MANAGEMENT OF CHRONIC NON MALIGNANT PAIN

Introduction

The Manitoba Prescribing Practices Program (MPPP) recognizes the important role served by physicians in relieving pain and suffering and acknowledges the difficulty inherent in dealing with pain management. While endeavouring to offer the best care possible, one is also compelled to do no harm. In no area of practice of medicine is this dichotomy more plainly faced than in the assessment and management of chronic non-malignant pain.

This guideline is intended as a framework for medical decision-making in the treatment of chronic non-malignant pain, and as an overview of current management rationale for this difficult medical problem.

Management

A rational understanding for the likely mechanisms of pain is a requisite for developing an effective clinical approach to treatment. Comprehensive assessment of such patients should provide reasonable clinical hypotheses about the pathophysiological processes that are contributing to the pain (nociceptive, neuropathic and/or psychologic). The goal is to complete evaluation in order to help the patient focus on getting better.

In some patients, the important therapeutic issues relate to an identifiable organic process and in others, to the degree of disability and associated psychological issues. There is a large group of patients with a form of chronic non-malignant pain which is best described as idiopathic, i.e. pain that is perceived by the clinician to be excessive for the degree of organic pathology evident. Physicians must be aware that some of those patients may have a primary psychologic cause for the pain, but unless a strong case for this can be made, the patient's pain is best termed idiopathic and the potential for possible organic processes left open. The subjective nature of pain precludes the development of a consistent and reliable "detector" with which to perceive the patient's pain. Physicians should not be deluded into believing they have somehow acquired or were gifted with this ability.

- Assessment

1. Take a complete pain history and perform a physical examination including an assessment of physical function and evaluation of disability.
2. Assess for the possibility of co-existent depression, sleep disorder, personality disorder, poorly developed coping skills, and level of social function.
3. Obtain all relevant documentation concerning prior investigations and consultations. Consider whether a new diagnosis may be present (e.g. newly extruded disk in a patient with chronic back pain), and arrange any further tests or consultation needed to assess the condition.

4. Assess for a history of recent or remote substance abuse. Available evidence suggests that chronic opioid therapy should be considered only after referral to a Pain Management Specialist. Such patients must be given clear guidelines for analgesic use including frequent follow up review appointments

- Treatment
  Consider how the patient can become empowered to get better. The treatment of chronic non-malignant pain is dedicated to two goals: enhanced function (broadly defined to include physical, psychological and social function), and improved comfort. This can be most optimally accomplished by a multi-disciplinary team approach.

- Non-Pharmacologic Analgesia Interventions:
  These can include:
  - a regular exercise program and weight loss for back pain
  - improved sleep or dietary habits in chronic daily headache
  - psychologic interventions such as behavioral or cognitive approaches
  - guidance in carrying out daily functions (available through an occupational therapist).
    When there is limited therapy for the disease or the pain, patients are often comforted by the offer to continue care and support. Functional improvement is defined as fewer days off work, return to work, greater social interaction, improved marital relations, or amelioration in other clearly definable activities.

- Treatment with Medication:
  Long-term treatment with medication should be considered if acute use results in relief of pain, functional improvement, or both. If relief of pain without functional improvement occurs, the former benefit should clearly exceed any identifiable adverse effect in order to justify long term analgesic use.
  Analgesic medications should initially include the non-opioid analgesics or the adjuvant analgesics. Long term therapy with one or more agents within these two general categories continues to be the preferred pharmaco-therapeutic approach in patients with chronic non-malignant pain (in contrast to those with cancer pain). Long term use of non-pharmacologic analgesic approaches should be considered, and these include neuro-stimulatory, and other approaches.
  Opioids are not first line drugs in management of chronic non-malignant pain. One must carefully weigh the benefit and potential problems associated with such medications when used long-term. (see Appendix I "Opioid Use in Chronic Non-Malignant Pain")
  Patients with idiopathic pain are not excluded from a trial of opioids. Rather, the clinician should exercise particular caution in those patients whose pain is idiopathic or appears to be primarily determined by psychologic factors.
  The purpose of the Triplicate Prescription Program is to prevent patients from seeking opioids from multiple physicians, and it should not discourage physicians from their usual practice of quality medical care.
  Physicians should not hesitate to refer patients to a Pain Management Specialist. The Pain Clinic at the Health Sciences Centre and St. Boniface Hospital offer such a service and are also available for specific advice on the management of patients with chronic non-malignant pain.

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OPIOID USE IN CHRONIC NON-MALIGNANT PAIN

The goal of chronic opioid therapy is not the elimination of pain (which may be impossible) but rather to control pain to a tolerable level; there is a clear emphasis on level of function of the patient in their social, work, and personal life. The following will outline management parameters of opioid use for chronic non-malignant pain.

1. Before initiating opioids, an adequate trial of non-opioid analgesics and adjuvant analgesics should have been carried out without success.

2. One physician is responsible for prescribing opioids. This responsibility must be delegated from time to time during the unavailability of the primary opioid prescribing physician.

3. Opioids in combination with non-steroidal anti-inflammatory drugs or acetaminophen should be considered. Fixed combinations of acetaminophen with oxycodone (Percocet) or codeine (Tylenol #3) are commonly used. No greater than 12 tablets of the above preparations may be taken per day because of the risk of acetaminophen toxicity. Fixed combination preparations are fairly safe but usually need to be administered every four to six hours.

4. Treatment of pain with opioids is actually a treatment trial, and like all therapeutic trials, may be effective or ineffective. Effective therapy may be defined as identification of a dose associated with meaningful partial analgesia and no adverse effects severe enough to compromise comfort or function. This dose must be one at which the clinician can comfortably maintain the patient given the clinician's level of experience and training. Opioids almost always need to be titrated upwards, and effective doses are commonly higher than the starting does. Personal discomfort by the physician at the apparent level of opioid requirement is a valid reason not to proceed, and may warrant the referral of the patient to a physician who has more expertise in chronic pain management.

5. There is no value in using partial agonist opioids like pentazocine. Meperidine (Demerol) has relatively poor oral bioavailability, is short-acting, and can be associated with accumulation of a toxic metabolite, normeperidine. Anileridine (Leritine) is chemically related to meperidine. The use of these two opioids in management of chronic pain syndromes is not recommended.

6. If a fixed combination preparation of an opioid and non-opioid analgesic is not satisfactory, then the patient may be tried on oral morphine. The syrup preparation is convenient for titration purposes, and is recommended. The recommended starting dose is 10 mg by mouth every four hours.

7. The patient can be initiated on short acting or long acting (sustained release) opioid preparations. The choice will be based upon patient history and clinical experience. Dosage schedules and titration will differ depending on the drug and preparation selected. Physicians should be familiar with the variety of

available opioids and preparations as individual titration is essential to achieve an optimal response.

8. Pain is not always stable or absolutely predictable. Episodic exacerbation or breakthrough pain can be treated with low dosage short acting analgesia. The patient should be prescribed a small amount of "breakthrough" medication to be used for this purpose. As part of their management plan, patients should be educated on adjusting their analgesic medication during episodes of exacerbation. Patients should not be fearful of taking additional medication if their pain is more severe. Appropriate instructions given to patients regarding adjustment of their medications during exacerbations will reduce and even eliminate unnecessary trips to hospital emergency rooms and limit unnecessary suffering. If an exacerbation persists uncontrolled by breakthrough medication beyond a few days, patients should be seen and reevaluated as soon as possible to rule out an associated acute or chronic event.

9. The physician should watch for apparent drug-related behaviours. Behaviours which could be used to label a patient as an abuser exist on a continuum, and pain-relief seeking behaviour can be mistaken for drug seeking behaviour. The clinician will need to monitor carefully for evidence of psychological dependency and drug abuse. Some behaviours which provide compelling evidence of abuse include the selling of prescription drugs, covertly obtaining prescription medications from more than one physician, concurrent abuse of prescription medications from more than one physician, concurrent abuse of related illicit drugs, repeated unsanctioned dose escalations despite warnings, and events such as prescription "loss". Other signs of compulsive drug use may be more subtle, including the use of the opioid to treat symptoms other than pain, frequent visits to emergency rooms, and hoarding of drugs obtained from routine prescriptions. Relapse after withdrawal is a feature of addiction that is difficult to interpret in the context of chronic non-malignant pain, as relapse of pain (and the re-institution of opioid therapy) can be rationally anticipated to occur sometimes.

10. Parenteral dosing of opioids to treat chronic non-malignant pain should be strongly discouraged, and daily IM injections abhorred. However, It is recommended that patients requiring parenteral dosing of opioids to treat chronic non-malignant pain should be seen by a Pain Management Specialist so that this type of therapy can be initiated and monitored.

11. The patient should be seen and assessed at least every 9 weeks and more frequently if needed (e.g. if there is a history of previous substance abuse). The clinician should specifically evaluate the patient for several distinct aspects of therapy at each visit, including:

- analgesic efficacy
- adverse pharmacologic events
- function (physical and psychological), and
- the occurrence of apparent drug abuse related behaviours (see Section 8).

12. The pharmacist and other allied health care providers involved in the patient's care should be advised of treatment goals and the importance of:

- episodes of exacerbation
- drug abuse related behaviours

13. Documentation is very important with this therapy and physicians should keep careful records that include reference to these various aspects of therapy. Once a regular dose of opioid is established, the patient should not request a refill of the prescription earlier than the established duration for the prescription.