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Addressing the Opioid Problem

At the recent CSIM annual meeting in Toronto the opening plenary session was “The North American Opioid Crisis.” This is a fundamentally important topic for internists. We frequently encounter patients in our clinics and hospitals who have opioid dependency issues and we need to have a compassionate and medically sound strategy to manage the problems before us. We also have the opportunity to help prevent a problem that is often started with a physician’s prescription.

While some opioid use problems have evolved from the illicit use of drugs, many more cases have begun with a prescription for the management of either acute or chronic pain problems. It is in the management of acute pain that physicians have the greatest potential to avert opioid dependency (and its associated co-morbidity). In the management of acute pain (e.g., musculoskeletal, pleuritic, or post-procedural) an opioid prescription should be for a maximum of 3–7 days, no more. Providing the patient with a two-week prescription of opioids is unnecessary, and puts the patient at risk for developing a dependency issue. Some patients will continue to use opioids beyond the first week if given a prolonged prescription even if the pain does not warrant their use. This is the first step in inadvertent use and subsequent dependency. If the acute pain remains sufficiently severe to require continuing opioid therapy beyond a week the patient should be re-assessed to understand why this might be the case.

For managing chronic pain issues (that have failed non-opioid therapy) opioid medications are likely to be a component of the therapy, but an escalation of the dose to more than 50 morphine mg equivalents per day is unlikely to bring the patient sufficient relief that would justify a higher dose. In the small percentage of patients that do require an unusually high dose to achieve the maximum clinical effect associated with opioid therapy, a maximum of 90 morphine mg equivalents may be necessary.¹ Going beyond that dose is pharmacologically unsound as the ceiling of the analgesia dose response curve will have been reached and increasing the dose will only increase the risk for adverse effects. Further, the problem of opioid related hyperalgesia may start to occur, which draws to the analogy of the dog chasing its tail. The dose continues to spiral higher and higher but the relief that the patient is looking for will never be attained. It is in these patients that we need to focus on measures that will help them to “live” with their pain rather than to focus on the elusive therapy that will reduce or eliminate their pain. There is no cure for chronic pain but there are non-opioid interventions that can improve a patient’s quality of life.

We can help to rectify the opioid problem if we endorse two prescribing behaviours. Acute pain management is to be treated with only 3–7 days of opioid therapy. Chronic pain should be managed with, at most 90 (preferably 50) morphine mg equivalents, along with adjunctive therapies that assist the patient to focus on improving the quality of their life, in spite of their persistent pain.

Reference

1. Busse JW, Craigie S, Juurlink DN, et al. Guideline for opioid therapy and chronic noncancer pain. *CMAJ* 2017 May 8;189:E659–66. doi: 10.1503/cmaj.170363.