



U.S. Department
of Veterans Affairs



THE UNIVERSITY OF
ALABAMA AT BIRMINGHAM

Knowledge that will change your world

Resist the Opioid Pendulum: Understanding Opioids and Pain, and how they relate to Addiction

Stefan G. Kertesz, MD, MSc

Diplomate, American Board of Addiction Medicine

Associate Professor, University of Alabama at Birmingham

Member, Opioid Safety Initiative at Birmingham VAMC

Pills to Needles Task Force

Disclosure: Opinions are my own and do not represent positions of the US Department of Veterans Affairs or the State of Alabama

Today's Dilemma

- ▶ Overprescribing is part of how we got here
- ▶ Prescribing is on its way down
- ▶ Deaths on their way up
- ▶ It's a complicated situation
- ▶ Some state initiatives targeting prescribing might help and most won't
- ▶ Most are looking at the wrong objective
- ▶ We need treatment

Sequence

- ▶ Let's separate a few categories of person
 - ▶ Physical dependence versus opioid use disorder (addiction)
 - ▶ Pain treatment with opioids versus opioid use disorder (addiction)
- ▶ The appeal of prescribing controls

I won't stop

- ▶ A patient with 1 rheumatoid arthritis
- ▶ Opioids reduce pain
- ▶ Doses were increased slowly over years but now stable at a high-ish dose
- ▶ Doctor got scared and decided to force the dose down
- ▶ Patient is miserable
- ▶ Might kill herself
- ▶ This is undertreated pain and “physical dependence”
- ▶ This is NOT addiction or “opioid use disorder”



I can't stop

- ▶ Can't stop because what?
 - ▶ A bottle of pills after surgery in a teen who previously used pot
 - ▶ Then another bottle from grandma's cabinet
 - ▶ Then pills on the street
 - ▶ Then heroin and fentanyl
 - ▶ MAYBE death
-
- ▶ This is addiction or "opioid use disorder"
 - ▶ It's Compulsive use despite harm
 - ▶ We don't call it "drug abuse" anymore



I better not stop



- ▶ A patient with diabetes
 - ▶ Insulin helps him control his blood sugar
 - ▶ He takes it every day
 - ▶ He needs more now than he did 3 years ago
-
- ▶ This is diabetes
 - ▶ He is physically dependent on the insulin
-
- ▶ He does not have addiction or “insulin use disorder”

I shouldn't stop

- ▶ A patient who used heroin from 1999 to 2010
 - ▶ He lost relationships, work, and had legal problems
- ▶ Now he takes a medicine that binds the same receptors
 - ▶ Buprenorphine (Suboxone)
- ▶ Now he is working a job and has a family

- ▶ This is a patient with opioid use disorder, in remission
- ▶ He is physically dependent on the buprenorphine
- ▶ He should not stop except after very careful review of risks



4 categories. 4 lessons



This person isn't "hooked" or "an addict"
We need not mess with her treatment

This person is stable on treatment for diabetes



This person is increasingly likely to die. He likely started with pills from a friend. He needs treatment

This person is now stable with a treatment that's still mostly unavailable for most people who need it



Prescribing controls: why the appeal

- ▶ Running up prescriptions created a supply of easily redistributed pills
- ▶ The data to support what we did was poor
- ▶ Some pain patients developed new opioid use disorder
- ▶ And some egregious prescribing still happens

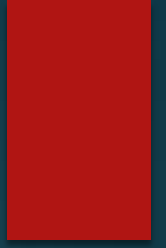
- ▶ If you want to look like you're doing something, new restrictions are cheap, fast, and create the impression of action

- ▶ But...let's talk about numbers

The problem with easy numbers:
who had the better game?

	Quarterback 1	Quarterback 2
Completions	18	34
Yards	206	280

What's wrong with that last question?



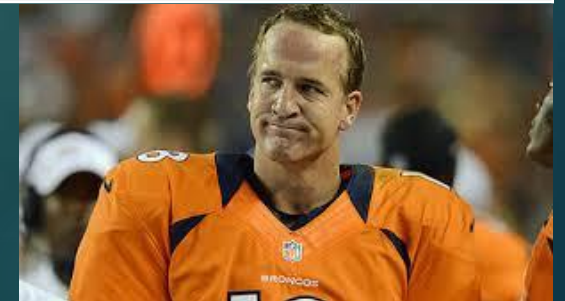
Who did better?

	Team 1	Team 2
Completions	18	34
Yards	206	280
Interceptions Lost	0	2
QB Rushing	26	0
RB Rushing	135	27
Fumbles	0	4
<i>Defensive/Special Team Stats</i>		
Sacks	1	0
Kick/Punt return for TD	1	0
Total Score		

43



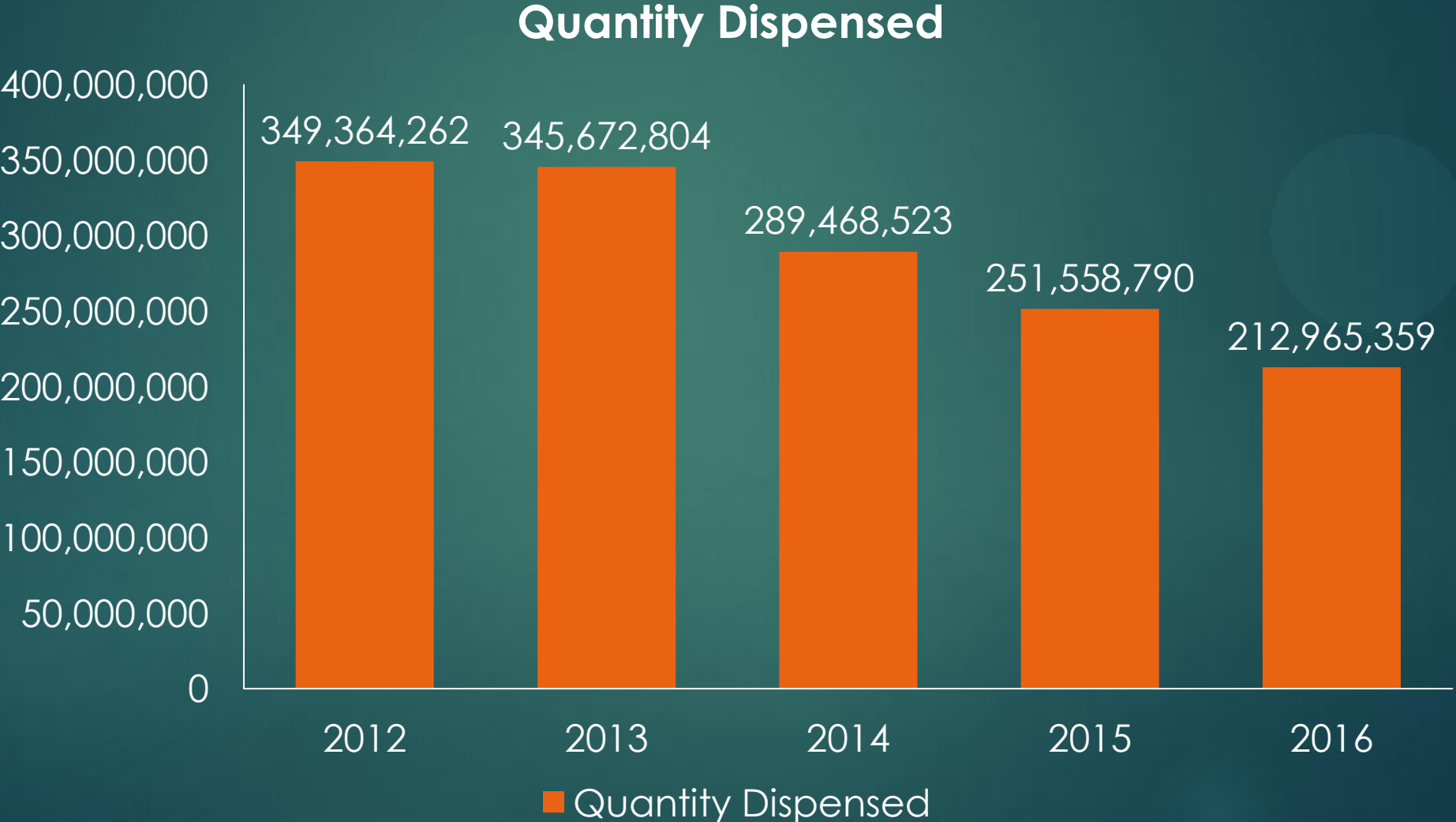
8



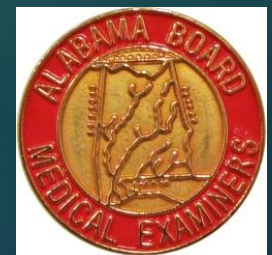
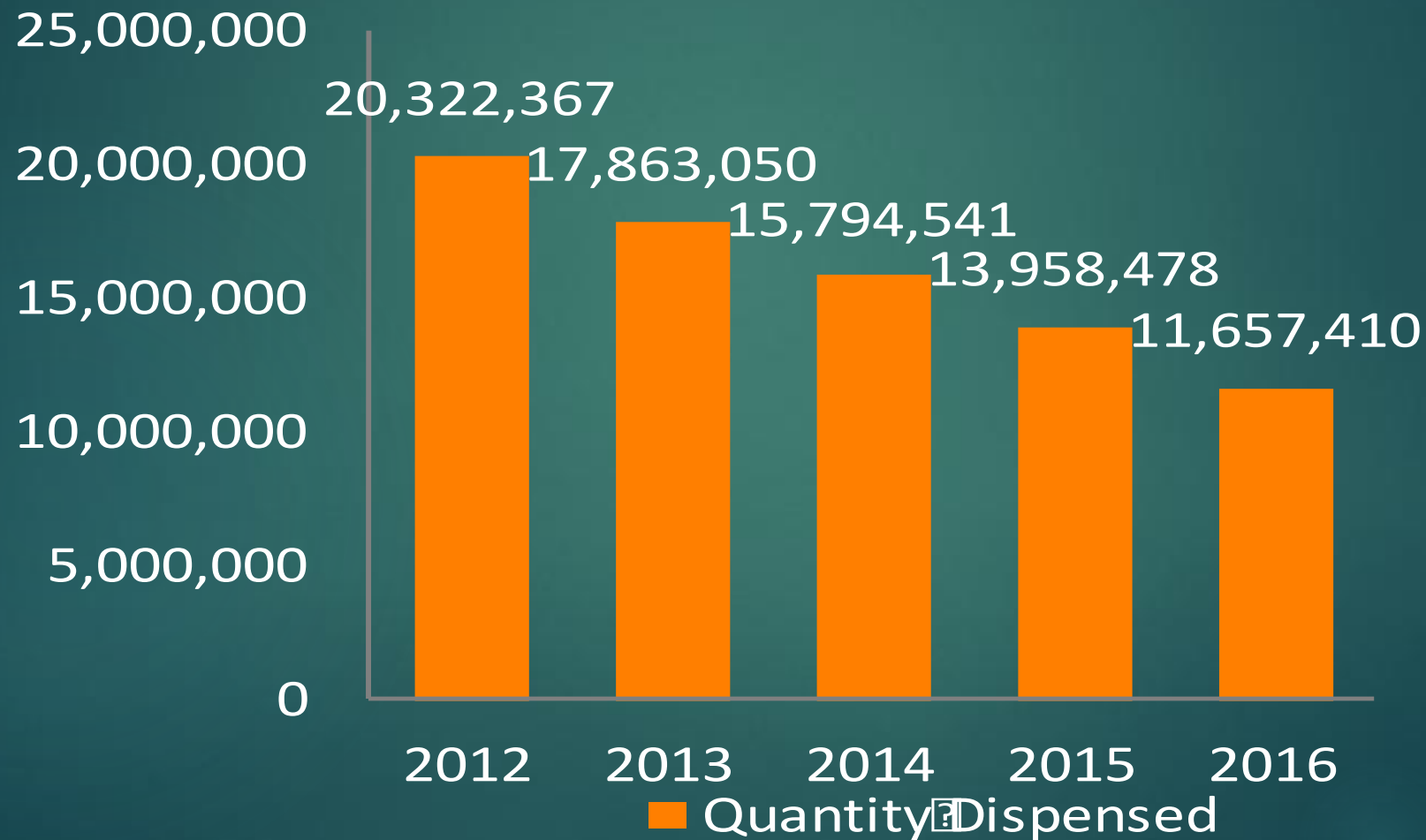
Balanced message

- ▶ Excess prescribing is part of how we got into this mess
- ▶ Opioid prescribing require care & caution
- ▶ The epidemic has changed a LOT
- ▶ Not every pain patient is a person with addiction in waiting
 - ▶ Per CDC, it's 0.9% at low doses, 5% at higher doses
- ▶ Making the same mistake backwards is not a solution

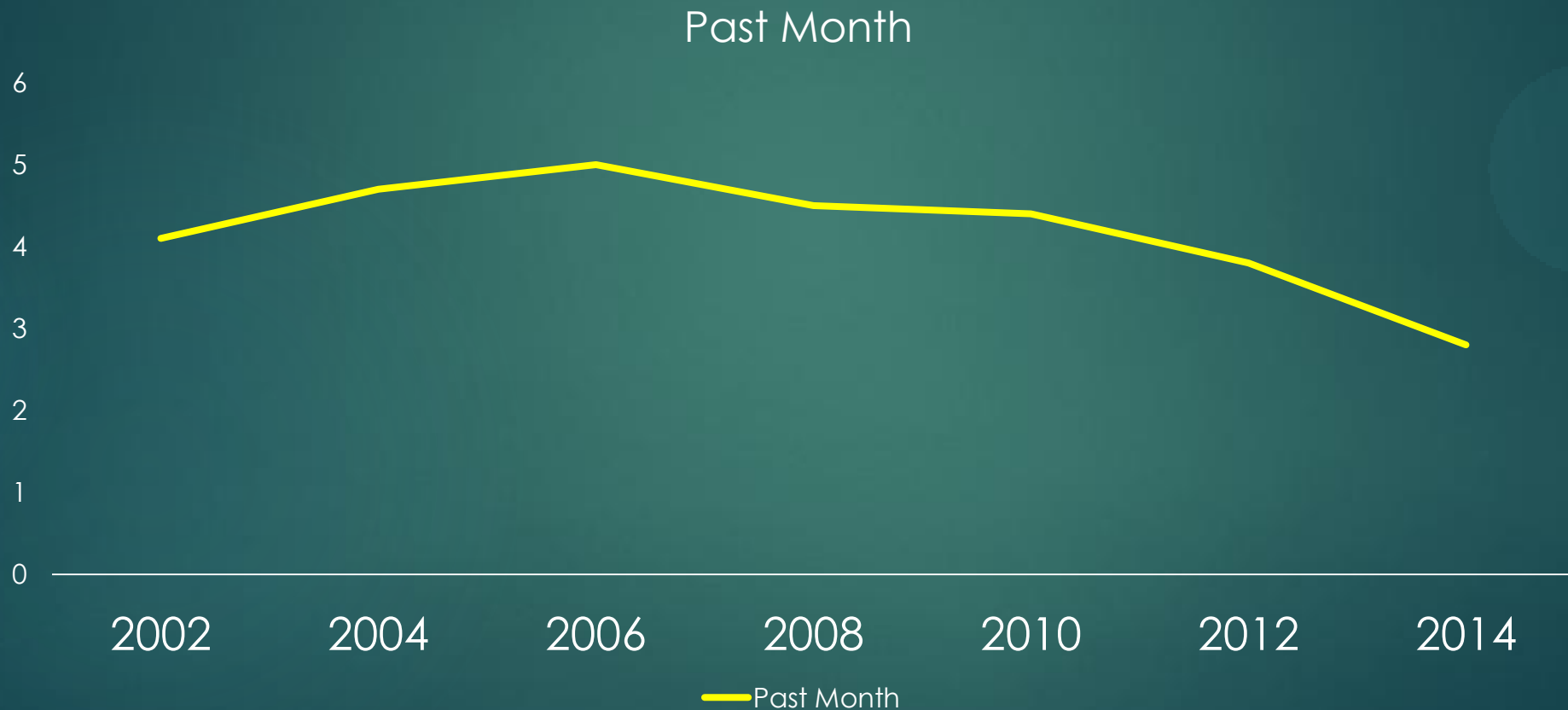
Total hydrocodone/APAP tabs dispensed in Alabama



Methadone Prescribed in the State of Alabama



Past month misuse of prescription pain relievers, 18-25 year olds



Overdose Deaths (2015-2016) in Jefferson County, AL

Category	2015	2016	%
Total drug overdoses	221	248	+12.2%

Category	2015	2016	%	Comment
Heroin	97	100	+3.09%	Of the 100 heroin and 105 fentanyl cases combined (205), forty (40) of the cases the cause of death was found to be a combination of heroin and fentanyl.
Fentanyl	49	105	+114.2%	
Cocaine	38	55	+44.7%	
Methamphetamine	5	22	+340%	
Prescription opioid	74	22	-70.2%	Note what is going down

Totals for each of the drugs reflect the total number of occurrences that drug was found in a decedent, either singly or in combination with others.

Breakdown

- ▶ When heroin is found, that's cause of death
- ▶ When fentanyl is found, that's cause of death
- ▶ Fentanyl is usually illicitly manufactured, not Rx
- ▶ Fentanyl testing costs extra, takes more time. It's STILL under-detected in all CDC reports
- ▶ When "prescription opioid" is named, it's
 - ▶ Often in combination with other agents that caused death
 - ▶ Often not prescribed for the person who died

Overdose Deaths (2015-2016)

Category	2015	2016	%
Total drug overdoses	221	248	+12.2%

Category	2015	2016	%
Heroin	97	100	+3.09%
Fentanyl	49	105	+114.2%
Cocaine	38	55	+44.7%
Methamphetamine	5	22	+340%
Prescription opioid	74	22	-70.2%

How many overdose deaths are from the prescription received?

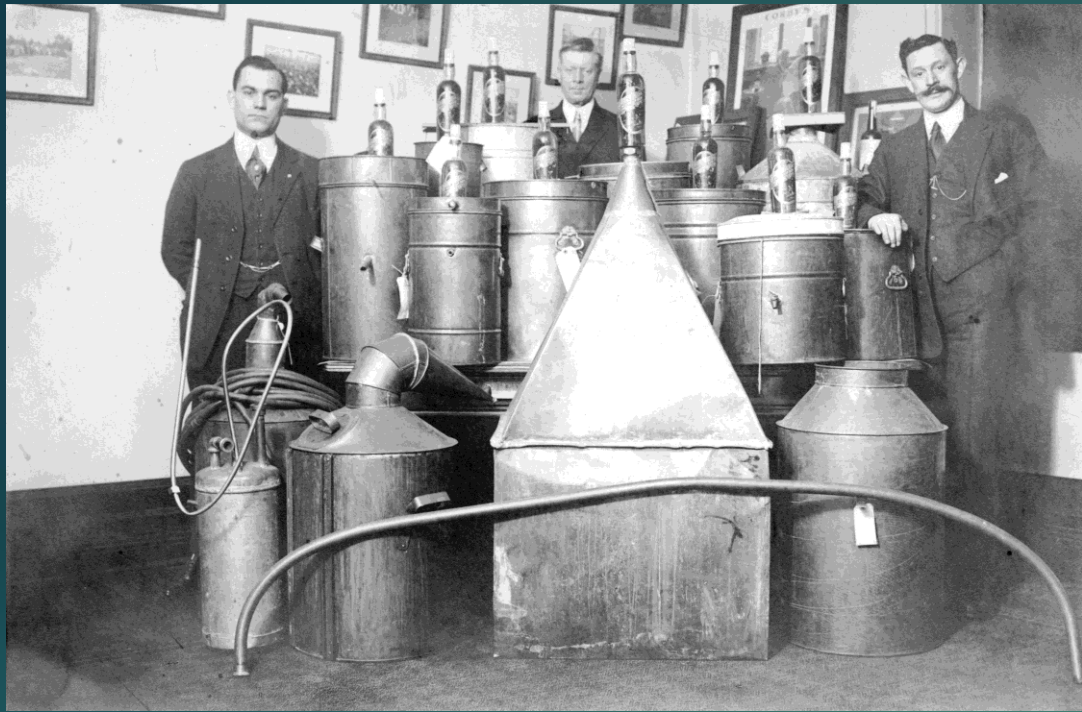
Table A3a: Proportion of Opioid-Related Overdose Decedents (2013-2014) with Prescription for Opioids (2011-2014)

Prescription in Same Month of Death vs. No Known Prescription	Rx in Month of Death	No Known Rx in Month of Death	Proportion
Fatal Overdoses	183	2009	8.3%
Summary	Based on observed data, 8.3% of opioid-related overdose decedents had an opioid prescription in the same month as their death		

Massachusetts report combining overdose death with statewide prescription database linkage

So will prescription controls solve our opioid crisis?

- ▶ Some might be reasonable, young adults + short-term problems
- ▶ But mostly, no, because
 - ▶ Prescriptions, DEA seizures, and young adult misuse are dropping
 - ▶ Overdoses and death rising
 - ▶ It's generals fighting the last war
- ▶ We need treatment, paid-for, evidence based
- ▶ Much could come from docs in offices
- ▶ We lack both:
 - ▶ Payment support
 - ▶ Treatment capacity (social and medical)



Still seized in 1918





Why I must take care, and am required to do so, when I prescribe


- ▶ Some do develop a new opioid use disorder (0.9% to 5%, per CDC)
 - ▶ **Especially if they are young**
- ▶ Some already have an opioid use disorder that they have not told me about
 - ▶ Especially if we don't get to know each other
 - ▶ Especially if I don't follow closely
- ▶ Some people could die, or have a fall, or have a side effect, unintentionally
 - ▶ This is more common if patients take a sedative like valium too
 - ▶ More common at higher doses

What is care and caution in my employer setting?

- ▶ Opioid consent agreement (not a contract)
- ▶ Regular follow-up (every 2 weeks to every 6 months)
- ▶ Urine drug test (at least every 6 months)
- ▶ Checking the Alabama Prescription Drug Monitoring Database
- ▶ Those last 2 can help but....
 - ▶ There is NO evidence they reduce risk to patients
 - ▶ They don't prove something
 - ▶ They are the basis for a conversation

The doctor's dilemma

- ▶ If I stop a prescription for a patient with pain, and they deteriorate, no one will notice, and I'm professionally safe
- ▶ If I stop a prescription for a patient with addiction, and they go out and die, I won't know and "my hands are clean"
- ▶ If I treat pain with opioids, and anything at all goes wrong with the patient, I'm liable
- ▶ If I treat a pain with opioids and the number of patients or the number of milligrams looks high, I'm under pressure from payers, state boards, possibly DEA and my employer



“People look for drugs when they don’t see other rewards. We have to think about the entire package: economic opportunity, social opportunity...

...If we only focus on how to control the supply of that one pill ...we’ll never get on top of this thing”

(interview with WVTM13)

A thought from the Surgeon General



“We cannot allow the pendulum to swing to the other extreme here, where we deny people who need opioid medications those actual medications. ... We are trying to find an appropriate middle ground.

US Surgeon General Vivek Murthy

