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European Review for Medical and Pharmacological Sciences 2015; 19: 4203-4206

The prevention of analgesic opioids abuse: expert opinion

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Abstract. – Opioids are drugs of reference for the treatment of moderate to severe pain. Their proper use and a periodic assessment of the patient are crucial to prevent misuse. A multidisciplinary group suggests strategies for all stakeholders involved in the management of pain and suggests the importance of the doctor-patient relationship.

Key Words:
Chronic pain, Pain management, Opioid, Addiction, Doctor patient relationship.

Introduction

Appropriate Pain Management

The diagnosis and treatment of pain is a clinical and ethical imperative, and access to controlled drugs for medical purposes, particularly pain medications, should be guaranteed to all patients in need[1,2]. Current clinical practice recommendations indicate opioids as the gold standard for treatment of moderate-to-severe acute and chronic pain, according to the WHO analgesic ladder and other international guidelines[3-7].

To establish an appropriate and personalized plan of care, a general assessment of the patient with pain is crucial, thus permitting an appropriate prescription of opioid medications. Accordingly, periodic re-assessment and accurate monitoring are essential for the correct management of pain pharmacotherapy (Table I).

As reported in the World Drug Report[8], at the international level availability of opioids for medical purposes does not correlate with abuse, misuse, or diversion[2]. Several countries with very high per capita opioid-medication availability do not show high levels of abuse. In contrast, some countries with limited access to these medications for medical purposes present a high level of abuse and misuse. Financial, cultural and legislative factors may interfere with the relationship beyond the role attributed to availability in a simplistic way.

The effectiveness of opioid medications in controlling pain and inducing analgesia may be associated, in a minority of cases, with addiction, misuse and non-therapeutic use, particularly in vulnerable individuals. However, addiction is rare in patients with no previous history of addiction[9]. Using a structured evidence-based review of 67 studies, Fishbain et al[10]. calculated the abuse/addiction rate to be 3.3%. When considering only patients with no history

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Table I. Systematic, accurate, and personalized management of people suffering with pain.

Assessment of physical, psychological, social/family existential suffering
Assessment of background pain (and breakthrough pain in cancer patients)
Assessment of the causes of pain with a proper diagnosis (for example assessing neuropathic, nociceptive or mixed pain) and evaluation of analgesic need
Selection of drugs on the basis of the characteristics of pain
Pharmacotherapy management (dose titration with immediate-release formulations to reach minimum effective dose and/or maximum tolerated, switching of route/opioid when needed, dose adjustments for tolerance, hyperalgesia, or adverse events)
Periodic re-assessment of pain
Counseling and assessment of misuse risk (patient, family, caregiver)
Multidisciplinary health care pathway for uncontrolled pain

of abuse/addiction, the percentage of abuse/addiction dropped to 0.2%[10]. Overall, these figures suggest a low risk of opioid abuse/addictive behaviour in clinical practice. Existing evidence and clinical experience suggest that in appropriately-selected patients, opioids have a low addictive potential and, in addition to their primary analgesic action, they are able to reduce suffering, enhance functional activity level, and improve quality of life[11].

From a clinical perspective, the symptoms of compulsive/addictive behaviour in patients with pain should also be distinguished from those related to "pseudoaddiction". The term "pseudoaddiction" is used to describe a reversible condition in patients with undertreated chronic pain showing erratic behaviour that resolves once pain becomes adequately controlled[12]. To this end, practitioners working in the pain management area should also differentiate the effects of tolerance in patients in need of higher dosage of opioid medications to maintain analgesia from the addictive behavioural pattern characterized by the compulsive cycle. Patients with unrelieved pain may in fact become focused on obtaining medications. For all these reasons, in patients with chronic pain a periodic review of the strategy and a detailed evaluation of behaviours are recommended (Table II).

To better explain the uncommon risk of addiction in patients with pain, the conditions to induce addictive behaviour and opioid use disorders should be considered extensively. Addiction is not simply related to the exposure to opioid medications, but to a complex series of social and neurobiological factors inducing loss of control over drug use. The addicted patient is characterized by compulsive use, craving, and continued use despite harmful consequences. The therapeutic use of opioids in patients with pain is usually not associated with any risk factor which underlies the development of substance use disorders in the clinical history. Furthermore, neurobiological data demonstrated that subjects suffer-

Table II. Strategies to manage the opioid treatment.

Appropriate use of opioids
Implement combination therapies with multiple drugs (aiming at opioid-sparing)
Reserve the higher doses and long-acting formulations for patients with persistent pain after titration
Prefer safe packages (e.g. child-proof packaging)
Prefer opioid with abuse-deterrent formulation or device should be preferred
Schedule frequent monitoring visits
Avoid under treatment of chronic pain
Discourage multiple prescriptions (centralize the prescription to the specialist or the GP who is in charge of the patient)
Avoid unecessary prescriptions
Check drug adherence periodically
Share the therapy strategy with the patient (including the benefit/risk ratio)
Continuous counseling
Screening patients at potential risk with validated tools (comorbidity drug abuse, non-drug abuse conditions, psychiatric conditions)
Discuss patients' management with other specialists (pain specialist, addiction specialist, GPs)

ing for neuropathic chronic pain undergo a series of neuro-plastic changes, which do not support the reinforcing, rewarding effects of opiates and potential abuse[13].

Although the prescription-drugs abuse epidemic in the United States[14,15] has been interpreted in different ways, the real nature of the phenomenon remains unclear. A variety of factors, typical of the normative, cultural and social conditions in the US could have induced the overwhelming rate of abuse that seems to be uncommon[16] and not expected in Europe and in Italy. This has led many experts in the US to propose strategies to reduce the risk of diversion[17,18]. To enhance the rate of appropriate use of opioid medications in patients requiring analgesia a multimodal approach should be applied not only by physicians, but also by other stakeholders (Table III).

For a long time analgesic opioids have been used in small amounts and only for terminal cancer patients with pain. With the recent approval of the Italian law no. 38/2010, opioids have become more readily available to patients needing analgesia. Although the access modalities to drug therapies in Italy is different from those applied in other countries and opioid abuse remains a rare event in patients with chronic pain[9,18,19], the strategies to avoid drugs abuse should be carefully considered. Multimodal strategies should be implemented and disseminated to reduce the potential risk of misuse and abuse: in particular the training of health professionals should provide the necessary skill for the mitigation of abuse and diversion. The use of opioids must be in full compliance with the approved indications to avoid misuse; however, the fear of abuse should not discourage the appropriate use of these effective drugs in the control of pain. Opioid treatment should not be denied in paediatric patients, according to the WHO indications. In fact morphine was recommended by WHO as second-line treatment after paracetamol or ibuprofen for persisting moderate to severe pain in children[20]. Appropriate management of pain is also recommended, both during and/or after treatments and diagnostic procedures[21]. In both these settings abuse and diversion are unlikely.

As a main element to avoid abuse and diversion, particular emphasis should be given to the concept of "therapeutic alliance" between the healthcare professional and the patient[22]. An individualized approach, considering not only the pain, but the entire person affected and his/her own needs and expectations, would significantly increase not only the benefits of pain pharmacotherapy and also decrease the risk of uncontrolled and abusive use. General practitioners should be fully involved in the multidisciplinary pathway of care in order to detect patients at risk earlier, centralize and monitor prescriptions, periodically reassess the chronic pain situation and involve patient and family in the management of opioid therapy. In this setting, a validation tool to

Table III. Multimodal strategies to manage the opioid risk.

1. Health Authorities
Mandatory training to physicians about the proper prescription of pain medications
Public awareness campaigns on the proper use of pain medications
Active surveillance of analgesic abuse
2. Scientific Societies
Guidelines to manage long-term opioid therapy
Validation of tools to assess the risk of drugs abuse
Multidisciplinary training program (for specialists and GPs)
3. Pharmacists
Surveillance of suspected abuse of opioid painkillers (multiple prescriptions, incorrect dosage)
Ensure the availability of all formulations of opioids (immediate, rapid or sustained-release)
Counseling on the correct dosage and storage
4. Nurses
Survey and counseling
Participation to the multidisciplinary risk assessment plan
5. Pharmaceutical companies
Implement child-proof packaging
Implement abuse-deterrent formulations
Promote the approved indications and proper use
Active monitoring and assessment of safety profile and risk/benefit ratio

aid the early detection of patients at risk is also crucial. Lastly, appropriate modalities should be adopted to not deny the necessary opioid medications to patients at risk of abuse affected by severe pain and addicted patients who are in need of analgesic interventions.

Acknowledgements

Editorial assistance for the preparation of this manuscript was provided by Luca Giacomelli, PhD. The views expressed herein are those of the authors and do not necessarily reflect the views of the United Nations.

Conflict of Interest

The Authors declare that there are no conflicts of interest.

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