prescribing privileges as well as about regulatory investigation and threats to licensing. While addiction and licensure are concerns, they should not prevent clinicians from providing appropriate care to their patients—especially if they are following the suggested guidelines for opioid therapy. A recent evidence-based review has noted that the risk of addiction is negligible in appropriately selected patients.<sup>11</sup>

Physical dependence is a predictable neural adaptation, called *tolerance*, that occurs in all patients receiving continuous opioid therapy.<sup>9</sup> Although tolerance can result in the need for larger or more frequent doses of medication to control pain—and it may increase such unwanted side effects as sedation, central depression, and nausea—tolerance is not the same thing as addiction.

*Addiction* is distinguished from tolerance by a persistent pattern of dysfunctional behaviors that are focused on the possession of medications, including a preoccupation with obtaining opioids despite having adequate analgesia, increased use of the drugs despite side effects that can lead to harm, loss of control in use, and aberrant behavior leading to drug possession.<sup>9</sup> Addiction can be difficult to distinguish from tolerance or *pseudoaddiction* (a misinterpretation of relief-seeking behavior that

resolves upon institution of effective analgesic therapy). The use of contracts and screening for these criteria will help clinicians distinguish tolerance from addiction. Referring difficult-to-treat patients to a pain specialist can increase the chance for treatment success.

Providers have a limited or poor understanding of the state and federal laws and regulatory guidelines regarding the proper prescribing practice of opioids for chronic pain.<sup>7</sup> The stigma and fear associated with substance use disorders may also contribute to the inadequate treatment of chronic pain. While these are valid concerns, they should not prevent PAs from providing appropriate care to their patients, especially if they are following the recommended guidelines in initiating opioid therapy. **JAAPA**

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- Sample controlled substance agreement

# Sample controlled substance agreement

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words “we” and “our” refer to the facility and the words “I,” “you,” “me,” or “my” refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below or, during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician’s knowledge. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

PHONE: \_\_\_\_\_

3. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.
4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.
5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or, during his/her absence by the covering physician, as set forth in Section 1 above. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.
6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.
7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
8. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.
9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted.
10. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

\_\_\_\_\_  
PATIENT’S FULL NAME

\_\_\_\_\_  
PATIENT’S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHYSICIAN’S SIGNATURE

\_\_\_\_\_  
DATE