COMMENTARY

Rethinking "doing well" on chronic opioid therapy

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The relief of suffering is the fundamental objective of medical practice. To this end, we often turn to medications, particularly when treating pain, one of the commonest forms of suffering we see. This is understandable. Patients want relief, doctors want to oblige, and it is intuitive that a medication with a known mechanism of action might help.

Unfortunately, the drugs in our pain toolbox are few in number, of limited effectiveness and encumbered by serious risks, particularly for chronic pain which, despite afflicting hundreds of millions worldwide, suffers from a remarkable dearth of evidence-based medications.[1] The treatment of chronic pain is largely based on anecdote, with success or failure determined only after a potentially risky experiment on the individual patient. In the context of a North American crisis that has sparked debate about the role of opioids in medical practice, it is worth reflecting on what, exactly, we are trying to accomplish when we prescribe these drugs for years at a time.

This reflection should begin by acknowledging that the goal of pain medication is not simply pain relief. Like any therapy, the goal is to confer more benefit than harm. With opioids, and at high doses in particular, we meet this objective far less often than we or our patients think. This claim is sometimes met with derision or even hostility — to question the use of opioids for chronic pain is to draw the ire of patients and, sometimes, the displeasure of colleagues.[2] Yet the claim warrants examination, if for no other reason than to understand why the practice has come to be questioned.

Consider the now-familiar narrative sometimes offered by patients with chronic pain: "Opioids don't just reduce my pain, they allow me to function. Nothing else works for me. Without them, I wouldn't even be able to get out of bed. I don't take extra doses or go to multiple doctors, and I certainly don't crush and inject my medication. I'm not an addict; I'm a legitimate pain patient." Anecdotes like this, delivered honestly and with conviction, can be powerful, particularly to those of us who have written the prescriptions.

A widely held view is that absent signs of addiction, patients who seem to be "doing well" on chronic opioid therapy are doing just that, and therapy should continue regardless of dose. This perspective reverberates on social media, is echoed in the popular press[3] and has figured prominently in criticism of guidelines advocating lower opioid doses.

KEY POINTS

- Opioid analgesia attenuates with time, while the harms persist or accrue as doses increase.
- For some patients, the primary benefit of opioids becomes the avoidance of withdrawal. This constitutes harm, but is easily misconstrued as ongoing effectiveness.
- More cautious opioid prescribing (including fewer new starts, avoidance of high doses and slow, collaborative tapers for those already on high doses) can improve the balance of benefits and harms for patients with chronic pain.

What is wrong with this perspective? In other words, why might some of these patients not be doing as well as they or their doctors perceive? Put simply, because the benefits of opioids have attenuated or even become illusory, while the harms, many of which are occult, persist or even accrue. This can happen right under the nose of a watchful, well-meaning physician, especially as the dose increases.

Opioid analgesia wanes over time because of tolerance, opioid-induced hyperalgesia or both. Crucially, this is accompanied by physical dependence, an adaptive response that develops quickly and is defined by symptoms of opioid withdrawal — including pain and dysphoria — when doses are lowered abruptly. Because withdrawal is extinguished by the simple resumption of opioids, is it any wonder that a patient would construe this as evidence of ongoing effectiveness? No, and it is a recipe for self-perpetuating therapy.

Even when opioids confer meaningful improvements in pain and function, harms abound. Aside from the unmistakable harms of addiction, overdose and death, opioids sometimes cause falls, fractures, constipation, reduced libido, infertility, osteoporosis, sleep-disordered breathing and motor vehicle collisions. Moreover, they are an independent risk factor for depression, and in some patients can paradoxically worsen pain, especially at high doses.[1]

Weighing what we now know, an unpleasant fact emerges: patients receiving chronic opioid therapy can easily be harmed more than helped by medications they perceive to be effective or even essential. It is impossible to know how many patients have been harmed in this way since a pill-centric "War on Pain" launched a massive, uncontrolled experiment on the North American population.[4] It is fair, however, to put this number well into the millions, and to characterize the War on Pain as one of the most spectacular failures of modern medicine.

Despite these concerns, some patients can derive improvements in pain and function that outweigh any adverse effects. However, identifying these individuals at the outset of treatment is impossible, and distinguishing them later in therapy can be difficult if benefit has come to be defined, in whole or in part, by the avoidance of withdrawal.

How should these considerations influence our prescribing? The answer depends on who has been asked, but some principles are incontestable. First, opioids should not be started without a clear plan for stopping them, with criteria for success and failure established ahead of time. Second, patients should be fully informed of the risks, including the possibility that dependence can evolve into something masquerading as benefit. Third, the dose should be minimized, because net benefit becomes less likely at higher doses.[5] Finally, the concomitant use of benzodiazepines, alcohol and other sedating drugs should be avoided to the greatest possible extent. The same is true of excessively rapid dose reductions, as might be implemented by physicians wishing to avoid regulatory scrutiny. The importance of this cannot be overstated. Opioid withdrawal causes inexcusable suffering and can drive patients to illicit sources; in some, it can even precipitate suicidality.[3]

It is clear that our approach to treating chronic pain must change, with a greater emphasis on evidence-based nondrug therapies[6] and multidisciplinary models of care. But we must also confront the fact that our prescribing has fuelled twin crises of addiction and of faulty pain management. This will sometimes necessitate difficult conversations with patients who are actively being harmed by opioids but who hold a strenuously different view.

These discussions should acknowledge the patient's perspective, but must also convey a key message: "As your doctor, it's my job to help you manage your pain, but also to be mindful of how pain medications can harm you, sometimes in ways that are hard to recognize." We must emphasize our shared goals of better pain control, improved function and quality of life. This task will be made easier if we explain that, for patients who taper from high-dose opioids, it is only in hindsight that something once unimaginable sometimes becomes apparent: opioids were not making life better — they were making it worse.

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