Add a Rung to the WHO Analgesic Ladder

BY SHERRY BOSCHERT
San Francisco Bureau

SAN DIEGO — Add a half step and a new rung to bring the World Health Organization's three-step "analgesic ladder" into the 21st century, Joshua P. Prager, M.D., said at a psychopharmacology congress sponsored by the Neuroscience Education Institute.

The venerable World Health Organization (WHO) pain management guidelines, crafted about 15 years ago, described treatments for three levels of pain: mild, mild/moderate, or moderate/severe pain, he explained.

For mild pain, the WHO recommends nonopioid therapies like acetaminophen or traditional nonsteroidal anti-inflammatory drugs. Mild/moderate pain calls for an opioid (codeine, dihydrocodeine, hydrocodone, or oxycodone), often with a nonopioid. For moderate/severe pain, treat with a pure opioid in sustained-release or rescue therapy (morphine, fentanyl, oxycodone, or hydromorphone), the WHO suggests. At all levels, consider including adjuvant therapy.

One goal of these guidelines was to convince physicians in Third World countries that it's okay to give opiates for pain, said Dr. Prager, a pain specialist in Los Angeles. To make the analgesic ladder more relevant to U.S. physicians in the 21st century, he adds a half step between the mild and mild/moderate rungs to include new medications that have appeared since the guidelines were written.

These include tramadol (Ultram), gabapentin (Neurontin), pregabalin (Lyrica), duloxetine (Cymbalta), the lidocaine patch, and cyclooxygenase-2 (COX-2) inhibitors. Despite recent controversy around possible cardiovascular problems from long-term use of high-dose COX-2 inhibitors, Dr. Prager said those drugs have been a real boon to his practice when used in lower doses to avoid the GI toxicity associated with chronic use of traditional NSAIDs, he said.

Dr. Prager has been a speaker for the companies that make tramadol, gabapentin, pregabalin, and one of the COX-2 inhibitors. He has received research funding from the company that makes the lidocaine patch.

Beyond the moderate/severe pain level at the top of the analgesic ladder, Dr. Prager adds a fourth rung of severity and treatment that is not yet recognized by WHO recommendations. Treatments for patients in this fourth rung with intractable or refractory pain would include spinal cord stimulation, direct delivery of medications to the spinal fluid, and neuroablation.

Dr. Prager said that several other pain management guidelines are available:

- The American Pain Society's Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer Pain.
- The American Society of Clinical Oncology's Cancer Pain Assessment and Treatment Curriculum Guidelines.
- The Oncology Nursing Society's Position Paper on Cancer Pain.
- American Society of Anesthesiologists guidelines.

Dr. Prager gives these guidelines to patients. "We find that if patients and families understand their rights to pain management, they will take a more active role."

The WHO also provides important recommendations in its 1990 Cancer Pain Relief and Palliative Care guidelines on when to start palliative care, Dr. Prager noted; these guidelines focus on palliative care for cancer therapy, but they could be applied to any chronic disease with associated pain, including sarcoidosis, peripheral vascular disease, or multiple sclerosis. ■

Pain Guidelines—By the Letter

All the best advice from the various pain treatment guidelines might be condensed down to these precepts, Dr. Prager suggested:

Ask about pain regularly.

Assess pain systematically.

Believe the patient and family members in their reports of pain and what relieves it. Physicians who are not pain experts may be skeptical about this approach, he acknowledged. "I would rather make the mistake of giving a pain medication to somebody who doesn't have pain, and then figure out what's going on, than withhold pain medicine from somebody who really needs it. Of those two types of errors, I think one is much worse than the other."

Choose pain control options appropriate for the patient, family, and setting. Take the family's beliefs into account when picking therapies and modes of delivery.

Deliver interventions in a timely, logical, and coordinated fashion. "There are a variety of ways of delivering drugs now that weren't available several years ago," he noted.

Fentanyl citrate lozenges or "lollipops" may cost about $10 each, but they can deliver enough analgesia to avoid a more costly at-home fentanyl infusion.

Empower patients and their families.

Enable them to control their course to the greatest extent possible.

Talk Therapy Helps Patients Regain Their Lives Despite Pain

BY BETSY BATES
Los Angeles Bureau

PALM SPRINGS, CALIF. — Physicians who doubt that chronic pain patients need and deserve cognitive-behavioral therapy as an adjunct to other treatments need to take an honest look at how well modern medicine treats pain, Dennis C. Turk, Ph.D., said at the annual meeting of the American Academy of Pain Medicine.

Opioids reduce severe, chronic pain by only about a third. Moreover, up to 50% patients discontinue opioid therapy because of a lack of efficacy or because of side effects.

At the end of interventional pain trials, the vast majority of patients have improved so little they would still qualify for a new trial.

Even surgical procedures that sever neurologic pathways believed to be responsible for a patient's pain often fail to alleviate the symptoms.

"Our best efforts still by and large don't cure people," said Dr. Turk, professor of anesthesiology at the University of Washington, Seattle.

Pain is real, but it is a subjective perception "resulting from the transduction, transmission, and modulation of sensory input filtered through a person's genetic composition and prior learning history and modulated further by [the person's] current physiological status, idiosyncratic appraisals, expectations, current mood state, and sociocultural environment," he said. In other words, "that arm or neck or shoulder is attached to a human being with a social context and with a history."

Underlying physical pain are emotional responses: fear, uncertainty, demoralization, and worry about the future. A family is involved, suffering as well.

Offering or referring patients for cognitive-behavioral therapy (CBT) acknowledges that pain may not be curable in every patient and recognizes that life must go on around it. It also gives patients credit for being capable of actively processing information and learning adaptive ways of thinking, feeling, and behaving, Dr. Turk said.

The exact CBT technique used is less important than the characteristics of the approach in general, according to Dr. Turk. All CBT should be:

- Problem-oriented.
- Time-limited.
- Educational.
- Collaborative (between patient and provider, and perhaps family members as well).
- Practical, using clinic and home exercises to consolidate skills and identify problem areas.
- Anticipatory of setbacks and lapses and able to teach patients how to deal with these.

In the context of pain, CBT can be particularly effective in helping patients reconceptualize their problems, making seemingly overwhelming hurdles become manageable.

It can help patients to believe they have the skills necessary to solve problems, transforming them from being passive and helpless to being "active, resourceful, competent," Dr. Turk said.

By utilizing real examples in a patient's life, CBT can help individuals recognize unhelpful thinking patterns such as overgeneralization, catastrophizing, seeing things in all-or-none terms, jumping to conclusions, selectively focusing on details rather than the big picture, and mind-reading the thoughts of others.

A CBT therapist then helps a patient learn to recognize problems associated with a life of pain and then propose his or her own adaptive solutions. Examples might include feeling bored and restless because of diminished activities, experiencing disharmony in family members due to altered roles, or suffering diminished self-esteem when a patient in chronic pain can no longer work.

A good CBT therapist guides the patient to set realistic solutions approached with step-by-step goals, practiced in sessions and during homework sessions tracked with diaries and charts.

Dr. Turk said he makes success highly attainable from session to session.

For example, if increased mobility is a goal and the patient already believes he can walk 1 block, he sets the bar at walking 8/10 of a block every few days for the first week.

Monitoring, reinforcement, listening, and adapting to changing realities are all key to CBT success. Perhaps most important is the anticipation of nonadherence. Right from the start, a therapist can tell patients to expect flare-ups in pain and "slip-ups" in behavior, and a plan can be devised to deal with those situations before they occur. ■

Adherence to a CBT Plan

1. Anticipate nonadherence.
2. Consider the prescribed regimen from the patient's perspective.
3. Foster a collaborative relationship based on negotiation.
4. Prepare for flare-ups.
5. Customize treatment.
6. Enlist family support.
7. Provide a system of continuity and accessibility.
8. Make use of other health care providers (such as occupational or physical therapists) as well as community resources.
9. Repeat, repeat, repeat everything.
10. Don't give up! Pain specialists represent Ellis Island or Lourdes to chronic pain patients. If they were easy patients, "they wouldn't be seeing you."

Source: Dr. Turk