Opioids: Current Issues & Prescribing Guideline Update

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Continuing Education Activity Details:

Activity Type: Knowledge-based
Target Audience: Pharmacists and Pharmacy technicians
Cost: Free for PPA members (not available to non-members)
Contact Hours: 0.25 (15 minutes) CEUs: 0.025
UANs: 0159-0000-16-015-H01-P
0159-0000-16-015-H01-T
Release date: May 19, 2016
Expiration date: May 19, 2019

At the completion of this activity the participant will be able to:

1. Recognize the current issues that increased opioid prescribing and overdose present nationwide and in Pennsylvania
2. Describe the most relevant points of the CDC’s recent guideline update regarding opioid prescribing for chronic pain patients

Introduction

Opioids have a long history of use in the medical community, and in certain situations, such as in acute nociceptive pain, neuropathic pain, or musculoskeletal injuries, opioids can be reasonable and effective therapies for improvement of function and reduction of pain. Despite limited high-quality data to support the long-term use of opioids for chronic non-cancer pain, many clinicians continue to prescribe opioids chronically for patients. Pain is difficult to quantify due to its subjectivity, and although some patients may require chronic opioids to help control pain, the lack of knowledge about harmful opioid effects has led to increased numbers of prescriptions. The CDC has observed a linear relationship between an increase in opioid prescription sales, substance abuse treatment admissions, as well as opioid overdose death
rates.\textsuperscript{3} Clearly, there needs to be a shift in the understanding of risk/benefit profiles for opioids and the way they are utilized. On March 15, 2016, the CDC released an updated guideline regarding opioid prescribing in chronic pain, excluding cancer, palliative, and end of life care.\textsuperscript{4} The guideline is meant to supplement current evidence and guide treatment decisions for the primary care clinician.

**Pennsylvania & National Statistics**

In 2014, Pennsylvania saw a statistically significant increase in the rate of drug overdose deaths, which translated to a 12.9% increase from 2013-2014. Pennsylvania also had the third highest number of drug overdose deaths out of any state in the nation; an alarming 2,732 people overdosed and died.\textsuperscript{5} These numbers are shocking and they represent a trend that is affecting the whole nation, not just Pennsylvania. Since 1999, overdose deaths involving prescription opioids have quadrupled. Additionally, the CDC reports that at least half of all U.S. opioid overdose deaths involve a prescription opioid.\textsuperscript{6} This can be due to a number of reasons, but a portion of the blame undoubtedly is attributed to increased availability of opioid prescription drugs, coupled with lack of knowledge on the part of both patients and professionals in terms of proper usage.

The DEA’s findings for Pennsylvania continue to paint a grim picture. In a 2014 analysis of drug-related overdose deaths in Pennsylvania, they report that more than 60% of overdose deaths involve the presence of an opioid, with oxycodone implicated most frequently.\textsuperscript{7} These facts and statistics may come as a shock to those unfamiliar with the problem in Pennsylvania.

Despite the negativity associated with opioid usage, collaborative group efforts have resulted in positive progress in Pennsylvania, such as a prescription drug monitoring program, as well as increased naloxone availability and training for pharmacists and other healthcare providers. Additionally, groups nationwide have been focusing their attention on the opioid crisis at hand. The recent CDC guideline update for prescribing chronic opioids is an example of a collaborative effort, and a step in the right direction for healthcare providers who are adamant about proper usage and helping to curb overdose deaths. While the guideline is not a solution to our problem, it can help to familiarize us with current good practices, allowing us to recognize what is appropriate and reasonable.

**CDC Guideline Update\textsuperscript{4}**

The newest CDC guideline is intended for primary care clinicians who treat patients 18 years or older, excluding patients receiving treatment for hospice, palliative care, or end of life decisions. The CDC defines chronic pain as “pain lasting longer than three months or past the time of normal tissue healing.” It is important for practitioners to recognize the scope of these guidelines as well as the purpose: to help make informed decisions about treatment of these individuals. This presentation is not meant to be a comprehensive review of the new guideline,
but its intention is to outline the main points that are relevant to pharmacists, and updates associated with the publication.

The CDC organized the guideline into three main focus areas:

1. Determining when to initiate or continue opioids for chronic pain

   - Nonpharmacologic and nonopioid therapy preferred for chronic pain

     i. Physical therapy, weight loss, cognitive behavioral therapy (CBT), and exercise for osteoarthritis – multimodal treatments are recommended and beneficial

     ii. Nonopioid therapies including NSAIDs and acetaminophen are effective for chronic pain, particularly arthritic and low back pain

     iii. Anticonvulsants (pregabalin & gabapentin), tricyclic antidepressants, and duloxetine are effective for neuropathic pain, fibromyalgia, and post-herpetic neuralgia – antidepressants are particularly useful if concomitant depression is present

     iv. Nonopioids are less risky, but still can have adverse effects, and should be monitored in cardiovascular, gastrointestinal, renal, or hepatic disease; anticholinergic properties of antidepressants need to be considered in elderly

     v. **Bottom line = Risks vs. benefits of chronic opioid therapy need to be assessed and reassessed frequently!**

   - Establishing Treatment Goals

     i. Setting realistic endpoints for pain relief and function

     ii. Discontinuing opioids if benefits do not outweigh risks

   - Risk and Benefit Discussion

     i. Many patients lack information – open communication is key!

     ii. Advise patients on benefits of short-term pain relief
iii. Discuss risks: respiratory depression, constipation, drowsiness, physical dependence, overdose, withdrawal, long-term addiction possibility, diversion

iv. Periodic review of comprehension, pain status, and function – at least every 3 months if chronic opioid is necessary

2. Opioid selection, dosage, duration, follow-up and discontinuation

- **Immediate-release Dosage Forms Preferred** Over Extended-Release/Long-Acting (ER/LA)
  
  i. ER/LA include methadone, transdermal fentanyl, and ER versions of oxycodone, oxymorphone, hydromorphone, and morphine

  ii. No evidence that ER/LA forms are more effective, safer, control pain better, or deter abuse – should be reserved for special situations when IR does not manage around the clock pain appropriately

  iii. Methadone and fentanyl particularly risky – complex/unconventional dosing, unpredictable PK/PD, QT prolongation with methadone

- **Use Lowest Effective Dosage & Titrate Slowly**
  
  i. Use caution if increasing to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day

  ii. Taper weekly dosage by 10-50% is recommended by experts when discontinuing

- **Acute Pain Follows Same Rules**
  
  i. Lowest effective dosage of IR products to control pain preferred

  ii. 3 days often sufficient, more than 7 days rarely needed

3. Assessing risk and addressing harms of opioid use

- **Continuous Re-Evaluation** of Benefit/Risk During Therapy
  
  i. Guidelines reiterate this point ad nauseam but it is very important for proper usage of opioids
ii. Assess all aspects of patient – **social history** (past addiction, mental health issues, etc.) is just as important as medical history to determine potential risks/harms that can develop on therapy

iii. **Important considerations** – patients with breathing issues, pregnant women, renal or hepatic insufficiency, prior nonfatal overdose

iv. **Offering Naloxone (reversal agent)** – should not be a stigma attached to naloxone education and dispensing in individuals at high risk of overdose (high daily dosage, prior overdose, history of substance abuse)

v. **In Pennsylvania, due to a standing order**, naloxone can be obtained without a prescription, can be administered by lay persons after education and can potentially save lives!

- **Review Patient’s History of Opioid Prescriptions**
  
  i. PA will soon have **prescription drug monitoring program (PDMP)** established – keep an eye out, this can help assess potential misuse or abuse
  
  ii. Can also assess prescriptions from multiple practitioners
  
  iii. Again, continuous review of PDMP data at least every 3 months

- **Periodic Urine Drug Testing**
  
  i. Assess for potential controlled substances/illicit substances being utilized concomitantly with prescribed opioid therapy

- **Avoid Opioid + Benzodiazepines Together!**
  
  i. *Important point – both classes cause respiratory depression, can be significant when used together*
  
  ii. Greatly increased risk for fatal patient overdose
  
  iii. If used together, requires collaboration between providers to ensure safety

- **Medication-Assisted Treatment – If Necessary**
  
  i. Patients taking opioids chronically can develop **opioid use disorder**
Both buprenorphine and methadone are potential options, along with behavioral therapy.

Restrictions and qualifications apply, requires investigation and collaboration.

Health care providers who are interested in learning more about proper usage of opioids can read about opioid dispensing guidelines, which were developed by the Pennsylvania Pharmacists Association in conjunction with the PA Department of Health, and they are meant as an additional tool to help instill best practices. Guidelines can be found here:


Also, an additional set of opioid prescribing guidelines have been adopted by the Pennsylvania Medical Society, the state, and endorsed by Pennsylvania Pharmacists Association. Those guidelines can be found here:


References


