Opinion

Opioid Crises and the resulting Pain Crisis

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The patient wouldn't, couldn't get out of her truck.

Her husband had asked me to talk to Cheryl M. when she came to pick him up. "She's in so much pain," he said. "In the morning she wakes up and cries, saying she doesn't want to live." Perhaps, I could help. I invited Cheryl in but she said she had a long drive home and she was afraid to get out of the truck, even for a bathroom break. The pain was too severe. So the consult took place the next day, by telephone. The lessons concern both the proper prescription of Opioids for non-cancer, chronic pain and the means by which many physicians and chronic patients are being discouraged from their appropriate use.

There is, in Canada, a widely reported "Opioids crisis" resulting from the use of illegal, contaminated street drugs causing death. One result has been a tightening of regulations regarding the prescription of Opioids by physicians and what some are privately calling a crisis for patients with chronic pain. First, some history: Cheryl, 55 years old, suffered a traumatic brain injury and lower-limb paralysis in 1985 following a devastating automobile accident. After months of therapy she learned to walk again albeit with a drop-foot, lower limb neuropathies ("I just can't feel some things") and limited bladder control. "After that accident I never had any real pain," she reported. But then, in February, 2016, she fell and "fractured my tail bone," an injury that one physician suggested may have displaced screws or metal supports implanted after the 1986 spinal injury.

Since February 1986 she has suffered daily severe chronic pain.

Her family physician grudgingly prescribes 120 Percocet tablets per month; renewals are issued only when Cheryl insists she needs at least that to get through the day. Cheryl rations their use--fearing that she might run out --and only takes one (on rare occasions two) when the pain is severe. The worst times are in the morning when she takes one Percocet after getting up. "The pain is so bad I'm crying and want to die," she said. Cheryl worries that dependence on pain relief medicines may make her addicted. News of the "Opioids crisis" scares her, as do news stories of doctors prescribing pain medications unwisely. A result f these stories, and the deaths resulting from contaminated illegal drugs, is that professional authorities have tightened regulations on prescriptions and argued for increased supervision of those prescribing them to non-cancer patients. Cheryl is afraid her physician may cut her off. For her part, her physician is likely concerned that a pattern of continued prescription for Cheryl and perhaps others like her may lead to an official practice review.

The first task was to explain to Cheryl the difference between appropriate treatment for chronic pain following traumatic injuries and either inappropriate prescription practices or the use of street-level drugs that have been contaminated. "You shouldn't worry about becoming addicted when you're using this medication carefully to get through the day," I said. I told her that she did not need to live in constant pain and urged her to request through her family physician a palliative consult or referral to a hospital-based pain clinic. Other drugs and treatment modalities are available and likely would be of significant help.

In discussing her current situation Cheryl said the Percocet decreased the pain after twenty or thirty minutes and helped her through the day. A full palliative consult would probably add an anti-depressant for use at night and, perhaps, a secondary prescription for break-out pain. While waiting for her physician to refer to those specialists we developed a program that has helped significantly in the short term.

One key was to understand the drug's timing and to utilize that data.

Like many patients, Cheryl takes medication only when the pain already is bad. Since she acknowledges the drug does work, after a period, the trick is to take her medication before it becomes severe. I recommended she keep a tablet by her bedside and, as she begins to waken, take it without getting up. After a "bit of a snooze," she then can get out of bed. In several cases this simple change in a patient's medication regime has significantly improved life quality and functioning.

I suggested she keep a notebook, a "pain book" in which she record drug use and the daily events that seemed to increase pain or, perhaps, lead to next-day exacerbations. This teaches appropriate timing. For example, a long drive after our meeting led to an excruciating night and 'morrow. Across that drive she didn't take any medication until the pain was near intolerable. Understanding this, she can first take her allotted medication before the pain becomes severe, perhaps after a half-hour drive, and then again four or five hours later on the ride home. Preventing the exacerbation through drug timing is something a notebook teaches the patient.

It also provides a measure of empowerment, giving the patient a sense of awareness and control. And, too, it provides the confidence needed to speak concretely with a physician. Here is when it happens and here is what I did. As importantly, of course, it provides data a competent physician can use to better evaluating patient needs and practices.

In our discussions I emphasized that both care and prescription are the responsibility of her attending physician. My place is not to impinge on that relationship. My degrees are not clinical and as a consultant in palliative and chronic care my role is to help the patient's understand his or her experiences and then communicate them to the primary physician. I urged her to inform her physician that she had spoken with me and assured her I would, if requested, speak with her doctor or file a report on our conversation with her physician.

The lessons, I believe, are several.

A first lesson was the desirability of a full palliative consult in cases like Cheryl's. As our understanding of the neurology of pain has improved new drugs, new "adjuvant" therapies, and new approaches are rapidly appearing. Most non-specialists are unaware of these advances, however. Even if Cheryl's condition is permanent her life quality can be significantly improved through expert palliation. In other cases where I've been engaged patients benefited from mild antidepressants or other medications. Short-term, break-out drugs have been in some cases deployed (sparing) to stop severe exacerbations. Most family physicians and specialists not trained in palliation are unaware of these protocols.

Importantly, the notebook technique provides a number of advantages for the patient and the physician. First, it teaches patients to use allotted pharmaceuticals wisely. There is also the psychological advantage of empowerment and precise awareness of one's condition. For the physician, the data can help identify pain triggers and in the management of chronic pain syndrome. According to Cheryl's husband, simply the knowledge there was something practical she could do was important. So, too, was the fact someone in authority said she does not need to live in bad pain, that there was hope..

Finally, the crisis resulting from the use of illegal Opioids must be separated from the necessary and appropriate use of prescription medications necessary for the palliation of patients with chronic non-cancer pain. This will require a general education program of the public, professional bodies and those governing prescription drug use in jurisdictions where the crisis threatens a second, crisis for patients needing excellent, supervised, palliative treatment.