

# Effective Management of Chronic Pain in the Methadone Maintenance Patient

Chronic pain may be defined as a condition in which the perception of pain is of sufficient duration — greater than six months — and of sufficient intensity to interfere significantly with daily function and general wellbeing.

As more than 60 per cent of MMT patients have chronic pain, it is important to know that chronic pain cannot be cured, but it can be treated even though treatment may be considered controversial.

It is common for patients with chronic pain to develop problems with opioids. Sometimes the use of opioids becomes so uncontrolled that the risk associated with opioid use outweighs the benefit. In this instance, MMT may be a way of reducing the risk to the patient. However, physicians should be aware that daily methadone therapy, as prescribed in an MMT program, is not a treatment for chronic pain.

It is important to consider that different circumstances and desired endpoints will require different reasons for methadone titration. For example, with an Opioid Dependence Disorder (ODD), it may be to reduce craving, improve function in chronic pain or reduce pain in palliative care.

Each situation is distinctive and every MMT patient who complains of chronic pain needs to be thoroughly assessed before receiving treatment. This is particularly crucial when the treating physician contemplates opioid analgesic therapy. For the most complex cases, consulting physicians or multidisciplinary teams experienced in

## Physicians should consider the following when dealing with MMT or other high risk patients with chronic pain:

1. Take a detailed, complete history of the pain disorder,
2. Take a detailed, complete history of the substance dependence disorder(s),
3. Develop a detailed plan for dealing with the pain complaints,
4. Maximize use of adjuvant medications before an opioid trial,
5. Consider use of long acting opioids, if an opioid must be used,
6. Use highly controlled dispensing intervals such as daily dispensing,
7. Consider use of pill counts to reduce likelihood of diversion,
8. Ensure initial and regular urine toxicology testing to check for use of drugs or other non-prescribed medications,
9. Create a clearly-understood agreement, often written, with the patient

the management of dual diagnosis (pain and addiction) should be sought.

Recognizing that specialist resources are limited, physicians should consider additional training in the field of chronic pain and ODD to develop some degree of expertise in the assessment and safe management of these patients. This reduces the risk of sporadic or interrupted care for MMT patients.

In ideal circumstances, the less opioids used in treatment, the better. Once a patient is stabilized on MMT, non-opioid and other non-pharmaceutical interventions can be tried and are often effective. However, if

- that delineates expectations, roles and responsibilities of all involved parties,
10. Ensure open and timely communication amongst all treatment providers and the patient – the MMT program, the chronic pain clinic, the primary healthcare provider, and others,
  11. Monitor quality of recovery activities,
  12. Be aware that problematic opioid usage has existed, exists, or may exist again, and appropriate steps must be taken to reduce the harm associated with such usage. Optimum improvement in comfort and function is the primary objective.
  13. If suspicions are high, default to treatment of the most dangerous disease, i.e. addiction,
  14. Seek assistance from the multidisciplinary teams of the MMT program and/or the chronic pain clinic to provide the patient with the best possible care.

the use of non-opioid adjuvant therapy fails to improve functionality and/or provide adequate comfort then a trial opioid therapy should be considered.

The CPSA is currently enhancing the Guidelines for the Management of Chronic Non-cancer Pain. These guidelines will facilitate an effective approach to dealing with chronic pain, including the MMT patient.

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