



## **OPIOID THERAPY FOR CHRONIC NONMALIGNANT PAIN: SUGGESTED GUIDELINES FOR HEALTHCARE PROFESSIONALS**

When treating patients diagnosed with moderate to severe pain, opioids may be considered as part of the pain management plan along with other analgesic and rehabilitative approaches. The primary goals of opioid therapy should be established to emphasize both “meaningful” pain relief and “measurable” improvement gains in physical and social function.

Always take a balanced approach when prescribing opioids. Consider treatments that will provide patients with both the most effective relief and a careful assessment of potential risks for addictive disease, abuse, and diversion. If you have not been thoroughly trained in prescribing opioids, or are uncomfortable prescribing these medications, you may want to refer patients to pain specialists.

### **When patients report pain:**

- Accept their reports of pain
- Talk to them about their pain
- Look for causes of pain by
  - Conducting a comprehensive pain assessment
  - Getting a thorough medical history, including addiction or substance abuse problems
  - Reviewing all medical records
  - Giving a complete physical examination
- Talk to your patients about treatment options and about following a treatment plan.

### **Consider opioid therapy for moderate to severe nonmalignant pain, when:**

- Opioids are likely to work well
- Other therapies with equal or better therapeutic benefit have been tried, but did not work
- Medical risk of opioid use with co-morbidities has been considered
- Patient is deemed responsible in medication use

- It is compatible with known practice standards of particular pain syndrome.

*Opioid therapy may be contraindicated if there is a history of substance abuse, severe character pathology, or a chaotic home environment.*

**Before the start of opioid therapy, talk to your patients about the risks, benefits and possible/likely side effects. Be certain that they understand your recommendations. Obtain an informed consent. Some common effects include:**

- Likelihood of constipation
- Probable physical dependence, although relative low risk of addiction
- Possible sedation and cognitive impairment with opioids only or when combined with other drugs that sedate or cause hypnotic effects; these effects tend to decrease over time.

**When prescribing opioids, consider the following:**

- Select an opioid appropriate to that individual
- Establish an around-the-clock dosing schedule
- Remember that long-acting opioids are preferred for persistent pain
- Co-administer short-acting for breakthrough pain on case-by-case basis
- Allow several weeks for a period of initial dose titration
- Titrate to meaningful analgesia effect along with the goal to improve function
- Encourage patients' to monitor their pain and keep a personal record of pain and medications (e.g. *American Pain Foundation's Pain Notebook*, available at <http://www.painfoundation.org/downloads/Notebook.pdf>).

**Follow your patient closely during the initial phase (at least monthly). Once opioid dose is stable and primary treatment goals have been reached, fewer visits may be required. Every follow-up visit should address and include documentation about:**

- Pain relief status (degree of analgesia)
- Presence of opioid-related side effects (and effective management strategies)
- Functional status (physical and psychosocial)
- Existence of any aberrant drug-related behaviors

**Reassess your patient when/if pain worsens:**

- Look for patterns and relationships between the pain occurrence and activity, emotional state and/or time of day. Patient self-monitoring tools are most helpful.
- Calculate the total opioid use per day and document. Assess the average daily opioid dose that is required that keeps your patient within acceptable pain levels and satisfactory improvement in function.
- Consider adjustments in opioid treatment plan, such as:
  - Increasing the stable (total daily) dose
  - Providing for co-administration of short-acting “rescue doses” for breakthrough pain with instructions on how and when to be used
  - Allowing for one or two extra opioid moderate- to long-acting opioid doses on identified “bad” days followed by an equal reduction of dose on subsequent “good” days
  - Changing therapies such as switching to a different opioid, adding a new adjuvant, or requesting a specialty evaluation
- Watch for signs when opioid dose escalation is not providing pain relief. This may be a signal that the pain problem is not opioid-responsive. Re-evaluation of the pain syndrome may be necessary.
- Make sure that all changes in the pain plan are clearly stated and agreed upon with your patient and document in the medical record.

### **EVALUATING VULNERABILITY TO ADDICTION, DIVERSION, OR ABUSE OF OPIOIDS**

Opioids are powerful and effective medications that, unfortunately, have the potential for abuse or diversion. It is therefore important to carefully assess patients who exhibit strange or aberrant opioid-related behaviors. Some behaviors may signal serious addiction, abuse, or diversion problems, while other behaviors may indicate that your patients are not getting satisfactory pain relief, or that they are fearful/anxious about not getting appropriate relief.

#### ***Behaviors that Require Close Scrutiny***

**Addiction, abuse, or diversion problems may be present when your patients:**

- Take multiple doses or do not adhere to recommended therapy in spite of warnings
- Report prescription loss several times or requests prescriptions early
- Demonstrate patterns of obtaining prescriptions from other healthcare providers (including emergency departments and dentist offices) without informing the

primary opioid prescriber. This is a significant problem if prior warnings to cease this behavior have been given

- Show deterioration in function at work, home, or social settings that appear to be related to opioid use
- Repeatedly resist recommended changes in therapy despite clear evidence of adverse physical or psychological effects from the opioids
- Abuse alcohol or illegal drugs

**You *know* there are problems when you discover that your patients:**

- Steal or “borrow” drugs from others
- Alter oral formulations of opioids and snort or inject intravenously
- Obtain prescription drugs from non-medical sources
- Sell prescription drugs
- Forge prescriptions

### ***Behaviors that Signal Problems Other Than Addiction, Abuse, or Diversion***

Your patients may exhibit strange behaviors that signal problems, but they do not necessarily mean that they are addicted to, abusing, or diverting opioids. Instead, these behaviors may indicate under-treatment or fears about not getting pain relief. For example, patients may:

- **Complain aggressively about the need for higher doses of medications.** This may mean that their pain has not been adequately relieved, or they fear they are not being heard or validated.
- **Be unwilling or unable to provide names or locations of past healthcare professionals or treatment facilities treating their pain.** This can mean that they may have had problems with previous professionals or facilities and fear unfair scrutiny because they may have experienced a breach of trust in the past.
- **Either openly acquire similar drugs from other medical sources or hoard medications during periods of reduced symptoms.** This may be a serious problem or it may indicate general fears about running out of medications or specific fears about their pharmacies not having their medications in stock when refills are due.
- **Request specific drugs.** Patients may know which drugs work for them and which ones do not from past opioid trials, or they may have had negative or positive past experiences with particular drugs.

- **Be “overly” knowledgeable about their pain problems and drug therapies.** They may be well educated and expect to be active participants in their pain treatment plan.
- **Escalate doses without your knowledge or approval, or fail to adhere to a prescribed therapy on only one or two occasions.** The circumstances may be reasonable and justified. This may be an opportunity to re-assess pain problems and treatment plan - and require a re-commitment between your patient and you.
- **Use medication to treat another symptom (insomnia, anxiety, increased stress).** This may be indicative of a knowledge deficit. Review your patient’s understanding of how the opioid is working for pain relief. Emerging symptoms require assessment and treatment because they may affect pain relief. An adjustment in the treatment plan may be required.
- **Report unexpected psychic effects.** This may be an idiosyncratic effect or may indicate the need for psychological evaluation (i.e., flashbacks of repressed trauma).
- **Resist a change in therapy and/or express high level of fear or anxiety when a change in medication is clearly indicated.** This may be a legitimate concern about the return of severe pain from past experience or fear of unknown.

## **ASSESS AND ADDRESS EVIDENCE OF ABERRANT BEHAVIORS**

### **Considerations in the treatment plan may include:**

- Re-assessment of pain problem and adjustment in treatment plan
- Continuation of therapy by adding more structure and guidelines
- Consultation with pain specialty
- Consultation with behavioral health specialist
- Consultation with addiction medicine specialist
- Gradual tapering and discontinuation of opioid therapy; continue managing pain care
- Gradual tapering and discontinuation of opioid therapy, referring to comprehensive pain care program
- Do not abandon.

Adapted from Portenoy, Payne & Passik, “Acute and Chronic Pain”, 2003  
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