Pain and the Opioid Crisis: Origins and Solutions

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Who Are the Players?
Russell Portenoy MD

Patient Advocates Call on Brandeis to Fire Kolodny
Andrew Kolodny, MD

DISCLAIMER
- No current financial relationships to disclose
- Clinical Associate Professor, WSSOM
- Medical Director, Michigan Professional Recovery Program
- Medical Director, Dawn
- Past President, Mich Society of Addiction Medicine
- Consultant, USA, DEA & BCBSM
- Provider, Packard Health & St Joes [IHA]
How Bad Is It?

Overdose Deaths U.S. 1999-2016

CDC, 2018: opioid sales 2006 - 2017

Prescription Drug Crisis in Michigan: MAPS data

While the number of patients using Schedule II-IV drugs and the number of dispensations have been stabilizing or decreasing, the number of deaths are increasing.
Prescription Drug Crisis in Michigan: MAPS data

Conclusions:
- Prescription opioids have leveled off/decreasing.
- Despite this, OD deaths are increasing due to Fentanyl.
- Patients will routinely tell you that they “moved to heroin”.
- They are being exposed to Fentanyl instead (50%+)

Are Providers Behind the Opioid Epidemic?

WHERE DID THE OPIOIDS COME FROM?
- Unless:
  - It fell off a truck, or
  - Was purchased on the Internet,
It all came from this.

Michigan is 10th in the US: 107 prescriptions/100 people.

WHY do doctors over prescribe?

The Four D’s:
- Dishonest?
- Dated
- Disabled
- Duped

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Op-Ed: Up to 15% of doctors are drug addicts. I was one of them
The Four D’s:

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In closing arguments, doctors’ lawyers say addicts duped their clients into writing prescriptions.

Pressure on Doctors?

Public Health & Policy

Opioid Crisis: Scrap Pain as 5th Vital Sign?
— Groups call on JCAHO to re-evaluate policies that could lead to opioid overprescribing.

By 2004 this phrase was deleted from the accreditation standards manual.

Suing JCAHO?

Controlled Substance Act: Bottom Line

- The prescription must be for a legitimate medical purpose (pain).
- It must be prescribed in the usual course of professional practice (monitor for addiction/diversion).
- It cannot be prescribed for treatment of opioid withdrawal or maintenance, (except for buprenorphine and a methadone dispensing clinic).

The Fourth D: defamation

Lembke, Anna. Why Doctors Prescribe Opioids to Known Opioid Abusers. n engl j med 367;17 nejm.org October 25, 2012.
Consequences of the Opioid Crisis

- Restriction on dose (< 90 mg of morphine)
- Exclusion of formulations (Oxycontin, etc)
- Limits on duration (3 days without MAPS*, 7 days with)
- Limits on who can prescribe (Michigan, March 2019)
- Requirements for prescription search
- Requirements for urine drug screens
- Increased availability of addiction treatment
- FORCED OPIOID TAPERS/ABRUPT DISCONTINUATION

* MAPS = Michigan Automated Prescription Search

Opioid Tapers and substitution

- Your provider may CUT your dose by 10/25/50%
- They are told to be concerned about anything close to or over 90 mg of morphine (= 9 Norco 10 mg)
- Your provider may TAPER your dose
- Your provider may REFER you to a specialist

How Fast Should Tapers Be?:

CDC MMWR March 18 2016 p 26

- The CDC recommends that tapers may need to be 10% per week OR SLOWER, especially when the patient has been taking the opioid for years.
- The taper may need to be stopped for a while and restarted and slowed down when the patient reaches a low dose.

When does the CDC recommend abrupt discontinuation?

- “If clinicians suspect their patient might be sharing or selling opioids and not taking them….opioids can be discontinued without causing withdrawal” (p30 CDC)
- Another reason: addiction = referral
- Otherwise: abrupt discontinuation is NOT recommended!

Forced Taper

Tapered to zero: In radical move, Oregon’s Medicaid program weighs cutting off chronic pain patients from opioids

Forced Taper → Suicide?

- “Medicolegal Risks of Tapering opioids”
- Risk of death by suicide can be a concern for patients with primary affective symptoms, especially in the context of a complicated pharmacotherapy regimen.
ABRUPT discontinuation: examples

- "I'm not prescribing opioids anymore. Here's your last prescription."
- "We got you an appointment with Dr. Christensen. Here's enough to make it to the appointment."
- "You tested positive for MJ" (The doctor signed the Medical Marijuana Card!)
- "You tested positive for heroin. You're discharged".

The above can lead to complaints of...

Patient Abandonment

- This occurs when:
  - There is an established relationship between you and the doctor
  - You still need medical treatment
  - Your care was stopped so abruptly that there is not enough time to find a replacement.
  - You must suffer an injury.

Patient Ethics

- Nonmaleficence - "do no harm"
- Beneficence - "do the best thing" for the patient
- Autonomy - allow the patient to choose the treatment (assumes informed consent).

These principles would suggest:

- Gradual tapers vs abrupt tapers/discontinuation
- Referral for addiction

THE MICHIGAN OPIOID LAWS

- Run a MAPS before EVERY prescription.
- Get an informed consent ("Start Talking")
- Parental involvement for minors
- Documented prescriber-physician relationship
- DRUG TESTING NOT REQUIRED
- 3 days for acute pain without a MAPS
- 7 days for acute pain with a MAPS

Why the Time Limit?

Chad Brummet, MD, et al., Univ of Mich

- 6% of patients who get opioids after surgery are "dependent" long term
- Who does it happen to?
- No relation to dose
- No relation to type of surgery (minor vs major)

Effect of duration of first use
MMWR, March 17, 2017/66 (10); 265-269

- If you are opioid naive, and get a 7 day prescription, you have a 5 to 15% percent chance of being on opioids 1 to 3 years later.
- If you are opioid naive, and get a 28 day prescription, you have a 15 to 25% percent chance of being on opioids 1 to 3 years later.

Downside of Narcan Rescue: the “White Paper”

The Moral Hazard of Lifesaving Innovations: Naloxone Access, Opioid Abuse, and Crime
75 Pages · Posted 5 Mar 2018 · Last revised: 19 Apr 2018
Jennifer L. Duska
University of Virginia - Frank Batten School of Leadership and Public Policy
Anita Mukherjee
University of Wisconsin - Madison - School of Business

Opioid Overdose Rescue: naloxone (Narcan)

4 mg !!!!!

Prescription Searches: why are you violating my privacy?

- The provider has to check your narcotic prescriptions every time a prescription is written!
- Except post-surgery, if only for 3 days.
- The provider can LOSE THEIR LICENSE if they don’t.

NARx Score

Relative Risk of Fatal Overdose by NARx score
Huizenga, Breneman, Appriss, Inc

- <100 1
- 100-199 8
- 200-299 10
- 300-399 10
- 400-499 16

What About Sedatives?

- Benzodiazepines: Xanax, Klonopin, Valium, Librium
- Sleepers: Ambien, Lunesta, Sonata
- Gabapentin
- Muscle Relaxers: Flexeril, Robaxin, Zanaflex
- SOMA

What About Benzodiazepines?

- Benzodiazepines TRIPLE the risk of opioids if your patient currently uses them.*
- They DOUBLE the risk even if they have stopped (if)*
- Benzodiazepines are associated with dementia**
- SOMA: part of the Holy Trinity (Soma, Norco, and Xanax)
- Benzodiazepines may paradoxically increase pain***
- Gabapentin is the most common non-opioid found to be involved in opioid OD deaths (MAPS data)

*Park TW et al.  BMJ 2015; 350:h2698
**Billioti de Gage S et al.  BMJ 2012; 345 e 6231

What is the benefit of Marijuana for Chronic Pain?

First Aid
The Doctor Is In!

Cannabis and Cannabinoids

- National Academy of Sciences: There is conclusive or substantial evidence that cannabis or cannabinoids are effective for the treatment of chronic pain in adults.
- U of M: A trial in a MS clinic decreased opioids by 44% and increased QOL 45% (Koehene et al. Subs Use Misuse 2018 Aug 24. 53(10): 1602-1607)
- There was a 24% decrease in opioid OD deaths in states that implemented “medical marijuana” compared to states without.

What Are the Phytocannabinoids?

- Tetrahydrocannabinol (THC)
- Cannabidiol (CBD)

But......

- Is Cannabis Addicting?
- Does Cannabis cause withdrawal?
- Is Cannabis safe during pregnancy?
- Is Cannabis safe while driving?
Finally: What Will Your Provider Do?

Most providers will not START someone on opioids.
- There is no good data that it works.
- There is good data that it causes harm.
- Your doc is painting a bullseye on their back.

If you are ALREADY on opioids:
- Your provider may continue them, but want to decrease/taper the dose (especially if > 90 mg of morphine)
- Your provider may DISCONTINUE them abruptly

What Will Your Addictionist Do?

If you are NOT on opioids:
- Opioids will probably NOT be started (see above).
- You may be offered buprenorphine (Suboxone/Zubsolv/Butrans)
- You may be offered non narcotic meds (except now, gabapentin)

What Will Your Addictionist Do?

If you ARE on opioids:
- Your addictionist will probably NOT continue the opioids.
  - They don’t know you
  - They need to be concerned about continuing the opioids
What Will Your Addictionist Do?

If you ARE on opioids:
- You may be offered the buprenorphine TABLET (Suboxone/Zubsolv)
  - Approved for addiction, used for chronic pain "off label".
- You may be offered the buprenorphine PATCH (Butrans)
  - Much weaker, often ineffective.

If you do not want to switch over to buprenorphine, you may be offered detox meds to help with withdrawal.
- You (may) feel better once off the meds.

Contact Information

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