Prescription opioid use in multiple sclerosis

INTRODUCTION

Pain can be one of the worst symptoms of multiple sclerosis (MS). Modifiable factors, including depression and anxiety, may influence its severity and impact. Opioids used for chronic non-cancer pain may be prescribed to persons with MS when neuropathic pain therapies are ineffective. Given the potential harms of opioid use and limited data supporting their utility in MS, it is important to understand the extent of opioid prescribing for persons with MS. We estimated incidence, prevalence and patterns of opioid prescription in an MS population and a matched cohort without MS. We assessed whether comorbid mood/anxiety disorders modified the association between MS and prescription opioid use (hereinafter ‘opioid use’).

METHODS

Briefly, this matched retrospective cohort study was conducted in Manitoba, Canada. Online supplemental appendix 1 details methods and references.

We identified Manitobans with MS from 1984 to 2016 using a validated definition relying on health claims; the earliest demyelinating disease claim constituted the index date. A general population cohort was matched 5:1 on sex, year of birth (± 5 years) and residence region to the MS cohort, after excluding anyone with diagnosis codes for demyelinating disease or MS disease-modifying therapies. Each control was assigned the index date of their matched case. From these cohorts, we selected incident MS cases and matched controls with an index date of ≥1997, excluding individuals with cancer/demyelinating disease or MS disease-modifying therapies. We censored anyone who developed cancer or entered palliative care post index when relevant codes first appeared and censored individuals on death or leaving the province.

Using validated definitions, we updated mood/anxiety disorder status annually (active vs inactive/absent). Individuals with schizophrenia were not excluded.

New (incident) users of opioids were those with no dispensation of ≥1 year before initial dispensation. Prevalent opioid users were individuals with ≥1 opioid dispensation in the year of interest. We measured time from first opioid dispensation to discontinuation. We described use patterns among cohort members with ≥5 years of follow-up post-index. We noted use of non-steroidal anti-inflammatory drugs, cannabinoids, tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors and anticonvulsants based on ≥1 dispensation.

We estimated the crude annual incidence and prevalence of opioid use, overall and stratified by sex and age. We age and sex standardised the estimates. To assess the association between cohort (MS vs non-MS), mood/anxiety disorders (active vs inactive/absent) and opioid use, we employed multivariable generalised linear models. We tested two-way interactions between cohort and mood/anxiety status. Covariates included sex, age, residence region, socioeconomic status, disease duration, index year, number of physical comorbidities and annual number of classes (types) of prescription medications dispensed, after excluding opioids.

RESULTS

We included 2918 persons with MS and 14,539 persons without MS (online supplemental appendix table e1). In 2016, the crude incidence/1000 persons of opioid use was 1.49-fold higher (rate ratio [RR] 1.49, 95% CI 1.35 to 1.64) in the MS cohort (62.94, 95% CI 58.34 to 67.54) than in the non-MS cohort (43.89, 95% CI 42.39 to 45.40). Temporal trends are shown in online supplemental appendix figure e1. Average annual incidence rate of opioid use did not differ by sex in either cohort (figure 1). Opioid use was higher in the MS than in the non-MS cohorts at all ages; this effect was greatest in those aged ≥65 years (age×cohort interaction, p = 0.0081; figure 1). Over the study period, the MS cohort had 1.71-fold higher crude prevalence/1000 persons of opioid use (226.4, 95% CI 220.7 to 232.2) than the non-MS cohort (132.5, 95% CI 130.6 to 134.4).

Time to discontinuation of opioids by 25% of those initiating treatment was 12 days longer in the MS cohort (see online supplemental appendix 1). Among incident opioid users with ≥5 years of follow-up who had MS but no mood/anxiety disorder, 30.0% obtained only one opioid dispensation, and 8.4% used opioids continuously for ≥3 months. In contrast, among individuals with MS and a mood/anxiety disorder, few had only one dispensation (11.4%), and 11.4% used opioids continuously for ≥3 months (11.4%) (online supplemental appendix figure e2).

After adjusting for covariates, the MS cohort had an increased incidence (RR 1.18, 95% CI 1.08 to 1.29) and prevalence of opioid use (RR 1.49, 95% CI 1.41 to 1.57) than the non-MS cohort (online supplemental appendix table e2). Having an active mood/anxiety disorder was associated with an increased prevalence of opioid use (RR 1.22, 95% CI 1.17 to 1.27), but there were no statistically significant interactions between cohort and mood/anxiety disorders on opioid use (all p > 0.05).

DISCUSSION

We examined opioid use in people with and without MS over two decades. On average, the annual prevalence of opioid use was 226/1000 persons with MS, but only 132/1000 persons without MS, an adjusted relative increase of 49% in the MS cohort. This higher use of opioids was irrespective of the presence of a mood/
anxiety disorder, similar to prior findings for benzodiazepines. Notably, average incidence of opioid use in those with MS aged ≥65 years was quite high, at 83/1000 persons, and prevalent use affected one in four persons. Although incident opioid use was only slightly higher in the MS cohort, higher prevalent use indicated longer duration of use, which was corroborated by our examination of patterns of use. In both cohorts, mood/anxiety disorders were associated with longer duration of opioid use.

One American survey of individuals with MS found that 37.7% currently used opioids. Our finding that approximately 10% of our MS cohort used opioids long-term highlights the need for further pain management research in MS as guidelines state that opioids should not be first-line therapies, given the uncertainty regarding long-term benefits.

Study limitations included inability to assess use of over-the-counter acetaminophen–codeine combinations or to exclude non-MS-related pain syndromes in the MS cohort. We applied validated definitions to identify individuals affected by mood/ anxiety disorders, but these only capture individuals receiving care from insured (i.e., physician) providers.

Prescription opioid use is more common in people with MS than those without MS. Both MS and mood/anxiety disorders are associated with longer durations of chronic opioid use. Given the limited evidence supporting opioid use for pain management in MS, the high prevalence of opioid use in persons with MS is concerning and indicates a pressing need for alternative pain management strategies.

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Acknowledgements The use of Aggregated Diagnosis Groups codes for risk adjustment in regression models was created using The Johns Hopkins Adjusted Clinical Group Case-Mix System V3. The authors acknowledge the Manitoba Centre for Health Policy, University of Manitoba, Winnipeg, Manitoba, and the Manitoba Population Health Research Data Repository under project #2014-030 (HIPC #2014/2015-19A). The results and conclusions presented are those of the authors and no official endorsement by the Manitoba Centre for Health Policy, Manitoba Health, or other data providers is intended or should be inferred.

Contributors RAM: drafting/review of the manuscript for content, including medical writing for content; major role in the acquisition of data; study concept or design, analysis or interpretation of the data. JDF: drafting/review of the manuscript for content, including medical writing for content; major role in the acquisition of data; study concept or design, analysis or interpretation of the data. RW: analysis or interpretation of data. MB: drafting/review of the manuscript for content, including medical writing for content, and analysis or interpretation of data. JS: drafting/review of the manuscript for content, including medical writing for content, and analysis or interpretation of data. AK: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. LLM: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. CH: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. JJM: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. CH: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. AS: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. AA: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. MB: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. DH: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. CH: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. JB: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. JR: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. SG: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. AM: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. MM: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data. AH: drafting/review of the manuscript for content, including medical writing for content; analysis or interpretation of data.

Funding This study was funded by the Canadian Institutes of Health Research (THC-135234), Crohn’s and Colitis Canada. RAM is supported in part by the Waugh Family Chair in Multiple Sclerosis. LLM is supported in part by the Bingham Chair in Gastroenterology. JS is supported by CIHR #333252. LML is supported by a tier 1 Canada Research Chair. RE-G is supported by University of Manitoba Start-Up Funding.

Competing interests RAM received research funding from Canadian Institutes of Health Research, Research Manitoba, Multiple Sclerosis Society of Canada, Manitoba Health Research Foundation, Crohn’s and Colitis Canada, National Multiple Sclerosis Society, Consortium Jbf MS Centers and the Arthritis Society, US Department of Defense. She is supported by the Waugh Family Chair in Multiple Sclerosis. She is a coinvestigator on a study funded in part by Biogen Idec and Roche (no funds to her or her institution). RW reports no direct research funding from CHIR, Brain and Behavior Research Foundation and the MS Society of Canada. JS received research funding from the Canadian Institutes of Health Research and holds stocks in Johnson and Johnson. SBP received research funding from Canadian Institutes of Health Research, the MS Society of Canada, Roche, Biogen and the Government of Alberta. AS received financial and in-kind support from an IBM/IOMVR Advanced Analytics Grant and Callian Inc. LL received research funds from Canadian Institutes of Health Research, NSERC and the Arthritis Society. CH had research funds for unrelated studies from Pfizer and consulted for Astra-Zeneca Canada. RE-G received research funds from Canadian Institutes of Health Research, University of Manitoba Start-Up Funds. AK received research funds from the National Health Research, the Heart and Stroke Foundation and Research Manitoba. JDF received research grant support from the Canadian Institutes of Health Research, the National Multiple Sclerosis Society, the Multiple Sclerosis Society of Canada, Crohn’s and Colitis Canada and Research Nova Scotia, and consultation and distribution royalties from NAPPI Research Trust. JIM conducted clinical trials for Biogen Idec and Roche, and received research funding from the MS Society of Canada, the MS Scientific Foundation and Research Manitoba. CNB consulted with Abbvie Canada, Amgen Canada, BMS Canada, JAMP Canada, Janssen Canada, Pfizer Canada, Roche Canada, Sandoz Canada and Takeda Canada, and received unrestricted educational grants from Abbvie Canada, BMS Canada, Janssen Canada, Pfizer Canada and Takeda Canada. He has been on speaker’s bureaus of Abbvie Canada and Shire Canada. SBP holds the Cuthbertson & Fischer Chair in Pediatric Mental Health at the University of Calgary. The sponsor had no role in the design and conduct of the study; collection, management, analysis and interpretation of the data, and preparation, review or approval of the manuscript.

Patient consent for publication Not applicable.

Ethics approval We accessed administrative databases held in the Population Research Data Repository at the Manitoba Centre for Health Policy with approval from Manitoba’s Health Information Privacy Committee and the University of Manitoba Health Research Ethics Board (H2014-201).

Provenance and peer review Not commissioned; externally peer reviewed.

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INTRODUCTION

We have previously reported the initial case reports until she died and have now went postmortem analysis. This patient had a 24-year history of episodic and semantic memory loss, but at that point memory function was intact.1 Following this, there was a slow progression of cognitive and behavioural disorder that was initially dominated by amnestic symptoms and only mild personality change. Neurological examination demonstrated that the pathological tau deposits were intact as well as the ventral striatum, with prominent disinhibition, change in appetite and musicophilia. In addition, there was mild deposition of the fibrillary tangles, most prominent in the posterior temporal gyrus. There was a gradient, in that the supratentorial tangles were more severe in the temporal lobe where there was a gradient, in that the supratentorial tangles were more severe in the temporal lobe versus the frontal cortex. Pathology showed extensive deposition of hyperphosphorylated tau protein, and, to a lesser extent, the dentate nucleus. Immunohistochemistry for tau revealed deposits. The tau pathology was prominent involvement of mesial temporal lobe structures. Tau immunohistochemistry showed extensive deposition of hyperphosphorylated tau protein, and, to a lesser extent, the dentate nucleus. Differential tau immunohistochemistry with repeated MR brain imaging (11 scans in total) as well as flortaucipir PET imaging showed strong binding of the tracer2 similar to that seen over a 20-year period, during which we accepted the finding in this study.

METHODS

A patient with a Q351R mutation was referred to our unit for memory concerns and parkinsonism with bradykinesia, rigidity and both resting and postural tremor. She was initially assessed clinically, and attended research appointments until her death in her late 60s. She died in her late 60s, 24 years after the presentation. The brain weighed 1079 g and both cerebral hemispheres showed mild cortical atrophy and cerebral atrophy in a frontotemporal pattern. The cortical abnormalities were most marked in the lateral temporal and parietal lobes (figure 1A,B,C). In the left hemisphere, ventrally, was seen later in the condition as fibrillary tangles, most prominent in the posterior temporal gyrus. There was a gradient, in that the supratentorial tangles were more severe in the temporal lobe versus the frontal cortex. Pathology showed extensive deposition of hyperphosphorylated tau protein, and, to a lesser extent, the dentate nucleus. Immunohistochemistry for tau revealed deposits. The tau pathology was prominent involvement of mesial temporal lobe structures. Tau immunohistochemistry showed extensive deposition of hyperphosphorylated tau protein, and, to a lesser extent, the dentate nucleus. Differential tau immunohistochemistry with repeated MR brain imaging (11 scans in total) as well as flortaucipir PET imaging showed strong binding of the tracer2 similar to that seen in other cases of a mixed 3R/4R tauopathy, similar to that of a mixed 3R/4R tauopathy, similar to that of a mixed 3R/4R tauopathy.

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