EDITORIAL

Opioid prescribing to provide effective analgesia for various medical conditions has increased annually for many years. This trend was promoted decades ago by several organizations including two of which I am a member, the American Pain Society and the International Association for the Study of Pain. Certainly, opioid risks were known and discussed at various meetings over those years. Some presentations were specifically devoted to use of opioids in chronic non-cancer pain. However, during this time, there was no major consensus that such an escalation of prescribing these valuable medications would likewise increase cases of addiction and overdoses.

Recently an IMS’ report clearly indicated that in 2015 opioid prescribing was down in every state in this country [1]. That is good progress and shows significant attention to and corrective action of over-prescribing. Some of this excess is most certainly related to treating certain conditions not very responsive to opioid-induced analgesia, e.g., neuropathic pain.

In March, 2016, the CDC released its Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, an impressive 50-page document [2]. A strongly recommended path for treatment of pain is to initiate non-pharmacologic therapy (e.g., osteopathic manipulative treatment (OMT), cognitive behavioral therapy (CBT)), followed when necessary by non-opioid pharmacology (e.g., {non-steroidal anti-inflammatory drugs (NSAIDs)}) and last, if needed, a trial of opioids. There are 12 key recommendations spread among three major sections: 1) Determining when to initiate or continue opioids for chronic pain, 2) Opioid selection, dosage, duration, follow-up, and discontinuation, and 3) assessing risk and addressing harms of opioid use. This report cites many supportive articles, clearly indicating that a significant degree of time and effort were expended to it. Recognizing the need to differentiate important situations, the document listed important exclusion criteria: cancer, palliative, and end-of-life care. This decision appropriately indicates a focus on opioids in chronic pain for which a diagnosis is unclear or even unknown. In such cases, continued prescribing of opioids without benefit is properly regarded as problematic.

This increased emphasis is present not only at the federal level but also within some states. Pennsylvania has now engaged its medical schools to examine their respective curricula to ensure adequate coverage of pain where opioids may be indicated. The overall statement is, “The information collected will be used by the task force to guide state-wide efforts at improving physician education related to these topics.”

At PCOM, pain management education continues through all four years. Osteopathic physicians teach many manipulative (non-drug) procedures to reduce pain. Other clinical faculty discuss methods to provide analgesia within their respective specialties.

As a medical scientist and educator specializing in neuropharmacology, with a specific focus on pain management, I have always (for over 20 years) presented many lectures on opioid pharmacology and adjuncts (e.g., antidepressants; anticonvulsants) to medical students. However, before studying their first specific drug class in our curriculum, they are also educated on drug abuse issues, especially etiology and the difference between addiction, a serious psychosocial disorder, and physical dependence, neurophysiologic compensatory responses to pharmacological effects initiated by prolonged use of a drug. Students are informed that giving a patient an opioid will not automatically convert a normal well-adjusted person presenting with opioid-sensitive pain into a heroin-seeking addict the next day. In fact, most patients who take narcotics for legitimate pain do not become addicted. However, any patient taking an opioid of approximately 60 mg of oral morphine or equivalent daily for one week will develop tolerance and, with a longer duration of such pharmacotherapy, physical dependence.

I discuss two drugs to exemplify these points. For addiction, if it was only the specific molecule that created addiction for all users, I ask for consideration of alcohol. About 10% of those who drink alcohol become alcoholics [3] but if it truly was just ethanol, then every person who had a drink would become addicted. Of course, they do not. Ten percent is still too large, and I wish it was zero, but the point is that addiction is a serious, complex condition which a certain drug may facilitate but will not cause on its own. Only when other factors are present does a drug propel a person into abuse. The addictive personality explains this as well as obsessional focus on gambling, shopping, sex, video games and
even the internet. To help explain physical dependence, I ask coffee-using students to have none on a Saturday. The groans are palpable in class but most of those who perform this self-experiment later report feeling sluggish and having headaches throughout that day. These are predictable compensatory responses that occur when chronic use of a drug that stimulates the CNS and constricts cerebral arteries is terminated somewhat abruptly. This example facilitates their understanding of physical dependence. It is not addiction.

My pain management instruction includes a discussion of the need to provide adequate pain management even to patients who are drug addicts. Of course, in this latter case, management will involve more physician time to establish that the source of such pain is based upon an accurate diagnosis using objective procedures wherever possible.

Considering all aspects in planning actual pain management for appropriate patients involving opioids, the initial question is not, “How much should I give?” It is, “How much does the patient need?” We never want a patient to suffer so much that they wish for death; in this instance, pain becomes a suicidogen [4]; that situation should not occur, especially within the field of medicine.

In conclusion, current national levels of over-prescribing, addiction, overdoses and deaths connected to opioids have created a role at both federal and state levels to focus on this problem by examination of medical school curricula. Where deficiencies in amount of information and critical thinking are evident, especially regarding non-drug and non-opioid therapies, improvement will be strongly encouraged. If gaps continue to exist, there is the possibility of mandates. Since cooperation from medical schools in this endeavor is evident, continued improvement in pain management education will most likely occur independently.

REFERENCES
2. www.cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1er-ebook.pdf