Understanding and Addressing the Public Health Epidemic of Opioid Abuse

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NEW JERSEY POISON AND INFORMATION SERVICE

Personal Disclosures

- I have seen more bad than good coming from the expanded use of opioids.
- I am concerned about the influence of conflict of interest on prescribing and on disease determination.

That said….

- I believe pain relief is very important and no patient should suffer needlessly from severe pain
  - But expectations have to be *rational* and *managed*, and risks have to be understood by both providers and patients.
    - Particularly complex given the subjective nature of pain

Three Inextricable Epidemics

Chronic Pain

- >100 million pts
- $635 billion (APS)
  - CV ($309 billion)
  - Cancer ($243 billion)
  - Diabetes ($188 billion)

Prescription Drugs

- Addiction, Abuse
- Overdose
- >19,000 Deaths (CDC)
- $78 billion annually

Illicit Opioids

- Addiction, Abuse
- Overdose
- Death (many)
- Cost (countless)

Gaskin, J Pain 2012;13:715-724
American Pain Society

CDC
Florence CS. *Med Care.* 2016;54:901.

Lucrative trade

Thou hast the keys of Paradise, oh just, subtle, and mighty opium!

Thomas De Quincey, Confessions of an English Opium-Eater, 1821

Opium den

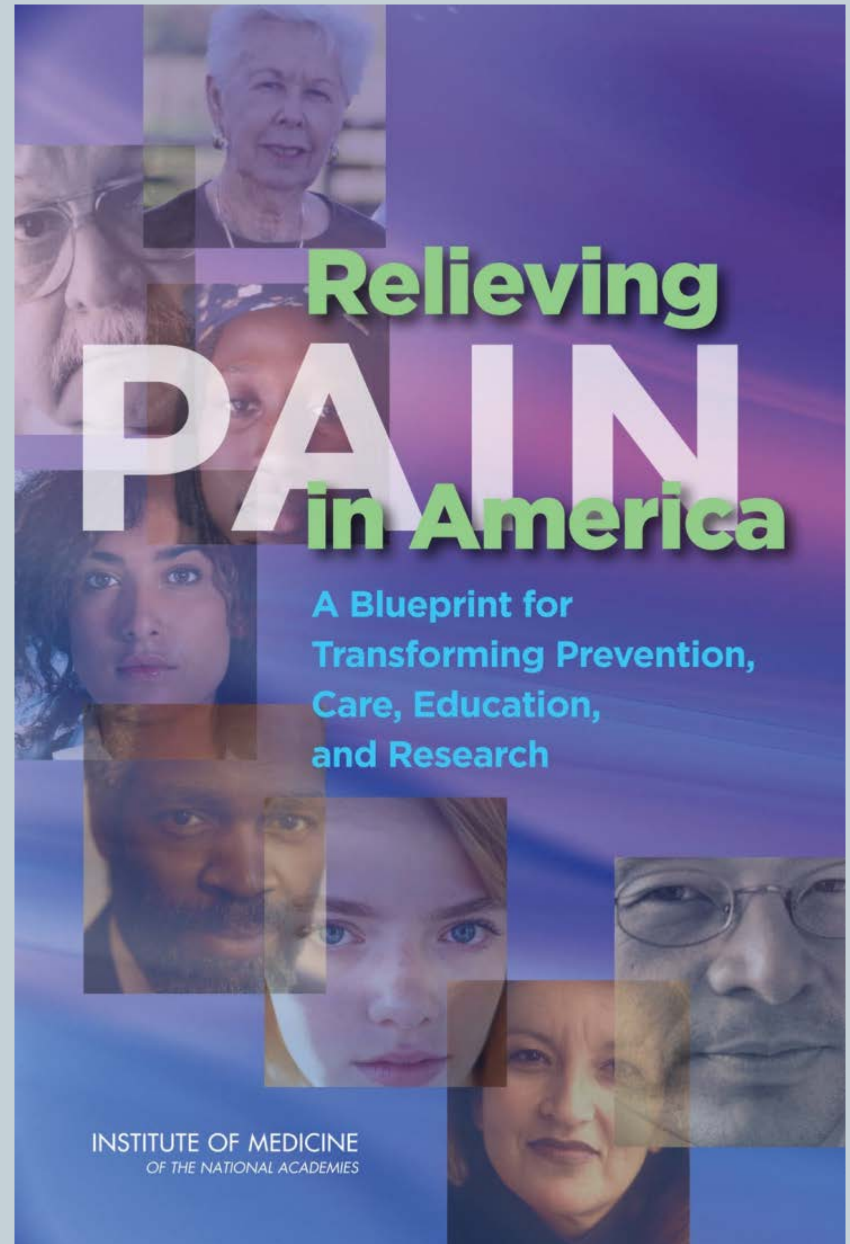
Opium Wars

First Opium War: 1839–1842
Second Opium War: 1856–1860

- Harrison Narcotic Act, 1914
  - Cannot use opioids to treat addiction
- Controlled Substance Act, 1970
  - Set up Schedules I-V for DEA and FDA
- Narcotic Addict Treatment Act (NATA), 1974
  - Created methadone maintenance treatment programs
- Drug Addiction Treatment Act of 2000 (DATA)
  - Established buprenorphine programs
- White House National Drug Control Strategy
  - Annual review of Prescription Drug Abuse Action Plan
- The Comprehensive Addiction and Recovery Act of 2016
  - Signed by the President on July 22, 2016

Chronic pain affects 116 million people in the US

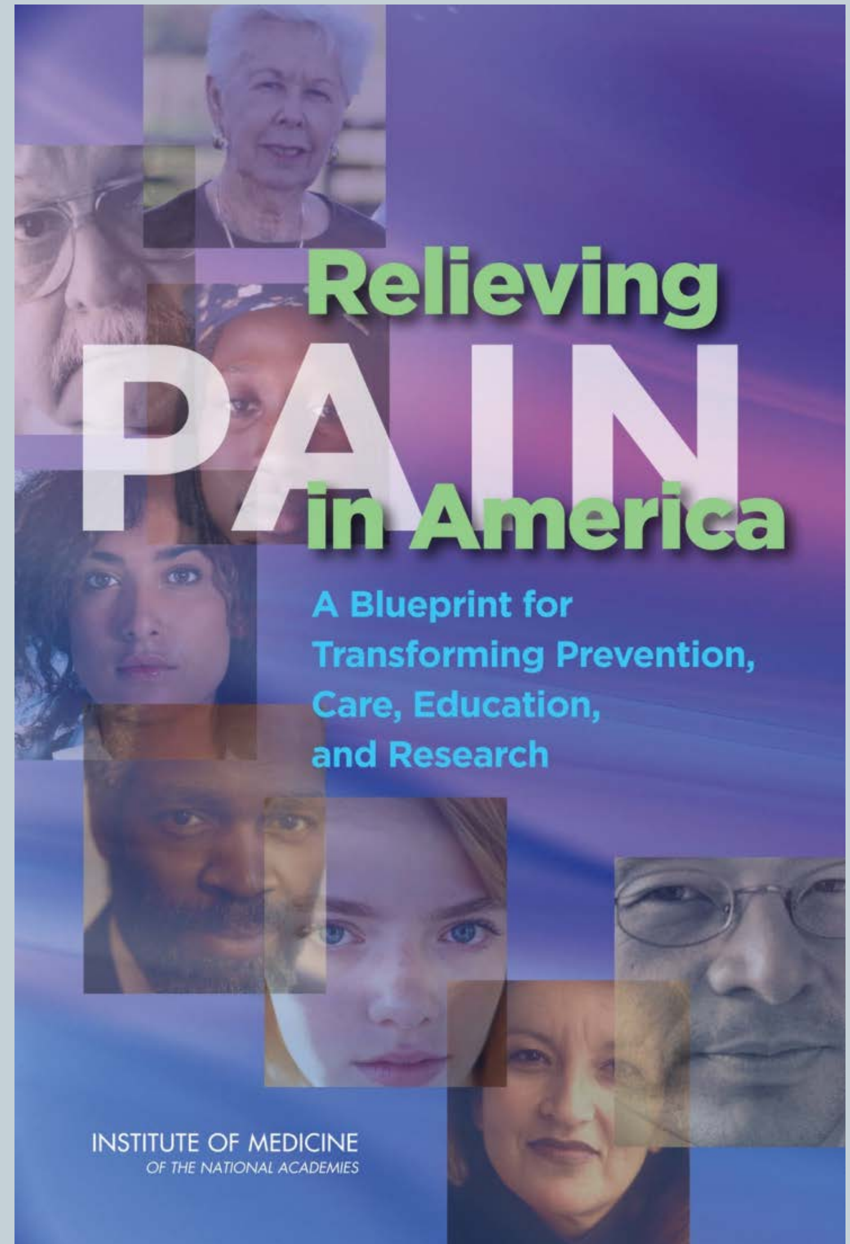
- 37% of the US population
- 47% if children are removed from the calculation



IOM April 2011

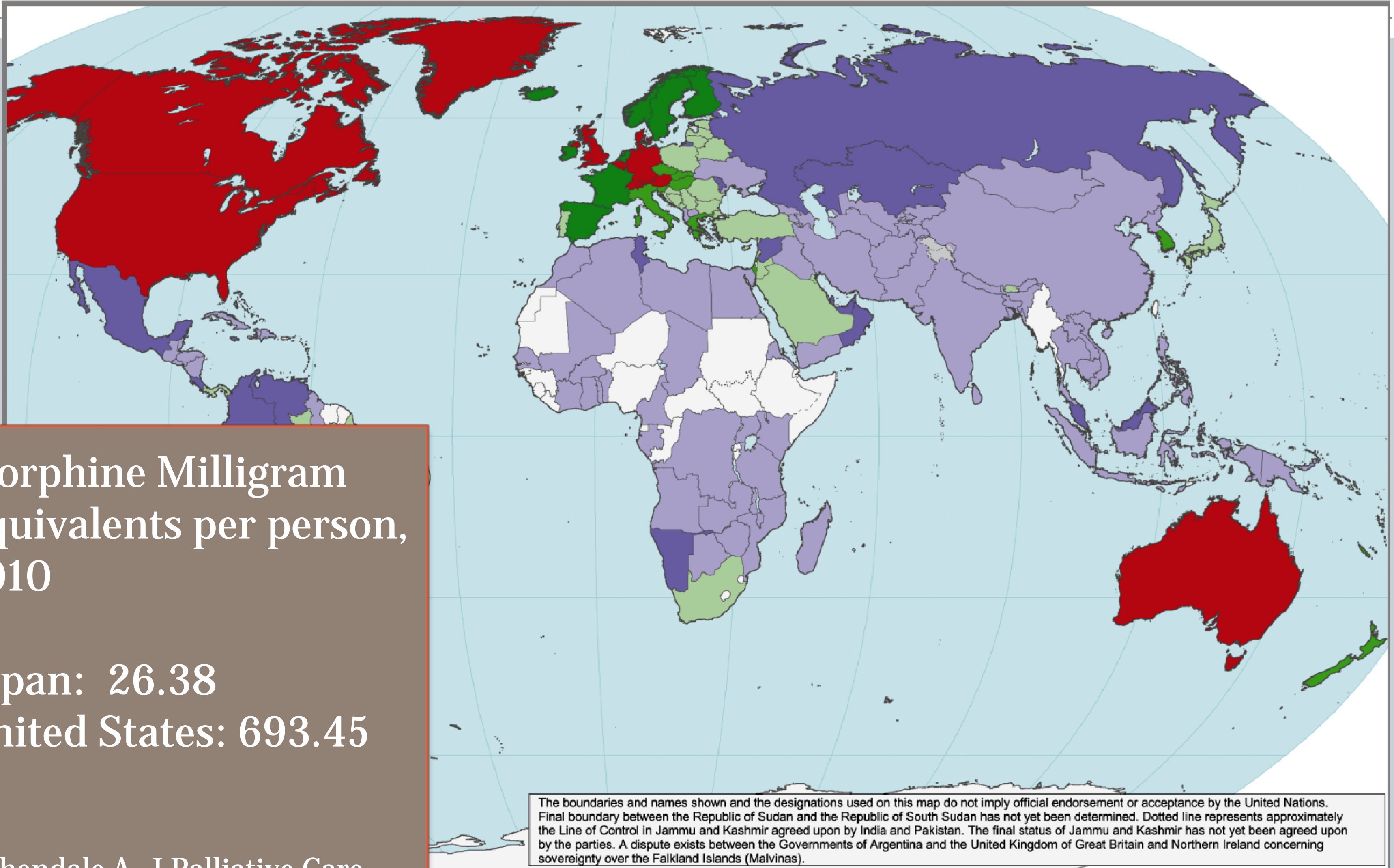
Pain is woefully undertreated, despite…

- Dozens of approved medications
- The 5th vital sign (Joint Commission)
- Patient satisfaction scores (Centers for Medicare & Medicaid Services)



IOM April 2011

"The US accounts for 4% of the world's population but uses 80% of its prescription opioid"



Morphine Milligram Equivalents per person, 2010

Japan: 26.38
United States: 693.45

Mehendale A. J Palliative Care Med 2013:3: 151-3

International Narcotics Control Board for the UN; 2012

38 percent of Americans use **prescription painkillers**

31 percent of Americans use **tobacco products**

WAPO.ST/**WONKBLOG**

Source: SAMHSA

Icons by Schmidt Sergey and Majo Puterka, The Noun Project

The New Opium War:
Individual Patients versus Public Health

- Create a demand for opioid analgesics despite limited evidence of their safety or effectiveness
  - Especially chronic pain syndromes
- Convince regulatory agencies that they should promote aggressive pain relief
  - Use words like “oligoanalgesia” and “opiophobia”
- Convince doctors that these drugs are safe and effective long-term (they are not)
  - “If your pain is so bad, you can’t get addicted”

- Porter and Jick
- NEJM 1980
- 11,882 patients
- Boston Collaborative Drug Program

“Proof that addiction is rare in pain patients”

- Porter and Jick
- NEJM 1980
- 11,882 patients
- Boston Collaborative Drug Program

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

Jane Porter
Hershel Jick, M.D.
Boston Collaborative Drug Surveillance Program
Boston University Medical Center
Waltham, MA 02154

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

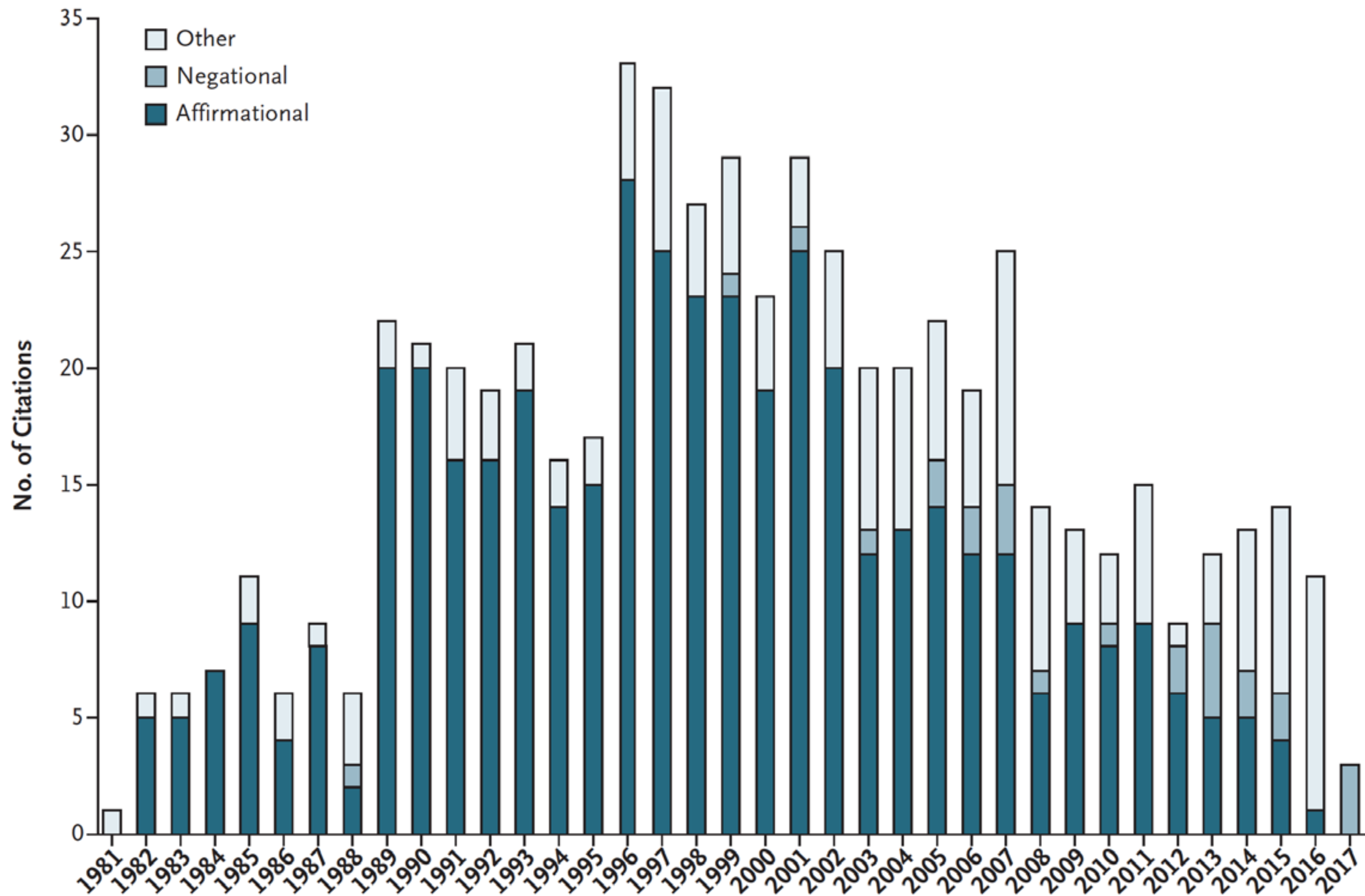
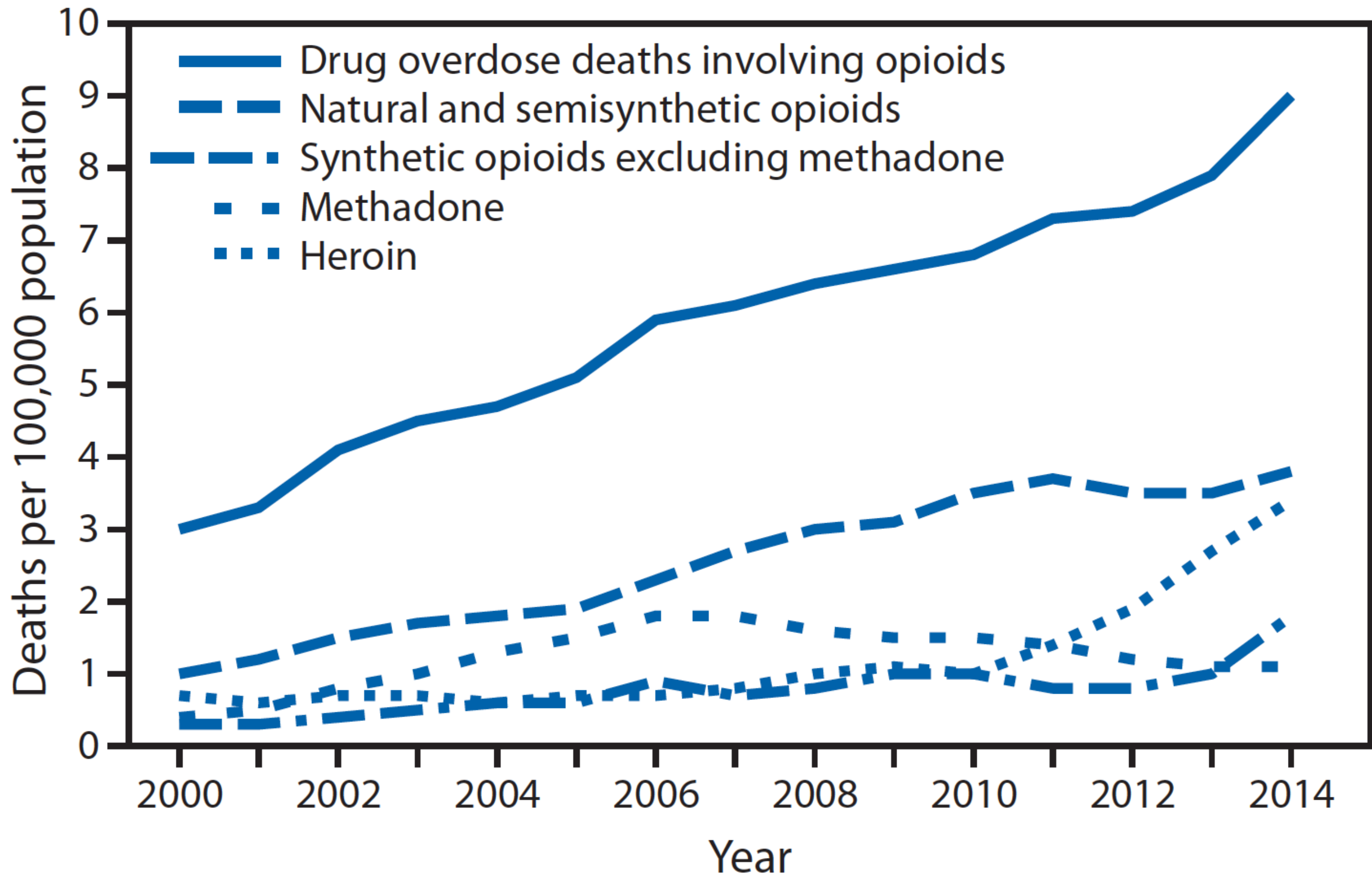


Figure 1. Number and Type of Citations of the 1980 Letter, According to Year.

Shown are number of citations of a 1980 letter to the *Journal* in which the correspondents claimed that opioid therapy rarely resulted in addiction. The citations are categorized according to whether the authors of the articles affirmed or negated the correspondents' conclusion about opioids. Details about "other" citation categories are provided in Section 2 in the Supplementary Appendix.

Leung P. NEJM 2017



Rudd RA. *MMWR*. 2016;64:1378-1382

Drug Deaths in America Are Rising Faster Than Ever

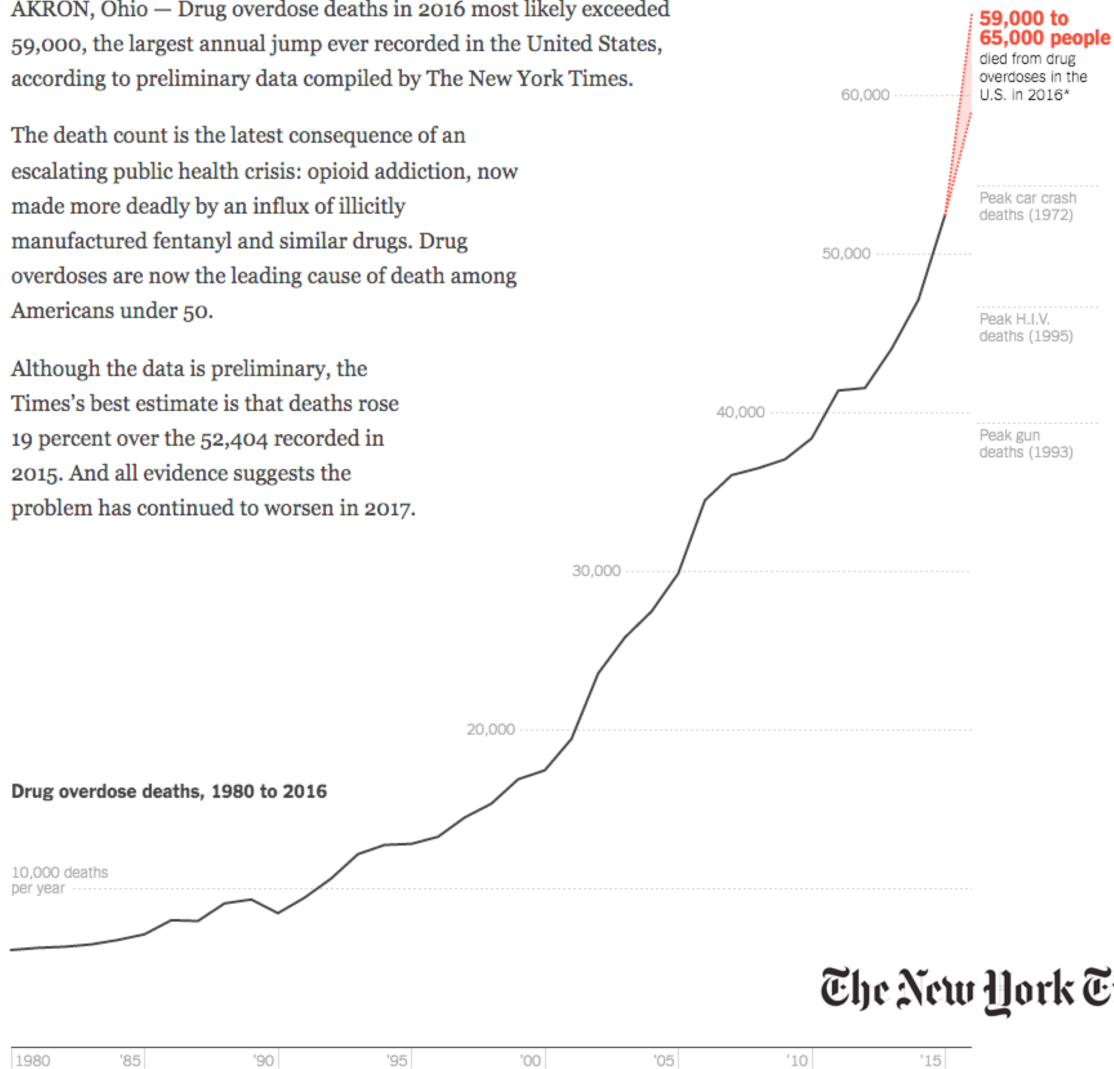
By **JOSH KATZ** JUNE 5, 2017

New data compiled from hundreds of health agencies reveals the extent of the drug overdose epidemic last year.

AKRON, Ohio — Drug overdose deaths in 2016 most likely exceeded 59,000, the largest annual jump ever recorded in the United States, according to preliminary data compiled by The New York Times.

The death count is the latest consequence of an escalating public health crisis: opioid addiction, now made more deadly by an influx of illicitly manufactured fentanyl and similar drugs. Drug overdoses are now the leading cause of death among Americans under 50.

Although the data is preliminary, the Times's best estimate is that deaths rose 19 percent over the 52,404 recorded in 2015. And all evidence suggests the problem has continued to worsen in 2017.



Drug overdose deaths, 1980 to 2016

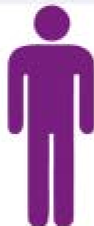
*Estimate based on preliminary data

The New York Times

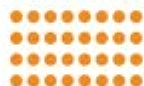
Public Health Impact
Death Is The Tip Of The iceberg

In 2008, there were 14,800 prescription painkiller deaths.[4]

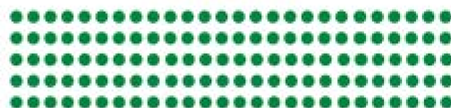
For every 1 death there are...



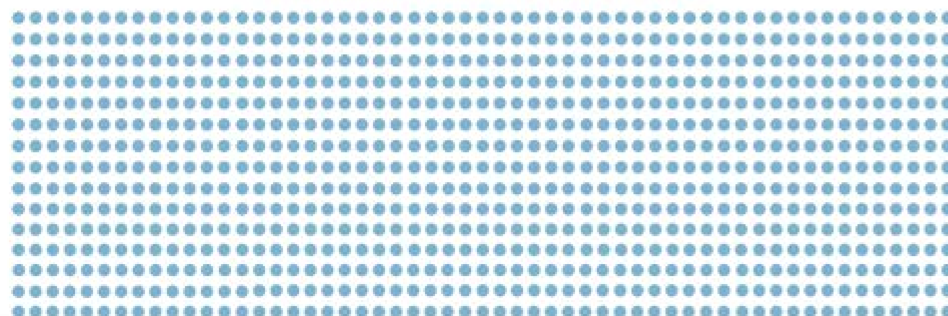
10 treatment admissions for abuse[9]



32 emergency dept visits for misuse or abuse[6]



130 people who abuse or are dependent[7]



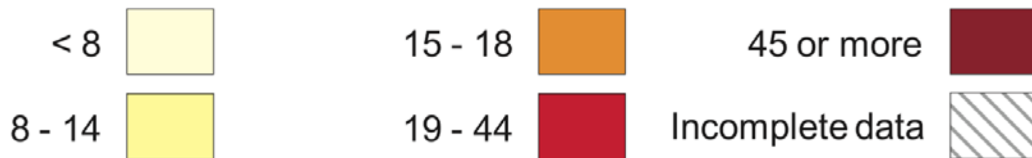
825 nonmedical users[7]

Treatment admissions are for primary use of opioids from Treatment Exposure Data set
Emergency department (ED) visits are from DAWN,Drug Abuse Warning Network, https://dawninfo.samhsa.gov/default.asp
Abuse/dependence and nonmedical use in the past month are from the National Survey on Drug Use and Health

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

1999

(range 1 - 50)

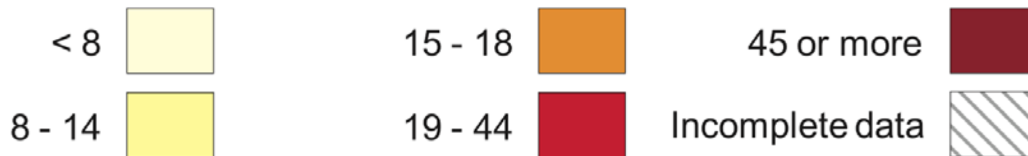


SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2001

(range 1 – 71)

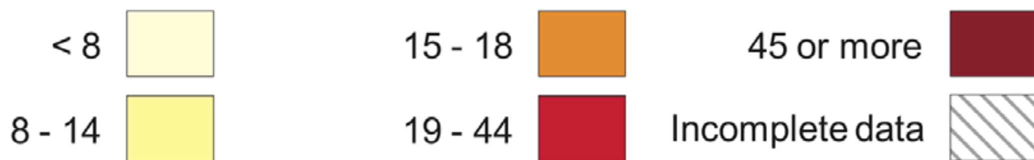


SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2003

(range 2 – 139)

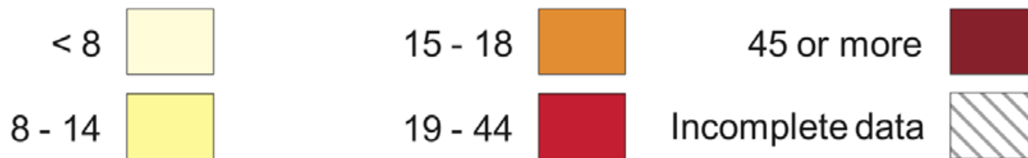


SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2005

(range 0 – 214)

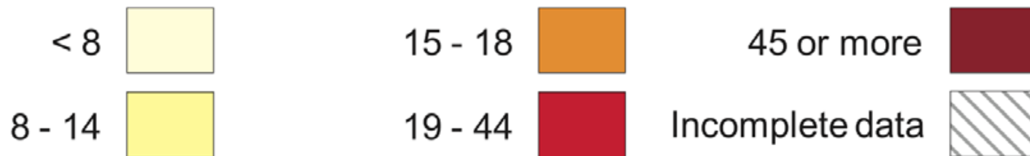


SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2007

(range 1 – 340)

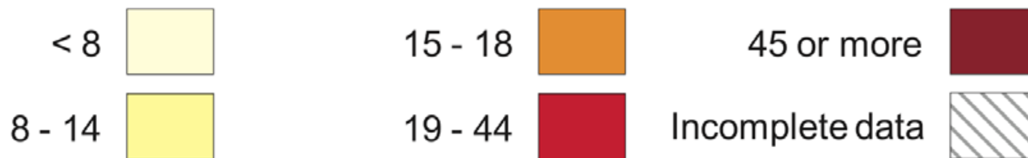


SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2009

(range 1 – 379)

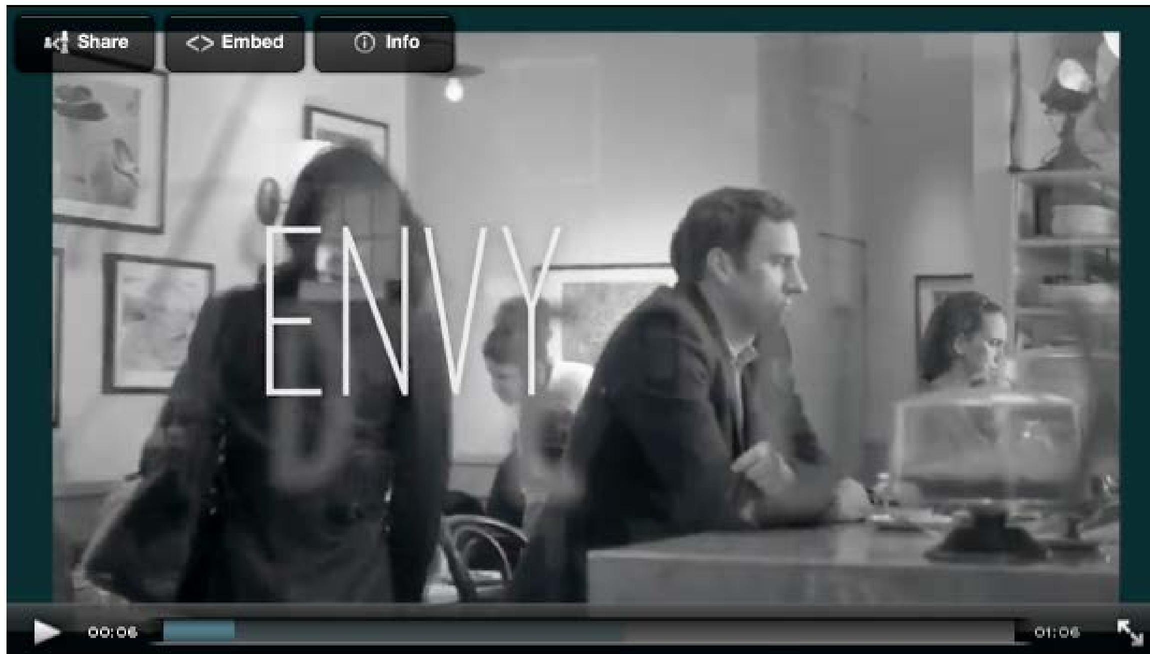


SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Everyone is talking about the weird constipation and diarrhea ads that aired during the Super Bowl

Lara O'Reilly

11h 5,601 3

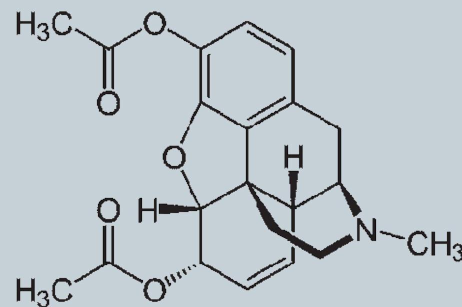


It was somewhat surprising — among the sodas, and cars, and big name consumer goods brands — to see an ad about constipation airing during the Super Bowl this year. And then to see another referencing diarrhea!

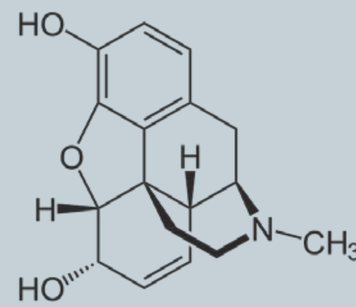
"Oxy" euphoria

- Oxycodone, fentanyl, hydromorphone, and morphine bind the mu-1 opioid receptor
  - Pain relief, but also euphoria
- Lipid solubility, receptor specificity, binding affinity

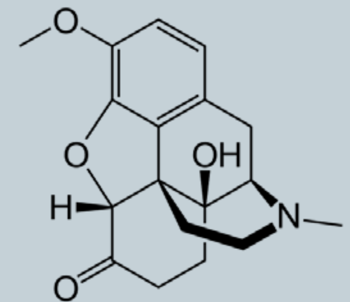
Why isnt heroin legal?
or
Is oxy just legal heroin?*



Heroin
(diacetyl morphine)



Morphine



Oxycodone

*Okie S. N Engl J Med 2010; 363:1981-1985

ORIGINAL INVESTIGATION

Long-term Analgesic Use After Low-Risk Surgery

A Retrospective Cohort Study

Asim Alam, MD; Tara Gomes, MHSc; Hong Zheng, MSc; Muhammad M. Mamdani, PharmD, MA, MPH; David N. Juurlink, MD, PhD; Chaim M. Bell, MD, PhD

Background: This study evaluated the risk of long-term analgesic use after low-risk surgery in older adults not previously prescribed analgesics.

Methods: We conducted a retrospective cohort study using linked, population-based administrative data in Ontario, Canada, from April 1, 1997, through December 31, 2008. We identified Ontario residents 66 years and older who were

to 30 145 patients (7.7%) at 1 year from surgery. An increase in the use of oxycodone was found during this time (from 5.4% within 7 days to 15.9% at 1 year). In our primary analysis, patients receiving an opioid prescription within 7 days of surgery were 44% more likely to become long-term opioid users within 1 year compared with those who received no such prescription (adjusted odds

Patients receiving an opioid prescription within 7 days of surgery were 44% more likely to become long-term opioid users within 1 year compared with those who received no such prescription (adjusted odds ratio, 1.44; 95% CI, 1.39-1.50).

SPECIAL ARTICLE

Opioid-Prescribing Patterns of Emergency Physicians and Risk of Long-Term Use

Michael L. Barnett, M.D., Andrew R. Olenski, B.S., and Anupam B. Jena, M.D., Ph.D.

ABSTRACT

BACKGROUND

Increasing overuse of opioids in the United States may be driven in part by physician prescribing. However, the extent to which individual physicians vary in opioid prescribing and the implications of that variation for long-term opioid use and adverse outcomes in patients are unknown.

METHODS

We performed a retrospective analysis involving Medicare beneficiaries who had an index emergency department visit in the period from 2008 through 2011 and had not received prescriptions for opioids within 6 months before that visit. After identifying the emergency physicians within a hospital who cared for the patients, we categorized the physicians as being high-intensity or low-intensity opioid prescrib-

CONCLUSIONS

Wide variation in rates of opioid prescribing existed among physicians practicing within the same emergency department, and rates of long-term opioid use were increased among patients who had not previously received opioids and received treatment from high-intensity opioid prescribers. (Funded by the National Institutes of Health.)

Early Prescription Opioid Use for Musculoskeleta[l] Disorders and Work Outcomes

A Systematic Review of the Literature

Nancy Carnide, MSc,† Sheilah Hogg-Johnson, PhD,*† Pierre Côté, DC, PhD,†‡ Emma Irvin, BA,* Dwayne Van Eerd, PhD,*§ Mieke Koehoorn, PhD,*|| and Andrea D. Furlan, MD, PhD*#*

Objectives: Musculoskeletal disorders (MSDs) are a common source of work disability. Opioid prescribing for MSDs has been on the rise, despite a lack of data on effectiveness. The objective of this study was to conduct a systematic review to determine whether early receipt of opioids is associated with future work outcomes among workers with MSDs compared with other analgesics, no analgesics, or placebo.

Methods: MEDLINE, EMBASE, CINAHL, and CENTRAL were searched from inception to 2014 and reference lists were scanned. Studies were included if opioids were prescribed within 12 weeks of MSD onset. Eligible outcomes included absenteeism, work status, receiving disability payments, and functional status. Two reviewers independently reviewed articles for relevance, risk of bias, and data extraction using standardized forms. Data synthesis using best evidence synthesis methods was planned.

Discussion: Current literature suggests that opioids provided within the first 12 weeks of onset of an MSD are associated with prolonged work disability. However, the conclusions of these studies need testing in a high-quality study that addresses the methodological shortcomings identified in the current review.

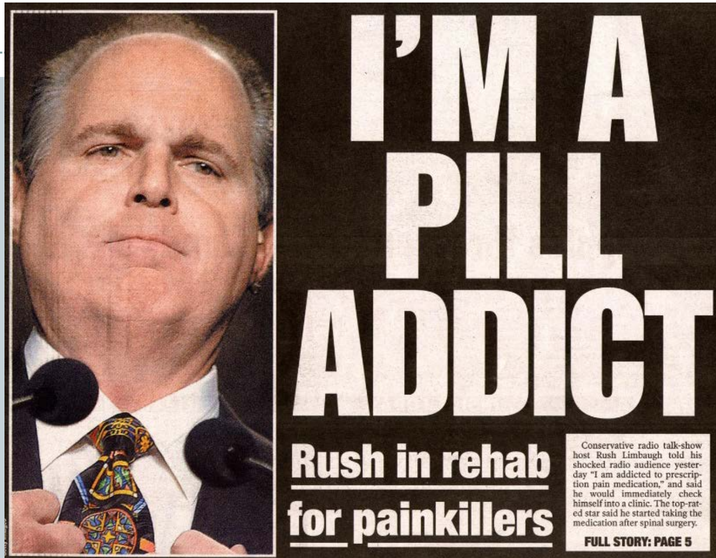
Key Words: opioids, musculoskeletal disorders, work outcomes, systematic review, risk of bias

(*Clin J Pain* 2017;33:647–658)

Received for publication May 11, 2016; revised December 12, 2016; accepted October 22, 2016.

From the *Institute for Work & Health, Toronto, ON, Canada; †Dalla Lana School of Public Health; #Department of Medicine, Faculty of Medicine, University of Toronto, Toronto, ON, Canada; ‡Faculty of Health Sciences, University of Ontario Institute of Technology, Oshawa ON, Canada; §School of Public Health and Health Systems, University of Waterloo, Waterloo, ON Canada; and ||School of Population and Public Health, Faculty of Medicine, University of British Columbia, Vancouver, BC, Canada.

Prescription for Addiction



I'M A PILL ADDICT

Rush in rehab for painkillers

Conservative radio talk-show host Rush Limbaugh told his shocked radio audience yesterday "I am addicted to prescription pain medication," and said he would immediately check himself into a clinic. The top-rated star said he started taking the medication after spinal surgery.

FULL STORY: PAGE 5

Rush Limbaugh
Conservative Radio Host

Matthew Perry
"Friends"

Bad tooth, dental visit, addict

Legal script changes life

Jul. 27, 2013 | Comments

Pin it

t Clement works on a fence at a home in Byram. Clement, who was hooked on the painkiller being prescribed the medication because of a dental issue, is now able to cope with the issue with edication. / Rick Guy/The Clarion-Ledger

tchell

Somehow, Scott Clement survived.

On Labor Day weekend in 1997, the 35-year-old insurance agent throbbed with pain from an abscessed tooth and called a dentist for medicine.

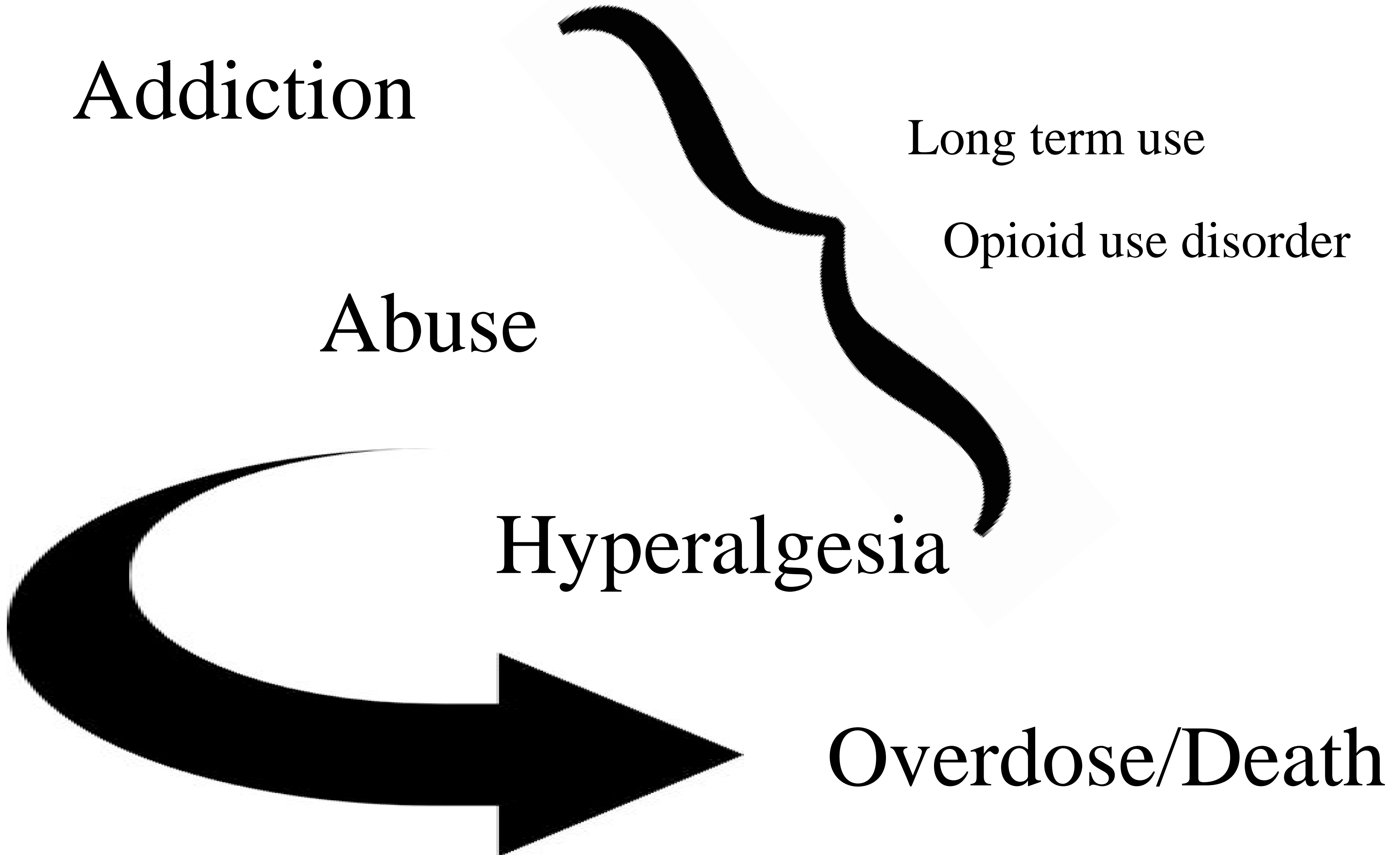
Days later, struggling to sleep, he took a couple of the oxycodone painkillers and found himself overwhelmed by "a ridiculous sense of well-being," he said.

It began his descent into addiction.

Going through the rest of the oxycodone, Clement returned to the dentist, who refused to prescribe more. He went online instead, ordering as many as he could.

UPS made regular deliveries to his insurance agency, and he was gulping 40 pills a day.

Consequences of opioid prescribing

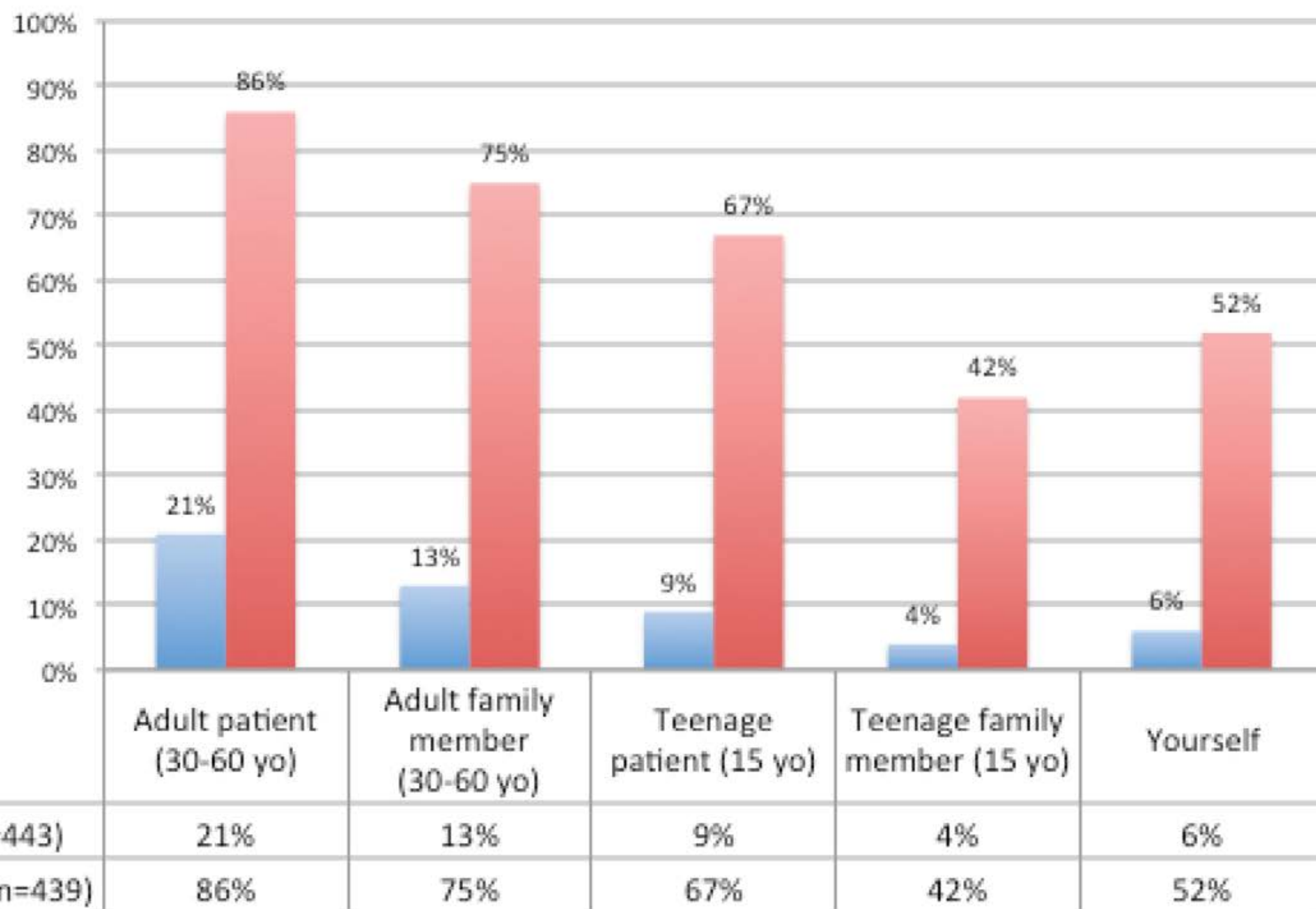


An Epidemic of Iatrogenic Addiction

The Best Way To Treat Opioid Addiction
Is To Prevent It

You Cannot Develop Addiction
Without Exposure To An Opioid

**Keep Opioid Naïve Patients
Opioid Naïve**



	Adult patient (30-60 yo)	Adult family member (30-60 yo)	Teenage patient (15 yo)	Teenage family member (15 yo)	Yourself
Ankle Sprain (n=443)	21%	13%	9%	4%	6%
Ankle Fracture (n=439)	86%	75%	67%	42%	52%

Pomerleau AC, et al. *West J Emerg Med*. 2016;17(6):791-797.

Would you give your child HEROIN for a sports injury?

Ask Your Doctor How Prescription Drugs Can Lead to Heroin Abuse.

BEFORE THEY PRESCRIBE - YOU DECIDE.

Strategies to Curb the Prescription Opioid Problem

Pain Guidelines

SPECIAL ARTICLE

Opioids for chronic noncancer pain

A position paper of the American Academy of Neurology

Gary M. Franklin, MD, MPH

Correspondence to Dr. Franklin: meddir@uw.edu

ABSTRACT

The Patient Safety Subcommittee requested a review of the science an
idly emerging public health epidemic of prescription opioid-related mor
States. Over 100,000 persons have died, directly or indirectly, from
States since policies changed in the late 1990s. In the highest-risk
deaths have exceeded mortality from both firearms and motor vehi
evidence for significant short-term pain relief, there is no substantial e
relief or improved function over long periods of time without incurring
dence, or addiction. The objectives of the article are to review the follo
of the epidemic; (2) the evidence for safety and effectiveness of opioid
state policy responses; and (4) recommendations for neurologists in
practices/universal precautions most likely to improve effective and s
the likelihood of severe adverse and overdose events. Neurology® 201

Neurology 2014;83:1277-1284

Centers for Disease Control and Prevention

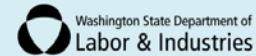
MMWR

Morbidity and Mortality Weekly Report

Early Release / Vol. 65

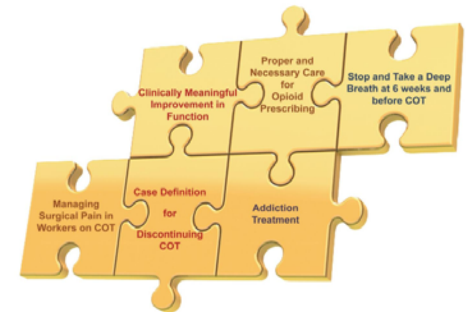
March 15, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016



Guideline for Prescribing Opioids to Treat Pain in Injured Workers

Effective July 1, 2013



Office of the Medical Director

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.

New York City Department of Health and Mental Hygiene

New York City Emergency Department Discharge Opioid Prescribing Guidelines

Note: *These guidelines do not replace clinical judgment in the appropriate care of patients nor are they intended to provide guidance on the management of patients while in the ED.*

In the management of patients with acute or chronic non-cancer pain discharged from an emergency department,

1. Consider short-acting opioid analgesics for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.
2. Start with the lowest possible effective dose if opioid analgesics are considered for the management of pain.
3. Prescribe no more than a short course of opioid analgesics for acute pain. Most patients require no more than three days.
4. To assess for opioid misuse or addiction, use targeted history or validated screening tools. Prescribers can also access the New York State Controlled Substance Information (CSI) on Dispensed Prescriptions Program for information on patients' controlled substance prescription history.
5. Avoid initiating treatment with long-acting or extended-release opioid analgesics.
6. Address exacerbations of chronic or recurrent pain conditions with non-opioid analgesics, non-pharmacological therapies, and/or referral to specialists for follow-up, all as clinically appropriate.
7. Avoid when possible prescribing opioid analgesics to patients currently taking benzodiazepines and/or other opioids. Consider other risk factors for consequential respiratory depression.
8. Attempt to confirm with the treating physician the validity of lost, stolen, or destroyed prescriptions. If considered appropriate, replace the prescription only with a one-to two-day supply.
9. Provide information about opioid analgesics to patients receiving a prescription, such as the risks of overdose and dependence/ addiction, as well as safe storage and proper disposal of unused medications.

PRESCRIBING OPIOID PAINKILLERS IN THE EMERGENCY DEPARTMENT

People sometimes misuse opioid painkillers, either by taking them in ways they weren't prescribed or by taking someone else's prescription. In New York City, one in four overdose deaths involve opioid painkillers. Our emergency department will only provide pain relief options that are safe and appropriate.

FOR YOUR SAFETY, WE DO NOT:

* **Prescribe long-acting opioid painkillers.**
  Such as oxycodone (OxyContin®), morphine (MSContin®), fentanyl patches (Duragesic®) or methadone.
* **Prescribe more than a short course of opioid painkillers.**
  3 days in most cases.
* **Refill lost, stolen or destroyed prescriptions.**

Prescription opioid painkillers can be just as dangerous as illegal drugs.

- Opioid painkillers can cause confusion, drowsiness and increased sensitivity to pain.
- People can become dependent on or addicted to opioid painkillers.
- An overdose of opioid painkillers can cause a person to stop breathing and die.

Keep your prescription opioid painkillers safe!

- Keep opioid painkillers in their original labeled containers.
- Keep opioid painkillers out of sight and out of reach of children, preferably in a locked cabinet or on a high shelf.
- Get rid of opioid painkillers you are no longer using by flushing them down the toilet.

Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

July 15, 2016

New Legislation Enacted to Limit Initial Opioid Prescribing to a 7 Day Supply for Acute Pain

TO FURTHER REDUCE OVERPRESCRIBING OF OPIOID MEDICATIONS, EFFECTIVE JULY 22, 2016, INITIAL O
LIMITED TO A 7 DAY SUPPLY PER N
SECTION 3331, 5. (b), (c). A practitione
supply of an opioid medication for acute
resulting from disease, accidental or int
practitioner reasonably expects to last c
NOT include prescribing for chronic pai
hospice or other end-of-life care, or pair
practices. Upon any subsequent consul
issue, in accordance with existing rules
or new prescription for an opioid.

WORKERS COMP

New Jersey's 5-day opioid prescription bill signed into law

Louise Esola

2/17/2017 1:42:00 PM

SHARE

Prescription Drug Benefits | Prescription Drug Management

In a little less than 90 days doctors, in New Jersey who want to prescribe opioids to their patients for the first time will only be able to prescribe them for five days.

New Jersey Gov. Chris Christie on Wednesday signed into law Assembly Bill 3, which introduced sweeping changes in opioid prescribing and addiction treatment. Workers compensation experts have stated that such laws governing the timing and amount of prescription will apply to all licensed doctors, regardless of payer.

The New Jersey law mandates the shortest time limit in the United States, according to Mark Pew, senior vice president at Prium, a Duluth, Georgia-based medical cost management firm.

RELATED STORIES

Pilot program aims to help
opioid use

California closed drug form
spotlight on opioids

Opioids create dilemma fo

New Jersey may limit opio

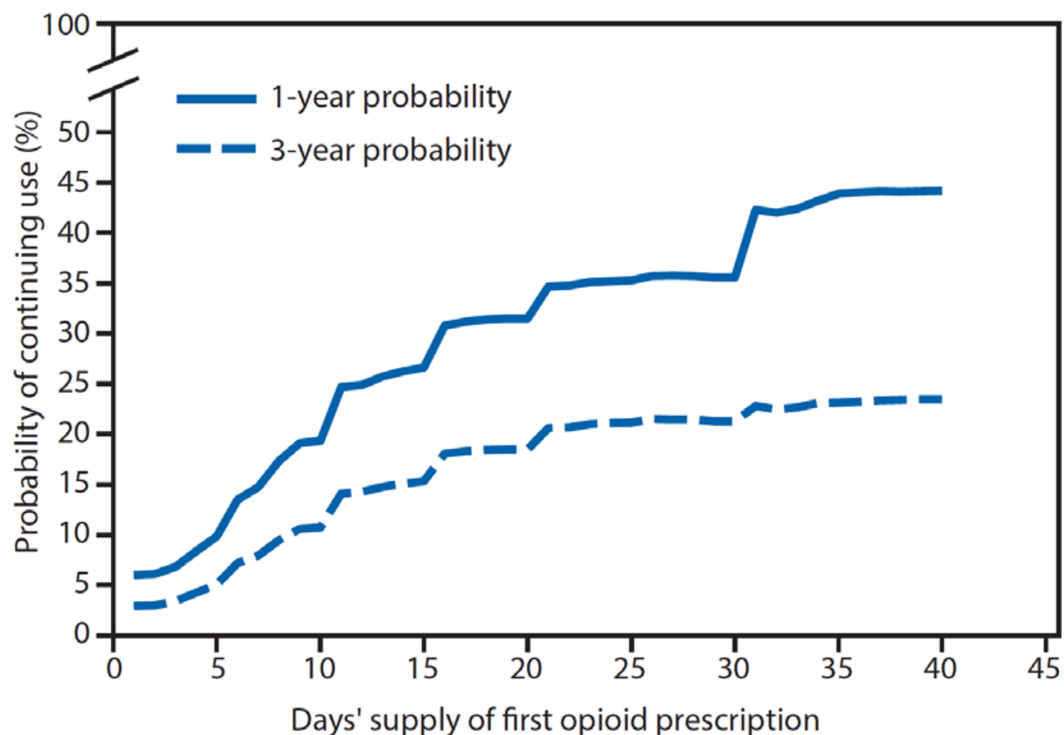
Tidal wave of opioid-relate

Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015

Anuj Shah[1]; Corey J. Hayes, PharmD[1,2]; Bradley C. Martin, PharmD, PhD[1]

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 66 / No. 10
March 17, 2017

FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



* Days' supply of the first prescription is expressed in days (1–40) in 1-day increments. If a patient had multiple prescriptions on the first day, the prescription with the longest days' supply was considered the first prescription.

NJ Prescription Monitoring Program (NJPMP)

New Jersey Division of Consumer Affairs

DCA HOME | NJPMP INFO | PRESCRIBERS / PHARMACISTS | ENFORCEMENT | TREATMENT | MEDIA | BE AWARxE | PROJECT MEDICINE DROP

Practitioners: New Registration
Click Here

Information about the New NJ PMP Law
Click Here

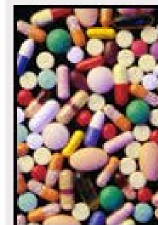
Proposed regulations for the Prescription Monitoring Program were published in the NJ Register on 11/16/15.

(View Proposed Regulations)

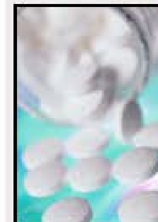
For too many New Jerseyans, addiction begins in the medicine cabinet.

Please be advised that beginning March 1, 2015, pharmacies will be required to report information to the NJPMP on a daily basis using the ASAP 4.2 format. . Prescriptions must be reported to the database no more than one (1) business day after the date the controlled substance was dispensed. In order to help facilitate any software conversion that may be necessary, the NJPMP will defer enforcement until September 1, 2015.

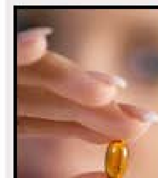
The New Jersey Prescription Monitoring Program (NJPMP) is an important component of the New Jersey Division of Consumer Affairs' initiative to halt the abuse and diversion of prescription drugs.



How many Americans die from an overdose caused by prescription painkiller abuse every day?



How many teenagers out of 5 mistakenly believe prescription drugs are "much safer" than illegal drugs?



Is the number of U.S. teenagers and adults who abuse prescription drugs greater than those who use cocaine,

She gets her hair from her mom.
Her eyes from her dad.
And her drugs from her
grandma's medicine cabinet.

BE AWARE. DON'T SHARE.
www.lockyourmeds.org

Strategies to Curb the Prescription Opioid Problem

Action/Reaction for Aberrant Use

- Counseling for compliance
- Taper and discontinue if concerns arise
  - Exit strategy
- Refer for addiction treatment
  - 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 Guidelines 2016]

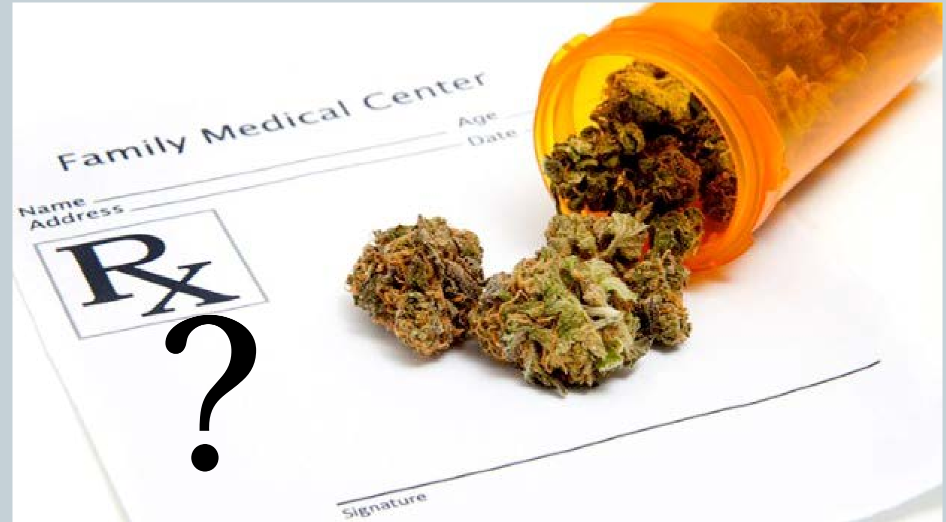
Some Alternatives to Opioids

- Rest, Ice, Compression, Elevation
- Immobilization
- NSAIDs, APAP (not tramadol)

- Antidepressants
- Anticonvulsants

- Exercise
- Weight loss
- Yoga
- Stress reduction, meditation
- Guided imagry
- Cognitive behavioral therapy
- Herbal medicine
- Aromatherapy
- Homeopathy

- Physical therapy
- TENS
- Anesthetic blocks
- Accupuncture
- Biofeedback



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Intravenous Subdissociative-Dose Ketamine Versus Morphine for Analgesia in the Emergency Department: A Randomized Controlled Trial

Sergey Motov, MD*; Bradley Rockoff, MD; Victor Cohen, PharmD; Illya Pushkar, MPH; Antonios Likourezos, MA, MPH; Courtney McKay, PharmD; Emil Soleyman-Zomalan, MD; Peter Homel, PhD; Victoria Terentiev, BA; Christian Fromm, MD

Contents lists available at ScienceDirect

American Journal of Emergency Medicine

journal homepage: www.elsevier.com/locate/ajem

Ultrasound-guided serratus plane block for ED rib fracture pain control☆,☆☆

Instead of opioids, an E.R. in New Jersey now ... alter... injec...

By JAN ...

The Use of Intravenous Lidocaine for Renal Colic in the Emergency Department

Annals of Pharmacotherapy
2016, Vol. 50(3) 242
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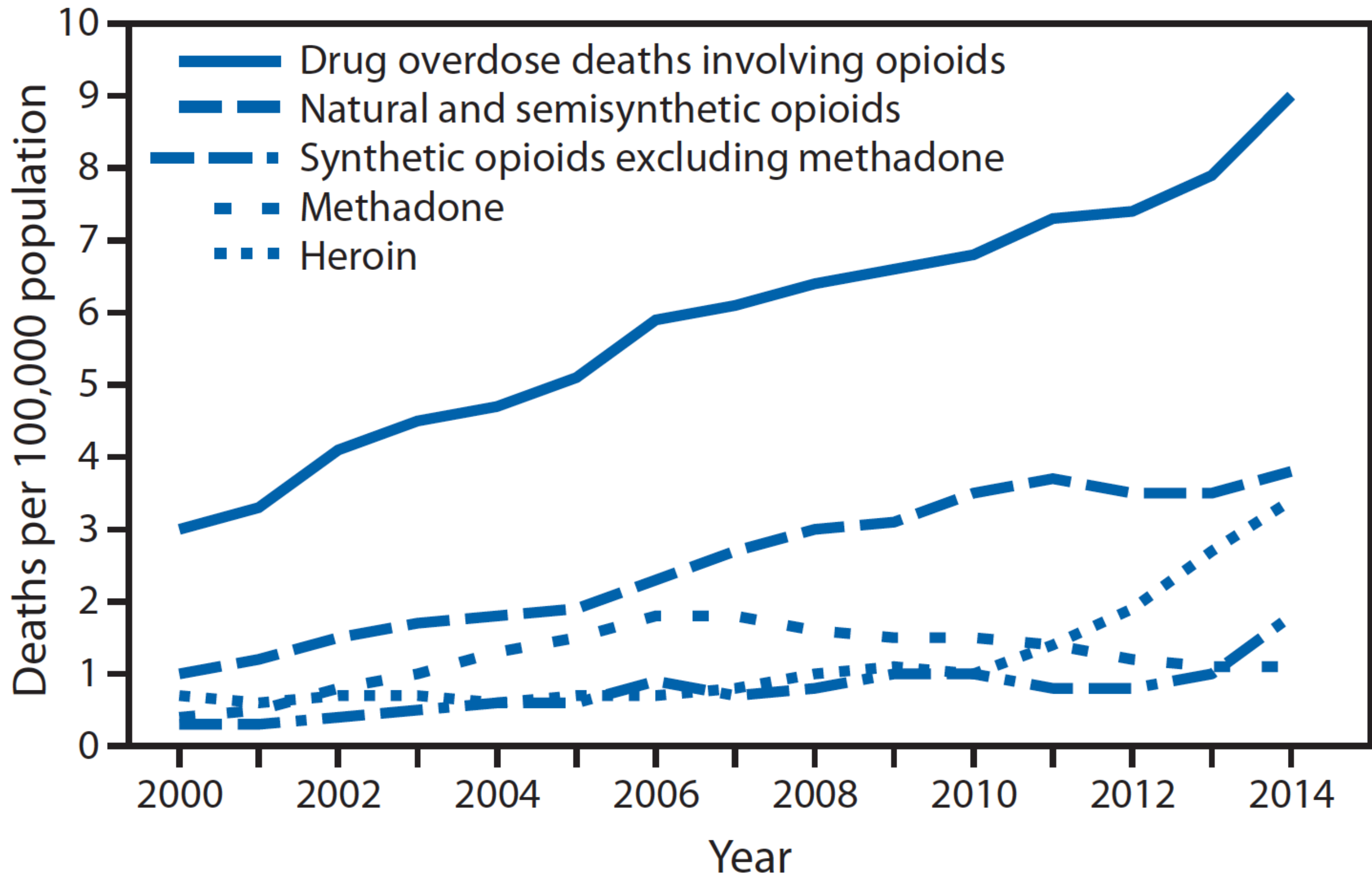
DOI: 10.1177/1060028015625661
aop.sagepub.com

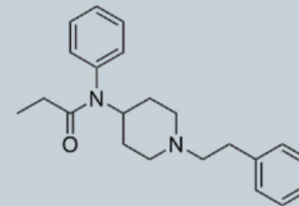
FIGURE 2. Drug overdose deaths* involving opioids,[†,§] by type of opioid[¶] — United States, 2000–2014



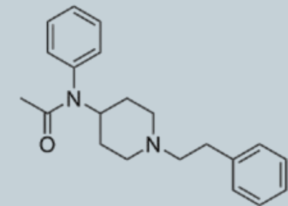
Rudd RA. *MMWR*. 2016;64:1378-1382

Fentanyl and Analogs

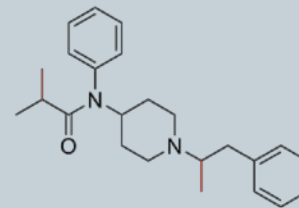
- 80-100 fold more potent than morphine
  - 35-50 fold more potent than heroin
- Initially derived from pharmaceutical sources
- Currently largely nonpharmaceutical (NPF)
  - Many analogues



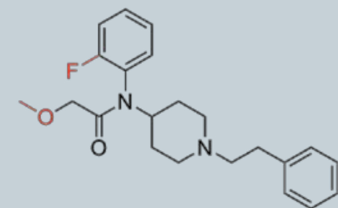
(a) Fentanyl



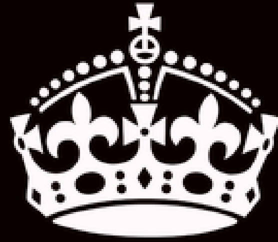
(b) Acetyl fentanyl



(c) (Iso)butyryl fentanyl



(d) Ocfentanyl



KEEP
CALM
AND
CARRY
NALOXONE

OTHER OPIOID MYTHS

Pain is a vital sign

TAMPER RESISTANT FORMULATIONS ARE

There is an epidemic of untreated pain

Pseudoaddiction exists

It is better to over treat than to under treat pain

Goal is "pain score zero"

Opioids are effective in chronic non-cancer pain

We can educate our way out of the crisis

High dose opioids are safe if opioid tolerant

Always assume a patient claiming pain is in pain

We are responsible to help with the solution…

- Prescribe as if for your family or friend
  - PDMP
- Keep opioid naïve patients opioid naïve (when possible)
  - Prevention is the key to reducing the toll of addiction.
- Integrate the risks of addiction and overdose into your opioid prescribing
  - Our patients should hear about these risks
- Rationalize expectations for pain relief
- Recognize symptoms or signs of aberrant drug use and do something

Thank you.

Questions?
Comments?
Concerns?

Feel free to email me at:
lewis.nelson@rutgers.edu