These are difficult times for the pain practitioner. Long held beliefs about efficacy of interventions with a steady patient flow to our offices is being challenged by the payers including Medicare and Medicaid. Traditional medications including antidepressants, anticonvulsants, nonsteroidal anti inflammatories show questionable benefit especially in long-term use. Physical therapy, chiropractic, massage, pool therapy is limited or poorly reimbursed. The much discussed and supported cognitive behavioral therapy and intensive, interdisciplinary pain rehabilitation is available to almost no one. And the current hot button item to the media is inappropriate prescribing of opioids with unintentional overdose deaths. Having been involved as an expert in many defense cases, even the careful, contentious pain practitioner could find his or her practice being challenged in court; the subtleties of practice with the nuances of patient interactions being left to largely uninformed juries. One such case I reviewed recently concluded in Boston with the federal government accusing the practitioners of criminal activities including drug trafficking. The trial exonerated the doctor and his nurse practitioner on all counts, but as you well know, the damage to these providers and to those following the case has been done, having a chilling effect on all those prescribing opioids. What keeps you or I from a similar fate?

Within the landscape of changing recommendations and difficult practice decisions comes the 3rd edition of the Washington State Interagency Guidelines on Prescribing Opioids for Pain developed by the Washington State Agency Medical Directors’ Group in collaboration with Senior State Officials, an Expert Advisory Panel, Actively Practicing Providers, and Public Stakeholders. Bonica started the discussion on pain management in Seattle and Washington is leading the way again with the advice of many respected clinicians and strict rules regarding the use of medications, implantable pumps and stimulators based on their interpretation of the available evidence. This is the same group that first recommended the statewide morphine equivalent (MEQ) recommendations, specifically, 120mg daily MEQ required a non pain provider to seek consultation and approval of this dose with an approved pain specialist in order to continue to prescribe the opioid. With a short list of approved providers (ABPM certified doctors were originally not on the approved list), patients found themselves without access to the opioids they had taken for years. The non pain providers often decided not to treat chronic pain with hundreds in primary care posting signs and sending letters to patients to seek pain management from other providers.

Washington has been very careful in reviewing the available trials to make their recommendations. The new guidelines continue to recommend the 120mg MEQ before referral but the group considered lowering this to 80mg. 30% documented clinically meaningful improvement in function on standardized scales are included in the new guideline. Much more emphasis on harm is discussed and well referenced: ‘constipation, nausea and vomiting, dizziness, drowsiness, abuse, inhibition of endogenous sex hormone production with resulting hypogonadism and infertility, immunosuppression, falls and fractures in older adults, neonatal abstinence syndrome, cardiac arrhythmia related to methadone, sleep disordered breathing, opioid-induced hyperalgesia, non-fatal overdose hospitalizations, emergency department visits, and death from unintentional poisoning’. With such clear evidence of harm, and poor data showing benefit for long-term use, why would anyone prescribe opioids?

There will be much debate about the Washington recommendations but be certain that these guidelines will have an effect far outside the Pacific Northwest. It has not been that long since opioids were considered too dangerous to use for end of life cancer patients. The last 25 years of more liberal use led to hydrocodone being the most prescribed drug in the United States. Today, I hear colleagues, thought leaders in pain management describe themselves as opiophobs. The author of a cited article in the Washington guidelines from a Cochrane review proclaims: “The findings of this systematic review suggest that proper management of a type of strong pain killer (opioids) in well-selected patients with no history of substance addiction or abuse can lead to long-term pain relief for some patients... However, the evidence supporting these conclusions is weak, and longer-term studies are needed to identify the patients who are most likely to benefit from treatment.”

Many if not most of us reading this message prescribe opioids for some of our patients with chronic non cancer pain. We have done this and continue to do it based on clinical experience and perceived efficacy in these patients. Randomized controlled trials do not adequately reflect what happens in the provider office dealing with the suffering patient in the context of limited...
resources, failed traditional care and ongoing pain. More careful research and practice guidelines like the 3rd edition of the Interagency Guidelines on Prescribing Opioids for Pain are needed. Washington has led the way in helping understand this complex, heated debate. Anyone who understands the issues has an opinion with some of the most passionate voices coming from patients being denied care. Perhaps 25 years from now we will look back at today and wonder about the difficult times faced by the pain practitioners. Maybe opioids will be reserved for anatomically verified, severe acute, post operative, and end of life cancer pain only. Unintentional overdoses will be minimal since almost no one will have access to opioid management. Or perhaps the next generation of analgesics will be 100% efficacious with no side effects and no addiction. Or maybe Washington will publish its 8th edition of the Interagency Guidelines on Prescribing Opioids for Pain and the debate will continue. I hope the practice for us pain practitioners will be easier than it is today.

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