

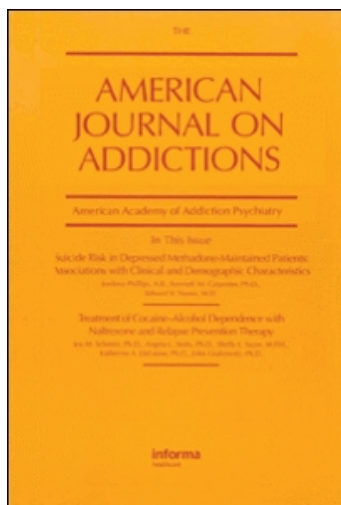
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# Cautionary Guidelines for the Use of Opioids in Chronic Pain

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*Guidelines for the use of opioids in the treatment of chronic pain have recently been proposed by the American Academy of Addiction Psychiatry. Older guidelines proposed by American pain organizations had the effect of liberalizing opioid prescription. In recent years, dramatic increases in prescribed opioids have been followed by equally dramatic rises in morbidity and mortality from prescription opioids. In addition, new research has increased knowledge of the long-term effects of opioids. These new guidelines propose increased caution in regard to opioid prescription for chronic pain. (Am J Addict 2009;18:1–4)*

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In 1997, suggested guidelines for the use of opioids in chronic pain were proposed by a consensus of American pain organizations.<sup>1</sup> These and other guidelines included cautions about the use of chronic opioids, but the effect seemed to be to liberalize such use and legitimize it for most patients who complained of ongoing chronic pain despite other treatments.<sup>2</sup> Clinically, however, the nature of opioid dependence is such that even if pain becomes minimal, medical withdrawal is likely to be uncomfortable when left to the patient to effect, or if the prescribing physician is inexperienced in this process. The physician who is inexperienced in withdrawing patients from opioids may simply conclude that the patient is unable or unwilling to tolerate discontinuation. Both patient and physician may then agree that it is best to continue opioids, whether or not benefits are actually present or the long-term risks of continuation are recognized.

During the past decade, prescription drug dependence has become a major problem, particularly with reference to opioid pain medications. Seekers of addiction treatment are increasingly dependent on prescription opioids rather than on heroin.<sup>3</sup> The problems appear to go beyond persons with addiction seeking to obtain prescription opioids in addition to, or in preference to, illicit drugs. This population includes

patients who have never used illicit opioids, and who only seek opioids by doctors' prescriptions.

There has been a dramatic increase in the prescription of opioids for chronic pain in recent years.<sup>4</sup> With regard to spine pain alone, costs for prescribed narcotic analgesics in the United States rose 423% from 1997 to 2004, with no improvement in these conditions, judged by ongoing surveys of pain and function.<sup>5</sup> In addition, during that time period, there have been exponential increases in adverse events associated with prescribed opioids, including rapidly rising rates of emergency room visits related to prescription opioids and unintentional deaths due to prescribed opioids.<sup>6</sup> Clinicians have been cautioned to watch for addiction in patients being considered for long-term opioid treatment, but this can be quite difficult, especially for the practitioner without specialized training in addictions. Substance dependence disorders do not always present with obvious pathological behaviors, and this is particularly true if supply of the drug is easily obtained. Use of standardized screening tools, while strongly recommended, will not detect patients in denial or those who do not respond honestly to the questions.

Opioids have an important role in acute pain management of moderate to severe pain, but the dangers of chronic use have long been of concern. In recent years, this notion has been challenged or de-emphasized, and many clinicians who treat chronic pain have assumed that maintenance opioids retain analgesic efficacy despite a lack of good evidence for this assumption.<sup>7</sup>

From a cultural perspective, there are wide variations in the use of opioid analgesics in different countries.<sup>8</sup> There is no evidence that chronic pain patients are doing better in countries that have higher rates of prescribing opioids for chronic pain. In fact, the opposite has been demonstrated. In Denmark, a country that has prescribed opioids for chronic pain in increasing amounts for many years, a large epidemiological study found that chronic pain patients maintained on opioids do much worse in terms of ongoing pain and disability.<sup>9</sup>

Furthermore, much has been learned about the physiological concomitants of chronic opioid intake in recent years. Chronic stimulation of the mu opioid receptor results in a cascade of cellular responses with multiple overlapping

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mechanisms, which can result in enhanced pain sensitivity, known as hyperalgesia.<sup>10</sup> Some of the cellular responses to chronic opioid intake that are thought to contribute to hyperalgesia include an increase in neuropeptides such as dynorphin,<sup>11</sup> cholecystokinin,<sup>12</sup> and substance P<sup>13</sup>—all of which have been demonstrated to enhance pain sensitivity—and the activation of glial cells, producing inflammatory cytokines and resulting in amplified pain.<sup>14</sup> Experimental studies with methadone maintenance patients who are being treated with high doses of this powerful analgesic demonstrate that these patients are not protected from painful stimuli at all, but rather are more sensitive to them,<sup>15</sup> and this is consistent with clinical experience. A review in the *New England Journal of Medicine* concluded that, at least in high doses, opioid treatment of chronic pain is “neither safe nor effective.”<sup>16</sup>

In an attempt to limit the overprescription of opioids and problems associated with dependence and abuse, the board of directors of the American Academy of Addiction Psychiatry has approved policy guidelines with respect to opioid use in chronic pain management (available at: [http://www.aaap.org/policies/Policy opioids & chronic pain 4-08.pdf](http://www.aaap.org/policies/Policy%20opioids%20&%20chronic%20pain%204-08.pdf)). The goal of these guidelines is to allow the use of opioids for chronic nonmalignant pain in patient/physician partners who believe that the medications are efficacious, but also to set a limit on unengaged and unthinking use of opioids that can be damaging to some patients and allow diversion of opioids by other patients. These guidelines are intended to maximize the benefit of opioid prescription and minimize harm (including addiction and death) to the patients involved, or to persons to whom prescription opioids may be diverted.

## **POLICY ON PRESCRIPTION OF OPIOIDS FOR CHRONIC NONMALIGNANT PAIN**

There is controversy in medicine related to the use of opioid medications for the treatment of persistent or chronic pain. There is a broad range of caring practice (including safe alternatives to opioids) that provides for relief of suffering and improvement in patient well being, and there are practice patterns that may be harmful to patients by virtue of the consequences of opioid use or by failure to consider the whole person in prescribing for pain. This Public Policy of the AAAP outlines recommendations for responsible practice in the prescription of opioids for chronic pain.

- I. Decisions to prescribe daily opioids for more than one month should be accompanied by careful review of the patient’s treatment plan by the prescribing physician.
  - A. There should be a full history and physical available, either done by the physician, or performed by a consulting physician, exploring
    - i. Whether the Patient’s subjective reports of pain are disproportionate to objective medical findings.
    - ii. Whether nonphysiological findings are present on exam (eg, Waddell signs).

- B. Some State Medical Licensing Boards consider the standard of practice when prescribing opioids chronically for non-malignant pain to be both a decrease in symptoms and an improvement in functioning. High dose opioids, when chronically prescribed, generally have not been shown to be effective for the management of persistent, nonmalignant pain, utilizing this standard of both symptom reduction and increase in level of function. In addition, there is significant evidence that high-dose opioids, when prescribed chronically, may induce a state of increased pain sensitivity or hyperalgesia. In fact, patients often report reduced pain when opioid doses are significantly reduced or discontinued. High dose opioids have been associated with medical complications and deaths, especially when used in combination with sedative-hypnotics such as benzodiazepines. In addition, prescribing large quantities of opioids is associated with misuse and diversion, such as selling or sharing pills. Therefore, prescription of daily high dose opioids is generally not recommended.
- C. Assessment of the risk of addiction should be an ongoing process.
- D. Risk factors include:
  - i. History of addiction
  - ii. History of childhood abuse or neglect.
  - iii. Comorbid psychiatric disorders including somatoform disorders.
  - iv. Family history of addiction in first degree relatives
- II Before starting a patient on opioid treatment for a chronic pain condition, it should be determined that that there is a low risk of harm, that the benefits outweigh the risks, and/or that a consultation has been ordered from a psychiatrist or pain specialist.
- III If maintaining a patient on chronic opioids for pain, the physician must monitor the patient for potential harm, including noting the following warning signs of possible substance use disorder.
  - A. Intoxication.
  - B. Signs of illicit drug use.
  - C. Lost prescriptions.
  - D. Escalation of the need for opiates without any new cause of pain.
  - E. Failure to improve in pain.
  - F. Failure to improve in function.
  - G. Obtaining opioid prescriptions from other doctors.
- IV. If any of the warning signs above are noted, the physician should document them, and consider medical detoxification from opioids. The physician who prescribes ongoing opioid therapy should be capable of detoxifying patients from opioids, or should be prepared to refer them to someone who can detoxify them and provide for appropriate treatment when necessary.

- V. If a patient comes to the physician already on opioids, the physician should perform an evaluation, and resist automatically continuing the prescription.

Approved by the American Academy of Addiction Psychiatry  
Board of Directors  
May, 2007

## DISCUSSION

The following discussion elaborates some of the points made in sections I–IV of these guidelines.

### Section I (Concerning Prescription of Daily Opioids for More Than One Month)

If pain is disproportionate to physical findings, this does not mean that the patient does not feel and suffer from pain. It also does not mean, however, that opioids will be helpful for such pain. In fact, other problems, including psychological issues, should be attended to, and non-opioid treatments for pain are more likely to be helpful with less risk of harm. Waddell signs,<sup>17</sup> such as pressure on the top of the head or simulated spine rotation (keeping the shoulders and hips in the same plane) eliciting complaints of increased back pain, are common in certain chronic pain populations,<sup>18</sup> and there is no evidence that opioids are helpful for these nonphysiological signs when they are present.

### Section II (Concerning Starting a Patient on Opioid Treatment for a Chronic Pain Condition)

The prescribing physician should be familiar with alternatives to chronic opioids in the treatment of pain, and should be familiar with substance misuse and dependence and its management. The prescribing physician should recognize the potential danger of increasing the opioid dose when warning signs are present. The prescribing physician should be able to recognize the difference between opioid maintenance for opioid dependence and effective management of pain.

### Section III (Concerning Maintaining a Patient on Chronic Opioids)

Failure to improve is a judgment that can be difficult to make. The opioid-dependent patient will often be fearful of losing the source of opioid prescriptions, and will report that he or she will be worse if opioids are not continued. It will only take a few minutes to renew a prescription, whereas switching to non-opioid forms of pain management may require spending some additional time with the patient to develop a new treatment plan and to provide reassurance and encouragement to a fearful, reluctant individual. A busy clinician can be tempted to just continue treatment as usual, even when it is not in the best long-term interests of the patient.

Collateral information from relatives, significant others, and other treating physicians can be very helpful in assessing the effectiveness of opioid treatment. Periodic urine toxicology

screens can be useful as illicit substance use is prevalent in opioid-maintained chronic pain patients, and is a substantial risk factor for opioid misuse.<sup>19</sup> Urine drug testing that includes screening for the opioids being prescribed can provide valuable information regarding adherence. Drug screening should be considered a diagnostic tool, not a punishment or invasion of privacy, and this should be explained to the patient as part of the overall treatment plan.

### Section IV (Concerning Warning Signs and Medical Withdrawal)

A clinician should be equally comfortable and skilled at reducing and/or discontinuing opioid treatment as he or she is in initiating or maintaining such, if opioid maintenance is being considered. If the clinician is not experienced in medically withdrawing opioids when indicated, he or she should have arrangements made in advance for referral to an appropriate alternative practitioner or facility, and the patient should be made aware of these arrangements prior to beginning maintenance treatment.

### Section V (Concerning the New Patient Seeking Continuation Of Opioids)

The new patient who presents for continued treatment and who is already on daily opioids should be evaluated for the source of the pain and the effectiveness of past treatment, as well as assessed for signs of misuse or addiction to the prescribed medication. Permission to contact previous providers should be obtained. The physician should not prescribe opioids against his or her better judgment if pressured to do so.

## REFERENCES

1. American Academy of Pain Medicine. The use of opioids for the treatment of chronic pain. A consensus statement from the American Academy of Pain Medicine and the American Pain Society. *Clin J Pain*. 1997;13:6–8.
2. Savage SR. Opioid use in the management of chronic pain. *Med Clin North Am*. 1999;83:761–786.
3. Rawson RA, Maxwell J, Rutkowski B. OxyContin abuse: Who are the users? *Am J Psychiatry*. 2007;164:1634–1636.
4. Von Korff M, Deyo RA. Potent opioids for chronic musculoskeletal pain: Flying blind? *Pain*. 2004;109:207–209.
5. Martin BI, Deyo RA, Mirza SK, et al. Expenditures and health status among adults with back and neck problems *JAMA*. 2008;299:656–664.
6. Moore TJ, Cohen MR, Furberg CD. Serious adverse drug events reported to the food and drug administration, 1998–2005. *Arch Intern Med*. 2007;167:1752–1759.
7. Streltzer J, Johansen L. Prescription drug dependence and evolving beliefs about chronic pain management. *Am J Psychiatry*. 2006;163:594–598.
8. Breivik H, Collett B, Ventafridda V, Cohen R, Gallacher D. Survey of chronic pain in Europe: Prevalence, impact on daily life, and treatment. *Eur J Pain*. 2006;10:287–333.
9. Eriksen J, Sjøgren P, Bruera E, Ekholm O, Rasmussen NK. Critical issues on opioids in chronic non-cancer pain: an epidemiological study. *Pain*. 2006;125:172–179.
10. Chang G, Chen L, Mao J. Opioid tolerance and hyperalgesia. *Med Clin North Am*. 2007;91:199–211.
11. Vanderah TW, Suenaga NM, Ossipov MH, Malan TP Jr, Lai J, Porreca F. Tonic descending facilitation from the rostral ventromedial medulla

- mediates opioid-induced abnormal pain and antinociceptive tolerance. *J Neurosci*. 2001;21:279–286.
12. Xie JY, Herman DS, Stiller CO, et al. Cholecystokinin in the rostral ventromedial medulla mediates opioid-induced hyperalgesia and antinociceptive tolerance. *J Neurosci*. 2005;25:409–416.
  13. King T, Gardell LR, Wang R, et al. Role of NK-1 transmission in opioid-induced hyperalgesia. *Pain*. 2005;116:276–288.
  14. Watkins LR, Hutchinson MR, Ledebor A, Wieseler-Frank J, Milligan ED, Maier SF. Glia as the "bad guys": Implications for improving clinical pain control and the clinical utility of opioids. *Brain Behav Immun*. 2007;21:131–146.
  15. Doherty M, White JM, Somogyi AA, Bochner F, Ali R, Ling W. Hyperalgesic responses in methadone maintenance patients. *Pain*. 2001;90:91–96.
  16. Ballantyne JC, Mao J. Opioid therapy for chronic pain. *N Engl J Med*. 2003;349:1943–1953.
  17. Waddell G, McCulloch JA, Kummel E, et al. Nonorganic physical signs in low back pain. *Spine*. 1980;5:117–125.
  18. Streltzer J, Eliashof BA, Kline AE, Goebert D. Chronic pain disorder following physical injury. *Psychosomatics*. 2000;41:227–234.
  19. Katz N, Fanciullo GJ. Role of urine toxicology testing in the management of chronic opioid therapy. *Clin J Pain*. 2002;18(4 Suppl.):S76–82.