American Academy of Addiction Psychiatry (AAAP)

USE OF OPIOIDS IN THE TREATMENT OF CHRONIC, NON-MALIGNANT 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. Prescription of opioid medications to patients with a potential for dependence, tolerance, or addiction, whether known or unknown to the prescribing physician, may have lethal consequences for the patient.

Some state medical licensing boards consider the standard of practice when prescribing opioids chronically for non-cancer pain to be both a decrease in symptoms and an improvement in functioning. **High dose opioids, when chronically prescribed, 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 completely 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 or diversion, such as selling or sharing pills.

Recommendations

These recommendations and guidelines for responsible practice in the prescription of opioids for chronic, non-malignant pain are presented by the American Academy of Addiction Psychiatry.

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 prescribing physician, or performed by a consulting physician, exploring:

1. whether the patient's subjective reports of pain are disproportionate to objective medical findings;
2. whether nonphysiological findings are present on examination (e.g., Waddell signs).

B) Because of issues of hyperalgesia, potential for morbidity or mortality and the risk of diversion, a decision to prescribe daily high dose opioids for chronic, non-malignant pain is generally not recommended.

C) Assessment of the risk of addiction should be an ongoing process in all patients prescribed daily opioids on a chronic basis.

D) Risk factors for the development of a substance use disorder include:

1. history of addiction to opioids, alcohol and/or other drugs;
2. family history of addiction in first degree relatives;
3. history of sexual abuse or sexual trauma;
4. history of childhood abuse or neglect;
5. comorbid psychiatric disorders including mood and somatoform disorders.

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

III. Before starting a patient on opioid treatment for a chronic pain condition, it should be determined that that there is a relatively low risk of harm; that the anticipated benefits outweigh the risks; and/or that a consultation has been sought from an addiction medicine specialist, addiction psychiatrist, pain medicine specialist, or more than one of these consultants, as indicated by the patient's clinical presentation.

II. If maintaining a patient on chronic opioids for pain, the physician must monitor the patient's functional improvement, as well as the potential for harm, including the following warning signs of possible substance use disorder:

A) intoxication;
B) signs of illicit drug use;
C) reports of lost or stolen 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) acquisition of opioid prescriptions from other physicians and prescribers.

IV. If any of the warning signs above are noted, the physician should document them, and consider medical withdrawal of the patient from opioids. The physician who prescribes ongoing opioid therapy should be capable of safely withdrawing patients from opioids, or should be prepared to refer patients for medical withdrawal and for appropriate addiction treatment when necessary.

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