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SUBSTANCE USE DISORDER—SUBSTANCE–INDUCED DISORDER CLINICS FOR PAIN–MEDICATION ADDICTIONS AND ADDICTED PATIENTS' PAINS: FUTURISTIC NEED FOR PAIN PHYSICIANS SUB–SPECIALIZING IN ADDICTION–MEDICINE

To the Editor:

Although pain assessment as the fifth vital sign has been in- use since 2001, recent discussions about discarding it as the fifth vital sign are not new for the medical community.[1,2] However, the formalization to counter the underlying concerns is truly new, when in the year 2016, bills for Promoting Responsible Opioid Prescribing (PROP) Act of 2016 namely H.R.4499-114th Congress and S.2758-114th Congress were introduced in the Unites States House of Representatives and Senate, respectively.[3,4] These bills could have been prompted by the alarming rise in drug overdose- related mortality rates over the years.[5,6] Presumably, this in turn could be associated with the prevalence of zealous opioid-based pain management in response to high expectations from pain-relief protocols to treat the fifth vital sign (all types of pains: acute or chronic, cancer or non-cancer). The recent evidence in medical literature about increased nonoverdose mortality (mortality due to causes besides overdose)[7] associated with prescription opioids for chronic noncancer pain does not help the cause for aggressive focus on pain and its relief by opioids. So, it is interesting to see where this all this will lead the future of pain medicine in the US.

As getting rid of pain as the fifth vital sign does NOT mean abandoning the patients in pain, one thing that cannot be denied is that pain needs management. However, how it is assessed and how it is treated need to be revisited for the sake of safe prescribing, dispensing, and consuming of opioid analgesics. Constant push to ask the patients about their pain can pre-empt them to report pains. Without a follow- up question about whether they think they actually need pain medication for their reported pain can lead to zealous dispensing and consuming of pain medications. This could be potentially avoided by "Do NOT Ask, Let THEM Tell." Instead of asking for pain levels, the patients should be allowed to voice on their own. Alternatively, their symptoms themselves should have the tell-tale signs warranting the pain medications: for example, when pains are assessed by Behavioural Pain Assessment Scale.[8] However, there seems to be a major gap in the medical research wherein studies have NOT compared (and hence NOT validated) direct correlation between non-verbal pain scales versus. verbal pain scales in the verbalizing patients because the medical research community seems to have assumed that the "gold-standard" verbalization about pain scores on the verbalized scales supersedes the need for pain assessment on the nonverbal pain scales in the verbalizing patients. Additionally, it appears that to avoid the legal and financial liability of under-treating the pain, the society may have wandered off the path of nonmaleficence (do-no-harm) by ending up over-treating pain, potentially with critically high amounts of prescribed opioids. It does not mean that interventional pain procedures are being utilized any less.[9] However, in the society as a whole, the use of pain medications is still escalating, no-holds-barred. At least, it can be safely presumed that without any interventional pain procedures in the play for the multimodal pain management, the current situation in the society would have been bleaker.

Where does this leave the future of opioid-based pain management? From opioids' industry perspective,[10,11] its resilience would allow it to spring back with renovated (not relegated) resurgence to possibly evolve and explore the futuristic markets focusing on the under-explored economic avenues inwith regards to naltrexone-, methadone-, and buprenorphine-like drugs. However from the providers'' and prescribers'' perspective, the steps that might be needed for better future for appropriate opioid-based pain management, could be: a) development of substance (opioid) use disorder-substance (opioid) induced disorder (SUD-SID) online-portal for the corresponding patients (with data accessible ONLY to the providers, prescribers, dispensers, and regulators nationally); b) background checks for diverters with mandated reporting to the US Department of Justice & Drug Enforcement Administration-Office of Diversion Control (DEA-ODC);[12] c) mandated transfer of care for Pain-Meds' Addictions & Addicted-Patients' Pains (PA-AP) management to SUD-SID clinics which would need to be developed across the country for

acquiring the unique, specific, and sole responsibility for management of SUD-SID patients; and d) strongly motivated pain physicians taking the lead to sub-specialize and get certified in addiction medicine[13,14] (an independent sister-sub-specialty of addiction psychiatry) for running these futuristic SUD-SID clinics. The futuristic creation of national SUD-SID online-portal is NOT as outlandish as it appears because when the prescribers and dispensers are mandatorily required to register with the DEA and are most likely under the constant DEA-ODC surveillance for the substances prescribed and dispensed, the responsibility for appropriate utilization of the substance should also be shared with the consumers (patients) by bringing them under the umbrella of appropriate surveillance. Besides establishing a safe-haven for specialized and goal-directed care of PA-AP, the transfers to futuristic SUD-SID clinics (manned by pain-addiction medicine specialists) would provide the majority of pain physicians (inexperienced in addiction medicine) with a medico-legally appropriate exit-strategy from PA-AP management, in contrast to the abandonment (discharge) of SUD-SID patients.[9]

For this appealing future to materialize, the first and foremost thing that pain clinics must do is to develop programs to screen objectively, regularly, and mandatorily all their patients for the signs of evolving SUD-SID on prescription opioids and related drugs as per the standards. Once those screening methods based on Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)[15] are developed and executed by pain practitioners in day-to-day functioning of the present- day pain clinics, the diagnosed SUD-SID patients would automatically and easily be registered into SUD-SID online-portal before mandatorily getting transferred out to SUD-SID clinics for future management from thereon. By ensuing futuristic laws, the mandatory transferring out to freely available and abundant SUD-SID clinics in the future would ensure that the future pain clinics (freed from SUD-SID patients) would primarily focus only on the interventional pain management while utilizing minimal opioid use in their non-SUD-SID patients for the shortest periods possible.

For objective assessment of need to transfer to SUD-SID clinics, it will be important for pain practitioners to familiarize themselves to utilizing SUD-Criterion A encompassing 11-Criteria in total: (1-4) when patient is demonstrating loss of control when it comes to the substance; (5-7) when patient seems socially impaired due to the substance; (8-9) when patient does not hesitate to use substance despite associated risks; and (10-11) when patient shows signs of aberrant biochemical responses to the substance (DSM-5 have the detailed diagnostic criteria on pages 541-542, 546-547, and 547-548).[15] One thing to remember is that tolerance and/or withdrawal for prescribed substances (when clinically appreciated and/or objectively discerned based on laboratory test results) are NOT counted while making SUD diagnosis in the case when SUD is related to prescribed medications.[16] Complementarily, SID encompasses Criterions that define a) intoxication related to the substance, b) withdrawal due to the absence of substance, and c) mental disorders caused by the substance (DSM-5 have the details on pages 485-490).[15] Although DSM-5 has decided to abandon the use of the terms "addiction," "abuse," or "dependence," it has been allowable and foreseeable for the physicians sometimes utilizing these terms colloquially when stressing the gravitas of SUD-SID while educating their patients. For example, even though national SUD-SID online-portal would NOT be a "dead-end street" and the patients would be able to come off the online-portal based on their response to SUD-SID management, their historical record might NEVER be expunged in the light of likelihood for SUD-SID recurrence (failure to achieve sustained remission for ≥ 12 months).[15] Empathetically, the futuristic national forum of the physicians caring for SUD-SID patients could consensually decide that only severe disorder patients (presence of ≥ 6 criteria according to DSM-5)[15] would get included in SUD-SID national online-portal.

In summary, the future of pain medicine appears promising with primary focus potentially getting redirected to the interventional pain management, whilst hopefully, SUD-SID patients would universally get transferred to the designated and futuristically booming SUD-SID clinics for long-term care of PA-AP.

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ERRATUM

In the article, Webster LR: Interpreting labels of abuse-deterrent opioid analgesics. 2017; 13(6): 415-423, the author omitted two drugs from **Table 4. Liking and take drug again Emax deltas of abuse-deterrent compared with non-abuse-deterrent formulations** on page 421. The corrected article is available at: *http://www.wmpllc.org/ojs-2.4.2/index.php/jom/article/view/767*.

Table 4. Liking and take drug again E_{max} deltas of abuse-deterrent compared with non-abuse-deterrent formulations[21]

		Oral (Crushed)		Oral (Chewed)		Intranasal		Intravenous	
Drug (brand name, dose)	**Comparator**	**Mean drug liking, mm**	**Mean take drug again, mm**	**Mean drug liking, mm**	**Mean take drug again, mm**	**Mean drug liking, mm**	**Mean take drug again, mm**	**Mean drug liking, mm**	**Mean take drug again, mm**
Morphine ER (MORPHABOND ER, 60 mg)	Crushed morphine ER (intranasal)					13.75		9.96	
Oxycodone IR (ROXYBOND, 30 mg)	Crushed oxycodone IR (intranasal)					11.8	19.9		