Pain: Sorting Out the Solution

Marie-Eileen Onieal's November editorial, The Pain Paradox, touched a pain point with readers. Here are substantial, articulate comments as to what the underlying problem is and how we can attempt to solve it.

DISTINGUISHING DEPENDENCE FROM ADDICTION

Four years ago, I left my career at a large urban VA hospital due to cancer; residual effects of my treatment have prevented my return. I share this as it reflects my personal experience with pain management.

As a Certified Addiction Registered Nurse–Advance Practice, I worked in a substance abuse clinic for 15 years, providing everything from primary care to detoxification and opiate replacement maintenance. I also consulted on cases throughout the facility and advocated for patients with substance abuse histories in regard to care management concerns, including pain. I spent a great deal of time educating staff from all areas on proper care for patients with a variety of substance abuse and addiction concerns.

In order to better address the conundrum of appropriate pain management, a fine distinction needs to be made between *dependence* and *addiction*. Chemical dependence is a physiologic status and a medical diagnosis; reduction or discontinuation of a culprit drug will result in symptoms of physiologic withdrawal. Addiction, on the other hand, is a legitimate brain disease that might be better thought of as a mental health disorder. It manifests signs and symptoms very similar to those of chemical dependence.

Perhaps the distinction is best revealed by example: A 65-year-old woman who is on opioid-based pain management for two weeks due to a complicated orthopedic injury will need to be tapered off to avoid physiologic symptoms of withdrawal. Yet, she is not considered a drug addict.

The behavioral characteristics of addiction are familiar: drug-seeking, illicit use, presentation with unexplained withdrawal symptoms, etc. Additionally, process addictions involve the same neurochemical pathways as chemical addictions. When they abstain, gamblers, sex addicts, and television addicts manifest the same anxiety and psychologic or even physical symptoms of withdrawal. The pathophysiology of the addiction process is established in addiction medicine literature.

The problem is that this knowledge has not been extended to practice. In my experience, poorly managed pain has a much greater risk for unintended negative consequences than aggressive management with opiods and adjuncts in a patient with a history of heroin addiction. Pseudo-addiction is real, and patients present with signs and symptoms similar to those of addiction: demanding, making specific requests, history of multiple providers (doctor shopping), and elevated anxiety.

Anyone who has experienced poorly managed severe pain will share stories of the drive to get relief at almost any cost. These people are not drug addicts. They are patients in need of informed, aggressive, and compassionate care.

Fear-based inadequate pain management creates instability and desperation in patients. Their intensive search for relief is nothing but rational. A clinician's withholding of adequate care due to social prejudice, fear (of the DEA), and/or ignorance in a field where knowledge and tools are widely available is bad care at best and negligent incompetence at worst. Ultimately, it is the patient who suffers the consequences.

The well-known but often denied chasm between medicine and mental health has gone on too long. Medical practitioners need to

- Be better able to identify and distinguish between potential and current chemical dependence and true addiction.

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- Be willing to treat pain aggressively in patients with a known history of addiction in order to prevent relapse or exacerbation of their addictive use.
- Develop a working knowledge of strategies to treat pain while minimizing risk for addiction and dependence.
- Commit to the intensity of practice that is required for effective pain management in any population.

Yes, my suggestions imply a labor-intensive approach. But there are no 20-minute appointments with a heroin addict. And time spent appropriately assessing patient risk for substance abuse, treating legitimate pain management needs, and intensively following up will reduce the medical and mental health costs associated with poorly managed pain in low-risk patients, and the hugely expensive and potentially tragic outcomes associated with poorly treated drug addicts.

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PAIN MANAGEMENT: HOW ABOUT HOLISTIC?

I recently received the letter and instruction card for prescribing narcotic analgesics from US Surgeon General Vice Admiral Vivek H. Murthy, MD, MBA. While I agree in principle with the movement to improve pain management, I feel there is a lot being overlooked in this crusade and would like to suggest alternative evidence-based methods that don't involve prescription narcotics.

I have extensive training in energy therapy, guided imagery, and ozonotherapy. Healing touch is one well-researched energy therapy that has been shown to reduce pain. I have performed and published research demonstrating its efficacy (see **http://healingbeyondborders.org/index.php/research-integrative-health/research**); patients' functional abilities improve, and they are able to decrease or eliminate use of pain medication. Providers from many disciplines, including MDs, DOs, NPs, and DCs, practice healing touch. Training for healing touch is available worldwide. The certification process is similar to masters-level education, including both classroom and hands-on clinical practice experience. My practice uses healing touch for patients, and I teach classes using the international curriculum.

In addition to the research published on the efficacy of guided imagery (another method of pain relief therapy), I have personally witnessed and been part of several successful examples in my clinical practice. In the burn unit, Dr. Jean Achterberg Lawlis and I used guided imagery to relieve pain in patients with third- and fourth-degree burns over 70% or more of their body. We performed tanking and dressing changes without narcotic pain medications; patients were comfortable during treatment and slept peacefully after. In another instance, a 23-year-old man presented with major chest and spine injuries after a motorcycle accident. Morphine (100 mg IV) did *nothing* to relieve his pain. But guided imagery of racing his stock car around a racetrack eliminated any need for narcotics during dressing changes. I've also worked with women prenatally, teaching guided imagery for smooth, successful deliveries without pain medications or epidural.

Ozonotherapy has an extensive international evidence base, and many studies show that it relieves pain without the need for narcotics (see **http://aaot.us/?page=Literature**). I have seen many cases of chronic pain relieved by major autohemolytic therapy and prolozone injection therapies. Here, too, patients are able to decrease and eventually stop their narcotic medications. Some patients are able to avoid joint replacement surgery, achieving improved function and comfort without the adverse effects of steroids.

An effective way to release muscle tension and relieve pain from injury (eg, low

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Training in Alternative Pain Management Methods

Energy Therapy

Healing Beyond Borders **(http://healingbeyondborders.org/index.php/education/hti-healing-touch-certificate-program/curriculum-and-class-descriptions)**

Guided Imagery

American Holistic Nurses Association **(www.ahna.org)**

The Academy for Guided Imagery **(http://acadgi.com/whatisguidedimagery/index.html)**

The Academy of Integrative Health and Medicine **(www.aihm.org/about/what-is-integrative-medicine/)**

Weil™ (Dr. Andrew Weil) **(www.drweil.com)**

Ozonotherapy

The American Academy of Ozonotherapy **(http://aaot.us)**

Oxygen Healing Therapies **(www.oxygenhealingtherapies.com/ozone_therapy.html)**

back pain, plantar fasciitis, whiplash, carpal tunnel) is through massage therapy. Providers who refer patients to massage practitioners can avoid narcotic medication prescriptions by addressing the problem that is causing the pain. Chiropractic care is a standard care for low back pain; it can also resolve problems that cause migraines, trigeminal neuralgia, and Bell's palsy without narcotics, steroids, or the sedating muscle relaxants and seizure medications. Yet several veterans in my community were denied chiropractic care until they had tried narcotics and physical therapy (which involved a four-hour roundtrip car ride, no less). Oh, and in the meantime, they were prescribed an additional narcotic!

By focusing only on narcotics, we miss out on other options to treat pain. If we overlook the full range of evidence, then the "evidence-based" mantra isn't truthful, nor is it useful. To follow the pledge to "do no harm," we must treat the *causes* of pain. Of the Surgeon General, I request: Please don't just send us a teaching card on how to prescribe narcotics. Get providers involved in seeking continuing education credits in therapies that help us avoid prescribing them in the first place.

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KEEPING PAIN A PRIORITY

Before pain was introduced as the "fifth vital sign" and the Joint Commission issued its standards, more than a decade's worth of international research indicated that pain was largely ignored, untreated, or undertreated. The best tools available to treat pain (opioids) were reserved for patients on their deathbed. The horrific results of the SUPPORT study at the nation's leading hospitals revealed that most patients had severe, uncontrolled pain up until their final days of life.[1] Unfortunately, research suggests we are still reserving opioids for the last days or weeks of life.[2]

In 1992 and 1994, the Department of Health and Human Services issued clinical practice guidelines highlighting the huge gap between the availability of evidence-based pain control methods and the lack of pain assessment and treatment in practice.[3] When these guidelines failed to change practice, the Joint Commission added "attending to pain" to its standards—the first effort to *require* that evidence-based practices be utilized. Twenty years later, the National Academy of Science issued a report stating that, despite transient improvements, the current state is inadequate since pain is the leading reason people seek health care. Patients with pain report an inability to get help, which is "viewed worldwide as poor medicine, unethical practice, and an abrogation of a fundamental human right."[4] Since I started working as an NP in 1983, I have never seen as many patients with pain stigmatized, ignored, labeled, and denied access to treatment as I have in the past year.

Pain afflicts more than 100 million Americans and is the leading cause of disability worldwide.[5] Acute pain that is not effectively treated progresses to chronic pain in 51% of cases.[6] An estimated 23 million Americans report frequent intense pain, 25 million endure daily chronic pain, and 40 million adults have high-impact, disabling, chronic pain that degrades health and requires health care intervention.[6,7] The most notable damage is to the structure

and function of the central nervous system.[8] Brain remodeling and loss of gray matter occurs, producing changes in the brain similar to those observed with 10 to 20 years of aging; this explains why some of the learning, memory, and emotional difficulties endured by many with ongoing pain can be partially reversed with effective treatment.[9] Left untreated, pain can result in significant biopsychosocial problems, frailty, financial ruin, and premature death.[10-14]

Prescription drug misuse and addiction also affect millions and have been a largely ignored public health problem for decades. Trying to fix the pain problem without attending equally to the problems of nonmedical drug use, addiction, and overdose deaths has contributed to the escalation of health problems to "epidemic" and "crisis" proportions. Although most patients who are prescribed medically indicated opioids for pain do not misuse their medications or become addicted, the failure to subsequently identify and properly treat an emergent substance use disorder is a problem in our current system.[15] Unfortunately, making prescription opioids inaccessible to patients forces some to abuse alcohol or seek drugs from illicit sources, which only exacerbates the situation.[16] A national study performed over a five-year period revealed that only 10% of patients admitted for prescription opioid treatment were referred from their health care providers.[17] So, health care providers may have been part of the problem but have not been fully engaged in the solution.

Although opioids are neither the first-line, nor only, treatment option in our current evidence-based treatment toolbox, their prudent use does not cause addiction. Only 1% of patients who receive postoperative opioids go on to develop chronic opioid use, and adolescents treated with medically necessary opioids have no greater risk for future addiction than unexposed children. It is the nonmedical use of opioids, rather than proper medical use, that predisposes people to addiction.[18,19] Discharging or not treating patients suspected of "drug-seeking" exacerbates the problem. Rates of opioid prescription have declined, while overdoses of illicitly manufactured fentanyl increased by 79% in 27 states from 2013 to 2014.[20] In Massachusetts, only 8% of people who fatally overdosed had a prescription, while illicit fentanyl accounted for 54% of overdose deaths in 2015 and more than 74% in the third quarter of 2016.[21] We need to screen for nonmedical use, drug misuse, and addiction before, during, and after we treat with this particular tool.

Unfortunately, the prevalence of pain and addiction are both increasing, especially for women and minorities—but there are safe, effective medications and non-drug approaches available to combat this.[22-24] These problems will not go away on their own, and every health care professional must choose to be part of the solution rather than perpetuate the problem. A good place to start is to become familiar with the Surgeon General's Report and the National Pain Strategy. Educate your patients, colleagues, and policy makers about the true nature of these problems. Take a public health approach to primary, secondary, and tertiary prevention by recognizing and treating these conditions in an expedient and effective matter. When problems persist, expand the treatment team to include specialists who can develop a patient-centered, multimodal treatment plan that treats co-occurring conditions. If we continue to ignore these problems, or focus on one at the expense of the other, both problems will worsen and our patients will suffer serious consequences. **CR**

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