Chronic Pain, Depression Need 'Rational Plan'

BY BETSY BATES

Pain and depression are common bedfellows, entwined in a complex relationship of situational and neurophysiologic connections that are not yet fully understood.

Numerous studies point to frequent comorbidity, yet physicians treating patients who present with chronic pain often fail to assess for depression and anxiety.

The opposite also can prove true, with psychiatrists failing to diagnose chronic pain in a significant percentage of their patients—particularly those with depression, said Dr. Alan Schatzberg, chairman and chief of psychiatry at Stanford (Calif.) University, in an interview.

"Pain is not commonly asked about in assessing depressed patients but is extremely commonly present," he said.

In a cross-sectional international interview study of 18,980 subjects, nearly half of those with major depression also reported having a chronic pain condition (such as back pain, joint/articular pain, or headaches)—a fourfold elevation over people who were not depressed, reported Dr. Schatzberg and Dr. Maurice M. Ohayon, also of Stanford (Arch. Gen. Psychiatry 2003;60:39-47).

On the flip side, in people whose presenting problem is chronic pain, the prevalence of depression in the literature has ranged from 30% to 60%.

It remains unknown whether depression is the "cause or the consequence" of chronic pain, said Dr. Michael Clark, a psychiatrist who directs the Johns Hopkins Pain Treatment Program in Baltimore.

Intuitively, living with chronic pain puts significant stresses on a person's life and relationships. But increasing evidence points to multiple pathways of shared neurobiology as well, explaining the long-appreciated analgesic effects of tricyclic antidepressants, Dr. Clark said.

Today's armamentarium holds a wide variety of medications for chronic pain, starting with the anticonvulsant pregabalin (Lyrica), a GABA analogue, and the serotonin-norepinephrine reuptake inhibitor duloxetine (Cymbalta). Both have received Food and Drug Administration approval for fibromyalgia, and duloxetine also has garnered approval for the treatment of generalized anxiety disorder, depression, and diabetic peripheral neuropathy. Despite the on-label specifics, these drugs are cited by many experts as cornerstones of therapy for a wide range of patients with pain and comorbid psychiatric diagnoses, especially depression and anxiety.

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DR. CLARK

"If I have a patient with both an emotional disorder and a pain disorder, I very well may put them on Cymbalta or on the combination of Lyrica and Cymbalta, which act through different mechanisms and have a synergistic effect in some patients," said Dr. Gerald M. Aronoff, a psychiatrist and medical director of Carolina Pain Associates in Charlotte, N.C.

The strategy, along with a fervent belief in coordinated nonpharmacologic adjunct treatments that include supervised exercise, physical and occupational therapy, and cognitive-behavioral psychotherapy, allows Dr. Aronoff to reduce doses of opioids, which are central to management in many pain programs, especially those directed by nonpsychiatrists.

"My desire is not to have people on opioids indefinitely, but to get people through a difficult phase in their lives," he said.

Numbing a patient's sensations may do nothing for the ripples of distress that can accompany pain: depression, relationship problems, and a crisis of self-efficacy and self-esteem.

Although tricyclic antidepressants are viewed as "old school" by some physicians treating chronic pain, Dr. Clark disagrees.

By the time patients see him, they may have been prescribed an array of the newer, more expensive drug choices, so he may turn to a tricyclic antidepressant (such as amitriptyline or doxepin) or an antiseizure medication such as divalproex (Depakote) or lamotrigine (Lamictal).

"Often, no one else has tried these medications in these patients," he said, explaining that rare side effects, careful titration, and blood monitoring are not daunting once one is familiar with them.

Dr. Jon Mark Streltzer, professor of psychiatry at the University of Hawaii, Honolulu, maintains that the controversy surrounding long-term, high-dose opioid use for chronic pain is a matter of difference among individuals, rather than a specialty-specific perspective. "There are practitioners on both sides of the issue in all specialties," he said. "There are competitive schools of thought."

Dr. Streltzer generally opposes the use of high-dose opioids for chronic pain management, preferring to maintain patients (where possible) on acetaminophen (1 g, 4 times daily) while using a program aimed at function, activity through functionally directed therapy, and cognitive-behavioral psychotherapy.

That said, acetaminophen "won't work on opioid-dependent patients," he warned. "Almost nothing will work until the dependence is treated."

Dr. Clark said decreasing efficacy of opioids at standard doses results in patients on extremely high doses by the time they arrive at a tertiary pain clinic.

For example, patients commonly present to his clinic on doses of 600 mg/day of morphine or oxycodone, and individuals on 1,000 mg/day are not unheard of.

"At that point, you have to say, 'Is this really helping your problem? If it was, you probably wouldn't be here. Could it be hurting you?' Well, yeah, probably it is, in terms of some cognitive impairment, and a whole host of effects on autoimmune and endocrine function. Like anything else, you have to look judiciously at the specific risks and benefits for an individual patient," he said.

Dr. Aronoff advises "erring on the conservative side" when treating any chronic pain patient with opioids or any other medications, since he considers these patients to be at high-risk for self-harm.

"I can't overemphasize that it is very important to do a very thorough mental status examination before prescribing any of these medications that have toxicity at low doses,'' he said.

Within the larger context of chronic pain, patients with generalized pain syndromes deserve special consideration, Dr. Clark said.

Central sensitization appears to be the common denominator among fibromyalgia, interstitial cystitis, diffuse low back pain, chronic fatigue syndrome, irritable bowel syndrome, and headache syndromes, with resulting amplified pain sensations.

Depression itself may be a problem of central sensitization, he added. Such patients describe vague symptoms with a lack of clearcut etiology and a seemingly disproportionate degree of disability.

"The most important thing is you don't want to give these patients a little bit of everything and think that's the answer: a little bit of occupational therapy, a little bit of physical therapy, a little bit of psychotherapy and psychopharmacology.

"Throwing ingredients into a soup without a recipe is not the answer. These patients need to have someone design a rational plan for their care," Dr. Clark said.

Dr. Schatzberg and Dr. Streltzer reported no relevant financial conflicts with regard to this story. Dr. Aronoff and Dr. Clark have both served on the speakers bureau or as consultants for Lilly Pharmaceuticals, maker of Cymbalta, and Pfizer Inc., maker of Lyrica. Dr. Aronoff also has been a speaker and/or consultant for Cephalon Inc., maker of several pain medications, and Endo Pharmaceuticals, maker of several opioids. ■

Program Relieves Comorbid Depression and Chronic Pain

BY MARY ANN MOON

Optimized antidepressant therapy and pain self-management produced substantial and sustained improvements in patients with comorbid depression and chronic pain.

The program, which was assessed in a study of 250 patients, was implemented in two primary care clinic systems by a nurse care-manager supervised by a physician, reported Dr. Kurt Kroenke of the divisions of internal medicine and geriatrics, Indiana University, Indianapolis, and his associates (JAMA 2009;301:2099-110).

They conducted the Stepped Care for Affective Disorders and Musculoskeletal Pain (SCAMP) study to determine whether pharmacologic and behavioral treatments would prove synergistic in treating the comorbid conditions.

A total of 123 adults were randomly assigned to receive the study intervention: 3 months of optimized antidepressant therapy, followed by an additional 3 months of pain self-management instruction, followed by 6 months of relapse prevention. The antidepressants that were selected for the trial were venlafaxine (Effexor), fluoxetine, sertraline (Zoloft), citalopram (Celexa), bupropion, mirtazapine (Remeron), and nortriptyline (Aventyl). The authors noted that the trial "was not designed to test any particular antidepressant." The remaining 127 subjects served as a control group, receiving usual care.

The pain self-management program included at least five in-person and eight telephone contacts during which patients learned about "chronic pain triggers and flare-ups; coping with fear and other negative emotions; and strategies for physical activity, muscle relaxation, deep breathing, distraction, sleep hygiene, and working with clinicians and employers" to manage their disability.

Compared with usual care, the intervention produced "substantial" (at least 50%) reduction in depression severity within 1 month, which was sustained throughout 1 year of follow-up.

The intervention also produced a 30% or greater reduction in pain, which was evident within 1 month of starting the program and was sustained for 1 year. The authors noted several limitations of the study: Generalizability was limited because the subjects were drawn from urban underserved and Veterans Affairs clinics, a lack of blinding, and discordance between patient self-report and electronic health record data.

The study was funded by the National Institute of Mental Health. Dr. Kroenke reported receiving research funding and/or honoraria from Eli Lilly (Aventyl, Prozac), Pfizer (Zoloft), Wyeth (Effexor), and Astra-Zeneca and Forest Laboratories (Celexa). Dr. Blair reported receiving one-time consultant fees from Wyeth, Abbott, and Cephalon. None of the other authors reported any financial disclosures. ■