

Chronic Opioids for Chronic Low Back Pain— Solution or Problem?

Low back pain is a complex and most difficult management problem for patient and physician. It is a well-nigh ubiquitous problem in humans, for it affects 85 percent of us, according to some surveys.¹ Most low back pain resolves with or without medical intervention,² but the refractory type seen by physicians and pain clinics, alas, does not. This type often does not have a specific diagnosis or solution, and despite all manner of therapeutic effort, it is very difficult to control and consumes a great deal of health care resources.³

Most comprehensive pain clinics see many such patients (55 percent of referrals to our pain clinic are for back pain). Do they have a more severe problem, or do they just complain more? We really don't know, though often they seem not to have serious tissue disease.

Modern understanding of the cause of such pains runs the whole spectrum from pure nociception caused by tissue damage to environmental factors³ (often work related⁴), with many combinations of these and maybe other as yet unknown causes. The condition poses a great diagnostic challenge. Single-modality therapy rarely works for this symptom, and for those patients with the more complex genesis of symptoms (including psychological and environmental factors), drugs in general and opiates in particular can so easily become part of the problem rather than the solution.⁵

In 1968 when I first started working with chronic pain patients in Seattle, 75 percent were taking excessive amounts of medications (opioid or sedative hypnotics) when first seen in the clinic. Detoxification from these medications, along with the other rehabilitative aspects⁵ of informed pain therapy, was associated with improvement. Since that time most pain clinics have had this

experience. Consequently, when presented with such problems, pain clinics offer a standard therapy to avoid opioids or, if the patient is already on them, to reduce and perhaps eliminate them. This approach has been and still is a basic tenet of most pain clinic protocols. It seems to be the best at the moment, but successful graduates often still have a symptomatic pain, albeit less disruptive to their lives. Unfortunately we still do not have the solution to chronic low back pain. Patients who do not qualify for formal pain programs often are maintained on opioids, and we have many in our system.

Despite the above caveats regarding opiates, there are patients with chronic back pain who could and should have their pain better controlled with opioid therapy so they can be more functional. Increasing numbers of physicians think so,⁶ and I suspect many physicians have a cadre of such patients.⁷ It seems that prescribing long-term opioid therapy is relatively widespread.⁷ This prescribing habit appears to be more common with general practitioners and rheumatologists, who are more likely to prescribe these drugs for the long term, than with other specialists. Apparently the protagonists of such prescribing believe symptom control to be a higher priority than increased function. It also seems that physicians are less likely to prescribe long-term opiate therapy in the Midwest than in other parts of the United States.⁷

There has in recent years been a backlash of clinicians claiming that patients with chronic noncancer pain can be optimally served by prescribing chronic opiate therapy. Brown and colleagues⁸ in this issue of the *Journal* make such an argument. This topic is controversial because as yet there is no definitive study to give license to such prescribing. The work done so far is mainly reports of series of such patients, without more rigorous blinded, controlled studies. Findings from these series, however, suggest that with appropriate selection and monitoring, opiate treatment can be done.^{6,9}

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In this current issue Brown et al ask the question, "Are there lots of such patients out there who can cope with and be benefited by chronic opioid therapy?" They offer a timely question and a cogent review to support challenges to the conventional restriction of opioids (as cited by authors in their reference list). If we now customize opiate therapy for acute postoperative pain, is it not appropriate to consider doing the same for some chronic nonmalignant pain patients?

Although the authors cite the increasing number of reports involving hundreds of patients that suggest this therapy is safe and effective and, therefore, worth prescribing for many patients who complain of low back pain, they rightly point out the lack of controlled trial data to validate these reports. Controlled study information suggesting that such prescribing can be done and might help symptoms is just starting to appear in the medical literature.^{10, 11}

In a double-blind study Arkininstall et al¹⁰ demonstrated that for a 3-week period a new long-acting codeine preparation was a better analgesic than a placebo in a group of chronic pain patients. This window of time is very brief for chronic pain, and longer-term studies are desperately needed.

A major difficulty is selecting and monitoring those patients who would be suitable for long-term therapy. As in much of medicine, patient and family education is rightly stressed as an important aspect of prescribing such medications to these patients. Initial and periodic communication with an individual from the patient's environment (a family member or partner) can be an invaluable help in both initial assessment and monitoring follow-up. The authors suggest joint interviews (I would suggest that the interviews are often more informative if performed separately!). One must always remember, however, that it might be important to the partner that the patient seeks opioid treatment; reasons can range from wanting the patient's drugs for personal use, to selling the drugs for profit (the street value of some of the synthetic opioids can be substantial), to having the patient "dosed up" on opioids and thus permitting the spouse an independent existence. Be aware!

Are there supplemental aids to help in evaluation and maintenance of such therapy? Brown et al suggest the Chronic Pain Grade described by

Von Korff et al and the Roland scale as useful adjuncts to clinical evaluation of severity, and functional impairment, respectively. Pain diaries⁵ are also helpful as a cheap and easy-to-evaluate record of pain severity, function, and medication consumption, all of which are important with ongoing therapy.

Alas, there are as yet few specifics for selecting the appropriate patient,⁷ but the ideal is probably an individual who has a history of medical compliance, who is stable socially (ideally in both work and marriage), and who needs a finite drug intake. It is easier to recognize someone who is not suitable, such as a person in a chaotic social or work (disability) environment, someone with serious psychiatric diagnoses, or someone who makes excessive demands for prescribed drugs.

Monitoring patients on long-term opioid therapy is most important, especially during the introduction and establishment of therapy, with respect to all the many problems anticipated (for example, functional compromise). Enlisting cooperation through open dialogue with family, employer, pharmacist, other physicians—anyone involved in the patient's symptoms and therapy—is essential to ensure that all are aware of the treatment plan. If (or when) problems arise, Brown et al suggest the physician freely seek consultation with alcohol or other drug dependency services; even the neighborhood pain clinic can be helpful. Pain clinics have been assessed by referring family physicians, and the evaluation and advice regarding management have been found to be helpful.¹² When in doubt or difficulty, seek advice.

In our pain clinic we have maintained many chronic pain patients on the opiate methadone for long periods during the last three decades. Until the recent development of the longer-acting oral morphine preparations, methadone was the longest-acting oral analgesic opioid available. Methadone is much cheaper than most other commercially available analgesics and is surprisingly free of the constipating and nauseating side effects. The dosage usually prescribed for chronic pain patient maintenance ranges from 2 to 5 mg four times a day. In contrast, the codeine used in the above-mentioned study by Arkininstall et al¹⁰ created a feeling of nausea in 30 percent of the codeine consumers.

Although all agents have their advocates, opioids other than the longer-acting morphines and

methadone do not seem suitable for satisfactory long-term administration in these patients. Meperidine is most unsatisfactory because of sporadic oral absorption patterns, and it is metabolized to normeperidine, an active agent that in large doses can cause myoclonic convulsions. Also with other short-acting agents, such as oxycodone, the frequent ingestion intervals are less compatible with the hoped-for restoration of normal life patterns of uninterrupted sleep at night and alertness during normal business hours. Codeine is a most widely prescribed drug, it can be tolerated with time, and recent controlled trials suggest it delivers analgesia to selected patients. Unfortunately improvement in function has not been shown. The opioid antagonists pentazocine and butorphanol are usually unsatisfactory because the side effects are usually not compatible with an active functional lifestyle.

Summary

The article by Brown et al does not provide data to justify long-term opioid use but does suggest a treatment option for the many patients who have chronic back pain and who want the help that our medical delivery system often does not provide.

Having worked in a tertiary referral pain clinic that serves many low back pain patients who have demonstrated the ineffectiveness of chronic opiate therapy, I am strongly ambivalent about recommending prescribing ongoing opioid therapy for chronic pain patients. The caveats about prescribing opioids for such patients are most appropriate (ie, do not prescribe opioids for those who have a history of problems with opioid therapy or for whom increased intake is associated with decreased function); however, for patients who do not display these problems (and there could be many out there), I am sympathetic with the sentiments expressed by Brown et al. A trial of these drugs might be warranted if all else fails and continued therapy with opioids seems justified, but only with zealous attention to monitoring function and therapeutic compliance, as outlined by the authors.

With regard to the doses needed for control, the method of opioid administration might be important, that is, whether it is in tablets or in a masking vehicle. In this day of open dialogue, it is not fashionable to blind the patient to the drug or dose, but I believe blinding has a place in the care

of a particular group of patients whose symptom (pain) can vary considerably with time.¹³ I have found that most chronic pain patients rarely, if ever, reduce their analgesic intake in better times, but an attentive physician can if masking vehicles are used. Thus the physician can limit the amount of drug consumed long term. In my personal experiences with comparable chronic nonmalignant pain patients (albeit in different hemispheres), the average opioid maintenance (methadone) dosage was halved by prescribing the drug in a masking vehicle rather than as a tablet.

If pain complaints are reduced and if function is improved according to the record (eg, patient is working) and the relatives' report, and if you, the prescribing physician, are happy, then a long-term regimen of opioid therapy is probably fine. Further controlled trials are needed to see whether this therapy works, and if so, what are the optimal agent(s) and dosages, what is optimal monitoring, and most important of all, who is the optimal patient who might derive not only analgesia but also functional benefit rather than compromise from this therapy. If we cannot make patients better, we must not make them worse.

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ABFP ANNOUNCEMENT

Policy Statement Regarding Changes in Reciprocity Agreements

The Board of Directors of the American Board of Family Practice has made a decision that eligibility to sit for the American Board of Family Practice Certification Examination through reciprocity will be available only to physicians who have satisfactorily completed formal training in family practice.

After the July 1998 examination, physicians will not be allowed to sit for the ABFP examination via the reciprocity route unless they have completed formal training accredited by a nationally recognized accrediting organization within the country in which they are certified. Applications will have to be satisfactorily completed by February 1, 1998. This means that Canadian applicants who have not completed a residency will have to have resided in the United States prior to August 1, 1997.