

Palliative Care Strategies

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"Making a difference in the lives of patients"

**Anesthetic and Life Support Drugs Advisory Committee
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I am writing this letter to provide comment to the committee reviewing the use of opioids for pain management. My background in pain management extends almost 20 years as a clinician and consultant in the areas of cancer pain, hospice care, chronic non-cancer pain and post-operative pain management. I continue to serve, and have served as the pain and palliative care pharmacist specialist at Group Health Cooperative of Puget Sound, a 500,000 plus member staff-model HMO, for over 15 years. My role at Group Health encompasses both clinical duties as part of a pain team, as well as clinical administration duties, having responsibility for developing pain management treatment guidelines, algorithms and protocols. Another "hat" I wear relates to consulting with and education of practitioners in pain management. In the past five years I have lectured at numerous CME-accredited continuing education programs, providing intensive pharmacological education to hundreds of physicians, nurses and pharmacists in the area of pain management. My chief goal in the educational area is to help ensure that practitioners know when and how to clinically, ethically and legally use pharmacological agents for the management of pain.

I can appreciate the desire of this committee to try and balance the societal mandate between effective palliation of pain and minimizing the risks of analgesics. Most pain management experts agree that while medications are not the only answer to chronic and acute pain conditions, often times there are no other options. Millions of persons in this country suffer from cancer and chronic non-cancer pain due to such diverse conditions as headaches, arthritis, fibromyalgia, diabetic neuropathy, vascular disorders, phantom limb pain, post-herpetic neuralgia, and non-specific low back complaints. I think that we stand on common ground when I state that medications should not be viewed as "quick fixes" nor should they be utilized as a sole strategy in the comprehensive management of a patient's pain syndrome. However, I would also state that we should not view the long-term use of medications such as opioids as inherently "bad medicine" or the patient who uses such medications for pain as the "enemy" in the battle against pain. Pain is the enemy that we must focus our fight against. This battle often requires using a multitude of modalities, including medications, and in many instances opioids. One concern I have with the committee's intent to review opioids for pain is that there appears to be an the assumption that opioids are more of a problem than a solution and that other medications are inherently safer. The standard of practice for pain management includes the use of a variety of medications, including simple

analgesics (acetaminophen, aspirin, non-steroidal anti-inflammatory drugs - NSAIDS), adjuvant agents (antidepressants, anticonvulsants, N-methyl-D-aspartate (NMDA)-receptor antagonists, muscle relaxants, etc.) and opioids. Additionally, the literature suggests that carefully selected patients with pain syndromes will often achieve great benefit from the ongoing use of medications, with the caveats of: medications should not to be used as the sole strategy, non-pharmacological alternatives should be fully explored and utilized when appropriate, and if one or more medications are prescribed, they should be used to complement, not supplant an interdisciplinary approach¹⁻²².

Exploring alternatives to opioids yields the fact that while simple analgesics are readily available, have a reasonable cost and have a high safety margin when used on a short-term basis, unfortunately, chronic use of these agents is often associated with serious adverse effects and vital organ damage, especially in patients with certain risk factors or who exceed the manufacturer recommended dosages²³⁻⁴⁵. Additionally, the efficacy of simple analgesics is often insufficient for patients with moderate to severe pain. Misuse of acetaminophen and NSAIDS is well documented in the literature and associated complications from such therapy can be worse than the original problem of pain. Additionally when practitioners are pressured to not prescribe opioids, patients are often forced to rely on over-the-counter approaches that are ineffective and more toxic than many opioids.

Opioids represent a class of medications that certainly can provide the quickest, most effective analgesia for the severest of pain conditions. However, I am of the opinion, and much of the literature would agree, that the decision to implement maintenance opioid therapy in a patient with chronic pain should always be carefully appraised. Factors such as patient reliability in adhering to specific instructions, coexisting psychosocial disorders, pathology of the patient's pain syndrome, availability of other options, physician-patient relationship and concurrent medications or diseases states, should be considered prior to implementation of opioid therapy. Additionally, the patient should clearly understand that initially, opioid therapy is being implemented on a "trial basis". However, "trials" should be sufficiently long (suggest minimum of 1 -2 months), with adequate dose titration to establish therapeutic value. Practitioners initiating opioid therapy should consider implementation of an opioid agreement, a patient diary, and establish reasonable treatment goals. Upon completion of the opioid trial, patients demonstrating therapeutic benefit, compliance with all therapy guidelines and a lack of aberrant behaviors should be considered for maintenance therapy with opioids. Aberrant behaviors (e.g. prescription forgery, illicit drug usage, continual "loss" of medication, etc.) occurring at any time should be thoroughly investigated and if proven, opioid therapy should be tapered and discontinued and the patient referred to an addiction specialist.

I believe, and the literature supports the concept that successful utilization of opioid therapy must be balanced between improvement or stabilization in functional status and provision of sufficient analgesic benefit. Numerous controlled and uncontrolled trials⁴⁶⁻⁶⁵ utilizing maintenance opioid therapy in patients with chronic non-cancer pain syndromes suggest that the use of opioids do provide functional improvement and analgesia in many patients. Furthermore, these studies and others⁶⁶⁻⁷⁴ suggest that utilizing chronic maintenance therapy with selected opioids in this diverse group of patients is not as dangerous as once thought in terms of

addiction, abuse of medication, uncontrolled physical dependency and unrestrained tolerance to the medications.

One of the problems I currently see with the maintenance use of opioids for chronic pain is the overuse of short-acting, immediate-release opioids (IR/SA) (e.g. codeine-, hydrocodone-, propoxyphene- or oxycodone-acetaminophen/aspirin combinations (e.g. Tylenol #3®, Vicodin®, Lortab®, Darvocet®, Percocet®, Tylox®, etc.) for patients with continuous pain. Clinical experience suggests that while the quick onset of action of IR/SA oral opioids can be an advantage for a patient experiencing sudden flares of acute pain, the regular administration of such agents for continuous pain can be detrimental. Indiscriminate use of IR/SA opioids produces a “peak-valley”, roller-coaster ride of opioid blood levels for many patients. Based on clinical experience, patients who are overly focused on their pain condition and spend extraordinary time worrying about pain, have a tendency to use greater quantities of medications. Patients who self-administer IR/SA analgesics whenever there is pain (“pain-contingent” manner), often lose perspective of the chief purpose of the medication, which is to improve their function. Additional concerns of short-acting opioids include interruption of sleep patterns and acetaminophen toxicity from excessive use of opioid-acetaminophen combination agents.

Based on both clinical and behavioral reasons, when it is necessary to utilize an opioid as maintenance therapy, I recommend utilizing an agent with a long-acting delivery system. Clinically, well-designed long-acting delivery systems minimize fluctuations in opioid blood levels and prevent many of the peak/trough effects associated with IR/SA opioids. Behaviorally, patients who self-administer long-acting medications on a set time schedule (“time-contingent” manner) reduce the potential of acquiring learned associations between medication taking and pain relief⁷⁵. In a published review on the use of opioids for chronic pain, Savage states, “the experience of chronic pain, regardless of its physiologic basis, may be shaped by a variety of cognitive, behavioral, psychological, and other variables, and it is therefore reasonable to consider that if opioid use is made contingent on the experience of pain, opioids may potentially act as a reinforcement to the presence of pain, or to the perception of pain...which may tend to perpetuate pain in the absence of opioid administration”.⁷⁶

In my clinical experience, in order for opioids to be used effectively, prior to the selection of a specific medication several questions should be asked. For example: Will the patient’s pain condition likely respond to medication therapy? (If yes, target one medication initially, and then consider the use of combination therapy). How strong of a medication does the patient’s pain condition warrant? (If the pain is mild, simple analgesics are acceptable, providing there are no contraindications. If the pain is moderate to severe, consider the role of opioids). Is the patient’s pain condition sporadic or continuous? (Continuous pain usually requires medications administered on a continuous basis, usually with a long-acting delivery system). Is the patient at risk for specific adverse effects? (Consideration must be given to compliance and minimization of adverse effects if attaining the chief goal of functional improvement is to be realized). Many other questions also need to be addressed and medications applied accordingly based on the principles discussed. What are your goals of therapy? What are the patient’s goals of therapy? Is pain

affecting sleep? Is there potential for diversion? Does the patient have impaired renal function? Are there economic issues that need to be addressed?

Patients are justifiable in their demands for practitioners to make valid attempts to prevent undue suffering and functional loss from all types of pain. New therapies, delivery systems and methodologies for managing pain are being discovered and made available. Federal and state regulatory agencies are providing health care practitioners with a stamp of approval to aggressively treat severe pain with medications, including strong opioids. Chronic pain, similar to other chronic diseases, must be managed, and not merely treated. Medications are not the only option for patients with chronic pain, and when selected, decisions should be based upon the literature, applied in a consistent manner, ensuring that patients are fully informed and educated on the desired outcomes and potential risks. Clinical guidelines, from either published sources, or developed specifically for individual practice sites should be utilized to minimize practice variation. While we do not yet have every answer for all types of pain, tools are currently available which can make a difference in the lives of millions of patients if these tools are applied properly. The right drug, at the right dose, administered to the right patient, monitored for appropriate outcomes, may afford significant functional improvement for a patient with chronic pain. In the committee's review of the use of opioids for pain management, I implore you to refrain from any decision that will limit the use of opioids for pain management. Focus on educating practitioners on how to use the medications, not on restricting access. In our search to improve the quality of life in patients we must remember that medications themselves have no inherent morality. It is the inappropriate use of medications, or lack of use, that oftentimes lies the morality of medicines.

Sincerely,



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