



The Forgotten Patients: Those Who Benefit From Opioid Treatment

Recently healthcare professionals and the general public have been deluged with information about deaths from opioid (and other drug) overdoses, about patients who misuse or divert their prescribed opioids, about doctors who are in fact criminals who run pill mills, etc. The recommended solutions invariably are to decrease the supply: Teach prescribers to decrease number of prescriptions they write for opioids, put a limit on the number of opioid pills or the milligram dose per day or per month that a physician can prescribe, ship fewer opioid pills to pharmacies, etc.

Among all of these efforts to reduce the availability of opioids, one group of patients have been largely forgotten—those who have legitimate chronic pain, who are compliant with their opioid medication regimen as well as other modalities, and whose level of functioning has been improved as a result of their current treatment approach. These are patients who see their physician every month or two, whose random urine drug screens and data on the state's prescription monitoring website confirm their compliance, who take their prescriptions each month to the same pharmacy, who have probably been on the same dose for a long time, who may well be physically dependent on their medications (ie, would develop withdrawal symptoms if the opioid were stopped suddenly) but are not addicted (ie, persons who psychologically dependent, those who use their opioids compulsively, continue despite significant adverse consequences, and whose life is centered around obtaining, using, and recovering from the effects of the drug).¹

The current strategies for diminishing diversion have had a significant negative impact on many of these compliant patients who were benefiting from their opioid treatment. For one, some pharmacies are now receiving smaller supplies of opioids, especially Schedule II drugs. A patient who shows up at the pharmacy on the day his new opioid prescription is due is increasingly being told that his particular pharmacy (Walgreen or CVS, etc.) doesn't have the OxyContin,

oxycodone IR, or other opioid. If the patient is lucky, the pharmacist will call around to find another pharmacy that has the medication. If unlucky, the patient may have to start making phone calls or driving all around town to find a pharmacy that has the medication. If he doesn't succeed and has to wait until his pharmacy gets another shipment (days later), the patient will likely experience withdrawal symptoms, and, depending on their severity, may need to go to an emergency room to get some medication to tide him over. In another scenario, the patient may find himself able to fill his long-acting opioid at his usual pharmacy, but has to find another pharmacy to fill his prescription for the breakthrough pain, immediate-release opioid.

What are the results of all this?

- Increased anxiety for the patient every month when it's time to get his prescriptions filled. Increased anxiety can cause increased pain
- Experiencing withdrawal symptoms along with increased pain if the medication is not available
- Possible emergency room visit
- A prescription monitoring program (PMP) report showing that, contrary to the agreement the patient signed, he is getting his medications filled at more than one pharmacy
- Potential difficulties for the prescribing physician if regulatory scrutiny reveals that his patients are getting prescriptions filled at multiple pharmacies.

Physicians Less Willing To Prescribe Opioids

Some physicians are no longer willing to prescribe opioids for patients because of their fear of increased regulatory scrutiny. They may decide to taper the patient's opioid regimen or, worse, simply cut him off. Withdrawal symptoms are unpleasant enough for addicts; but it's worse for chronic pain patients. They experience not only withdrawal symptoms if their opioid is abruptly stopped, but they also are likely to develop increased pain, and this is true even if the dose is decreased slowly. It's important that a physician

who decides to reduce the opioid dose have an alternate plan for dealing with return of the patient's pain. This may include massage, referral for counseling, pool therapy, non-opioid medications, etc. And these modalities may or may not suffice.

Finally, some insurance companies and workers' compensation companies are using the current anti-opioid mood to try to save money by refusing to pay for the previous dose, even if the patient is functioning well and the insurance company claims to make decisions based on the patient's functioning. The insurance company looks for anything that supports their decision. For example, in states that limit the total daily opioid dose or number of pills unless prescribed by a pain specialist, the company can refuse to pay for more than that amount. Other

companies have hit upon the clinically unproven concept of "opioid-induced hyperalgesia" (OIH) to arbitrarily reduce payment on the grounds that the patient's high dose of opioid is the reason he has pain, so that the solution is to decrease or take him off the medication. There is no evidence that OIH, which has been shown in rat studies and in some studies on acute surgical patients, has any relevance to the clinical management of chronic pain.²

Yes, opioid misuse and diversion are real problems. But it's time to remember the principle of balance espoused by the Drug Enforcement Agency. They wrote, "For many patients, opioid analgesics—when used as recommended by established pain management guidelines—are the most effective way to treat their pain, and often the only treatment option that provides

significant relief."³ Let's not forget these patients.

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