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Target Audience Neurologists, family physicians, general practitioners, internal medicine specialists, rheumatologists, physical medicine and rehabilitation specialists, osteopathic medicine specialists, and other physicians and healthcare professionals who treat patients with pain

Learning Objectives After reading this newsletter, participants should be able to:
- Discuss the recent FDA advisory on methadone use in managing patients who have pain
- Address important barriers to effective chronic pain management when treating patients with prescribed opioid analgesics
- List common misconceptions regarding opioid analgesics
- Identify the serious adverse effects of under-treated pain

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GUEST EDITOR

Steven D. Passik, PhD
Associate Attending Psychologist
Department of Psychiatry and Behavioral Sciences
Memorial Sloan-Kettering Cancer Center
Associate Professor of Psychiatry
Cornell University Medical College
New York, New York

Dr Passik has indicated that he is a retained consultant for Cephalon Inc., Endo Pharmaceuticals Inc., Ligand Pharmaceuticals, and Alpharma Inc; is a member of the speakers bureau for Cephalon Inc. and Endo Pharmaceuticals Inc.; and receives grant/research support from Cephalon Inc.

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Safety First: Prescribing Methadone for Pain

Lynn R. Webster, MD, Medical Director, Lifetree Clinical Research and Pain Clinic
Salt Lake City, Utah

Dr Webster has indicated that he is a consultant for Cephalon Inc, Pharmaceutical Technologies International Inc, Elan Corporation, and King Pharmaceuticals Inc; and receives research support from Advanced Bionics Corporation, TorreyPines Therapeutics, Xenoport Inc, Takeda Pharmaceutical North America, Inc, Jazz Pharmaceuticals, Zars Pharma, Forest Laboratories, Merck, Purdue Pharma, Durect Corporation, Mallinckrodt Inc, GlaxoSmithKline, Neurogesx Inc, Predix Pharmaceuticals Inc, Elan Corp, and Elite Pharmaceuticals Inc.

Methadone is a powerful, effective medication for pain; but it can also be fatal if prescribed or consumed incorrectly. On November 27, 2006, the FDA issued a public health advisory for methadone, entitled *Methadone Use for Pain Control May Result in Death and Life-Threatening Changes in Breathing and Heart Beat.*[1] This is strong language, but it should not be a surprise to healthcare professionals because any strong pain medication can cause death if used improperly. The FDA advisory contains updated prescribing data and a **black-box warning** which states that taking more methadone than prescribed "can lead to an overdose and possible death." This seems appropriate considering the alarming increase in patients who have been harmed by methadone. The intent is to help practitioners keep patients safe. Methadone is a good and useful medication with some special properties that must be respected when prescribing or consuming it for pain.

The involvement of methadone in overdose deaths is increasing, according to both the US Substance Abuse and Mental Health Services Administration (SAMHSA) and medical-examiner data from several states reporting a rise in methadone-related deaths, including Florida (up 51% from 2003-2004), Maryland (up 950% from 1997-2001), North Carolina (up 729% from 1997-2001), and Utah (up 1,358% when comparing the intervals of 1991-1998 with 1999-2003).[2-6] Although it is clear that at least some methadone taken for pain contributed to these fatalities, the exact reasons for the deaths are still unclear.

Clinicians who prescribe methadone for pain and their patients may be underestimating the risk of respiratory depression associated with methadone. The unique pharmacologic properties of methadone may be contributing to the problem. The analgesic half-life is much shorter than the interval during which methadone can cause respiratory depression in the methadone-naïve patient. According to the FDA, pain relief from a dose of methadone lasts approximately 4 to 8 hours, but methadone stays in the body up to 59 hours. Other reports suggest that the methadone half-life can be as long as 100 hours. As a result, methadone may accumulate to a toxic level after the first few days of treatment, and toxicity can occur before the body has had time to develop a tolerance.

More research is needed to establish the cause of death reported, but at least some of the contributing factors and dangers can be discerned.

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EDITOR'S PERSPECTIVE

Waking Up to the Realities of Pain Management

Steven D. Passik, PhD

In this issue we have a couple of wake-up calls. (Were we asleep or is it just that we hit the snooze button?) The *Voices of Chronic Pain* Internet survey, nicely reported by Mark Palangio, and beautifully reviewed and contextualized by Dr Art Lipman, tells us once again that chronic pain is debilitating, stigmatizing, time-consuming and not particularly well treated. With the ongoing societal focus on prescription drug abuse and diversion, and the souring of the regulatory environment around opioids, it is no longer terribly sexy to talk about the undertreatment of pain. But it never has been, nor is it now, terribly sexy to live with it either. We owe it to our patients to wake up, shake off some of our bewilderment, and be advocates for aggressive and effective pain management approaches. The *Voices* survey also tells us that we owe it to our patients to stop seeking simple solutions to complex problems, such as which new intervention, psychotherapy, or class of drugs will act as some kind of panacea. One of the more recently hailed panaceas, methadone (the darling of payors looking for ways to do pain management on the cheap), has shown itself to be particularly problematic when used incorrectly. In this newsletter we are fortunate to have a useful and pragmatic piece on safe methadone prescribing by Dr Lynn Webster, a national expert on many subjects, including the recent phenomenon of methadone-related overdoses.

The opioid-treated patients participating in the *Voices* study continued to report pain despite their treatment with these medications. Obviously, we should not abandon opioid therapy, as many patients report that they are effective. For those of us who remember the beginning of the "opioid age," there was tremendous enthusiasm that if we simply liberalized the prescribing of these agents, chronic pain would be virtually eradicated. There is no doubt that thousands of people have benefitted from these efforts. But the downside of opioids, that now seems to rule the day, communicates, among other things, pain clinicians' collective bewilderment with another panacea going down in flames. As I think over the past several decades in pain management, one panacea after another has met this fate. This pattern does not suggest that any of these treatments are totally without value. Rather, in our zeal to relieve suffering, we engage in a certain amount of magical thinking about new approaches, over-apply them, and then become bewildered with the results, sometimes even abandoning these approaches entirely. (Anyone who has not heard a lecture by Dr Dennis Turk on this subject, should.) As someone once said, "You gotta use new drugs while they are still new, before they have side effects and while they still work."

And as I travel around now, I hear similar rumblings. Buprenorphine is generating a lot of enthusiasm. Let's set appropriate expectations and not hail it as the new panacea—or else, it too will fail. The wake-up call is that no single approach can possibly be uniformly applicable in a patient population as diverse as the chronic pain population. Many interventions are helpful in some pain patients. The art of pain management is in combining treatments in multimodal approaches that help our patients live better with chronic pain. Time to wake up, colleagues.

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ABOUT THE NIPC

The National Initiative on Pain Control® (NIPC®) is an integrated CME education initiative that was established in 2001 to help physicians improve outcomes for their patients who have pain. Living with pain has deleterious effects on many aspects of the patient's life including deterioration of physical functioning, the development of psychological distress and psychiatric disorders, and impairment of interpersonal functioning. Of special concern, less than optimal training of physicians in pain disorders has led to the underassessment and undertreatment of patients who are living with pain. The program heightens physician awareness of the impact of pain on the patient's daily living in terms of quality of life, lost workdays, and societal/familial consequences.

NIPC addresses the barriers to achieving pain control by providing potential pathways for action and expected amelioration of their patients' pain. By providing physicians with the latest advances and strategies in pain management, they will be better able to translate clinical data into clinical practice.

All NIPC programs are developed and continuously evaluated by the NIPC Education Council, an expert, multidisciplinary team of specialists, researchers, and practicing physicians in pain management. The NIPC Faculty includes nationally respected experts in the pain management field.

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Safety First: Prescribing Methadone for Pain

CONTINUED FROM THE COVER

Overuse in search of pain relief: Patients experiencing uncontrolled pain will take more medication than prescribed, trying to escape the pain. They may reason, in essence, if one tablet is good and two are better, then three must be great. A patient may have done this in the past with a different opioid medication, not realizing that methadone's long, variable half-life makes any deviation from the treatment plan extremely dangerous.

Mixing with alcohol or other drugs: Patients may introduce another danger when mixing methadone with other substances, particularly alcohol or benzodiazepines. Physicians may not realize the additive and potentially synergistic effect on suppressing respiration when methadone is combined with benzodiazepines and great caution is advised during combination therapy.

Too high a dose: Errors also occur when clinicians are initiating methadone therapy, making the conversion from other medications to methadone, or escalating the methadone dose while feeling falsely confident that a patient's opioid tolerance or pain status ensures safety. Although polypharmacy is responsible for most overdose deaths, it is frighteningly clear that at least a few decedents took methadone exactly as their doctors directed and died anyway.

Sleep: Recent preliminary reports suggest methadone may contribute to an increased prevalence of sleep apnea.[7] Benzodiazepines with methadone appear to be additive in their association with sleep apnea. Caution is advised when either or both drugs are used to facilitate sleep.

Misplaced faith in conversion tables: Most conversion tables use a ratio to estimate the equianalgesic dose of one opioid to another. It is often assumed that the tolerance achieved by a patient on a current regimen of opioids allows the clinician to begin methadone at a rate equal to the exact morphine equivalent. However, cross tolerance is incomplete, even for individuals currently prescribed high doses of other opioids. Therefore, it is potentially dangerous to use the equianalgesic dosing guidelines published in available conversion tables when determining the starting dose of methadone. These tables—which are designed for a single use, not for chronic administration—may also imply no upper limit exists for the starting methadone dose. This is belied by evidence that patients are at risk for overdose during the conversion period.

Cardiac arrhythmias: Methadone has been shown to produce torsades de pointes, or QTc interval prolongation.[8] This association appears to be dose related. Therefore, patients on a dose close to or above 100 mg per day should have an EKG to monitor the potential effect of methadone on the QTc interval. Other drugs known to prolong the QTc interval could produce an additive effect and thus the potential for this type of drug interaction must be considered when prescribing methadone.

> ***Clinicians should start methadone therapy with a low dose and titrate slowly to an analgesic effect.***

The FDA warning makes reference to life-threatening risks such as respiratory depression and cardiac arrhythmias in

CONTINUED ON PAGE 10

Many more studies are needed to determine the root causes of deaths involving methadone. Until more data are available, patients should be advised of a few vital yet simple steps to avoid tragedy associated with the misuse of methadone and other pain medications:

1. **Never take a prescription painkiller unless it is prescribed to you.** Everyone responds differently to pain medications. What is safe for one person may not be safe for another.
2. **Do not take pain medicine with alcohol.** Never mix the two; it is a dangerous combination that can be deadly. Alcohol increases toxicity of pain medication.
3. **Do not take more doses than prescribed.** Even after the effects of pain medicine seem to have worn off, it is still depressing the respiratory system. Some medications like methadone may relieve pain for a few hours but will have a prolonged respiratory depressant effect. The body must develop a tolerance to the respiratory depressant effects before the dose can be increased.
4. **Use of other sedative or anti-anxiety medications can be dangerous.** Combining pain medicines with other sedative drugs, such as Valium, can increase the toxicity of the pain medication. Only take other medications if directed by the prescribing doctor.
5. **Avoid using narcotic medications to facilitate sleep.** Narcotic medications can suppress respiration during sleep. Speak to your physician about safe methods to manage pain during sleep.
6. **Lock up prescription painkillers.** If consumed by children or other family members, or stolen and sold on the street, prescription pain medicine can kill.

Chronic Pain Impacts Patients' Lives: Results of a National Survey

Mark Palangio, MS, *Senior Medical Writer, Thomson Professional Postgraduate Services®, has indicated that he has no relevant financial relationships to disclose.*

Introduction

Chronic pain affects millions of individuals in the United States and is responsible for physical disability, loss of productivity, and diminished quality of life. Causes of persistent pain include such chronic disorders as cancer, arthritis, and diabetes, as well as injuries, such as a herniated disc or torn ligament. The main treatment goals for chronic pain are relief and improved function. Pharmacotherapy is the cornerstone of chronic pain management, and numerous agents are available, including opioid, non-opioid, and adjuvant analgesics. Virtually all types of pain respond to opioids, which are frequently used to treat moderate-to-severe pain that is unresponsive to non-opioid therapy alone. Unfortunately, many people who have chronic pain avoid using opioids because of long-held misconceptions.

Survey Methods

To better understand attitudes and unmet needs among individuals with chronic pain who use opioids for pain management, the American Pain Foundation (www.painfoundation.org) conducted a national Internet survey, known as the *Voices of Chronic Pain*.[1,2] The specific objectives of this survey were to determine:

- Degree of pain control
- Severity, duration, and frequency of pain
- Physical, social, and psychological effects of chronic pain
- Impact of chronic pain on daily life
- Attitudes toward opioids

In this survey, chronic pain was defined as pain recurring monthly or more frequently that required treatment by a physician or other healthcare professional. The survey consisted of a written questionnaire of 35 multiple-choice questions and was administered by a national public opinion polling firm between May 2 and May 8, 2006.

Respondents participating in the survey were screened for the following criteria:

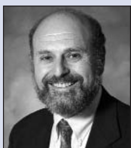
- Aged 18 years or older
- Experienced pain on a regular basis
- Visited a physician or other healthcare professional in the past 12 months
- Prescription pain medication use on a weekly basis or more frequently
- Opioid use

The final sample included 303 people with chronic pain who are using opioid therapy. In this study group, the mean age was 50 years, 52% were women, and 70% were employed full-time.

Most Common Treatments for Chronic Pain

Most of these people with chronic pain were under the continuing treatment of a healthcare professional. In this sample, 71% reported having been to a physician or other healthcare professional in the

The Imperative for Managing Pain



Arthur G. Lipman, PharmD, FASHP, Professor of Pharmacotherapy, College of Pharmacy; Adjunct Professor of Anesthesiology, School of Medicine; Director of Clinical Pharmacology, Pain Management Center, University Healthcare, University of Utah Health Sciences Center, Salt Lake City, Utah
Editor, *Journal of Pain & Palliative Care Pharmacotherapy*

Dr Lipman has indicated that he receives grant/research support from Medgenex Inc and Progenics Pharmaceuticals Inc; is a retained consultant for Endo Pharmaceuticals, Pfizer Inc, and Merck & Co Inc; and is a member of the speakers bureau for Endo Pharmaceuticals and Purdue Pharma.

In 1987, John Liebeskind and Ronald Melzack wrote that they were "appalled by the needless pain that plagues the people of the world, in rich and poor nations alike. By any reasonable code, freedom from pain should be a basic human right limited only by our ability to achieve it."[1] When these great pioneers in pain research wrote these words two decades ago, clinicians and scientists knew relatively little about pain management, compared with our current knowledge and armamentarium of drugs and interventions. Yet, one might ask whether this new information and available treatments for pain have been used to better educate the public and improve patient outcomes.

The recent *Voices of Chronic Pain* study, a national survey of chronic pain patients currently taking opioid analgesics (see article beginning at top of this page), provides important contemporary data on pain and its management in the United States. The study clarifies several important and often misunderstood concepts. For example, breakthrough pain requiring rescue doses of strong analgesics is common in chronic nonmalignant pain, not just in cancer pain. The study also documents what many of us have already suspected: low back pain is the most common type of chronic pain, and opioids are important medications that dramatically improve many patients' quality of life and are safe and effective when used properly. Yet the study revealed that many patients are hesitant to use opioids and/or feel stigmatized when they do so. Over a quarter of the patients (28%) who

past month and 22% within the past 3 months.

On average, respondents took a prescription medication almost 3 times each day, with 12% taking the medication more than 4 times a day, 43% of respondents 3 to 4 times a day, and 27% at least twice a day. Moreover, 44% took a prescription nonsteroidal anti-inflammatory drug and 20% reported using cortisone. Over-the-counter products were used by 31% of respondents.

Hydrocodone/acetaminophen (Vicodin®) was the most common opioid analgesic, with 45% of respondents reporting use of this product. The next most common opioid analgesics were oxycodone/acetaminophen (Percocet®) and controlled-release oxycodone (OxyContin®), which were taken by 18% and 16% of respondents, respectively.

Degree of Chronic Pain Control

Low back pain was the most common form of chronic pain reported, with 96% of respondents experiencing this type of pain on a regular basis. Other types of chronic pain included joint pain (90%), muscle pain (88%), arthritis (82%), neck pain (80%), upper back pain (77%), pain related to other medical treatment (68%), and headaches and migraines (65%).

A striking finding of this survey was that chronic pain control is far from optimal, despite treatment with opioids. Surprisingly, severe pain was reported by 91% of respondents. Fibromyalgia (75%) was the most common type of severe pain; chest pain (69%), low back pain (65%), joint pain (42%), pain related to medical treatment (41%), headaches or migraines (36%), neck pain (36%), and arthritis (34%) were also reported.

Almost all respondents (99%) stated they experienced multiple types of severe pain. On average, more than 8 different types of chronic pain were experienced on a monthly basis or more frequently, with more than 3 of these pain states considered severe. Respondents also reported having lived with these chronic

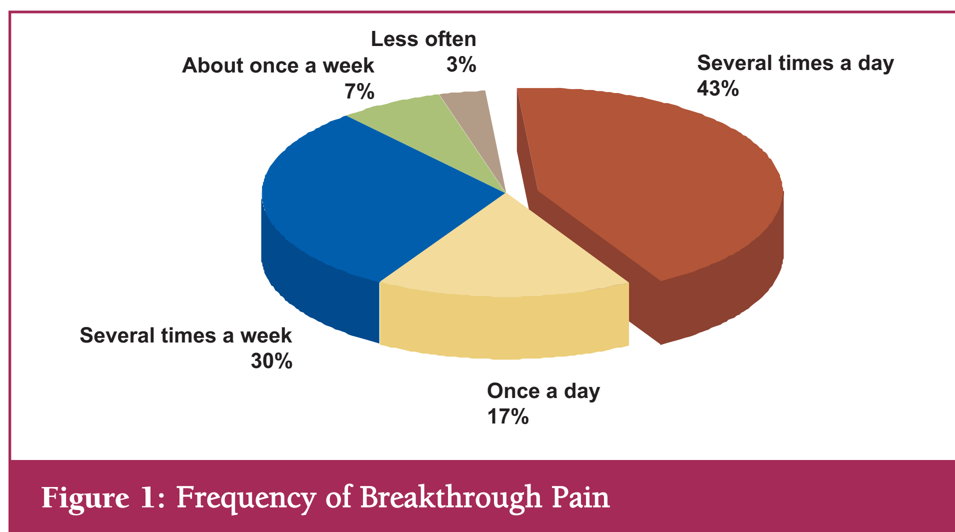


Figure 1: Frequency of Breakthrough Pain

require opioid analgesics do not tell others that they take these medications because of the fear of being stigmatized.

Unfortunately, a mythology about opioids has developed, causing fear among patients, their families, clinicians, and policymakers about opioid use. Ironically, opioids, when used properly, often are safer for chronic use than nonprescription nonsteroidal anti-inflammatory drugs or acetaminophen.

Many Americans consider chronic pain a sign of weakness.

In fact, several recent studies have shown the serious risks and complications surrounding the use of these over-the-counter medications.[2-4] On a more positive note, some organizations that have discouraged opioid use in the past have modified their positions. In its 1997 public policy statement, the American Society of Addiction Medicine recognized that drug-seeking behavior may not indicate substance abuse but may, in fact, be due to "pseudo-addiction." [5] However, other entities, most notably the US Drug Enforcement Administration, continue to suggest that legitimate opioid use in medical care may lead to substance abuse. The facts do not support the latter contention.

It is tragic that many Americans regard chronic pain as a sign of weakness rather than as a disease. It has been documented that 25% of American adults have experienced pain lasting at least 1 day and 10% have experienced chronic pain persisting for at least one year.[6] The majority of chronic pain patients can function with appropriate, multimodal management that typically

Are healthcare professionals contributing to incorrect and harmful attitudes about pain?

includes both pharmacotherapy and non-pharmacologic approaches. Rarely is medication alone sufficient; indeed, self-management, including stretching, strengthening, and other techniques, is

pain conditions for many years, in many instances more than a decade. The longest reported chronic pain condition was headaches or migraines, which on average persisted almost 16 years.

Controlling breakthrough pain or severe pain flares was rated "important" by 96% of respondents and "very important" by 79%. However, patients continued to have frequent episodes of breakthrough pain or severe flares on an average of twice each day, or about 14 times each week. Furthermore, breakthrough pain was experienced by 97% of patients at least weekly and 60% at least once daily (Figure 1). Only 6% reported having a "great deal of control" over their pain. Additionally, 51% stated that they have "only a little" or "no control" over their chronic pain.

Impact of Chronic Pain on Daily Life

In this survey it was apparent that chronic pain affected all aspects of daily life, as evidenced by the 97% of respondents reporting either a physical or social hardship as a direct result of their pain. The most common limitation was difficulty walking or moving, as reported by 89% of respondents. Additionally, 86% stated inability to sleep, and 77% reported feeling depressed. Many also described symptoms of depression, including an inability to concentrate (70%), strained relationships (52%), and loss of appetite (46%) (Figure 2).

Notably, 67% of those mentioning depression as a result of pain were receiving some form of treatment for depression. Moreover, most patients (59%) indicated an impact on their overall enjoyment of life.

Chronic pain also had other negative effects on daily life. Among respondents, 67% stated that they "strongly agree"

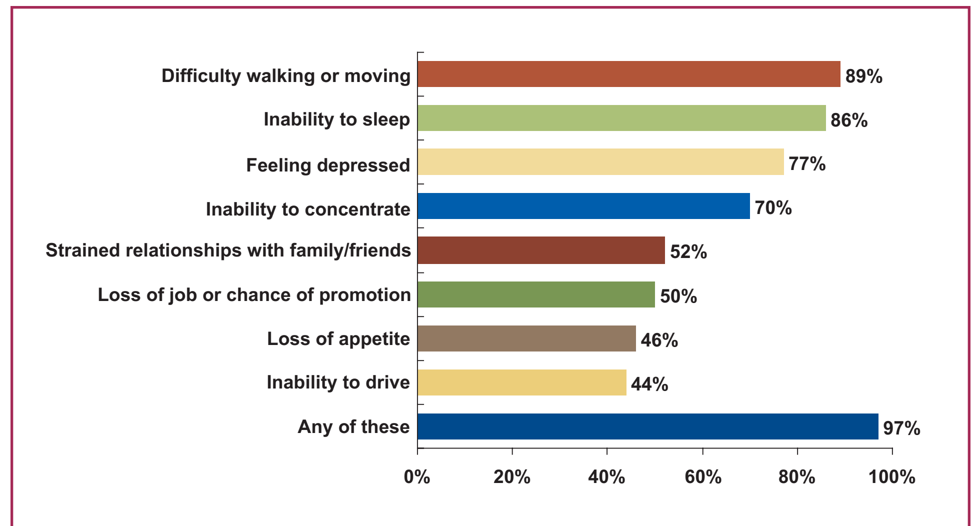


Figure 2: Occurrences as a Result of Chronic Pain

often crucial for pain relief. Those of us who practice in chronic pain management programs rarely "fix" our patients' pain. Rather, with our help, patients manage their pain. However, for them to do so effectively, strong analgesics often are required.

The *Voices of Chronic Pain* study confirms the significant hardships, such as physical limitations and negative effects on social life and well-being, that chronic pain patients experience. Of interest, 97% of chronic pain patient respondents who were currently using opioids for pain management reported a physical or social hardship as a direct result of their pain. Although these patients need these medications to function, fewer than half (48%) "strongly agreed" that opioids are "safe to take."

Chronic pain seldom occurs without comorbidities.

We must ask ourselves where patients are getting these messages. Are healthcare professionals contributing to these incorrect and harmful attitudes? Regrettably, nearly every pain clinician knows physicians, pharmacists, nurses, psychologists, or other health professionals who overtly or subtly support mistruths about opioid use. Not surprisingly—but very disappointingly—only 48% of the respondents taking opioids believed that they were getting sufficient information from their healthcare professionals about these medications, and nearly 40% reported that they did not receive enough information to meet their needs.

Chronic pain seldom occurs without comorbidities. *Voices of Chronic Pain* reveals that more than three in four (77%) chronic pain patients taking opioids experience depression. Antidepressant pharmacotherapy can be helpful, but good support systems and counseling also are needed. If society stigmatizes these patients and reinforces the negative stereotypes often associated with opioid use, depression is usually worsened.

When 15 other healthcare professionals and I were invited to Washington in August 1990 to serve on the Pain Management Guideline Panel of the Agency for Health Care Policy and Research of the US Public Health Service,

that they become upset when they experience limitations because of their pain, and 33% stated that they "strongly agree" that there may not be a real solution for their pain. Nearly 70% of respondents felt that their chronic pain greatly impacted their work, with 50% reporting job loss because of chronic pain.

Patient Attitudes Toward Opioids

In this survey, patient attitudes toward opioids were mixed. On average, 48% reported that they "strongly agree" that opioids are "safe to take" if given the instructions of healthcare professionals. Regarding the issue of safety, 31% of respondents believed that opioids are "very safe," as opposed to 14% who stated that opioids are dangerous. However, among these individuals with chronic pain, 38% reported that they "strongly agree" that it is "hard to consistently control pain" with opioids.

As to efficacy, a total of 86% of respondents rated opioids as "very effective" or "somewhat effective" and only 9% stated opioids were "ineffective" (Figure 3).

There also appeared to be a stigma associated with opioid use. In this group, 29% of respondents reported that they do not tell others that they take these medications, with privacy being the most common reason, although 66% stated that they do let others know that they take opioids to manage their pain. Respondents also mentioned that they were afraid of what others may think (17%) or that others may ask to share the medication (17%) versus 57% who do not share this information because of privacy issues (Figure 4).

Despite these negative attitudes, patients typically considered opioids convenient to use, with 43% stating that these medications were "very convenient." However, many expressed that they would prefer a less frequent dosing regimen, with 46% desiring twice or once daily administration.

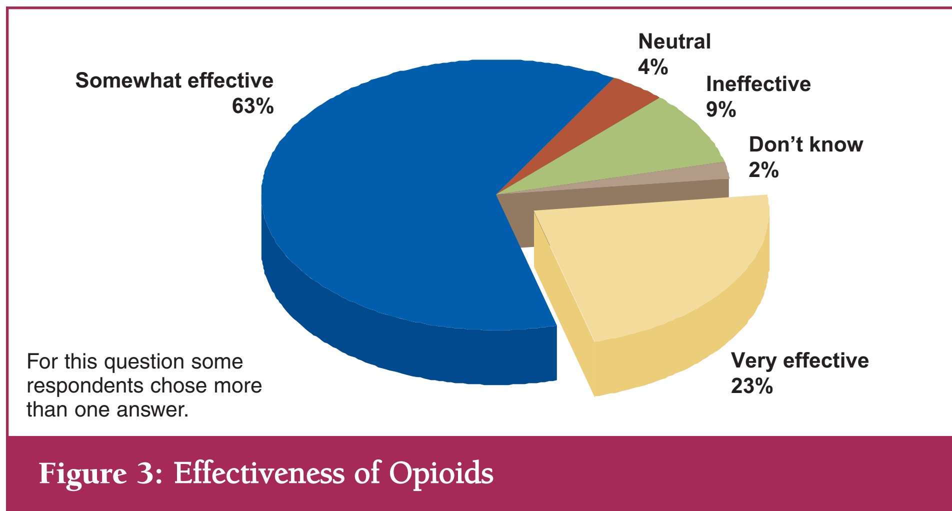


Figure 3: Effectiveness of Opioids

none of us fully appreciated the serious adverse sequelae of undertreated pain. A team of research librarians from the National Library of Medicine assisted us in researching the world pain literature. To our surprise, a large body of literature revealed that serious physiologic, psychologic, and even immunologic outcomes result from undertreated pain. Adverse physiologic outcomes include catabolism, increased risk of thromboembolic events, autonomic stimulation that produces cardiovascular risk, salt and water imbalances, and slowed gut motility that impairs absorption of orally administered medications. Psychologic outcomes include anxiety, depression, sleep disturbance, and existential issues. In addition, pain impairs the immune response, most notably by decreasing natural killer cell counts.[7,8]

> ***Good patient care must be based on a favorable risk-to-benefit ratio.***

While all drugs have some inherent risks, good patient care must be based on a favorable risk-to-benefit ratio. When we understand the very real risks of undertreated pain, we realize that some risk from interventions to manage the pain is acceptable. When used properly, opioids have relatively low risk after the first week of regularly scheduled therapy, which is when tolerance to respiratory depression occurs. In fact, most opioid side effects lessen after a few days of regularly scheduled therapy and can usually be managed with patience and symptomatic medications such as antiemetics for a few days and regular use of stimulating laxatives.

It is unfortunate that some interventional pain clinicians often discourage opioid use in favor of highly remunerative interventions. Some managed care organizations and health insurance plans question and discount well-proven opioid pharmacotherapy while at the same time unquestioningly approving unproven and even some disproven

> ***Pain management is a team sport because it is multidisciplinary, multimodal, and collaborative.***

The survey also underscores the desire for new pain management options. Most respondents (77%) stated that they "agree" with searching for new options to control pain, and only 14% stated that they "strongly agree" with being satisfied with current medications. The majority of respondents (52%) also felt that they were receiving less than the optimal level of information on how to manage chronic pain.

Conclusions

Chronic pain continues to be a difficult therapeutic challenge. This survey revealed that, despite being under medical care and receiving opioid therapy, patients with chronic pain needlessly suffer. Severe pain was reported by the vast majority of opioid users, and breakthrough pain was experienced at least weekly by virtually all respondents. Most respondents believed that they do not have full control over their chronic pain. Such evidence suggests that many of the treatment options given to these patients are ineffective.

The survey also depicts chronic pain as a condition that pervades all aspects of patients' daily lives, including physical functioning, work, interpersonal relationships, and psychological well-being. Negative patient attitudes toward opioids are significant barriers to adequate pain management. Less than one third of respondents considered opioids to be very safe, and nearly one third were concerned with being stigmatized by opioid use. Clearly, better efforts are needed on the part of healthcare professionals in dispelling patient misconceptions, as well as applying proven concepts of chronic pain management to every-day clinical practice.

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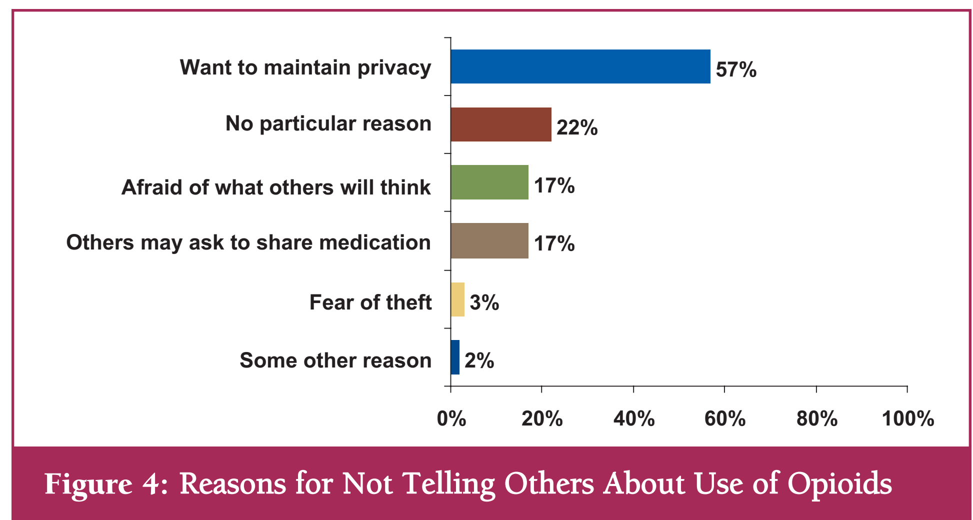

Figure 4: Reasons for Not Telling Others About Use of Opioids

interventional procedures. Increased advocacy for pain patients and appropriate, evidence-based pain management is needed. Organizations such as the American Pain Foundation are heeding the call for this important work. The *Voices of Chronic Pain* study provides valuable data that will further enable such groups to advocate for improved pain control.

When valuable tools such as the *Voices of Chronic Pain* report become available, it is incumbent upon all of us who work in this field to disseminate the information to increase public awareness and knowledge about pain, and to lobby policymakers and legislators for improved pain management. We often say that pain management is a team sport because it is interdisciplinary, multimodal, and collaborative. This study provides valuable information that better arms us to dispel myths about pain, understand the patients who suffer from it, and become aware of the effective treatments that are available but are often underused because of false beliefs.

The expression that "the pen is mightier than the sword" is hackneyed but nonetheless remains true. If we have to fight to improve pain management in American society, the *Voices of Chronic Pain* study provides valuable ammunition to support our cause.

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- Apply the basic documentation and medico-legal requirements necessary to support appropriate opioid prescribing

SCHEDULE

SPEAKER	DATE	CODE	TIME			
			EASTERN	CENTRAL	MOUNTAIN	PACIFIC
Cole	Thursday March 15, 2007	B160-01	7:00 PM	6:00 PM	5:00 PM	4:00 PM
Moskowitz	Monday, March 19, 2007	B160-02	12:00 PM	11:00 AM	10:00 AM	9:00 AM
Cole	Monday, March 19, 2007	B160-03	7:00 PM	6:00 PM	5:00 PM	4:00 PM
Chevlen	Tuesday, March 20, 2007	B160-04	8:00 PM	7:00 PM	6:00 PM	5:00 PM
Chevlen	Wednesday, March 21, 2007	B160-05	9:00 PM	8:00 PM	7:00 PM	6:00 PM
Fine	Thursday, March 22, 2007	B160-06	12:00 PM	11:00 AM	10:00 AM	9:00 AM
Cole	Monday, March 26, 2007	B160-07	7:00 PM	6:00 PM	5:00 PM	4:00 PM
Moskowitz	Tuesday, March 27, 2007	B160-08	9:00 PM	8:00 PM	7:00 PM	6:00 PM
Fine	Wednesday, March 28, 2007	B160-09	8:00 PM	7:00 PM	6:00 PM	5:00 PM
Fine	Thursday, March 29, 2007	B160-10	12:00 PM	11:00 AM	10:00 AM	9:00 AM

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Safety First: Prescribing Methadone for Pain

CONTINUED FROM PAGE 3

patients receiving methadone. The reasons for some of these risks could encompass several factors such as methadone interactions with concomitant medications, sleep apnea, and the time of the last daily dose in relation to the onset of sleep.

Until more research is available to clarify the risk factors, clinicians should start methadone therapy with a low dose and titrate slowly to an analgesic effect. As with all opioids, the starting dose of methadone depends on the patient's age, degree of opioid tolerance, severity of pain, concomitant medications, and general health. Yet methadone's pharmacologic properties call for a conservative approach for even the most opioid-tolerant patients. Careful monitoring of the individual patient's response is key.

Dose changes should not occur more often than weekly, to allow a steady state of methadone to develop and for the peak side effects to become evident.

The FDA advisory refutes dosing recommendations that were too lenient in the past and may have led practitioners to prescribe pain medication at higher-than-safe dosages. For now, safe practice supports starting the conversion with a ceiling dose of no more than 30 mg/day (10 mg/day for elderly or infirm patients). Dose changes should not occur more often than weekly, to allow a steady state of methadone to develop and for the peak side effects to become evident. If patients are taking concomitant benzodiazepines, the starting dose and speed of titration may need to be adjusted downward.

For patients who are being converted from another opioid to methadone, clinicians should slowly titrate the other opioid downward as they slowly titrate methadone upward. This practice will minimize the risk of unintentional overdose by the patient who is trying to control his or her pain but finds methadone only works for 4 to 6 hours.

Patient counseling must include an emphasis on following all medical instructions to the letter: no escalation of doses and no mixing of methadone with other prescriptions, alcohol, or illicit substances. Patients should be warned that any deviation in this regard can be fatal.

These guidelines represent a more conservative recommendation than is seen elsewhere. Certainly, some patients are able to tolerate a much more rapid conversion or titration. Nevertheless, given the reports of deaths associated with methadone, these starting guidelines should help clinicians ensure patient safety and give methadone pain therapy a greater chance of success.

The FDA advisory emphasizes the importance of knowing the signs of methadone overdose and getting medical attention immediately if any of the following occur:

- Trouble breathing or shallow breathing
- Extreme tiredness or sleepiness
- Blurred vision
- Inability to think, talk, or walk normally
- Feeling faint, dizzy, or confused

Banning methadone for pain is not the answer. Methadone has proved to be an effective treatment for several chronic pain conditions. It has excellent bioavailability, is a good match with most short-acting opioids used to treat breakthrough pain, is very affordable, and possesses long-acting pharmacologic properties that make it especially attractive for treating pain patients at risk for abusing prescription opioids. Its continued value as an analgesic depends on clarifying methadone's unique properties to all practitioners who use methadone to treat pain. Because many thousands of people are still undertreated for pain, these problems must be swiftly addressed and a national education program launched now. ☙

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EDITOR'S NOTE: *Dr Lynn R. Webster, President of the Utah Academy of Pain Medicine and Medical Director of Lifetree Clinical Research® & Pain Clinic in Salt Lake City, began a national educational campaign last year to inform doctors, people with chronic pain, and communities across the country about the increasingly serious issue of unintentional overdose deaths with prescription medications, including methadone. He also recently formed a 501 C 3 organization with a mission to educate physicians, patients, and communities on health issues, with an emphasis on pain-related education and research to offer solutions.*

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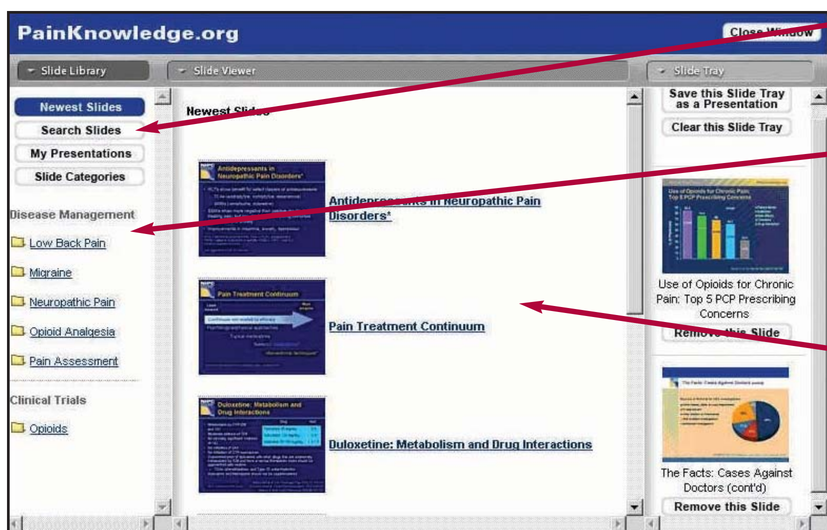

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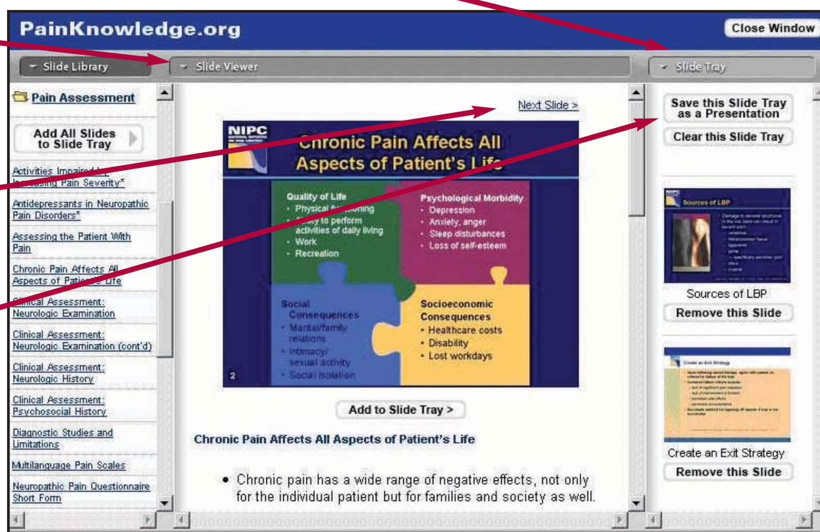

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