



Chronic Pain and the Use of Opiates

The argument to treat pain reasonably and humanely

"Opioid analgesia is one of the most prolific therapies that we have to offer patients with cancer pain, and there is no reason to think that patients with other diseases are any less deserving of relief or that their pain is any less amenable to treatment. Although there is currently no ideal analgesic for chronic pain, medications that act on μ -opioid receptors are the closest thing that we have."

Contrary to the days when physicians admonished patients that pain "is not going to kill you," it is now known that excessive pain can cause damage and, in some extreme cases, can cause death. It is also recognized today that when pain is controlled, medications targeting the primary disease can be more effective.

In this comprehensive yet concise "primer," [in *Hospital Practice* 2000] Daniel Brookoff, M.D, Associate Director, Comprehensive Pain Institute, Methodist Hospitals of Memphis, addresses the significant issues surrounding treatment for chronic pain in general and the use of opioids specifically. He believes that opioid medications allow us to treat chronic pain as aggressively as we would any pathogen, but that barriers are being too slowly dismantled. Dr. Brookoff also believes, however, that "with controlled use," particularly the controlled-release opioids offer "real hope for safe and sustained pain relief."

"Many patients with chronic pain have been refused treatments by previous caregivers who apparently believed that their pain was not real."

The safety and efficacy of opioids in treating chronic pain, Brookoff notes, have long been established. He suggests that patients with moderate to severe pain (regardless of origin) who have not found relief with disease-specific treatments or nonopioid analgesics, be given an opioid trial. Brookoff reviews beneficial and adverse effects of morphine, fentanyl, oxycodone, methadone and levorphanol, stressing that the effects of any opioid must be evaluated in the context of the individual patient and his/her current physical condition. For patients with continuous pain who respond well to an initial trial, Brookoff recommends sustained-release opioids. He reviews common opioid side effects and defines often-confused pain management terms, emphasizing that this confusion alone continues to be a potent barrier to appropriate and effective opioid prescribing.

Dr. Brookoff urges that opioids not be reserved as a last resort for the treatment of chronic pain but, in-

stead, used to "rescue patients in severe pain" who have not responded to other treatments, including mild analgesics. After initial pain relief is achieved, adjuvant therapies, treatments that are more aggressive and nonpharmacological approaches should be tried, and are more likely to be successful. Please note the order in which this is suggested. Get at least some relief first with opioids, *then* try the adjuvants to enhance the effects of the opioids. This will reduce the overall dose needed for pain relief and minimize the side effects of opioids.

"Pain must be regarded as a disease... and the physician's first duty is action—heroic action—to fight disease." Benjamin Rush

Many patients with chronic pain are not "cured," despite years of conventional therapies. This is difficult medicine for many professionals who are schooled long and hard as in how to search for a cure. Therefore, the "un-curable" may be passed over. However, says Brookoff, though they cannot be cured, these patients can be healed. While the underlying disease may be intractable, the symptomatic pain need not be. The point is, there is no reason why a patient should remain in pain, and no reason a doctor in good conscience should allow it. He closes with the poignant words of Marcia Angell: *"Few things a doctor does are more important than relieving pain ... pain is soul destroying. No patient should have to endure intense pain unnecessarily. The quality of mercy is essential to the practice of medicine; here, of all places, it should not be strained."* (Brookoff D. *Hosp Pract.* 2000;September 15: 69-84.)

As you know, I treat chronic pain aggressively primarily with the use of long-acting opioids. If I feel that it is appropriate to refer you to an interventional pain specialist, who can perform an epidural (an injection into the site to provide long term pain relief), I will do so; otherwise, I will offer you long-term treatment. Currently, there are some regulatory oversights from both the federal and state government concerning the prescribing and treating of chronic pain. While it is recognized as being a vital and necessary medical issue, abuse and diversion are also involved and so I, the pain physician, must take steps to ensure that your pain is legitimate and that other options for pain relief have been explored. It doesn't mean that we have to reinvent the wheel, but we do have to be thorough. There are a few rules that I go by in my practice and many will be covered during the first chronic pain appointment.

Here are a few guidelines that should be followed when you or your family member are coming for the first pain visit to allow my staff and I to begin treating your pain as quickly as possible.

Bring medical records, especially imaging studies that are pertinent to your chronic pain. If you hurt your back, I don't want to see your CT scan of your head or medical records about your appendix.

We will order medical records from your last providers, so please have their names and addresses available. If you don't have them, then the process of helping you get out of pain will be much slower. This is done even if you have brought your own medical records. We need copies of records that have not passed through your hands first.

If you are coming here for initial pain treatment and you have not had a workup done yet, then we will begin the workup while we also begin to treat your pain. *If there has been no workup done and you have no insurance, then you will need to seek care elsewhere, e.g., UMC, to at least get the workup done there.* Once that workup has been done and we have reviewed it, then we can begin to discuss treatment.

Due to severe side effects we have noticed with one particular chronic pain medication, we will no longer be **starting** anyone on OxyContin® or use oxycodone **in any form** to start. **There will be no exceptions to this rule.** If you have already been started on OxyContin® here and you are very stable in your dosing and it is a fairly low dose (*by our standards*), then we will leave it alone. However, if the dose should begin to not work as well and you need a higher dose, then you will be changed over to another long-acting opioid. If your dose is high (*by our standards*) then you will be changed over to another long-acting opioid. This is not punishment. This is something that will help you in the long-term.

Despite what State law may assert, **marijuana in any form is not allowed to be used in this practice for any reason...period.** Regardless of any membership in any cannabis club or any other "legal" documents, if you decide that smoking marijuana is more important than taking pain medications, please do not even begin the process of coming here. Urine and blood tests are drawn *randomly* and there needs to be no overt suspicion to request a fluid sample from you. **And if you are caught, you will be summarily discharged.** So if you value your pain relief, then you will avoid compromising circumstances, situations, and behaviors.

Finally, you must be seen *each and every month* to receive your medication. There will be no exceptions to this rule. I require that a progress note be written for each and every Schedule II/III medication (long-acting and short-acting opioids) to provide evidence that we

are seeing you before giving you prescriptions wantonly. If you do not show up to your appointment, you may go into withdrawal and this will cause you discomfort until you can get in to be seen. **Your failure to keep your appointment is not an emergency on my part and we will not treat it as such.** This may sound harsh, but I discovered the hard way that when I tried to be more understanding and forgiving, I got abused more and more. So I have implemented this more draconian program.

Please understand that we are not assuming anyone is coming in to the office asking for controlled substances to either abuse or sell, but good medical practice dictates that we must ensure that the people who do need these medications can get them. This can only be done with a screening process.

Finally, we do use other adjuvants to treat your chronic pain besides opioids. The primary adjuvants we use include the anti-depressants, testosterone (if appropriate), growth hormone (if you wish to pay for it), and medications that can block neuropathic pain, including a new and exciting drug called Namenda®. Though this has been marketed to treat Alzheimer's Disease, there are clinical trials currently in the works to assess this medication for chronic pain management and some of my colleagues here in Fresno have also had great results (as have I) in treating neuropathic pain.

In addition to medications (both analgesics and adjuvants), exercise and diet are important components to any pain regimen and I desire that you become more physically fit. Therefore, once your pain control is stable, we will begin physical therapy to help build muscle tone and endurance. Learning Tai chi for stabilization, balance and pain relief will also be discussed and encouraged. We will also discuss diet. If you have a bad back with failed surgeries, carrying 100 lbs of extra fat around your waist is not going to help the pain condition. In addition, we will *strongly encourage* you and *help* you to quit smoking to enhance your health and allow your body to recover from the ravages that chronic pain has wreaked on your body and the damage that you did to your body to cope with the unrelenting pain. In other words, we need to approach your pain the same way we approach any other disease...comprehensively.

If you have any questions about the treatment of chronic pain, or you would like to set up an appointment to be evaluated for the treatment of chronic pain, please make an appointment with my nurse practitioner or myself. Also, please ask to be given an *Initial Pain Assessment* form to fill out before your first appointment for pain. This will allow you to fill it out more completely and to speed up the appointment time.