Chronic Non-Terminal Pain Management - Recommendations

1. **Do your own evaluation.** Perform a thorough history and targeted physical exam, together with appropriate tests, as indicated. Obtain and review records from previous caregivers to supplement your understanding of the patient’s chronic pain problem, including past treatments. Ask your patient to complete a Brief Pain Inventory (BPI) survey or other objective pain assessment tool to document and better understand their specific pain concerns. After completing your initial evaluation, attempt to establish a working diagnosis and tailor a treatment plan to functional goals that your patient identifies with you, reviewing them from time to time.

2. **Risk Stratification for all.** Assess both the mental health status and risk for substance abuse in each patient with a diagnosis of chronic pain. Mental health metrics such as PHQ-2 or PHQ-9 (for depression) and GAD-7 (for anxiety), are useful screening tools. Ask patients about any past or current history of substance abuse (alcohol, prescription medications or illicit drugs) prior to initiating treatment for chronic pain. A risk assessment survey (e.g. Opioid Risk Tool, SOAPP or COMM) should be completed at intake for every patient seeking treatment for chronic pain. Since risk levels may vary over time, repeat these assessments accordingly at follow-up visits. *The use of chronic opioids in “high risk” patients is strongly discouraged.*

3. **Set functional goals with your patients that include achievable targets for pain management.** In general, it is unrealistic for patients to expect complete resolution of their chronic pain with any specific treatment or combination of therapies. Nevertheless, it is important to have a conversation with your patient about their treatment plan and set realistic goals for improvement. Work together towards improving pain control and achieving specific functional goals, as both are key outcomes. Functional goals might include increasing physical activity level, resuming a job/hobby or improving the quality of sleep. A multifaceted plan, focusing on function and utilizing appropriate medications together with non-pharmacologic treatment modalities will usually provide the optimal balance of risk and benefit for most patients. It is recommended that you review functional assessment tools periodically with your patients at follow-up visits.

4. **Utilize evidence based treatments, including non-opioid options initially, where possible.** Refer to the flowchart entitled “An Approach to Managing Chronic Non-Terminal Pain” for detail regarding a broad range of possible treatment options for your patients, based on their specific pain diagnosis. Give strong consideration to non-pharmacologic therapies, in addition to the various medications available. Also utilize available first-line pharmacologic options before prescribing opioids. When you believe that an opioid trial is warranted, use the lowest dose of medication required to reduce pain and improve functioning. This will help to reduce the risk of overuse and also minimize the adverse effects that typically arise with this class of medication. Also explain from the outset that opiates will be discontinued if pain does not improve or if functional goals are not met. *Don't begin a treatment that you are not prepared to stop.*

There is a lack of evidence-based support for the use of opioid therapy in general, and specifically for several chronic conditions including: chronic headache, low back pain and pelvic pain, as well as fibromyalgia and functional bowel disorders like Irritable Bowel Syndrome. Use non-opioid pharmacologic agents and other available treatment modalities for pain management in these situations. Also, avoid prescribing ingredients of known “drug abuse combinations” such as alprazolam (Xanax®) and carisoprodol (Soma®, now a Schedule IV controlled substance) together with opioids, as safer alternatives exist.

5. **Discuss the potential risks and benefits of opioid treatment** for chronic pain, as well as expectations related to prescription requests and proper medication use. Provide a simple and clear explanation to help patients understand the key elements of their treatment plan. Together, review and sign a “Treatment Agreement”, which includes the details of this discussion for all patients that are prescribed controlled substances (opioids, benzodiazepines, stimulants) on an ongoing basis. Refer to the sample “Opioid Consent Form and Treatment Agreement” included in the Tool Box.
6. **When prescribing opioid medications for patients, periodic scheduled visits are required.** Evaluate patient progress and compliance with their treatment plan regularly and set clear expectations along the way (e.g., attending PT, counseling or other treatment options). Follow-up visits for patients with a stable treatment plan and receiving regular controlled substance prescriptions should probably occur at least once every 3-4 months. For patients working with you to achieve optimal management, more frequent visits would be appropriate. **“High risk” patients and patients receiving high doses of opioids require closer monitoring.**

There is no obligation to prescribe controlled substances on an initial visit for new patients unless you have all of the information that you require to prescribe safely. This includes obtaining records of past treatments from primary care providers, imaging centers, pain clinics and other specialists. Review your patient’s past medical history (including an INSPECT report), and perform your own medical/psychosocial assessment. Then determine if your patient is an appropriate candidate for an opioid trial, to supplement their other treatments.

7. **Remember the 5 A’s when managing your chronic pain patients with opioids:**

   - **Assess** (and screen for mental illness in general), ask about **Activities of Daily Living** (ADL’s), provide **Analgesia** to assist patients in meeting their functional goals, minimize **Adverse effects** of treatment, and monitor for **Aberrant** drug use behaviors.

8. **Prescription drug monitoring programs (PDMP) are valuable tools,** so please use them regularly for both new and established patients. These programs track all of controlled substance prescriptions filled by patients state-wide. Links have been established between many states and will ultimately provide nation-wide coverage. PDMPs are easy to use and there is no cost, so please register with your state’s registry and integrate this process into your routine when seeing these patients. It is recommended that you run a PDMP report at least once every 3-6 months, or more often as desired or deemed appropriate. You will derive valuable information that impacts decision-making at the point of care. Use of this essential resource will help to protect you, your practice and most importantly, your patients from unsafe patterns of medication use.

9. **Urine drug monitoring (UDM) protects you and your patients.** Like PDMPs, urine drug monitoring has evolved to become a standard of care when prescribing opioids for chronic pain. This is a useful tool that complements your other risk assessments; it will help you to identify patients using illicit substances and assist in monitoring patient adherence to their prescribed medications. UDM should be performed at the initiation of an opioid trial and also periodically thereafter. The actual frequency may vary depending on past UDM results and the level of risk for a particular patient, if known. Higher risk patients and patients receiving high doses of opioids (including those receiving other controlled substances) should have UDM performed more frequently. It is important that you fully understand the specifications and limitations of the particular drug tests that are available to you. Ensure that confirmatory testing (by mass spectrometry technique) is performed if screening (immunoassay) results are inconsistent or not acknowledged to be accurate by your patient. Discussion with patients regarding the need for UDM should be appropriately framed around their safety. When UDM suggests “inconsistent” medication use patterns or the presence of illicit substances, review these findings with your patient to determine an appropriate plan going forward. This may include discontinuing medication(s). Document your plan and the details of your discussion in the patient's record. Saliva testing is an acceptable alternative if urine testing is not available.

10. **Action is required** as a patient’s MED escalates beyond 30 mg per day. Take the time to see your patient for a complete review if they continue to report intolerable pain or if they demonstrate lack of functional improvement over time. Then based on your assessment, consider these possible actions:

   a) Institute a slow, compassionate therapeutic wean of the opioid (or rotate to another opioid, if appropriate).
   b) Refer patients to an addiction specialist for evaluation when a substance use disorder is suspected.
   c) Enhance mental health support and physical well-being with a modified treatment plan that you monitor, in collaboration with a mental health professional, when indicated.
   d) Refer to a pain management specialist for consultation and/or ongoing care.
Taper or discontinue opioids when your patient’s pain is poorly controlled on appropriate doses of medication OR if there is no functional improvement with opioid treatment. The increased risk for adverse outcomes (including death) are more frequently observed when the Morphine Equivalent Dose (MED) of medication prescribed is >50-60 mg/day. Patient mortality risk is more pronounced for patients treated with opioids that have any of the following active co-morbid issues: benzodiazepine use, illicit substance use/abuse, alcohol overuse, untreated mental health issues (e.g. depression) or chronic respiratory problems like obstructive sleep apnea or COPD.

**Equianalgesic Comparisons**

*Commonly used opioids that correspond to a Morphine Equivalent Dose (MED) of 60 mg include:*

<table>
<thead>
<tr>
<th>Hydrocodone (short-acting): 50 mg daily (e.g. Vicodin® 10/300 mg, one tablet q4-6h) = 5 tabs per day</th>
<th>Equianalgesic to 50-100 mg Oral Morphine (mg)/day&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone (short-acting): 40 mg daily (e.g. Percocet® 10/325 mg, one tablet q6h) = 4 tabs per day</td>
<td>Fentanyl Patch&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Oxycodone (long-acting): 40 mg daily (e.g. Oxycontin® 20 mg, one tablet twice daily) = 2 tabs per day</td>
<td>Hydromorphone (Dilaudid®)</td>
</tr>
<tr>
<td>Fentanyl (transdermal patch): 25 mcg daily (e.g. Duragesic® patch, 25 mcg applied once every 3 days)</td>
<td>Óxycodone/acetaminophen</td>
</tr>
<tr>
<td></td>
<td>Hydrocodone/acetaminophen&lt;sup&gt;c&lt;/sup&gt;</td>
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</tbody>
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<sup>a</sup> Equianalgesic tables should only serve as a general guideline to estimate equivalent opioid doses. These tables do not address critical individual factors (gender differences, organ dysfunction, bidirectional differences in equivalence with certain opioids, drug interactions, and large inter/intra-individual differences in pharmacokinetics and pharmacodynamics that may alter equianalgesia.

<sup>b</sup> When used in chronic pain, transdermal fentanyl patches (dosed in mcg), are roughly equivalent to 50% of the total daily dose of oral morphine in milligrams.

<sup>c</sup> It is difficult to provide calculated equivalences between an opioid and a compounded analgesic that contains an opioid together with an adjuvant analgesic.

**References for chart:**


[www.globalrph.com/narcoticonv.htm](http://www.globalrph.com/narcoticonv.htm)

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References:

Indiana’s Prescription Drug Monitoring Program:  www.in.gov/pla/inspect.htm

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Bohnert AS, Valenstein M.  Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths.  JAMA, April 6, 2011 – 305(13): 1315-1320

Results from the 2009 National Survey on Drug Use and Health: Summary of National Findings.  U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration;  www.oas.samhsa.gov/nsduh/2k9nsduh/2k9resultsP.pdf


