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Pain Management Today®
CONTROLLING PAIN, IMPROVING LIVES®
VOL 1, ISSUE 5

Pain Management Today® eNewsletter series

Each issue in this 10-part series will focus on key topics surrounding the use of opioid therapy. A feature article will be written by an expert in the field of pain management and accompanied by commentary from a primary care physician that will address the topic from a day-to-day practice perspective. To aid in the application of the principles raised in the eNewsletter series in your practice, each issue will follow a step in the National Initiative on Pain Control® (NIPC®) treatment algorithm, which highlights key steps in managing and treating patients who are receiving opioid therapy.

Issue 5 of the eNewsletter series, written by John F. Peppin, DO, FACP, discusses addressing patient concerns associated with chronic pain treatment and opioid use.

Perry G. Fine, MD
American Pain Foundation Board of Directors
NIPC Chairman

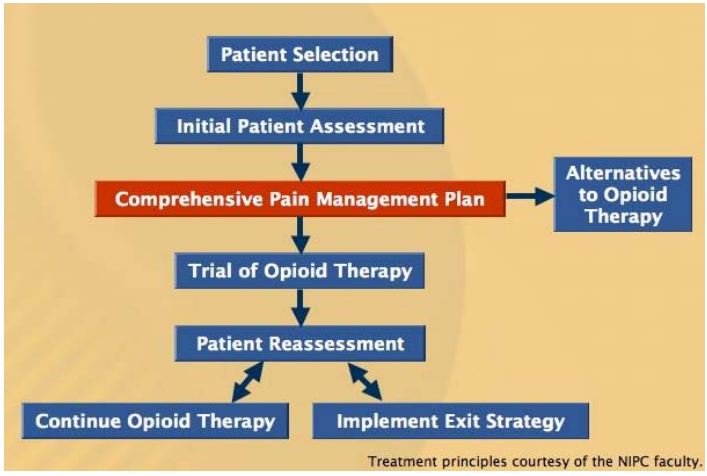
Author

John F. Peppin, DO, FACP
Director, Clinical Research Program, The Pain Treatment Center of the Bluegrass; Associate Medical Director, Hospice of the Bluegrass, Lexington, Kentucky

Dr. Peppin reports that he has received clinical research support from Alpharma, LLC, Arcion Therapeutics, AstraZeneca, Cephalon Pharmaceuticals, GlaxoSmithKlein, GW Pharmaceuticals, Johnson & Johnson, King Pharmaceuticals, Inc, NeurogesX, Progenics Pharmaceuticals Inc, Sangamo BioSciences, Inc,

Addressing Patient Concerns Associated With Chronic Pain Treatment and Opioid Use

In a 2010 review, approximately 30% of adults in the United States reported chronic pain greater than 7 out of 10 lasting at least 6 months.[1] Opioid analgesics can aid in relieving pain and improving quality of life for many patients, but patients frequently cite concerns regarding opioid use. Although some concerns are realistic, many are fueled by misinformation and lack of knowledge on the part of both the patient and the clinician. In addition, the media recently have focused heavily on negative aspects of opioids, which has led to an increase in concerns among patients regarding opioid addiction, abuse, and diversion. This article discusses some common concerns regarding opioid therapy and methods for identifying and addressing these concerns in clinical practice.



Treatment principles courtesy of the NIPC faculty
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Sucampo Pharmaceuticals, and Xenon Pharma. He served on advisory boards in 2010 for Astellas Pharma, AstraZeneca, Eli Lilly and Company, King Pharmaceuticals, Inc, NeurogesX, Progenics Pharmaceuticals Inc, Purdue Pharma LP, Shionogi Pharma Inc., Theravance, Inc. and Trevena, Inc. He has spoken for AIT Laboratories, Ameritox Ltd, Astellas Pharma, Covidien, Endo Pharmaceuticals, King Pharmaceuticals, Inc., NeurogesX, Progenics Pharmaceuticals Inc., Pfizer, Inc, Shionogi Pharma Inc, Theravance, Inc and Trevena, Inc.

Needs Statement

This activity has been planned in accordance with the need to educate health care professionals on strategies for improving assessment, treatment, and management of individuals with pain receiving opioid therapy and overcoming barriers that hinder their appropriate care.

Educational Objectives

1. Identify and address common patient concerns regarding opioid therapy that can limit effective pain management

2. Engage in an ongoing dialogue with those living in pain regarding individualized treatment and management strategies, including an active role in self-care

Steering Committee

Perry G. Fine, MD

Common misperceptions among patients about opioid therapy include confusion between physical dependence and addiction, the perception that all patients receiving long-term opioids become addicted, concerns that opioids may cause persistent sedation and cognitive blurring, the belief that tolerance inevitably makes opioids ineffective over time, and—in contrast—expectations that opioids alone can effectively relieve chronic pain. Patients may also have experienced situations that may strongly color their views, such as relatives receiving high-dose opioid therapy for control of extreme suffering at the end of life, or family members or friends having addiction issues. Family members and others who are directly or indirectly involved in the patient's care and whose views may powerfully influence treatment decisions also may have inaccurate opinions with respect to opioid therapy. Therefore, it is critical to provide balanced and realistic education regarding this class of medication to patients and their significant others. Good communication and patient education is empowering, and can protect your patients and your practice as well as improve treatment outcomes.

The history and physical examination offer an excellent context for the clinician to gather relevant information on potential patient misinformation, biases, or preconceived notions that could negatively influence opioid treatment, while also gathering information on co-occurring health factors and comorbid conditions that could influence opioid therapy. Asking patients about past treatments affords an opportunity to acquire information that could guide treatment decisions going forward. First and foremost, allow ample time for patients to tell their story related to both their pain and past pain treatments. This up-front investment in time will be repaid as time goes on. It is important to note concerns regarding treatment, which may be related to both opioids and other pain therapies. For example, if the patient or a family member had a bad experience with physical therapy or surgery, the patient may express hesitation regarding that particular treatment. Concerns regarding opioid side effects may also be an issue for patients.

Any information gleaned during the history and physical examination should be documented in the medical record. Such documentation can be a tremendously helpful reference for future visits and can aid in understanding and addressing a patient's hesitancy in starting a specific treatment.

The identification of comorbid illnesses and diseases is critical not only for the patient's care but also can relate to treatment misperceptions and the patient's ability to accept treatments. Data from a study in the Netherlands showed that 84% of patients with chronic hip and knee pain also suffered from 1 or more moderate or severe coexistent diseases.[2] Sleep disorders, psychiatric issues, and other diseases are frequently seen among patients with chronic pain, and chronic pain patients may also exhibit symptom clusters similar to those seen in the cancer population.[3] Patients may not realize that they have these comorbid issues; therefore, it is important to discuss the implications of a history that suggests these disorders and any associated risks they may pose in order to select treatments that are specific to the patient's unique circumstances.

It may also be helpful to discuss with the patient the need for additional workups, testing, or referrals to other health care professionals to further understand and address any comorbidities. A frank discussion with the patient concerning comorbid findings and the need for referrals or other therapies should be an important part of the patient evaluation. This discussion can aid in reducing misperceptions the patient may have; for example, the patient may not realize that there are specific reasons for taking medications as directed, including safety concerns. In addition, hoarding medication and going without to "save up for a rainy day" will only cause increased pain and suffering. Further, patients may not understand the comorbidity-related risks of taking opioids; for example, the presence of sleep apnea may increase a patient's chance of a serious adverse event when opioids are taken.

When biases and prejudices that may inhibit opioid therapy are discovered, they are best addressed through informed consent counseling that covers intended outcomes and foreseeable or potential adverse effects. This requires that clinicians have a working, in-depth knowledge of both opioid pharmacology and the specific medical, psychological, and social aspects of each patient they are treating. This in turn requires an understanding of addiction, abuse, and diversion potential. (For more information regarding these issues, please see Issue 3 of this series.) For instance, a patient who is in his or her late 50s who has never had a substance dependency problem and has no other risk factors is unlikely to become addicted during the course of opioid therapy. However, such a patient who has teens or young adults coming and going in the household may have a potential diversion situation that must be prevented.

Professor of Anesthesiology,
Pain Research Center,
University of Utah School of Medicine,
Salt Lake City, Utah

David A. Fishbain, MD, FAPA
Professor of Psychiatry,
Adjunct Professor of Neurological Surgery and Anesthesiology, University of Miaimi, Miller School of Medicine, Miami, Florida

Seddon R. Savage, MS, MD
Director, Dartmouth Center for Addiction, Recovery and Education,
Associate Professor of Anesthesiology,Dartmouth Medical School, Hanover, New Hampshire

Common side effects such as bowel dysfunction should be anticipated and discussed with the patient along with a concrete approach to prevention and treatment. Again, asking patients about their past experience with opioids or other pain treatments can be very helpful in anticipating and addressing potential side effects.

Patients often assume a passive role in treatment and expect the clinician to "fix" them; a body of evidence suggests that this is common in patients with chronic pain conditions.[4] As with all chronic conditions, however, the expectation of an imposed cure is a misconception. An active patient role is critical to effective long-term management. A strategy that engages patients in their own care may not only be therapeutic but may also improve adherence to the specified treatment plan. We expect a patient who has experienced a coronary event to be involved in behavioral changes that will improve his or her longevity and future outcomes (changes in diet, exercise, smoking cessation, etc); similarly, patients' active involvement in their pain control is a central tenet of effective chronic pain management. Asking the patient, "What are you willing to do to achieve…?" filling in the query with the desired goal of treatment, can help engage him or her in goal setting and, ultimately, achieving pain relief.

In summary, patients frequently hold firmly to misconceptions concerning the opioid class of medications. The initial interview and an ongoing review of concerns should discern some of these misconceptions so they can be resolved. Chronic pain is usually physiologically, psychologically, and socially complex. A complete evaluation at the initial visit can dramatically help the clinician understand patients and any concerns they may have regarding opioid therapy. A continued patient-clinician relationship with open communication can also greatly improve adherence and therapeutic outcomes.

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Commentary: The PCP Perspective

Addressing Patient Concerns Associated With Chronic Pain Treatment and Opioid Use

In the last decade, the pendulum of expert medical opinion has swung from its previously somewhat restrictive attitude—that chronic opioid analgesia (COA) was appropriate primarily for cancer pain syndromes—to a much more "permissive" posture that suggests COA for a variety of noncancer chronic pain syndromes. The controversy over which pain syndromes, which patients, and in which circumstances COA is appropriate continues to rage on, with patients, and sometimes clinicians, caught in the crossfire.

There are some generally agreed-upon knowledge points in reference to chronic pain management. The fundamental goals are 1) restoration of functionality, and 2) relief of the burden of pain. Unfortunately, sometimes the order of these fundamental goals is reversed, with clinicians believing pain relief is the primary goal instead of recognizing that pain resolution is intended to return the patient to appropriate social, psychological, and vocational functionality. Indeed, it is completely reasonable to ascertain functional limitations imposed by chronic pain syndromes, with an eye towards specifically improving those deficits with adequate analgesia. Except in chronic deteriorating conditions (eg, metastatic cancer syndromes), relief of pain without goals for functional

Commentator

Louis Kuritzky, MD
Clinical Assistant Professor,
Family Medicine Residency Program,
Department of Community Health &

Family Medicine, University of Florida College of Medicine, Gainesville, Florida

Dr. Kuritzky has disclosed that he serves on the advisory board for Ortho-McNeil-Janssen Pharmaceuticals, Inc.

Upcoming eNewsletter Topics

Vol 1, Issue 6
Opioid Therapy in Patients With a History of Substance Use Disorders

Authored by
Seddon R. Savage, MS, MD

Commentary by
Michael Rosenthal, MD

Vol 1, Issue 7
Urine Drug Testing

Authored by
Michael M. Bottros, MD
Paul J. Christo, MD, MBA

Commentary by
Marc E. Babitz, MD

restoration (or at least improvement in function) is shortsighted.

The "best" analgesic for any individual patient is the agent that can provide the best functional restoration as well as pain relief, with an acceptable tolerability profile. Different therapies may be more efficacious for different patients, and it is important to consider the safety profile and inherent risks of any agent that is prescribed, be it an NSAID, opioid, or other therapy. Clinical trials specifically performed in populations with chronic noncancer pain syndromes such as knee or hip osteoarthritis have found that COA is highly effective, well tolerated, and safe.[1,2]

Patients for whom opioid analgesia is the best therapeutic choice should be reassured that use of opioids does not create addiction in the majority of cases. Sustained use of opioids will produce some degree of dependency (the existence of a withdrawal syndrome upon discontinuation) in most persons, which can be addressed by gradual opioid discontinuation rather than abrupt cessation. Opioid addiction is rarely caused by COA. This has been amply demonstrated by large databases of hospitalized burn victims[3]; in such populations, the incidence of substance misuse (diversion or addiction) has been demonstrated to be the same as that of the general population. Rather, the tendency to abuse opioid analgesia reflects a personality diathesis that may be unmasked by—but not caused by—COA.

For patients with concerns about addiction, it can be helpful to open the discussion of opioids as a potential therapy as follows: "It looks like your knee problem is not only causing you pain, but it is also limiting your ability to do the things you want to do. There are several good approaches to make things better. In addition to physical therapy or other nonpharmacologic therapies, several types of medications may be helpful. One of the most effective and safe long-term medical treatments may be the group of pain medications called opioids. We have learned that when patients have important pain problems like you do, they can use such medications successfully over the long term without any major risk of addiction."

As clinicians address an ever growing population of aging patients with chronic nonmalignant pain syndromes, challenges over best management will continue to arise. Clinicians should be confident that well-chosen COA is an appropriate long-term consideration for some chronic nonmalignant pain syndromes. Patients may need clarification of the risk-benefit characteristics of COA specifically in reference to concerns about addiction.

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Evaluation Survey

This independent medical education activity is sponsored by the American Pain Foundation (APF) and supported through an educational grant from Endo Pharmaceuticals.