Fixing pain management could help us solve the opioid crisis

February 2 2018, by Meredith Craigie

Credit: Anete Lusina from Pexels

Australia is facing a critical public health issue of poorly managed pain. The combination of poor health outcomes, inappropriate prescribing for pain and non-prescription use of opioids has resulted in opioid-related

deaths surpassing the national annual road toll.

And prescription opioids were involved in more than 70% of drug-related deaths in Australia in 2017.

What should opioids be used for?

Opiods began being commonly prescribed in the 90s, despite limited research supporting their effectiveness for chronic pain that wasn't caused by cancer.

Opioids are best used for acute pain management, to manage severe pain after surgery, injuries or burns, pain from problems such as kidney stones, gallbladder stones, pancreatitis and heart disease and in special situations like childbirth and end of life care.

Despite this, opioids became regularly prescribed for a wide range of pain conditions. This includes headaches, back pain, period pain, joint pain and chronic abdominal pain, despite little or no evidence they were effective.

Research has shown chronic use of opioids can make sufferers more sensitive to pain over time, an effect known as hyperalgesia. Recurrent short-term use for headaches in particular can lead to medication-overuse headaches that are worse and last longer.

It's apparent 25 years on that the long term use of opioids has resulted in a wider range of harms than was expected. Problems include chronic nausea and constipation, hormone suppression causing low libido, osteoporosis and dental problems, immune suppression increasing the risk of infections, cognitive impairment and sleep disordered breathing that can lead to death. And this is not to mention the significant dependence and addiction problems.

How should we be treating pain?

Pain management approaches, if skilfully applied, are much safer and more effective for most people. These include non-drug strategies such as physiotherapy or exercise physiology, mind-body relaxation techniques such as breathing techniques and mindfulness meditation, hypnosis and other behaviour therapies. As well as lifestyle changes such as stretching, walking and pacing activity, diet and nutrition changes, improving sleep hygiene and addressing relationship problems. These should be first line treatments.

If these fail, non-opioid analgesics (such as paracetamol, anti-inflammatories, topical treatments, anticonvulsants and antidepressants) or medications specific for the condition (such as tryptans for migraine, disease-modifying drugs for rheumatoid arthritis and other autoimmune diseases) are safer and may be more effective in treating chronic pain. This is because they work through the many other, complex mechanisms and brain pathways involved in persistent pain.

Few specialists, long waiting times and challenging travel arrangements to attend pain management clinics mean many chronic pain sufferers can't easily access the most effective care. They have to rely on their time-poor GP for whom writing a prescription for an opioid is quick and easy. Arranging referrals to several allied health professionals as part of a co-ordinated plan is too difficult for many.

How are opioids prescribed?

All strong opioid medications are classified under Schedule 8 of the Therapeutic Goods Act, which controls how medications and other poisons are made available to the public.

Schedule 8 medications can be prescribed for up to two months without additional permission. But should the prescription be continued beyond that, the prescriber must apply for an "authority to prescribe" from the relevant state or territory health department.

Pharmacists are required to send regular reports of opioid dispensing back to the health department and Medicare, to monitor who is receiving the medication and the prescriber.

Low dose codeine used to be Schedule 3 (pharmacist only medication), but has now been moved to Schedule 4 (prescription only medicine). Schedule 4 medicines can be prescribed by a medical practitioner without further permission.

Prescription of strong opioids such as morphine in amounts meant to last more than two weeks requires a separate authority from Medicare (a federal agency). A range of measures are available to enforce the legal requirements of opioid prescribing, but the rigour of application varies widely across the country depending on resourcing and staffing.

Lag times in reporting and lack of information sharing between the state-based systems hinders the detection of doctor shopping, especially across state borders. It also makes it harder to detect use for indications and in amounts not specified by the doctor, and opioid addiction.

Opioid misuse in Australia is a complex societal problem. It can't be blamed on any one group of medical practitioners, regulators or patients. Options for tightening up federal rules are under consideration.

Having a national, real-time prescribing tracker could help to alleviate some problems. But educating medical practitioners and consumers about better pain management strategies is essential if we're to achieve changes in attitudes and behaviours that will lead to safe and appropriate

use of opioid medications.

This article was originally published on The Conversation. Read the original article.

Provided by The Conversation