Opioid Epidemic: Myths and Facts

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The Opioid Epidemic: A National Public Health Emergency

- CDC declared opioid induced deaths as a national epidemic.
  - 91 Americans die every day from an opioid overdose.
  - Over 64,000 people died of drug overdoses in the US last year up 22% from 2015.

The Opioid Epidemic: A National Public Health Emergency

- Drug overdose is now the leading cause unintentional death of people under age 50 in the US.

How Did We Get Here?

- We're experiencing the consequences of managing pain with prescription opioids for 25 years.

- Pain Crusade during the 1980's & 90's: Pain as the 5th vital sign
  - There was an entire movement and physician were being told that there was an unrecognized epidemic of pain in America.

How Did We Get Here?

- AMA suggested Joint Commission standards were encouraging overprescribing of opioids:
  - Hospital respects patient's right to pain control
  - Hospital assesses and reassess patient's pain
  - Hospital treats pain or refers patient for treatment

How Did We Get Here?

- Long Acting opioids (MS Contin and OxyContin) were thought to be safe.
- Marketing by pharmaceutical companies (ex. Purdue Pharma and Endo).
- Primary care reimbursements: short time, fast visits.

How Did We Get Here?

- Amid the growing epidemic, many doctors also don’t learn much about pain management while in medical school.
  - A 2011 study found that during four years of training, a typical U.S. medical student spends only nine hours learning about pain.

How Did We Get Here?

- Two decades of research outcomes and data, consensus emerged that opioids were unhelpful, even risky, for some types of chronic pain (back, headaches, fibromyalgia).

Annals of Internal Medicine

REVIEW

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

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Background: Increases in prescriptions of opioid medications for chronic pain have been accompanied by increases in opioid overdoses, abuse, and other harms and uncertainty about long-term effectiveness.

Purpose: To evaluate evidence on the effectiveness and harms of long-term (>3 months) opioid therapy for chronic pain in adults.

Data Sources: MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL (January 2008 through August 2014); relevant studies from a prior review; reference lists; and ClinicalTrials.gov.

Study Selection: Randomized trials and observational studies that involved adults with chronic pain who were prescribed long-term opioid therapy and that evaluated opioid therapy versus placebo, no opioid, or nonopioid therapy; different opioid dosing strategies; or risk mitigation strategies.

Data Extraction: Dual extraction and quality assessment.

Data Synthesis: No study of opioid therapy versus no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction. Good- and fair-qua[…] chronic […] oid abu[…] dysfunc[…] outcom[…] creased […] ent opioid dosing and risk mitigation strategies is limited.

Limitations: Non-English-language articles were excluded, meta-analysis could not be done, and publication bias could not be assessed. No placebo-controlled trials met inclusion criteria, evidence was lacking for many comparisons and outcomes, and observational studies were limited in their ability to address potential confounding.

Conclusion: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

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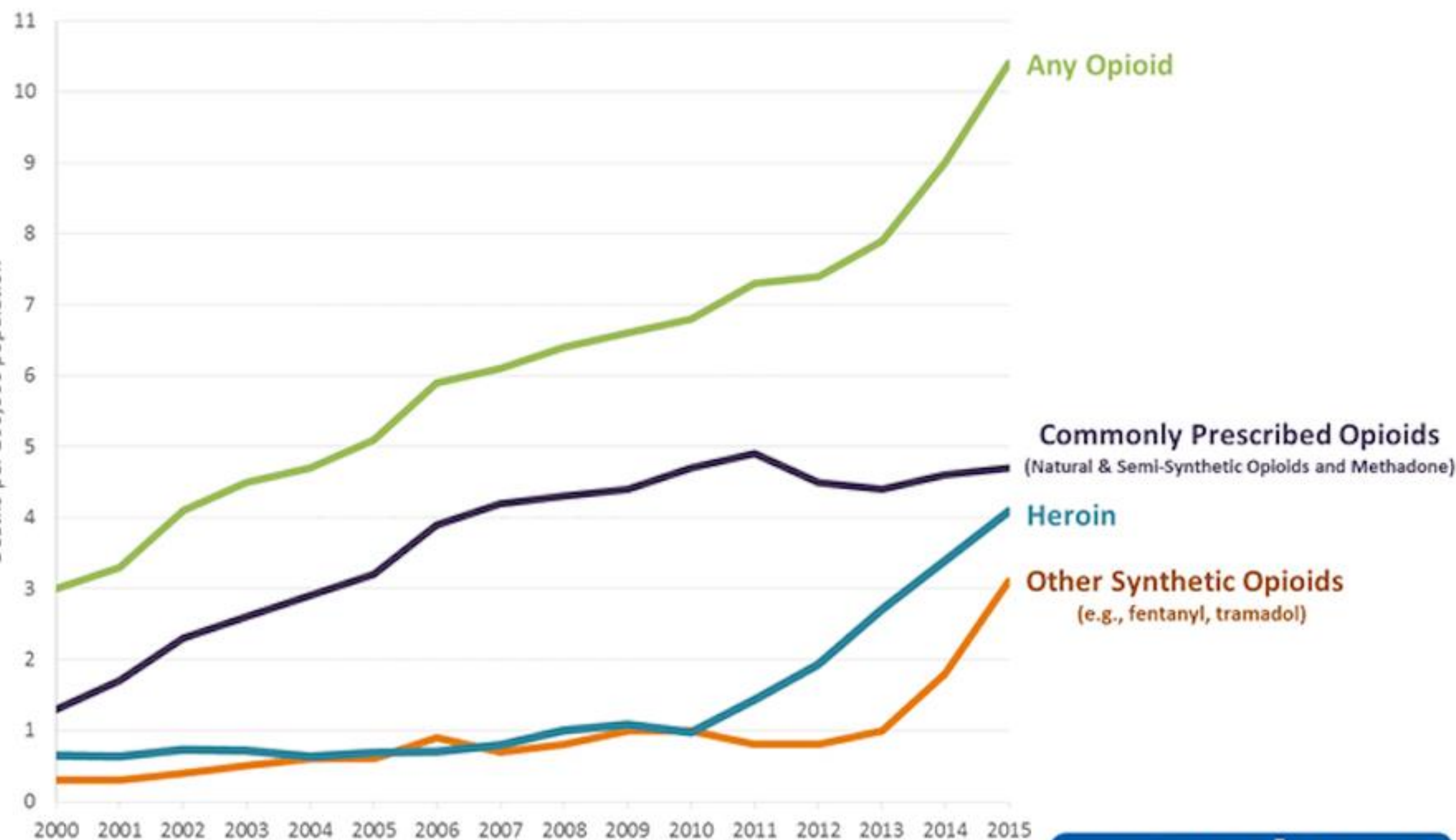
The Opioid Epidemic: A National Public Health Emergency

- Decreased prescription opioid deaths 4.9% annually from 2012 through 2016.

- Heroin and fentanyl deaths in 2016 have increased 540% in just the past 3 years.


Overdose Deaths Involving Opioids, United States, 2000-2015
11
10
9
8
7
6
5
4
3
2
1
0
2000
2001
2002
2003
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2005
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2008
2009
2010
2011
2012
2013
2014
2015
Any Opioid
Commonly Prescribed Opioids
(Natural & Semi-Synthetic Opioids and Methadone)
Heroin
Other Synthetic Opioids
(e.g., fentanyl, tramadol)
SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://wonder.cdc.gov/.
www.cdc.gov
Your Source for Credible Health Information

Here We Are: Opioid Epidemic

- Majority of heroin/fentanyl users report opioid misuse began with prescription drugs.

- Heroin laced with fentanyl and other drugs has increased its lethality
  - Lower price of heroin and decreasing access to prescription opioids increased heroin use
  - Abuse deterrent formulation of OxyContin made it harder to inject, causing some to switch to heroin

Tackling the Opioid Crisis

- June 2016: AMA lobbied to have pain removed as 5th vital sign.

- Fall 2016: Obama Administration asks medical and pharmacy schools to include opioid and pain management education in curriculums.

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Tackling the Opioid Crisis

- October 2017: The White House Administration has identified it as a "public health emergency," and a national commission and a commission of state governors have issued recommendations for action.

NC Opioid Crisis

- According to NC DHHS and the CDC, North Carolina has experienced a 350% increase in drug overdose deaths since 1999.
- NC is one of 19 states that saw statistically significant increase in drug overdose death rates from 2014 to 2015.
  - #1 city in US for opioid abuse: Wilmington NC

NC Opioid Crisis

- This epidemic is devastating families and communities.
- It is overwhelming medical providers and is straining prevention and treatment efforts.

Strengthen Opioid Misuse Prevention (STOP) Act

Transitions LifeCare
Founded as Hospice of Wake County • 1979

NC Opioid Crisis

- Governor Roy Cooper signed the “Strengthen Opioid Misuse Prevention (STOP) Act into law on June 29, 2017 which is aimed at curtailing the opioid abuse epidemic in NC.
  - The objective is to reduce or eliminate **inappropriate** opioid prescribing.

NC Opioid Crisis

- NCMB passed a Public Health Law to require prescribers to complete required course work on pain management and addiction.
- Medical board suggests use of NC controlled substances reporting systems.

Targeted Substances

- The **STOP** Act applies to all "targeted controlled substances" (all Schedule II and Schedule III opioids or narcotics).

How does the STOP Act limit opioid prescribing and when do these limits go into effect?

Effective Jan. 1, 2018, the STOP Act establishes limits on initial prescriptions for:

-acute pain a 5-day supply

-post-surgical pain a 7-day supply

Rationale

- 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.

(Recommendation category A: Evidence type: 4)

Specific Patient Populations

- It does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.

- Medications are prescribed for the treatment of cancer or another condition associated with cancer.

Sites of Practice

- This provision does not apply to prescriptions issued by practitioners ordering targeted controlled substances to be wholly administered in a hospital, nursing home, hospice facility, or residential care facility.

Multi-State Info Sharing Network

- NC prescribers who use the NC Controlled Substances Reporting System (NC CSRS) can currently obtain patient information from other states to enable two-way prescription data sharing with individual states:
  - Virginia, SC

Tools and Materials

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your pain in the past week?*
0="no pain", 10="worst you can imagine"

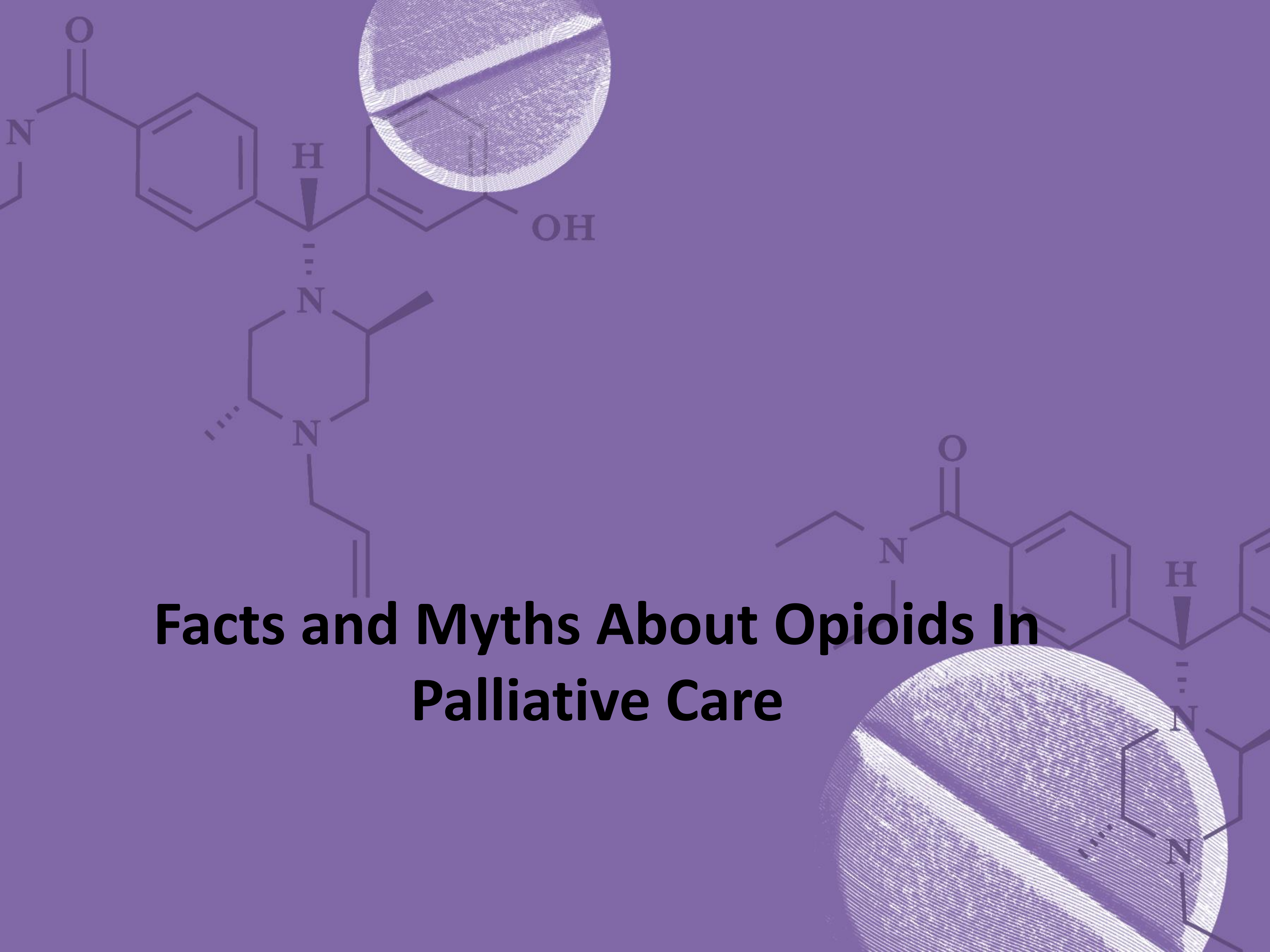
Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your general activity?*
0="not at all", 10="complete interference"

CDC — U.S. Department of Health and Human Services, Centers for Disease Control and Prevention

TO LEARN MORE

- Provider and patient materials
  - Checklist for prescribing opioids for chronic pain
  - Fact sheets
  - Posters
  - Web banners and badges
  - Social media web buttons and infographics
- CDC Opioid Overdose Website
  www.cdc.gov/drugoverdose/index.html


Facts and Myths About Opioids In
Palliative Care

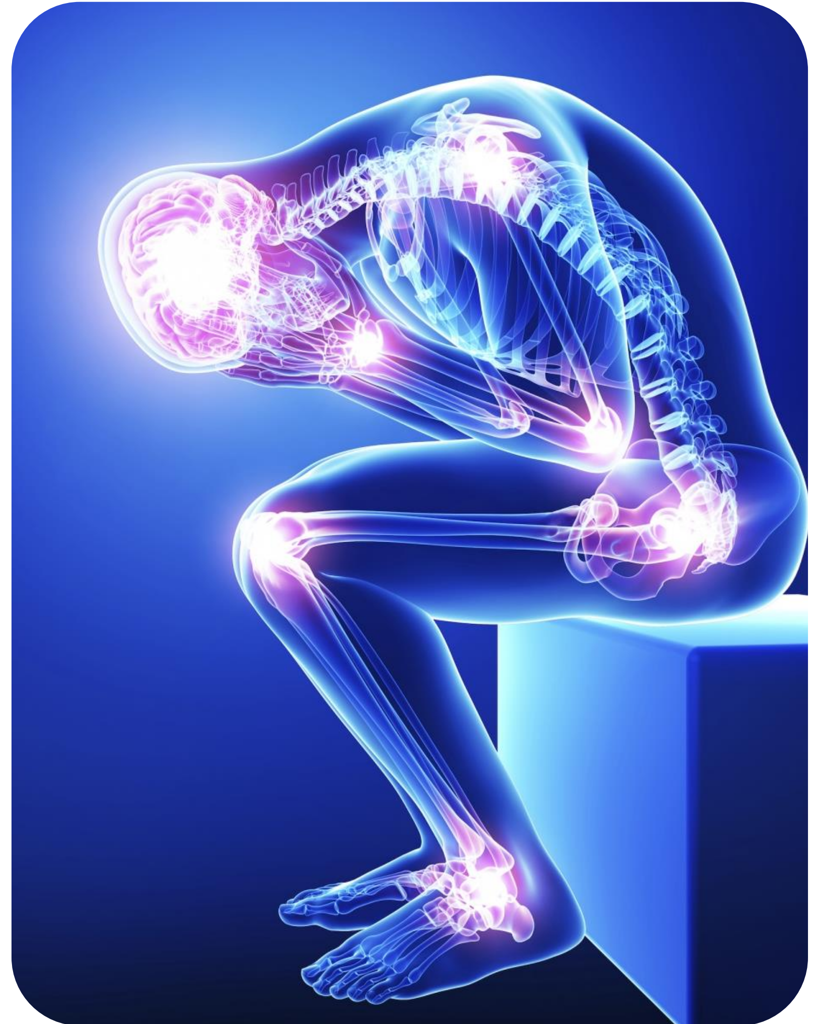
Fall Risk
Nothing by Mouth
Activity Level
NO
PASSING
ZONE

Mrs. Elle

- An 83 year old former nurse has been hospitalized because of severe pain.
- She has pancreatic cancer with metastases to liver and lung.
- She has severe abdominal pain and opioid therapy with morphine is recommended for pain relief.

“Opioidphobia”

- Hospice & patients with severe symptoms from chronic, progressive diseases may not receive the appropriate treatment using opioids on such strict guidelines.



“Opioidphobia”

- The result can be a reluctance to use medication to secure comfort and a failure to provide adequate relief to a very vulnerable group of patients.

There is no “limit” or maximum acceptable dose for pain patients.

MYTH

"Do not give my mother morphine for her cancer pain. You will make her stop breathing!"

FACT

- Several studies looked at the effect of opioid use on survival and none of the studies reported that opioids had shortened life.

- Pain is "nature's own antidote to respiratory depression." Berry 1994

(Ekstsrom 2014;Ben-Aharon 2008; Mahler 2015; Bercovitch 1999; Morita 1998;Morita 2001; Thorns 2000; Badger 1987).

FACT

- A large study of opioid use at the end of life from the US National Hospice Outcomes Project, as well as a systematic review of various other countries, found no difference in survival with absolute opioid dose or change in opioid dose.

FACT

- Studies of patients with advanced cancers showed no evidence that chronic breathing failure is either common or severe in those receiving high doses of morphine J Pain Symptom Manage 1991;6:411-422.
  – Gradual titration of morphine reduced respiratory rates and dyspnea but did not have a significant effect on other respiratory parameters. (Clemens et al)

Stages of Opioid Toxicity

- Morphine-related toxicity will be evident in sequential development of:
  - Drowsiness ---→
  - Confusion----→
  - Loss of consciousness--→ before respiratory drive is significantly compromised

Myth

“I will not prescribe morphine for my patient with advanced COPD with shortness of breath- she is not on hospice.”

FACT

- Opioids are gold standard in treatment of dyspnea (shortness of breath) – endorsed by numerous guidelines.

(Ekstsrom 2014;Ben-Aharon 2008; Mahler 2015)

- They have been found to be effective in alleviating dyspnea and, when used carefully, they do not to have serious side effects, such as respiratory depression.

FACT

- Used for advanced dyspnea management for many disease states, not just for management of end-of-life refractory dyspnea.

Abernethy AP1, Currow DC, Frith P, Fazekas BS, McHugh A, Bui C. BMJ. 2003 Sep 6;327(7414):523-8.48.

- Sustained morphine used for Shortness Of Breath for COPD patients.
  - Less dyspnea, improved quality of life
  - Better sleep
  - Constipation

2010-2011Consensus Statement for Advanced COPD (ACP and CTS)

- Appropriate titration and monitoring of opioids in COPD is safe and well tolerated (lack of adverse effect on blood gases).

- Use opioids as adjunctive treatment to reduce dyspnea and improve quality of life.

Myth

"No morphine, I do not want my mother to become a drug addict!"

FACT

- Depends on their personal risk of addiction.
  - Screen for risk factors: a family history of addiction, a personal history of alcohol and drug abuse, or certain psychiatric disorders.

  - Use of recreational drugs increases likelihood of prescription pain medication addiction

Lewis, C., Corley, D., Lake, N., Brockopp, D. (2015). Overcoming barriers to effective pain management: The use of professionally directed small group discussions.

FACT

- Fears about psychological dependence (addiction) are often exaggerated when opioids are used to treat severe pain or dyspnea.
- The abuse of opioids are rarely seen in patients with cancer or other severe pain, nor do these medications lead to addiction in terminally ill patients.

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- patients should be asked to rate the intensity of their breathlessness as part of a comprehensive care plan, opioids should be dosed and titrated for relief of dyspnea in the individual patient, American College of Chest Physicians Mahler DA, Chest. 2010 Mar;137(3)
- Open, uncontrolled trialin 20 terminal ca pts, 5mg or 2.5 x reg95% reported less dyspneaNo change in respiratory rate or effort. No change in arterial O2 sat or end- tidal PaCO2.Bruera E J Pain Symptom 1990; 5(6):Crossover Placebo Controlled Trial10 consecutive ca pts on stable opioidDose increased 50% (avg 34.5 mg sc)Good relief, no resp depressionBruera E Ann Intern Med 1993; 119:906.Randomized double-blind trial9 elderly cancer patientsReceived either 5mg sc or 3.75mg more than regular dose.In 45 min sig lower mean dyspnea by VAS & Borg scalesNo changes observed in respiratory effort or rate,No change in O2 satsMazzocato C, Ann Oncol. 1999; 10(12).
- 14 palliative care patients with dyspneaAll treated with hydromorphone and carefully monitoredIn 30 minutes, average dyspnea dropped 5.2 to 1.1 on 10 point scaleRespiratory rate decreased 39 to 35 breaths / minperipheral oxygen saturation unchangedtranscutaneous arterial pressure of carbon dioxide unchangedClemens KE, Support Care Cancer. 2008; 16(1):93-9

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- Starting dose will vary based on symptom severity, frailty, co-morbiditiesOutpatient with moderate symptoms, one possible beginning might behydrocodone or oxycodone 2.5 to 5mg every 4-6 hours as neededWith regular use of laxativeInpatients with more severe symptoms may benefit fromparenteral doses of morphine or hydromorphone to get relief quickly and determine effective dosing.Remember sleepless patient, finally comfortable, can look overmedicatedFamily and staff require some educating also.Don’t forget the laxative!

- (The Opioid Epidemic Myths Facts - TASMN Meeting Mark P 1-14-2020)