Transcript Details
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Rethinking Opioids: Key Considerations for Balancing Pain Management and Patient Risk

Announcer:
You're listening to *Living Rheum* on ReachMD. On this episode, we'll hear from Dr. Martin Cheatle, who's the Director of Behavioral Medicine at the Penn Pain Medicine Center as well as an Associate Professor of Psychiatry, Anesthesiology, and Critical Care and the Director of Pain and Chemical Dependency Research at the Center for Studies of Addiction at the University of Pennsylvania. He'll be discussing the relationship between chronic pain and opioid usage, which he spoke about at the 2025 Congress of Clinical Rheumatology East conference. Let's hear from Dr. Cheatle now.

Dr. Cheatle:
In general, opiates are effective. For chronic noncancer pain, they're not considered to be first-line therapy at all. Some of the biggest myths— it always bothers me when I read an article that the opioid crisis started with prescription opiates to pains, and that's really a false narrative. So we overprescribed opiates. They got into the aquifer of the community and were diverted to people who are susceptible to addiction. If you look at the real data, the percentage of patients who develop an opioid use disorder who have chronic pain, who are on long-term opioids, is 8–10 percent. In our population, what percentage develop an alcohol use disorder? Ten to 12 percent. Cocaine, ten to 12 percent. So it got diverted, and that was the first wave. The second wave was heroin. Again, not patients who were chronic pain sufferers. And the third wave we're in is fentanyl. But again, those are not people who have chronic pain.

The take-home message is opiates are not first-line therapy for any type of chronic non-cancer pain, but if someone is low risk, they've gone through every type of treatment, and they are suffering, they do have a place in a subgroup of patients who are well-monitored and well-assessed.

So we have these receptors in the spine and the brain, and there's an upregulation and acute and chronic pain receptors, and it goes into the spine up to the brain. Things are happening at the spinal cord level in terms of those opiate receptors, and then it hits the brain. What we know about the neuroscience of pain is a lot goes on in the brain. We look at this pain experience as affected by depression, anxiety, and catastrophizing. I think a lot of the problems we've had in current pain medicine intervention is it's all medical and not psychosocial, and there's lots of data to support that.

And the other thing is that chronic pain is a brain disease. So if you look at neuroimaging studies, when patients go from no pain to acute to chronic pain, in that transition to acute to chronic pain, there are actually structural changes in the brain. So I think we have to see this as a chronic disease instead of chasing it as a symptom. The ICD-10/11, for the first time, has had chronic pain as a distinct disease, and that's really important for people who suffer from chronic pain. It is a disease in its own right. And what I tell patients is that having chronic pain is like being a diabetic. It's real. It's not going away. There's a medical component and a behavioral component, right? We can give people insulin for diabetes, but if you don't change your behavior, you're going to have a bad outcome. So the neuroscience is all wrapped up in not just this pathway to the brain and these receptors, but interacting with psychosocial factors that are commonly not addressed fully.

I had a young woman who was 38 years old. She had her first spine surgery at age 12. She had four more surgeries. The last one nicked her sciatic nerve, so she had horrible back pain and excruciating leg pain, complex regional pain syndrome. She did everything everyone asked—injections, spinal cord stimulator, every class of medications—and she was just barely surviving. And she would be someone who had intermittent opiates—I mean, take it as needed, not around the clock—would probably benefit from that and also help her have some analgesia so she can have quality of life. The pendulum has gone from everyone needs to have opiates and you're a bad doctor if you don't give opiates to everyone who walks in the door, and now you're a bad doctor if you give anybody opiates and

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opiates are the devil's dandruff. It's about being able to look at risk factors for opioid use disorder and bad outcomes. We have to be realistic.

Sometimes there's a legacy patient who is the nightmare of any primary care doctor, rheumatologist, or people who do cognitive medicine. So you inherit this patient who comes in on a high dose of opiates. What do I do with this patient? It's about taking the time to develop a therapeutic relationship with the patient, which is challenging. The literature suggests that patients will adhere if you have a therapeutic relationship with them. But now we live in a culture where it's 10-minute appointments, so you have to be really clever at doing this. I recommend a lot of physicians to get some training in motivational interviewing, which is a really powerful tool to slowly edge them to the right behavior.

Most patients want to get better, but they're fearful of the pain, they see pain as a threat, and I see a lot of patients where I know the opiates aren't working for them. They're still eight out of ten, and you're sitting on the couch, and you say to the patient, "Do you really think this is working for you? Because we're at a high dose, and you're not functional, and you're not doing well emotionally." And again, if you can develop that rapport, even over time—maybe it doesn't have to be the first time—and you slowly start getting at them working in a therapeutic relationship, I think most patients, not ones who want to abuse it or who have an opioid use disorder, will slowly start coming off the opiate. So that's one scenario that I think is really difficult.

And the one thing that all good physicians are—and physicians want to do the right thing—is not pushing people off the edge. So again, I think it's about taking the time, and maybe you have to use ancillary staff to do all this because the physician doesn't have enough time to do this. But there's lots of resources out there on how to really set up a clinic so that it's not that opiates can be part of the approach, but it has to be done in a very thoughtful manner.

Announcer:
That was Dr. Martin Cheatle discussing the relationship between chronic pain and opioid usage. To access this and other episodes in our series, visit *Living Rheum* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!

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