

***OPIOID USE IN
CHRONIC NON-CANCER PAIN***

Proposal for a Common Approach Across
Canada

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Discussion Paper
by
Workers' Compensation Board of British Columbia

for

Medical Directors
of
Workers' Compensation Boards of Canada

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OPIOID USE IN CHRONIC NON-CANCER PAIN

EXECUTIVE SUMMARY

- Opioids are not the drug of choice for chronic non-cancer pain, but in an appropriate clinical setting, oral opioids are currently considered an acceptable medical intervention for chronic benign painful conditions.
- The prescription of opioids must meet current medical practice standards and all legal and regulatory requirements.
- In the context of Workers' Compensation, long-term opioid prescription for chronic non-cancer pain should only be considered for treatment of an injured worker if:
 - prescription of opioids is not the first line of treatment;
 - prescription of opioids is part of an integrated approach to pain management;
 - there is a written treatment agreement between patient and physician;
 - there is a primary prescriber;
 - the route of prescription is oral;
 - behavioural symptoms that suggest opioids may increase the complexity of the injured worker's problem are carefully considered;
 - there is evidence that treatment with opioids results in improvement of both pain AND function, enabling the injured worker to return to work; and
 - there is appropriate oversight by the Workers' Compensation Board.

I. INTRODUCTION

The use of opioids for the treatment of pain became increasingly common in Western medicine during the last decades of the 20th century. This occurred first in palliative medicine, particularly for cancer patients. When the burden of human suffering was weighed against concerns about the addictive potential of narcotic medications, the risk seemed minor compared to the gains in the patient's quality of life at life's end stages. Notably, despite large doses of opioids (usually morphine), many of these patients were able to function quite normally, without evidence of addictive behaviour or functional impairment.

Evidence-based medicine, however, requires that benefit of interventions be shown before widespread use is adopted, and so researchers and pharmaceutical companies are currently assessing the potential role of opioid medications in treatment of non-cancer pain including acute pain (which now tends to be treated more aggressively than in the past) and chronic non-cancer pain.

In the interim, in an appropriate clinical setting, oral opioids are presently considered an acceptable medical intervention for chronic benign painful conditions, and many physicians have started to recommend long-term use of opioids for patients with chronic non-cancer pain. Organizations responsible for ensuring patient safety (like Canadian provincial medical colleges and American state medical boards) have responded by issuing guidelines that address the use of opioids for treatment of these patients.

When the Medical Directors of the Workers' Compensation Boards of Canada met in Halifax in October 2001 they noted that Canadian Workers' Compensation Boards (WCBs) lacked updated guidelines on the use of opioids for injured workers with chronic non-cancer pain and agreed that WCB policies and guidelines should be developed. Because injured workers are a unique patient population, the Medical Directors recognized that a review of the existing literature and guidelines for opioid use in treatment of these injured workers was a necessary first step.

This discussion document proposes a common approach to the use of opioids for treatment of injured workers with chronic, non-cancer pain.

Please note:

Opium is an extract from the seed pod of a certain species of poppy. It contains morphine, codeine, and thebaine.

Opiates include the above three constituents of opium as well as substances that are derived from them. Opiates include semi-synthetic opioids such as heroin, which is derived from synthetically acetylated morphine.

Opioids are a broad class of drugs sharing "opium" like characteristics. This encompasses opiates as well as synthetic opioids, which are drugs that have similar analgesic properties but are not derived from morphine, codeine, or thebaine.

II. LITERATURE REVIEW

A number of studies, statements and guidelines on the use of opioids for treatment of non-cancer pain were reviewed: a complete list of these sources is found in the Bibliography.

A brief annotated outline follows. It highlights some of the significant features of the most relevant of the documents reviewed. The documents include up-to-date, substantive, evidence-based assessments of the world literature on opioid treatment of non-cancer pain and material that provides a foundation of best practices for WCB policy development. The documents reviewed are organized by type of issuing agency: Medical Review Bodies, Organizations Representing Physicians, Patient Advocacy Groups and Workers' Compensation Boards.

A. *Medical Review Bodies*

A number of medical review bodies, both in Canada and in the United States, have developed statements, guidelines and positions on reasonable goals for the use of opioids in treatment of patients with chronic non-cancer pain.

- Guidelines from the **Colleges of Physicians and Surgeons of British Columbia¹, Alberta², and New Brunswick³** suggest that "the treatment of chronic, non-cancer pain is dedicated to two goals: enhanced function (broadly defined to include psychological and social function), and improved comfort."
- A survey of the members of **US Medical Boards** notes in their "proposed guidelines" that an "emphasis should be given to attempts to capitalize on improved analgesia by gains in physical and social function."^{4, 5}
- In November 2000 the **Ontario College of Physicians and Surgeons** released a clinical reference guide entitled Evidence-Based Recommendations for Medical Management of Chronic Non-Malignant Pain. *This is a high quality evidence-based review and should be considered necessary reading for anyone wishing to delve into the subject in greater detail. It raises many key issues for policy and practice development.*

The document is clinically oriented. As does most of the literature on prescription of opioids for treatment of chronic, non-malignant pain, it notes that "despite the unquestionable value of opioid drugs in management of cancer pain, the opioid literature on chronic non-malignant pain presents conflicting data."⁶

While it does not directly address policy considerations important in a workers' compensation or insurance setting, much of the document is relevant to WCB policy and practice directives (the sample "treatment agreement," for example, includes elements that should become part of any final 'practice' document that is developed by Canadian Workers' Compensation Boards. Many of these elements appear in the "treatment agreement" developed by Washington State Department of Labor and Industries).⁷

B. Organizations Representing Physicians

- The **American Society of Anesthesiologists' Task Force on Pain Management** (Chronic Pain Section) produced a 1997 report entitled Practice Guidelines for Chronic Pain Management. This report suggests that available guidelines be implemented with four main purposes in mind:
 - optimize pain control, recognizing that a pain free state may not be achievable;
 - minimize adverse outcomes and costs;
 - enhance functional abilities and physical and psychosocial well being; and
 - enhance the quality of life for patients with chronic pain.⁸

- In the 1997 policy summary entitled The Physician's Role in Helping Patients Return to Work After an Illness or Injury, the **Canadian Medical Association** stated that "the treatment or care should be evidence-based, when possible and should identify the best sequence and timing of interventions for the patient."⁹

C. Patient Advocacy Groups

- In November 1998, the **Canadian Pain Society** produced and approved a document entitled Use of Opioid Analgesics for the Treatment of Chronic Non-Cancer Pain: A Consensus Statement and Guidelines from the Canadian Pain Society.¹⁰ The publication reflected work done earlier by the American Academy of Pain Medicine,¹¹ the American Pain Society,¹¹ and the Probationary Section on Chronic Pain of the Ontario Medical Association.¹² In its 1998 document, the Canadian Pain Society Task Force stated that "the goal of long-term opioid therapy is improved quality of life for the patient in pain. This improvement should include, as a minimum, a significant decrease in pain severity and ideally an improvement in physical, psychological, social and occupational functioning."

D. Worker's Compensation Boards

- In a document entitled Opioids to Treat Chronic Non-Cancer Pain, The **Washington State Department of Labor and Industries** suggests that in order to be an appropriate candidate for long-term treatment with opioids the patient "has substantial reduction in pain and continuing substantial improvement in function, and has reached maximal medical improvement."⁷
- Report of the Chronic Pain Expert Advisory Panel, a February 2000 report prepared for the **Ontario Workplace Safety and Insurance Board (WSIB)**, reviewed the literature on chronic pain using a systematic, evidence-based approach. On the subject of opioid use in treatment of chronic pain, the Panel concluded that "there is moderate evidence that oral opioid analgesics would benefit workers with chronic musculoskeletal pain in the short to intermediate term" ("moderate" or "level 2" evidence means one relevant high quality scientific study or multiple "adequate" scientific studies).¹³

A February 2000 WSIB report, A Second Report of the Chronic Pain Advisory Panel, addresses the policy issues arising from the use of opioids to treat injured workers with chronic, non-cancer pain.¹⁴

E. Review of the Literature: Practice and Policy Recommendations

The studies and statements reviewed on the use of opioids for treatment of non-malignant pain included both evidence-based assessments and policy documents.

The review of the literature suggests that there is limited evidence for use of opioids to treat injured workers with chronic, non-cancer pain. In an appropriate clinical setting, oral opioids are currently considered an acceptable medical intervention for chronic benign painful conditions, however, the prescription of opioids must meet current practice standards and all legal and regulatory requirements.

The WSIB's report of The Chronic Pain Advisory Panel¹³ and the Washington State Department of Labor and Industries Opioids to Treat Chronic Non-Cancer Pain⁷ can be considered as models and sources of information in the development of WCB policy and practice standards.

III. APPROPRIATE USE OF OPIOIDS IN THE TREATMENT OF INJURED WORKERS WITH CHRONIC NON-CANCER PAIN

Opioids are not the drug of choice for chronic non-cancer pain. The Evidence-Based Recommendations of the College of Physicians and Surgeons of Ontario⁶ provide an excellent overview and discussion of various treatment options.

When considering the use of opioids, it is important to understand the diagnosis, or at least the probable pathophysiology underlying the condition being treated. Where there is no clear understanding of pathophysiology, introducing opioids into the treatment equation is questionable. Careful examination of the available evidence to determine whether opioid use or other treatment is clinically appropriate is essential.

A. A Stepwise Approach to Consideration of Treatment with Opioids

Most experts recommend that consideration of treatment with opioids should be done in a step-wise approach, using the World Health Organization Analgesic Ladder¹⁵ for cancer pain (found in Addendum A). In addition to the long-term considerations for treating non-cancer pain, there are a number of caveats to keep in mind:

- The dose of acetaminophen being consumed by a patient, as fatal liver toxicity can result.
- Non-steroidal anti-inflammatory drugs, including cox-2 inhibitors, have potentially significant gastro-intestinal, renal, and cardiovascular side effects.
- Drugs with short half-lives such as meperidine (Demerol) should be avoided if a patient is undergoing treatment with opioids.
- Chronic neuropathic pain is reported to be less responsive to opioids than other chronic musculoskeletal conditions.

Selection criteria may be found in Addendum B, "How to Assess Whether an Opioid Trial is Indicated."

Opioids are considered only when non-opioids are unable to adequately control pain. If non-opioids are inadequate, a physician would then typically prescribe a combination of opioid and non-opioid analgesic (such as acetaminophen with codeine +/- caffeine). When the maximum daily intake for acetaminophen has been reached and the escalation of opioids appears to be significantly ameliorating pain, oral morphine could be prescribed on a round-the-clock dosage. The equi-analgesic dosage guidelines in the Compendium of Pharmaceuticals and Specialties provides a useful guide to initial dosing.

Increases in dosing may occur twice weekly as long as:

- There continues to be responsiveness to the opioid; and
- There are no unmanageable adverse effects.

If an increasing dose of opioids has no impact on the patient's pain, the physician should reconsider whether use of opioids is indicated for the condition. Once a stable dose is reached, then the patient can be switched to long-acting oral opioids in equi-analgesic doses.

The use of opioids by other than the oral route is discouraged for chronic non-cancer pain, and should only be considered in a highly controlled environment. In the case of injured workers with chronic non-cancer pain, it may be reasonable to limit WCB payment for long-term use of opioids to the oral route, as the risks of parenteral treatment appear to outweigh the benefits.

Treatment goals¹⁶ may be found in Addendum C.

B. Prescribing Opioids for Injured Workers

Long-term use of opioids should be under the direction of a single physician, and prescriptions should be filled at a single pharmacy. To ensure safe use of the opioids, written treatment agreements between physician and patient should be in place for all injured workers on chronic opioid therapy. A copy of this agreement should be placed in the WCB claim file and reviewed at least annually. Both physician and patient should abide by the criteria specified in this agreement.

Addendum D includes a copy of a model therapeutic agreement between patient and physician for a trial of opioid therapy. Addendum E includes a sample letter from the prescribing physician of the injured worker under consideration for opioid therapy.

The patient should be seen regularly by the physician, and an assessment of pain control and functional improvement should take place at each visit. These visits should occur frequently until the patient is on a stable regimen. Once on a stable regimen for a permanent condition, a WCB review of the medication and treatment agreement is recommended annually.

"Apparent Drug Abuse Related Behaviours Checklist" (found in the Ontario College of Physicians and Surgeons Evidence-Based Recommendations)⁶ discusses the differences between tolerance, dependence and drug addiction. In the case of dependence, a process of weaning from opioids is recommended. In the case of drug addiction, treatment with opioids should be discontinued.

Also relevant to the WCB is a case in which a patient diagnosed with a DSM-IV pain disorder¹⁷ (ICD-9 code 307) takes a large variety of medication of questionable benefit and uses drugs inappropriately as part of the behavioural disturbances that characterize this state. Additional behavioural traits of this disorder include physical inactivity, inability to work, and social isolation. According to the Evidence-Based Recommendations, these patients "should only be prescribed analgesic medication with oversight as one part of a pain management program. In other words, the mainstay of treatment for these patients is unlikely to be the analgesic medication, but rather an integrated approach to pain management."⁶ Addendum F includes detailed information on pain disorders.

C. Treatment of Chronic Non-Cancer Pain: Underlying Goals

Since opioid (and other) analgesics may not completely relieve an injured worker's pain complaints, it is important to remember that the goals underlying the treatment of patients with chronic non-cancer pain are twofold: amelioration of pain and improvement of function.

The Evidence-Based Recommendations note that the goals of a treatment program for chronic non-cancer pain include both pain relief and functional restoration. A treatment program that focuses on analgesics without incorporating psychosocial and behavioural approaches may reinforce pain-related behaviour and undermine a rehabilitative program targeted to functional restoration. The focus of chronic opioid therapy should therefore be on time-contingent analgesic use rather than on pain-contingent analgesic use.⁶

D. Return-to-Work

While therapeutic decisions may initially overshadow any return-to-work plans, the treating physician should recognize that the ultimate goal is to return the injured worker to safe, appropriate work in a timely manner. In many cases, return to work forms an essential component of the treatment of pain, due to the positive physical, emotional, and social effects of work itself. It is in everyone's best interests to discuss return-to-work with the worker and set expectations at an early stage. When making recommendations about return-to-work, the physician should assess both the worker's injury and bio-psycho-social factors.

A number of Canadian and international documents review aspects of worker/patient care and provide guidelines for return-to-work; these are necessary reading for all health care providers involved in the clinical care of injured workers.^{18, 19, 20}

IV. CONCLUSION: PROPOSAL FOR A COMMON APPROACH

When the Medical Directors of the Workers' Compensation Boards of Canada met in Halifax in October 2001 they noted that Canadian Workers' Compensation Boards lacked updated guidelines on the use of opioids. They agreed that appropriate WCB policies and guidelines on this issue should be developed. This discussion document proposes a common approach to the use of opioids for the treatment of injured workers with chronic, non-cancer pain.

Opioids are not the drug of choice for chronic non-cancer pain, but in an appropriate clinical setting, oral opioids are currently considered an acceptable medical intervention for chronic benign painful conditions.

The prescription of opioids must meet current medical practice standards and all legal and regulatory requirements.

In the context of Workers' Compensation, long-term opioid use for treatment of an injured worker's chronic non-cancer pain should only be considered if prescription of opioids is not the first line of treatment; use of opioids is part of an integrated approach to pain management; there is a primary prescriber; there is a written treatment agreement between patient and physician; the route of prescription is oral; careful consideration is given to behavioural symptoms that suggest opioids may increase the complexity of the injured worker's problem; there is evidence that treatment with opioids results in improvement of both pain AND function, frequently enabling the injured worker to return to work; and there is appropriate oversight by the Workers' Compensation Board.

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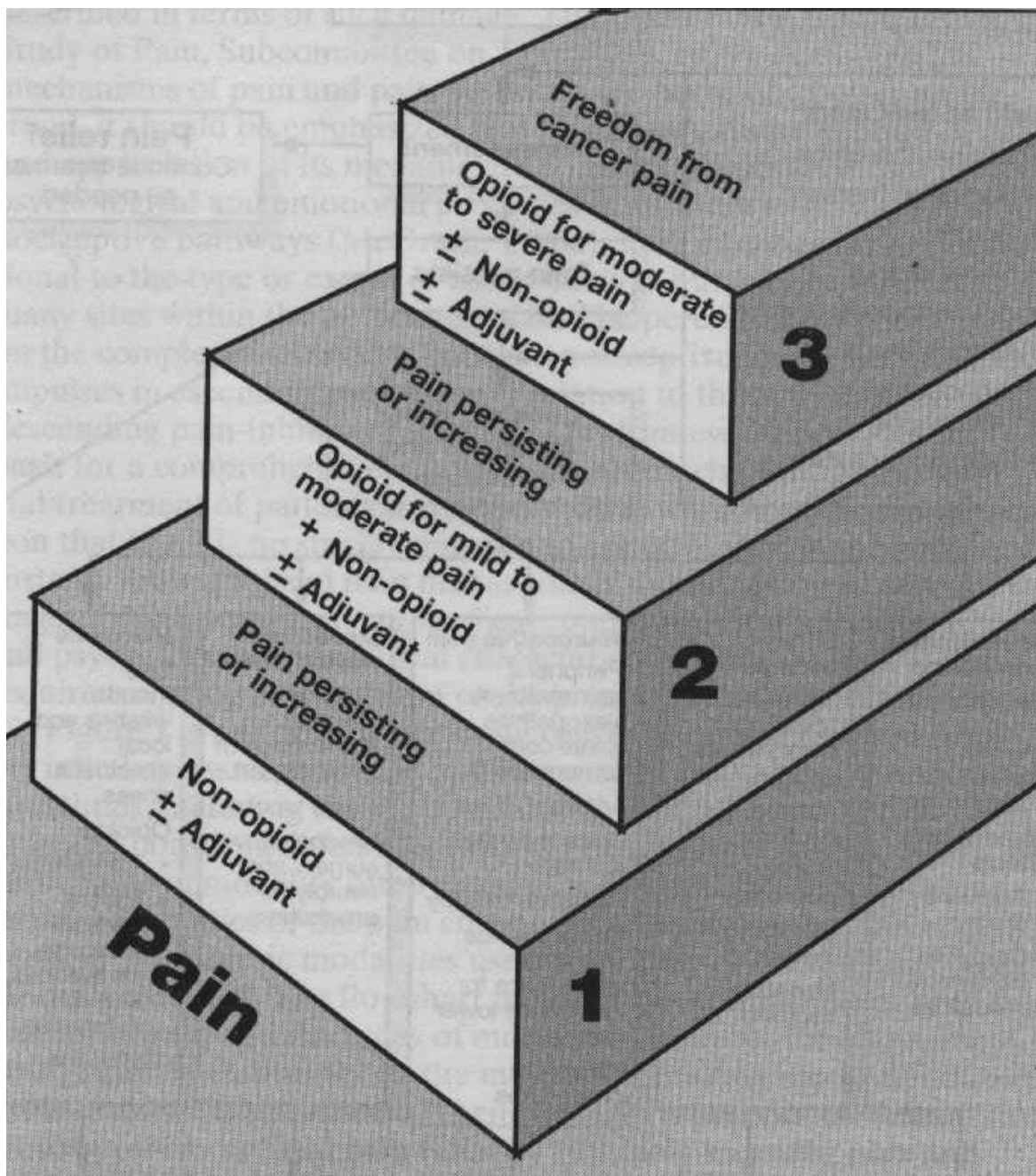
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Addenda

Addendum A

WHO's Pain Relief Ladder For Cancer Pain



From - World Health Organization Analgesic Ladder - Reference 15.

Addendum B

TABLE 1. How to Assess Whether an OPIOID Trial is Indicated

TABLE 1. HOW TO ASSESS WHETHER AN OPIOID TRIAL IS INDICATED

1) IS THE PATIENT LIKELY TO IMPROVE?		2) IS THE PATIENT LIKELY TO ABUSE OPIOIDS OR HAVE OTHER ADVERSE OUTCOMES?
MAY IMPROVE	PROBABLY WILL NOT IMPROVE	
<ol style="list-style-type: none"> 1) Patient has taken opioids in the acute and subacute phases with some improvement in pain and function. 2) Other conservative measures have failed (NSAIDs, etc.) and opioids have not been tried. 3) Your pain diagnosis falls into one of the following three categories: <ol style="list-style-type: none"> a) Nociceptive pain (for example, ischemia, tissue destruction, arthritis, cancer, arachnoiditis). b) Neuropathic pain (for example, sciatica, carpal tunnel syndrome, trigeminal neuralgia, postherpetic neuralgia, phantom limb pain). c) Mixed nociceptive and neuropathic pain. 	<ol style="list-style-type: none"> 1) Patient has taken opioids in the acute and subacute phases with NO improvement in pain and function (assuming appropriate dosing, etc.). 2) The pain diagnosis falls into the category of somatoform disorder. A consultation should be considered to address the underlying problem. In particular, conversion disorder, somatization disorder, or pain disorder associated with psychological factors (DSM-IV 307.80) is associated with poor response to opioids. 	<p>The risk of abuse or adverse outcome is high if any of the following are present:</p> <ol style="list-style-type: none"> 1) History of alcohol or other substance abuse, or a history of chronic, high dose benzodiazepine use. 2) Active alcohol or other substance abuse. 3) Borderline personality disorders. 4) Mood disorders (e.g., depression) or psychotic disorders. 5) Other disorders that are primarily depressive in nature. 6) Off work for more than 6 months. 7) Poor response to opioids in the past. <p><i>Note: When special circumstances seem to warrant the use of these drugs in the types of patients noted above, referral for review is indicated.</i></p>

From - State of Washington Department of Labor and Industries. Opioids to Treat Chronic Non-Cancer Pain. Provider Bulletin 00-04. May 2000 - Reference 7.

Addendum C

Treating Pain: An Update on the Use of Narcotics

2. TREATMENT GOALS

The goal of treatment is not to eliminate the pain, but rather to control and keep it at an acceptable level so that the patient can function better physically and psychosocially.

Opiates are not first-line medications in the treatment of nonmalignant pain, but they may sometimes be useful when all reasonable trials with other non-narcotic analgesics and non-medicinal approaches have failed.

Nobody will deny that a patient who is suffering has a right to be relieved of his pain, and all will agree that any drug possibly leading to dependence must be judiciously prescribed.

Once the attending physician has made the diagnosis and solicited the opinion of consultants, he may draw up a treatment plan to propose to the patient, including its goals and probable duration. The goal of treatment is not to eliminate the pain (which may be impossible), but rather to control and keep it at an acceptable level so that the patient can function better physically and psychosocially.

The physician must pursue the following goals:

- reduce the severity of the subjective pain;
- reduce the misuse of medication and invasive procedures;
- help the patient manage his own pain and its related problems;
- optimize and maintain physical activity;
- minimize the cost of treatment without sacrificing the quality of care.

RULES TO FOLLOW

When devising a treatment plan, the physician must keep the following rules in mind:

- intervene early and vigorously at the onset of a painful condition to prevent persistent pain from setting in;
- treat the acute pain effectively with adequate doses of analgesics;

- recommend, on the first visit, a brief period of rest, quickly followed by active rehabilitation;
- explain the pain and its harmful effects to the patient;
- assess chronic pain appropriately; this assessment is of prime importance because certain kinds of pain do not respond to opiates. Opiates are not first-line medications in the treatment of nonmalignant pain, but they may sometimes be useful when all **reasonable** trials with other non-narcotic analgesics and non-medicinal approaches have failed;
- show prudence when prescribing narcotics;
- adopt a staged approach to alleviating pain (*See Appendix 5*);
- consider the use of adjunctive therapy (coanalgesia) at every stage;
- show caution when prescribing opioids to a patient with a history of substance abuse. This type of patient should preferably be followed in a setting specialized in substance abuse, or by a multidisciplinary team;
- question an opiate's potential to treat a patient's pain syndrome if the pain is not relieved by initially low doses;
- recognize and stress the importance of managing the medication's side effects, and discuss this subject with the patient.

CHOOSING AN ANALGESIC

Avoid using the following opioids for acute pain and prohibit their use in the treatment of chronic pain:

- **meperidine: poor oral absorption, short half-life, neurotoxic metabolite;**
- **pentazocine: ceiling effect, combined agonist-antagonist properties, potential for abusive use, dysphoria.**

Coanalgesic medications, while not analgesics from a pharmacological point of view, can nonetheless interfere with the transmission or perception of the pain impulse. They are used alone or in combination with analgesics, and at all stages of analgesia.

When choosing an analgesic, one must:

- opt for an analgesic that matches the severity of the pain;
- know the pharmacology of the chosen medication;
- not prolong the use of ineffective analgesics;
- use a pure agonist as first-line medication;
- avoid combining an agonist with an agonist-antagonist;
- avoid combining two agonists;
- favour the use of long-acting narcotics in fixed dosages;
- avoid using the following opioids for acute pain and prohibit their use in the treatment of chronic pain:
 - meperidine: poor oral absorption, short half-life, neurotoxic metabolite,
 - pentazocine: ceiling effect, combined agonist-antagonist properties, potential for abusive use, dysphoria (See Appendix 6).

ADMINISTRATIVE ROUTES

The choice of administration route depends on the treatment's efficacy, the patient's condition and the medication's dosage forms.

The parenteral route should be discouraged in the treatment of nonmalignant chronic pain.

CHANGING FROM ONE OPIATE ANALGESIC TO ANOTHER

Before changing an analgesic, one must first ensure that:

- the first analgesic is taken regularly and according to the medication's half-life;

- the doses were appropriately increased and the optimal dose reached;
- the pain is well evaluated;
- coanalgesia was used as needed;
- the side effects are treated.

It must be remembered that the crossed tolerance [cross-tolerance] between opiates is not perfect [complete], which would justify prescription of the new analgesic at two-thirds (2/3) the daily dose of the original opiate, taking equivalences absolutely into account.

COANALGESIA

Coanalgesic medications, while not analgesics from a pharmacological point of view, can nonetheless interfere with the transmission or perception of the pain impulse. They are used alone or in combination with analgesics, and at all stages of analgesia. For example, one may prescribe:

- antidepressants (amitriptyline, desipramine, paroxetine, venlafaxine) in cases of neurogenic-type lancinating pain;
- anticonvulsants (carbamazepine, phenytoin, gabapentin, lamotrigine) in cases of neurogenic pain and paroxysmal neuropathies;
- muscle relaxants (baclofen) in cases of muscle spasm.

CRITERIA FOR OPIOID TREATMENT OF NONMALIGNANT PAIN

There is no easy solution to the treatment of nonmalignant chronic pain. While opioids are not the first choice, they may sometimes be useful. In all cases, an exhaustive assessment of the patient and of any psychological component of the pain is essential.

The patient receiving an opiate analgesic should have follow-up visits with one and the same attending physician at least once a month until his condition is stabilized; thereafter, he will be followed regularly on a two, four or six-month basis, depending on his condition and how the pathology progresses.

The process must be a rigorous one and include the following steps:

- setting precise goals: not promising to completely eliminate the pain;
- underlining the importance of regular physical and mental activity;
- describing the treatment and side effects;
- taking the patient off all sedatives and alcohol;
- putting the accent on a dosage at fixed intervals and not prn (preferably long-acting);
- one physician only must take responsibility for the treatment and prescribe the medication;
- the physician must sign a treatment contract with his patient, specifying notably that "lost" prescriptions will not be renewed;
- the patient must consult one pharmacist only;
- reassessing and adjusting the dose every one to two weeks, until a stable dose is achieved;
- obtaining an objectifiable measure of the pain (using pain scales) to evaluate how well the pain is controlled;
- setting an objective to gradually eliminate the short-acting prn analgesics;
- making the pain tolerable so that physical and social activity may be increased;
- changing to a long-acting form to be taken every 12 or 24 hours, once the patient has been stabilized with a dose of opiates every four hours for at least three days;
- recommending that the patient keep a daily journal which includes the time at which the narcotics are taken and the severity of the pain measured using a similar visual scale.

From - Treating Pain: An Update on the use of Narcotics pp 4-6, Collège Des Médecins Du Québec, March 1999 – Reference 16.

Addendum D

Therapeutic Agreement – Trial of Opioid Therapy

This agreement is being undertaken between _____, (the patient), and Dr. _____, (the doctor), to define the responsibilities of the patient during a trial of treatment of a chronic pain problem using scheduled opioid therapy.

1. The patient hereby agrees that this ____ month trial of treatment has been explained to him/her in terms of the purpose, the side-effects of the medication and the risks involved. During dosage adjustments drowsiness can be a temporary side effect. During these times the patient agrees not to drive a vehicle nor perform other tasks that could involve danger to self or others. The doctor will advise the patient when these activities are safe to perform again.
2. The patient understands that using scheduled opioids to treat chronic pain will result in the development of a physical dependence on this medication, and that sudden decreased or discontinuation of the medication will lead to the symptoms of opioid withdrawal. The patient understands that opioid withdrawal is uncomfortable but not physically life threatening.
3. The patient agrees not to change the dose nor the frequency of taking their medication without first consulting the doctor, and to follow-up with the doctor, on a prescribed basis, for monitoring of this treatment.
4. The patient agrees to keep the prescribed medication in a safe and secure place, and that lost, damaged or stolen medication will not be replaced until the next regularly scheduled visit.
5. The patient agrees not to give, sell, lend or in any way provide his/her medication to any other person, nor to obtain medication from anyone but one previously agreed upon, licensed pharmacist.
6. The patient agrees not to seek or obtain, **ANY** mood-modifying medication, especially pain relievers or tranquilizers, from **ANY** other physician, without first discussing this with the doctor. If a situation arises in which the patient has no alternative to obtaining his/her necessary prescription except from another physician, the patient must advise that physician of this agreement, and immediately advise his/her doctor that he/she obtained a prescription from another physician.

7. In patients taking chronic opioid therapy, there is a small but definite risk that opioid addiction can occur. Almost always, this occurs in patients with a current or past history of other drug/alcohol abuse. Therefore, the patient agrees to refrain from the use of **ALL** other mood-modifying drugs, including alcohol, unless agreed to by the doctor. The moderate use of nicotine and caffeine are an exception to this restriction. The patient agrees to submit to timely, random urine, blood or saliva testing, at the doctor's request, to verify compliance with this and to be seen by an addiction specialist if requested.
8. The patient understands that one of the main goals by which the success of this treatment will be judged is significant demonstrable improvement in the patient's functional capabilities. The patient also understands that if significant demonstrable improvement in the patient's functional capabilities does not result from this trial of treatment that the WCB may not continue to provide payment for the opioid beyond that which is necessary to withdraw the patient from the medication.
9. The patient agrees to attend and participate fully in any other assessments or pain treatment programs which may be recommended by the doctor at any time.
10. The patient understands that the doctor will be providing regular reports to the WCB on the trial of treatment and the patient's compliance with this agreement.

The patient understands that ANY deviation from the above agreement may be grounds for the doctor to discontinue opioid therapy at any time, and that the WCB may discontinue providing payment for the opioid beyond that which is necessary to withdraw the patient from the medication.

Signed at _____ on _____, 200____.

(patient)

(witness)

(doctor)

(witness)

Addendum E

Sample Letter

February 6, 2003

Attention Medical Advisor,
Workers' Compensation Board of _____

Re:

WCB Claim No.

As the primary care physician for the above named person, I would like to request the WCB authorize payment for treatment of

his/her (diagnosis)

with, a drug recognized as having potential for addiction or dependency.

I have screened the above named client for past addiction behavior and or substance abuse, past or future potential, as per current Clinical Practice Guidelines, with which I am familiar, and find no indications of such addictive behavior or risk thereof.

As the prescribing physician, I am prepared to undertake to monitor my patient for the therapeutic response as recorded by pain rating scales, and/or improved level of functioning, eg., return to work, improved social activity, improvement in mood, compliance with prescribed doses, lack of addiction behavior (eg. unscheduled refills, lost prescriptions, self adjusted dose increases), and to report these findings to the Board from time to time as required.

Signed: _____
(Attending Physician)

Name: _____

Date: _____

Addendum F

Pain Disorder (From DSM-IV)

- A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
- B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
- D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
- E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

Code as follows:

307.80 Pain Disorder Associated With Psychological Factors: psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. (If a general medical condition is present, it does not have a major role in the onset, severity, exacerbation, or maintenance of the pain.) This type of Pain Disorder is not diagnosed if criteria are also met for Somatization Disorder.

Specify if:

Acute: duration of less than 6 months

Chronic: duration of 6 months or longer

307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition: both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain. The associated general medical condition or anatomical site of the pain (see below) is coded on Axis III.

Specify if:

Acute: duration of less than 6 months

Chronic: duration of 6 months or longer

Note: The following is not considered to be a mental disorder and is included here to facilitate differential diagnosis.

Pain Disorder Associated With a General Medical Condition: a general medical condition has a major role in the onset, severity, exacerbation, or maintenance of the pain. (If psychological factors are present, they are not judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain.) The diagnostic code for the pain is selected based on the associated general medical condition if one has been established (see Appendix G) or on the anatomical location of the pain if the underlying general medical condition is not yet clearly established - for example, low back (724.2), sciatic (724.3), pelvic (625.9), headache (784.0), facial (784.0), chest (786.50), joint (719.4), bone (733.90), abdominal (789.0), breast (611.71), renal (788.0), ear (388.70), eye (379.91), throat (784.1), tooth (525.9), and urinary (788.0).

From - Diagnostic Criteria from DSM-IV. American Psychiatric Association
p. 461 – Reference 17.

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