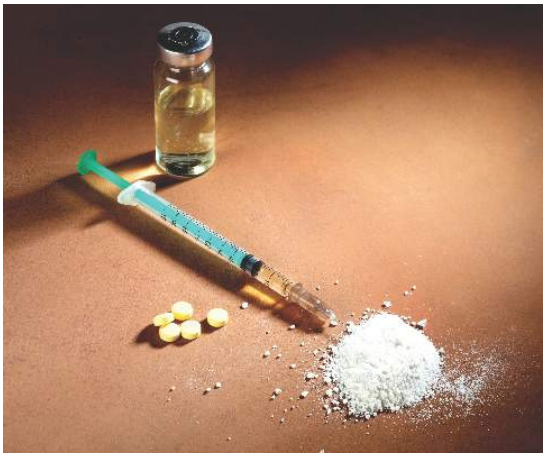
How Physicians Can Reverse The Opioid Crisis

By: M. ALEXANDER OTTO, Family Practice News Digital Network | MARCH 17, 2016

In about 2002, Dr. Gary Franklin realized the state of Washington might have a problem.

A *big* problem.

A state resident who'd suffered a back sprain and filed a workers' compensation claim died 2 years later – not from heart disease or cancer or stroke, but from an unintentional prescription opioid overdose, recalled Dr. Franklin, medical director of the Washington State Department of Labor and Industries.



"I had never seen anything so sad," he said.
The case prompted the neurologist and his colleagues to review Washington state workers' compensation claims. What they uncovered was a local trend that would explode into a national scourge: a marked increase in opioid poisonings among Washington state residents with everyday aches and pains who, in the past, would never have been prescribed opioids.

The gateway drug turned out to be oxycodone (OxyContin), which was heavily marketed at the time as a safe choice for pain relief with little abuse potential. Purdue Pharma has since paid a $600 million federal fine for deceptive marketing.

"This is the worst man-made epidemic in modern medical history," said Dr. Franklin, also a research professor at the University of Washington, Seattle. "It was made by modern medicine, and it's up to modern medicine to turn it around."

For the United States to recover from the opioid crisis, Dr. Franklin said, the medical community must reduce oral opioid prescriptions for noncancer pain. Others interviewed for this story said doctors also have to overcome their aversion to in-office addiction treatment, and find new options for everyday chronic pain.

The first step is "to forget everything you were told in 1999," said Dr. Franklin. That includes the notions that addiction is rare, opioids are indicated for noncancer chronic pain, and doses should be increased if patients become tolerant.

Those messages led to overprescribing, which in turn "led to an oversupply problem that's feeding misuse and diversion. It's only recently that it has become a heroin problem; the vast majority of heroin users these days start on prescription opioids," he said.

The Washington workers' comp claims data triggered "a complete rethinking of our approach to chronic pain and a shift to other treatment strategies," said Dr. David Tauben, chief of pain medicine at the University of Washington, Seattle.

In 2007, Washington became one of the first states to issue opioid treatment guidelines, which are updated regularly. Among other steps, prescribers were urged to limit doses and durations.

Since then, the state has seen a nearly 40% reduction in prescription opioid poisonings. "We also found that with dose reductions" for back pain, headaches, and similar non cancer issues, "pain subsides, function improves, and patient satisfaction" goes up, said Dr. Tauben, who was involved in creating the guidelines

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DR. FRANKLIN

Dr. Gary Franklin

Clamping down, pushing back

The Centers for Disease Control and Prevention in March released similar guidelines, including a suggested 3-day limit for acute pain prescriptions and a cap of 90 morphine milligram equivalents per day for chronic noncancer pain – the amount in a single 60-mg oxycodone tablet.

Meanwhile, Food and Drug Administration officials are planning a regulatory overhaul to address opioid approval, labeling, and prescribing concerns. In many places, doctors are also facing new opioid training requirements.

The Washington state experience suggests that such efforts are likely to help reverse the opioid crisis.

It's not about getting rid of the drugs, explained Dr. Gail D'Onofrio, chair of emergency medicine at Yale University in New Haven, Conn.

"Opioids are really good for certain things," especially cancer pain and, for a few days, acute pain. But "we've kind of lost our way," Dr. D'Onofrio said. "We don't need to give people 3 months of narcotics for a knee replacement" or 3 weeks of narcotics for a wisdom tooth extraction.

"We are all guilty" of overprescribing, and "just like everywhere else, we've seen the problems; every year, it's getting worse," she added. In response, "we are changing how we use opioids, adapting the guidelines from the CDC and other groups," and tailoring them to different services.

At the Yale emergency department, oral opioid prescriptions are now generally limited to 3 days, except for renal colic patients, who might get a few days more. "We do not fill opioid scripts and don't reorder them for patients." Instead, "we talk to the prescriber and tell them what's going on," Dr. D'Onofrio explained.

'Primary care must get involved; that's where chronic pain presents.'

DR. TAUBEN

Dr. David Tauben

Yale's not alone in cutting back. After years of growth, U.S. oral opioid sales appear to be declining. In fact, in some quarters, there's concern the clampdown will go too far.

The CDC received more than 4,300 comments about the draft version of its guidelines. Some patients were worried about losing access to drugs that have helped them. And, while supportive of the goals, some professional groups questioned the evidence behind the proposals and worry about undertreatment of pain, among other issues.

"The problem with a lot of the guidelines is that they're all around limiting prescribing. They don't really tell doctors what to do instead," said Dr. Peter Friedmann, an addiction treatment specialist in Springfield, Mass., and chief research officer for Baystate Health.

An alternative for chronic pain

For noncancer chronic pain, recent evidence supports multimodal therapy. Opioids might bring temporary relief, but "throwing drugs at people isn't going to solve the problem," said Dr. Tauben, the University of Washington pain expert.

Dr. Peter Friedmann

"Multimodal therapy" means focusing more on the burden of pain instead of its intensity, with team-based care. Reducing the burden – anxiety, sleeplessness, reduced mobility, and other problems – seems to reduce the significance and intensity of pain to the point where it can be managed, if needed, with nonsteroidal anti-inflammatory drugs (NSAIDs), trigger-point injections, and other nonopioid options.

Depending on the patient's needs, primary care physicians might find themselves coordinating services from psychologists, physical therapists, social workers, or others.

For the approach to work, the impact of pain has to be accurately gauged, along with underlying psychological or social issues; to save time, the University of Washington has patients complete an online survey prior to their office visit.

There are national efforts underway to support the approach, and a growing recognition that "by doing it right, you save downstream costs. Primary care must get involved; that's where chronic pain presents," Dr. Tauben said.

Batting cleanup

There's a role for primary care when patients are hooked on opioids, too. Requests for early refills and higher doses are a clue.

"Given the stigma, a lot of doctors don't want to deal with addiction, but we have to deal with it. We need to move addiction treatment into the mainstream of what we do in medicine," Dr. Friedmann said. "These patients are no more or no less challenging than any other patients we deal with; the only way doctors are going to find that out is by starting to manage some of them."

He estimates that about 60% of his patients do well on buprenorphine, a sublingual, partial opioid agonist that blocks the effects of full agonists and dulls withdrawal symptoms. Incorporating it into practice "is not something you need to figure out yourself," Dr. Friedmann noted. There are training programs and people who can help.

There simply aren't enough methadone clinics to handle the current situation, especially in suburbs and rural areas where drug dealers have found a new market for heroin. Another option, abstinence programs, "have contributed to the problem of overdose;" people lose their tolerance, reuse, and die, he said.

Buprenorphine treatment might soon get easier. The FDA is expected to make an approval decision soon on probuphine, a matchstick-size subdermal implant that delivers buprenorphine continuously for 6 months.

Dr. Gail D'Onofrio

'We don't need to give people 3 months of narcotics for a knee replacement.'

DR. D'ONOFRIO

Dr. Friedmann disclosed relationships with Alkermes, Inavir, and Orexo. The other doctors had no relevant disclosures.