EDITORIAL

Why does the pain specialist not meet the needs of the referring physicians?

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Pain is one of the most common symptoms for which patients seek the help of healthcare professionals.[1] Primary care physicians (PCP) play an important role in the initial phase of evaluation of these patients and management of chronic pain. Opioid therapy is highly effective in the control of pain; yet, many PCPs have concerns in prescribing opioids, especially for patients with chronic noncancer pain. Back pain is the second leading symptom seen by physicians in the United States. Opioids are commonly prescribed for chronic back pain. These are effective for short-term pain relief, and there is modest evidence for long-term pain relief. However, substance use disorders occur in about 25 percent of the patients taking opioids for back pain.[2] The concerns of the PCP in opioid prescription relate mainly to the appropriateness, abuse of prescriptions, addiction, tolerance, drug interactions, and possible medical litigation.[3] It is important to recognize that pain specialists are no different from the PCPs in regard to concerns with opioid therapy and its legal ramifications. Why should the pain specialist therefore take the added liability of prescribing opioid therapy indefinitely for the chronic pain patient? Pain physicians are trained to manage patients with chronic pain; yet, their decisions to prescribe opioids for long-term management of noncancer pain are often influenced by factors such as age, gender and race of the patient, and the referring physicians.[4]

Wilkens and Belgrade[5] in this issue of the journal examined whether pain clinics satisfy the requests of referring physicians. They used survey as a tool and obtained data from PCPs in urban and suburban areas. The major area of concern for PCPs was opioid prescription for noncancer pain. The factor most important to the PCP with regard to opioid therapy was the history of the patient relating to chemical dependency, psychiatric disorders, and dose escalation, as reported in previous surveys.[3] The PCPs surveyed in the current study[5] were reasonably "comfortable" with prescribing opioids for chronic noncancer pain. However, they were only moderately satisfied with the support received from the pain specialist. The latter is because of poor communication between the pain specialist and referring physician with regard to management strategy. The issues that need to be addressed by pain specialists include: selection of patients with worrisome histories for opioid treatment and providing a regimen of opioid treatment with contingency plans for avoiding dose escalation.

It is not uncommon for PCPs to treat noncancer pain patients with opioids and refer them to pain specialists when dose escalation occurs, probably because of the concern that these patients will abuse the prescription. With such a referral, the expectation is that the pain specialist will take over the prescribing process and manage the patient indefinitely. With the limited number of pain specialists in the United States, this practice would overwhelm the chronic pain clinics. Therefore, it is important that a system be developed that allows the patient on chronic opioids for noncancer pain to return to the PCP. This is where communication between the PCP (referring physician) and the initial evaluation by the pain specialist becomes critical, so as to formulate a strategy to return the patient back to the PCP.

In the survey of PCPs in this article,[5] 88 percent of the clinics in the suburban areas had a clinic opioid policy compared with only 52 percent for the urban practices. The use of opioid contracts is becoming increasingly popular in the PCP offices. A recent study demonstrated a 60 percent adherence rate to the contract with a median follow-up time of about 2 years.[6] In addition a tripartite agreement for chronic opioid management between the PCP, pain specialist, and the patient is highly valuable and effective.[7] Explicit in the agreement is the understanding that the PCP would assume prescribing refills for the opioids once the regimen has become stabilized by the pain specialist. This trilateral agreement has been found to have a good success rate once all the parties sign the contract. The main causes of failure have been the inability of the patients to get the PCP to sign. In the latter event, the patient needs to be weaned off the opioids over a period of time and discharged to the PCP. This trilateral opioid contract may be an effective tool for a networking specialty and PCP services in the delivery of chronic opioid therapy. In fact, in the survey done by Wilkens and Belgrade,[5] 70 percent of the PCP responders favored the

coordinated return of the chronic pain patient by the pain specialist to the PCP once the opioid dose has been stabilized. In addition, with the emerging medical electronic information era, the trilateral agreement should extend to involve the pharmacy in which the patient obtains the opioids. The pharmacist can also play an integral role in making sure that patients are not dispensed early refills and are adhering computerized integrated system to track opioid prescriptions. This four point agreement should drastically reduce opioid abuse and diversion and facilitate greater ease for prescribing opioids by medical professionals.

Other surveys of PCPs regarding opioid therapy have demonstrated the lack of formal medical training in opioid management for chronic pain as a significant factor in the referral to the pain specialist for continuing the narcotics indefinitely.[8] As pain specialists, it is our responsibility and duty to educate the referring medical specialties and facilitate the establishment of narcotic agreements for the safety and improved outcomes of our chronic pain patients.

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