



Readers' Comments

To the Editor:

I would like to commend Dr. Gilbert *et al.*, "The Ten Cs of Chronic Noncancer Pain: Universal Precautions for the Treatment of the Chronic Noncancer Pain Patient" (*AJPM* 2005; 15(1):22-32) on their overview of the complex nature of comprehensive chronic noncancer pain management. As a practitioner in this field, I agree with much, if not most, of what they wrote, and I am highly envious of their statewide KASPER system which tracks patients' use and, when detected, their abuse of medications. I look forward to the day that my state of Florida adopts such a progressive and essential tool for the safety of both patients and physicians.

In contrast, however, I would like to note that their patient treatment contract (pages 28-29), contains language in points 8 and 9 which I find counterproductive to good pain management. These points, in summary, state that if a patient runs out of medication earlier than their next scheduled refill, then no medication will be dispensed to them before the next refill date. In other words, if they lose, over-use, sell, or share their medication, then they will have to go without medication until their scheduled refill date. I believe it to be unacceptable medical practice to actually enforce such rules.

As I outlined in my article "Patient Compliance Coding: Controlling Patient Access to Narcotic Medication – One Physician's Experience" (*AJPM* 2004; 14(3):97-106), if we prescribe pain medications to a patient, then, as physicians, we have a moral and legal responsibility to safeguard them from harm. However, if a patient runs out of pain medication early, and we force them to go without it until their next scheduled refill date, we are potentially casting them into a state of withdrawal which may, for patients with critical co-morbidities, be a fatal error. Instead, what we should do is grade our patients compliance as outlined in my article, and only

allow them to possess at any one time the amount of medication for which they can demonstrate compliant responsibility.

I do understand my colleagues' good intentions of attempting to thwart patient mis-use of pain medication by incorporating points 8 and 9 into their treatment contract. In actuality, however, both patients and physicians are better served by acknowledging the variable nature of patient compliance and tailoring each patient's treatment to their individual abilities through patient compliance coding.

—Robert Ben Mitchell, DO
North Miami, Florida

RESPONSE

To the Editor:

I appreciate the response by Robert Ben Mitchell, DO, of North Miami, Florida, and his thoughtful opinions regarding our article "The Ten Cs of Chronic Non-Cancer Pain: Universal Precautions for the Treatment of the Chronic Non-Cancer Pain Patient" (*AJPM* 2005; 15(1):22-32). I agree with Dr. Mitchell that all care to patients should be individualized. If a patient runs out of medication earlier than the next office visit for what appears to be a legitimate reason, than it is perfectly acceptable pain management practice to provide that patient with relief.

Acute pain in any individual should be treated appropriately, even with opiates, if indicated. The guidelines we have published are strictly for *chronic non-cancer pain*. However, these patients should also receive help for acute pain. If, for example, we receive a call from an emergency room physician who feels that a

chronic non-cancer pain patient has a legitimate acute problem requiring breakthrough pain medication, such as a fracture or sprain, then we would approve an acute breakthrough pain medication to treat that individual appropriately until the next office visit. Even a patient in a methadone clinic for opiate addiction who presents with a condition such as an acute cervical disc rupture requiring surgery should be given the usual postoperative pain medicine for the acute problem along with the regular dose of methadone. Once such a patient is discharged from the hospital, that patient should return to the methadone clinic. If an increase in the patient's chronic pain medicine is required to treat an acute disorder, we would cancel the refills on the smaller dosage because we prefer not to have any overlapping prescriptions for the same type of medication. Alternatively, we might write an order for a different type of medication for the acute disorder to avoid overlapping prescriptions of the same medicine.

Certainly, in a patient with a critical co-morbidity, the guidelines may not be strictly enforced. However, in over 15 years of private practice, I have not had a patient who had a medical complication from narcotic withdrawal. Indeed, narcotic withdrawal is fairly safe compared to sedative withdrawal. Even on therapeutic doses of sedatives, however, most patients experience only mild to moderate symptom rebound, which disappears within a few weeks, and in such cases, no special treatment is needed (1).

I think the real point of the research is the utility of urine drug screens and prescription monitoring programs. These programs are probably the best tools we have to detect patient non-compliance. While the prevalence of opiate addiction in society may be in the range of only 6%, the prevalence of recreational abuse and use of other medications, including THC, cocaine, and illicit narcotics make the treatment of chronic non-cancer pain patients a complex proposition. Polysubstance abuse is the norm rather than the exception. In 1981, the Department of the Navy found that 47% of sailors had abnormal urine drug screens; and since sailors come from the general population, this finding points to a high prevalence of recreational drug use and abuse. By the year

2000, after the institution of urine drug screening, the rate of positive screens had dropped to 1%. These findings led to the initiation of the Federal Workplace Drug Testing Program (2).

In any case, it is clear that in society there is a high prevalence of recreational use and abuse of a variety of medications and substances, and it is clear that urine drug screening is probably the best test to detect and deter. In fact, a recent Supreme Court decision has cleared the way for urine drug testing in public schools (3). Since it is well known that most addictions start at a young age, someday urine drug testing should be extended to all children, perhaps as early as middle school. Such testing may prevent many problems before they start. I believe that drug screening should not only be used by all pain clinics but should also be extended into the general population. Stopping problems before they start will make the treatment of chronic non-cancer pain much easier. Abnormal urine drug screens should not be used to punish a student or patient, but rather as an opportunity to guide them to treatment.

Likewise, the Kentucky All Schedule Prescription Electronic Reporting System (KASPER) should be extended nationwide (NASPER). Kentucky has the unfortunate notoriety of some of the highest rates of prescription drug abuse per capital in the country, even though it has been one of only two states to monitor all schedules of prescription medications. Improvements in the prescription monitoring system, such as allowing methadone clinics, emergency rooms, and VA hospital emergency rooms and clinics to report to this system will only improve the care of all patients. Patients with the disease of addiction frequently turn to such places as an alternative source to obtain medications. It is well known that less than 20% of patients with the disease of opiate addiction are in treatment, and 70% of patients being treated for opiate addiction in a methadone clinic will relapse in the first 90 days. The KASPER system is the best way to detect those relapses, which will continue to go unchecked without an appropriate system in place. Obviously, the identities of patients in methadone clinics and the identities of their physicians should be protected. However, this protection could be achieved through

KASPER by listing the patient's primary care provider. KASPER is a great program, and these improvements will make it an even more successful program for detecting non-compliance.

Urine drug screen and prescription monitoring programs are the best tools available to the pain practitioner to detect and deter substance/drug use, abuse, relapse, and other diseases of addiction, and they should be extended. The challenge facing today's pain practitioner is not the risk of initiating opiate addiction – since this is rare – but the high prevalence in society of recreational use and abuse of substances and drugs in patients being referred for pain management.

—John W. Gilbert, MD
Lexington, Kentucky

REFERENCES

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