SciMedCentral

Journal of Substance Abuse & Alcoholism

Editorial

Prescription Opioid Abuse in the US: The Perfect Storm with No Proven Strategies to Mitigate the Escalating Problem

Thomas T. Simopoulos*

Harvard Medical School, USA

*Corresponding author

Thomas T Simopoulos, Harvard Medical School, Boston, MA, USA, E-mail: tsimopou@bidmc.harvard.edu

Submitted: 25 November 2013

Accepted: 13 December 2013

Published: 16 December 2013

Copyright

© 2013 Simopoulos

OPEN ACCESS

EDITORIAL

Over the past two decades, the popularity of chronic opioid therapy (COT) for non-malignant pain has exploded. Presently, hydrocodone is the number one prescribed medication in the US. The adaptation of this therapy has become widespread despite the lack of clinical evidence for long-term safety and efficacy [1]. Emerging data has implicated an association of high dose COT with recurrent hospitalization, a higher probability of surgery, and a propensity towards a higher level of functional disability [2,3]. The key questions are how did clinicians quickly accept COT without a strong evidence-based foundation for patient selection, monitoring, and long-term efficacy/safety? A review of the opioid epidemic in the US indentifies that laws governing opioid prescribing patterns were altered in a liberal fashion that was supported by various organizations known to embrace high dose COT [4]. The Joint Commission on the Accreditation of Healthcare Organization (JACHO) in 2000 implemented pain standards that established the right to pain relief, which favored the use of opioids. There were multiple sustained release preparations of opioid medications introduced to the market by the pharmaceutical industry. A very large and modestly regulated sales force proceeded to aggressively market these medications to physicians who had little knowledge of the long-term outcomes. By 2007, opioid analgesic related deaths exceeded that of heroin and cocaine combined [5].

Despite the now recognized high risk of COT, as well as long-term costs, the use of this therapy continues at an alarming rate. COT fits well into faced paced clinical practice as well as the expected “quick fix “in today’s culture. The fee for services health-care system that is driven by procedures is especially vulnerable to COT. Poor patient selection for many often-elective operations, not uncommonly result in incomplete pain relief with the continuation of opioids in order to maintain patient satisfaction. Furthermore, the referral-based system further drives COT, as patients are often referred to chronic pain treatment centers for ongoing care. From this point COT may become a lifetime therapy with little to no regard for risk stratification.

How can we mitigate the risk of COT keeping in mind that it is driven by a variety of influential forces coupled with a lack of physician knowledge? The latter is being addressed by multiple states that recently require continuing medical education in pain management with specific focus on opioids. A focus on enhancing selection and monitoring purported to address the former. Multiple opioid screening tools have become available in order to predict aberrant behaviors before initiating and while on COT. A careful review of these screening instruments pointed out multiple shortcomings, which included: lack of validation in multiple populations and clinical settings, ease of use, and reliability [6]. At this point, the overall clinical impact is therefore uncertain. Urine drug testing (UDT) has been proposed as a means to ensure compliance with drug therapy and at the same time evaluate for the presence/absence of other controlled/illicit substances. Indeed clinicians are using UDT with reasonable consensus with regards to number of random test per year as well as substances detected [7]. However, there is a lack of evidence in present guidelines on the interpretation of UDT results, and it is therefore not surprising that clinicians vary widely in actions taken based on a positive/negative test result [8]. Prescription monitoring programs (PMPS) have been mandated in each state as a result of the National All Schedules Prescription Electronic Report Act to track statewide controlled substances, have shown some promise in reducing multiple prescribing [9]. The limitations of PMPS are that many physicians lack awareness and access. Finally, PMPS are state specific and patients can get around them by going to multiple states.

The grim reality is that COT is touted to be the only effective analgesic option for some patients but with no strong clinical evidence of efficacy and at a huge expense to society in terms of human life and economic loss. Indeed, most pain societies continue to support opioids for chronic non-malignant pain. Unfortunately, there is no overwhelming evidence that the means exist to improve the opioid epidemic any time soon.

REFERENCES

1. Kissin I. Long-term opioid treatment of chronic nonmalignant pain: unproven efficacy and neglected safety? J Pain Res. 2013; 6: 513-529.

SciMedCentral

2. Breivik H, Collett B, Ventafridda V, Cohen R, Gallacher D. Survey of chronic pain in Europe: prevalence, impact on daily life, and treatment. Eur J Pain. 2006; 10: 287-333.

3. Cicero TJ, Wong G, Tian Y, Lynskey M, Todorov A, Isenberg K. Co-morbidity and utilization of medical services by pain patients receiving opioid medications: data from an insurance claims database. Pain. 2009; 144: 20-27.

4. Manchikanti L, Helm S 2nd, Fellows B, Janata JW, Pampati V, Grider JS, et al. Opioid epidemic in the United States. Pain Physician. 2012; 15: ES9-38.

5. http://www.cdc.gov/Home and Recreational-Safety/pdf/poison-issue-brief.pdf

6. Sehgal N, Manchikanti L, Smith HS. Prescription opioid abuse in chronic pain: a review of opioid abuse predictors and strategies to curb opioid abuse. Pain Physician. 2012; 15: ES67-92.

7. Clancy Z, O'Connell K, Couto J. The use of urine drug monitoring in chronic opioid therapy: an analysis of current clinician behavior. J Opioid Manag. 2013; 9: 121-127.

8. Pesce A, West C, Egan City K, Strickland J. Interpretation of urine drug testing in pain patients. Pain Med. 2012; 13: 868-885.

9. Manchikanti L, Manchukonda R, Damron KS, Brandon D, McManus CD, Cash K. Does adherence monitoring reduce controlled substance abuse in chronic pain patients? Pain Physician. 2006; 9: 57-60.

Cite this article

Simopoulos TT (2013) Prescription Opioid Abuse in the US: The Perfect Storm with No Proven Strategies to Mitigate the Escalating Problem. J Subst Abuse Alcohol 1(1): 1003.