

Commentary

Opioids for non-operable osteoarthritis and soft-tissue rheumatism

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Abstract

Reviews of oral opioid trials have shown that many side-effects need to be considered when treating patients with non-operable osteoarthritis and soft-tissue problems. European and American guidelines recommend their use with or without paracetamol. The controversy surrounding the use of non-steroidal anti-inflammatory drugs/cyclo-oxygenase-2 inhibitors is limiting physician and patient choices. There is a great need for alternative medication or ways of using current compounds.

Moore and McQuay [1], in this issue of *Arthritis Research & Therapy*, reviewed 34 trials using oral opioids against placebo or a comparator. The review included 5,500 patients; importantly, 4,000 patients contributed to the side-effect profile. It is this profile that is significant in today's world of public and patient safety. Doctors and patients do need help, and preferably evidence, to make choices when treating all types of musculoskeletal conditions. Moore's review highlights two problems: first, that the trials were of short duration, and second, that the side-effect profiles were a problem, causing patient withdrawals of at least 22%.

The European League Against Rheumatism recommends opioid analgesics with or without paracetamol as useful alternatives for patients in whom non-steroidal anti-inflammatory drugs (NSAIDs), including cyclo-oxygenase-2 (Cox-2) selective inhibitors, are contra-indicated, ineffective and/or poorly tolerated [2,3].

The American Pain Society and the American College of Rheumatology give similar advice for the use of opioids in rheumatoid arthritis (RA) as well as osteoarthritis (OA) [4,5].

Trials have shown that opioids are effective in OA and RA and improve sleep and quality of life [6]. If opioids are effective, are they safe? Schug and colleagues [7] showed that they have a good safety record and most have a high therapeutic index. In acute overdose, respiratory failure can occur but there does not seem to be any specific organ toxicity. The side-effects of nausea, vomiting, somnolence and sedation can present problems. It is accepted that patients usually rapidly develop tolerance to these side-effects. Unfortunately, tolerance does not develop for constipation, so this side-effect needs treatment. In Moore's review, dry mouth was experienced by 25% of patients, which is a significant problem for this age group of 55 years and over. These problems do limit the use of oral opioids – most patients who require medication for non-cancer pains are over 65 years old and very often constipation is already a problem, especially with the use of concomitant medication for co-morbidities. Constipation as a drug side-effect is rarely acceptable to patients, even in the older age groups, as most people wish to enjoy independence and the best possible quality of life. The withdrawal rate in trials is 22% [1], but this is likely to be an underestimation; in reality, most patients cannot tolerate nausea and somnolence for long even if they are assured that it will wear off given time. Car driving becomes difficult, even dangerous, and the quality of life generally deteriorates.

It is important, when using opioids, to select patients with care. All patients require a physical, psychological and social assessment. This will include addressing patients' beliefs, fears and expectations about their pain and the use of opioids. Care in opioid use must be exercised if there is or

has been a history of drug or alcohol use or psychiatric problems such as depression, psychosis or any risk or history of suicidal tendencies. This assessment should also take into account similar factors relevant to any household member(s).

The emotive problems of dependence and addiction need addressing. When treating pain, addiction is defined as 'a persistent pattern of dysfunctional opioid use that may involve any or all of the following: adverse consequences associated with the use of opioids; loss of control over the use of opioids, preoccupation with obtaining opioids, despite the presence of adequate analgesia' [8,9].

Physical dependence is a physiological phenomenon characterized by symptoms associated with abrupt termination of regular opioid use [8,9]; it is not predictive nor diagnostic of addiction. The withdrawal effects of insomnia, muscle contraction and nausea are usually non-serious and generally last from 7 to 10 days [7]; these can be minimised by a gradual tapering of therapy.

I think it is the fear, by both patients and doctors, of addiction and dependence that has limited the use of oral opioids. This problem continues to create prejudice against the liberal use of opioid drugs in conditions other than their use for cancer pain. It is unlikely that Moore's review of oral opioids [1], the removal of some Cox-2 inhibitors or the growing evidence that NSAIDs are probably just as toxic as Cox-2 inhibitors to the cardiovascular system will overcome this reluctance to prescribe opioids to vast numbers of patients.

If a proper initial assessment of patients and their social circumstances is undertaken, then fears can be allayed and patients 'at risk' can be excluded from opioid treatment. Regular follow-up assessments should pre-empt most problems. Opioid drugs significantly reduce pain scores for patients with chronic non-malignant pain and, importantly, clinical trials also show that they improve a patient's quality of life. The recent controversy around Cox-2 inhibitors/NSAIDs has made the management of OA pain more difficult and led to patients suffering. Assessments of patients for opioids and wise use will begin to reverse this trend.

Many patients with soft-tissue problems and non-operable osteoarthritis will require pain relief. Education of patients and the use of paracetamol, glucosamine, topical NSAIDs and rubefacients will help many but not all patients: there will be some who require or demand more pain relief. Primary care appointments are much longer than previously, but appointments are still at a premium so the individualization of treatment of all patients is still an unattainable goal. The major drawback of the Cox-2 inhibitors/NSAID controversy is that we are unable to treat our patients' pain adequately; this will continue to be true while the risks of treatment continue to take preference over the benefits of treatment and informed choice.

Conclusion

Patients still require pain relief; all NSAIDs/Cox-2 inhibitors have cardiovascular and renal side-effects, and the older NSAIDs have severe gastrointestinal ones too. Most patients with OA requiring pain relief are over 65 years old with comorbidities: NSAIDs/Cox-2 inhibitors are not the preferred choice of the European Medicines Agency (EMA) [10]. Oral opioids will be accepted by some patients but not the majority. The addition of opioid matrix patches are a welcome addition and hold out the possibility of a lower incidence of side-effects. Matrix patches seem to be acceptable to both patients and doctors and are less likely to be open to abuse.

Competing interests

The author(s) declare that they have no competing interests.

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