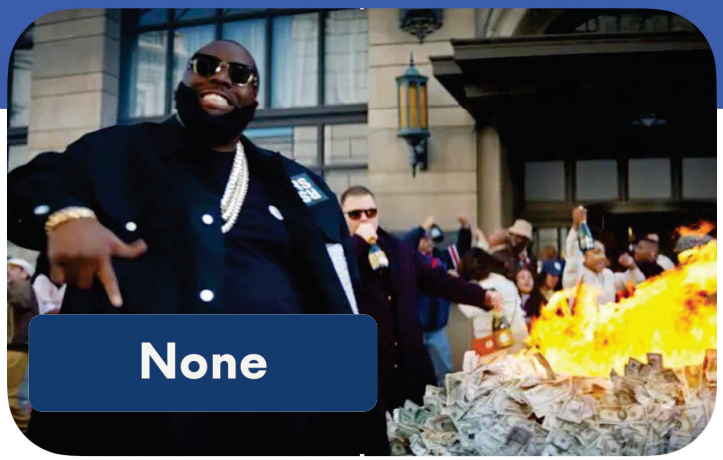
Opioid Stewardship

Your Role In Combating the Epidemic

JARON D. RAPER, MD FACEP

FINANCIAL CONFLICTS:



Content Outline

Topics for discussion

01 A Brief History of Opioid Use

02 Opioid Prescribing

03 Treatment of Opioid Use Disorder

Opioids: Includes natural or synthetic chemicals that interact with opioid receptors

Opiates: Refers only to natural opioids

Narcotics: Technically only refers to opioids, but only used to refer to their nonmedical use

— CDC.GOV

Opioid Timeline

The 1800's

- Industrial production of morphine in 1820's
- Hollow bore needle invented in 1855
- Bayer introduces diacetylated morphine or "Heroin" as cough remedy in 1898

Harrison Narcotic Act of 1914

- By 1870's, physicians began to raise the alarm
- 1910 opioid "street" use was sreading rapidly
- In 1914 the Harrison Narcotic Control Act was passed

"Opiophobia" 1914-1980's

- Negative stigma was associated with chronic pain, especially if unexplained
- Physicians became reticient to treat pain with opioids until immediately terminal

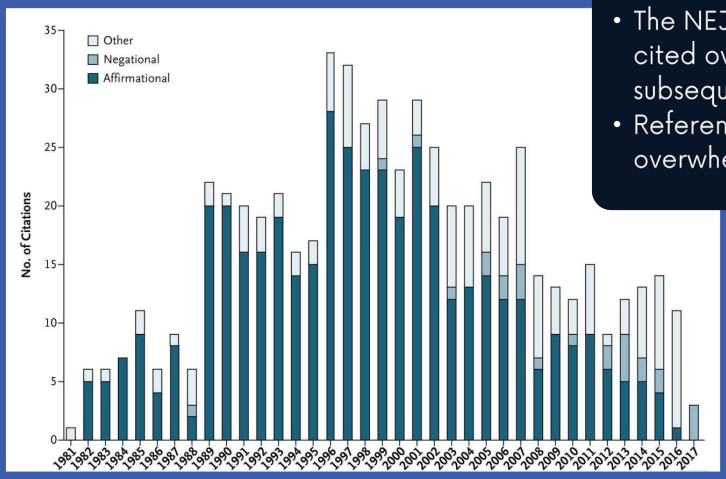
1980 Landmark NEJM Article...

To the editor:

Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients1 who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,2 Percodan in one, and hydromorphone in one. **We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.**

Jane Porter
Hershel Jick, M.D.

1980 Landmark NEJM Article...



The Tide Begins to Turn...

- The NEJM article goes on to be cited over 600 times over the subsequent 37 years
- References are overwhelmingling affirmational

Opioid Timeline (Cont.)

Oxycontin 1995

- FDA approves Oxycontin 1995
- Purdue Markets the drug as less addictive
- 1995-2001 Oxycontin generates 2.8 billion (90% revenue)
- 1997-2002, prescriptions increased from 670,000 to 6.2 million

Pain as the 5th Vital Sign 1995

- American Pain Society, and VA shortly therafter adopt the 5th vital sign as standard
- TJC pushes for quantitative pain assessments
- DEA and federation of state medical boards promise less regulation

Nonmalginant Pain 1997

- Opioids for cancer pain standard treatment since the 80's
- Opioids for "nonmalignant" pain
- "opioid tolerance, physical dependence or addiction seldom cause difficulties"

The Current State of the Pandemic

- Drug involved overdose deaths have been increasing in every year since 1999 (except 2018)
- National emergency declared in 2016
- Simultaneous substantial increases in funding for OUD

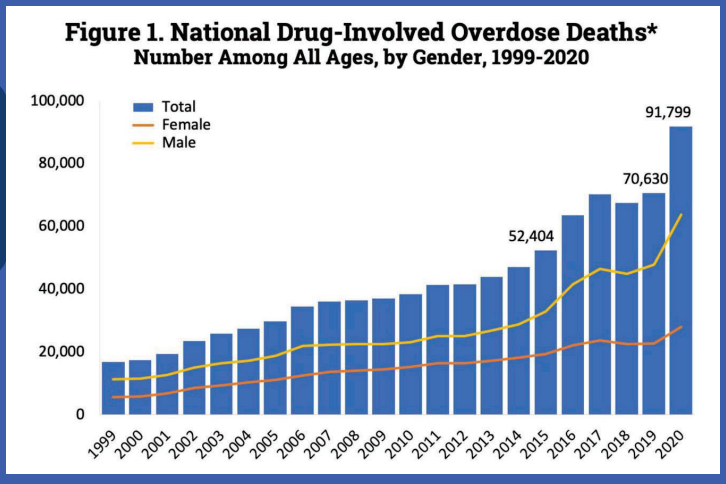


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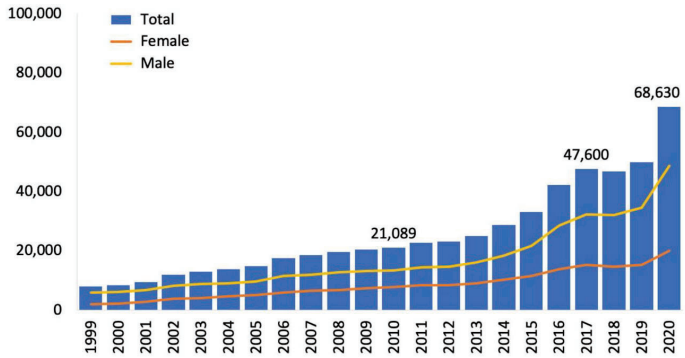
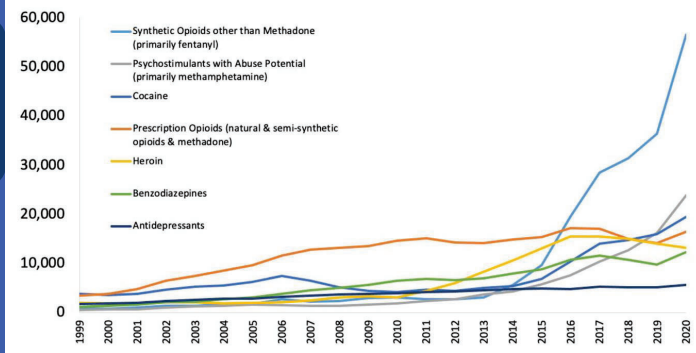
Figure 3. National Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2020



The Current State of the Pandemic

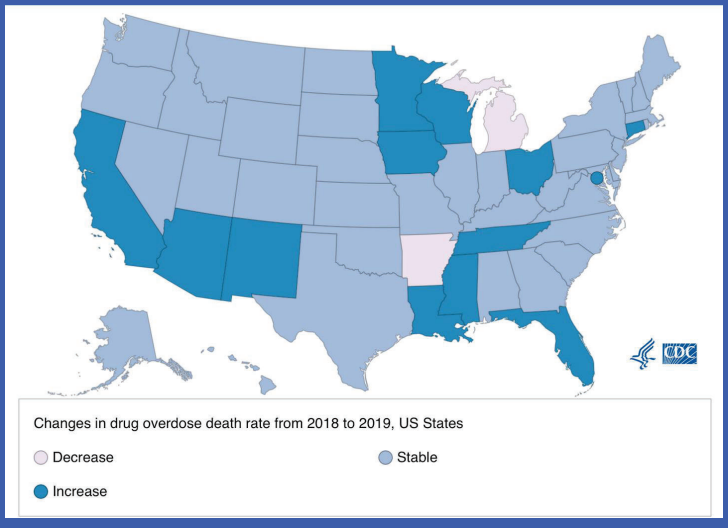
- Rx opioid related overdose deaths have downtrended recently
- Fentanyl related overdose deaths have accelerated rapidly
- Psychostimulants/Cocaine also on the rise

Figure 2. National Drug-Involved Overdose Deaths*, Number Among All Ages, 1999-2020



The Current State of the Pandemic

- Only two states saw a significant drop in overdose death rates
- The southwest and southeast saw significant increases
- Alabama saw stabilization of rates for the last few years, without decline



So Where Are We Today?

- In 2020, we lost over 91,000 people to overdose deaths in the US alone
- 60,000 of those deaths were due to Opioids
- No state saw a decline in opioid related overdose from 2018-2019

HOW DO WE MOVE FORWARD?

"The best ways to prevent opioid overdose deaths are to **improve opioid prescribing, reduce exposure to opioids, prevent misuse, and treat opioid use disorder**"

-cdc.gov

Key Concepts

Prescribing

Multimodal Pain Therapy +

Naloxone Candidate? +

Calculate MME +

Check the PDMP +

Review Guidelines

Treating OUD

Treatment & Supporting Recovery

Prescribing an Opioid?

A multi-stage approach

Multimodal Pain Therapy
Reduces pain and acute postoperative opioid use

Naloxone Candidate?
Review HHS guidelines on who should get an Rx for naloxone

Check the PDMP
Check for other prescribers, other Rx's that place the patient at high risk

Calculate MME
Avoid new Rx for 50MME/day or greater, target 20MME/day

Review Guidelines
Consider published opioid Rx guidelines and standard of care

CONSIDERING A NEW RX FOR ACUTE PAIN?

5-6% of Patients Recieving a New Opioid Rx Will Have Persistent Use

Are there any alternatives?

Multimodal Pain Therapy

A multi-tier approach

Non-Pharma Interventions
PT, Yoga, homeopathic pain control

NSAIDS/COX-2 Inhibitors
Reduce pain and acute postoperative opioid use

Alternative IV Rx
IV anesthetics and Ketamine reduce acute postoperative opioid use

Acetaminophen
Reduce pain and acute postoperative opioid use

Regional Anesthesia
Peripheral nerve blocks, epidural anesthetics, shown to decrease acute postoperative pain and chronic pain

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The Prescription Drug Monitoring Program

Statewide Electronic Database

BENEFITS
- Identify patients with multiple prescribers
- Calculate the total MME
- Identify patients with other high risk Rx's

WHEN TO CHECK
- at least every 3 months
- Before every new opioid prescription

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Acute Pain: New Opioid Rx Guideline

Procedure Specific Recommendations

- Panel included surgeons, residents, NP's, pharmacists and their patients
- In terms of Oxycodone 5 mg
- No Rx >20 tablets

Procedure	Range (minimum-maximum)
General surgery	
Laparoscopic cholecystectomy (procedure 1)*	0—10
Laparoscopic inguinal hernia repair, unilateral (procedure 2)*	0—15
Open inguinal hernia repair, unilateral (procedure 3)*	0—10
Open umbilical hernia repair	0—15
Breast surgery	
Partial mastectomy without sentinel lymph node biopsy (procedure 4)*	0—10
Partial mastectomy with sentinel lymph node biopsy (procedure 5)*	0—15
Thoracic surgery	
Video-assisted thoracoscopic wedge resection	0—20
Orthopaedic surgery	
Arthroscopic partial menisectomy	0—10
Arthroscopic ACL/PCL repair	0—20
Arthroscopic rotator cuff repair	0—20
ORIF of the ankle	0—20
Gynecologic surgery and obstetric delivery	
Open hysterectomy	0—20
Minimally invasive hysterectomy	0—10
Uncomplicated cesarean delivery	0—10
Uncomplicated vaginal delivery	0
Urologic surgery	
Robotic retropubic prostatectomy	0—10
Otolaryngology	
Thyroidectomy, partial or total	0—15
Cochlear implant	0
Cardiac surgery	
Coronary artery bypass grafting	0—20
Cardiac catheterization	0

Panel members included surgeons, surgical residents, pain specialists, surgical nurse practitioners, patients, and pharmacists.

What about Chronic Pain?

Opioid Risk Tool

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

For Adult Patients with Chronic Pain

- <4 = Low Risk
- 4 - 7 = Moderate Risk
- >7 = High risk

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MORPHINE MILLIGRAM EQUIVALENTS

50 MME/day are 2x as likely to overdose compared to 20 MME/day

Overdose risk continues to increase as MME increases

Calculating MME's

Speaking a Common Language

1 MME	5 MME	7.5 MME	4 MME	30 MME
1 mg Morphine	5 mg Hydrocodone	5 mg Oxycodone	1 mg Hydromorphone	12.5 mcg Fentanyl (Patch)

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PRESCRIBING NALOXONE

<1% of Patients who should be given a Naloxone Rx recieve one

So Who Needs an Rx for Naloxone?

Provide naloxone Rx if:

The patient is prescribed opioids AND...

- **50 MME/Day or Greater**
  eg. 5mg Hydrocodone Q3H = 40 MME/Day
- **PMH Resp. Disease**
  eg. COPD, OSA, PHTN, etc.
- **Simult. benzo Rx**
  eg. clonazepam, lorazepam
- **Substance use disorder or MH disorder**
  eg. excessive alcohol use, depression

Provide naloxone Rx if:

The patient is high risk for <u>EXPERIENCING or RESPONDING</u> to opioid overdose including individuals...

- **Illicit opioid use/misusing Rx opioids**
  eg. family member, police officer, etc
- **Using stimulants**
  eg. methamphetamine, cocaine, etc
- **Receiving treatment for OUD**
  eg. beprenorphine, methadone, naltrexone
- **OUD and recent loss of tolerance**
  eg. recent incarceration, rehab, etc.

Treating Opioid Use Disorder

Treatment & Supporting Recovery

Defining Opioid Use Disorder

DSMV Criteria

Severity Classification

- 2-3 = Mild
- 4 - 5 = Moderate
- >5 = Severe

Opioids are often taken in larger amounts or over a longer period of time than intended.
There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
Craving, or a strong desire to use opioids.
Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
Important social, occupational or recreational activities are given up or reduced because of opioid use.
Recurrent opioid use in situations in which it is physically hazardous
Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

Treatment and Prevention

Naltrexone

- Receptor antagonist
- No abuse potential or street value
- Increases sobriety, decreases overdose frequency
- Compliance is a major challenge

Buprenorphine

- Partial agonist
- Excellent compliance rates
- Increased sobriety, decreased criminal activity, decreased overdose frequency
- As of April 2021, X-waiver no longer required

Methadone

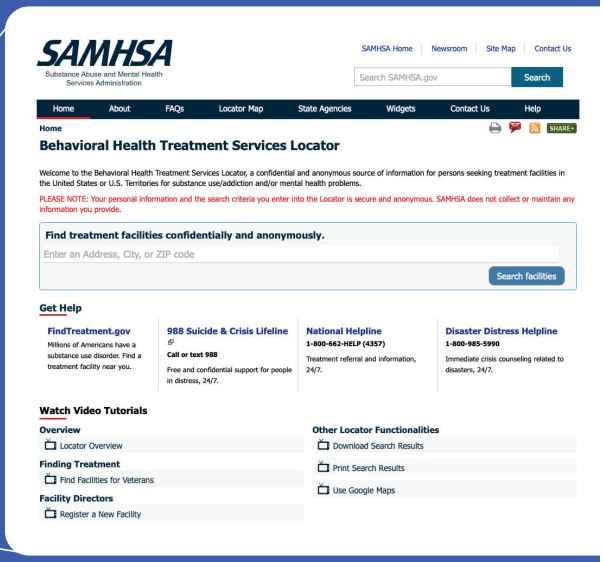
- Full agonist
- Reduces illicit use, overdose death, criminality, ID transmission
- Sigificant street value, high overdose risk

Buprenorphine

Special Considerations

- PO, and Injectable/Implantable options
- Monthly visits
- Patients should be in mild/moderate withdrawal to start
  - Can precipitate withdrawal
- Lower oversdose risk than methadone
- Anyone with DEA license can prescribe

Additional Resources



Takeaways

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Naloxone Candidate? +

Check the PDMP +

Calculate MME +

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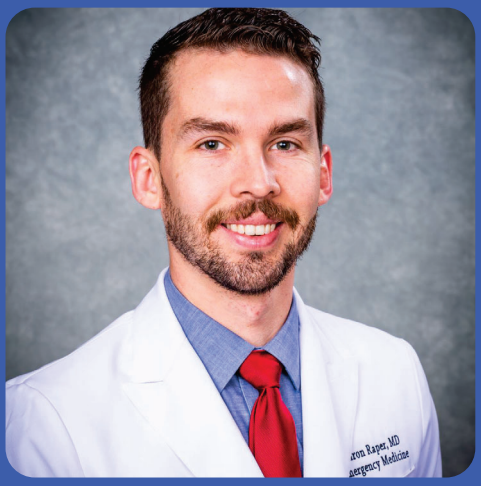

Phone Number
205-934-3640

Email Address
jaronraper@gmail.com

Twitter
@JaronRaperMD