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BMJ

BMJ 2011;343:d5142 doi: 10.1136/bmj.d5142

ANALYSIS

Facing up to the prescription opioid crisis

Deaths resulting from prescription opioids tripled in the United States between 1999 and 2007 and are also increasing in many other countries, including the United Kingdom. **Irfan A Dhalla**, **Navindra Persaud**, and **David N Juurlink** describe how this situation developed and propose several ways to reduce morbidity and mortality from opioids

Irfan A Dhalla *lecturer* [1 2 3 4], Navindra Persaud *research fellow* [3 5 6], David N Juurlink *division head, clinical pharmacology* [1 4 7]

[1]Departments of Medicine and Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada; [2]Department of Medicine, St Michael's Hospital, Toronto; [3]Li Ka Shing Knowledge Institute, St Michael's Hospital, Toronto; [4]Institute for Clinical Evaluative Sciences, Toronto; [5]Department of Family and Community Medicine, St. Michael's Hospital ; [6]Department of Family and Community Medicine, University of Toronto; [7]Sunnybrook Research Institute, Toronto

Over the past 25 years, physicians in many countries have become increasingly willing to prescribe opioids for chronic pain with causes other than cancer. The burgeoning use of opioids has been accompanied by a steep increase in opioid related mortality. In the United States, deaths involving opioid analgesics increased from 4041 in 1999 to 14 459 in 2007 (fig 1⇓) and are now more common than deaths from multiple myeloma, HIV, and alcoholic liver disease.[1] Opioid prescribing and opioid related deaths—most of them unintentional and of relatively young people—have also increased elsewhere, including in the United Kingdom. While drug specific data are not universally available, deaths involving oxycodone have increased especially rapidly in several jurisdictions, including Ontario in Canada and Victoria, Australia (fig 2⇓).[2 3]

The International Narcotics Control Board has noted that addiction to prescription opioids is a problem in almost all countries. For example, the board has estimated that between 1.4 million and 1.9 million Germans are addicted to prescription drugs.[5] In the United Kingdom, the former chair of the House of Commons All Party Parliamentary Group on Drug Misuse has expressed concern that the United Kingdom may face a similar epidemic to that of North America in 5 to 10 years, and one doctor has called the increased prescribing of strong opioids for chronic non-cancer pain in the UK a "disaster in the making."[6] Indeed, deaths involving methadone and codeine roughly doubled in England and Wales between 2005 and 2009, while deaths involving heroin or morphine remained unchanged.[7] Deaths involving tramadol have also become increasingly common in the UK.[7]

In this article, we describe the evolution of the prescription opioid crisis in North America and propose several potential solutions. In addition to reducing morbidity and mortality in countries where the burden of opioid related harm is already high, implementation of these proposals elsewhere could prevent the spread of the crisis to other countries.

Rise of opioid related harm

The therapeutic use of compounds derived from the opium poppy predates written history. The first semi-synthetic opioid, diamorphine, was marketed as a cough suppressant by Bayer in 1898. Its proprietary name—heroin—reflected a keen appreciation of its euphoric properties. However, it soon became clear that heroin was rapidly metabolised to morphine and consequently shared all of its associated risks, including addiction, central nervous system depression, and death. In the early part of the 20th century, the morbidity associated with opioids led many countries to pass laws restricting their use. For example, the United States approved the Harrison Narcotics Tax Act in 1914, making it illegal for physicians to prescribe opioids to treat addiction, and the League of Nations banned heroin outright in 1925. Drug manufacturers responded to these restrictions by synthesising and marketing several new opioids, including oxycodone and hydromorphone. But by the early 1930s, international regulations had been broadened to restrict the sale of all opioids. For the next few decades, opioids were prescribed relatively infrequently.

During the second half of the 20th century, most physicians became comfortable prescribing opioids for acute pain and pain due to cancer. Opioids have improved the quality of life for millions of patients with such pain. In contrast, opioids were rarely prescribed to patients with chronic pain from other causes until the 1980s, when opinion leaders began to advocate their broader use. In the 1990s, coincident with the approval and marketing of several new opioid formulations in North America, the notion that chronic non-cancer pain was under-recognised and undertreated became widespread. By the mid-1990s, the

Correspondence to: I A Dhalla, 30 Bond Street, Toronto, ON M5B 1W8, Canada dhallai@smh.ca

pendulum had swung sufficiently far that physicians reluctant to prescribe opioids for chronic non-cancer pain came to be criticised as being "opiophobic."[8]

Marketing in the evidence void

Many physicians are unaware that there is no evidence from randomised controlled trials to support the popular assertion that the benefits of long term opioid therapy outweigh the risks.[9] The trials that have been completed were generally short term (less than 16 weeks) and used placebo comparators (rather than paracetamol or non-steroidal anti-inflammatory drugs). Furthermore, because these trials invariably excluded patients at high risk of serious adverse events, neither their safety nor efficacy findings can be generalised to everyday clinical practice.[10]

The evidence for the use of opioids in chronic non-cancer pain is sufficiently limited that the authors of one Cochrane review concluded that they should not be used even for severe osteoarthritic pain.[11] A recently published observational study supports the assertion that the risks of opioids outweigh the benefits in this setting.[12] The dearth of high quality evidence has left those who write clinical practice guidelines in the unenviable position of having insufficient evidence with which to formulate meaningful recommendations. As a result, rather than recommending for or against the long term use of opioids, some guidelines merely recommend that physicians "consider the evidence related to effectiveness" before deciding to initiate treatment.[13]

Despite the paucity of evidence, drug manufacturers have aggressively promoted opioids for use in patients with chronic non-cancer pain. The case of OxyContin, a sustained release formulation of oxycodone sold by Purdue Pharma in North America, warrants particular consideration because successful legal proceedings against Purdue and several of its executives have made public many aspects of its marketing.[14 15] In court documents and a United States Congressional investigation, Purdue acknowledged that its employees misled physicians about the risk of addiction. Some Purdue employees suggested that OxyContin could be used to "weed out" addicts and drug seekers,[15] while others capitalised on the prevalent misconception that oxycodone is less potent than morphine[15] when the converse is true. Certain aspects of Purdue's marketing methods are particularly remarkable in light of the drug's abuse liability and potential lethality. The manufacturer targeted physicians who prescribed OxyContin frequently, paid its sales representatives large bonuses as an incentive to increase OxyContin sales, and issued coupons entitling new patients to free samples at participating pharmacies.[16]

Other opioid manufacturers have also been cited for inappropriate marketing. For example, Janssen Pharmaceuticals was warned by the US Food and Drug Administration for making false safety claims and unsubstantiated effectiveness claims about its transdermal fentanyl patch.[17] Similarly, the FDA warned King Pharmaceuticals that "the omission of serious and potentially fatal risks" associated with its morphine-naltrexone product was "especially egregious and alarming in its potential impact on the public health."[18]

Reducing opioid related harm

Most clinicians acknowledge that opioid related harm is a major public health problem, but there are no universally accepted solutions. Given the scale of the problem—there are more deaths from prescription opioids in North America than from heroin and cocaine combined—we believe an aggressive approach is necessary. We propose several strategies that, if implemented together, could substantially reduce the number of deaths involving opioid analgesics.

Marketing restrictions

We suggest the abolition of specific marketing practices for prescription drugs with potential for abuse. Drug companies should be prohibited from linking employee compensation with the volume of opioid prescriptions, and coupons entitling new patients to a free prescription should not be permitted for potentially addictive drugs. Additionally, regulatory authorities should ensure that all promotional material for opioids is accurate and adheres to existing regulations. Regulators should evaluate advertisements before they are deployed rather than simply warning manufacturers after misleading claims have been widely disseminated. Marketing that contravenes policy should be discouraged by a meaningful deterrent, so that companies do not come to view penalties as the cost of doing business. It is worth noting that the $634m (£387m; €440m) fine given to Purdue for misbranding OxyContin represents substantially less than a single year of the drug's sales (US sales for 2010 were $3.5bn[19]).

The ultimate regulatory sanction would be to rescind approval for individual opioid formulations. At least one group with support from people affected by opioid related harm (www.banoxycontin.com) has lobbied the FDA to ban OxyContin. Although this is clearly a radical measure, it may be the only way to effectively counter the durable consequences of Purdue's illegal marketing. In support of this argument is evidence that OxyContin sales in the United States continued to increase after Purdue's guilty plea agreement was widely publicised. Although it could be argued that the withdrawal of one opioid would simply lead to increased use of another, the UK experience after the withdrawal of co-proxamol indicates that this might not be the case.[20]

Patient and physician registries

Many jurisdictions require that physicians who prescribe methadone for opioid addiction, as well as their patients, register with a governmental or quasi-governmental authority. The reasons for this are that methadone toxicity can be fatal, the drug is often sold illegally, and that some patients seek prescriptions from multiple physicians and pharmacies. Each of these observations is also true for other prescription opioids. In our view, the legitimate privacy concerns associated with registries are offset by public health considerations. Registration of high dose or long term treatment for chronic non-cancer pain would allow education to be targeted at physicians who prescribe opioids frequently or at very high doses.[21 22] Setting a dose threshold for registration may also remind physicians that the risk of opioid related mortality in patients with chronic pain is strongly associated with the prescribed dose.[23]

Real time electronic databases

In some jurisdictions (such as, Kentucky and British Columbia), prescriptions for opioids and other controlled substances are maintained in a centralised database accessible to physicians and pharmacists before they prescribe or dispense a drug. These "real time" electronic databases could make it much harder to obtain opioids from multiple doctors or pharmacies. Real time databases would also help avoid synergistic drug interactions that occur when multiple central nervous system depressants are prescribed and might also strengthen the physician-patient

relationship by allowing the physician to verify a patient's history. Where these databases exist, we believe physicians and pharmacists should be required to access them before prescribing or dispensing opioids.

Education

Given the attention paid to physicians by drug company representatives,[16] regulatory authorities should consider educational outreach programmes to improve the appropriateness of opioid prescribing.[20] Educational outreach programmes use some of the same marketing principles as the drug industry (such as, face to face meetings, frequent encounters, and concise reading material) but use independent healthcare professionals. Physicians could be educated about the lack of evidence supporting the long term use of opioids for chronic non-cancer pain, the relative potency of commonly used opioids, the potential for dangerous interactions with sedatives and alcohol and how to screen for drug misuse and diversion, as well as the safety, effectiveness and availability of potential alternatives, including paracetamol, non-steroidal anti-inflammatory drugs, antidepressants and non-pharmacologic treatment options.

Most jurisdictions have yet to implement public education campaigns highlighting the potential hazards of prescription opioids, particularly when combined with alcohol or sedatives. Such initiatives should be seriously considered, particularly in light of the effectiveness of public education campaigns aimed at reducing deaths from motor vehicle collisions, melanoma, and alcohol related illness.

Research

Finally, drug companies and research funding agencies should encourage and support well designed studies to characterise the patient populations that stand to benefit from long term opioid treatment. The FDA and the European Medicines Agency should go further and mandate long term trials to better delineate the circumstances in which the benefits of opioids justify the potential risks. Industry initiated long term clinical trials are a matter of course in oncology and cardiovascular medicine, yet no such trials have been conducted on the use of opioids for chronic non-cancer pain.

Conclusion

Although opioids are a valuable option for the treatment of acute pain and chronic cancer pain, the risk:benefit ratio is not nearly as clear in patients with non-cancer pain. With more than 1000 deaths every month in the United States, the risks of long term opioid therapy may outweigh the benefits in unselected populations. Maintaining access to opioid analgesics for appropriately selected patients while striving for major reductions in opioid related deaths is a challenging objective that must be a priority in the years ahead.

We thank Arthur Slutsky, Allan Detsky, Lewis Nelson, Donald Redelmeier, Tara Kiran, Moira Kapral, and Lorraine Ferris for helpful advice and Angela Rintoul for providing the raw data for fig 2.

Contributors and sources: All three authors are practising physicians who regularly prescribe opioids. DNJ and IAD have published several papers describing opioid related harm in Ontario, Canada. Both also serve on the Committee to Evaluate Drugs, which makes recommendations to the Ministry of Health and Long Term Care in Ontario regarding which drugs should be paid for publicly. IAD wrote the first draft of this manuscript. DNJ and NP revised the draft. All authors approved the submitted version. IAD is the guarantor.

Competing interests: All authors have completed the ICJME unified disclosure form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years, and no other relationships or activities that could appear to have influenced the submitted work.

Provenance and peer review: Not commissioned; externally peer reviewed.

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Accepted: 1 August 2011

Cite this as: *BMJ* 2011;343:d5142

Figures

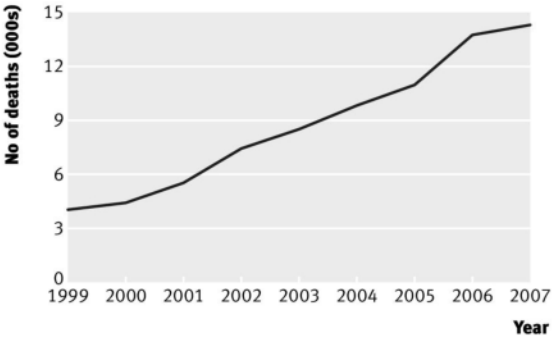


Fig 1 Deaths involving opioid analgesics in the United States[1 4]

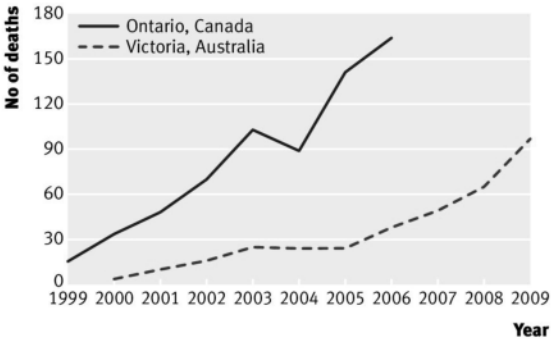


Fig 2 Deaths involving oxycodone in Ontario, Canada (data from Dhalla et al[2] updated with coroner's data) and Victoria, Australia[5]

Responsible Prescribing Practices

April 10-12, 2012

Walt Disney World Swan Resort

Learning Objectives:

1. Describe how cautious, evidence-based prescribing practices can lower opioid-related overdose deaths while maintaining appropriate access for medically needed treatment of chronic pain.
2. Identify "best practice" strategies that can be used by clinicians for pain management treatment.
3. Explain evidence-based practice and policies for provider education and patient education programs being utilized across the US.

Orlando, FL • April 10-12, 2012
NATIONAL RX DRUG ABUSE SUMMIT
NationalRxDrugAbuseSummit.org

Disclosure Statement

- All presenters for this session, Dr. Rollin M. Gallagher, Dr. Andrew Kolodny, and Robert Sproul, have disclosed no relevant, real or apparent personal or professional financial relationships.

The Opium Poppy

Papaver Somniferum

Crude Opium Latex on Poppy Head

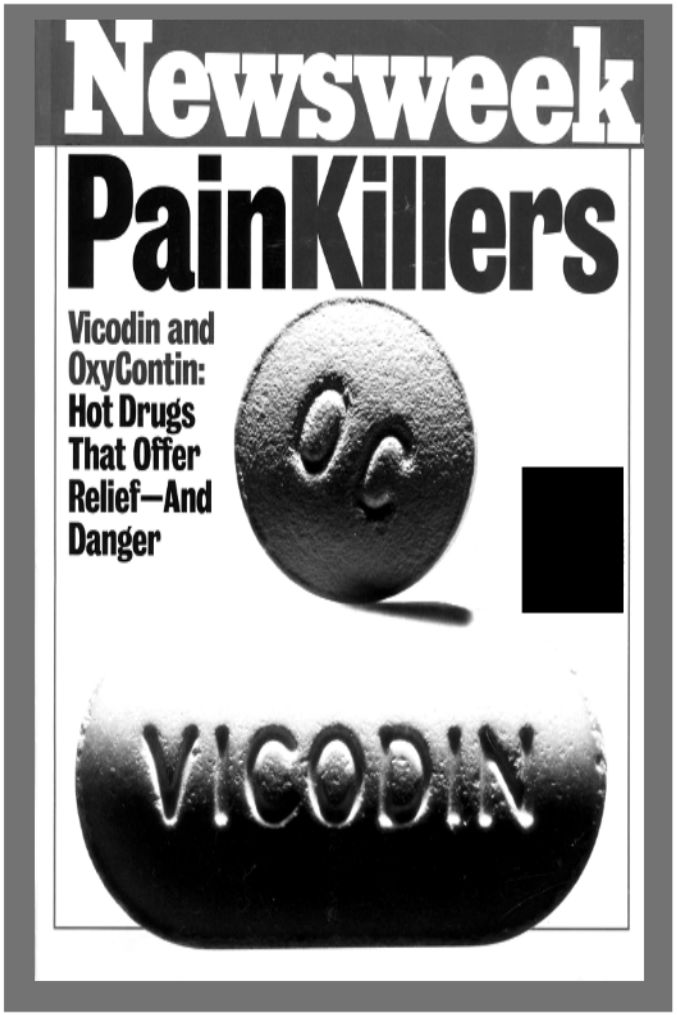
Orlando, FL • April 10-12, 2012
NATIONAL RX DRUG ABUSE SUMMIT
NationalRxDrugAbuseSummit.org

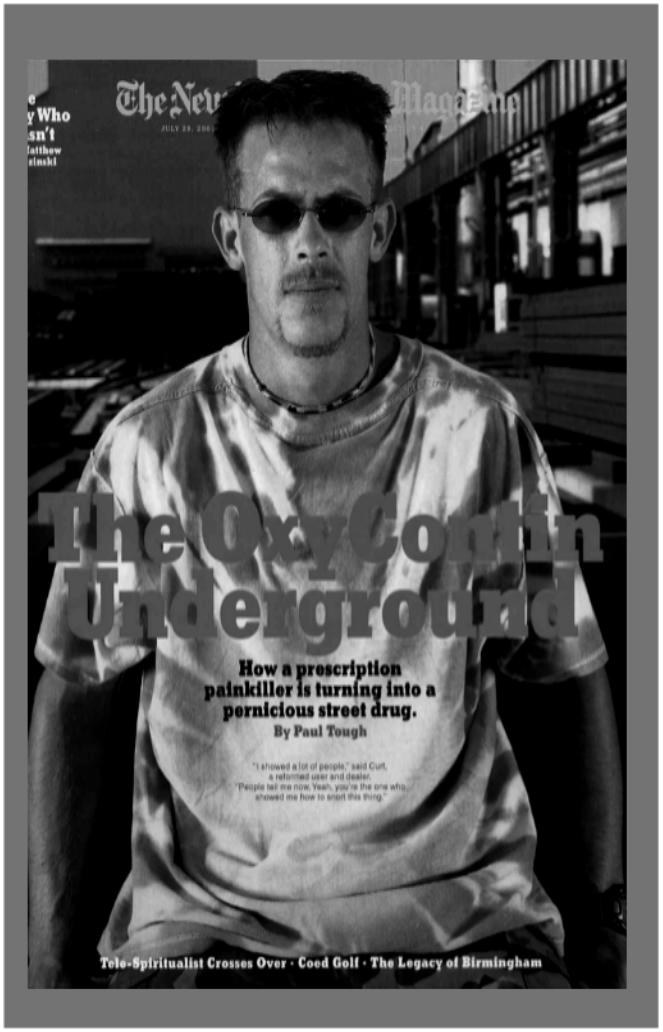
Opioids

- Morphine
- Codeine
- Heroin
- Hydrocodone (Vicodin, Lortab)
- Methadone
- Oxycodone (Percodan, Oxycontin)
- Hydromorphone (Dilaudid)
- Meperidine (Demerol)

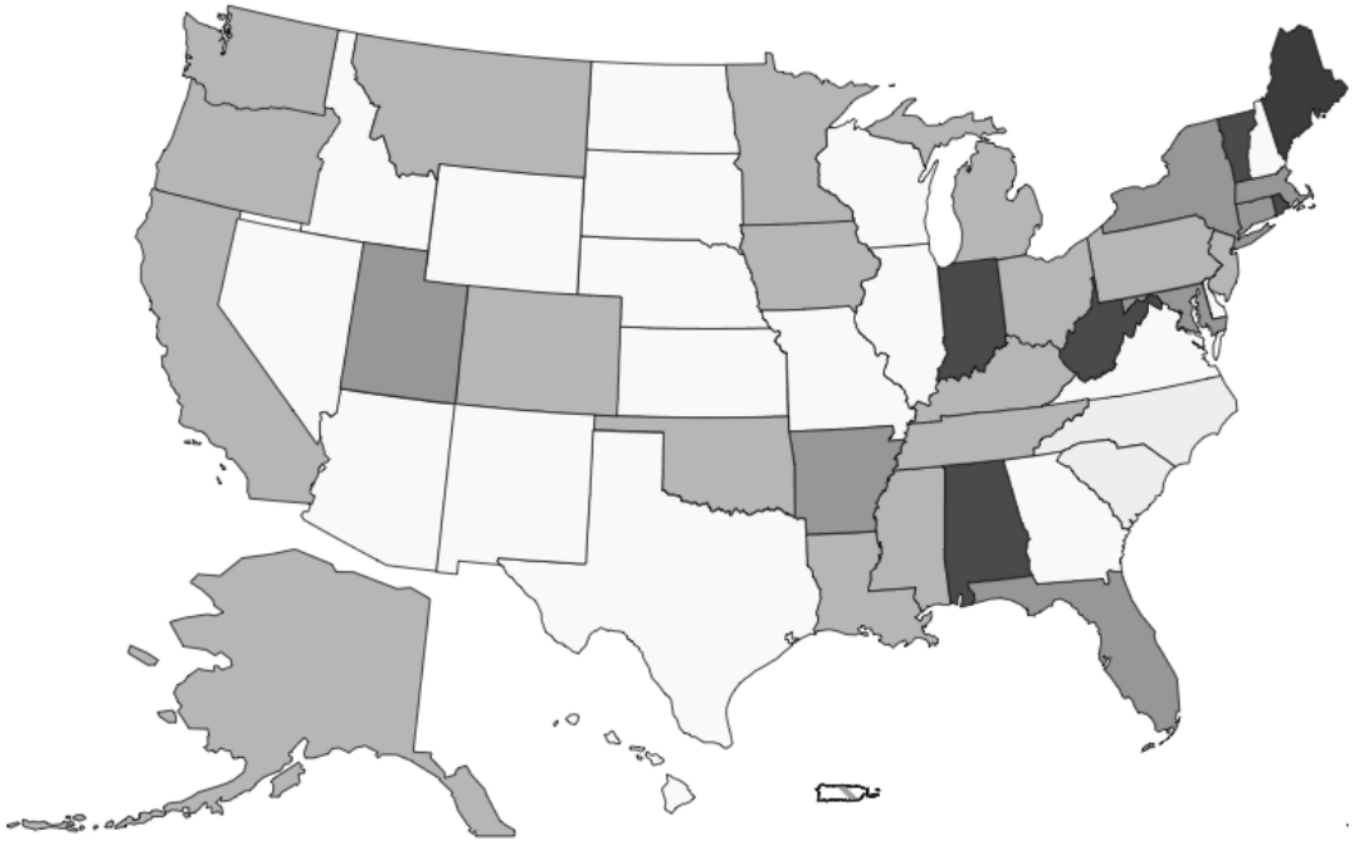

FARBENFABRIKEN
vorm.
FRIEDR. BAYER & Co
ELBERFELD.
Heroin
Nom déposé


BAYER
PHARMACEUTICAL PRODUCTS.
Send for samples and Literature to
ASPIRIN
The substitute for the salicylates
PROTARGOL
QUINALGEN
EUROPHEN
HEROIN
The sedative for coughs
LYCETOL
The uric acid solvent
SOMATOSE
STCOSE
SALOPHEN
FARBENFABRIKEN OF ELBERFELD CO.
40 STONE ST NEW YORK.


Newsweek
PainKillers
Vicodin and OxyContin: Hot Drugs That Offer Relief—And Danger
VICODIN


The OxyContin Underground
How a prescription painkiller is turning into a pernicious street drug.
By Paul Tough
Tele-Spiritualist Crosses Over · Coed Golf · The Legacy of Birmingham

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



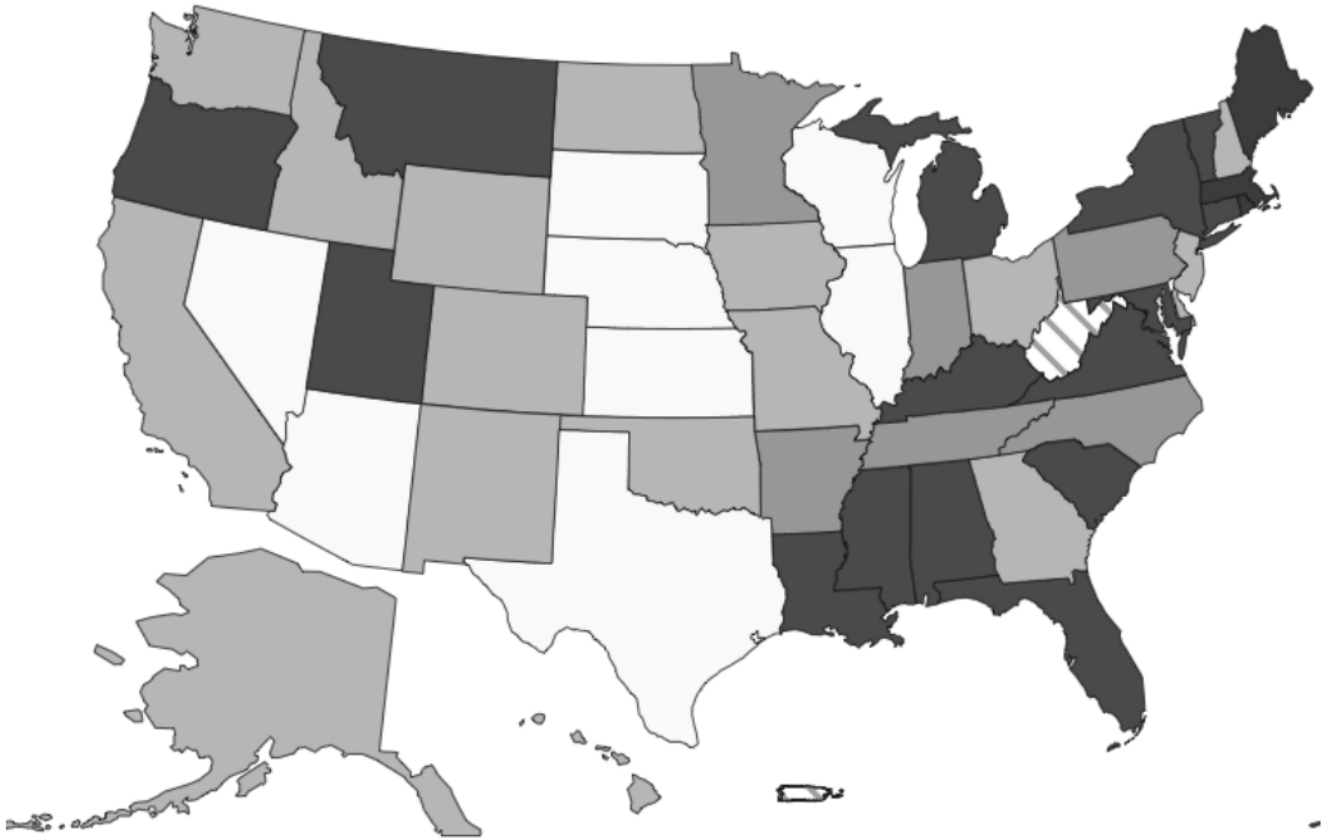
1999

(range 1 - 50)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



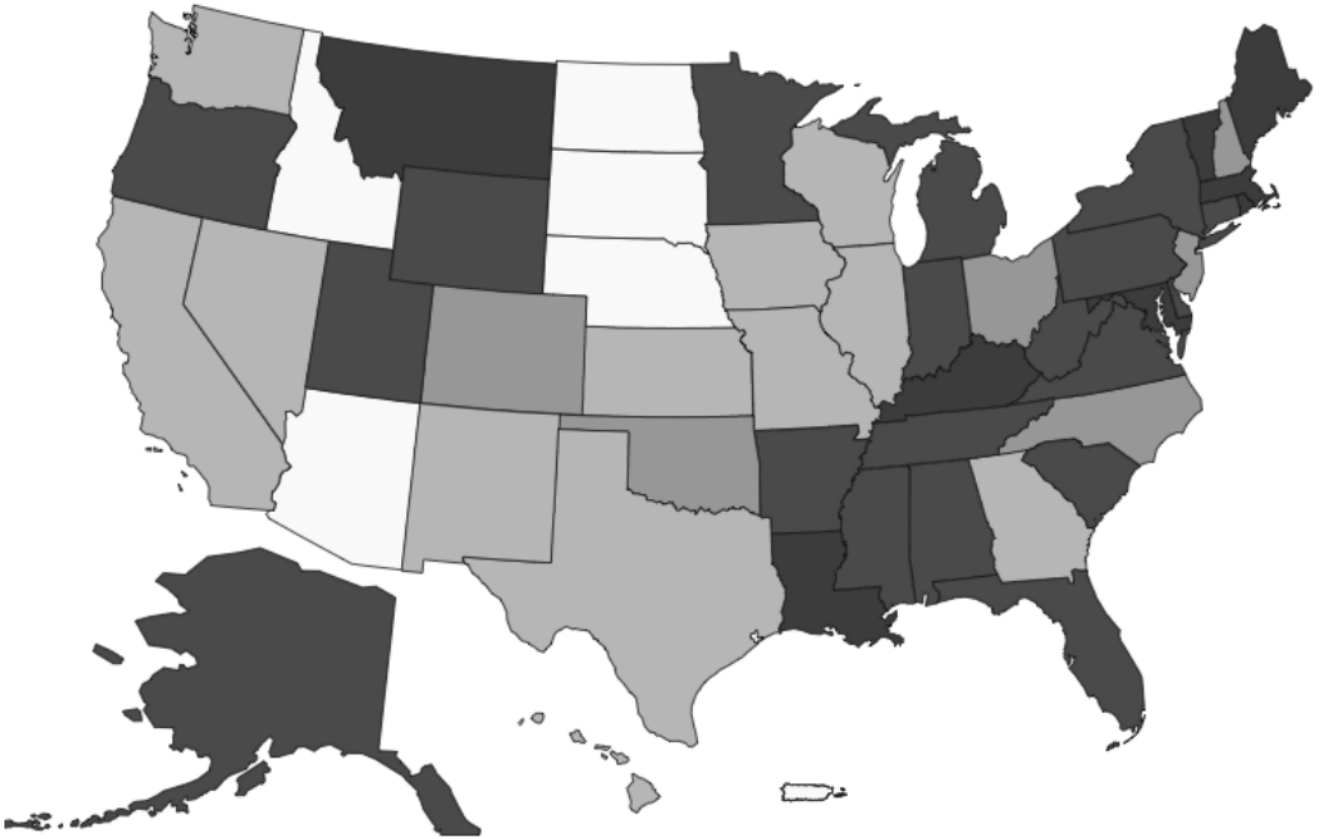
2001

(range 1 – 71)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



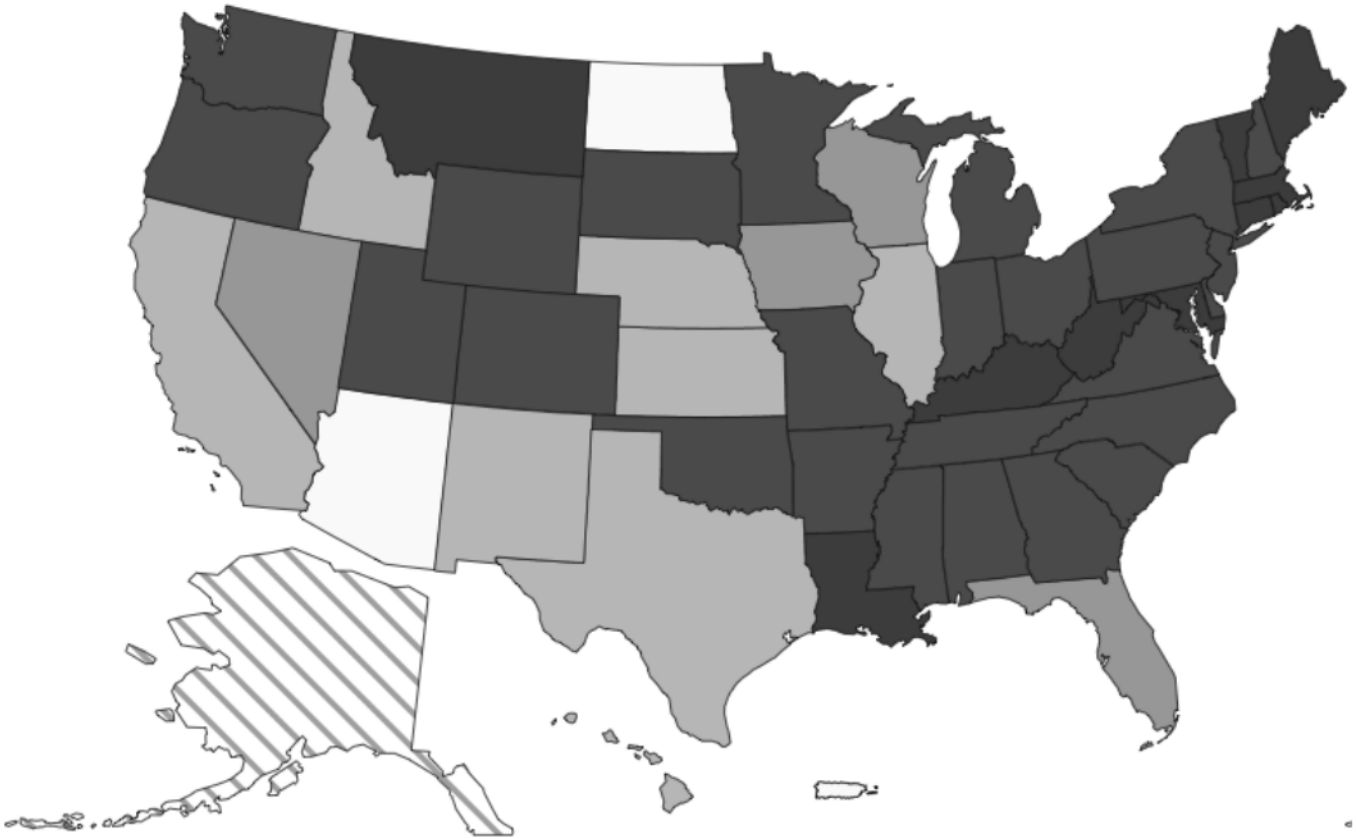
2003

(range 2 – 139)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



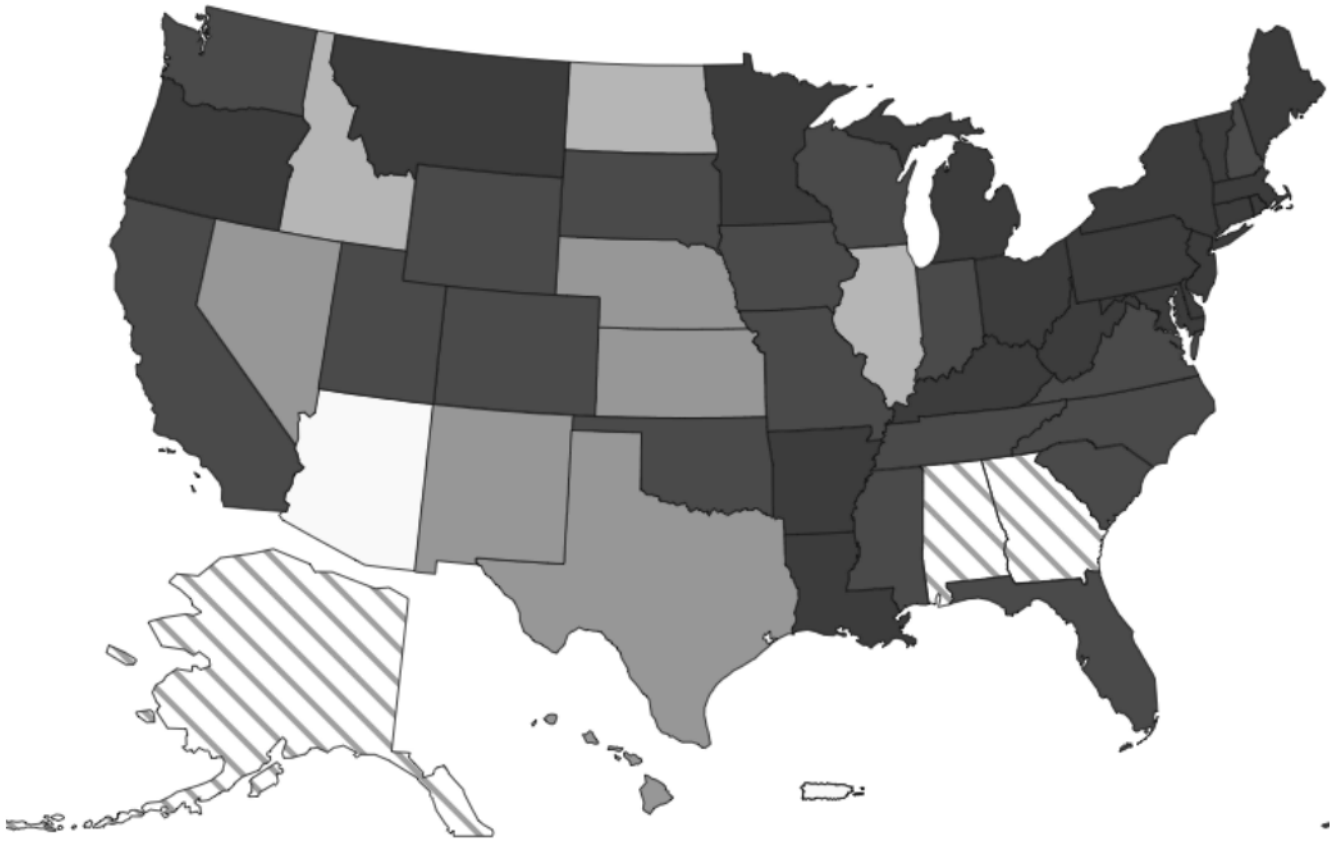
2005

(range 0 – 214)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



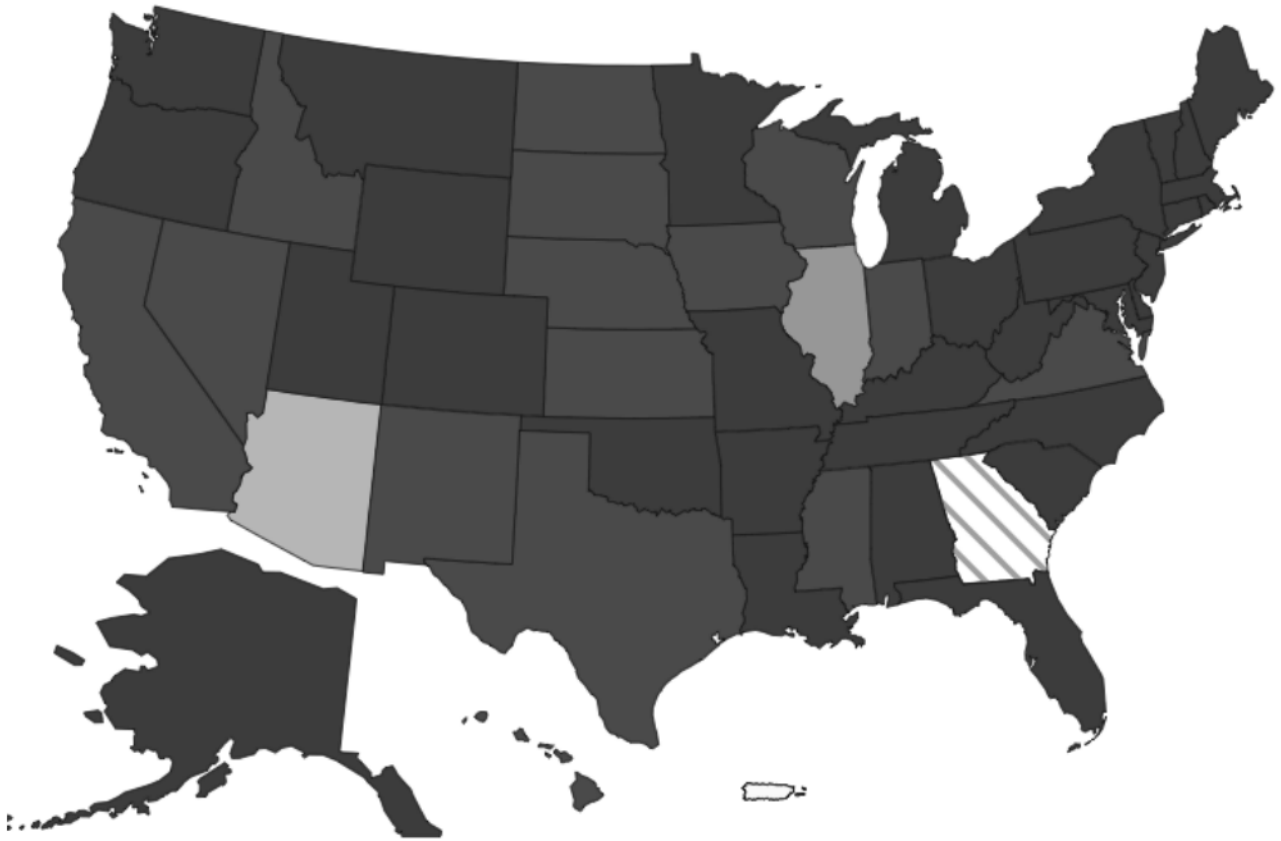
2007

(range 1 – 340)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



2009

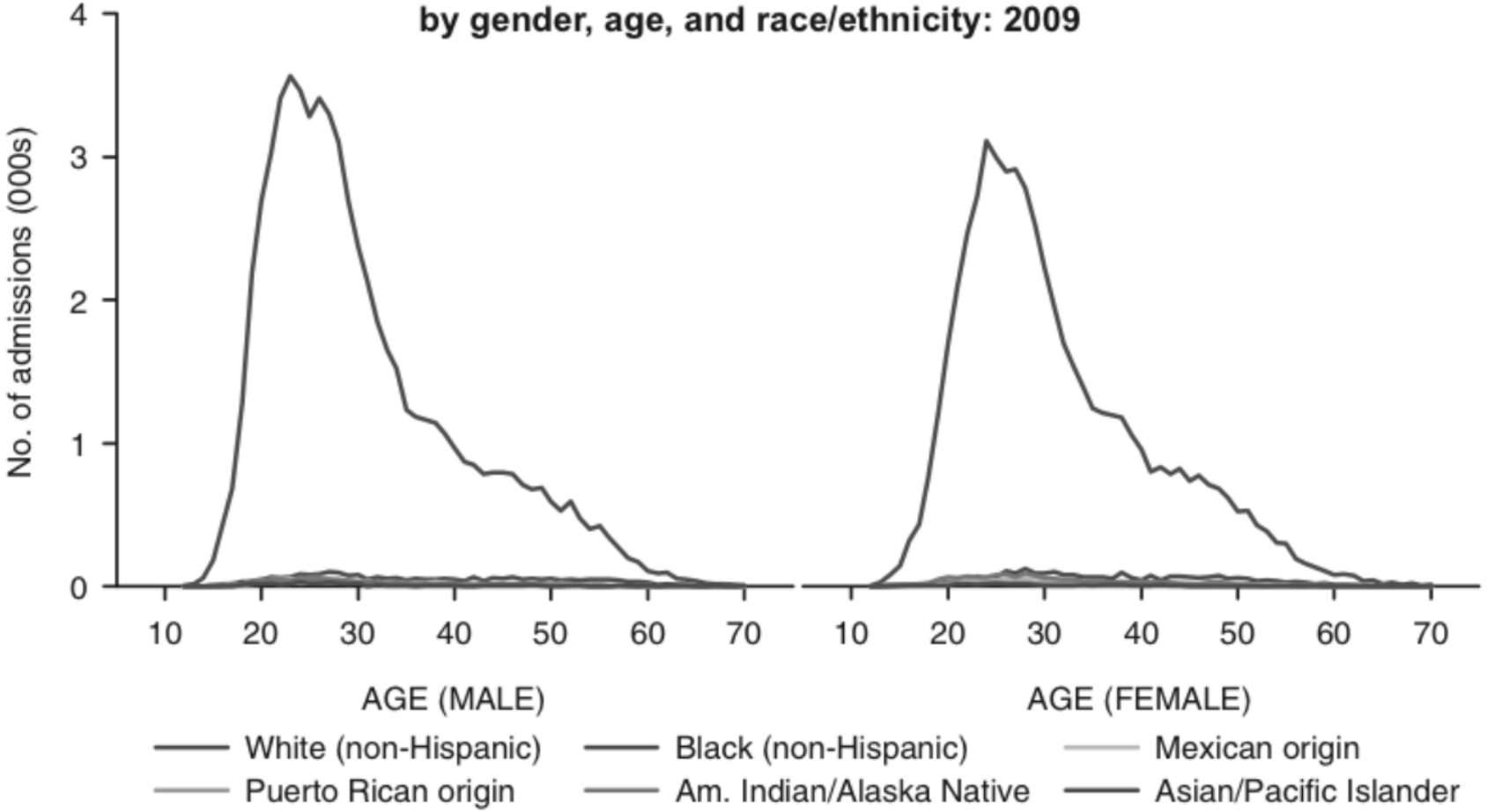
(range 1 – 379)

< 8	15 - 18	45 or more
8 - 14	19 - 44	Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

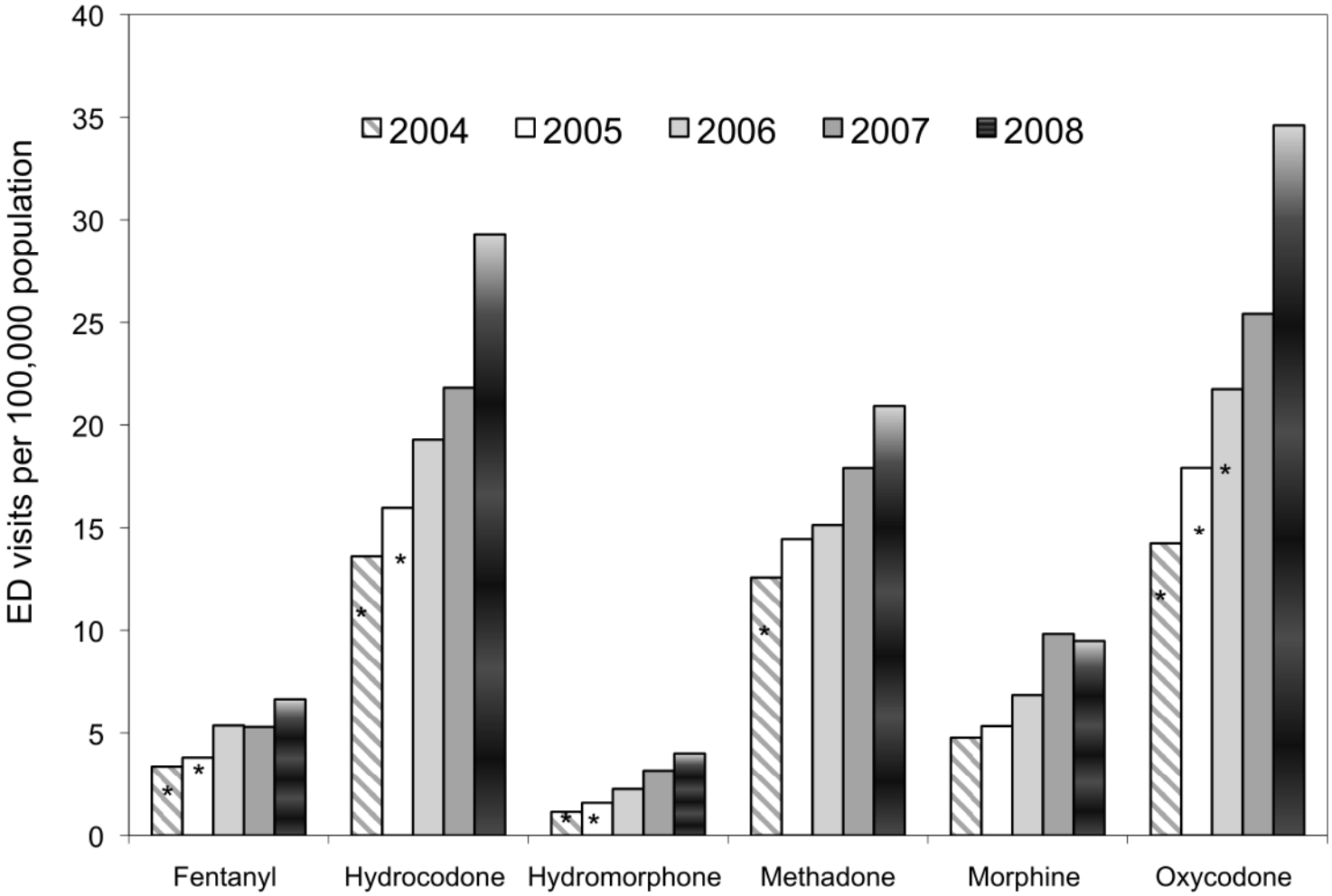
Characteristics of opioid-addicted, treatment-seeking patients

Figure 9. Non-heroin opiate admissions, by gender, age, and race/ethnicity: 2009



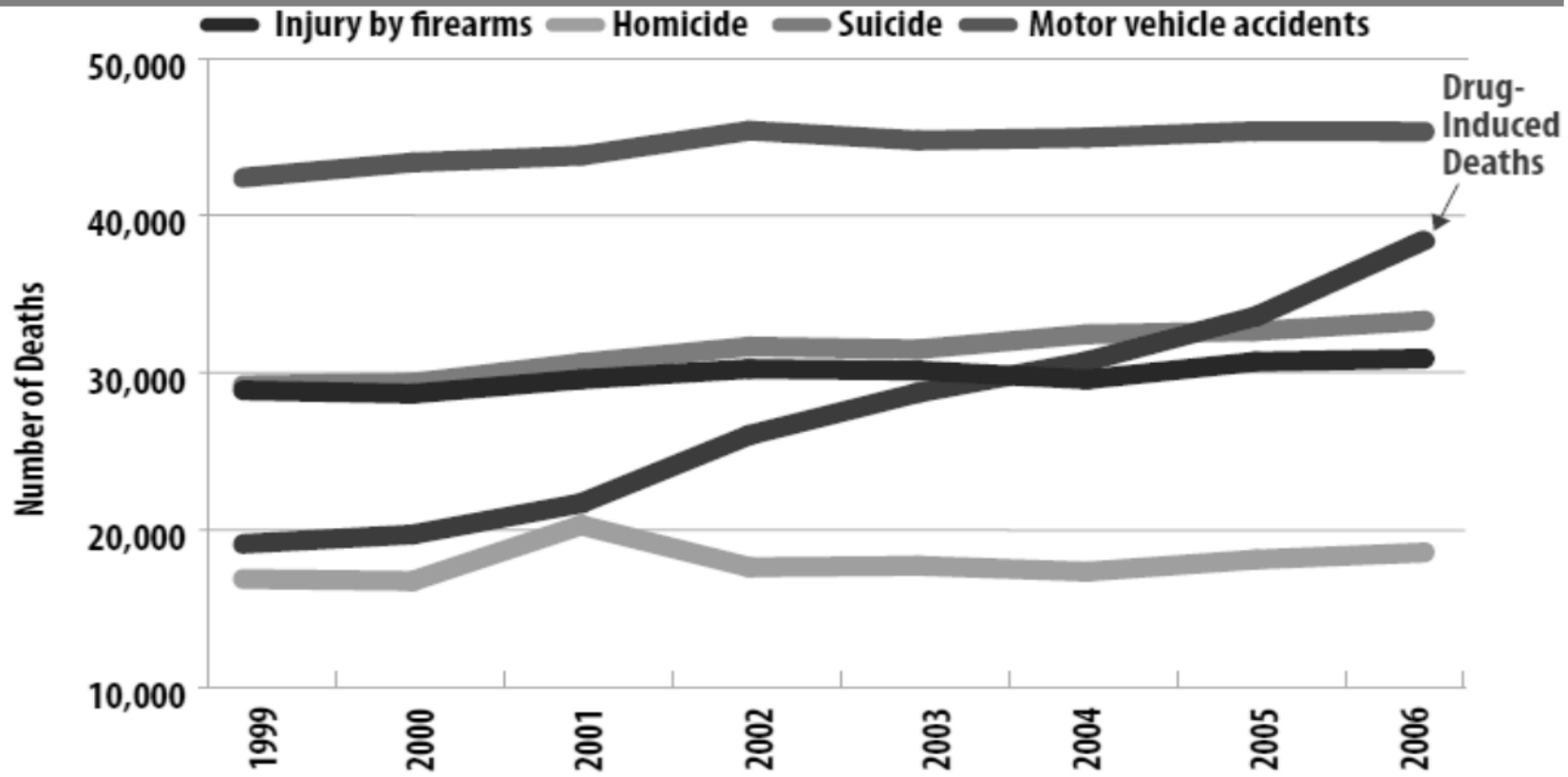
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Rates of ED visits for nonmedical use of selected opioid analgesics increased significantly in the US



* Indicates a rate that was significantly less than the rate in 2008.
Note: Drug types include combination products , e.g, combinations of oxycodone and aspirin.

Number of drug-induced deaths compared with other types of deaths, US, 1999-2006



Causes of death attributable to drugs include accidental or intentional poisonings by drugs, drug psychoses, drug dependence, and nondependent use of drugs. Drug-induced causes exclude accidents, homicides, and other causes indirectly related to drug use. Not all cause categories are mutually exclusive.

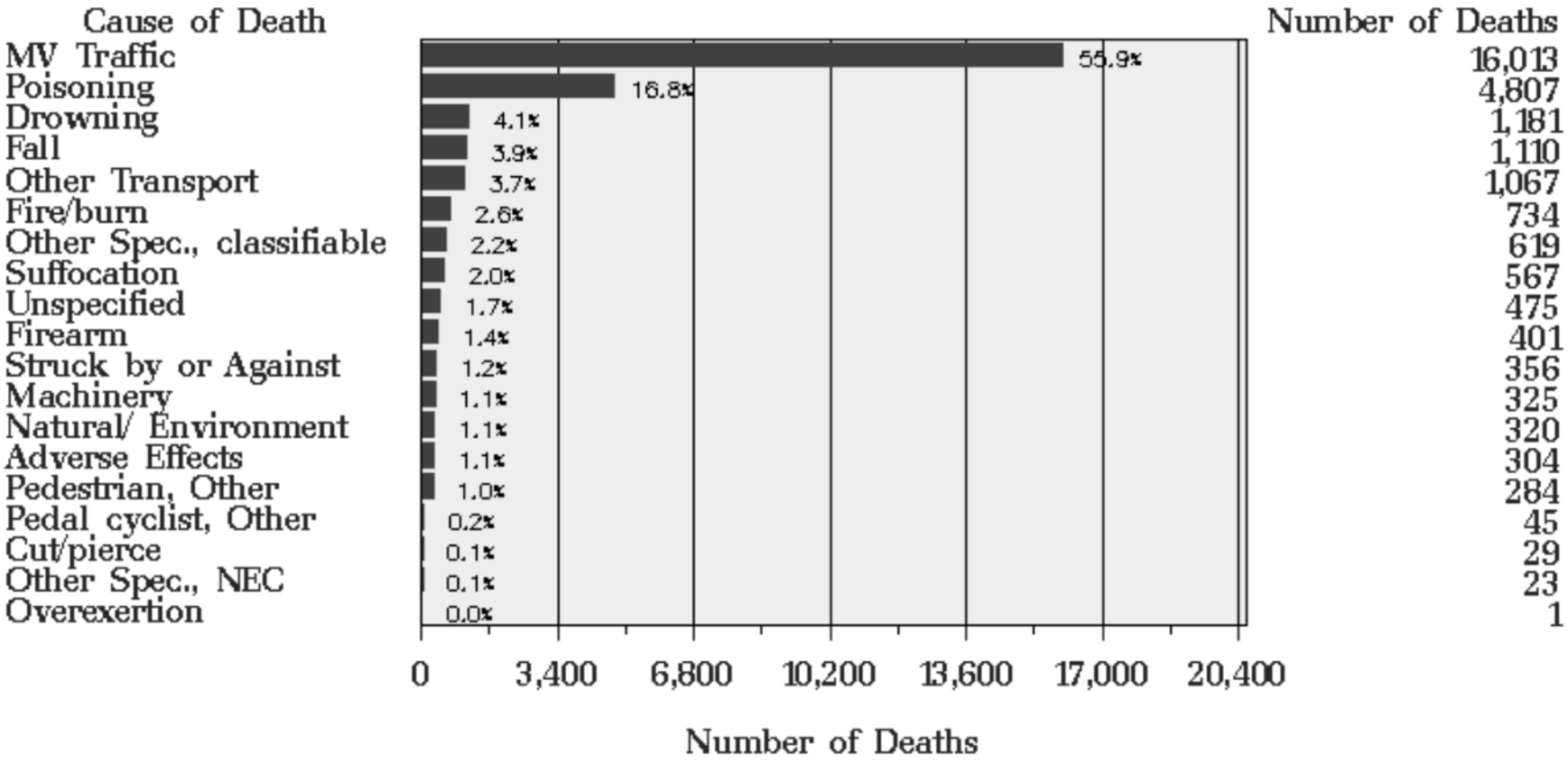
Source: National Center for Health Statistics/CDC, *National Vital Statistics Report, Deaths: Final Data for 2006* (April 2009).

1996, United States

Unintentional Injuries and Adverse Effects

Ages 19–50, White, Non–Hispanic*, Both Sexes

Total Deaths: 28,661



NEC means Not Elsewhere Classifiable.

WISQARS™ Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

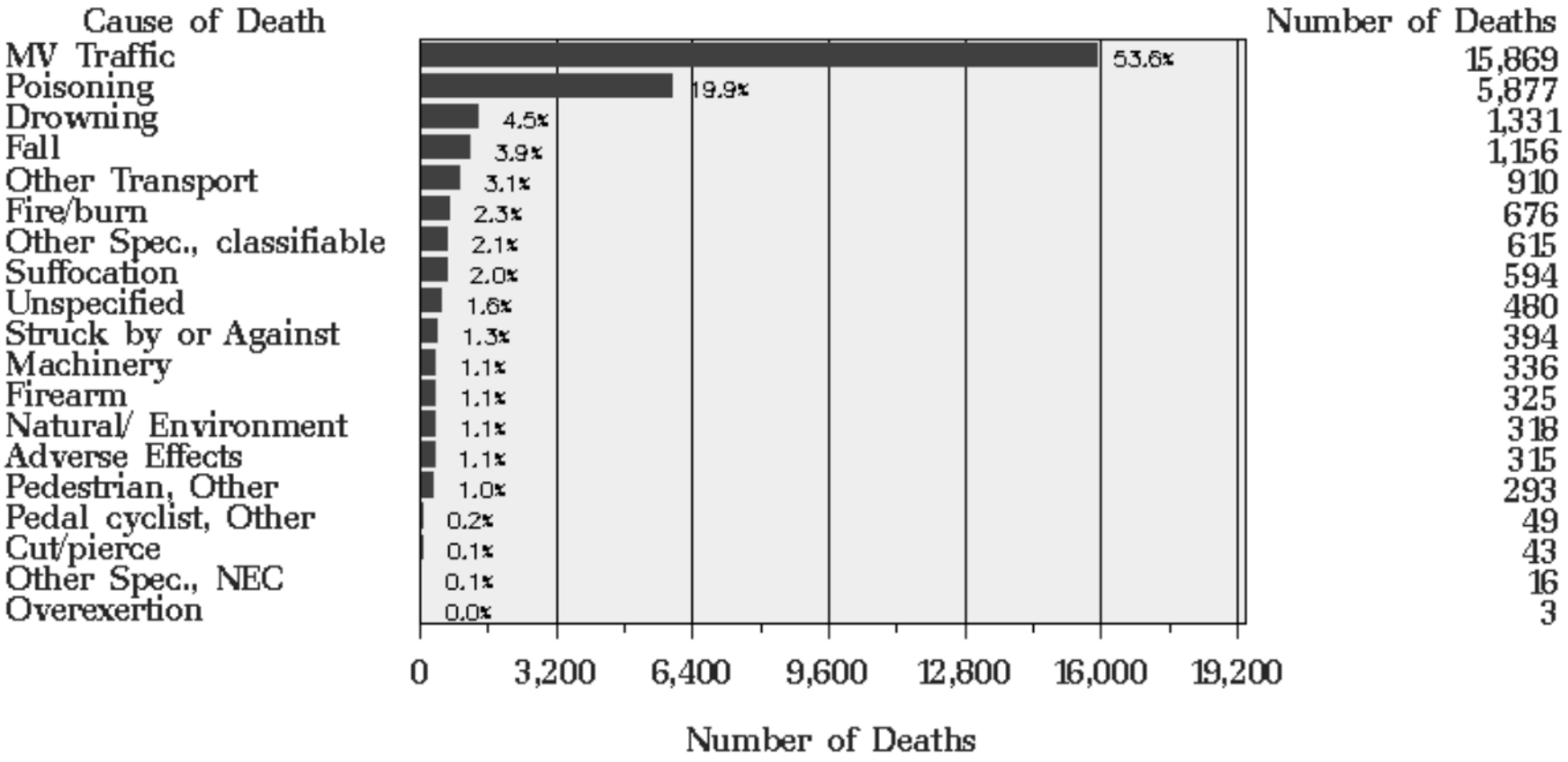
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

1998, United States

Unintentional Injuries and Adverse Effects

Ages 19–50, White, Non–Hispanic*, Both Sexes

Total Deaths: 29,600



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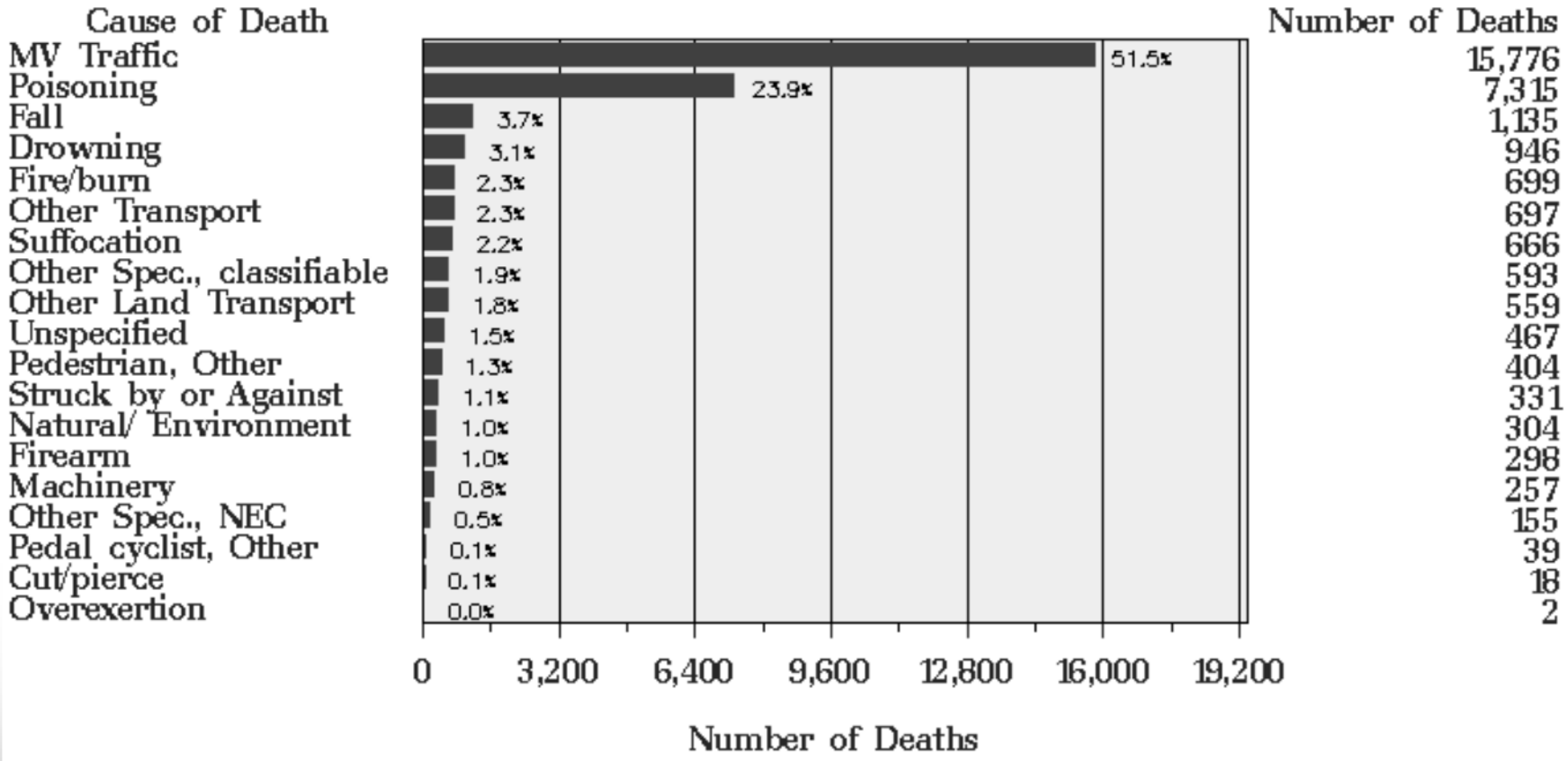
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

2000, United States

Unintentional Injuries

Ages 19–50, White, Non–Hispanic, Both Sexes

Total Deaths: 30,661



NEC means Not Elsewhere Classifiable.

WISQARS™ Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

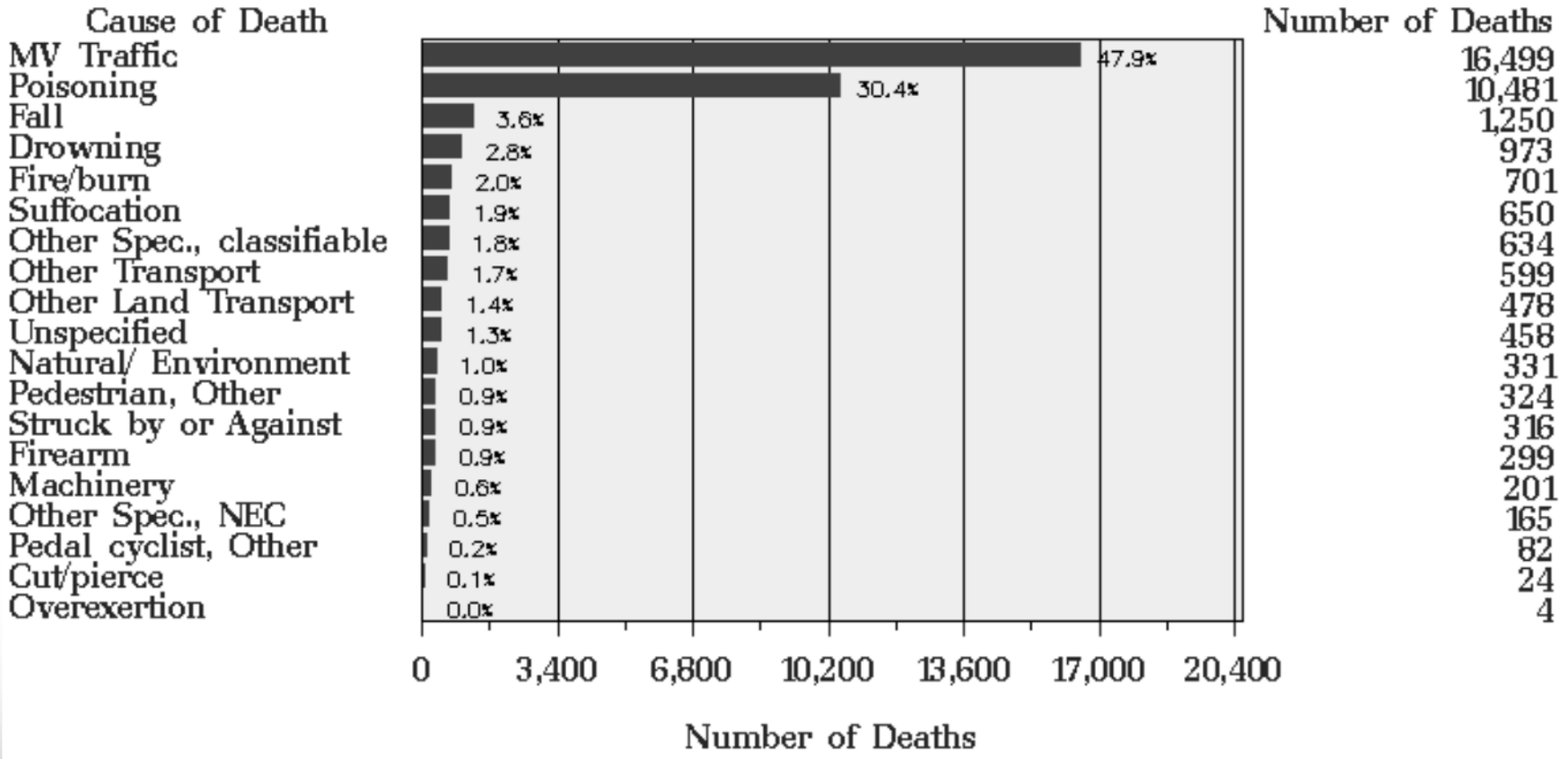
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

2002, United States

Unintentional Injuries

Ages 19–50, White, Non–Hispanic, Both Sexes

Total Deaths: 34,469



NEC means Not Elsewhere Classifiable.

WISQARS™ Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

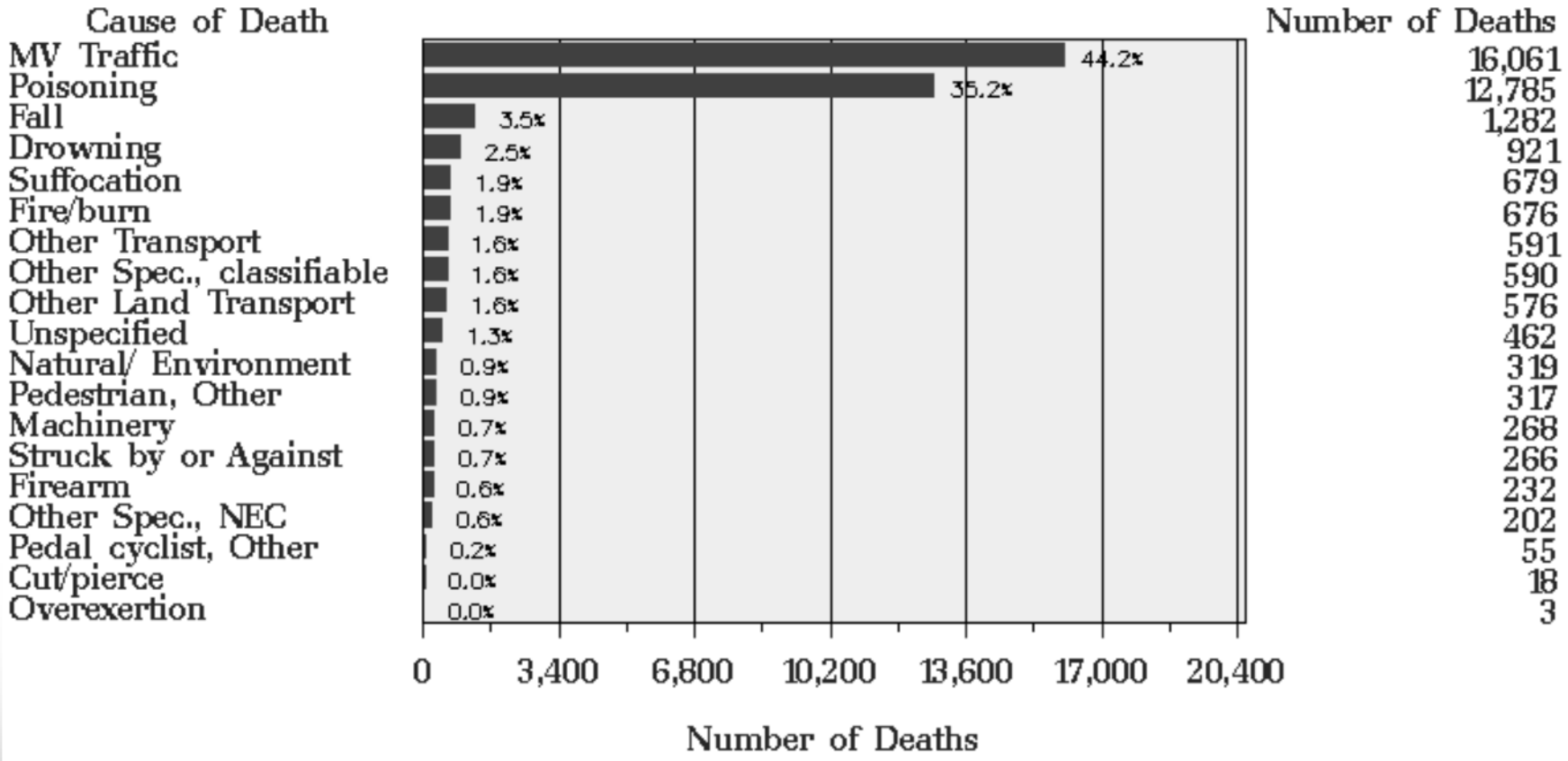
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

2004, United States

Unintentional Injuries

Ages 19–50, White, Non–Hispanic, Both Sexes

Total Deaths: 36,303



NEC means Not Elsewhere Classifiable.

WISQARS™ Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

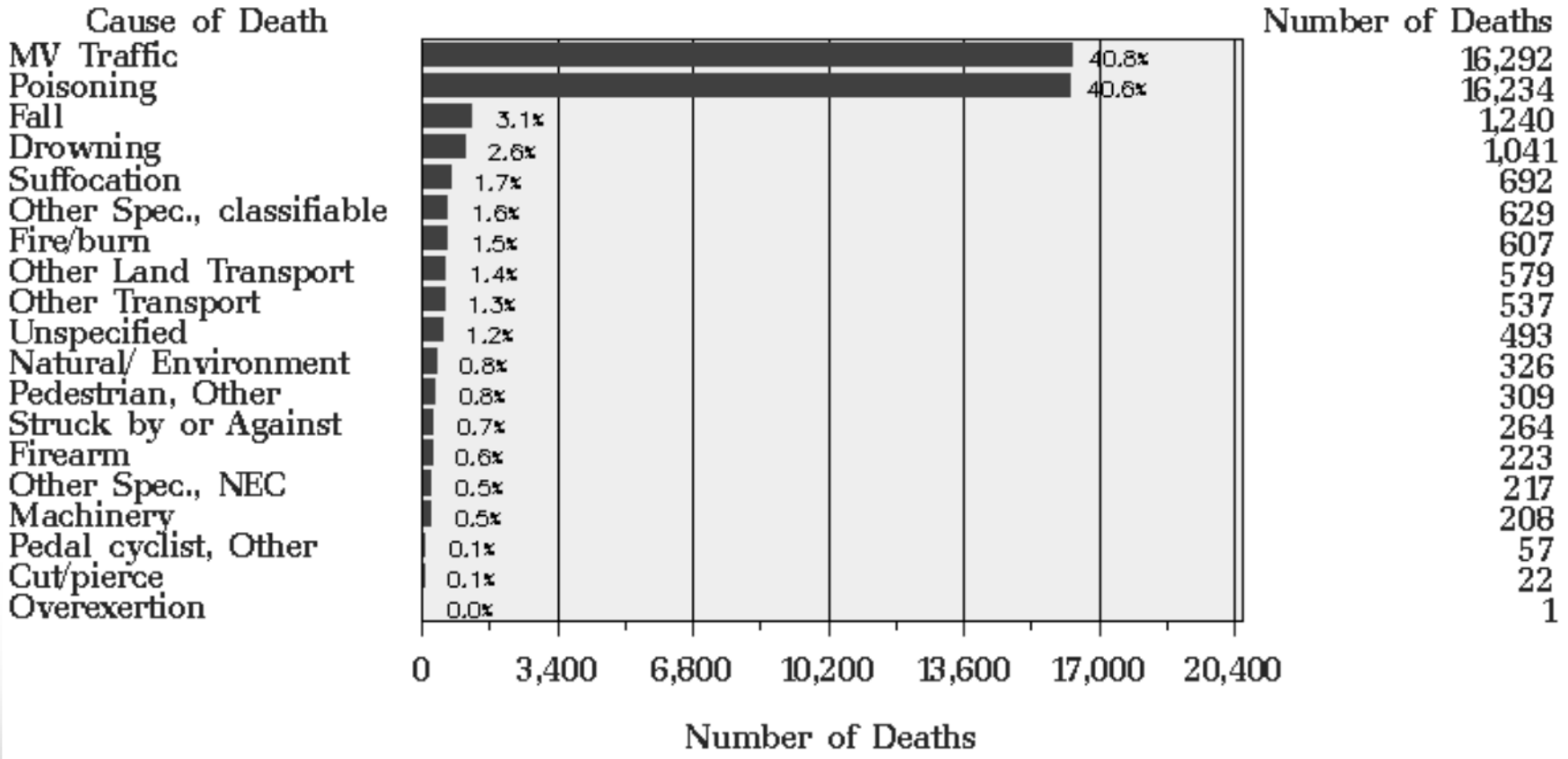
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

2006, United States

Unintentional Injuries

Ages 19–50, White, Non–Hispanic, Both Sexes

Total Deaths: 39,971



NEC means Not Elsewhere Classifiable.

WISQARS™ Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

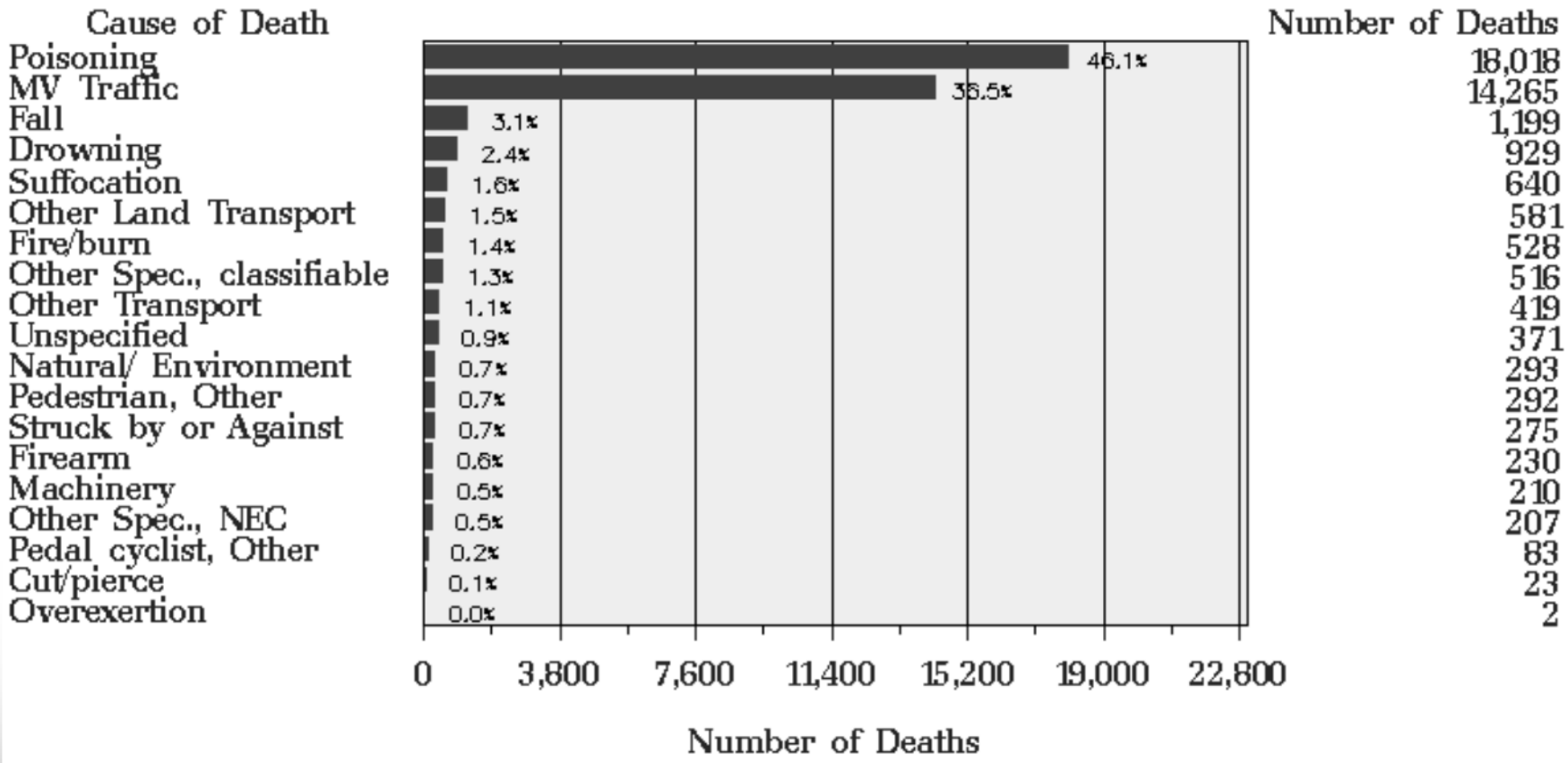
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

2008, United States

Unintentional Injuries

Ages 19–50, White, Non–Hispanic, Both Sexes

Total Deaths: 39,081

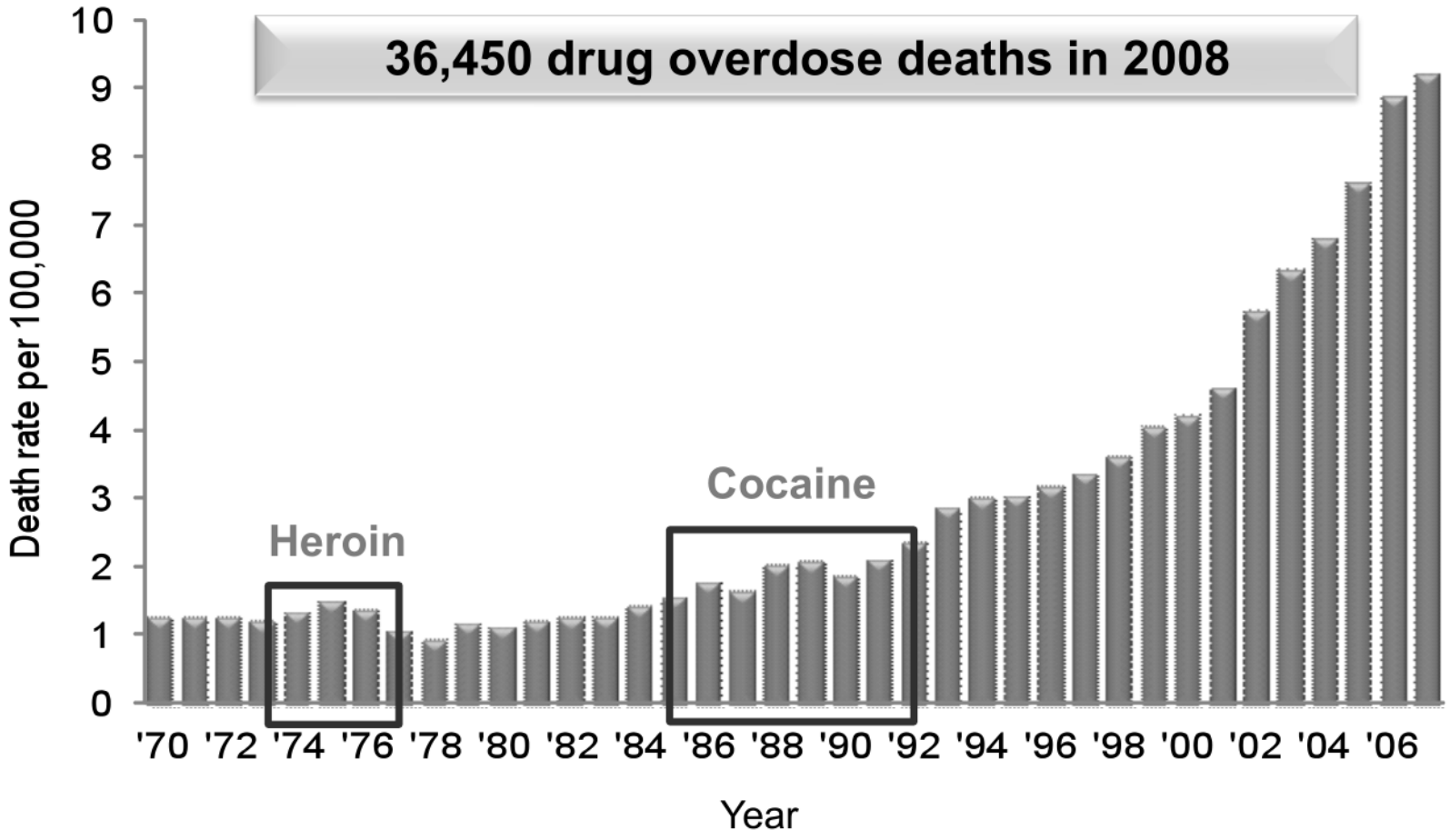


NEC means Not Elsewhere Classifiable.

WISQARS™ Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

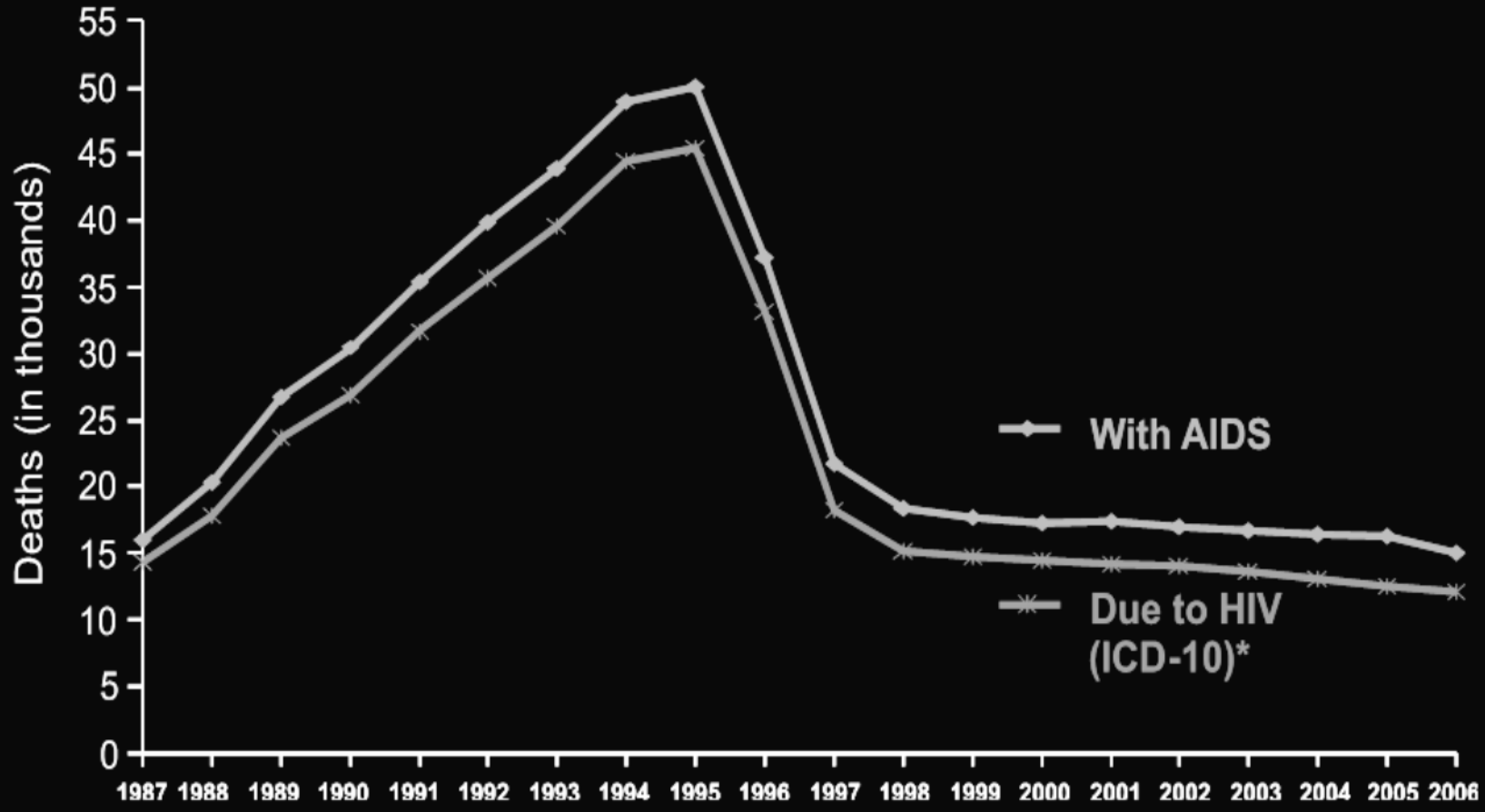
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Unintentional Drug Overdose Deaths
United States, 1970–2007



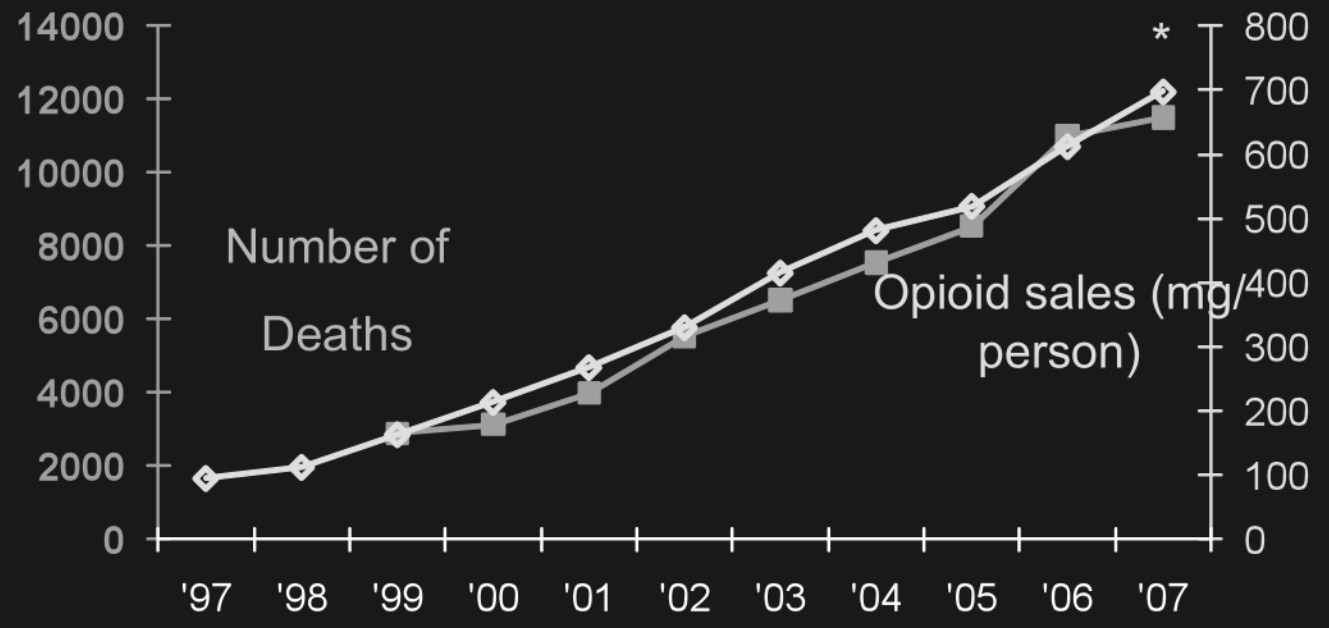
National Vital Statistics System, http://wonder.cdc.gov

Comparison of Mortality Data from AIDS Case Reports and Death Certificates in Which HIV Disease Was Selected as the Underlying Cause of Death, United States, 1987–2006



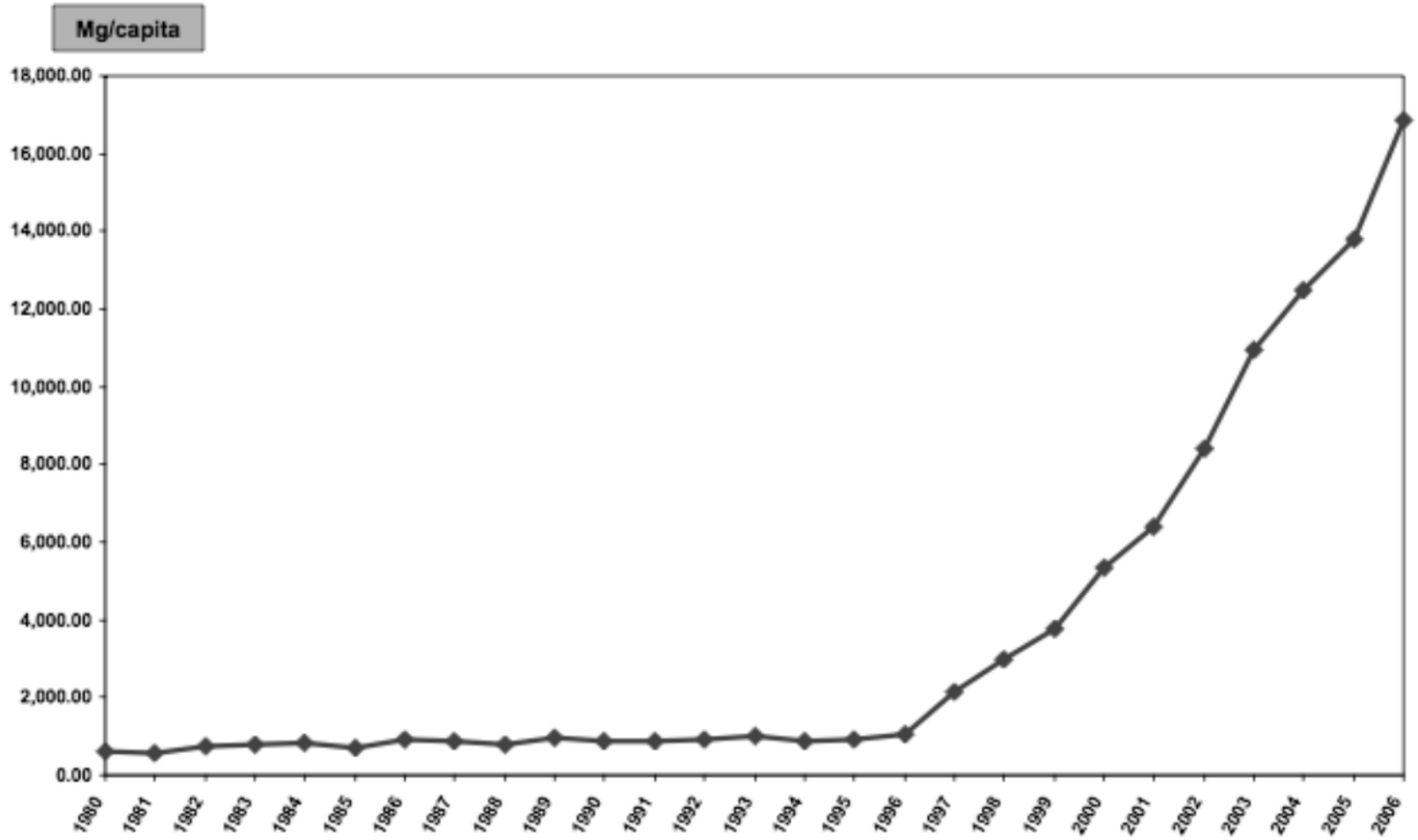
*For comparison with data for 1999 and later years, data in the bottom (red) line for 1987–1998 were modified to account for *ICD-10* rules instead of *ICD-9* rules.

Unintentional overdose deaths involving opioid analgesics parallel per capita sales of opioid analgesics in morphine equivalents by year, U.S., 1997-2007



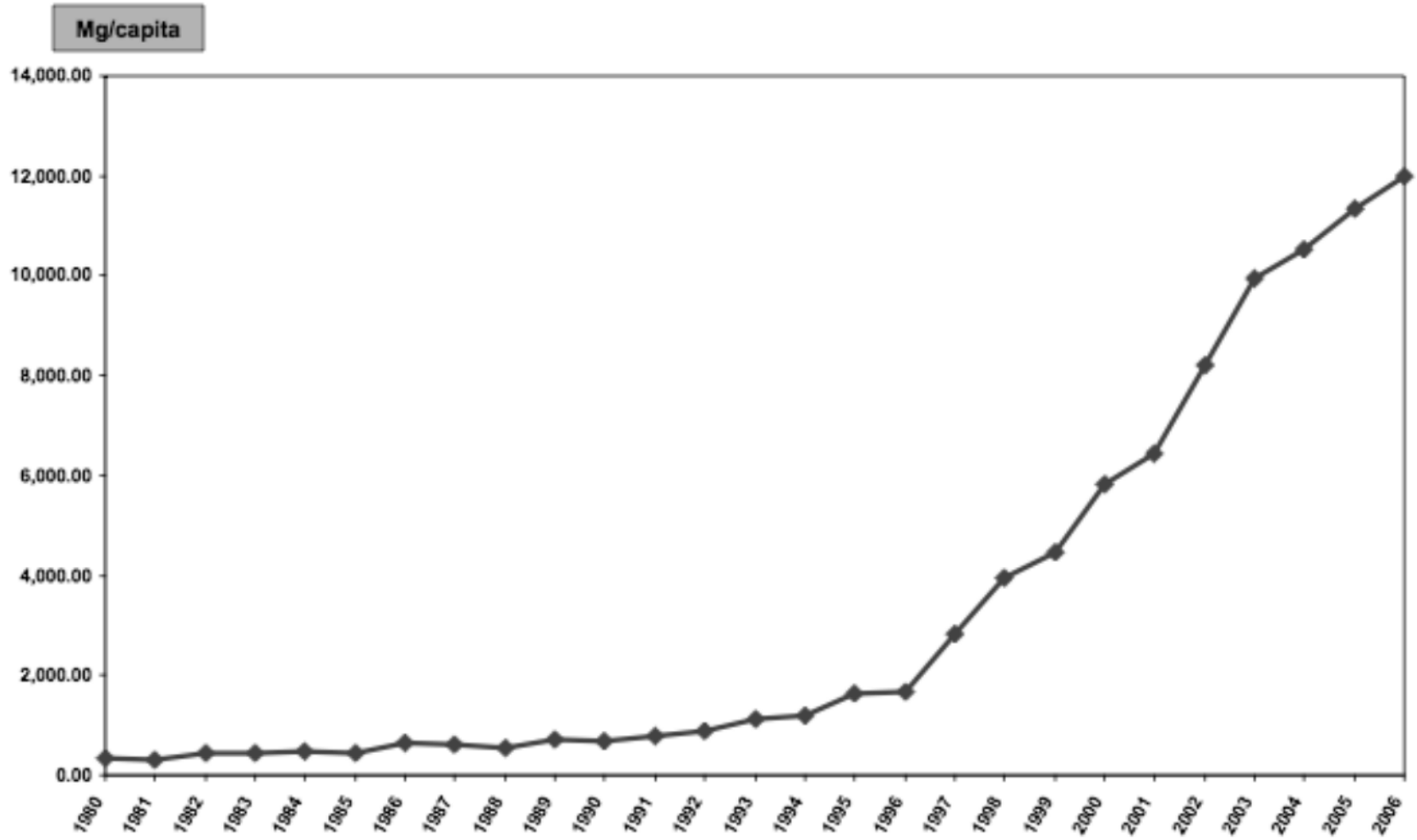
Source: National Vital Statistics System, multiple cause of death dataset, and DEA ARCOS
* 2007 opioid sales figure is preliminary.

New York Consumption of Oxycodone
1980 - 2006



Sources: U.S. Dept of Justice, Drug Enforcement Administration, Office of Diversion Control

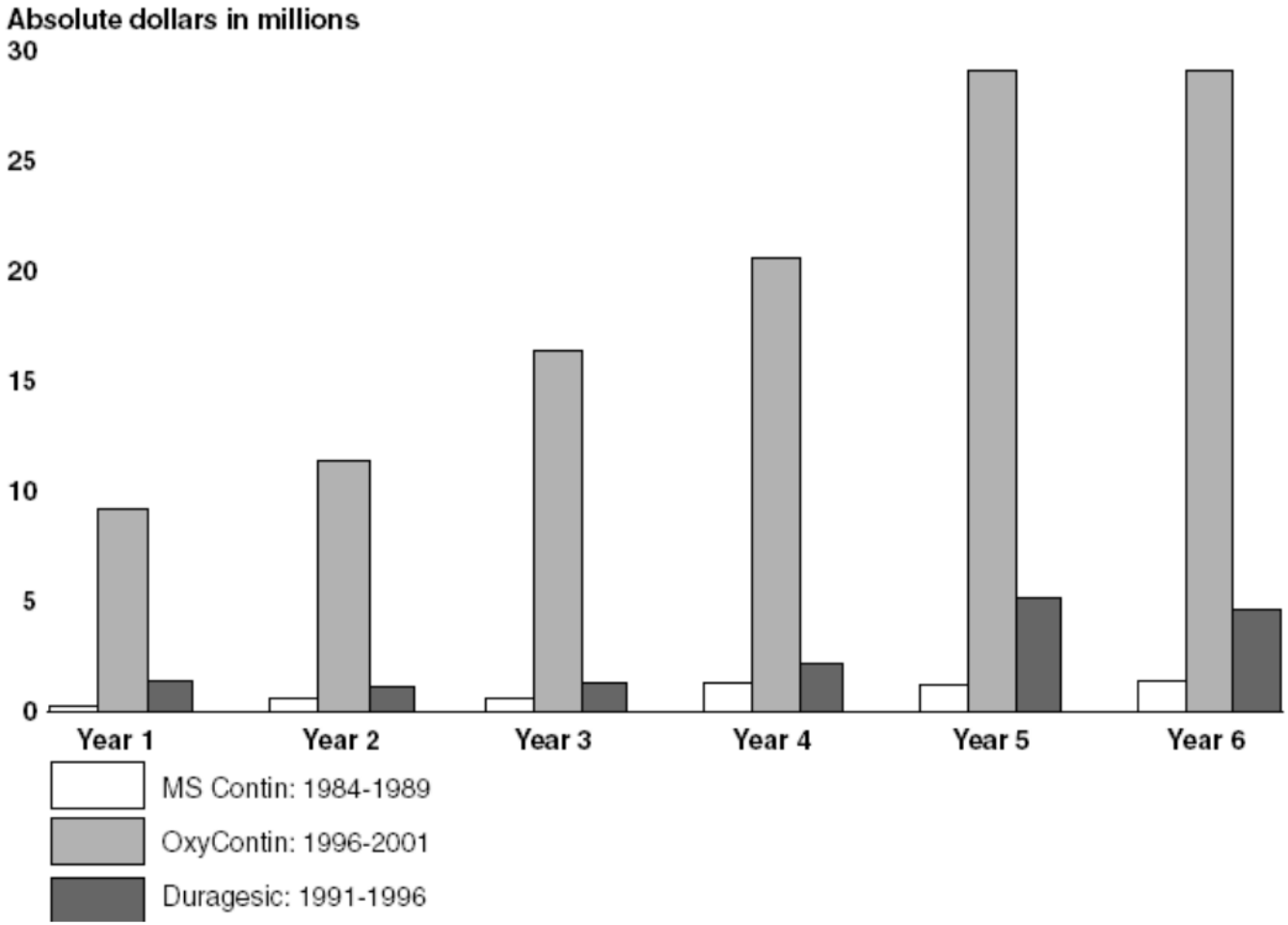
New York Consumption of Hydrocodone 1980 - 2006



Sources: U.S. Dept of Justice, Drug Enforcement Administration, Office of Diversion Control

Dollars Spent Marketing OxyContin (1996-2001)

Figure 1: Promotional Spending for Three Opioid Analgesics in First 6 Years of Sales

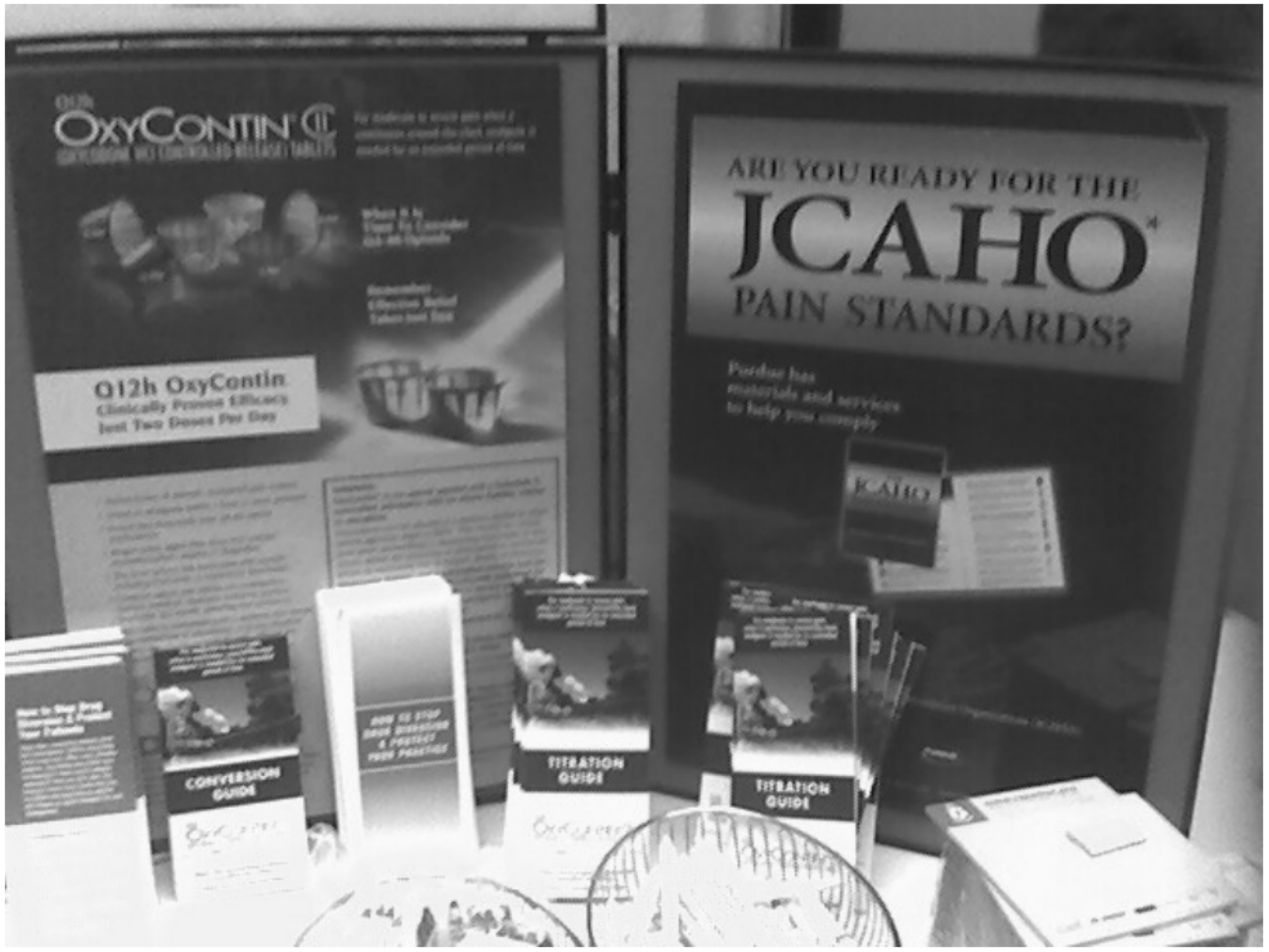


Source: United States General Accounting Office: Dec. 2003, "OxyContin Abuse and Diversion and Efforts to Address the Problem."

Industry-influenced “Education” on Opioids for Chronic Non-Cancer Pain Emphasizes:

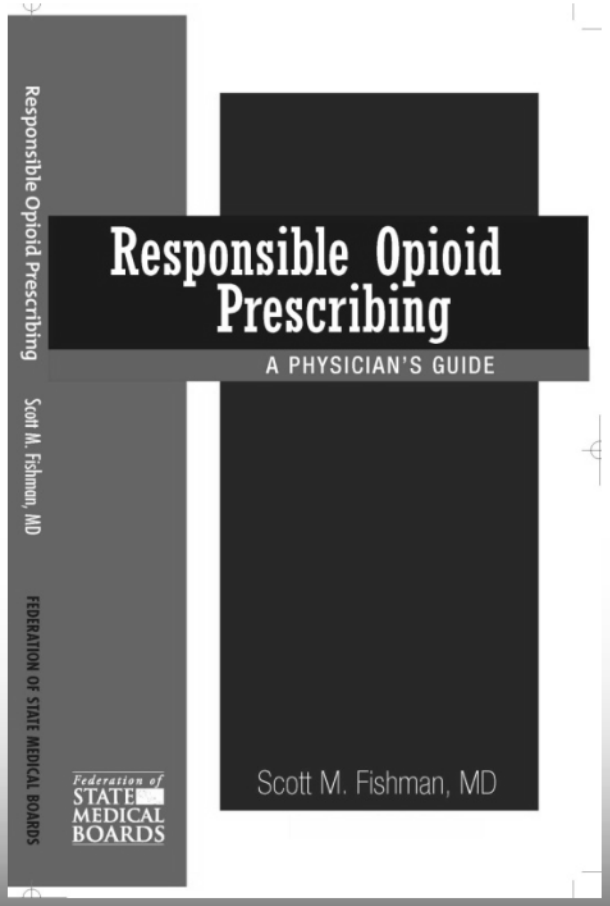
- Opioid addiction is rare in pain patients.
- Physicians are needlessly allowing patients to suffer because of “opiophobia.”
- Opioids are safe and effective for chronic pain.
- Opioid therapy can be easily discontinued.

Photo taken at the The 7th International Conference on Pain and Chemical Dependency, June 2007



Federation of State Medical Boards of the United States, Inc

Model Policy for the Use of Controlled Substances for the Treatment of Pain



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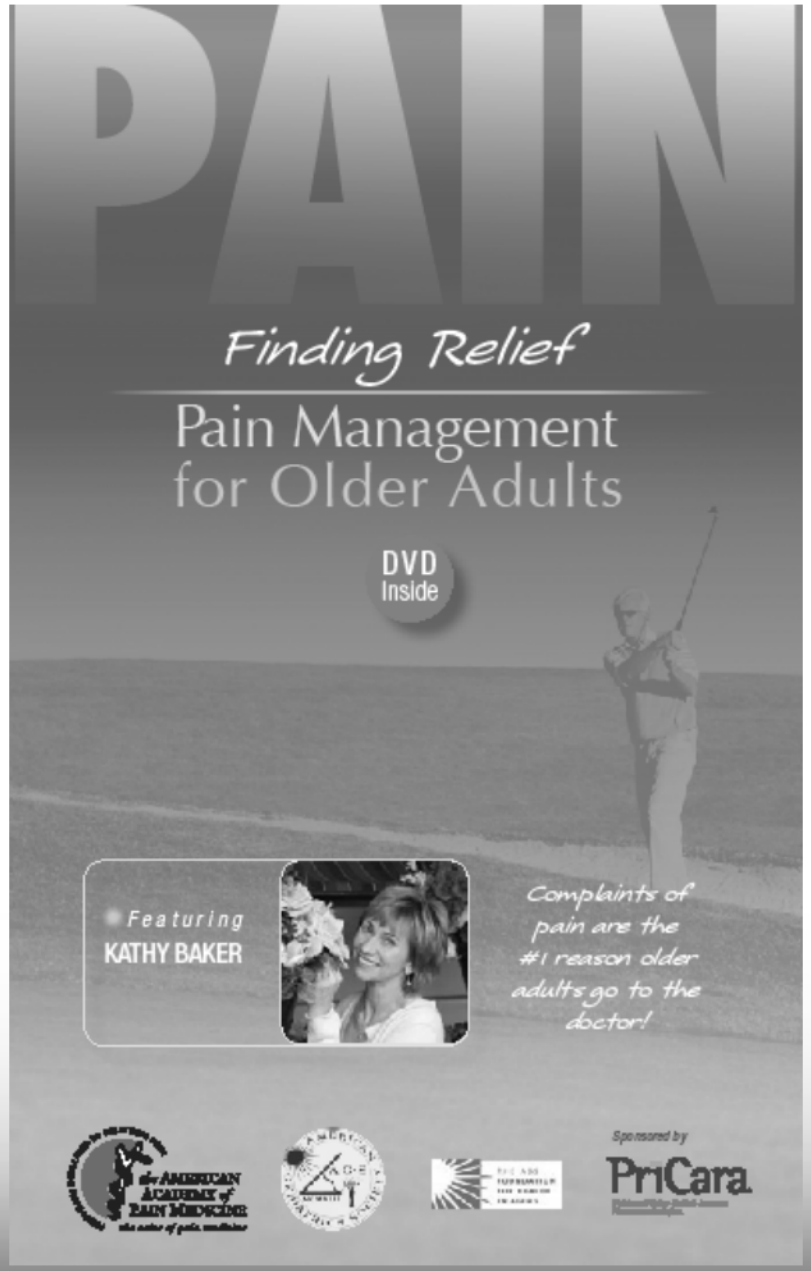
Federation of State Medical Boards House of Delegates, May 2004. http://fsmb.org. Accessed March 2010.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The Emperor's New Paradigm:

Patient Selection, Risk Stratification & Monitoring

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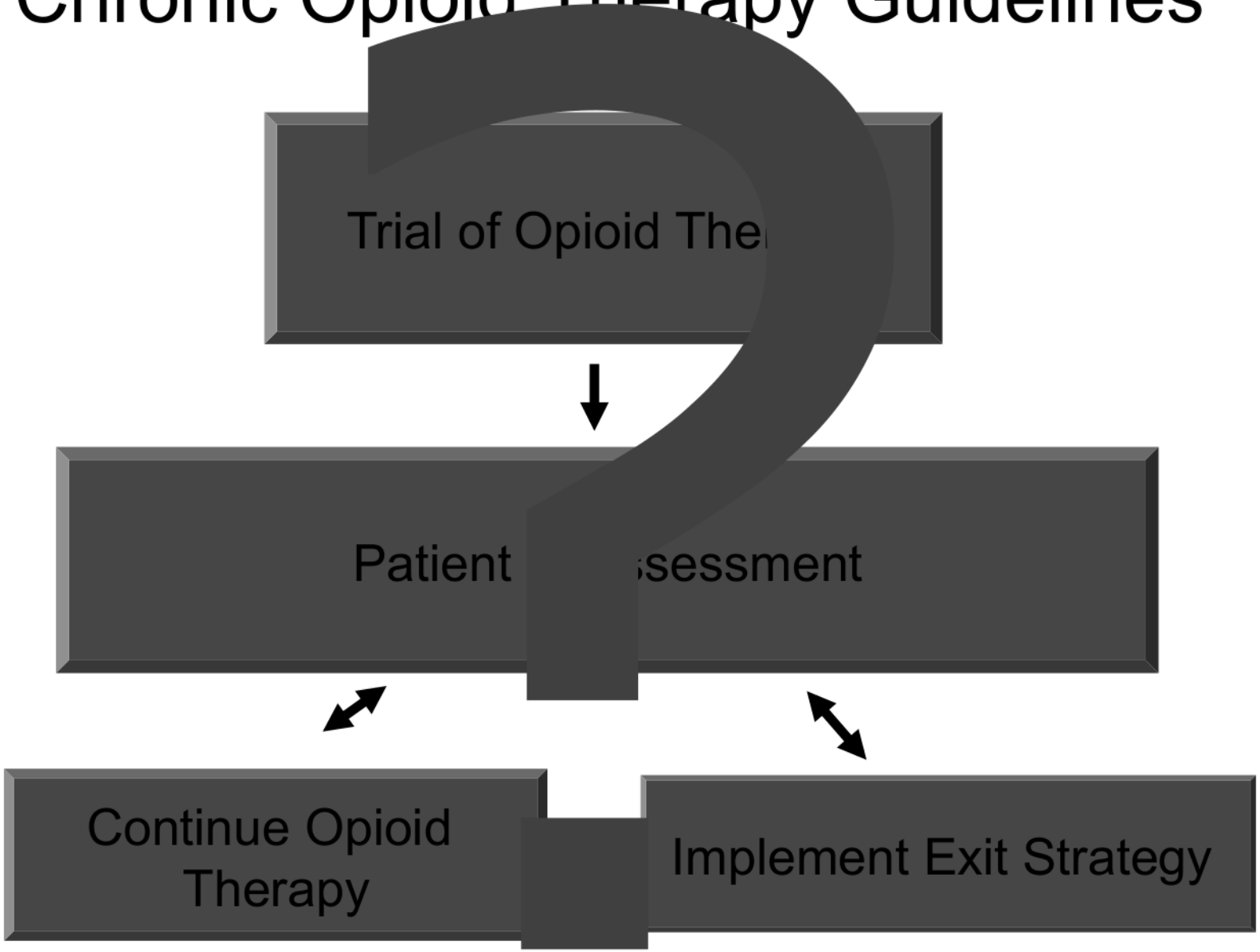
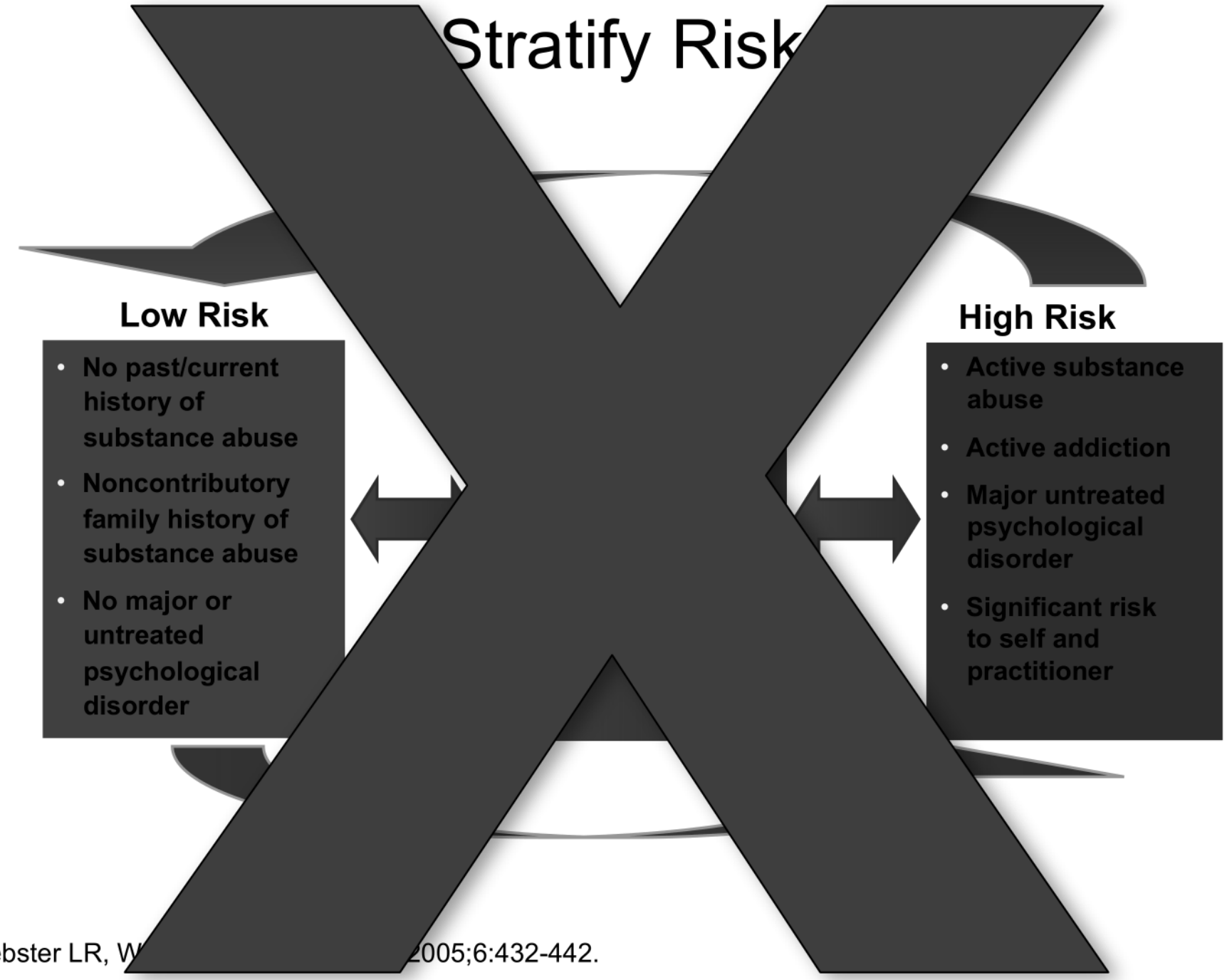
Chronic Opioid Therapy Guidelines



Chou R, et al. *J Pain.* 2009;10:113-130.

*Clinician accepting primary responsibility for a patient's overall medical care.



Webster LR, W 2005;6:432-442.

Clozapine vs Opioids

Comparison of methods for preventing serious adverse events

	Clozapine for Schizophrenia	Opioids for Chronic Pain
Evidence-Based Treatment	Yes	No
Adverse Event (AE) Risk(%)	Agranulocytosis 1%	Addiction 25%
Routine lab monitoring	Weekly WBCs	Urine Toxicology
Monitoring can prevent AE	Yes	No
Patient Registry	Yes	No

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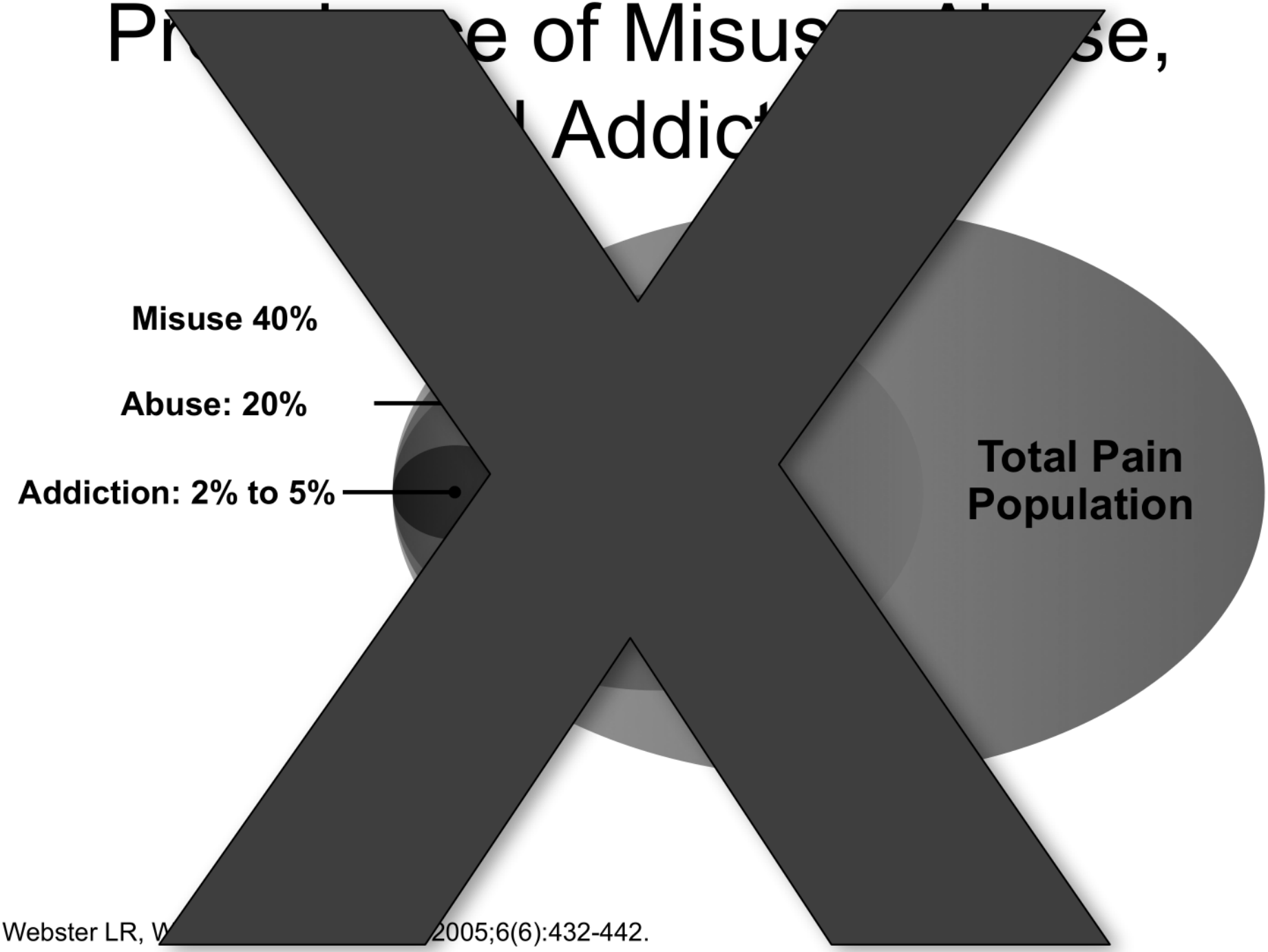


Webster LR, W 2005;6(6):432-442.

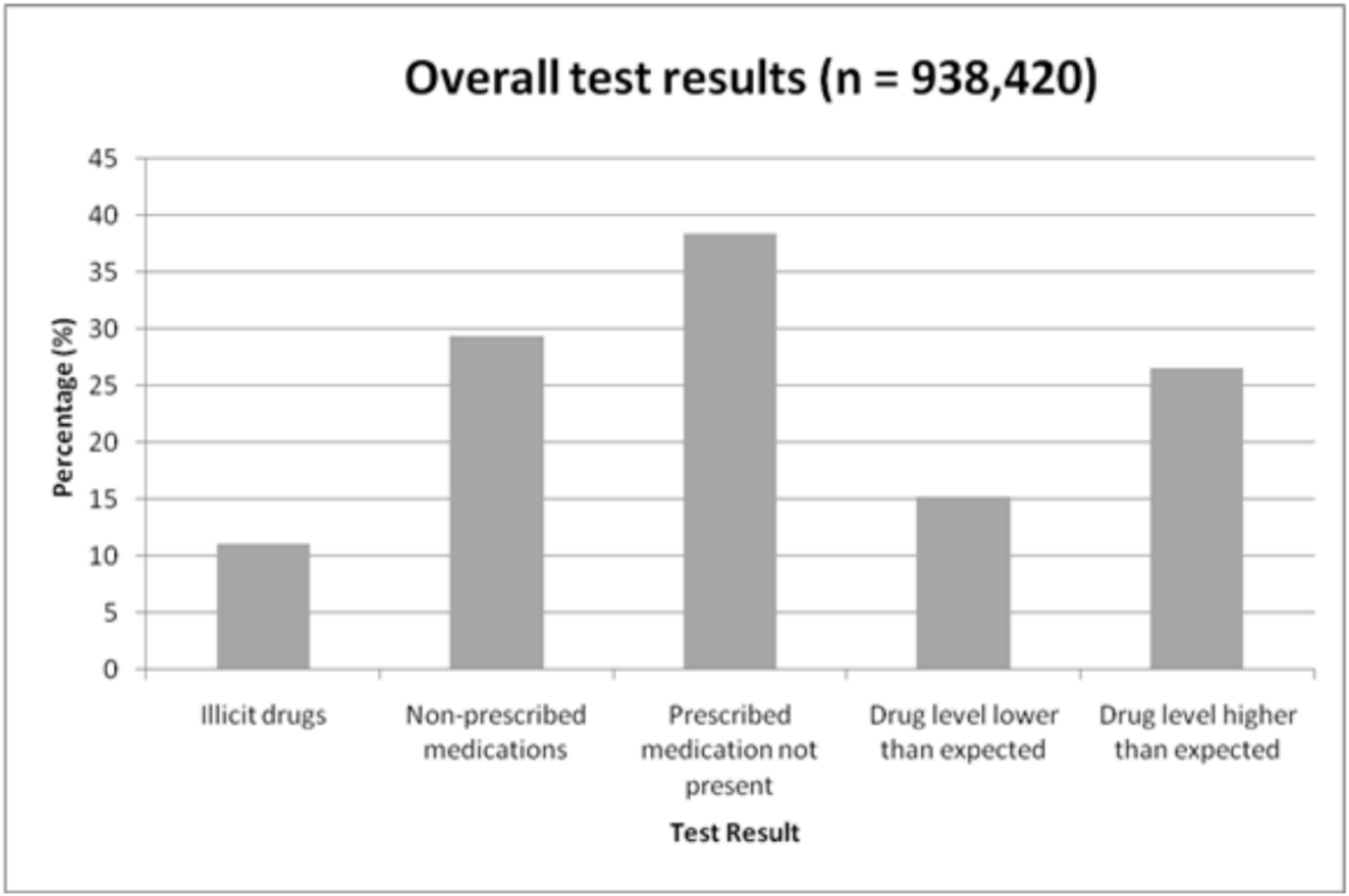
Monitoring Aberrant Drug-taking Behavior

- Probably predictive
  - Selling prescrip
  - Prescription forge
  - Stealing or borrowi patient's drugs
  - Injecting oral formulatio
  - Obtaining prescription d non-medical sources
  - Concurrent abuse o drugs
  - Multiple unsanct escalations
  - Recurrent p

- Ss
  - e complaining about higher doses
  - oarding during periods of ced symptoms
  - equesting specific drugs
  - cquisition of similar drugs from er medical sources
  - nctioned dose escalation es
  - ved use of the drug to er symptom
  - ychic effects not e clinician

Portenoy 1998

Urine Tox Results in Chronic Pain Patients on Opioid Therapy



Source: Couto JE, Goldfarb NI, Leider HL, Romney MC, Sharma S. High rates of inappropriate drug use in the chronic pain population. *Popul Health Manag*. 2009;12(4):185–190.

Controlling the epidemic:
A Three-pronged Approach

- Primary Prevention- prevent new cases of opioid addiction

- Secondary Prevention- provide people who are addicted with effective treatment

- Supply control- collaborate with law enforcement, DEA and OPMC to over-prescribing and black-market availability

Develop and Implement a Standard of Care

Opioid Prescribing in 2012-The Wild West

Opioid Prescribing Rules

•Require urine toxicology for all patients receiving long-term opioid therapy

•Require a physical exam and documentation that alternative treatments have failed

•Set dosing limits to prevent high dose prescribing

•Require screening for addiction before & during treatment

•Require screening for depression before initiating therapy

•Mandate training in pain and addiction

Limit Pharma Influence

- Prohibit drug rep detailing for opioids
- Consider legal action against opioid manufacturers
- Advocacy with FDA:
  - to limit approval of new opioids
  - Up-schedule hydrocodone combos (Vicodin)
  - Label changes for all opioids

Summary

- The United States is facing a public health crisis fueled by overprescribing of opioids.

- Prescribers and the public need to be better informed about risks of opioid use/misuse

- Interventions to bring this epidemic under control are within our grasp.

Questions?

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