Safe and Effective Narcotic Use in Chronic Pain - Frankly Speaking EP 16

Transcript Details

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Dr. Frank Domino

Hi, this is Frank Domino. With me today is Jill Terrien. Jill is the Director of the Adult Gerontology and Family Nurse Practitioner Programs at the University of Massachusetts Medical School, Graduate School of Nursing in Worcester, Massachusetts. And today, we're going to be talking about opioid-related deaths. Thank you for joining me today, Jill.

Jill Terrien:

Thank you, Frank. So, Frank, what did the CDC have to show about opioid-related deaths? It's something that's a really hot topic in our society.

Dr. Domino:

It is, Jill, and the CDC just came out with this report. If you take a step back, probably somewhere between eight and nine years ago, the rate of accident related death surpassed motor vehicle related accidents as the leading cause of death in the United States under the age of 45. The most common cause of that accident-related death was accidental prescription overdose. And the drug class that had that greatest degree of causing death, as we all know now, is opioids. The CDC took a random sample out of this huge database of over one million patients from 2006 to 2015, who are on chronic opioids, but did not have cancer or a history of substance abuse. And they looked at what predicted being dependent upon opioids, and what might predict a terrible

outcome. They correlated the length of prescription that a patient might receive and its effect long-term.

Jill Terrien:
So, what is that length of time, Frank? What is that risk?

Dr. Domino:
So, they correlated the length of days of pills with adverse outcomes, and what they found was that if you were giving a patient a prescription for five days of an opioid, the chance of them being dependent upon that at one year was about 20%. So, one in five people who had a short prescription for pain, that risk goes way down when you go less than five days. If you give a patient a prescription for 31 days of an opioid in the treatment of acute pain, the chances of them being on an opioid at a year is 35%. So, one in three people end up stuck on an opioid at least at one year and possibly, very likely for the rest of their life. If you give a second prescription for an opioid, that doubles that risk. So now you're almost, you're taking 75, 80% of the people who had an acute injury and converting them to a lifelong dependency on opioids. One of the other things that really struck me was they correlate it with doses of opioids and they used the morphine equivalent tool. And it turned out to be about 700 milligram equivalence of morphine. So, I never know what that means. So, what it means is if you took a full-strength acetaminophen/oxycodone combination, something like Percocet, and you dosed it at two pills, four times a day. If you gave that prescription for six days, you destined that patient to likely be dependent upon opioids at one and three years.

Jill Terrien:
That's incredible. One thing I'm thinking of, Frank, when you're giving prescriptions for opioids for, like you talked about the first prescription for five days and the risk of that person being on opioids a year later was like one in five or 20%, what kind of diagnoses went along with these? Did they talk about that in the article?

Dr. Domino:

Well, they didn't specifically drill down into diagnoses. The CDC correlated it primarily with number of pills and outcomes. But they do give plenty of examples. And it's everything from acute injury, like acute low back pain, acute fracture. Most concerning was postoperative care. Patients who had had a procedure were given a prescription, and often it was a short prescription, but it was longer than five days. And sometimes they were easily able to get refill after refill, and that led to the greater dependency. Two other factors have led to opioids being such a grave concern, and it ultimately leading to be the leading cause of death. One is, as we all know now back in the latter part of the last decade, there was a variety of issues around safe, long-acting opioids, and providers being convinced that they could use opioids for chronic pain, and that that was safe. And we now know, in retrospect, that that was not the case. The other factor that's prompted opioid-related death to the forefront is changes that we made in society. We limited speed limits in urban areas to 65 miles an hour. Cars became required to have seatbelts, and a variety of airbag protections. Those few changes, both the rise of supposedly, but not chronic opioids that were safe, and the changes with motor vehicle laws led to this huge opioid epidemic.

Jill Terrien:

Was there anything else, Frank, eight or nine years ago that could have contributed to this as well, such as some of the changes we made in the hospital with the pain being the fifth vital sign. I've heard different things, and maybe the CDC did not comment on that in your review.

Dr. Domino:

The CDC did not. But Jill, I could not agree with you more. For reasons that remain ambiguous, both in the inpatient and outpatient setting, we began using pain scales. And I'm sure all of our listeners are familiar with them, and they're still used in many places today as a quality marker. There's never been any data that demonstrates they improve outcomes, and now I think we have quite a bit of data that shows that it may have actually made matters much, much worse.

Jill Terrien:

Thank you, Frank. I'm wondering, did you find anything about the effectiveness of opioids in the treatment of chronic nonmalignant pain?

Dr. Domino:
Well, a systematic review was published last year that's really remarkable, included 10 randomized controlled trials, and it looked at how effective chronic opioids were in managing chronic pain. And it turns out, non-opioid analgesics are quite effective in improving physical function. Opioids were not found to be efficacious. That's right, after the acute pain is addressed, opioids play no positive role in any outcome that's been looked at: Getting the patient back to work, getting the patient's quality of life improved, getting the patient's pain reduced, none of those things are correlated with chronic opioid use, it's really quite remarkable. But what did work? Well, like I said, nonsteroidal anti-inflammatories, truly effective. Our older, low-dose tricyclic antidepressants are effective. Gabapentin, SNRIs, and lately, some topical agents. They've been very popular, and sometimes can be very, very expensive.

Jill Terrien:
So going along the lines of our patients, if opioids really aren't that effective with pain at certain points, especially the chronic nonmalignant pain that you're talking about, why do people want them?

Dr. Domino:
So this is really the answer. Patients want opioids because it makes them not worry as much about opioid withdrawal. Opioid withdrawal is the real feature that has people worried. They're taking these pills, their anxiety level might be reduced a bit, they know that if they don't take them, they start feeling terrible. What does opioid withdrawal look like? Well, its most common presentation will begin about 24 hours after the last dose, and it'll present with agitation, severe anxiety, myalgias, lacrimation, and severe insomnia. So patients want those opioids, need those opioids, like many other highly addicting drugs, not so much for its euphoric effect, or its pain relieving effect, but for the prevention of withdrawal. The way to recognize this, and that patients

don't, more often than not, I've never met a patient who is dependent upon a medication who liked that state. When the CDC first began presenting this data a number of years ago, I made a commitment to my practice to wean my patients off opioids. And so that's been my role, and I started with a patient-centered discussion about, one of the things I'm committed to doing is not doing any harm. And we know that this is the leading cause of death in many age groups.

So I say, "I want to wean you off." If they're well insured and I have a resource nearby, I'll involve a substance abuse person or a psychiatrist. If not, the best data shows, reduce the dose by 10 to 20% every week. That'll allow them to take less and less over time and almost have no risk of withdrawal. And once I get them off, I make it clear to them that in the future, if they need surgery or something like that, certainly they can go back on opioids. But the key here, and this is probably the most important take-home message, is that if you're going to be given a prescription for an opioid, it has to be less than five days. Giving them more than five days just correlates with every adverse outcome that you wouldn't want them to do. You mentioned earlier, that one in five, or 20%, when the number needed to harm is that great, we really need to ask ourself, "Is this a wise thing to do for something that's not life threatening?" Let me give you a parallel example. Someone has an acute appendicitis and they're ill, well we know that intervening improves their longevity, decreases their mortality. This is a high level, high acuity thing, where intervening is necessary. No one's died from chronic pain, but many people have died from the treatment of chronic pain, and it's up to us as providers to take a new approach.

Jill Terrien:
So Frank, what I'm hearing from you to sum it up, is when you have that patient that you're seeing, that you're going to prescribe opioids, that you really have to talk to them about the risks versus the benefits. And maybe it's not the best type of medication to give them at that moment, but that you're going to reassure them that you're going to be there to take care of them, and that you want them to contact you if they have any questions, that they're not alone.

Dr. Domino:
I think that's very true. You have to do this in the context of your patients' relationship. And

patients, if you've got a long standing relationship with them, they're going to totally trust you. I think the areas that can lead to overuse of some medications are when that relationship isn't there. Someone's covering for you. It's an emergency room event. Or it's a brief interaction with a proceduralist who maybe just gives you the prescription and doesn't have that informed consent discussion.

Jill Terrien:
Great.

Dr. Domino:
Well, thanks, Jill. I appreciate you coming. To summarize, limit your prescriptions for acute pain to under five days. Encourage patients to consider weaning off chronic opioids for those that are on. Be more aggressive with non-opioid related treatments, and have a great patient-centered relationship with your folks to help them live well and not become a statistic in the opioid death crisis. Thank you again for joining us today on Frankly Speaking.