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Guidelines for managing chronic non-malignant pain

Opioids and other agents

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Although not uniformly applied in practice, the tenets guiding the treatment of patients with cancer pain are well established.[1] Chronic pain caused by conditions other than cancer, frequently termed "chronic non-malignant pain," can be as severe as cancer pain.

Management principles, including how and when to use strong opioids, are less clearly defined for pain caused by conditions other than cancer. More education is needed about techniques of patient assessment and principles of chronic pain diagnosis, about treatments available for chronic pain management, and about establishing reasonable treatment goals to manage chronic non-malignant pain. Many physicians see the use of opioids for chronic pain as controversial. Physician fear of iatrogenic addiction, fear of inducing tolerance, perceived risk of penalties by regulatory agencies, and unfamiliarity with selection and dosing of opioids in the setting of chronic non-malignant pain limit consideration of opioid use.

This article outlines the spectrum of problems encountered in assessing and managing patients with chronic non-malignant pain (with some emphasis on how regulatory bodies influence the medical use of opioids) and presents *Guidelines for Management of Chronic Non-malignant Pain*, recently published by the College of Physicians and Surgeons of Alberta.[2] We write this article to stimulate discussion at the level of provincial Colleges of Physicians and Surgeons and among physicians who care for patients with chronic pain.

Opioids for chronic non-malignant pain

Methods of patient assessment and establishment of treatment goals for chronic non-malignant pain have been well described in the standard textbooks of pain management. However, the role of strong opioid medications in the management of chronic non-malignant pain is less well-defined. In Canada, published advice on their use is sparse. Guidelines from the Quebec College go so far as to recommend that physicians who administer opioids to chronic non-malignant pain patients for more than 8 weeks "... secure another physician's opinion before continuing such therapy."[3] Legislation criminalizing physician prescribing that willingly facilitates prescription medication

diversion is currently being considered by Parliament.[4] In contrast, other regulatory bodies recommend considering opioids in selected circumstances.

Regulations in Europe. Canada is fortunate, compared with other parts of the world where the use of opioids even for chronic cancer pain is hampered by regulatory barriers and fear of iatrogenic addiction. Per capita medical opioid consumption in Germany, Italy, and France is less than 2% of that in other parts of Europe, such as the United Kingdom.[5] Restrictive laws and regulations have been correlated with low medical opioid consumption, but appear unrelated to incidence of drug death, a marker of illicit opioid use.

In Italy, a physician must obtain special prescription forms in order to prescribe morphine, and must sign each form in the presence of a local medical association officer.[6] The amount prescribed cannot exceed an 8-day supply. Paradoxically, the rate of drug deaths in Italy is approximately five times that in Great Britain, which has considerably less restrictive opioid regulations.[6] Low per capita medical opioid consumption could also relate, in part, to cultural factors, such as patient or family aversion to opioid use. A recent British survey of members of the Intractable Pain Society revealed broad support for opioid use for carefully selected patients with non-malignant pain.[7]

Regulations in the United States. Opioid regulations in the United States are legislated at both the federal and state level, and therefore vary through the country. A recent review of this topic has highlighted several recent changes in

Alberta guidelines for managing chronic non-malignant pain

The problem of chronic non-malignant pain is staggering; the cost of annual lost productivity caused by chronic pain in North America is measured in billions of dollars. Other less easily measured parameters, such as failed marriages or poor quality of life, underscore the gravity of the situation.

A rational understanding of the likely mechanisms of pain is required to develop an effective clinical approach. Comprehensive evaluation of patients should provide reasonable hypotheses about the pathophysiologic processes contributing to the pain (nociceptive, neuropathic, or psychologic).

For some patients therapy is aimed toward identifiable organic process and for others toward the degree of disability and associated psychologic issues. A large group of patients have chronic non-malignant pain that is best described as idiopathic, ie, pain perceived by the clinician to be excessive for the degree of organic disorder evident. Some of those patients have a primary psychologic cause for the pain, but unless a strong case for this can be made, the patient's pain is best termed idiopathic and the potential for organic processes left open.

Standard guidelines

There is usually no easy solution to offer patients with chronic non-malignant pain. Standard advice on management includes the following.

- Perform a complete pain history and physical examination.
- Assess for coexisting depression, sleep disorder, personality disorder, poorly developed coping skills, and poor social functioning. These issues are addressed separately from the medical condition causing the pain; sometimes pain cannot be changed but a person's response to a difficult situation can be.
- Obtain all relevant documentation concerning prior investigations and consultations. Consider whether a new condition is present (eg, newly extruded disk in a patient with chronic back pain) and arrange further tests or consultation needed to assess the condition. The goal is to complete the evaluation in order to help the patient focus on getting better.
- Help the patient to get better. Treatment of chronic non-malignant pain attempts to enhance functioning (broadly defined to include physical, psychologic, and social functioning) and improve comfort.
- Long-term treatment with analgesic medication should be used if analgesics relieve pain, improve functioning, or both. Analgesic medications should initially include nonopioid analgesics or adjuvant analgesics. Long-term therapy with one or more agents within these two general categories continues to be preferred for patients with chronic non-malignant pain (in contrast to those with cancer pain). Long-term use of nonpharmacologic analgesics should be considered.
- Opioids are not first-line drugs for chronic non-malignant pain but are occasionally helpful. Physicians should carefully weigh the benefits and potential problems associated with such medications when used long term.
- A multidisciplinary team approach is optimal.

Guidelines for opioid use

- The underlying medical condition causing the pain should be established, and the pain should appear to be commensurate

what is viewed as an evolving concept of what constitutes acceptable standards of care.[8] Federal laws have mistakenly incorporated chronic use of opioid medication within the legal definition of addiction. Recent Intractable Pain Acts in California and Texas have validated prescription of opioid analgesics by physicians to patients with intractable pain, excluding patients using drugs for nontherapeutic purposes.

Clinical practice guidelines for chronic cancer pain have been published[9] and reflect strategies to respond to widespread undertreatment of cancer pain in the United States.[10] However, use of opioids for chronic non-cancer pain remains a polarized, albeit evolving, arena of clinical practice.

Efficacy and risk of addiction. Addiction is defined as a "behavioral pattern of drug use, characterized by overwhelming involvement with the use of a drug (compulsive use), the securing of its supply, and a high tendency to relapse after withdrawal."[11] Addiction is a state where a person takes a medication for its psychic effect, not for its pain-relieving effect, and is characterized by loss of control, compulsive drug use, and continued drug use despite harm.

One recent US survey found that 70% of cancer patients feared opioid addiction.[12] The actual risk of subsequent addiction among patients who have first received opioids for medical indications appears to be extremely low.[13] Repeated appeals for medication by patients with unrelieved cancer pain have led some health care providers to mistake pain relief-seeking behaviour for drug-seeking behaviour.[14]

Judicious use of opioids for chronic non-malignant pain has been increasingly reported in the

with the diagnosis. Clinicians should exercise particular caution in treating patients whose pain is idiopathic or appears to be determined primarily by psychologic factors.

- A history of recent or remote substance abuse is a relatively strong contraindication; chronic opioid therapy should be considered only under the most extraordinary circumstances for such patients.
- An adequate trial of nonopioid analgesics and adjuvant analgesics should have been carried out without success.
- One physician only should prescribe opioids to any patient.
- In order to start opioid therapy, the principles of the World Health Organization "analgesic ladder" should be employed.[24] Patients should first receive opioids in combination with nonsteroidal anti-inflammatory drugs or acetaminophen. Opinion concerning opioid therapy is evolving, and the decision to rely on combination products or other products before considering trials of morphine or similar opioids is arbitrary and based on convention, rather than pharmacologic principles.
- Treatment of pain with opioids is actually a treatment trial, and like all therapeutic trials, can be effective or ineffective. Effective therapy can be defined as identifying a dose associated with meaningful partial analgesia and no adverse affects severe enough to compromise comfort or functioning.
- If a fixed combination preparation of an opioid and nonopioid analgesic is unsatisfactory, then oral morphine may be tried. Behaviours that provide compelling evidence of abuse include selling prescription drugs, covertly obtaining prescription medications from more than one physician, concurrent abuse of related illicit drugs, repeated unsanctioned dose escalations despite warnings, and events such as prescription "loss." Relapse after withdrawal is a feature of addiction that is difficult to interpret in the context of chronic non-malignant pain, as relapse of pain (and the reinstitution of opioid therapy) can be rationally anticipated to occur sometimes.
- Parenteral dosing with opioids to treat chronic non-malignant pain should be strongly discouraged, and daily intramuscular injections abhorred.
- An agreement between patient and prescribing physician should clearly state that there is to be no unsanctioned dose escalation, no selling of opioids, no injecting of opioids, no seeking of opioids from another physician, and no hoarding of opioids. This contract should clearly define consequences of violation, which include a non-negotiable end to the prescribing relationship between physician and patient.
- The patient should be seen and assessed every 9 weeks and more frequently if needed (eg, if there is a previous history of substance abuse).
- Flares of pain can be treated with small extra doses of opioid by mouth; each monthly prescription should include a few extra doses for this purpose.

The goal of chronic opioid therapy is not to eliminate pain (which could be impossible) but rather to control pain to a tolerable level; emphasis is clearly on the patient's level of functioning in social, occupational, and personal life.

Addiction is quite distinct from tolerance and physical dependence; true addiction resulting from appropriate medicinal use of opioids is rare. Clinicians must monitor for the possibility that opioids are contributing to disability, impairing function directly, or producing adverse pharmacologic effects that lead to impaired functioning.

literature. Success of therapy has been defined as an improved level of comfort, which is usually but not always accompanied by an improved level of functioning. Surveys attesting to the efficacy of such therapy do not support the notion that medicinal use of opioids results in enslavement to the drug when appropriate care is taken in selecting patients.

One survey of 100 patients who received opioids as a long-term treatment of chronic non-malignant pain documented good or partial relief of pain for 79 patients. Pain relief was correlated with improved functioning, and there was no case of addiction to opioids.[15] Another such survey documented reduction in pain and a relative paucity of side effects.[16] However, the physician's role as patient advocate must be balanced with the risk of acting in the role of an unwitting facilitator, who provides a drug supply to a substance abuser who is feigning a painful illness. Use of opioids for patients with a history of substance abuse should be undertaken only with great caution.[17]

Physical dependence. Physical dependence is a response to a drug characterized by the occurrence of an abstinence syndrome after abrupt dose reduction or administration of an antagonist.

Risk of tolerance. Tolerance is a poorly understood phenomenon in which increasing amounts of medication are required to maintain drug effects. Tolerance to opioids could result in subsequent failure of a previously effective regimen. However, published reports indicate that tolerance is generally uncommon among patients who have non-malignant pain and who receive oral opioids over a prolonged period. In one study, higher doses of analgesics were required during exacerbations of pain, but most patients subsequently returned to baseline opioid use.[16] Based on these and other data, there appears to be an important role for opioids in a subpopulation of patients with chronic non-malignant pain.[17]

Chronic pain syndrome. More frequently seen is chronic pain syndrome, whereby a patient takes a variety of medications with questionable benefit, and uses drugs inappropriately as part of the behavioural disturbances that characterize this state. Other behavioural traits of chronic non-malignant pain syndrome include physical inactivity, inability to work, and social isolation. Analgesic medications should be used in this setting only as part of a carefully controlled overall pain management program.

Physicians' fears of penalties

Fear of penalties from regulatory agencies has been reported by North American physicians as contributing to underuse of opioids.[18,19] One possible explanation for this fear is that medical licensing and disciplinary bodies know little about opioid analgesics.

A survey of US state medical licensing and disciplinary board members deserves particular mention.[20] Only 75% of board members thought that prescribing opioids for an extended period to patients with cancer pain was both legal and acceptable medical practice; only 12% thought that administering opioids to patients with chronic non-malignant pain and no history of opioid abuse was both lawful and generally acceptable medical practice. Almost none of these medical legislators could accurately distinguish between addiction (psychologic dependence), physical dependence, and tolerance.

A second possible explanation for physicians' fear of penalties is a failure by regulatory bodies to recognize clearly their own two competing interests: a facilitating role in the quality of medical care and a policing role in preventing diversion of drugs to illegitimate uses. Practice standards established by regulatory agencies can be too vague to protect physicians reliably from being wrongly accused of misprescribing habits.[21] One leading pain researcher has made an impassioned plea that science and sound judgment replace myth and fear of penalties in the use of opioids for chronic non-malignant pain.[22]

Appropriate use

Regulatory bodies must address society's dual goals of, on the one hand, impeding the inappropriate use of drugs (such as drug diversion) and, on the other hand, strongly supporting legitimate medical care and judgment in relieving pain (such as chronic opioid therapy for carefully selected patients in appropriate medical settings). It is in this spirit that the College of Physicians and Surgeons of Alberta began developing guidelines for managing chronic non-malignant pain.[2]

A working group was struck by the College, consisting of three pain specialists and a member of the medical staff of the College. The group reviewed published clinical studies spanning the past 70 years as well as practice options elsewhere in North America and Europe. Information from the College of Physicians and Surgeons of Alberta triplicate program was used to identify common patterns of aberrant prescribing by physicians. The triplicate prescription program is a computerized registry of all prescriptions by Alberta physicians for all opioids (except codeine preparations), amphetamines, butalbital,

and anabolic steroids. It is designed primarily as an educational tool, to inform physicians when their patients receive prescriptions of scheduled medications from multiple physicians.

The guidelines were internally reviewed and revised and were then externally reviewed by an internationally recognized pain authority before being mailed directly to all Alberta physicians. These guidelines are in two sections: the first describes general principles of assessment and management of chronic non-malignant pain and the second specifically addresses the use of opioids in this clinical setting (see below[23,24]).

Summarized recommendations for managing chronic non-malignant pain are as follows.

- Perform a complete pain history and physical examination.
- Consider nonpharmacologic analgesic interventions, using a multidisciplinary approach.
- Consider nonopioid medications.
- Consider opioids if other measures are ineffective. Opioids can be offered as a therapeutic trial, if patients fulfil strict criteria. Long-term opioid therapy can be considered for patients who responded well to such a trial. ■

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