Another kind of pain for patients and doctors

By ACSH Staff — August 16, 2015

Both aspirin and heroin were discovered in the 1800s. Ironically, Bayer developed and marketed heroin as a less addictive version of morphine and other opium products. That didn’t work out so well, and by the 1920s, it was banned from use and sale. It is now classified by the DEA as a Schedule I drug no approved medical use and a high potential for abuse. The rest you know.

Aspirin was invented as a more effective alternative to salicylic acid and salicin two components of willow trees that have been were used as crude extracts for 2,000 years to reduce pain and fever.

Heroin, Vicodin, Percocet, etc all belong to a family called opiates (or opioids). They are powerful analgesics that act at pain receptors in the brain. They are also very addictive, which is causing a huge problem in the US in recent times.

Aspirin is a non-steroidal anti-inflammatory drug (NSAID). Since its discovery, there have been many others developed, such as Advil (ibuprofen), Aleve (naproxen), Voltaren (diclofenac) others.

But NSAIDs come with their own set of baggage especially gastrointestinal bleeding, ulcers. Some NSAIDs are worse than others, but they are all bad for chronic use. One atypical NSAID (Celebrex) was designed to avoid the GI side effects of the rest of them. It does this in certain patients, but is not as powerful as the standard NSAIDs, and is not really useful for acute pain, such as headache. Celebrex also has some cardiovascular risk associated with long-term use.

So, here we are, between 200 and 2,000 years later, and there is still no good method (some might argue that only terrible methods is more appropriate) for controlling chronic, severe pain. The standard of care is still opioids, despite their obvious baggage. This is rather amazing, especially since during this very long time period, one disease or infection after another has rolled over and cried uncle.

I have written extensively about the impossible task of balancing addiction and abuse against legitimate medical needs, where I have taken issue with the DEA in the New York Post [1] in 2013, the New York Times on Science 2.0 [2], and, recently, discussed the unintended consequences of bad policy here [3].

This seemingly impossible problem to solve is discussed, this time in an op-ed [4] by Dr. Danielle
Ofri, who is an associate professor at N.Y.U. and a physician at Bellevue Hospital in New York City.

Dr. Ofri discusses the very difficult problem that faces physicians when they are managing pain in their patients. Part of the problem is trust: Here it was again: the dreaded pain conundrum. A patient requests a strong pain medication and the doctor has to figure out whether the request is legitimate.

And, it works both ways: do I trust [my patient's] story, and, conversely, how will my decision affect Mr. W.'s trust in me?

Doctors cannot win, since this issue is more a matter of what is the least bad alternative under treating pain in patients with legitimate needs or unknowingly contributing to an insidious addiction process, where both the length of time using a narcotic, and when/if the need for the drug becomes more than simply pain relief.

To make matters worse, the DEA has stuck its nose in. Their focus is (presumably) on controlling addiction, but this has been a dismal failure. When more restrictive rules were places on narcotic pills, pretty much everyone lost. Vicodin and Percocet have become very difficult to obtain. As a result, addicts were forced to buy the pills off the street, where they can cost as much as $20 per pill. The result: a huge surge in heroin use.

Heroin is much cheaper, but has far worse problems:

- Frequently, heroin isn't even heroin anymore. Rather it is partially or completely replaced by fentanyl a heroin-like molecule that is about 100-times stronger than morphine. The extreme potency of fentanyl guarantees that more overdoses will occur. Even a small error in cutting the drug can easily be fatal.

- Heroin users frequently share needles, so the incidence of HIV and hepatitis C infection are on the rise.

- Patients with legitimate needs are the real victims. Doctors and pharmacists know that they are being carefully watched, so they are incentivized to undertreat rather than over treat pain.

Dr. Ofri says it best: [W]hen patients feel judged by their doctors, and doctors are exhorted to not undertreat pain and simultaneously pilloried for overprescribing pain meds, this relationship can be sabotaged. That isn't good for anyone's health.