Managing pain and expectations with long term opioids
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Story from the Frontlines:

A 69 year old woman with a history of chronic low back pain, obesity, and depression was started on short acting opioids eight years ago for acute low back pain after a fall. Plain films showed degenerative disease of the spine. Her back pain persisted and a long acting opioid was added. She had adequate control of her pain for about six months until she experienced worsening low back pain. Both short and long acting opioids were increased. She had several more acute exacerbations of her pain over the years that resulted in similar up-titrations of her pain medications. For the past three years, she has been on a stable dose of long acting morphine sulfate 90mg three times daily and immediate-release oxycodone 10mg, two tablets 3 times daily as needed.

She recently called for a refill of her pain medications and was given her usual 120 tablets per month. She later called back and requested 180 tablets because that was the amount prescribed the month prior. In reviewing her medication record, the prescription was indeed written for 180 tablets by a different clinician in the practice. It was discovered that when a new script is generated in instead of a refill, the electronic medical record (EMR) automatically fills the number dispensed based on amount and frequency. In this case, taking 2 tablets every 8 hours as needed equals 180 tablets. She became accustomed to taking 20mg three times daily scheduled whereas in the past, she was using it twice daily on average. Once again, the patient has become dependent on a higher dose of opioids.

Teachable Moment:
Opioids have been essential in the treatment of malignant pain as well as acute pain after injury or surgery. On the other hand, there is very limited evidence to support the use of opioids for chronic nonmalignant pain.\(^1\) High dose opioids have not been shown to decrease severity of chronic pain or improve overall health and function.\(^2\) On the other hand, there is evidence that higher daily dose of opioids for nonmalignant pain is associated with increase opioid-related mortality.\(^3\) Falls, constipation, sleep apnea, endocrine dysregulation, and cognitive and neuropsychological impairments are among the many harms that have been associated with long-term opioid use. Even with such risks and limited evidence of benefit, prescriptions for opioids have increased 600% from 1997-2007. During this time period, there was a 350% increase (from 4000 to 14000) in unintentional fatal overdoses from prescription opioids and a 400% increase in admissions for opioid addiction treatment.\(^4\) Currently over 80% of opioids are dispensed to patients with chronic pain with more than half of those exceeding 50 mg (morphine equivalents) daily.\(^5\)

The story of our current patient happens too often. Acute pain treated with opioids is often warranted but in the management of chronic, non-malignant pain we should be mindful of the risks of long term opioid therapy. Treatment with non-opioids such as acetaminophen, NSAIDs, SNRIs or TCAs should be considered first. Cognitive behavioral therapy, support groups for chronic pain, and physical therapy can also be trialed. If long-term opioids are considered, clinicians should frequently assess functional and pain status, monitor for misuse, and set expectations for exacerbations to avoid escalation of dosage. Having a single prescriber, or at least a single practice is also preferred. For patients already on high dose opioids, frequently revisiting readiness of a patient to reduce and ultimately discontinue is invaluable.
Thomas Sydenham once said, “of all the remedies it has pleased almighty God to give man to relieve his suffering, none is so universal and so efficacious as opium.” Effective pain management is an essential part of caring for patients. The challenge lies in the balance of achieving adequate pain control to alleviate suffering and promote function while minimizing harms.

References:


