

Opioid Crisis—A U.S. Public Health Emergency: Recommendations for Doctors

What is the opioid crisis?

Prescriptions for opioids almost quadrupled from 1999 to 2015 and accounted for more than six out of 10 overdose deaths in 2015.¹ During this same time period, however, there was not an increase in reporting of patients with pain, or increased pain levels.^{2,3} Ninety-one (91) Americans die every day from opioid and heroin overdoses in communities across the United States.⁴ In 2016, more than half of the patient opioid-related deaths in 10 states (Maine, Massachusetts, Missouri, New Hampshire, New Mexico, Ohio, Oklahoma, Rhode Island, West Virginia and Wisconsin) tested positive for fentanyl (subcutaneous patch with sustained/longer-term release of opioid), as reported in the State Unintentional Drug Overdose Reporting System (SUDORS), a part of the Centers for Disease Control and Prevention's (CDC) Enhanced State Opioid Overdose Surveillance (ESOS) program. In 2015, the five states with the highest rates of drug overdose deaths included West Virginia, New Hampshire, Kentucky, Ohio and Rhode Island.⁵

What are opioids?

Prescription opioids are more commonly used to treat moderate-to-severe pain after surgery or injury, and for the management of painful health conditions such as cancer. The acceptance and use of prescriptive opioids have seemingly increased regardless of their known risks, even though opioids have been proven to have decreased effectiveness with long-term use.

Opioid drugs work by binding to opioid receptors in the brain, spinal cord, and other nerve areas of the body, reducing the neurological messages of pain sent to the brain. This reduction also reduces the patient's feeling of pain.

Types of opioid medication:

- codeine
- [fentanyl](#) (available as a synthetic drug patch)
- hydrocodone
- [hydrocodone/acetaminophen](#)
- [hydromorphone](#)
- [meperidine](#)
- [methadone](#)

- [morphine](#)
- [oxycodone](#)
- oxycodone and acetaminophen
- oxycodone and [naloxone](#)

Risks associated with opioid prescriptive drugs:

- increased tolerance—patients may need to take more of the medication for the same pain relief
- physical dependence—patients have symptoms of withdrawal when the medication is stopped (diarrhea, nausea, vomiting, muscle pain, anxiety, irritability)
- increased sensitivity to pain—patients need more medication because their pain symptoms increase
- constipation
- respiratory depression
- nausea, vomiting and dry mouth
- sleepiness, sedation and dizziness
- confusion
- complications when combined with alcohol and other medications (antihistamines, sleeping aids, and some antidepressants)
- depression
- low levels of testosterone that can result in lower sex drive, energy and strength
- itching and sweating
- addiction
- overdose risks including death

Overdose prevention-responsibilities for all physicians:

The CDC has available for all prescribing physicians the *CDC Guideline for Prescribing Opioids for Chronic Pain*. A summary of the guideline can be found at [cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-a.pdf](https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-a.pdf), which outlines important factors to consider when initiating opioid prescriptions for chronic pain (not intended for patients who are in active cancer treatment, palliative care, or end-of-life care) and how to discuss the risks and benefits with patients. It should be noted that long-term opioid use often begins with treatment of acute pain.⁶ Physicians estimated that 24 percent of their patients with chronic pain on opioid therapy were addicted to or currently abusing opioids.⁷

- When opioids are used for acute pain, clinicians should initiate a goal and treatment plan with the patient and prescribe the lowest effective dose of immediate-release opioids.

- Prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
- Physicians should use their state prescription drug monitoring program (POMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Physicians should be aware that patient behaviors, such as seeking pain medications from several providers, or kinds of providers, and those seeking more medication than is indicated for their pain condition, may indicate an addictive condition or increased opioid need by the patient.⁸ Physicians should report such action and check state monitoring programs to avoid over prescribing.
- Avoid opioid and benzodiazepines concurrent prescribing and review all existing medications the patient currently uses.
- Consider offering naloxone when factors exist that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (2.50 MME/day), or concurrent benzodiazepine use.
- Evaluate benefits and harms with the patient frequently—every 1-4 weeks.
- Taper and/or discontinue use as appropriate.
- Offer treatment for opioid disorders and addictions--resources to help with arranging for treatment include the Substance Abuse and Mental Health Services Administration's (SAMHSA's) buprenorphine physician locator (http://buprenorphine.samhsa.gov/bwns_locator), SAMHSA's Opioid Treatment Program Directory (<http://dpt2.samhsa.gov/treatment/directory.aspx>), and SAMHSA's Provider Clinical Support System for Opioid Therapies (<http://pcss-o.org>), which offer extensive experience in the treatment of substance-use disorders and specifically of opioid-use disorder.⁹

¹ Centers for Disease Control and Prevention. Increases in Drug and Opioid-Involved Overdose Deaths, United States, 2010- 2015. MMWR 2016.

² Chang H, Daubresse M, Kruszewski S, et al. Prevalence and treatment of pain in emergency departments in the United States, 2000 - 2010. Amer J of Emergency Med 2014; 32(5): 421-31.

³ Daubresse M, Chang H, Yu Y, Viswanathan S, et al. Ambulatory diagnosis and treatment of nonmalignant pain in the United States, 2000 - 2010. Medical Care 2013; 51(10): 870-878.

⁴ CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at <http://wonder.cdc.gov>.

⁵ https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm⁶ Dowell, Deborah; Haegerich, Tamara M.; Chou, Roger. CDC Guideline for Prescribing Opioids for Chronic Pain, https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-a.pdf.

⁷ Barry OT, Irwin KS, Jones ES, et al. Opioids, Chronic Pain, and Addiction in Primary Care. The journal of pain: official journal of the American Pain Society. 2010;11(12):1442-1450.

⁸ Meers, George W.; Alldredge, Brooks R. Learn to Spot Drug-Seeking Behavior, <https://www.reviewofoptometry.com/article/learn-to-spot-drugseeking-behavior>.

⁹ American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Publishing; 2013.

Additional resources:

Graphic displays of the problem:

<https://www.cdc.gov/drugoverdose/resources/graphics.html>

Where patients can get help:

<https://www.cdc.gov/drugoverdose/prevention/help.html>

Medicare Part D Opioid Prescribing Mapping Tool:

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap.html>