



By Paul O Jacobs, MD

What a Busy Primary Care Provider Wants to Know About Pain Management

Corridor Consult

Background

The field of pain management has seen dramatic change in the last decade. Our previous belief was that patients “learning to live with pain” and physicians not prescribing pain medication when pain was chronic equalled good medical practice. Advances in science are changing those long-held beliefs. Scientific knowledge about the complexity of chronic pain is at the basis for change in treatment recommendations. Such change has stimulated many pertinent questions for primary care providers. When should I use pain medications? How do I decide how strong an analgesic agent to prescribe? How long is it appropriate for patients to use these habit-forming agents? How do I know if my patient is addicted or abusing my prescriptions? These are but a few of the questions that I hear daily. Although I cannot offer a fail-safe and comprehensive set of answers for these questions, I can provide guidelines to consider and hope to shed some light upon these complex decisions.

Evaluation and Management

First of all, understand that pain is a subjective experience. We will never see our patient’s pain. Trusting our patient’s reports of pain is the place to start. In my view, we are only rarely purposely misled by our patients. Ask your patient to carefully consider how they would rate the pain on a 0 to 10 scale with 0 being “no pain” and 10 being “worst pain imaginable.” For pain that is graded between 2 and 5, non-steroidal anti-inflammatory agents (NSAIDs) or acetaminophen suffice. When pain is graded at 6-7, the pain is reaching a level where prescriptions are needed. Codeine, hydrocodone/acetaminophen, or oxycodone are the usual choices at this level of pain. When pain is clearly severe and labeled as 8-10 out of 10, these weaker opioids may not be strong enough. Oxycodone again is worth a try, and consideration of morphine-level agents becomes the most useful alternative. Placing a value on the pain itself is important, as is considering treating it even if it is not attached to a “serious” condition. Pain that is inadequately treated can initiate changes in the spinal cord and brain that form the foundation for chronic pain.¹⁻³ We are all aware of very innocuous conditions that ushered in more severe chronic pain disorders.

The next caveat about pain management has to do with the pain pattern. If the pain is intermittent, then analgesics that are short-acting can work well. If pain is a “24/7” type of condition, for which pain medications are used throughout every day, then long-acting or slow-release opioids are warranted and should be used in a time-contingent way rather than PRN. The choices for sustained-release agents are limited and include morphine, methodone, and fentanyl patches. Oxycodone in the form of OxyContin (Purdue Pharma LP, Norwalk, CT) is also a slow-release agent but has gained great notoriety because of its popularity “on the street,” so strict guidelines about its use are strongly recommended.

If the above “24/7,” sustained-release pain medications are prescribed on a long-term basis, most State Boards of Medical Examiners insist that an informed consent be placed in the medical record describing for the patient the side effects of these medications as well as their dose limitations, number of pills dispensed, and frequency of dispensing. The primary care physician who is in charge of the regimen is also named in this document. Periodic visits are recommended to assure that these medications are, in fact, helping pain to a substantial degree.⁴ Important measures of whether these medications are helping are questions that detect how well a person is functioning in life. If these medications are working, then patients should be able to tell us how they are improving their daily function because of this benefit.

Common Concerns

A common dilemma relates to concerns about possible abuse or addiction. Requests by members for more or stronger opioids trigger these concerns. Becoming familiar with some opioid physiology definitions is useful.

All people who use opioids daily become “dependent” upon them in that they will experience withdrawal or an “abstinence reaction” if they stop the agent without tapering off. Another aspect of opioid physiology is the tendency for the pain-relieving effects of these medications to lessen with time. This decrease in effectiveness is termed “tolerance” and is usually overcome by an increase in dosage of the opioid. When the benefit of the medication wanes, a patient may “seek” a higher dosage or more medica-

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tion, action that may mimic the drug-seeking behavior that accompanies addiction. This “pseudoaddiction” therefore represents a bona fide pain patient’s attempts to achieve better pain control in the face of tolerance. When the dosage is increased, the pain is lessened, and requests for escalation of dosage stops.⁵ Addiction, in contrast, is a behavioral syndrome in which diversion of medications, illicit routes of administration, taking medications for their euphoric effect, and surreptitiously obtaining drugs from multiple providers are characteristic behaviors. Escalation of medication dosage does not lead to “better functioning” but results only in further requests for more drugs.

Unfortunately, many honest, reliable patients with chronic pain do not respond to opioid analgesic administration. This lack of effect is based on the complexity of opioid receptors and on many other factors. In such cases, increasing doses of potent analgesic agents does not lead to good pain control. When confronted with this situation, assistance from a pain management expert can help you and your patient. Perhaps the patient’s switching to an alternative medication is needed. One of the tenets of pain management is that if a person is not responsive to opioids, their dosage should be tapered off.

Summary

The primary focus of this discussion has been the role that opioid medications can contribute to chronic pain management. I would, however, not wish to leave you with the impression that pharmacologic treatment of chronic pain as an isolated intervention will result in good pain control in all cases. Because of the complexity of chronic pain, most serious chronic pain sufferers will need their psychosocial issues addressed as well. For this reason, chronic pain experts admonish us to approach chronic pain management with a combination of behavioral approaches to chronic pain coupled with the use of opioids based upon the guiding principles we have articulated.

Conclusion

In summary, the bottom line on use of opioid agents is 1) they must be helpful; and 2) if they are helpful, they will enable your patient to have a greater degree of function in their daily life activities. ❖

References

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Suggested Reading

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Practice Tips
Pain is a subjective experience. Believe your patient—you will be right in doing so in the vast majority of cases.
If pain is severe, strong opioids deserve consideration if weaker ones are not sufficient.
If opioids are going to be prescribed on a long-term basis for chronic pain, sustained release agents given on a time contingent basis are preferred.
If opioids are going to be prescribed on a long-term basis, two criteria need to be met: <ul style="list-style-type: none"> • They need to be effective in controlling pain. • Better pain control should be associated with improved physical functioning in everyday life.
Document with good charting the pain management plan of action including use of opioids.
Complex chronic pain problems are rarely satisfactorily dealt with by prescribing drugs alone. Good pain management usually requires “behavioral” interventions, which specifically address the psycho-social stresses confronting the chronic pain patient.