TACKLING THE OPIOID ISSUE: THE US PERSPECTIVE
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What is the opioid issue? Let us say that it is the difficulty we have balancing the humane use of opioid medication against its dangers. Opioids are uniquely effective analgesics, capable of abolishing pain in some cases. Yet they are addictive, and have potentially lethal side effects, such as respiratory depression, that become important when there is loss of control over use – the hallmark of addiction. The current US perspective is that pain specialists have oversold the benefits of opioids, producing an epidemic of opioid abuse and deaths. The word 'epidemic' has been used by the US Center for Disease Control (CDC) to describe the current precipitous rise in prescription opioid related deaths.¹

The stark fact is that rises in treatment admissions for prescription opioid abuse and in prescription opioid related deaths have directly correlated with increased sales of opioids. Increased sales of opioids in the US are related almost exclusively to increased use for the treatment of chronic pain. It is not hard to imagine that opioids given in a hospital or other medical care setting are unlikely to be abused, since abuse requires action on the part of the recipient, and the patient in care is a passive recipient. The situation when opioids are taken at home is very different. Now the patient must control usage, and for susceptible individuals, such control is difficult. Despite what in retrospect seems an obvious difference between inpatient and outpatient usage, when opioid treatment for chronic pain began to be actively promoted in the 1980s, a strong argument for treatment was that during the treatment of pain, opioids were unlikely to cause addiction. The argument was inappropriately supported using inpatient data.²

Slow release opioid preparations were developed to help cancer patients at the end of life, and became a valuable addition to the armamentarium of drugs for palliative use. Cancer patients no longer needed to maintain a 3-4 hourly regime of taking pain medication, nor suffer the inevitable troughs in pain relief that tend to accompany regimes based on immediate release (short-acting) analgesics. The first slow release opioid to be launched in the US was MS-Contin™, and this was in 1984. Shortly thereafter, the idea that opioid treatment should be extended to patients with chronic non-cancer pain began to take root. The time was ripe for the pharmaceutical industry to actively engage in educational and promotional activities to help promote the concept that opioid treatment of chronic pain was safe, effective and necessary to avoid needless suffering. The long-acting opioids were promoted as safer and more effective than the short acting drugs, a prominent part of the argument being that the steady state produced would minimize euphoria and thus reduce addiction risk. OxyContin™ (slow release oxycodone) was launched in the US in 1996, and its promotion was targeted towards chronic pain indications. The US marketing effort was particularly aggressive and effective because the market is huge, and the healthcare fragmented. It soon became apparent, however, that rather than protecting against addiction, OxyContin™ was producing high levels of abuse as detected by various government and industry surveillance databases.³ ⁴ This abuse was occurring in opioid treated chronic pain patients as well as individuals who obtained prescription opioids without a prescription.⁵ The extent to which the problem was due to safety and efficacy issues related to long-acting opioids per se, or the indications for which they were being used, or the use of opioids in the outpatient versus inpatient setting, or the underlying risk factors that tend to be present in patients suffering chronic pain, remains unknown. Steps were taken by both government and industry to reduce the rise in abuse while preserving access for patients in need, but no measure taken to date has succeeded in reducing incidences of abuse or death.⁶
Two distinct but related metrics have also played a role in increasing opioid prescribing in the US – the first quality metrics, and the second patient satisfaction metrics. Realizing that guidelines had not been effective in solving the problem of uncontrolled pain, a group of concerned individuals approached The Joint Commission, the standard accreditation body in the US, and persuaded it to introduce pain management standards into its requirements for accreditation, which it did in 2001.\(^7\) The mandate required pain’s recognition, assessment, documentation and treatment, and required that systems should be in place to achieve these goals. A system that became instantly popular was the use of pain as the “fifth vital sign” whereby a pain level or score was routinely documented with the vital signs. Some institutions went as far as to write protocols suggesting how much opioid was needed to treat what level of pain, a move that was quickly reversed when its disastrous consequences were realized.\(^8\) The Joint Commission’s mandate added to several other efforts to safeguard patients’ rights to pain management, including the writing of intractable pain policies and an ethics charter.\(^9\) All these efforts served to make adequate control of pain an important component of patient satisfaction metrics, these being especially important in the competitive healthcare environment of the US.\(^10\)

Although most of the increased prescribing and its adverse consequences can be laid at the feet of increased prescribing for chronic pain, the creation of a population of opioid dependent pain patients has also impacted acute pain management. Not only is this a population that is refractory to opioid treatment of acute pain, it is also a population that may have support needs during acute illness, trauma or pregnancy that are complex and challenging for all involved in their care. It also introduces that most vexing of dilemmas for healthcare professionals – am I treating an addiction, or pain?

REFERENCES

1. NCHS Data Brief, Number 81, December 2011


