Opioid Use on the Rise:

Is the Pen Mightier Than the Alternatives When It Comes to Chronic Pain Management?

By Stacy Sellek

It’s no great revelation that the health care system is at a crossroads with regard to pain management. Moral, ethical, regulatory, and legal issues all play major roles in this complex, yet common, part of medical practice. This article provides an overview of pain management options, with a particular focus on the increasing use of opioids to treat chronic pain in the US and in Michigan, and how physicians – and patients – can use available resources to become more informed about treating chronic pain.

(Watch the next edition of Michigan Medicine for continued coverage of this issue.)

Prescription opioid use in the US is at an all-time high – roughly quadrupling between 1998 and 2008, according to the Centers for Disease Control & Prevention (CDC).

Michigan has experienced its own prescription boom in recent years, as well.

According to a 2012 report conducted by the Michigan Department of Community Health, almost every category of controlled drug has increased in the number of prescriptions since 2003. From 2003 to 2010, the biggest increase noted was with opioid antagonists (Suboxone/Subutex, Schedule III); the number of prescriptions increased rapidly (327 prescriptions in 2003, and 285,059 in 2010). Increases shown in Schedule II (stimulants and pain relievers) drug prescriptions from 2003 to 2010 include oxycodone (113 percent), methadone (146 percent), and hydromorphone (275 percent).

So what is driving this alarming increase, and what do physicians need to consider down the road?

**Patients in pain**

Michael D. Chafty, MD, JD, a former MSMS Board of Directors member and a Kalamazoo County anesthesiologist who runs a pain management clinic, explains that of the four main types of pain – acute non-malignant, chronic non-malignant, acute malignant, and chronic malignant – the growing problem of opioid misuse and abuse really pertains to the treatment of chronic non-malignant pain.

“We used to always be able to treat acute pain, but we never really addressed the issue of chronic pain,” he said. “What we are talking about is a problem of treating chronic pain with short-acting narcotics for a long period of time. These are highly addictive substances.”

The Most Commonly Prescribed Pain Relievers in Michigan in 2010:

- **Hydrocodone**
  (Vicodin, etc., Schedule III)
  at 5.8 million prescriptions

- **Codeine**
  (Tylenol #3 and #4, Schedule III)
  at 0.72 million

- **Oxycodone**
  (OxyContin, etc., Schedule II)
  at 0.69 million

(Source: “Michigan Epidemiological Profile – Focusing on Abuse of Alcohol, Prescription Drugs, Tobacco & Mental Health Indicators – March 2012 Update,” Michigan Department of Community Health, Bureau of Substance Abuse & Addiction Services, State Epidemiological Outcomes Workgroup)
In a 2011 telephone survey conducted by the Michigan Department of Licensing & Regulatory Affairs (LARA), 27.2 percent of Michigan residents sought treatment from a health care professional for a chronic pain condition in the past year. The survey results also showed that 29 percent of Michigan residents have sought treatment from a health care professional for an acute pain condition in the past year.

The Institute of Medicine’s 2011 report on pain estimated that 116 million Americans live with chronic pain.

“JCAHO [The Joint Commission] even called pain ‘the fifth vital sign,’” says Doctor Chafty.

Working against the odds
Despite their dedication to caring for their patients, however, many issues are conspiring against physicians doing the right thing when it comes to treating chronic pain – lack of adequate time with patients, cost of doing thorough testing, societal pressure and demand, “doctor shoppers,” etc.

“On the ethical side, you have to ask yourself, ‘Do I withhold medications from a patient who is suffering with pain?’ No one wants patients to suffer,” says Fred Van Alstine, MD, a Shiawassee County family physician, who serves on the MSMS Mental Health & Substance Abuse Committee, and as a medical examiner for many years. Doctor Van Alstine saw the tragic side of prescription drug misuse and abuse. “On the other hand, most of these [opioids] do more harm than good in the end.”

And thanks to the barrage of pharmaceutical advertising, Internet resources, mobile device applications, etc. – not to mention the fact that prescription drugs are deemed socially acceptable – patients today are increasingly savvy about prescription pain relievers and aren’t afraid to request them in the doctor’s office.

“I am very conservative when it comes to prescribing pain medications,” continued Doctor Van Alstine. “We actually have a policy posted on a sign in my urgent care clinic explaining that we do not renew prescriptions for narcotics or psychotropics because we can’t track the use in this setting,” said Doctor Van Alstine. “I know many physicians who would rather risk being taken in by a drug seeker than deny a patient relief from chronic pain.
but I believe you need a definitive physician-patient relationship that is well documented in order to safely prescribe narcotics.”

Almost a reverse take on the old “don’t take candy from strangers” adage, Doctor Alstine simply states, “I don’t prescribe narcotics to strangers. Period.”

Doctor Chafty also advises his colleagues to be cautious and do as thorough of a work-up as they can. “Patients are part of this, too. You can’t always rely just on what they are telling you. There are other signs like their behavior, appointment attendance history, overly-interested family members,” he advises. “We should be testing patients more often, using [Michigan Automated Prescription System] for tracking purposes, taking samples. In my clinic, we make patients sign an agreement before prescribing narcotics to them. It isn’t a legal document, but it outlines what is expected of them.

“All of this takes more time and sometimes costs more money,” he continues, “but it’s worth it to provide better patient care and, let’s face it, to protect your practice.”

(See the “Ask Our Lawyer” column on p. 4 of this issue to learn more about the Michigan Automated Prescription System, or MAPS.)

‘Right-sizing’ the Treatment

Both Doctor Chafty and Doctor Van Alstine cite a multidisciplinary approach as the best way to treat and manage chronic pain. This could involve a combination of therapy, conditioning, medications, injections, and/or surgery, and a variety of allied health professionals working as a team.

LARA concurs. As the agency responsible for regulating the medical profession with regard to safe prescribing practices, LARA advocated a multidisciplinary approach, and has created its own Pain & Symptom Management web page with a multitude of resources to educate physicians and other health professionals, as well as patients.

LARA also has collaborated with all of the medical schools in Michigan to provide them with a pain curriculum that previously was lacking in the programs. The curriculum is available on the LARA website. There are also further training opportunities for physicians, including a September 27 scope of pain training course.

One of the resources LARA touts the most for physicians is a book called Responsible Opioid Prescribing: A Clinician’s Guide by Scott Fishman, MD, Professor and Chief, Pain Medicine Division, University of California, Davis. Since 2009, LARA has received funding to distribute it to all newly-licensed physicians in Michigan.

In 2011, the MSMS House of Delegates adopted Res. 19-11: That MSMS actively educate physicians about the process and extent of prescribed opiate medication diversion in the community and urge the health care providers prescribing daily opiates in chronic pain patients to monitor those patients at a minimum with yearly quantitative urine drug screens. That same year, MSMS has offered members clinical education on pain management at the Annual Scientific Education.

MSMS has also created a resources page as a “one-stop-shop” for pain management resources: www.msms.org/pain.

The author is senior manager of communications at MSMS.

[Source: “Michigan Epidemiological Profile – Focusing on Abuse of Alcohol, Prescription Drugs, Tobacco & Mental Health Indicators – March 2012 Update,” Michigan Department of Community Health, Bureau of Substance Abuse & Addiction Services, State Epidemiological Outcomes Workgroup]