Prescription opioid use in multiple sclerosis

**INTRODUCTION**

Pain can be one of the worst symptoms of multiple sclerosis (MS).\(^1\) Modifiable factors, including depression and anxiety, may influence its severity and impact.\(^2\) 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 ≥1997, excluding individuals with cancer/palliative care. 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.

Contributors RAM: drafting/revision 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/revision 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. JMB: drafting/revision of the manuscript for content, including medical writing for content; major role in the acquisition of data. JS: drafting/revision of the manuscript for content, including medical writing for content; analysis or interpretation of data. LL: drafting/revision of the manuscript for content, including medical writing for content; analysis or interpretation of data. CH: drafting/revision of the manuscript for content, including medical writing for content; analysis or interpretation of data. AK: drafting/revision of the manuscript for content, including medical writing for content; analysis or interpretation of data. AS: drafting/revision of the manuscript for content, including medical writing for content; analysis or interpretation of data.

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Patient consent for publication Not applicable.

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Introduction

A patient with a Q351R mutation was assessed by a neuropsychologist and neurologist over 10 years, while still living at home and was able to go to work. At this time, there was a slow impairment with other cognitive domains, and later cortices. Striatal atrophy, particularly affecting the temporal and insular cortices, was seen later in the condition as well (figure 1D). In contrast, posterior cortical involvement also, was dominated initially by amnestic symptoms and only mild personality change. Neurological examination showed the presence of marked memory impairment with other cognitive domains, and later cortices. Striatal atrophy, particularly affecting the temporal and insular cortices, was seen later in the condition as well. Postmortem analysis confirmed the presence of marked memory impairment with other cognitive domains, and later cortices. Striatal atrophy, particularly affecting the temporal and insular cortices, was seen later in the condition as well. Postmortem analysis confirmed the presence of marked memory impairment with other cognitive domains.

Methods

The use of flortaucipir PET imaging showed strong binding of the tracer similar to that seen in other MAPT mutations (R406W and V337M). The neuropathological examination showed extensive deposition of hyperphosphorylated tau in the amygdala, basal ganglia (ventral >dorsal striatum), and brainstem (midbrain >pons >medulla). Neurites and dot-like tangles were frequent in the temporal white matter, basal ganglia (ventral >dorsal striatum), and, to a lesser extent, the dentate nucleus. Tau immunohistochemistry showed extensive deposition of hyperphosphorylated tau in the amygdala, basal ganglia (ventral >dorsal striatum), and brainstem (midbrain >pons >medulla). Neurites and dot-like tangles were frequent in the temporal white matter, basal ganglia (ventral >dorsal striatum), and, to a lesser extent, the dentate nucleus.

Discussion

The clinical presentation of this patient was unique due to the novelty of the mutation and its clinical features. The Q351R mutation is one of the mutations in the MAPT gene that causes frontotemporal dementia (FTD). The patient presented with a slowly progressive behavioral disorder that was characterized by a slowly progressive cognitive and behavioral disorder. The patient was still living at home and was able to go to work. At this time, there was a slow impairment with other cognitive domains, and later cortices. Striatal atrophy, particularly affecting the temporal and insular cortices, was seen later in the condition as well. Postmortem analysis confirmed the presence of marked memory impairment with other cognitive domains, and later cortices. Striatal atrophy, particularly affecting the temporal and insular cortices, was seen later in the condition as well. Postmortem analysis confirmed the presence of marked memory impairment with other cognitive domains.

References