Smärtlindring vid IC, från AUA meeting 2005

Dr. Christopher Payne, Stanford University, USA.

When Dr. Payne took the podium, **he urged his colleagues to treat IC patients' chronic pain** - something many urologists are reluctant to do and aren't comfortable with. "Pain management is, in and of itself, an appropriate and realistic goal, and it's appropriate for the urologist. It's our natural role as physicians to relieve pain and suffering and we have the tools to do it. We ***can*** do this," he said.

When pain is chronic, patients need much more than regular care, he emphasized. They need more evaluation, they need help from other specialists because other organ systems are often affected, and they need to work with a primary care physician who will coordinate their care over the long term. Because we can't cure the problem, the goal has to be to improve function. "we can link our use of pain medication and higher doses of pain medication to higher functional improvement and better quality of life. That is what's realistic. That's what we can accomplish," Dr. Payne told his colleagues.

Pain is complex, including more typical pain, deep organ pain, and nerve pain, so no single medication can take care of it all. Treatment has to be multimodal, he said, including different types of medications (opioids, nonsteroidal anti-inflammatory drugs, antidepressants, anticonvulsants, membrane stabilizers, and others), procedures such as nerve and epidural blocks, psychological support, and physical therapy. Combining medications can not only give better pain relief but can also reduce side effects. But opioids, he said, are the mainstay of therapy. They're well accepted for cancer pain, for AIDS pain, for neuropathic pain, and for many other disorders, "and yet for IC, he pointed out, "opioids are frequently not considered, and when they're considered, they're not offered. I believe this is not appropriate."

Dr. Payne tried to dispel misconceptions that many have about opioids. Tolerance and dependence, which are to be expected, are *not* addiction. Very often, patients who take opioids need higher doses over time to achieve the same relief, which is tolerance, and urologists should expect that. Dependence is a physiological response to stopping opioid medication that is nearly universal and it is *not* addiction, he emphasized. "Addiction is totally different. It is a psychologic and behavioral problem in which a person uses a drug compulsively despite evidence that it's harming them and continuing to use it despite the harm. The person exhibits the behavior we associate with addicts to procure medication. **This is a *rare* problem in patients who are being treated for a medical disease and chronic pain if they've been properly evaluated and followed**."

He advised his colleagues to use opioid contracts to protect themselves and patients from potential problems, and informed the audience that model contracts are available on the internet and from pain specialists.

Dr. Payne recommended using immediate-release preparations only for finding out what doses of long-acting opioids patients need or for patients who don't need pain medication every day and can manage with low doses. They can also be used for breakthrough pain as doctors find the right dose of longer-acting medication. There are a number of extended-release medications, and he encouraged urologists treating IC patients "to pick at least one and become familiar with how to use that agent." **Dr. Payne uses methadone primarily but also uses long-acting morphine preparations. Other choices include long- acting oxycodone (Oxycontin), fentanyl (Duragesic), and hydromorphone (Palladone). Meperidine, propoxyphene**, and mixed agonist-antagonists are poor choices, he said.

With opioids, he added, "it's very important to anticipate and treat the side effects, particularly constipation. You always start with stool softeners with the original prescription. We warn the patient about the potential need for laxatives, and we don't want to see somnolence (drowsiness). That's a bad side effect. Remember, we're trying to improve function. So if we see somnolence, and somebody can't focus at work, we know we've gone too far."

Dr. Payne left his colleagues with these thoughts: "I believe that it's appropriate to treat chronic pain, even when the underlying disease is not known or is untreatable. Multimodality therapy is the most effective way to treat chronic pain. Opioids are the keystone of treating chronic pain in most patients. And we need to focus our treatment on improving activity, on improving goals, improving function and quality of life, not aiming at total relief of pain. And I think, if we can do that, we'll make a great impact on our patients."