EXPERT OPINION

Opioid Therapy in Chronic Noncancer Pain

BY NEIL SKOLNIK, M.D. AND GINA MENICHELLO, D.O.

Chronic noncancer pain (CNCP) is a leading cause of disability and discomfort for patients in the United States. Health care expenses for chronic back pain alone were roughly $90 billion in 2005. Opioids have long been an accepted treatment for the pain associated with cancer or the end of life, and the past few decades have seen an increase in the use of opioids for chronic noncancer pain as well, although opioids in this setting remain controversial. The American Academy of Pain Medicine and American Pain Society recently gathered a multidisciplinary expert panel to formulate evidence-based guidelines on chronic opioid therapy (COT) for adults with CNCP (J. Pain 2009;10:113-30). These guidelines were devised to be applicable to both primary care and specialty centers, and to have as their goal the promotion of a "balanced approach" that recognizes the importance of addressing both pain control and improvement in functional status for patients, while at the same time developing procedures to protect against the increasing public health problem of prescription drug abuse.

Initiating Therapy

One of the most important aspects of initiating COT is proper patient selection. A thorough history and physical examination—as well as appropriate diagnostic tests to evaluate the patient's pain—should be completed. Clinicians should consider if the underlying condition causing pain can be treated with nonopioid therapy before deciding to start COT. Randomized trials demonstrating the benefit of COT are seen with patients who have moderate to severe pain that is unrelieved by nonopioid therapy. COT is effective for both neuropathic and non-neuropathic pain, and can be considered if the patient's functioning or quality of life is significantly affected and if benefits of therapy outweigh potential risks. It is important for patients to have reasonable expectations upon starting COT: Total pain relief is rare, and most patients' pain improves 2-3 points on a 0- to 10-point scale. One of the most significant risks associated with opioid therapy is drug abuse or misuse. The strongest predictor of drug abuse or misuse in COT is a personal or family history of drug or alcohol abuse.

After the patient receives informed consent regarding the risks and benefits of COT, the physician should consider a written management plan. This plan can include the goals of therapy, random urine drug screens, instructions for dispensing medications, follow-up timeline, consequences for misuse of medications, and clarification that opioids should be obtained from only one prescriber.

There is no evidence that any one opioid is better for initiating therapy. It may be safer to begin with short-acting opioids for initial therapy because they have a shorter half-life and possibly less risk of accidental overdose; however, there is insufficient evidence to recommend short-acting vs. long-acting opioids. The suggested benefits of long-acting opioids include more consistent control of pain, improved compliance, and lower risk of addiction or abuse. For breakthrough pain, short-acting or rapid-onset opioids used as needed may be effective. There is limited evidence at this time to recommend any specific opioid in this setting.

Methadone use has increased over the last decade, but clinicians need to be aware that it has complicated pharmacokinetics and should be used by clinicians familiar with its use and risks.

Monitoring Therapy

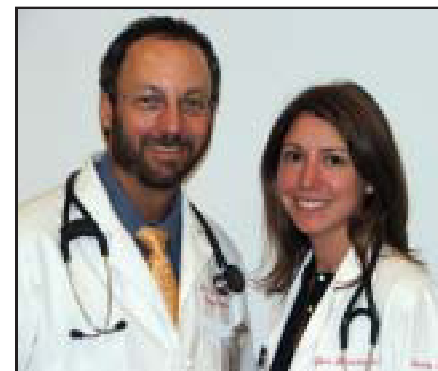
Patients on COT should be monitored periodically to assess level of function, pain severity, adverse events, compliance with drug regimens, and degree of progress to goals of therapy. Clinicians can obtain periodic urine drug screens in patients who are at high risk for drug abuse or misuse, and may consider such screening in low-risk patients. Patients with repeated dose titrations should be reassessed, especially for adverse effects and drug misuse. Opioid rotation may be considered for patients with intolerable adverse effects or those with inadequate pain control despite continued dose titration. Patients involved in aberrant drug-related behaviors should be weaned off COT. Therapy should also be tapered for patients who are experiencing intolerable adverse effects or who are not progressing to goals of therapy. Slower rates of weaning (for example, a 10% dose reduction per week) may help decrease symptoms of withdrawal.

When prescribing COT, clinicians should consider incorporating psychotherapeutic interventions for the treatment of CNCP.

The Bottom Line

When the benefits outweigh the risks, chronic opioid therapy is a reasonable and efficacious way to treat individuals with chronic noncancer pain. Patients should be selected carefully and monitored appropriately during treatment with chronic opioids.

An interdisciplinary approach, including psychotherapeutic interventions, may be beneficial for patients with chronic noncancer pain. ■



DR. SKOLNIK is an associate director of the family medicine residency program at Abington (Pa.) Memorial Hospital. DR. MENICHELLO is an attending physician at Grand View Medical Practices at High Point in Chalfont, Pa.

Deadline Looms for Grandfathering Into Addiction Medicine

BY DAMIAN McNAMARA

The newly formed American Board of Addiction Medicine has certified more than 1,600 physicians as specialists in addiction medicine so far this year, including more than 200 internists. Physicians from multiple disciplines who meet expertise criteria are taking advantage of the opportunity to be "grandfathered in" to the nascent specialty by taking a special 6-hour certifying examination.

Dr. Kevin B. Kunz, president of the American Board of Addiction Medicine (ABAM), said in an interview that the 15 physicians on the ABAM board of directors will create a new examination to certify physicians after the grandfathering option ends in December. Previously, only psychiatrists could claim addiction-related board certification.

Official recognition of addiction expertise is being expanded to include internists, family physicians, emergency physicians, ob.gyns., surgeons, pediatricians, preventive medicine physicians, and neurologists.

"There are already folks out there toiling in relative obscurity in addiction medicine," internist Peter D. Friedmann said in an interview. "Creation of the ABAM was driven by the need for better recognition within medicine." The American Society of Addiction Medicine provided a certification exam for years, "but it was not accorded the same respect and gravitas as fields that have their own subspecialty boards." Dr. Friedmann of Brown University in Providence, R.I., is one of the internists who took advantage of the grandfathering option.

Criteria for certification grandfathering include at least 1,950 hours over the past decade providing addiction-related care, research, and/or education; 50 hours of CME related to addiction medicine in the past 2 years; letters of recommendation supporting proficiency in this area; and successful completion of the examination.

Primary care physicians will continue to play a large role in addiction care because "there will never be enough ABAM-certified specialists to treat everyone," Dr. Friedmann said. "It would be like expecting everyone with hypertension to be treated by a cardiologist."

"So many of the more than 120 million emergency department visits each year are due to substance abuse," said Dr. Gail D'Onofrio of the ABAM board of directors and section chief of emergency medicine at Yale University in New Haven, Conn. Dr. D'Onofrio cited a statewide survey of seven Tennessee EDs showing that 31% of screened patients tested positive for substance abuse and 27% were assessed as needing substance abuse treatment.

Unfortunately, emergency physicians identified only 1% as having a diagnosis or problem related to substance abuse (Ann. Emerg. Med. 2003;41:802-13). ABAM plans to establish addiction medicine residency programs and get them recognized by the Accreditation Council for Graduate Medical Education (ACGME). "We expect these programs to be in place by 2011, after which time we will add a residency requirement to ABAM certification, as well as a maintenance-of-certification program," Dr. Kunz said.

There is a core content shared among all specialties treating addiction, and therefore one examination, but individual specialties could add their own content to fellowship programs, Dr. D'Onofrio noted.

Once these requirements are in place, ABAM will seek recognition from the American Board of Medical Specialties (ABMS), which may take another 4-6 years. "We want addiction prevention, screening, intervention, and treatment to become routine aspects of medical care, available virtually any place health care is provided," noted Dr. Jeffrey H. Samet, ABAM president-elect and professor of medicine at Boston University.

Reimbursement for addiction-related services remains a challenge. "These are difficult patients who take time and for whom there has been little reimbursement," Dr. Kunz said. Although reimbursement codes for addiction screening and brief intervention in addiction are recognized by Medicare, some states, and some private insurers, "reimbursement for doing this work is still quite low," Dr. Friedmann said. Better financial incentives are needed to encourage physicians to get into this field and make it a career, he added.

The codes for screening and intervention "are very important. You can't get doctors to do something they won't get paid to do," Dr. Sokol said. ■

The next ABAM examination is scheduled for Dec. 11, 2010. Application deadlines are Oct. 31, 2009; Jan. 31, 2010; and April 30, 2010. More information is available at www.asam.org/ABAM.html.

Pages 12a—12d