Opioids for Chronic Non-malignant Pain: Can we justify the risk?

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Story from the Front Lines:

A middle-aged man presented to establish primary care. A recent hospital discharge summary indicated his medical problems might be challenging to manage. He had COPD, hypertension, diabetes, and depression; he was also recently homeless. But his discharge summary couldn't prepare me for what I was to encounter when I stepped into his room. "I am scared that I might use my gun on myself. I'm surprised I haven't already." His medical problems took a backseat to the more pressing issue of getting him immediate psychiatric care. I also learned that day that he was being prescribed methadone by another clinician for chronic back and abdominal pain, but was trying taper himself off due to cost.

I saw him the next month, and after starting an antidepressant and establishing with psychiatry, his depression was under better control. We addressed his COPD, which was severe and required supplemental oxygen, unusual for his age. After taking a family history I sent an alpha-1-antitrypsin deficiency genetic test, which ultimately returned positive. Also at that visit, my patient revealed he had been unable to taper completely off the methadone, and asked if we could prescribe a pain medication his insurance would cover. I converted his low dose methadone to long acting morphine 15 mg twice daily. He was also taking adjunctive ibuprofen and gabapentin.

Over the next 8 months I saw him four more times. He had obtained stable housing in a group home. He saw his mental health provider regularly who eventually prescribed a low dose benzodiazepine to help him sleep at night. At every visit, it seemed, pain was his primary concern, though I was often more concerned with addressing his COPD and trying to convince him to see a pulmonary specialist. Ultimately after modestly increasing his dose of morphine several times, I told him that I would not increase his total daily dose beyond the 75 mg he was receiving, as his most recent dose increase had not reduced his level of pain nor improved his function. That visit was the last time I saw my patient.

I received notification of hospitalizations he had over the next few months for pneumonia. I read his discharge summaries; his lung function was worsening. In the fall that year, I received a letter. My heart sank as I read. The coroner's office notified me of my patient's death at his group home, and that they would be performing an autopsy. I felt certain that prescription drugs had contributed, and my suspicion was confirmed when I read the final report: "The cause of death is deemed to be accidental prescription drug overdose."

Teachable moment:

Chronic pain is a highly prevalent condition, affecting 100 million Americans (1). Opioid pain medications are some of the most commonly prescribed drugs in the U.S., and along with the ever-increasing number of prescriptions written have come a corresponding increase in deaths attributed to overdose of those prescription opioids - 16,000 in 2010 alone (2). Despite frequency of use, the evidence to support using opioids for the indication of chronic non-cancer pain is weak. A 2010
Cochrane Review of 26 studies (none randomized control trials) concluded there was weak evidence to suggest that patients able to continue opioids long-term without adverse effects had clinically significant pain relief; there was no conclusive evidence about improvement in function (4).

Guidelines for prescribing opioids in such cases are similarly unclear: to summarize, prescribe if the benefit outweighs the risk. Guidelines emphasize methods to standardize prescribing and follow up evaluation, including assessing risk of misuse, prescribing contracts, and using pain scales (3).

My experience with my patient leaves me wondering, if the most notable risk of using opioids in chronic pain is accidental death (an alarmingly frequent occurrence), while the possible benefit is decreased pain without functional change, do the benefits for this indication ever outweigh the risk? If the answer is perhaps not, we should develop clear guidelines to better reflect that.

References:


2. CDC Morbidity and Mortality Weekly Report. 2011. 60(43); 1487-1492.
