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CMT Newsletter

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Coming Up

Non-medical use, abuse, diversion, and morbidity associated with prescription narcotics are rapidly increasing across the United States.

The Dilemma of Prescribing Opiates – Treating Pain Effectively versus Abuse and Diversion

Failure to provide adequate treatment for pain has been a widespread problem in medicine. Despite the fact that it has been shown on multiple occasions that post-surgical patients treated with narcotics for pain relief rarely become addicted to them, it has taken major campaigns by professional societies, regulatory authorities including the Joint Commission, and advocacy groups to drive home the point that withholding adequate analgesia not only increases patient suffering but also leads to prolongation of recovery periods and increased health care costs. On April 10, 2009 The Centers for Medicare and Medicaid Services (CMS) issued revised guidelines for recognition and management of pain. These guidelines once again stress the need for a proactive assessment of patients' pain and for facility-wide efforts to insure adequate treatment. The CMS guidelines are one more signal that pain management is still too often ignored or mishandled in the clinical setting.

There is a flip side to the increasing attention given to the proper use of analgesic medications. Non-medical use, abuse, diversion, and morbidity associated with prescription narcotics are rapidly increasing across the United States. In an analysis of the 2002-2004 National Survey on Drug Use and Health, Becker et al (2007) found that 4.5% of the population had past-year non-medical use of prescription opioids. Also in 2007, Wu et al published data showing that nearly one in ten adolescents had a history of non-prescribed use of prescription pain relievers. A recent newspaper article reported that prescription drug overdoses accounted for the most drug-related deaths in Oregon in 2008, with methadone and oxycodone leading the list (The Oregonian, March 31, 2009). Such statistics are now easy to find in the published medical and epidemiological literature as well as the popular media and warn us that a great deal of opiate abuse, morbidity, and mortality stems directly from prescriptions written by clinicians who are innocently attempting to manage their patients' acute and chronic pain.

Evidence is lacking for many opiate prescribing practices and beliefs

Only three studies followed patients taking opioid analgesics for more than four months; the actual efficacy of chronic administration of opioid medications is still unproven.

The disturbing rise in prescription painkiller misuse mandates that prescribers and health care programs insure that opiates are administered only when evidence substantiates their efficacy, tolerability and safety. Unfortunately, recent articles highlight that this is not always the case. In February 2009, the American Pain Society and the American Academy of Pain Medicine jointly reissued their guidelines for opioid treatment of non-cancer pain. The third in a series of three articles concerning the guidelines highlight the things we do not actually know yet about opiate prescribing (Chou R, Ballantyne JC, Fanciullo GJ, Fine PG, Miaskowski C: Research gaps on use of opioids for chronic noncancer pain: Findings from a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical guidelines. J Pain 2009; 10P:147-159). Some of the areas of uncertainty highlighted by the paper may surprise clinicians:

1. No evidence exists to tell the prescriber how to predict which patient will actually respond to an opiate analgesic.
2. Although all guidelines call for written opioid treatment plans that are agreed to by both the prescriber and the patient, only one study with a sample size of 20 has actually looked at whether these “contracts” improve treatment outcome. That study found they do not.
3. Only three studies followed patients taking opioid analgesics for more than four months; the actual efficacy of chronic administration of opioid medications is still unproven.
4. “Evidence on opioids specifically for low back pain, fibromyalgia and daily headache is very limited or did not show a clear benefit (p. 152).”
5. No study has evaluated the use of opiate analgesics at doses higher than 200 mg/d of morphine (or equivalent), although such doses are very often prescribed.

A clinician may assume he or she is utilizing an evidence-based practice when he or she selects a patient with a particular set of clinical characteristics who is complaining of headache or low back pain, exhausts non-opiate interventions to no apparent benefit, gets the patient to sign an informed consent document and then prescribes an opiate analgesic at whatever dose and for whatever period that seems to work. In fact, such a strategy is not compatible with the scientific evidence and instead totally relies on the clinician’s intuition and the patient’s perception of response. While neither of those are necessarily flawed ways of making clinical decisions, they are not substitutes for scientific evidence, rigorously conducted trials, and clinical guidelines.

Opiates may actually make pain worse in some situations

Another recent article emphasizes that intuition may give us the wrong guidance when it comes to prescribing opiates for pain management. We might feel safe in assuming that opiates cannot make painful conditions worse but, according to a study by Hay and colleagues, that assumption may be incorrect (Hay JL, White JM, Bochner F, et al: Hyperalgesia in opioid-managed chronic pain and opioid-dependent patients. J Pain 2009;10:316-32). The authors performed tests of pain sensitivity on three groups of subjects: a group of patients with non-cancer pain who were taking either methadone or morphine; a group of patients maintained on methadone for the treatment of opiate-dependence; and a control group of opiate-naïve subjects. Both groups of subjects taking opiates on a chronic basis had lower pain thresholds during the cold pressor test, compared to the control group. In effect, taking opiates had made the patients more likely to experience pain. Thus, not only is there scant evidence that chronic administration of opiate analgesics for non-malignant pain is helpful, there is a body of preclinical and clinical research showing that in some circumstances it can make things worse.

Care Management Technologies (CMT) has developed a unique Opiate Monitoring Program that balances the importance of providing adequate analgesia for patients in pain with the need to improve opiate prescribing practices and reduce the risks of diversion and misuse. The CMT approach is to use audit and feedback to actively educate clinicians, using their own cases, about the proper use of narcotic painkillers. Prescribers receive educational notifications if their opiate prescriptions fall outside of evidence-based guidelines or if their patients might be misusing their prescribed medication. Among other innovations, the new Opiate Monitoring Program provides clinicians with evidence of a history of previous substance abuse that might not otherwise be known to the prescriber and encourages clinicians to review opiate prescriptions that extend beyond the acute treatment of non-malignant pain. CMT believes that active and direct education and notification of clinicians are among the most cost-effective ways of insuring that evidence-based prescribing practices are routinely followed.

Industry News

Federal Drug Czar Gil Kerlikowski recently stated he will push for more states to adopt prescription-monitoring programs, databases in which doctors and pharmacists log prescriptions for addictive drugs in order to curtail abuse and misuse.

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Coming Up

Controversy Sweeps Through Pediatric Psychopharmacology