

Commentary: Empower and Educate Patients Diagnosed With Chronic Nonmalignant Pain

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Sullivan and Ferrell,¹ in their provocative and interesting article, raise several important and relevant issues and provide the treating physician with ethical guidelines and a new paradigm to address individuals with chronic nonmalignant pain (CNMP). This information should be of particular benefit to primary care providers, who are becoming the major caregivers for those with CNMP.

Although emphasizing that untreated pain is recognized as a public health concern, the authors present a case history and discuss ethical ways of addressing an individual's pain and related problems.

Although this case presentation is helpful for the discussion, the fact that the patient is elderly and has history of breast cancer clouds the issue. More typical for the primary care physician is a relatively young individual in the 30s or 40s with complaints of musculoskeletal pain localized to the lumbosacral region, so-called "whiplash injuries," or complaints of diffuse body ache usually diagnosed as "fibromyalgia syndrome."

The authors clearly recognize the different approaches physicians take to address individuals with "malignant pain"—that is, pain associated with cancer—and those with CNMP. With regard to the majority of individuals with CNMP, the authors cite studies and surveys indicating that the pain is not proportional to objective disease, such as back pain and headaches. However, these individuals describe significant limitations with regard to their ability to function.

The authors correctly note a significant shift in the past decade toward recommendations to treat nonmalignant pain with opioids for analgesia. Select patients with chronic noncancer pain can have sustained analgesia and can function better with opioids, without becoming addicted.

The authors identify several concerns in the use of opioids in patients with CNMP. These include the following:

1. The focus has been solely on the harm of opioid treatment without clarifying goals for treating individuals

with CNMP. Opioids provide about 30% relief and often do not improve physical function, the authors note.

2. Although the initial low estimates of iatrogenic addiction were based on patients with cancer pain, the authors state a current estimate indicating that 3% to 19% of patients with chronic pain may be abusing or addicted to opioids. Iatrogenic addiction is a serious potential harm for some patients and should be weighed and understood in light of potential benefits of chronic opioid treatment, they note.
3. Although efforts to improve treatment of CNMP have focused on increasing access to opioids, this movement has not been matched by attempts to increase access to other effective treatments, such as behavioral, cognitive behavioral, and multidisciplinary treatments.

In addition to these issues, in my experience, opioid treatment for noncancer pain raises other issues worth consideration. These include the following:

1. It increases patients' beliefs that they have an unusual and significant condition that requires opioid analgesia, thus reinforcing illness behavior and disability conviction.
2. Although opioids do not produce end-organ damage compared with other analgesics, they lead individuals to become dependent on the health care system, which can be as problematic as the physical dependence on opioids.
3. Chronic opioid therapy, while perceived as cheaper and easier to implement than pain rehabilitation, prevents patients from taking responsibility and control for the pain and their lives.
4. Limited practical access to physicians, within communities, who prescribe these medications on a long-term basis, and who will be the provider of opioids indefinitely.
5. Perception within the family, who may continue to reinforce the pain behaviors because chronic opioid use convinces them of the patient's significant medical illness.
6. Many individuals with structural conditions (failed back syndromes, arthritis, etc) function fully, without the need or use of opioids.
7. Opioids seem to induce personality changes, as noted by some patients and many family members.

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The authors correctly emphasize the need to break away from the dichotomy of *real versus unreal pain*. Although medical education centers on defining the pathologic bases for subjective pain and the need for assigning objective correlates, it is well recognized that pain is a biopsychosocial phenomenon and is modified by several legal and environmental issues. An extensive literature exists to show a lack of one-to-one correlation between pathologic/objective abnormalities that are seen on examination or radiologic studies with symptoms of pain. There is also a very poor correlation between the severity of pain reported and the resultant degree of disability. Numerous issues such as satisfaction in life and at work, psychological factors, economics, and social status all play a role in perception and reaction to pain.

In concluding their discussion, the authors note that the physical and psychologic dimensions of CNMP are intertwined. They emphasize the need to treat both the pain and suffering of the patient.

In emphasizing the ethical guidelines, the authors note the importance of the clinician to "believe the patient's report of pain, but negotiate about the treatment indicated." In more than 28 years of pain medicine experience, I have applied the rule that I would not judge the existence of someone's pain but would judge the underlying cause, if it can be found, and consider the appropriate combination of treatment to address the "person and the pain."

The authors recommend that physicians listen to and validate the patient's pain report without conceding to inappropriate demands for test or treatment. This point should be strongly emphasized.

In stressing treatment goals, I agree with the authors' view to negotiate a plan of care because "cure is rarely

possible." In doing this, the physician and the patient should agree on Specific, Measurable, Achievable, Realistic, and Time oriented goals (SMART goals). Patient education should underscore the tradeoff between comfort, vitality, and mental clarity with shared decision making.

The first responsibility to the patient is to avoid harm, the authors conclude. In addition to the surgeries, repeated invasive procedures, and overuse of medications, I strongly suggest that giving patients limited information without clarification can also lead to harm.

The authors should be commended for addressing many unrecognized and underemphasized problems related to using chronic opioids, including relatively minimal pain reduction, hormonal changes and alteration of immune function, pharmacologic tolerance, and opioid-induced abnormal pain sensitivity.

Finally, pain clinicians may wish to borrow from the literature on chronic headaches. An example is the well-received concept and entity of "analgesic rebound headache." One accepted characteristic of this condition is the use of opioids at least 2 days per week. It is very likely that a certain portion of patients with CNMP may have "rebound pain." Elimination of the medication causing rebound headache is the hallmark of treatment. Anecdotally, many clinicians and patients have observed that elimination of opioids—in some patients with CNMP—actually eliminates the pain.

I hope readers of the article will come to appreciate the need to listen and validate the patient pain complaints, educate patients about their conditions, and set specific long-term goals for improved function on the basis of shared decision making. Empowering patients should create a balanced approach to managing the complex needs of individuals with CNMP.

Reference

1. Sullivan M, Ferrell B: Ethical challenges in the management of chronic non-malignant pain: negotiating through the cloud of doubt. *J Pain* 6: 2-9, 2005

Recommended Reading

- Task Force of the Wisconsin Medical Society: Guidelines for the assessment and management of chronic pain. *Wis Med J* 103, 2004. Available from: www.wisconsinmedicalsociety.org