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Opioids and Chronic Pain-Now What?

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The statistics are frightening. Opioid abuse has reached epidemic proportions. Every year, nearly 15,000 people die from overdoses of prescription pain medications, more than due to heroin and cocaine combined. In 2010, one in 20 Americans over the age of 12 tried prescription pain medications for a nonmedical purpose, such as getting high. Almost half of a million Emergency Department visits in 2009 were attributed to people misusing or abusing prescription opioids [1]. How did we get into this mess?

Opioids have been used for thousands of years for the relief of pain. Until recently, however, opioid use was restricted mainly to acute pain and cancer pain. Opioid use for chronic non-malignant pain was generally avoided due to concerns about dependence, tolerance, addiction and diversion. This restrictive practice of opioid prescribing began to change in the 1990s as studies showed that opioids could be used safely for long periods of time [2] and experts advocated the use of opioids for pain control for those with chronic non-malignant pain [3,4]. In 1996, the American Pain Society and the American Academy of Pain Medicine pledged support for long-term opioid therapy for chronic non-malignant pain [5].

The notion that opioids, when used to treat pain, rarely lead to addiction was promoted as well as the message that there is no "ceiling dose" for opioids unlike other analgesics available. Pain, being a subjective complaint, could be treated with escalating doses of opioid medications. As pain cannot be objectively measured, we were taught to believe the patient who says he is in pain. Since opioids, in general, make people feel better, if patients wanted more opioids, they were often given higher doses of opioids simply by reporting that their pain was uncontrolled. Doctors in the United States certainly took this message to heart; the United States with 8% of the world's population, now prescribes 50% of the world's opioids. In 2010, enough prescription opioids were prescribed in the United States to medicate every American adult around the clock for a month.

Has the increase in opioid prescribing led to better control of chronic pain? The evidence that long-term opioids work is disappointingly limited [6]. The harm, however, of chronic opioid treatment is increasingly evident. Around the same time that opioid prescribing has increased, so has opioid prescription drug abuse. From 1999 to 2007, the rate of unintentional overdose death in the United States increased by 124% [7]. We are now dealing with the consequences of having many patients who are physically dependent on long-term opioids and subject to the associated side effects of chronic opioid use-passivity, depressions and long-term neurological and endocrine changes. Addiction from opioid treatment, contrary to what was taught, is not uncommon.

Chronic pain continues to be an enormous problem leading to disability, poor functioning and depression. For some patients who suffer from chronic pain syndromes, sickle cell disease, arthritis, back pain and other conditions, long-term use of opioids may provide much needed relief. There are certainly many patients who have been able to function effectively and manage their pain with long-term opioids. However, on the balance, opioids for chronic pain have been a failure.

So what can be done now? For patients who are not yet started on opioids, we must be much more cautious. Other options for pain management, such as adjuvant medications, physical therapies and mind-body treatments should be aggressively pursued. Long-term opioid therapy should be used only in select cases. Available tools to minimize the risk of opioid abuse must be better utilized. Universal precautions in pain medicine should be standard practice [8]. These precautions include urine drug screening, opioid agreements, risk assessment tools and close monitoring of outcome and adverse effects. An accessible national prescription opioid database should be immediately implemented. Limiting opioid doses for chronic pain as legislated in the State of Washington and proposed by Physicians for Responsible Opioid Prescribing is an innovative idea. When used appropriately, opioids are a powerful and effective analgesic, however, in today's practice, and we are violating a basic tenet of medicine - to do no harm.

References

1. http://www.cdc.gov/Features/VitalSigns/PainkillerOverdoses/
2. Zenz M, Strumpf M, Tryba M (1992) Long-term oral opioid therapy in patients with chronic nonmalignant pain. J Pain Symptom Manage 7: 69-77.
3. Portenoy RK, Foley KM (1986) Chronic use of opioid analgesics in non-malignant pain: report of 38 cases. Pain 25: 171-86.
4. McQuay H (1999) Opioids in pain management. Lancet 353: 2229-2232.
5. (1997)The use of opioids for the treatment of chronic pain. A consensus statement from the American Academy of Pain Medicine and the American Pain Society. Clin J Pain 13: 6-8.
6. Von Korff M, Kolodny A, Deyo RA, Chou R (2011) Long-term opioid therapy reconsidered. Ann Intern Med 155: 325-328.
7. http://www.cdc.gov/injury/wisqars/index.html
8. Gourlay DL, Heit HA, Almahrezi A (2005) Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. Pain Med 6: 107-112.

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