



USE OF OPIOIDS IN THE TREATMENT OF CHRONIC, NON-MALIGNANT PAIN

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. The development of an opioid use disorder significantly increases the risk of suicide (1, 2). This suicide risk may increase with greater doses of prescribed opioids (3).

Recommendations

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

I. Physicians should first determine if the patient has Chronic Non-Cancer Pain (CNCP). CNCP is pain that is 1) unassociated with an imminently terminal condition, and is 2) unlikely to abate as a result of tissue healing, thus requiring long-term management. It also refers to pain not caused by on-going tissue pathology.

II. Decisions to prescribe daily opioids for CNCP 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.

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 CNCP is generally not recommended.

C) Assessment of the risk of addiction should be an ongoing process in all CNCP patients prescribed daily opioids on a chronic basis. Risk factors for the development of a substance use disorder and for which a conservative approach may be especially warranted 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. Co-occurring psychiatric disorders including mood and somatoform disorders.

D) Assessment for the risk of suicide should also be ongoing in all CNCP patients prescribed opioids. Risk factors for suicide may include:

1. Family history or past personal history of suicide attempts
2. History of, or current suicidal thoughts
3. Current/past psychiatric disorders including active substance use disorders
4. Access to firearms or other means of self injury (including opioids)
5. Precipitants/stressors including pain or other ongoing medical illnesses
6. Change in treatment such as discharge from a psychiatric hospital or provider

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 there is a relatively low risk of harm and that the anticipated benefits outweigh the risks. If there is any history suggesting a substance use disorder (SUD), chronic opioid analgesic therapy (COAT) should not be initiated without consultation with an addiction specialist.

IV. Continued COAT should be contingent on objective evidence of functional improvement with relative absence of harm. If maintaining a patient on chronic opioids for pain, the physician should 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.

V. If any of the warning signs above are noted, the physician should assess for the presence of an SUD and if present consult with an addiction treatment specialist to consider a range of treatment options including opioid agonist therapy versus medical withdrawal of opioids in addition to appropriate psychosocial treatments.

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References

1. Ilgen MA, Bohnert ASB, Ganoczy D, Bair MJ, McCarthy JF, Blow FC. Opioid dose and risk of suicide. *Pain*. 2016;157(5):1079-1084.
2. Ashrafioun L, Bishop TM, Conner KR, Pigeon WR. Frequency of prescription opioid misuse and suicidal ideation, planning, and attempts. *Journal of Psychiatric Research*. 2017;92:1-7.
3. Bohnert KM, Ilgen MA, Louzon S, McCarthy JF, Katz IR. Substance use disorders and the risk of suicide mortality among men and women in the US Veterans Health Administration. *Addiction*. 112(7):1193-1201.