

Chronic use of opioids in intractable facial pain

A case report

Göran B. C. Hampf and Eija A. Kalso

The Facial Pain Clinic, Institutes of Dentistry, University of Helsinki, and
The Pain Clinic, Department of Anesthesia, Helsinki University Central
Hospital, Helsinki, Finland

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The use of opioids in chronic non-malignant pain conditions is largely rejected by the health authorities. Their concern is mostly due to the potential problems of addiction and other adverse effects of opioids. However, in certain pain conditions opioids may be the only effective remedy. This article presents some guidelines for the use of narcotics for non-cancer pain. A case is presented in which methadone in small doses in combination with an antidepressant was the first drug capable of alleviating the patient's suffering. The drug was effective during a period of 9 months. □ *Addiction; antidepressant; narcotics; pharmacology*

Göran Hampf, Facial Pain Clinic, Institute of Dentistry, University of Helsinki, Mannerheimintie 172, 00300 Helsinki, Finland

The use of opioids for the treatment of non-cancer pain is controversial. It is widely opposed or rejected by the health authorities because of the potential risk of addiction and long-term adverse effects (1–4). Health authorities around the world have developed a control system that makes the prescribing of narcotics difficult and even repugnant (5). The advantage of this system is in that it prevents uncontrolled prescribing of narcotics. However, there are also many disadvantages, such as reluctance to prescribe opioids, even for the treatment of cancer pain (5). In certain non-malignant pain conditions narcotics may be the only effective treatment. Lately, there have been several reports (6–10) of long-term use of opioids in malignant pain, in which recent advances in the understanding of the pharmacology of these drugs have made it necessary to re-examine their role in the treatment of patients, even those with non-malignant chronic pain.

The controversy over the use of opioids for non-malignant chronic pain is due to reports of patients who have become addicted to narcotics and to the great publicity surrounding the prosecutions of physicians prescribing narcotics. On the other hand,

there have been reports by several groups (7, 9) of successful long-term use of opioids for the treatment of non-malignant chronic pain, although most of these studies are retrospective and did not contain control subjects.

In the Boston Collaborative Drug Surveillance Project 4 cases of well-documented psychologic dependence were identified out of 11,882; of these 4 the addiction was considered major in only 1 instance. In another survey in a headache clinic, narcotic abuse was identified in 3 patients out of 2369 (11, 12). These data suggest that patients without a prior history of substance abuse have an extremely small risk of abuse after short-term administration of narcotic drugs for a painful medical disorder. Abuse has been shown to be extremely rare in patients with cancer pain (5, 13).

It has been suggested that only nociceptive chronic pain syndromes respond to opioids. In a double-blind trial on the effect of opioids given intravenously as test doses on different kinds of chronic pain, nociceptive pain was alleviated by morphine, whereas idiopathic pain failed to respond (14). However, recently there have been reports of good

pain relief of neuropathic pain, and good results have also been described with small doses of methadone and doxepine (15). The following guidelines for the induction and monitoring of narcotic maintenance therapy can be recommended (modified from Tennant & Uelmen) (4):

1. Identify the cause of incurable chronic pain
2. Document that non-opioid therapies are inadequate
3. Test that the pain is opioid-sensitive
4. Know the patient's history (tendency for abuse)
5. Initially select a weak *oral* narcotic
6. Use a more potent oral narcotic only as a last resort
7. Monitor the patient at least monthly for sedation, motor function, and side effects
8. Simultaneously administer non-opioid pain therapies
9. Avoid benzodiazepines and sedative-hypnotics, prefer tricyclic antidepressants
10. The medication should be based on a group decision, but the primary responsibility should be taken by a *single* practitioner
11. Inform the patient about the potential risks of addiction.

Chronic opioid administration should be started only if all other methods have failed or are contraindicated.

Opioids should be administered orally on a regular schedule, and possible side effects like obstipation and dysphoria should be considered when planning the treatment. Partial opioid agonists like buprenorphine are recommended for their putatively lower abuse potential and their long effect. Slow-release morphine also has a prolonged effect.

As most of the reports emphasize poor results in the treatment of chronic pain conditions with a strong background of psychopathology, we would like to present a patient with intractable pain successfully treated with a small dose of methadone (10 mg/day) together with amitriptyline (150 mg/day) and with periodic use of perazine (8 mg/day).

Case report

In 1984 a retired nurse, aged 60, was referred to the Institutes of Dentistry of the University of Helsinki because of excruciating pain in her left mandible and left maxilla. The pain had started a year earlier at the time when she was treated by several dentists and several medical specialists. Her pain was diagnosed as 'intractable facial pain'. Each time she came to the clinic she was shaking with pain, her hands pressed over her painful face, and she was unable to sit in an upright position. According to the psychiatrists she had had a major depression since her daughter had been hospitalized for psychiatric reasons. Her retired husband had no or only little understanding of her pain. Their economic situation was good. She had been referred to a hospital for psychiatric treatment three times, but without any effect on her pain condition. The patient did not quite believe that she had a non-somatic pain condition, so she continued with the examinations and treatments prescribed by all her physicians. Until recently, she had obtained no subjective relief from her terrible pain.

So far the patient has visited our clinic 89 times during 6 years. Her main medication since 1985 has been 150 mg amitriptyline a day; later 2 mg clonazepam a day was added, supplemented in 1988 with 8 mg perazine a day, all without any subjective effect. So far she has had three psychiatric consultations, two internist consultations, two isotopic investigations, and one masticatory dysfunction consultation. All consultations have failed to produce any relevant result. One explorative operation was performed because of a suspicious radiographic finding; the patient has also had 15 roentgenograms, 2 series of acupuncture, 4 series of physical treatment, 22 visits for checking medication, 10 other minor non-invasive treatments (such as application of fluoride), and 37 other visits. In addition, she has visited the acute care unit of the main hospital several times. She has simultaneously been undergoing treatment at private practitioners, receiving different treatments including occlusal splints. She has also been tested for allergy to amalgam. Her dental fillings were removed

privately and exchanged for plastic ones, even though she was not allergic to amalgam. All (non-narcotic) painkillers, including carbamazepine, given by different specialists were repeatedly found to be ineffective.

One year ago we prescribed a test dose of slow-release morphine for her, to test its effect. Unfortunately, she showed her prescription on her next hospital visit and was told by the physician that under no circumstance should she take the medication. Not content with that, the physician tore our prescription into pieces in front of all his colleagues. In 1990 we made a new attempt and prescribed a daily dose of 20 mg methadone. For the past 5 months she has been taking a daily dose of 10 mg (sometimes 20 mg). Her pain, as rated on a 10-cm visual analogue scale (VAS), has decreased from 8.5 to 5.0. She has had pain-free periods, and for 6 months she needed no sleeping pills; her quality of life has thus improved. Six months after starting the methadone medication her pain returned slowly and 9 months later was the same as before starting the medication. At the moment the patient is referred for an electroconvulsive treatment to the Department of Psychiatry.

This particular patient was considered to fulfill the criteria for the use of opioids in non-cancer pain: 1) She has incurable chronic pain; 2) All other treatment modalities have been ineffective; 3) The pain is partly sensitive to methadone; 4) There has been no sign of drug or other abuse (even when she tried various drugs, she never took overdoses, and her drug concentration was regularly tested); 5-7) She is taking a small oral opioid dose and is checked regularly; 8) She is simultaneously taking amitriptyline and perazine; 9) Clonazepam has been withdrawn; 10) The decision was made by two physicians; 11) The patient has been informed about the risks of abuse.

Discussion and conclusion

Physicians prescribing opioids for non-malignant pain have sometimes been strongly criticized. Inappropriate prescription of narcotics leads to withdrawal of the

physician's licence, which has had the effect that many physicians do not even order the forms and cannot prescribe narcotics even when they are called for. Restoring a patient's quality of life, even with controversial methods, should not be rejected out of hand: sometimes we have to admit that unusual treatments might be beneficial, beyond the placebo effect.

Finally, as already stated, there might in rare cases be pain conditions of a non-nociceptive nature that are sensitive to opioids. These cases should be discussed at the multidisciplinary meetings of the pain clinic, where the group decision to start an opioid treatment should be made. One physician then takes responsibility for the treatment and its follow-up.

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