chronic pain was internationally recognized as a major health care problem and a disease in its own right. Today, countless medical experts and health agencies contend that chronic pain should be treated with the same priority as the disease that caused it.

History of Standards

The creation and endorsement of formal guidelines for the use of opioid analgesics in chronic pain management is relatively new. The American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) issued a statement in 1996 to define when and how opioids should be prescribed for patients with chronic pain. Despite this formal position, pain continued to be under-treated due to fears of legal and criminal liability for prescribing controlled substances. This prompted the development and 1998 adoption of the Model Guidelines for the Use of Controlled Substances by the Federation of State Medical Boards of the United States. This document, which became policy in 2004, defines when opioids are appropriate for acute and chronic pain and details patient monitoring to deter drug diversion.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has issued standards on pain assessment and management. The standards, which took effect in 2001, state that all patients have the right to appropriate assessment and management of pain; that all patients should be assessed for pain and receive individualized care; that response to treatment should be monitored; and that treatment plans should be modified when necessary.

Although the JCAHO standards provided a formal framework for pain management, they did not stipulate how appropriate management would be achieved, and a number of guidelines were subsequently issued. The prevalence of guidelines and JCAHO standards today means that failing to prescribe appropriate medications constitutes undertreatment of pain and a departure from acceptable standards of practice.

Opioid Need

An analysis of international studies shows that 1 in 5 adults and 1 in 3 older adults experience moderate to severe pain lasting more than 3 to 6 months. A study of more than 3,500 primary care patients in the United Kingdom found that about half reported pain lasting more than 3 months.

And an international study that included the United States revealed that about 20% of more than 5,000 primary care patients experienced pain for more than 6 months. Put in everyday terms, as little as 1 in 10 and as many as 1 in 2 patients who present to a health care provider may have chronic pain.

Trends in Prescribing

Arthritis and other musculoskeletal disorders are the most frequently mentioned chronic health conditions significant enough to result in activity limitations among U.S. adults ages 18 to 64.

An analysis of office visits and opioids prescribed for patients with musculoskeletal disorders in 1980 and 2000 revealed that office visits did not increase for these conditions. This analysis, which was based on data from the National Ambulatory Medical Care survey, also revealed that prescriptions for opioid analgesics for chronic pain doubled (8% to 16%), and the use of stronger opioid analgesics quadrupled (2% to 9%).

The increase in opioid analgesic prescriptions is a sign that progress has been made in pain management. However, this trend has not allayed concerns that increased use of opioids would lead to more opioid abuse and addiction. As a result, studies were conducted to identify any abuse of opioid analgesics.

Opioid Use and Abuse

Three studies used two sources of data to analyze medical use and abuse of opioid analgesics from 1990 to 2002. These datasets included the Drug Enforcement Administration’s Automation of Reports and Consolidated Orders System (ARCOS) and the Substance Abuse and Mental Health Services Administration’s Drug Abuse Warning Network (DAWN) for medical use and abuse.

The first study analyzed use and abuse of fentanyl, hydromorphone, oxycodone, morphine and meperidine from 1990 to 1996. Increased medical use did not appear to contribute to opioid analgesic abuse. The second study examined the use of fentanyl, morphine and oxycodone from 1997 to 2001 and documented similar results: Abuse was low despite increased medical use. The last study analyzed fentanyl, hydromorphone, oxycodone, morphine and meperidine from 1997 to 2002. Increased medical use was associated with increased abuse but remained a small part of total DAWN mentions.

The increased use and greater availability of opioid analgesics for legitimate medical purposes further indicate progress in pain management. Increased opioid abuse, albeit a relatively small part of total abuse as defined in the three studies, emphasizes the need for continued vigilance to minimize nonmedical use.

Evaluating for Opioid Use

Addressing a patient’s right to pain management and developing an appropriate treatment plan begin with a thorough evaluation of the patient and his or her pain complaint. This can be accomplished by focusing on four objectives:

- Determine whether an appropriate workup has been completed and whether additional studies are warranted. Rule out any occult cause for pain, and identify any other etiologies.
- Establish whether opioid analgesic use is indicated. Inadequate response to all

### Table 1

<table>
<thead>
<tr>
<th>Relative Contraindications (use only after careful consideration of risks and benefits)</th>
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<tbody>
<tr>
<td>• Unwilling or unable to comply with treatment plan</td>
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<tr>
<td>• Unable to manage therapy responsibly</td>
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<tr>
<td>• Social instability</td>
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<tr>
<td>• Acute psychiatric instability or high suicide risk</td>
</tr>
<tr>
<td>• Substance abuse including alcohol (recent or past)</td>
</tr>
<tr>
<td>• Current substance use disorder according to DSM-IV criteria (excluding caffeine and nicotine)</td>
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<tr>
<td>• Pregnancy</td>
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<tr>
<td>• Suspected illegal activity</td>
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<th>Absolute Contraindications (should not be used)</th>
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<tbody>
<tr>
<td>• Absence of pathology</td>
</tr>
<tr>
<td>• Illegal activity: active diversion, prescription forgery, active or recent illicit drug use, history of significant illegal activity</td>
</tr>
<tr>
<td>• Active untreated addiction</td>
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<tr>
<td>• Current substance abuse, including alcohol</td>
</tr>
<tr>
<td>• Buprenorphine + naloxone therapy (partial mu opioid agonist prescribed for and approved for opioid dependence only)</td>
</tr>
<tr>
<td>• Naltrexone therapy (opioid antagonist prescribed for treatment of alcohol or opioid dependence only)</td>
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*Reflects difference in opinion among health care providers.*