Opioid Crisis: Where Are We Now?

Pennsylvania Workers’ Compensation Conference

June 7, 2018
Objectives

- Review the **historic context** for the development of the current “opiod crisis” in the United States, highlighting its impact.

- We will dissemble at least **three common myths** about pain and opioid analgesics.

- Highlight the content of the 2016 **CDC Guideline** for Prescribing Opioids for Chronic Pain.

- Discuss **alternatives** to the manner in which opioid analgesics have been prescribed for the last 20 years.

- Review effect of the Pennsylvania PDMP (PA-Aware)
Dedication

FACTS

A civil society where your facts outweigh my opinions, every time.
Deaths

- 64,070 overdose deaths in 2016.
- 19.8 deaths per 100,000.
- 3.2 deaths per 100,000 (1996).
- 620% increase.

Lost?

Stand still. The trees ahead and bushes beside you
Are not lost. Wherever you are is called Here,
And you must treat it as a powerful stranger,
Must ask permission to know it and be known.
The forest breathes. Listen. It answers,
I have made this place around you.
If you leave it, you may come back again, saying “Here”.
Lost

No two trees are the same to Raven.
No two branches are the same to Wren.
If what a tree or a bush does is lost on you,
You are surely lost. Stand still.
The forest knows Where you are. You must let it find you.

David Wagoner
What happened?


What happened?


To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients' who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had a history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients, Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program, Boston University
What happened?

“What Consensus Statement on the Use of Opioids in the Treatment of Chronic Pain.”

~American Pain Society and American Academy of Pain Medicine
Total Drug Deaths

Source: National Center for Health Statistics, CDC Wonder
The Gory Details

Source: National Center for Health Statistics, CDC Wonder
What do we know?

Rest assured...

This problem had nothing to do with us.

<table>
<thead>
<tr>
<th>Table 3. Factors Associated with the Risk of Opioid Overdose or Addiction.</th>
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</thead>
<tbody>
<tr>
<td><strong>Factor</strong></td>
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<tr>
<td>Medication-related</td>
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<tr>
<td>Daily dose &gt;100 MME*</td>
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<tr>
<td>Long-acting or extended-release formulation (e.g., methadone, fentanyl patch)</td>
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<tr>
<td>Combination of opioids with benzodiazepines</td>
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<tr>
<td>Long-term opioid use (&gt;3 mo)†</td>
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<tr>
<td>Period shortly after initiation of long-acting or extended-release formulation (&lt;2 wk)</td>
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<tr>
<td>Patient-related</td>
</tr>
<tr>
<td>Age &gt;65 yr</td>
</tr>
<tr>
<td>Sleep-disordered breathing‡</td>
</tr>
<tr>
<td>Renal or hepatic impairment§</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Substance-use disorder (including alcohol)</td>
</tr>
<tr>
<td>History of overdose</td>
</tr>
<tr>
<td>Adolescence</td>
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</tbody>
</table>

* MME: Mean daily morphine equivalent dose. † Long-term opioid use is defined as use of opioids for >3 months. ‡ Sleep-disordered breathing is defined as sleep apnea, obstructive sleep apnea, central sleep apnea, or hyperventilation syndrome. § Renal or hepatic impairment is defined as a creatinine clearance <60 mL/min or an international normalized ratio >1.5.

**Table 5. Alternative Treatments for Chronic Pain.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nonpharmacologic</strong></td>
<td></td>
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<tr>
<td>Cognitive-behavioral therapy</td>
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<tr>
<td>Exercise therapy</td>
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<tr>
<td>Complementary medicine (e.g., yoga, meditation, acupuncture)</td>
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<tr>
<td><strong>Nonopioid analgesics</strong></td>
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<tr>
<td>Acetaminophen</td>
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<tr>
<td>Nonselective nonsteroidal antiinflammatory drugs; recommended as first-line pharmacotherapy for osteoarthritis and low back pain in multiple guidelines</td>
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<tr>
<td>Cyclooxygenase-2 inhibitors</td>
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<tr>
<td>Anticonvulsants (gabapentin or pregabalin)</td>
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<tr>
<td>Antidepressants (tricyclics and serotonin and norepinephrine reuptake inhibitors)</td>
<td></td>
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<tr>
<td><strong>Interventional and neural-stimulation therapies</strong></td>
<td></td>
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<tr>
<td>Epidural injection; may provide short-term improvement for certain pain-associated conditions (e.g., lumbar radiculopathy)</td>
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<tr>
<td>Brain, spinal cord, and nerve stimulation, including transcranial magnetic stimulation, transcranial direct current stimulation, electrical deep-brain stimulation, and stimulation devices for peripheral nerves or tissues</td>
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<tr>
<td><strong>Biofeedback</strong></td>
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<tr>
<td>Electromyography to help patients learn to control muscle tension and electroencephalography to help patients learn to influence brain electrical signals in order to modulate pain; may be beneficial in treatment of headaches, some forms of chronic back pain, and other pain disorders</td>
<td></td>
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<tr>
<td>Neurofeedback with the use of functional magnetic resonance imaging as a supplemental approach for chronic pain management</td>
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</tbody>
</table>
Mythology
(according to Morpheus)

Myth 1:

Opioids are the “gold standard” for pain relief.

(Inflammatory pain, visceral distention, depression, headache, heartache, anxiety, neuropathic pain...)

(according to Morpheus)
Mythology

Myth 2:

There is no “ceiling effect” for opioid analgesics.

(“When the ceiling is the roof.”

~Michael Jordan)
Mythology

Myth 3:

“Pain is what the patient says it is.”

(If true, this is a general allowance of “private language.”
But language is always a function of public agreement.
E.g., blue and salty.)
Opioids “**WORK.**”

Patient: “But Doc, Oxy[codone] is the only thing that has ever WORKED for me. I tried all them other things and none of them WORKED.”

You: “How much of the pain does the medicine relieve?”

*Audience Quiz: What does the patient say next?*
Patient: “It takes the edge off.”

Translation: “I depend on the psychic effects of the drug.”

This is not clinically meaningful analgesia. (30%)
What do we know?

- No study of greater than 16 weeks in opioid management of chronic noncancer pain (CNCP).
- Patients with psychologic diagnoses excluded from studies.
- If we do what we did, we will get what we got. (1996-2016)

Commentary: “New Opioid Policy: Are We Throwing the Baby Out with the Bathwater?” Mark Sullivan, MD, PhD, Pain Medicine 2017; 0: 1–5
High Quality New Information

- RT, masked (N=234) comparing opioid and nonopioid medication.
- Duration: 12 months.
- Endpoints: pain intensity, pain-related function, side effects.
- Only difference was more side effects in opioid group.
Any opioid exposure increased risk addiction by ~100-fold.

>90 MME inflection point

1 in 32 risk of overdose death if > 200 mg Morphine equivalence (MME)

CDC Guideline

- Patient monitoring (urine drug screening/pill counts/etc.), while recommended, has not been shown to prevent abuse and/or overdose.

- Patient monitoring and medical response to the results will, however, keep you out of jail and in good stead with the Medical Board. (Personal communication, DEA/MD OAG)

“Validated” Risk Assessment

The Opioid Risk Tool alleged that by asking 5 questions, one could stratify risk of aberrant medication-taking behavior.

Only predictive information was personal past history of drug abuse.

Practical Guidance: CDC mobile app
Acute Pain Prescribing

- Observational study: how often do patients refill?
- DoD Military Health System (N=215,140)
- GS: 4-5 days; Ortho: 7 days; “Women’s health”: 9 days.
- Nadir in probability of refill: 9/15/13 days.

Acute Pain Prescribing

- Interventional study: Providers were the subjects.
- Procedure: Lap chole (N= 170:200)
- Pre intervention: prescription for 250 mg OME, used 30.
- Post intervention: prescription for 75 mg OME, used 20.
- Nonopioid use same pre and post intervention.

“Reduction in Opioid Prescribing Through Evidence-Based Prescribing Guidelines.” Howard et al., JAMA Surgery, March 2018;153:3.
Don’t bother.

- The addition of abuse-deterrent properties marketed as a means to limit opioid abuse.
- Limits abuse through alternative routes of administration.
- Most abuse is via the oral route.
- Decrease in overdoses, not deaths.
- Cost: 1.4 billion to prevent 1 death.

“Benefits, Limitations, and Value of Abuse-Deterrent Opioids.” Curfman, et al., JAMA Internal Medicine, January 2018, Volume 178, Number 1; 131-132.
Time to say

- Pain is mandatory.
- Suffering is optional.
- Stoicism is pain-relieving.

(Not a solution, an approach.)
From way back when...

- Chronic pain rehabilitation program at Cleveland Clinic.
- Observational: (N=56/228) taking >100 MME at admission.
- 43/56 (93%) reported decrease in pain intensity with opioid elimination. 3/56 reported increased pain intensity.
- [Side effect elimination not documented.]

When the choices are fewer.

- High risk: mental disorders, substance use disorders, sedative use, and male.
- Tended to be on higher opioid doses and resistant.
- Total N=23,809; 8.75 years.
- Modest dose reductions and therefore modest risk mitigation.

Tapering, not elimination

- Chart review (N=50) over 12 months.
- End point: % reduction in chronic opioid dose.
- Tapered to 0: 6/50. Average reduction: 46%
- No reduction: 3/50.

What about us?

- Focus group study (N=40) providers.
- **Barriers:** emotional burden, inadequate resources, and a lack of trust.
- **Facilitators:** empathizing, preparation for tapering, individualization, guidelines and policies

“Those Conversations in My Experience Don’t Go Well’: A Qualitative Study of Primary Care Provider Experiences Tapering Long-term Opioid Medications.” Kennedy, et al., Pain Medicine 2017; 0: 1–11
Prescription Drug Monitoring

- **States with a prescription drug monitoring law that requires doctors to consult a prescription monitoring database before prescribing opioid painkillers**
- **States with a prescription drug monitoring law**
- **No prescription drug monitoring law**
PA Prescription Drug Monitoring Program (2014): Act 191

- ABC-MAP
  - Achieving Better Care by Monitoring All Prescriptions
  - Operational as of August 25, 2016
Pennsylvania Legislature (2016)

- PDMP first and every time a benzodiazepine or opioid is prescribed.
- At least 2 hours of CME regarding pain management, addiction, or opioid prescribing for renewal.
- Prescribing for minors requiring detailed parental consent
- Limitations on emergency department prescribing to no more than 7 day supply. Requirements for referral to treatment for those with suspected substance use disorder.
Pennsylvania Legislature (2016)

- Violation: may face licensure sanctions.
- Compliance: the physician is presumed to be acting in good faith and will have immunity in any civil action.
- 86 percent drop in the number of patients going to five doctors
- 97 percent drop in the number of patients going to 10 doctors
Sir William Osler

“One of the first duties of the physician is to educate the masses not to take medicine.”

“Father of Modern Medicine”
circa 1900
Opioids: Saddle or Pinto?
Thank You.

- Questions
- Comments
- Criticisms