Guest editorial:

Multidisciplinary pain clinics versus opioid treatment for chronic pain: Collaborators or antagonists?

Jennifer Schneider, M.D.

Published in Practical Pain Management, Nov-Dec 2008, p. 38

A recent letter from me, published in PPM, has aroused some reader comment regarding the roles of multidisciplinary pain clinics and pain management physicians like myself who use an armamentarium of pain medications for the treatment of chronic pain. For example, Dr. William Dicks Director of Chronic Pain and Behavioral Health Management Services at Bemidji Meritcare in Minnesota wrote, "In this clinic we stress the importance of getting rid of opioids." He states he often tells patients, "If I didn't really care about you I would give you narcotics." To this end, he laudably provides psychotherapy, physical therapy, occupational therapy, spiritual counseling, biofeedback, mind-body meditation, nutritional therapy, and consultations with various surgeons, internists, and neurologists. Physicians such as Dr. Dicks measure their success by the percent of patients who are discharged off opioids. He writes negatively about physicians who prescribe opioids for chronic pain, implying that such treatment does not benefit chronic pain patients, in contrast to his approach – and in fact, make his job more difficult. I am one of those physicians.

Physicians who practice primary care see the entire spectrum of chronic pain patients, some of whom would benefit from a more accurate diagnosis, others from non-drug therapies, and yet others from combinations of exercise, other modalities, and various pain medications including opioids. Certainly many would benefit from a multidisciplinary pain clinic such as Dr. Dicks describes. The difference between Dr. Dicks' outlook and mine is that I am the first to accept that those patients who are doing poorly on medication management and who have the right insurance, or can afford the cost of a protracted multidisciplinary pain program would benefit, at least in the short run. However, he apparently believes that there is no need for PCPs to become more knowledgeable about, and more

willing to prescribe, opioids, because apparently opioids are a class of medications that should rarely be used (except, presumably, for acute pain).

In the last issue of PPM, Dr. Forest Tennant reported an outcome study of some 30 patients who are doing well on long-term opioids. Dr. Tennant's report concerns a selected group of patients, who represent a subgroup of chronic pain patients. Dr. Dick discounts Dr. Tennant's report, which is a retrospective study of his own long-term patients and not a rigorous prospective placebo-controlled long-term trial. Unfortunately, such trials do not yet exist.

But what about studies of pain clinic graduates? To begin with, since patients who are doing well on opioids are unlikely to sign up for pain clinics, their patient population is already a highly selected sample of patients seeking a different approach. And once they complete the comprehensive pain clinic program, what happens to them? Ask their PCPs how those patients who return from the multidisciplinary clinic are doing two years later, and you will find out that a significant number are once again back on their pain meds -- not because they are inherently drug abusers seeking euphoria, but rather because once they are no longer receiving intensive, hours-per-day multidisciplinary treatment, and are back home, the benefits of that treatment may dissipate. Currently there are no published long-term outcome studies of pain clinic graduates. A relatively short-term study was just published by the Mayo Clinic, which reported on the 6 month outcome of 373 consecutive patients admitted to a comprehensive pain rehabilitation program. Those who arrived on opioids (about half) were withdrawn from opioids before discharge. Both groups had significant improvement in pain and activity at 6 months (Townsend et al, 2008). This is a start, but it is important to remember that the patients on opioids whom they saw were a sub-group selected for the fact that they were not doing well on their opioids; otherwise they would not likely have enrolled in the Mayo program. These results cannot be extrapolated to the whole spectrum of opioid-using patients.

I believe that multidisciplinary pain clinics tend to see patients who are doing poorly on opioids, and they provides a comprehensive alternative; pain specialists like myself, on the other hand, tend to see patients who've "tried

everything" *except* opioids and are doing poorly. Our approach generally includes not only opioids but also anti-inflammatories, anti-depressants, anti-seizure medications (for neuropathic pain), as well as a focus on improving function by means of exercise and increased activity. Both multidisciplinary pain clinics and pain specialists like me have a list of patients who have benefited from our particular approach. This does not mean that there is no place for the other's approach. Rather, there are chronic pain patients who are better off without chronic opioid treatment, and there are chronic pain patients whose life is improved by being on those medications. Most patients, whether or not they are on opioids, do better when they are simultaneously involved in an exercise program. It's not an either-or situation.

It's time that pain management specialists forego criticizing other specialists' treatment methods and recognize that different patients benefit from different approaches. And in order to facilitate evaluation of which types of treatments are most likely to work, we need well-planned long-term follow-up outcome studies that include both opioid users in outpatient pain practices and graduates of multidisciplinary pain clinics. Ideally, such studies should include all the patients in each program rather than case reports of successes. Only in this manner will we eventually know which approaches are most effective for which types of patients.

Reference:

Townsend CO, Kerkvliet JL, Bruce BK, Rome JD, Hooten WM, Luedtke CA, Hodgson JE. A longitudinal study of the efficacy of a comprehensive pain rehabilitation program with opioid withdrawal: Comparison of treatment outcomes based on opioid use status at admission.