Prescription Review Program and College Expectations

Dr. Rashmi Chadha
MBChB MScCH CCFP MRCGP ABAM

Consultant, Prescription Review Program
Prescribers Course – May 13, 2016
Disclosure

• Never had any commercial support or relationship with commercial interests
• Provide consultation to the College of Physicians and Surgeons of British Columbia
• Employed by Vancouver Coastal Health (VGH, South Mental Health and Addictions)
• Provided consultation to WorkSafeBC and the College of Registered Nurses of BC
Context
Indications for opioids

• Acute pain
• Cancer/end-of-life pain
• Chronic non-cancer pain

“A perfect storm of controversy…”

“... a War on Pain and a War on Drugs” —Dr. Scott Fishman

- Pain management
- Latrogenesis
- Addiction
- Diversion
“Canada, on a per capita basis, currently uses five times the amount of prescription opioids used in the United Kingdom”

Mg/capita Consumption of Morphine, United States of America, 1980-2007

Sources: International Narcotics Control Board; United Nations population data
By: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2009
How are we doing in Canada?

Table 1: Annual change rates and ratios for opioid dispensing in Canada, by province and for Canada (total), 2005–2011

<table>
<thead>
<tr>
<th>Province</th>
<th>Strong opioids</th>
<th>Weak opioids</th>
<th>Oxycodone</th>
<th>Opioid dispensing ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia (BC)</td>
<td>+48.5</td>
<td>-2.0</td>
<td>-3.8</td>
<td>-1.6</td>
</tr>
<tr>
<td>Alberta (AB)</td>
<td>+29.3</td>
<td>-3.9</td>
<td>-0.4</td>
<td>+1.7</td>
</tr>
<tr>
<td>Saskatchewan (SK)</td>
<td>+98.7</td>
<td>+1.2</td>
<td>+26.2</td>
<td>-3.4</td>
</tr>
<tr>
<td>Manitoba (MN)</td>
<td>+98.2</td>
<td>-2.9</td>
<td>+37.4</td>
<td>+3.0</td>
</tr>
<tr>
<td>Ontario (ON)</td>
<td>+39.5</td>
<td>-15.2</td>
<td>-12.3</td>
<td>-7.7</td>
</tr>
<tr>
<td>Quebec (QC)</td>
<td>+45.4</td>
<td>+2.9</td>
<td>-5.4</td>
<td>-2.2</td>
</tr>
<tr>
<td>New Brunswick (NB)</td>
<td>+39.0</td>
<td>+1.2</td>
<td>-0.7</td>
<td>+0.1</td>
</tr>
<tr>
<td>Nova Scotia (NS)</td>
<td>+43.5</td>
<td>+2.7</td>
<td>-4.6</td>
<td>-2.6</td>
</tr>
<tr>
<td>Prince Edward Island (PE)</td>
<td>+62.8</td>
<td>+6.0</td>
<td>-3.8</td>
<td>-3.2</td>
</tr>
<tr>
<td>Newfoundland (NL)</td>
<td>+71.8</td>
<td>+5.2</td>
<td>-1.3</td>
<td>+5.0</td>
</tr>
<tr>
<td>Canada (CA)</td>
<td>+43.4</td>
<td>-7.9</td>
<td>-3.3</td>
<td>-2.8</td>
</tr>
</tbody>
</table>


Fischer et al. BMC Health Services Research 2014, 14:90
http://www.biomedcentral.com/1472-6963/14/90
Is change afoot?

<table>
<thead>
<tr>
<th>Province</th>
<th>Strong opioids</th>
<th>Weak opioids</th>
<th>Oxycodone</th>
<th>Opioid dispensing ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia (BC)</td>
<td>+48.5</td>
<td>-2.0</td>
<td>-3.8</td>
<td>-1.6</td>
</tr>
<tr>
<td>Alberta (AB)</td>
<td>+29.3</td>
<td>-3.9</td>
<td>-0.4</td>
<td>+1.7</td>
</tr>
<tr>
<td>Saskatchewan (SK)</td>
<td>+98.7</td>
<td>+1.2</td>
<td>+26.2</td>
<td>-3.4</td>
</tr>
<tr>
<td>Manitoba (MN)</td>
<td>+98.2</td>
<td>-2.9</td>
<td>+37.4</td>
<td>+3.0</td>
</tr>
<tr>
<td>Ontario (ON)</td>
<td>+39.5</td>
<td>-15.2</td>
<td>-12.3</td>
<td>-7.7</td>
</tr>
<tr>
<td>Quebec (QC)</td>
<td>+45.4</td>
<td>+2.9</td>
<td>-5.4</td>
<td>-2.2</td>
</tr>
<tr>
<td>New Brunswick (NB)</td>
<td>+39.0</td>
<td>+1.2</td>
<td>-0.7</td>
<td>+0.1</td>
</tr>
<tr>
<td>Nova Scotia (NS)</td>
<td>+43.5</td>
<td>+2.7</td>
<td>-4.6</td>
<td>-2.6</td>
</tr>
<tr>
<td>Prince Edward Island (PE)</td>
<td>+62.8</td>
<td>+6.0</td>
<td>-3.8</td>
<td>-3.2</td>
</tr>
<tr>
<td>Newfoundland (NL)</td>
<td>+71.8</td>
<td>+5.2</td>
<td>-1.3</td>
<td>+5.0</td>
</tr>
<tr>
<td>Canada (CA)</td>
<td>+43.4</td>
<td>-7.9</td>
<td>-3.3</td>
<td>-2.8</td>
</tr>
</tbody>
</table>

Table 1: Annual change rates and ratios for opioid dispensing in Canada, by province and for Canada (total), 2005–2011.


Fischer et al. BMC Health Services Research 2014, 14:90
http://www.biomedcentral.com/1472-6963/14/90
Substitution effect?

Importantly, however, we also observed increases in select other ‘strong opioids’ – specifically, fentanyl and hydromorphone – in most provinces occurring in parallel to the decreases in oxycodone dispensing. These developments could point to a possible (partial) ‘substitution effect’, i.e. that other ‘strong opioids’ were increasingly prescribed where oxycodone utilization has been reduced, as possible development raised as a concern when the broad-based Oxycontin® delisting occurred.

Fischer et al. BMC Health Services Research 2014, 14:90
http://www.biomedcentral.com/1472-6963/14/90
Overvaluation of therapeutic effects?

“The explosive use of therapeutic opioids, however, is complicated by a lack of evidence regarding their effectiveness, long-term efficacy, and safety data in the treatment of chronic non-cancer pain, but there is irrefutable evidence of adverse consequences (46, 54-123)”
No long-term studies

“It can be concluded from this review there is strong evidence to support the initial effectiveness of opioids for the treatment of chronic pain, with much less clarity about long-term effectiveness.”

Efficacy of Opioids for Chronic Pain
A Review of the Evidence

Jane C. Ballantyne, MD, FRCA and Naomi S. Shin, BA
CDC: Parallel increases in opioid sales, deaths and substance abuse

US opioid sales quadrupled 2000-2010

Since 2008, 15,000 deaths per year. This exceeds MVA deaths in 30 states.


Source: Canadian Centre on Substance Abuse – July 2015 (with data from CADUMs and CTADS)
After Marijuana, Prescription and Over-the-Counter Medications* Account for Most of the Commonly Abused Drugs

Prevalence of Past-Year Drug Use Among 12th Graders

*Categories are not mutually exclusive

<table>
<thead>
<tr>
<th>Drug</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana/Hashish</td>
<td>34.8</td>
</tr>
<tr>
<td>Vicodin*</td>
<td>8.0</td>
</tr>
<tr>
<td>Cough Medicine*</td>
<td>6.6</td>
</tr>
<tr>
<td>Adderall*</td>
<td>6.5</td>
</tr>
<tr>
<td>Tranquilizers*</td>
<td>5.6</td>
</tr>
<tr>
<td>Salvia</td>
<td>5.5</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>5.5</td>
</tr>
<tr>
<td>OxyContin*</td>
<td>5.1</td>
</tr>
<tr>
<td>Sedatives</td>
<td>4.8</td>
</tr>
<tr>
<td>MDMA (Ecstasy)</td>
<td>4.5</td>
</tr>
<tr>
<td>Inhalants</td>
<td>3.6</td>
</tr>
<tr>
<td>Cocaine (any form)</td>
<td>2.9</td>
</tr>
<tr>
<td>Ritalin*</td>
<td>2.7</td>
</tr>
</tbody>
</table>

SOURCE: University of Michigan, 2010 Monitoring the Future Study

* Nonmedical Use
Misuse of prescription opioids

- CTADS 2013: Rate of abuse of pain relievers among youth (15 to 19 years) was 5.8%
- National College Health Assessment Survey (2013): Use of non-prescribed prescription opioids was 6.4% in post-secondary students
- Ontario Student Drug Use and Health Survey (2013): Reported 12.4% of students in G7-12 had use a prescription opioid for non-medical purposes
  - Between 6-12 % of youth/young adults are misusing prescription opioids
Sources of prescription opioids for those that abuse them (Adapted from SAMHSA 2010)

- Free from friend or relative: 56%
- Purchased from friend/relative: 17%
- Drug dealer/stranger: 11%
- Prescribed by one doctor: 7%
- Taken from friend/relative without asking: 4%
- Other source: 5%
Sources of prescription opioids for those that abuse them (Adapted from SAMHSA 2010)

- Free from friend or relative: 56%
- Purchased from friend/relative: 11%
- Drug dealer/stranger: 7%
- Prescribed by one doctor: 4%
- Taken from friend/relative without asking: 7%
- Other source: 5%
Sources of prescription opioids for those that abuse them (Adapted from SAMHSA 2010)

- Free from friend or relative: 56%
- Purchased from friend/relative: 17%
- Drug dealer/stranger: 7%
- Prescribed by one doctor: 4%
- Taken from friend/relative without asking: 11%
- Other source: 5%
Research article

Predictors of opioid misuse in patients with chronic pain: a prospective cohort study

Timothy J Ives¹,²,⁴, Paul R Chelminski*¹,⁴, Catherine A Hammett-Stal
Robert M Malone¹,²,⁴, J Stephen Perhac¹,⁴, Nicholas M Potisek¹,⁴,
Betsy Bryant Shilliday¹,²,⁴, Darren A DeWalt¹,⁴ and Michael P Pignon

- 196 CNCP patients on opioid treatment
- Opioid misuse (defined as -ve UDT for prescribed opioids, +ve UDT for non-prescribed opioids, doctor shopping, diversion, prescription forgery, stimulants in UDT) was 32%
- 40.3% of misusers had cocaine/amphetamines on UDT
- 24.2% of misusers had -ve UDT for prescribed opioids
Open air pharmacy 24/7
Premature opioid-related mortality

Premature opioid-related mortality

Trends and sex differences in prescription opioid deaths in British Columbia, Canada

Emilie J Gladstone, Kate Smolina, Steven G Morgan

- Between 2004 and 2013 there were 3,775 drug poisoning-related deaths and prescription opioids were involved in 1,674 of these
- The majority of prescription opioid deaths were secondary to opioids other than methadone (methadone was involved in 25% of deaths)
- Men experienced higher mortality rates than women
- The majority of prescription opioid deaths were unintentional (73% for women; 82% for men)

Let’s not forget....
Sweet, refreshing... VALIUM

...when denial is the best alternative.
Adverse effects of chronic BDZ use

- Over-sedation
- Impairment of executive function
- Paradoxical Effects
- Mood disorder
- Drug interactions
- Impaired psychomotor function
- Emotional blunting
- Iatrogenic addiction
- Pseudodementia
- Societal effects
Combinations
Benzodiazepines: A Major Component in Unintentional Prescription Drug Overdoses With Opioid Analgesics

• During 2003 to 2009 the two prescription drugs with the highest increase in death rates were oxycodone (265%) and alprazolam (234%)
• Benzodiazepines involved in >5,500 deaths in 2009 (five-fold increase since 1999)
• ED visits in the US for nonmedical use of BZD between 2004 and 2010 increased by 139%
• The opioid and BZD combination had the highest predicted model for drug related fatality

*Journal of Pharmacy Practice 27(1)*
Opioids + benzodiazepines/sedatives

- 40 to 60% of chronic pain patients concurrently use BDZ
- Concurrent BDZ use is high in patients on opioid maintenance treatment (~50%)
- Co-administration of BDZ with an opioid increases subjective ratings of “strength,” drug “liking,” and “high” from the opioid
- BDZ implicated in 40 to 80% of methadone-related deaths and 80% of buprenorphine-related deaths

Opioids + sedatives: complications

- Respiratory depression → overdose (BDZ implicated in as many as 80% of unintentional overdoses involving opioids)
- CNS depression
- Increased psychiatric comorbidity
- Increased risky behaviours
- Daytime somnolence → Increased risk MVA
- Cognitive disturbance
- Balance disorder
- Addiction
Substance abuse treatment admissions due to co-abuse of prescription opioids and BDZ increased by 570% between 2000 and 2010.

Admissions related to all other substance abuse decreased by 10% in the same time period.
Opioids + sedatives + alcohol: complications

- Respiratory depression → overdose
- CNS depression
- Increased psychiatric comorbidity
- Increased risky behaviours
- Daytime somnolence → increased risk MVA
- Cognitive disturbance
- Balance disorder
- Addiction
The College mandate: public protection
Public opinion

Solving the painkiller crisis: It’s in the hands of doctors

Carly Weeks
The Globe and Mail
Published Friday, Oct. 03 2014, 6:49 PM EDT
Last updated Friday, Oct. 03 2014, 7:18 PM EDT
Prescription Review Program (PRP)

- The Prescription Review Program is a peer review initiative of the College to review physician prescribing of controlled substances
- The fundamental purpose of this program is educational rather than disciplinary
- Quality assurance
  - Privileged under the *Health Professions Act*
What do we base our educational advice on?

- Opioid Prescribing: A Systematic Review and Critical Appraisal of Guidelines for Chronic Pain

- Teryl K. Nuckols, MD, MSHS; Laura Anderson, MPH; Ioana Popescu, MD, MPH; Allison L. Diamant, MD, MSHS; Brian Doyle, MD; Paul Di Capua, MD; and Roger Chou, MD

November 2013
Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain


Perspective: Safe and effective chronic opioid therapy for chronic noncancer pain requires clinical skills and knowledge in both the principles of opioid prescribing and on the assessment and management of risks associated with opioid abuse, addiction, and diversion. Although evidence is limited in many areas related to use of opioids for chronic noncancer pain, this guideline provides recommendations developed by a multidisciplinary expert panel after a systematic review of the evidence.
American Society of Interventional Pain Physicians (ASIPP) Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part 2 - Guidance

Laxmaiah Manchikanti, MD1, Salahadin Abdi, MD, PhD2, Sairam Atluri, MD3, Carl C. Balog, MD4, Ramsin M. Benyamin, MD5, Mark V. Boswell, MD, PhD6, Keith R. Brown, PharmD7, Brian M. Bruel, MD8, David A. Bryce, MD9, Patricia A. Burks, LPTa, Allen W. Burton, MD11, Aaron K. Calodney, MD12, David L. Caraway, MD13, Kimberly A. Cash, RT14, Paul J. Christo, MD15, Kim S. Damron, RN16, Sukdeb Datta, MD17, Timothy R. Deer, MD18, Sudhir Diwan, MD19, Ike ErieTor, MD20, Frank J.E. Falco, MD21, Bert Fellows, MA22, Stephanie Geffert, MLIS23, Christopher G. Gharibbo, MD24, Scott E. Glaser, MD25, Jay S. Grider, DO, PhD26, Haroon Hameed, MD27, Mariam Hameed, MD28, Hans Hansen, MD29, Michael E. Harne, MD30, Salim M. Hayek, MD, PhD31, Standiford Helm II, MD32, Joshua A. Hirsch, MD33, Jeffrey W. Janata, PhD34, Adam M. Kaye, PharmD35, Alan D. Kaye, MD, PhD36, David S. Kloth, MD37, Dhanalakshmi Koyyalagunta, MD38, Marion Lee, MD39, Yogesh Malla, MD40, Kavita N. Manchikanti, MD41, Carla D. McManus, RN, BSN42, Vidyasagar Pampati, MSc43, Allan T. Parr, MD44, Ramarao Pasupuleti, MD45, Vikram B. Patel, MD46, Nalini Sehgal, MD47, Sanford M. Silverman, MD48, Vijay Singh, MD49, Howard S. Smith, MD50, Lee T. Snook, MD51, Daneshvari R. Solanki, MD52, Deborah H. Tracy, MD53, Ricardo Vallejo, MD, PhD54, Bradley W. Wargo, DO55

6. A robust agreement which is followed by all parties is essential in initiating and maintaining opioid therapy as such agreements reduce overuse, misuse, abuse, and diversion. (Evidence: fair)

7. A) Once medical necessity is established, opioid therapy may be initiated with low doses and short-acting drugs with appropriate monitoring to provide effective relief and avoid side effects. (Evidence: fair for short-term effectiveness, limited for long-term effectiveness)

   B) Up to 40 mg of morphine equivalent is considered as low dose, 41 to 90 mg of morphine equivalent as a moderate dose, and greater than 91 mg of morphine equivalence as high dose. (Evidence: fair)

   C) In reference to long-acting opioids, titration must be carried out with caution and overdose and misuse must be avoided. (Evidence: good)
Opioid Treatment Guidelines
Clinical Guidelines for the Use of Chronic Opioid Therapy
in Chronic Noncancer Pain

American Society of Interventional Pain

Opioids for chronic noncancer pain
A position paper of the American Academy of Neurology

Figure 2  Risk/benefit of opioids for chronic noncancer pain
Opioid Treatment Guidelines

Clinical Guidelines for the Use of Chronic Opioid Therapy
in Chronic Pain

ASIPP - Opioid Guidelines 2012

American Society of Interventional Pain Physicians

Centers for Disease Control and Prevention

Morbidity and Mortality Weekly Report

Recommendations and Reports / Vol. 65 / No. 1
March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
Opioids for chronic noncancer pain
A position paper of the American Academy of Neurology

Table 2  What prescribers can do to safely and effectively use opioids for CNCP

<table>
<thead>
<tr>
<th>What prescribers can do to safely and effectively use opioids for CNCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid treatment agreement</td>
</tr>
<tr>
<td>Screen for prior or current substance abuse/misuse (alcohol, illicit drugs, heavy tobacco use)</td>
</tr>
<tr>
<td>Screen for depression</td>
</tr>
<tr>
<td>Prudent use of random urine drug screening (diversion, nonprescribed drugs)</td>
</tr>
<tr>
<td>Do not use concomitant sedative-hypnotics or benzodiazepines</td>
</tr>
<tr>
<td>Track pain and function to recognize tolerance and track effectiveness</td>
</tr>
<tr>
<td>Track daily MED using an online dosing calculator</td>
</tr>
<tr>
<td>Seek help if MED reaches 80-120 mg and pain and function have not substantially improved</td>
</tr>
<tr>
<td>Use the state Prescription Drug Monitoring Program to monitor all sources of controlled substances</td>
</tr>
</tbody>
</table>

Abbreviations: CNCP = chronic noncancer pain; MED = morphine equivalent dose.
BOX 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care

Determining When to Initiate or Continue Opioids for Chronic Pain

1. **Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.** Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. **Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.** Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. **Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.**

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. **When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.**

5. **When opioids are started, clinicians should prescribe the lowest effective dosage.** Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage 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.

6. **Long-term opioid use often begins with treatment of acute pain.** When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should 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.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. **Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.**

10. **When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.**

11. **Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.**

12. **Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.**
CDC Recommendations for Prescribing Opioids for Chronic Pain (1)

- Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain
- Clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks
- When opioids are started, clinicians should prescribe the lowest effective dosage
- Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to $\geq 50$ morphine milligram equivalents (MME)/day, and should avoid increasing dosage to $\geq 90$ MME/day
CDC Recommendations for Prescribing Opioids for Chronic Pain (2)

• Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should 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.
CDC Recommendations for Prescribing Opioids for Chronic Pain (3)

- If harm outweighs benefit, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
- Clinicians should incorporate strategies to mitigate risk into the management plan.
- Clinicians should review the patient’s history of controlled substance prescriptions using (PharmaNet) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose.
- When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing longitudinally.
- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently.
The bottom line...
Six steps to safe and effective prescribing for chronic conditions
Step 1

- Thoughtful patient selection
- High risk groups
  - Past or current addiction
  - Mental illness
  - Personality disorders
  - Youth
  - Functional somatic syndromes (fibromyalgia or irritable bowel syndrome)
  - Headache patients
Step 2

- Care with dose size:
  - Never exceed the equivalent of 200 mg MEDD (140 mg of oxycodone; 40 mg of hydromorphone)
  - Preferably avoid doses above 100 mg MEDD (65 mg oxycodone; 20 mg hydromorphone)
  - **Overdose risk increases three to five fold with doses over 100 mg MEDD**
  - Keep doses of other psychotropics modest as dose escalation invariably leads to harmful side effects
Step 2

- Care with dose size:
  - Never exceed the equivalent of 90 mg MEDD (60 mg of oxycodone; 18 mg of hydromorphone)
  - Preferably avoid doses above 50 mg MEDD (33 mg oxycodone; 10 mg hydromorphone)
  - Overdose risk increases three to five fold with doses over 100 mg MEDD
  - Keep doses of other psychotropics modest as dose escalation invariably leads to harmful side effects
Step 3

- Care with dispense size – don’t stock medicine cabinets
  - Individual health:
    - Medication administration error
    - Medication misuse
  - Public health:
    - Experimentation
    - Diversion
Step 4

- Avoid co-prescribing opioids with BDZ or other CNS depressants
  - Combinations kill – review polypharmacy
  - BDZ are not co-analgesic
  - Sedatives don’t make lives better—reserve them for short-term intermittent use only
  - Consider tapering long-term sedatives in recognition of risk and benefit
Step 5

• Make prescribing contingent on non-drug (lifestyle) interventions:
  – Moderate exercise
  – Sleep hygiene
  – Smoking/alcohol cessation
  – Healthy eating
  – BC Self-management Program (BounceBack, UVIC)
Step 6

• Use pharmacovigilance
  – Treatment agreements – act on red flags
  – PharmaNet profile review every time opioids or psychotropic medications are being prescribed (or considered)
  – Periodic physical examination
  – Blood work and random urine drug screens
  – Random pill counts
Six steps to safe and effective prescribing

1. Thoughtful patient selection
2. Care with dose size
3. Don’t stock medicine cabinets
4. Avoid prescribing combinations
5. Prescribe lifestyle interventions
6. Use pharmacovigilance
Engaging the patient in their treatment plan
• Tell them you care
• Tell them the truth
  – Prescriptions opioids:
    • kill and harm many people
    • more deaths than drinking and driving
    • more addiction than heroin and cocaine combined
  – Sedatives:
    • tolerance will develop
    • rebound symptoms can be even more problematic
  – Stimulants:
    • studies looking at long-term use (years/decades) and health effects are lacking
Tell them what you can’t/won’t do

- Provide hundreds of pills to take home
- Co-prescribe an opioid with a sleeping pill
- Combine different opioids and/or different sedatives
- Provide long-term prescriptions for immediate release stimulants to someone with a history of addiction
- Combine a stimulant with a sedative
- Exceed the equivalent of 90 mg MEDD
- Violate the treatment agreement
Give them hope

• “What would you really like to be able to do?”
• Keep your prescription pad on hand and provide an exercise and lifestyle prescription
• Emphasize positive functional gains at every opportunity
Watch the Dr. Mike Evans video (and get your patients to watch it too!)

**Opioids Videos**

Posted by admin on Mar 19, 2013 in Videos | 1 comment

Here are our Opioid videos in English and French!
Chronic Pain and Suffering Symposium

• Come to our excellent annual CME event