Opioid Prescribing Levels Off, but Is Less Really More?

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A nation’s opioid consumption was once seen as a sign of civility. The higher the per capita rate of morphine consumption, as calculated by the World Health Organization, the more advanced and caring a nation’s health care system was seen to be—this suggested better care of the elderly, the sick, the suffering, and the dying [1]. So it is of interest that when numbers from IMS Health were released earlier this year (and reported in a feature article in the Milwaukee Journal Sentinel) showed that opioid prescribing has experienced a slight decrease from 243 million prescriptions in 2011 to 241 million in 2012, this change was hailed as a sign of good things to come for Americans [2]. While a reduction in “pill mill” activity and inappropriate prescribing should be lauded, there is unfortunately much to be concerned about for both the majority of people with pain and the well-intentioned prescribers alike. Moreover, the sensationalization by mainstream media and by politicians has served to fuel a fire that creates negative outcomes for legitimate pain patients [3,4].

There is no question that at one time it was suggested that more opioids were better, while to some extent minimizing the risks to individual patients and to society at large. There is still some debate over the reasons for the rapid growth of opioid use. We argue that this growth was largely due to well-intentioned physicians and thought leaders who had positive experiences treating pain in the advanced cancer patient population. Expanded opioid prescribing in that arena led to dramatic improvements in quality of life, and as a result, many were hopeful that similar improvements would be seen in the much larger and more diverse chronic noncancer pain population [5–7]. However, the present anti-opioid pomposity suffers from the same lack of intellectual honesty. The past 2.5 years have served to prove that zealots for extreme positions (i.e., pro- or anti-opioid) could lead to poor outcomes for honest pain-stricken patients [8–11]. Unfortunately, it is the law-abiding patients who generally suffer in such turbulent times. We must remember that these medications are useful when used responsibly but can also be dangerous without proper management. Even with adequate training, staffing, and reimbursement, only a risk stratification approach backed up by validated tools for monitoring and managing risk are likely to mitigate poor outcomes in approaching our dual-, not singular-, current public health crises: the epidemic of prescription drug abuse/overdose and the epidemic of chronic pain.

Dramatically reducing access to opioids, and thereby the overall “societal exposure” to these medications, in and of itself is not likely to help us arrive at a balance between the need to treat pain and the need to avoid drug abuse. Addiction is not simply, “a disease of exposure.” [12] To illustrate this, the approximate rate of alcoholism among American adults is not 100%, but rather 8.15% [13]. Clearly, alcoholism, like other drug addictions, is the result of a complex interaction of genetic, familial, spiritual, psychiatric, and other factors combining with the drug and the circumstances of ingestion—rather than simply a matter of exposure. It is not the availability of and exposure to the substance that leads to addiction; it is a complex array of factors that all vary widely between individuals. While this does not mean that the distribution of potentially addictive substances should be haphazard, it does show that exposure alone does not lead to addiction [14]. We must assess and manage the other factors that influence substance abuse to mitigate and potentially overcome the risk associated with this exposure. Such action will lead to far greater patient care than simply condemning all exposure to opioids and therefore losing all potential benefits these medications can provide. Responsible prescribing could allow patients to still safely reap the benefits of opioid pain management while decreasing the potential risks [15–21].

It is clear that it takes three elements to create addiction. Exposure to a substance with rewarding properties is one of these factors but not sufficient to create addiction alone [22]. That exposure must also occur under two more key circumstances: in a vulnerable person (psychologically, genetically, and/or spiritually) and at a vulnerable time (under conditions of stress, at a younger age, when used specifically to get high or escape, etc.). We are an aging population and over 100 million people have chronic pain...
[23]. Pain is the number one reason why people seek medical care, and this is not likely to change anytime soon [23]. To make matters more complex, all people with pain are under some other form of stress; by the time a patient comes to a health care provider complaining of pain, they are often depressed, struggling at work, have given up enjoyable hobbies, and/or have drawn the ire or lost the support of family members. Thus, the entire enterprise of safely using opioids hinges on the assessment of the patient’s vulnerabilities and fashioning an individualized plan to deliver opioid therapy commensurate with their level of risk. This is a known (finite and small) set of vulnerabilities: family and personal history of substance abuse, age, history of sexual abuse, and psychological disease [17].

Is this risk stratification commonly done? Are opioids delivered in individualized ways with an artful integration of drug choice, psychological therapies, rehabilitative approaches, and use of monitoring techniques? Unfortunately this is not always the case; in fact the authors believe these are the exception rather than the rule in the far majority of patients. Instead of exploring the complications of this situation, there has been a tendency to engage in a backlash against prescribing opioids in general and expand use of terms such as “hyperalgesia” to justify the avoidance of opioids. The only (often overlooked) study [24] that actually examined hyperalgesia in patients on chronic opioids noted its likely presence in a small percentage of chronic pain patients and found the overall data on the subject to be lacking!

The vast majority of opioid prescribing for chronic pain is done in overly taxed and busy treatment settings. For example, one study suggested that busy primary care doctors use screening tools and perform risk assessments—even in high risk patients—at a much lower rate than experts [25]. Primary care providers are under pressure to see patients for short visits and no more frequently visit than once per month. While 8.8 million Americans are presently taking opioids for chronic pain, 5.5 million of them are being prescribed short-acting hydrocodone [26]. If opioid therapy was being delivered in an individualized fashion, it is unlikely that 60% of patients would be prescribed the same drug in the same low-risk model.

Many experts have advocated for triaging patients into various levels of risk (i.e. low, medium, and high) [27–30]. Only the lowest-risk patients (no history of addiction, no family history of addiction, no current psychiatric problems, older age) were ever intended for this once per month, mininally monitored, drug-only brand of opioid therapy; yet, there are indications that this is the predominant mode of delivering opioid therapy, driven largely by the demands of the health care system. Many health care options are not currently designed to support the specific needs of these patients: they do not support payment for more expensive, potentially safer long-acting drugs; they are not designed to cover more frequent visits; they automatically charge co-pays for each prescription even if the prescriber does not feel the patient can safely manage a month’s supply of medication; they often do not cover the psychological and rehabilitative treatments that patients require; and some third-party payers have recently begun balking at payment for urine drug screens to monitor patients at the frequency suggested by expert consensus.

The expansion of opioid prescribing in our country is partially a product of the current system and barriers, though the issue has been complicated by some unscrupulous “pill mills” and opportunists looking to take advantage of this new section of health care. In general, however, our health care system struggles when illnesses require complex and ongoing risk assessment or lacks an algorithm for unique patient outliers, extended psychological support, need for communication amongst a multidisciplinary team of providers, continuous monitoring, and time. When the illness also occurs in patients with limited finances or in situations in which patients are less likely to deal with their physician in good faith (out of embarrassment or fear that they will be denied access to care), poor outcomes are to be expected. Opioids serve to highlight this shortcoming in chronic pain. The only way forward is through advocacy for the kind of pain care that Americans deserve.

We must embrace a rational middle ground in which careful assessment and artful, multidisciplinary treatment with or without opioids is based on the particular risk-to-benefit ratio for that specific patient. When the decision to use opioids has been made, the next important question is simple: how will they be delivered? This question cannot be answered in a cookie-cutter fashion, whether out of force of habit because of immense time pressure or a need to do it with minimal expense. The answer to sustainable, effective patient care depends upon conscientious consideration of each patient’s unique circumstances: beginning with the outcome of their risk assessment and followed by deliberately selecting a specific drug, determining how much drug per prescription is to be provided, establishing how often the patient will be seen, judging how often monitoring should occur via urine drug screening, serum analysis if necessary, and providing the appropriate level of psychological and rehabilitative therapies to round out care.

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References


