Prescribing Opioids

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Mrs. Jane Doe is a 57 year old female. Chief complaint of chronic low back pain and radicular symptoms both hips and legs. MRI demonstrates mild to moderate spinal stenosis at L3-4. No previous back surgery. A consultation with Dr. Bruffett (Spine Surgeon) did not recommend surgery but referred her to me for a second opinion concerning her pain management. She has undergone a multitude of interventional spine procedures to include ESI, facet injections, and Radio-Frequency. She has had physical therapy many times without benefit. Despite the interventions she continues to suffer an extreme amount of pain. She works for the state highway department and has been employed there for 24 years. She is having a difficult time doing her job and has filed for disability. She has been opioid dependent for over 4 years and her current Pain Doctor (a good doctor and friend) has recommended implantation of intrathecal pain pump.
Mrs. Doe Medications:

- Cymbalta 60mg p.o. q d
- Neurontin 600mg p.o. tid
- Oxycontin 80mg p.o. tid
- Roxicodone 30mg p.o. q 4 prn
- Valium 10mg p.o. bid
- Ambien 10mg p.o. q hs
- Soma 350mg p.o. tid
Mrs. Doe 11 months later

- During our initial consultation she decided to become my patient.

- No further spinal procedures were done. Her opioid dependency was addressed.

- She went from Oxycontin etc., filing disability, and a planned intrathecal opioid pain pump to Celebex 200mg, Cymbalta 60mg, Flexeril 10mg, and remained employed.

- So we might have a problem and room for debate.
Recent Opioid History

- 1916 Oxycodone developed in Germany
- 2001 Oxycontin was the best selling opioid pain reliever in the country.
- 2007 Purdue Pharma was successfully sued for aggressive marketing and for downplaying its abuse and addiction potential.
Laudanum elixir: Opium in an alcohol base and Opium dens in the wild west

Morphine addiction among injured Civil War veterans well documented.

1874 Heroin was invented and marketed: a safe non-addictive substitute for morphine. Reminds us of the “safety” of sustained release opioid drugs.

The most important reason for the increase in opiate consumption during the 19th century was however the prescribing and dispensing of legal opiates by physicians and pharmacist to mostly women with "female problems" (mostly to relieve painful menstruation). Between 150,000 and 200,000 opiate addicts lived in the United States in the late 19th century and between two-thirds and three-quarters of these addicts were women.[11]

The Harrison Act 1914 controlled the use of opioids and cocaine. Preceded control of alcohol.
The 90’s

- The decade of pain as the fifth vital sign
- The Visual Analog Scale for pain (also used to as an “objective” measure titrate up a patient’s opioids); Pain is what the patient says it is!
- The introduction of sustained release opioid medications and the promise that they were more effective, safer, and less addictive.
- The idea that when opioids were prescribed for pain the risk of addiction was negligible.
- No one was addicted just pseudo-addicted; Patient was under treated.
- Titration was the way forward.
Chronic Benign Pain

- Robert Barth AMA Guidelines Jan/Feb 2013
- Chronic pain is common over half US adults.
- Neck, back, leg etc...
- Pain in the absence of tissue damage or any likely pathophysiological cause usually happens for psychological reasons.
Evidence Based Medicine

It must be right. It’s evidence based!
The Affect of our Education
(and remember it’s evidence based)

- Americans consume 80% of the world's painkillers.
- Pain Pill prescriptions are up 600% in last ten years
- Prescription painkillers now leading cause of accidental death (CDC statistic)
Increased Drug Diversion

A Medicaid patient can fill a prescription for #240 Percocet with a $5 co-pay and sell for $10-$20 per pill; $2400-$6000 dollar street value. A return on your investment of up to 1,199%; It’s how they afford all those bus trips into Florida and how it ends up in our schools.
Titration: Did it lower cost?

- A recent workers comp “My Matrix Invoice” on a new patient of mine showed monthly drug cost: Oxycontin 80mg disp. #90 cost $1,398.50 per month vs. oxycodone 15mg disp. #90 $73.44 vs. Lidoderm patch $289.04.
Have increased rates of Opioid Prescribing affected Disability Rates?

- In 1965 8.3% of disability claims were from back pain. Today it is 33.8%. (Social Security Administration; Lam Thuy)

- In 1985 2.2% of people ages 25-64 were disabled; In 2011 it was 5.5% and is growing.

- Back Pain and Mental illness are fastest growing causes of disability today. (Unfit for Work; Chana Joffe-Walt)

- The federal government spends more on disability payments than welfare and food stamps combined. (Unfit for Work; Chana Joffe-Walt)

- Higher Rates of disability are seen in low back patients prescribed opioids.

- (Ashworth J. Pain 2013)
Examinee-Reported History is not a Credible Basis for Clinical or Administrative Decision Making

- Robert Barth PhD
- AMA newsletter Sept/Oct 2009
- Look to other issues and secondary gains: drug access and disability/workers comp.
- Pronounced unreliability of Histories. Over time you don’t get the same story twice work related injuries.
- Additional findings indicate the severity of the problem.
The Value of MRI to Predict Low Back Pain

- Journal of bone and Joint Surgery 2001 (pg. 1306)
- David G. Borenstien et al.
- The findings on MRI were not predictive of the development or duration of low back pain.
- Individuals with the longest duration of low back pain did not have the greatest degree of anatomical abnormality.
- Clinical correlation is essential.
Prescription Narcotics: an Obstacle to Maximum Medical Improvement

- R. Barth PhD. AMA Newsletter March/April 2011
- Science Indicates that Narcotics can worsen pain.
- Opioid hyperalgesia.
- Prospective study of patients on chronic narcotics showed increased vulnerability to pain.
- Endocrine disruption: hypogonadism, adrenal insufficiency, growth hormone deficiency.
- Sleep abnormalities (REM sleep deprivation)
- Immune system Compromise, cognitive impairment, substance abuse.
What are Endorphins??
It’s more complicated than advertised

- Endogenous Morphine: inhibits pain pathways
- Many types of endogenous opioid peptides: enkephalins (delta) and dynorphins (kappa), Mu receptors...
- Produced in the pituitary gland and hypothalamus
- Produced in response to stress, exercise, pain, sex, food etc....
- They affect our testosterone levels, sleep cycles, bowel movements, mood, etc...
- They are not just about pain control; It’s just not that simple!!!!!
The drug companies have greatly influenced the education of physicians. Risk Evaluation and Mitigation Strategies (REMS) are also written by the drug companies.

The pharmaceutical companies should not be writing the REMS! An obvious and well tested conflict of interest.

Others must step up the resources to change the message and the cost curve.

We have a generation of wasted money and human capital.
Education beats Regulation

- Addiction and abuse awareness
- Study endorphines
- Teach new prescribing techniques. Stop titration!
- Teach how to taper opioids. Need an exit plan for patients.
- Renewed emphasis on the fundamentals of opioid pharmacology.
- Acknowledge the physician’s role in the prescription drug abuse epidemic and change it.
- Opioid Dependency is a disease state.
Make the Right Diagnosis

- Acknowledge the patient has a pain problem.
- Addicted and/or Drug Dependent
- Other medical problems and co-morbidities.
- Obesity is important; treat for weight loss
- Treat smoking habit; indicative of addictive tendencies.
- Psychiatric problems: bipolar, depression
Best Practice:  
An as needed non-scheduled model

- Patients need access to opioids.

- Short acting opioids are safer, and better for the long run. If they need 24/7 opioid use make it temporary;

- Sustained Release Formulations guarantee opioid dependency, tolerance, and opioid dose escalation. They have the highest risk of diversion, abuse, and addiction. The FDA recently acknowledge this fact.

- Distribute a monthly amount that will make it impossible to have an active opioid in the patients bloodstream 24/7. Give the patient’s opioid receptors a break!! Supplement don’t replace a patient’s endorphines.

- Think 30-60 tablets per month. Always write per month only when writing PRN dosing or the pharmacy will refill the prescription sooner than prescribed.
A PRN DOSING MODEL: (avoiding tolerance/dependency)

- Better long term pain control; No opioid hyperalgesia
- No drug dependency develops. No drug withdraw.
- No drug tolerance develops. The drugs stay effective!
- Addiction/abuse risk will be MUCH lower.
- Reduction in drug diversion and cost.
Drug Dependency
The Trap!

- The drug dependent patient takes drugs for both the condition prescribed and to avoid drug withdrawal.

- Anxious about flying but more anxious about running out of Xanax!

- My back hurts so I take hydrocodone but my back hurts when I go through drug withdrawal so I always need hydrocodone.
Opioid withdrawal

- 1. Rhinorrhea
- 2. Abdominal pain
- 3. Back pain
- 4. Restless leg syndrome
- 5. Piloerection (quit “cold turkey”)
- 6. Depression and despair

The euphoria index: Dilaudid > morphine = oxycodone > hydrocodone
Tapering: A medical skill to treat drug dependency

- There are times when a patient will need chronic around the clock opioid therapy; The challenge is getting their opioids reduced or eliminated when the storm has passed. Ex. Burn patients, extensive trauma, staged surgical procedures etc.....

- Significantly more complicated than advertised.

- The longer the patient has been on narcotics the longer it will take. (Think months not weeks)

- The greater the dose the longer it will take.

- Sustained formulations work well for tapering

- Always make the patient aware of a possible addiction co-morbidity. The patient is not to blame; anymore than if they had developed drug allergy.
Treating Drug Dependency (tapering)

- Key considerations:
  
  - Opioid dependency is a physiological disease state; A patient on Prednisone for 2 years is “steroid dependent” you would never consider tapering patient off in 3 weeks; you may never get the patient of steroids (chronic steroid dependent: addicted to cortisone?)
  
  - Opioids must be tapered in terms of months may take a year, may never happen to zero.

  - It’s an emotional experience; be ready for tears and cheers.
More Treatments

- Suboxone for addicted patients: the iatrogenic ones
- Don’t deal with the hard addict get them a psychiatrist
- Avoid polypharmacy. Find out what is really helping and what is not; look for wow factors.
- Break habits! Dose delay, not for sleep, as needed, skip a dose.
- Drug holidays. Use them!
- Set Goals, but be prepared to slow down, stay steady, or even back up.
- Treat other drug dependencies that are present and unhabituate any mind altering drug that you can. Ex. Benzo’s, Soma’s, etc..., Be Patient.
Treating Opioid Dependency

- Treat for depression. They will need it. Wellbutrin, SSRI, Cymbalata, TCA’s
- Treat sleep (OD patient is an insomniac, REM deprived) Tizanidine, Ambien, Temazepam, Benadryl
- Benzodiazepines for anxiety; sparingly if at all. Don’t start another problem.
- Lyrica, Gabapentin MAY or MAY NOT help.
- Prescription NSAIDS.
- Interventional treatments: Physical Therapy, ESI’s, surgical consult.
- Psychiatric treatment; Many patients will need it, especially if iatrogenic addicted
Addiction

- Be aware, make the patient aware and get the patient to self reflect on 4 C’s
  - 1. Control of drug
  - 2. Compulsive use of drug
  - 3. Craving or emotional attachment to the drug
  - 4. Continued use despite harm; could be job loss or detachment from family.
- Drug testing is a great tool.
- Addiction is a spectrum.
Know the Risk Factors

- Biological. Personal or family history of any drug or alcohol abuse (includes smoking).
- Psychiatric: substance use disorder; preadolescent sexual abuse; major psychiatric disorder
- Social: legal problems, history of MVA’s; involvement of problematic subculture, employment history
- Route of administration: I.V.>snort>smoking>oral
- Age of exposure and/or age of the patient (<45)
- Physical exam: frequent falls, ”spider bites”, poor hygiene, meth mouth, etc...
- Lost prescriptions, frequent call ins, etc..
- Drug use co-morbidities: hepatitis, STD’s etc..
Its an Imperfect Marathon

- Pain Management not Pain Cure Clinic.
- Realistic expectations
- What is the BEST why to treat a chronic benign pain problem for years. It’s a marathon not a sprint.
- Tell the patient the truth “you will have chronic pain and we will deal with it.”
It’s Worth it!!

- “I played ball with my son for first time in years”
- “I was trapped, I did not realize how much of my life was wasted”
- “I woke up for the first time in 2 years”
- “I have my husband back”
- “I’m free. My life dose not revolve around my next pill”
- “I got a job”
- “My back still hurts, but I am living my life again”