Prescription Drug Abuse and Misuse: An introduction and physician’s perspective

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Disclosures

• None
Objectives

• Describe national and state-level trends related to opioid misuse and abuse
• Define key terms related to abuse and addiction
• Describe the limitations of systems to combat diversion and prescription drug abuse
My Practice

• UAB-Huntsville Family Medicine
  – Outpatient
    • 36 Resident Physician Clinics
    • 6 Faculty Physician Clinics
    • 2 Pharm D Clinics
  – 25,000+ OV per year
  – Full spectrum family medicine with obstetrics
  – Huntsville, AL
My Practice

• UAB-Huntsville Family Medicine
  – Inpatient
    • 1000+ admissions per year
    • Full spectrum family medicine with obstetrics
  – Huntsville Hospital System, Huntsville, AL
My Practice

• Medical Ventures of America
  – Urgent Care and Stand-Alone Emergency Department
    • 6 full time physicians
    • 6 full time mid-level providers
    • 3 locations
    • Greater Orlando Area
    • 35,000+ OV per year
    • Full spectrum emergency medicine
My Practice

• Medical Ventures of America
  – Pain Management and Weight Loss
    • 2 full time physicians
    • 2 full time mid-level providers
    • 7,800+ OV per year
    • Invasive and non-invasive pain management
    • Medical weight loss and nutritional counseling
    • Leesburg, FL; Mount Dora, FL; The Villages, FL
My Practice

• Emergency Department Physician
  – Baptist Health Pensacola
  – Pensacola, FL
  – Jay, FL

• Certified in Addiction Medicine
  – Experience with buprenorphine
  – Experience with methadone
My Practice

• Emergency Department Physician
  – Baptist Health Pensacola
  – Pensacola, FL
  – Jay, FL

• Certified in Addiction Medicine
  – Experience with buprenorphine
  – Experience with methadone
Prescription drug misuse

- Defined as taking a medication in a manner other than that prescribed or for a different condition than for which the medication was prescribed.
Prescription drug abuse

- Defined as the intentional and inappropriate use of prescription drugs for purposes other than that prescribed, or in a manner or in quantities other than directed.
What does the CDC say?

• Are these numbers legitimate?
  – lies, damn lies, and statistics
• Are the numbers truly representative?
• How do we use these numbers?
Total U.S. Drug Deaths

More than 72,000 Americans died from drug overdoses in 2017.
National Overdose Deaths
Number of Deaths Involving All Drugs

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths
Number of Deaths Involving Opioids

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths
Number of Deaths Involving Benzodiazepines

Source: National Center for Health Statistics, CDC Wonder

Source: National Center for Health Statistics, CDC Wonder
Opioid Involvement in Cocaine Overdose

- Deaths Involving Cocaine
- Cocaine in Combination with Any Opioid
- Cocaine Only

Source: National Center for Health Statistics, CDC Wonder
Drugs Involved in U.S. Overdose Deaths, 1999 to 2017

- Synthetic Opioids other than Methadone, 29,406
- Heroin, 15,958
- Natural and semi-synthetic opioids, 14,958
- Cocaine, 14,556
- Methamphetamine, 10,721
- Methadone, 3,295


Values range from 0 to 30,000.
Opioid Prescribing

• 2006 to 2012 steady increase in opioid prescribing
• peaked in 2012
  – 81.3 Rxs per 100 persons (255m Rx)
• 2012 to 2017 decline
  – 2017 lowest since 2007
    • 58.7 Rxs per 100 persons (191m Rx)
• BUT: there remain hotspots which state specific and county specific data reveal showing
Opioid Prescribing
Number and age-adjusted rates of drug overdose deaths by state, US 2014

2014 Age-adjusted rate

- 6.3 to 11.0
- 11.1 to 13.5
- 13.6 to 16.0
- 16.1 to 18.5
- 18.6 to 21.0
- 21.0 to 35.5
Number and age-adjusted rates of drug overdose deaths by state, US 2015

2015 Age-adjusted rate

- 6.9 to 11.0
- 11.1 to 13.5
- 13.6 to 16.0
- 16.1 to 18.5
- 18.6 to 21.0
- 21.0 to 41.5
Statistically significant drug overdose death rate increase from 2015 to 2016, US states

Statistically significant increase

- No
- Yes

UAB MEDICINE
HUNTSVILLE
Statistically significant drug overdose death rate increase from 2016 to 2017, US States

Statistically significant increase

Statistically significant increase from 2016 to 2017

No
Yes
Drug overdose death rates by state per 100,000 people (2008)


Amount of prescription painkillers sold by state per 10,000 people (2010)

Kilograms of prescription painkillers per 10,000 people
- 3.7 - 5.9
- 6.0 - 7.2
- 7.3 - 8.4
- 8.5 - 12.6

Rate per 100,000 people (adjusted for age)
- 5.5 - 9.4
- 9.5 - 12.3
- 12.4 - 14.8
- 14.9 - 27.0

SOURCE: National Opioid Threat System (NOTS) of the Drug Enforcement Administration (DEA), 2010
Where do the opioids come from?

- Hard to study
  - self reporting by misusers and abusers
- ~50% get from a friend
  - steady for the past 5 years
- ~20-25% from a physician
  - steady for the past 5 years
Take Away

• 72,000 “drug deaths” in US in 2017
  – what does that mean?
    • states have different ways of reporting deaths
    • did everyone with any “drug” in their system who died get added to this number?
• 50,000 “opioid” deaths
  – almost 30,000 of those were synthetic fentanyl
    • the vast majority of fentanyl is illicit fentanyl
• of the 20,000 remaining opioid deaths 50% were in combination with benzodiazepines
• Alabama remains a high opioid prescription state
• vast majority of opioid misusers and abusers are not getting them from physicians
• Why now?

• Who is to blame?
  – Patients
  – Physicians
  – “Big Pharma”
Crisis

- 1860s: Morphine used during Civil War
- 1898: Heroin produced by Bayer Company
- 1914: Harrison Narcotics Act
  - Required prescriptions for opioids and cocaine
- 1924: Anti-Heroin Act
- 1970: The Controlled Substances Act
- 1980: “Addiction Rare in Patients Treated with Narcotics”
- 1995: OxyContin
- 2010-Current: DEA crack down on physicians and pharmaceutical companies
- 2018: CDC publishes guidelines for prescribing opioids
Patients

- 80% of American heroin users report prior use of prescription opioid medication
  - 94% of those report switching to heroin because it was cheaper
- Few patient prescribed opioids switch to heroin
  - Cost
  - Availability
  - “Better High”
National Overdose Deaths
Number of Deaths Involving Heroin

Source: National Center for Health Statistics, CDC Wonder
Patients

• 2 million people in the US diagnosed with opioid use disorder
• Only 1 in 5 will ever undergo specialized treatment
Physicians

Small number of physicians prescribing large quantities of medications

Or

System wide issue
California Workers Compensation Data

- 1% of prescribers accounted for 33% of all schedule II prescriptions
- 10% of prescribers accounted for 80% of all schedule II prescriptions
- Limited scope
- Does this hold up nationally?

- Top 10% of prescribers account for 57% of all prescriptions
- Top 3 specialties (pain management, anesthesia, and pain management & rehabilitation) have highest concentration but majority of Rx by non specialists
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Big Pharma

• Purdue Pharma
  – Founded in 1892
  – Sold in 1952 to Raymond, & Mortimer Sackler (brothers)
  – Merged in 1987 with Arthur Sackler’s company Purdue Fredrick
  – Rebranded in 1991 as Purdue Pharma
Purdue Pharma

- Oxycodone
- Hydrocodone
- Fentanyl
- Codeine
- Hydromorphone
Purdue Pharma

• OxyContin
  – Introduced in 1995-1996
  – Aggressive marketing
  – Studies showed no advantage over 4 times daily oxycodone or immediate release morphine
  – Company marketed a 12 hour efficacy and low abuse potential
  – Sales: $48 million in 1996 to $1.1 billion in 2000
  – 40 national speaker conventions in Florida, California, and Arizona
    • 5000 providers (all expenses paid)
  – A database driven marketing campaign
  – 671 sales representatives
  – 7-30 day free coupons
Risk of continued opioid use increases at 4-5 days

Likelihood of continuing to use opioids

Source: Centers for Disease Control and Prevention
Credit: Sarah Frostenson
Why now? Who is to blame?

- Very complex and multilayered answer
- Over the past centuries opioid use has waxed and waned
- Are today’s patients expecting the impossible from physicians in terms of pain control?
- With increased life spans are people today expecting to be as active in their 70s as in their 20s?
- Does the industrialization of the medical complex play a role?
- Have drug companies misrepresented their products?
What can be done?
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Recommendations and Reports / March 18, 2016 / 65(1):1–49

On March 15, 2016, this report was posted online as an MMWR Early Release.

Please note: An erratum has been published for this report. To view the erratum, please click here.

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View suggested citation and related materials

Summary

This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death.

CDC has provided a checklist for prescribing opioids for chronic pain [http://stacks.cdc.gov/view/c (http://www.cdc.gov/drugoverdose/prescribingresources.html)] with additional tools to guide clinic
Reducing the Risks of Relief--- The CDC Opioid-Prescribing Guideline

• April 21, 2016
• New England Journal of Medicine
• Thomas Frieden and Debra Houry
• Article outlining the current data on use of opioids for chronic pain and the data on abuse potential
• Provides 12 guidelines to be used by clinicians when prescribing opioids for chronic pain
The CDC Opioid-Prescribing Guideline

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient
The CDC Opioid-Prescribing Guideline

**OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION**

**CLINICAL REMINDERS**

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

1. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

2. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

3. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

4. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
The CDC Opioid-Prescribing Guideline

ASSESSING RISK AND ADDRESSING HARMs OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed
What Can Be Done?

• New York
  – Required prescribers to check the state’s PDMP before prescribing (2012)
  – 75% decrease in patients seeing multiple providers to obtain the same medication (2013)

• Florida
  – Regulated pain clinics and stopped healthcare providers from dispensing prescription opioids from their offices (2010)
  – 50% decrease in oxycodone linked deaths (2012)

• Tennessee
  – Required prescribers to check the state’s PDMP before prescribing (2012)
  – 36% reduction in patients seeing multiple providers to obtain the same medication (2013)
What Can Be Done?

• March 2016: Massachusetts enacted legislation limiting the initial supply of opioid medication prescribed by physicians
• Now: A growing number of states have guidelines restricting the supply of opioid medication prescribed by physicians
  – 5 of the states only apply to Medicare
  – 2 of the states have no actual limits
  – Alabama, Georgia, and Mississippi do not
  – Florida and Tennessee (2018)
Risk Factors

- Past or current substance abuse
- Untreated psychiatric disorders
- Younger age
- Social environments that encourage misuse
- Family environments that encourage misuse
- h/o overdose
Prescription Drug Monitoring Programs

- New Patients *(Family Medicine / Pain / Weight Loss)*
  - Review PDMP prior to evaluation
  - Explore PDMP with the patient
  - Address any concerns with an honest and upfront conversation
  - Multiple Prescribers = RED FLAG
  - Controlled Substances Agreement
  - I will be the only prescriber from this moment onward
Prescription Drug Monitoring Programs

- Return Visits (*Family Medicine / Pain Management / Weight Loss*)
  - Review PDMP EVERY time
  - Verify PDMP with Rx bottles
  - Contact the pharmacy if necessary
  - You must not be afraid to wean/discontinue treatment
  - Rely on Controlled Substances Agreement
  - Trust but verify
Prescription Drug Monitoring Programs

- New Patients *(Urgent Care and Emergency Department)*
  - Review PDMP prior to ALL controlled substance Rx
  - Explore PDMP with the patient
  - Address any concerns with an honest and upfront conversation
  - Multiple Prescribers = RED FLAG
  - Rarely will I give “emergency refills”
    - If I do I always contact the managing/prescribing physician
Prescription Drug Monitoring Programs
FAQs

• Who can access the PDMP?
• Am I required to access the PDMP?
• What if my patient is not listed in the PDMP?
• Where can I store the PDMP data?
• What if someone is committing fraud?
Prescription Drug Monitoring Programs
Alabama Requirements

• For 30 MME or less per day, use PDMP in a manner consistent with good clinical practice (what does this mean?)
• For more than 30 MME per day, review the PDMP at least two times per year and document the use of REMS (Risk Evaluation and Mitigation Strategy) in the medical record
• For more than 90 MME per day, review PDMP every time prescriptions are written, on the same day the prescriptions are written, and document use of REMS in the medical record.
• Exemptions: nursing home patients, hospice patients (must indicate hospice on Rx), active malignant pain, intra-operative care, in-patient prescribing (in-patient orders not discharge Rx)
# Prescription Drug Monitoring Programs

## Alabama Requirements

1. **Determine** the total daily amount of each opioid the patient takes.
2. **Convert** each to MMEs—multiply the dose for each opioid by the conversion factor (see table below).
3. **Add** them together.

## Calculating Morphine Milligram Equivalents (MME)

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<th>CONVERSION FACTOR</th>
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<td>Fentanyl trans-dermal</td>
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<td>Hydromorphone</td>
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<td>1-20 mg/day</td>
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<td>21-40 mg/day</td>
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<tr>
<td>41-60 mg/day</td>
<td>10</td>
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<tr>
<td>≥ 61-80 mg/day</td>
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<td>Oxycodone</td>
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### Morphine Milligram Equivalent Reference Guide

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*Codeine 30** = Tylenol 3  
*Codeine 60** = Tylenol 4

**GREEN** - check PDMP twice a year.
**GREY** - check every prescription.

**CAUTION:** Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

**USE EXTRA CAUTION**

**Conversion factor increased for**
- Fentanyl – only in day, and absorption other factors.

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These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.
Urine Drug Screens

• Not required
• Not perfect
• Can be good tools for screening
• In practice
  – 2 required annual tests
  – Random tests at the physician’s discretion
• Insurance coverage varies dramatically
• Costs vary dramatically
  – we charge $25 to all patients
Deaths

• Opioids
  – 42,000 in 2016 alone
  • More than gun deaths and motor vehicle deaths combined
  – More than 500,000 since 1999
  • More than total US deaths in WW2

• Rofecoxib (Vioxx)
  – 28,000 heart attacks or sudden cardiac deaths in 5 years
  – Removed from market

• Bromfenac (Duracet)
  – 4 deaths
  – 8 liver transplants
  – Removed from market after 1 year

• Propoxyphene (Darvocet/Darvon)
  – 2000 deaths in 20 years
  – Removed from market

• In total 35 FDA approved drugs all removed from the market with less deaths than opioids due to data showing non superior efficacy
Data

- Few studies for more than 6 weeks
- No study comparing opioid vs non opioid for more than 12 months
- Several studies show pain increases with chronic opioid use
- No good screening tool for addiction potential
- Addiction up to 26% in primary care practices for non cancer related chronic pain
- Risk exponentially increases with dose
  - 1-49 MME base
  - 49-99 MME doubles the risk
  - 100 + MME 9 times the risk
- Deaths:
  - 1 in every 550 patients started on opioids died of an opioid related cause within 2.6 years
  - At 200 MME daily this increased to 1 in 32
State Policies

- Percentage of adult (18-64y) patients with opioid prescriptions
- far left is 0%
- far right is 10%
- middle line is 5%
Continuing medical education required for clinicians who prescribe controlled substances
Data
Day supply limits to written prescriptions for opioids and/or schedule II drugs

- 3-7 days
- 30+ days
- Introduced/considered
Substance abuse disorder assessment required prior to opioid prescription

Data
Regulations mandate or allow pharmacists to check ID before dispensing prescriptions.
Data

Legalized medical marijuana
What Can Be Done?

- Judicious prescribing by physicians
- Use of pain management contracts
- Discussion of risk/benefit with patients
- Use of available resources such as Prescription Drug Monitoring Programs
- Diversion avoidance policies with use of random urine drug screens and pill counting
- Multi-disciplinary approach between physicians, pharmacists, and law enforcement
Case Presentations

• These cases were from a primary care practice, urgent care practice, emergency department, or pain management clinic

• These cases were not from practices that were designed to deal with substance abuse and addiction medicine

• It is reasonable to consider addiction a medical condition and to treat as such if you are qualified or to refer to an appropriate addiction specialist.
CASE PRESENTATION

55y M complains of chronic right knee pain

• Urgent Care
• Orthovisc injections every 6 months
• Occasional corticosteroid injection
• Does not want a knee replacement
• Active
  – Cycles 75+ miles weekly
  – Owns a construction company and investment firm
CASE PRESENTATION

55y M complains of chronic right knee pain

- Prescribed hydrocodone/acetaminophen 5/325mg PO q12 PRN #60 per month
- Compliant for 12 months
- Complaints of increase pain and noted RTC visits more often for pain
- Noted incorrect pill counts and consistent early refill requests
- Denied early refill/increased medication by our staff
- PDMP revealed multiple prescribers totaling over 200 tablets per month
CASE PRESENTATION

55y M complains of chronic right knee pain
- I had a discussion with the patient about his misuse which had turned into abuse
- I contacted the other prescribers and encouraged them to perform a PDMP query
- I arranged for the patient to have follow up with a pain management specialist with the understanding that he would be weaned from the medication and followed regularly
- At last check he was on oxycodone ER 30mg BID scheduled and had been compliant with clean PDMP for over 18 months
33y M, w/c referral, chronic neck and back pain

• Pain Management
• Imaging showed multi level disease
• 2 failed surgical interventions
• Oxycodone ER 30mg PO BID scheduled
• Oxycodone 10mg PO q12 hour PRN
• Dextroamphetamine/amphetamine 20mg ER daily
CASE PRESENTATION

33y M, w/c referral, chronic neck and back pain
• Compliant for 3 years
• Began to have complaints of increased pain and requesting not higher doses but higher quantities of medications
• UDS always consistent with treatment
• PDMP always clean
• Pill counts always correct
CASE PRESENTATION

33y M, w/c referral, chronic neck and back pain
- Concerning that he was asking for higher numbers of pills
- Another patient began to have incorrect pill counts and when confronted admitted the 33y M patient was soliciting patients in the waiting room and outside the office for medications
CASE PRESENTATION

33y M, w/c referral, chronic neck and back pain

• Reported to the local sheriff’s office
• Individual was investigated and found to be the lead person in a 57-person illegal opioid trade
• Last known location was in jail
CASE PRESENTATION

48y F, married to a local family medicine physician

- Pain Management
- Imaging revealed multi-level spinal stenosis
- Patient deferred surgery
- Started with hydrocodone/acetaminophen 5/325mg PRN #30 per month
- Increased over 3 years to oxycodone ER 30mg PO BID and hydrocodone/acetaminophen 10/325mg PO q12 PRN
CASE PRESENTATION

48y F, married to a local family medicine physician
- UDS appropriate
- Pill counts appropriate
- Always compliant with office visits
- PMPD revealed 4 other local physicians all supplying hydrocodone/acetaminophen including husband
- Brought both her and her husband in for an office visit and discussed the PDMP
- Encouraged the other prescribers to perform a PDMP query
- Discharged her from the practice with documentation in hand the day of the visit
- Provided information for addiction medicine specialist should the patient wish to pursue treatment
CASE PRESENTATION

22y F, former employee, recurrent kidney stones

– Urgent Care
– Began as a 1-2 time a year request associated with an office visit
– Increased frequency of requests even on telephone and stated was unable to come to the office but a family member could come by and pick up the prescription
CASE PRESENTATION

22y F, former employee, recurrent kidney stones

• PDMP review revealed multiple prescribing physicians over 12 months over multiple cities
• Discussed this with the patient
• Agreed to treat acute pain related to kidney stones in office under observation when required but no more controlled substances would be provided
CASE PRESENTATION

32y F, nurse, obesity

• Seen in weight loss clinic
• Phentermine hydrochloride 37.5mg daily
• Initially showed expected weight loss over first 6 months
• Became non compliant with dieting and exercise and hit a plateau of weight loss well short of previously designed goal
CASE PRESENTATION

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CASE PRESENTATION

32y F, nurse, obesity

- Demanded continuation of the medication even with non compliance to lifestyle modifications
- Stopped coming to f/u visits when explained that medication would be discontinued until a history of compliance with diet and exercise was documented
- Left poor reviews online
CASE PRESENTATION

32y F, nurse, obesity

- Returned 6 months later apologetic and stating that she had been restarted on a diet and exercise plan for 30 days and was ready to resume treatment
- PDMP showed #360 tablets from 3 different physicians and 6 different pharmacies since she was last seen
- Politely discussed with patient and officially discharged her from the practice and provided a letter stating this prior to her leaving that day.
CASE PRESENTATION

65y male, chronic low back pain, retired musician
• Pain Management
• 5 year h/o with practice
• Appropriate imaging studies
• Failed surgical therapy
• Hydrocodone/acetaminophen 10/325mg PO BID scheduled
• PDMP always appropriate
CASE PRESENTATION

65y male, chronic low back pain, retired musician

• Known prior cocaine use
  – counseled on cocaine abstinence during treatment and provided a “contract” which patient read and signed

• UDS showed cocaine in system
  – Confirmed on send out

• Patient weaned from medication over the next 90 days and discharged from practice

• Recommended to follow up with addiction treatment program

• Illustrative of shortcoming of PDMP alone
CASE PRESENTATION

57y F, chronic neck and back pain

- 10 year history with practice
- Imaging showing degenerative changes, disc disease, and stenosis
- Epidural injections
- Oxycodone ER 10mg PO BID
- No history of missed appointments
- No history of inappropriate UDS
- No history of inappropriate PDMP
- No history of non compliance
- Continues treatment with success
Pearls

• Remember the limitations
  – Only the information pharmacies provide are in the system
  – Each PDMP is state specific (though this is improving with some states sharing data)
  – Information maybe up to 2 weeks delayed
  – Do not rely on PDMP information alone in assessing misuse or abuse of controlled substances
Pearls

• You are NEVER under the obligation to write controlled substances
• Do not be afraid to express your concerns to your patients
• ALWAYS check the PDMP monthly (quarterly in some cases)
• ALWAYS have a written and signed Controlled Substances Agreement with your continuity patients explicitly outlining your expectations
Pearls

• NEVER write a controlled substance for an intimate partner

• Be cautious of writing a controlled substance for friends or family
  – I will never do continuity of controlled substances for friends and family

• Do not be afraid of bad reviews or “being turned into the board” – If a patient threatens me that is grounds for immediate termination
Pearls

• You can write for 90 days of a Schedule II substance by writing 3 separate 30-day Rx’s
  – Date each with the day they are written
  – Clearly indicate the fill on or after date for each
• Be careful not to let short term turn into chronic
• Discuss with the patient up front the length of treatment and document this in the chart
• Remember that often patients (and physicians) mistake withdrawal for chronic pain
References/Images

- CDC
- Alabama Department of Public Health
- Alabama Department of Mental Health
- Athenainsight (Athena Health)
- National Conference of State Legislature
Questions/Comments

• Feel free to contact me with any questions or comments

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