



PROP

Physicians for Responsible
Opioid Prescribing

Responding to the Prescription Opioid and Heroin Crisis: *An Epidemic of Addiction*

Andrew Kolodny, M.D.

*Chief Medical Officer, Phoenix House Foundation Inc.
Executive Director, Physicians for Responsible Opioid Prescribing
Senior Scientist, Heller School for Social Policy and Management, Brandeis University
Research Professor, Global Institute of Public Health, New York University*




Phoenix House
Rising Above Addiction

Conflict of Interests

I have no relevant financial relationships to disclose.

Opium





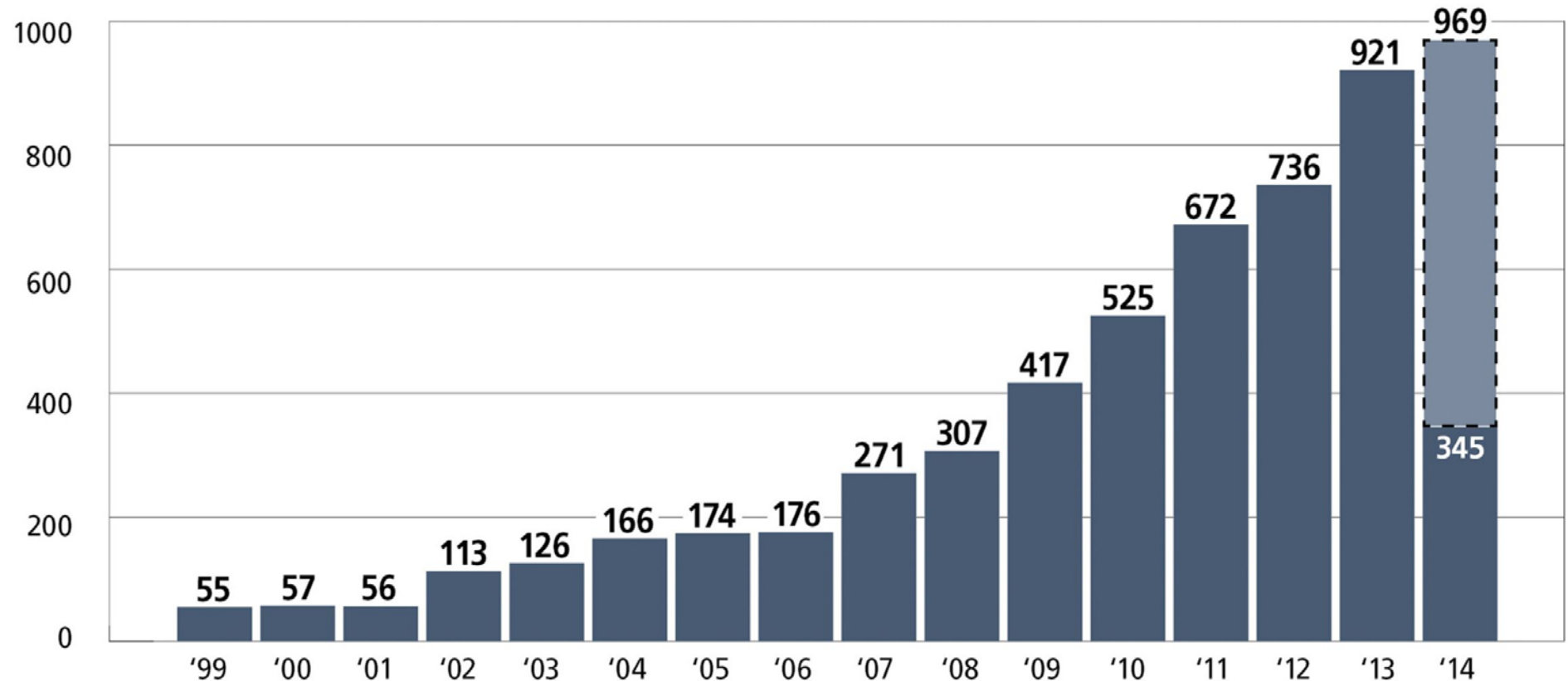
"OIC IS A DIFFERENT
TYPE OF CONSTIPATION"

A billboard advertisement featuring a snail whose shell is a white, round opioid pill with the word "OPIOID" embossed on it. The snail is moving to the left. Below the snail, the text reads: "OIC IS A DIFFERENT TYPE OF CONSTIPATION".



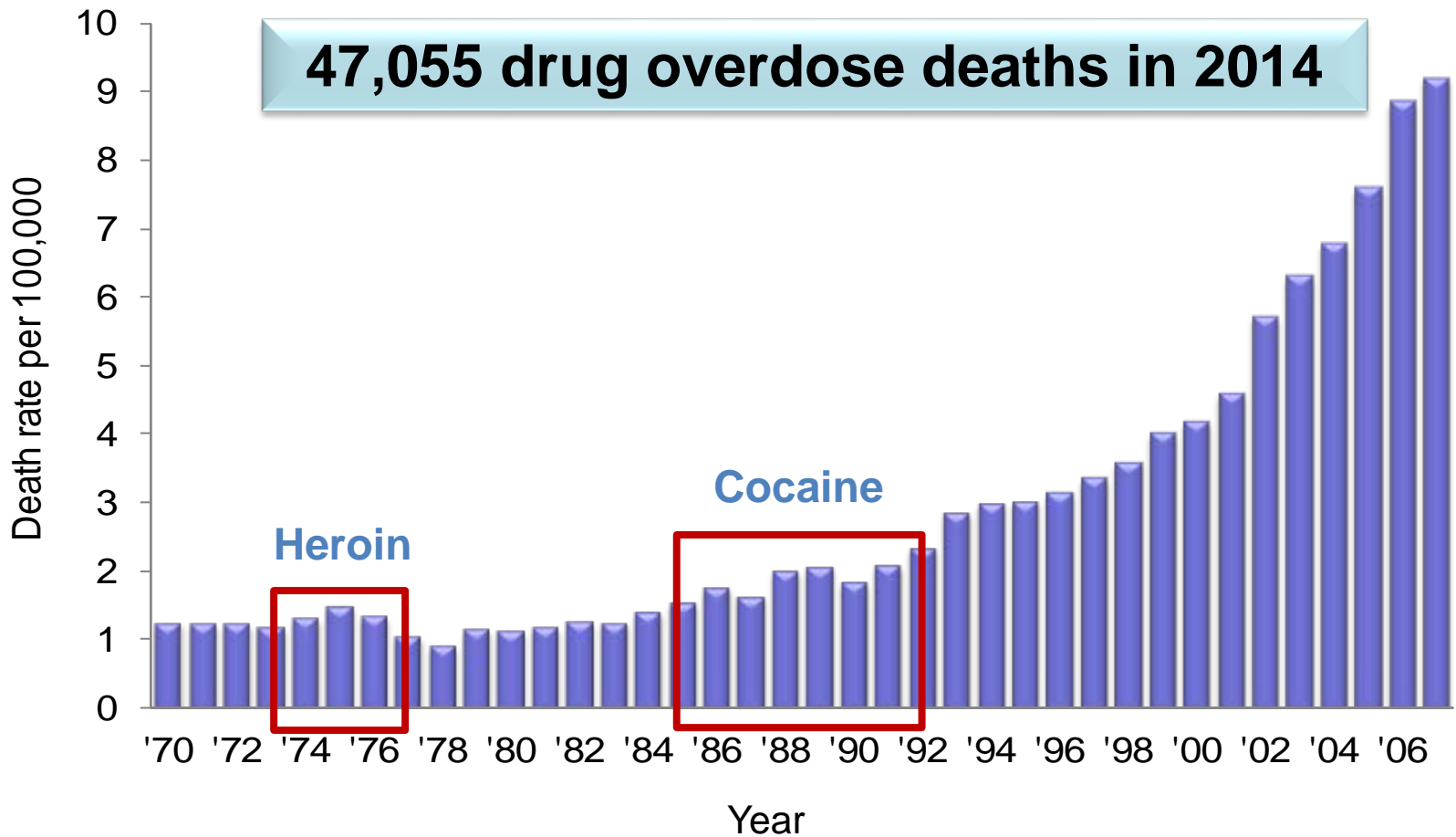
Rapid rise of infant drug dependency

In a decade, Tennessee has seen a tenfold increase in babies born dependent on drugs. Here's a tally of the number of hospitalizations since 1999. There are 345 cases logged in Tennessee as of the beginning of June 2014. Experts estimate that number will rise closer to 969 by the end of the year.

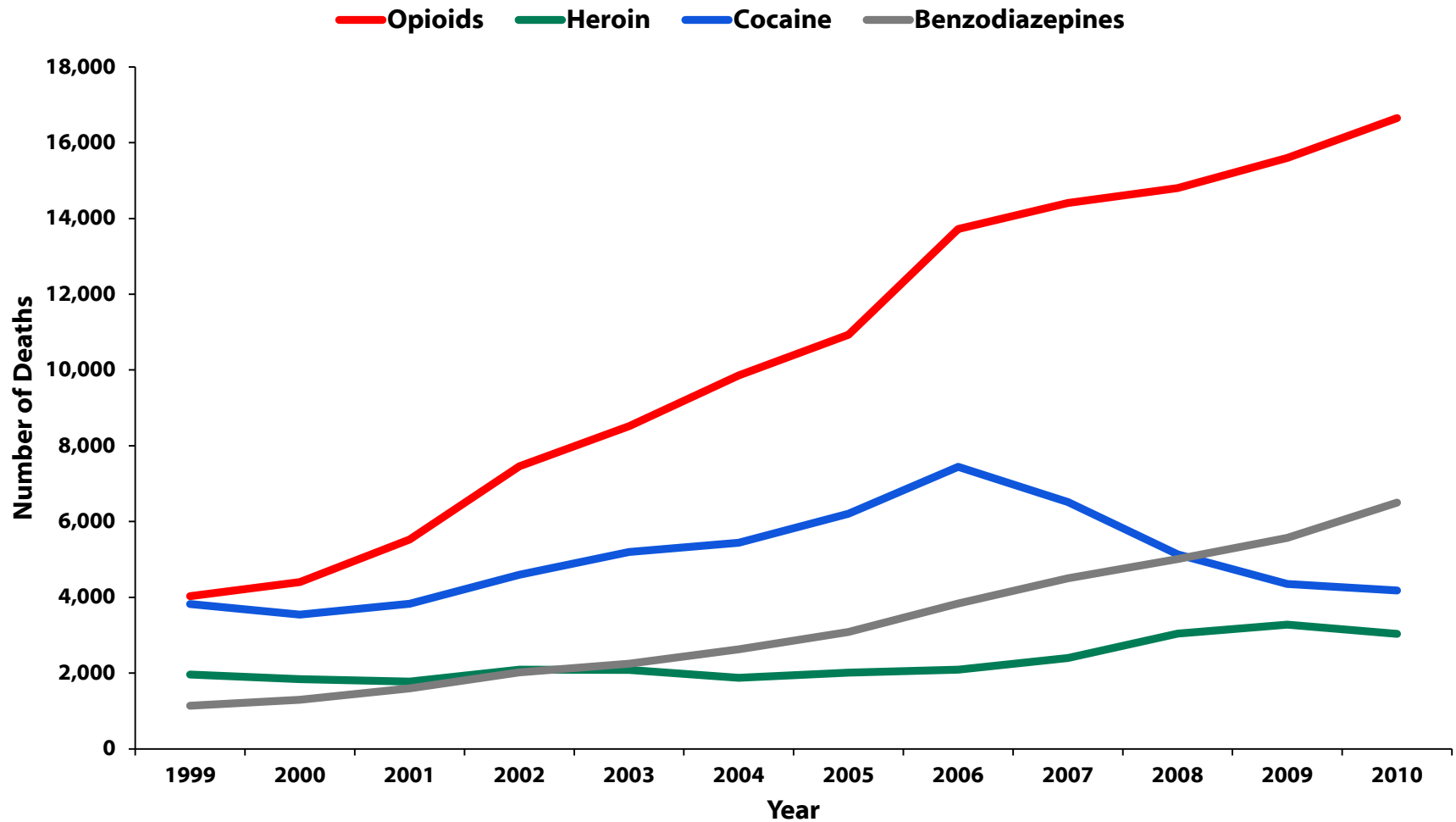


Source: Tenn. Dept. of Health

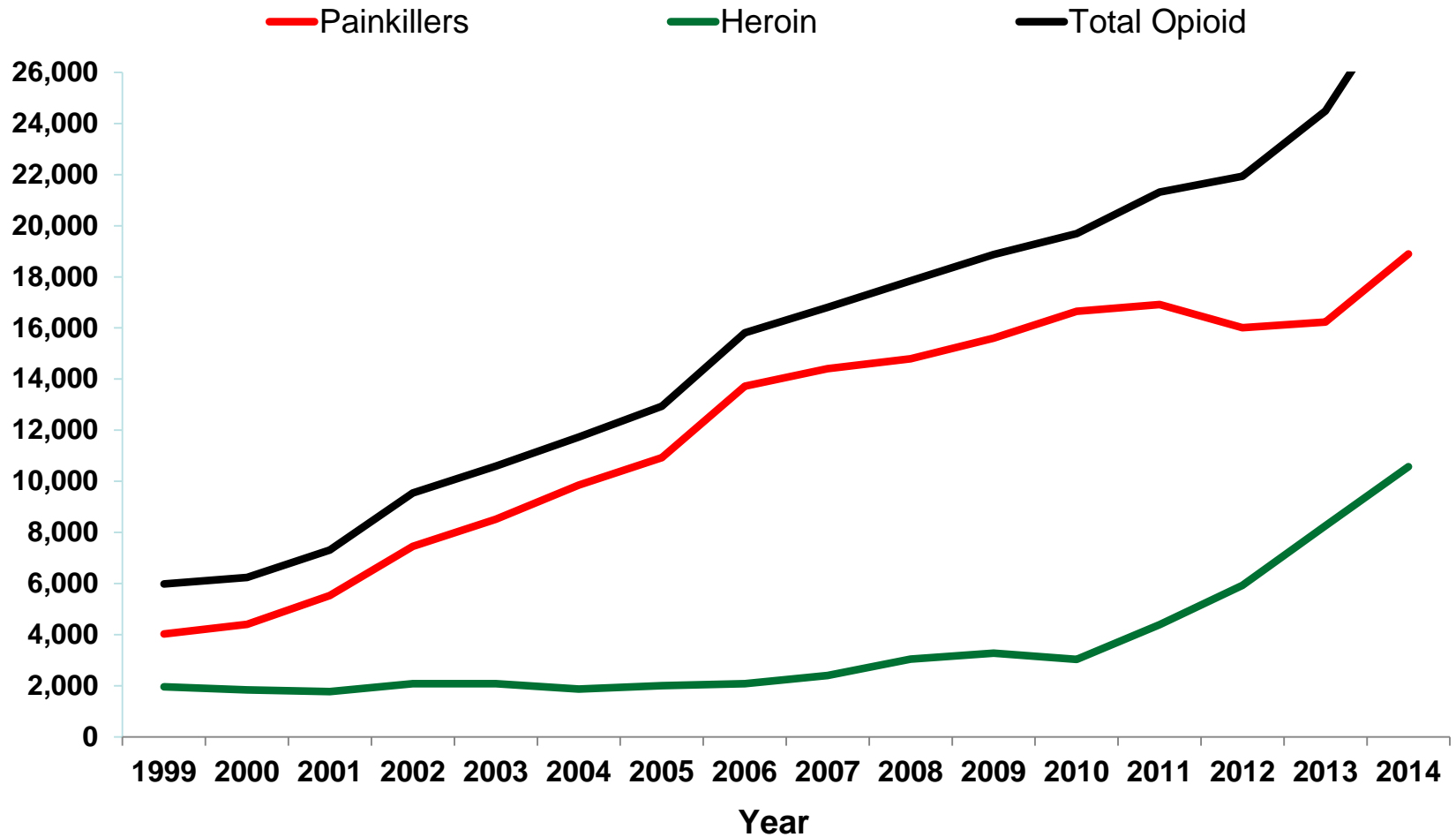
Unintentional Drug Overdose Deaths United States, 1970–2007



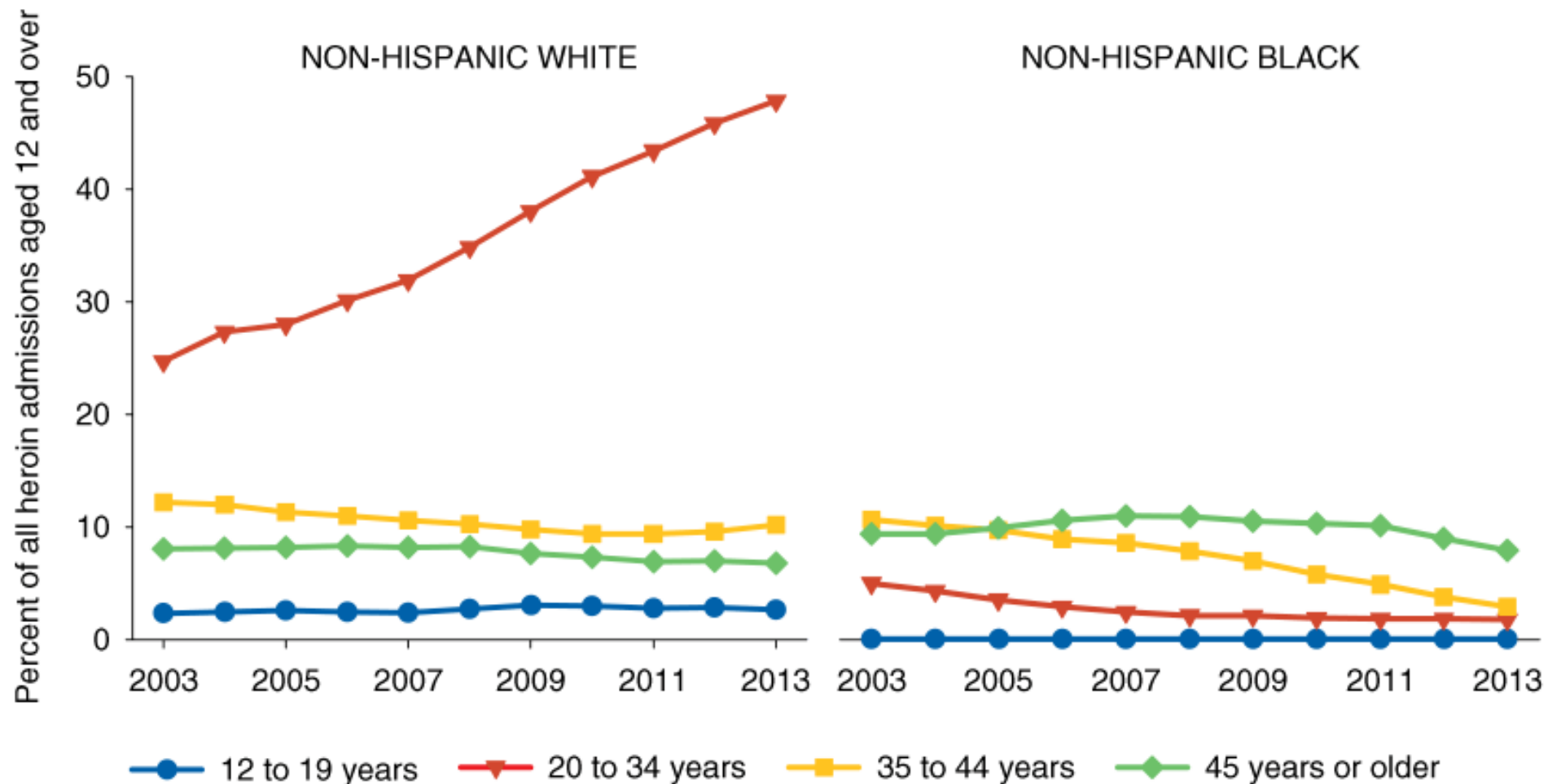
Drug Overdose Deaths by Major Drug Type, United States, 1999–2010



Opioid Related Overdose Deaths United States, 1999-2014

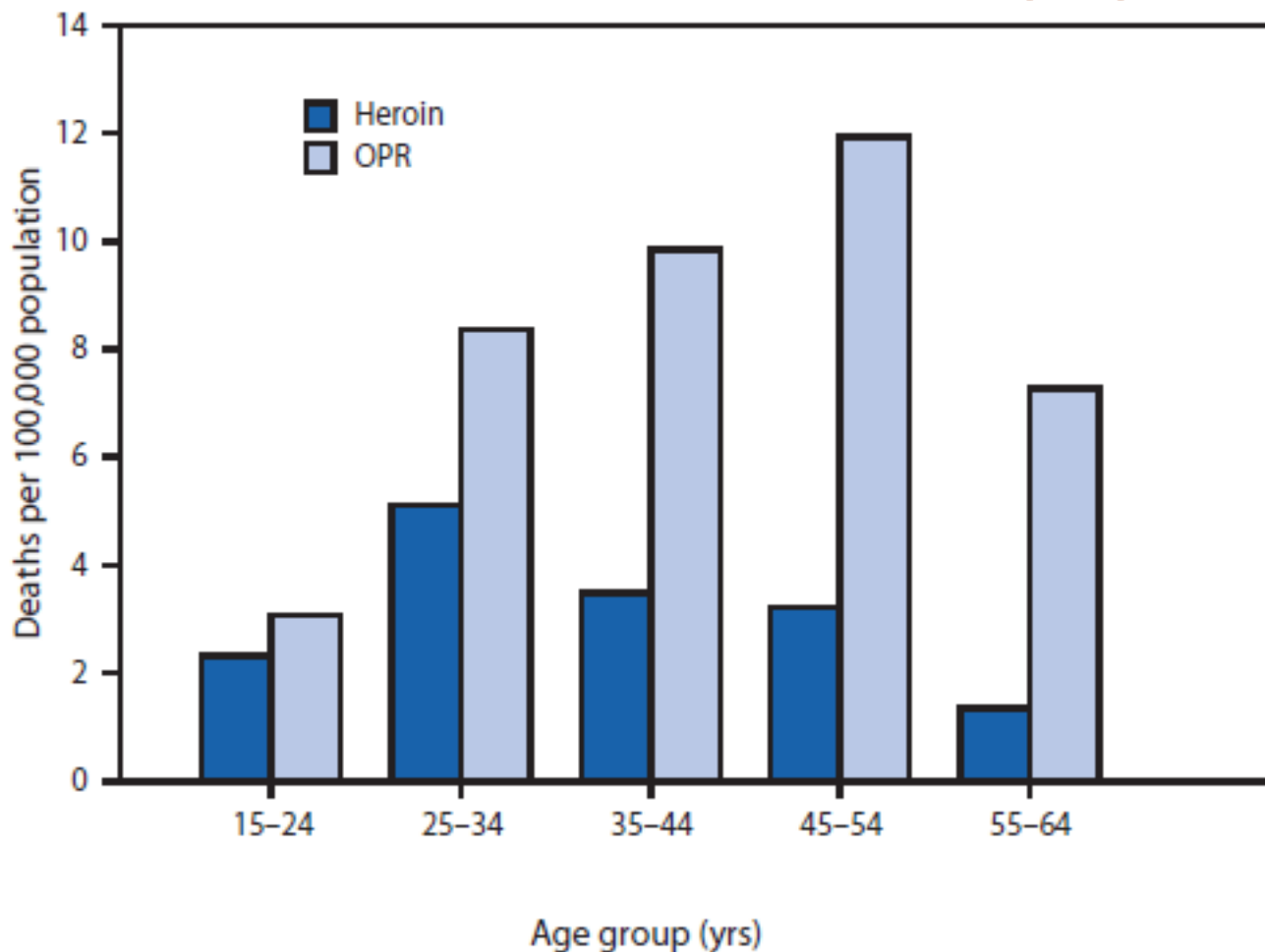


Heroin treatment admissions : 2003-2013



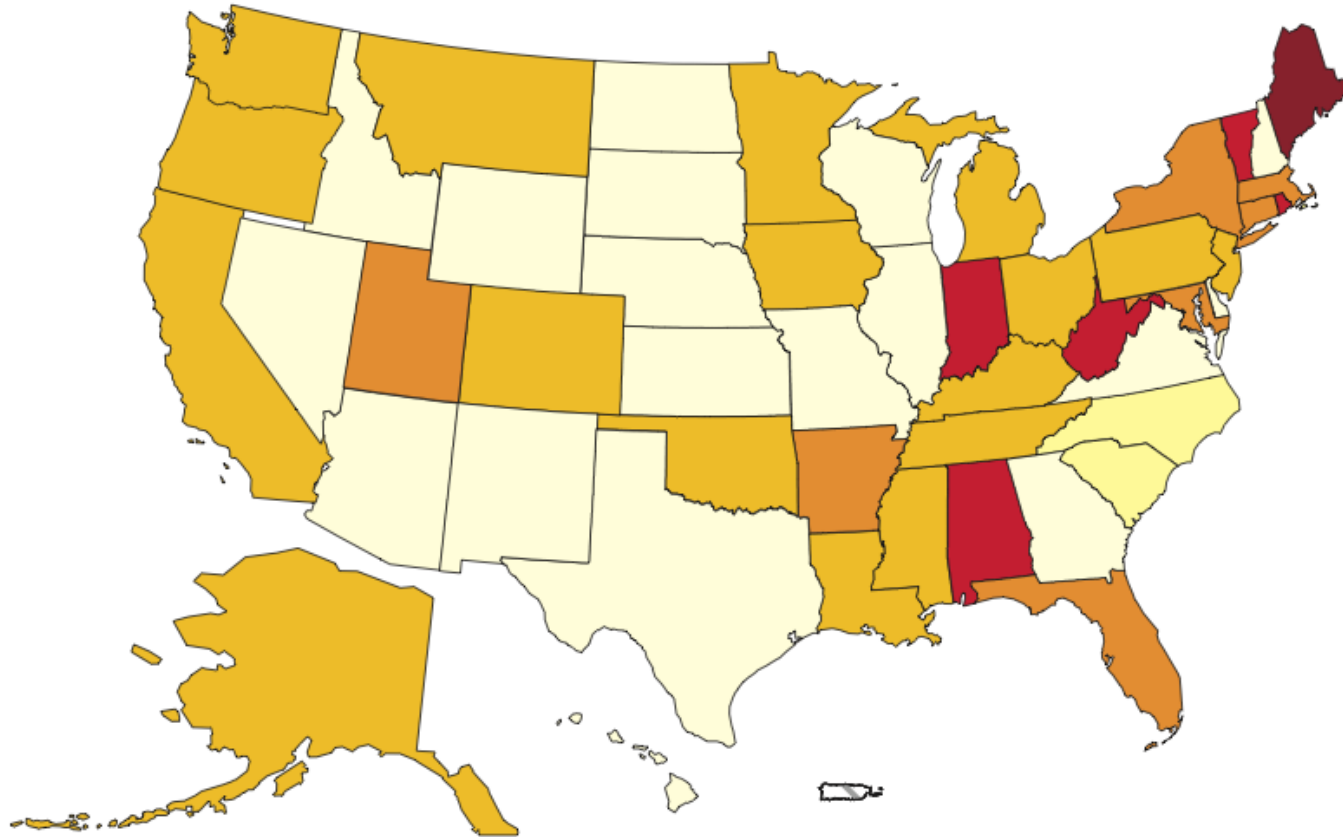
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 01.23.15.

Death rates from overdoses of heroin or prescription opioid pain relievers (OPRs), by age group



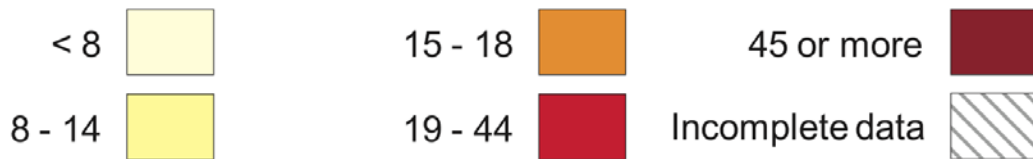
SOURCE: CDC. *Increases in Heroin Overdose Deaths — 28 States, 2010 to 2012*
MMWR. 2014, 63:849-854

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



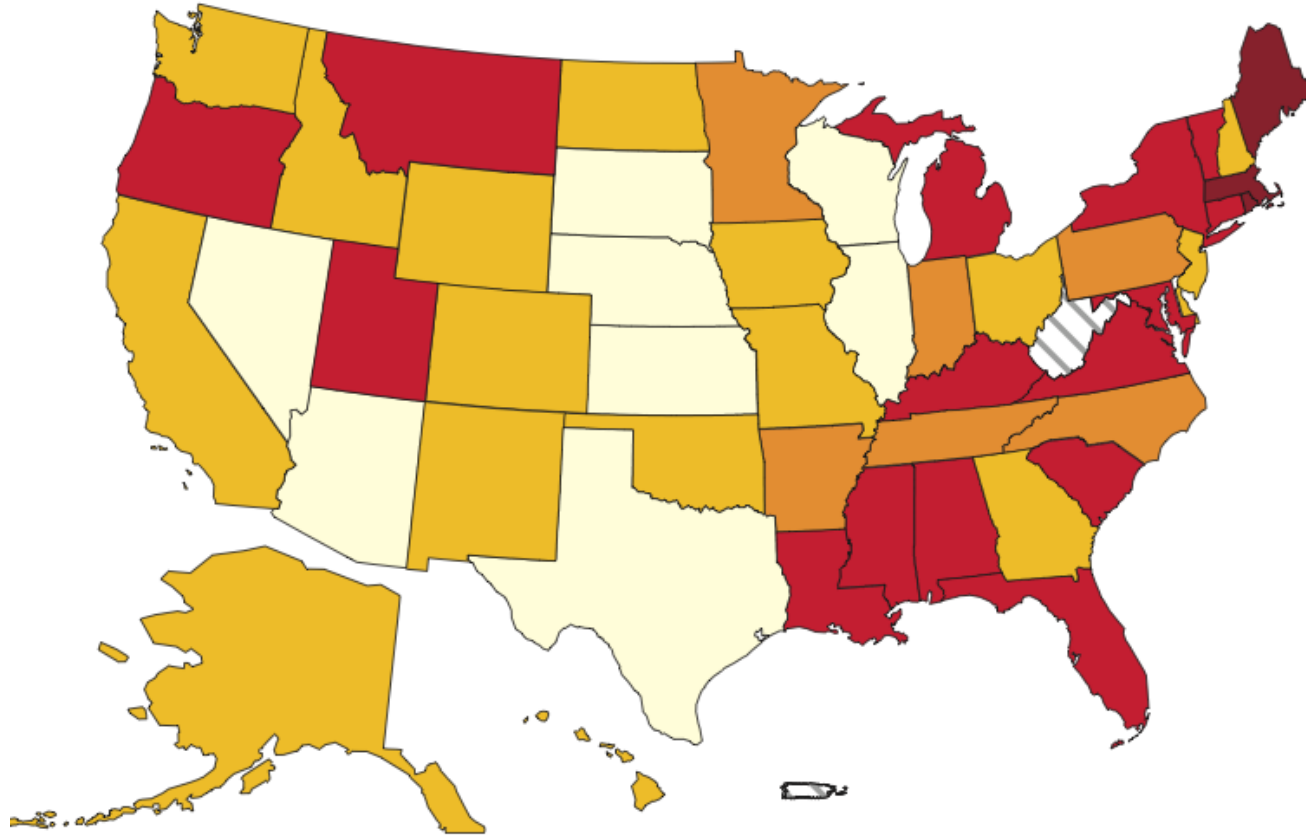
1999

(range 1 - 50)



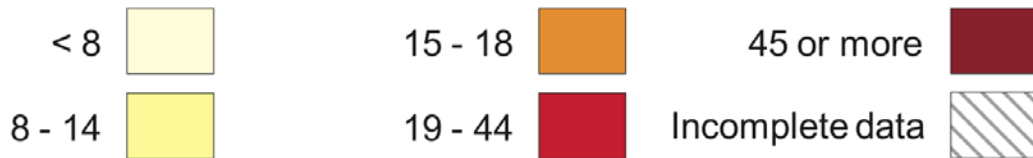
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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



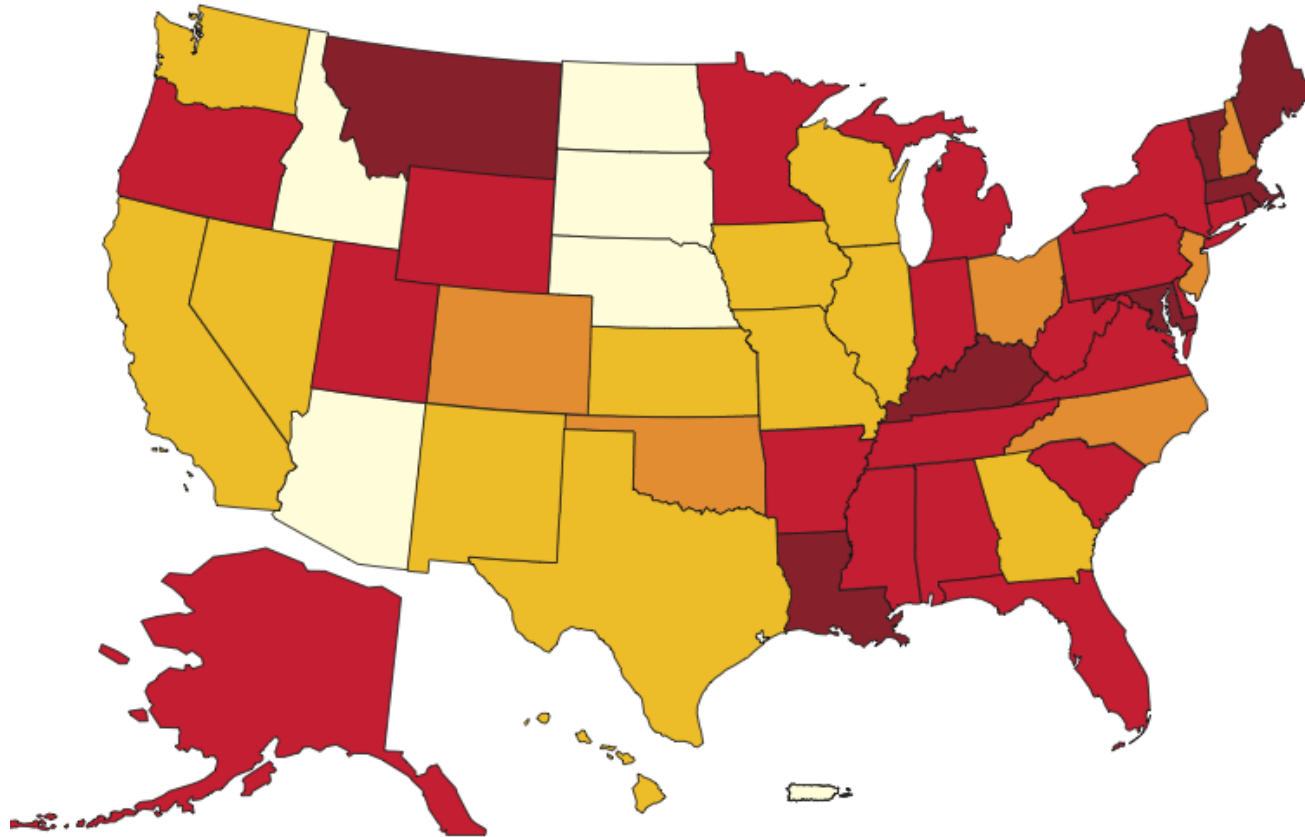
2001

(range 1 – 71)



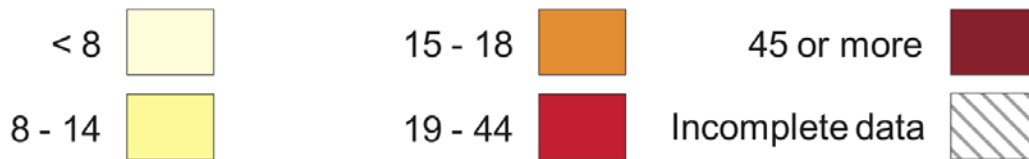
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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



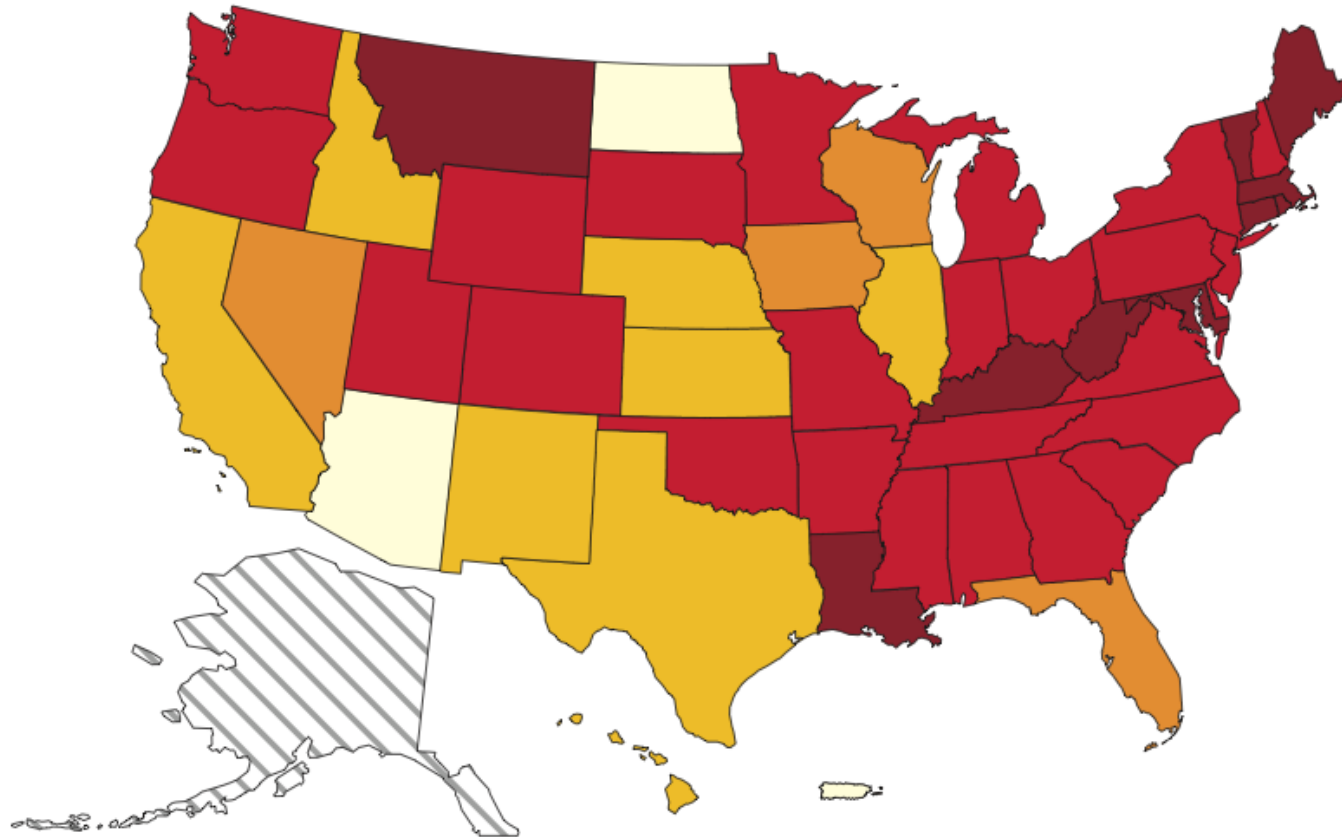
2003

(range 2 – 139)



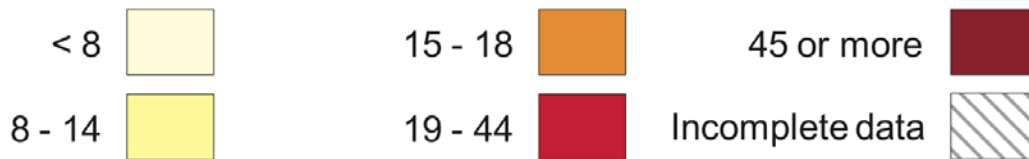
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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



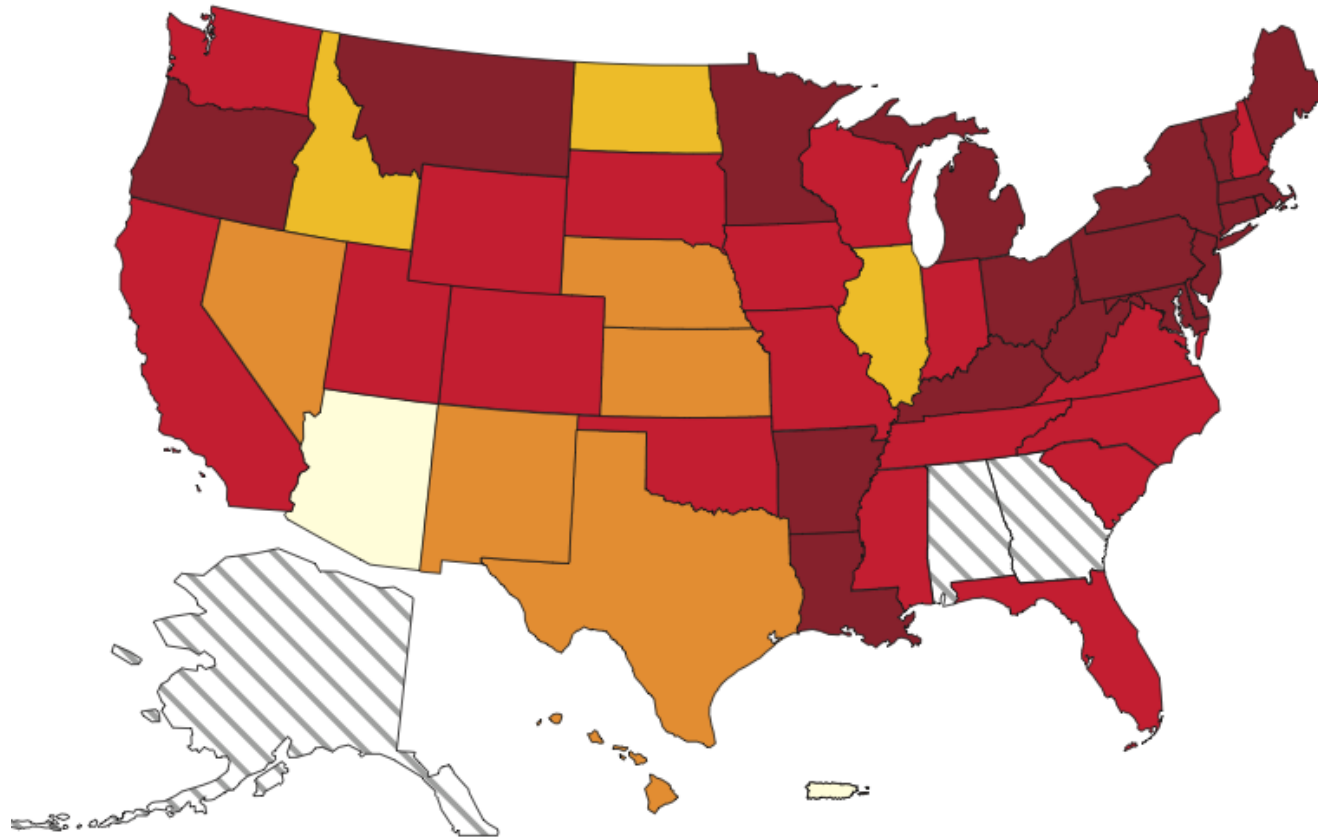
2005

(range 0 – 214)

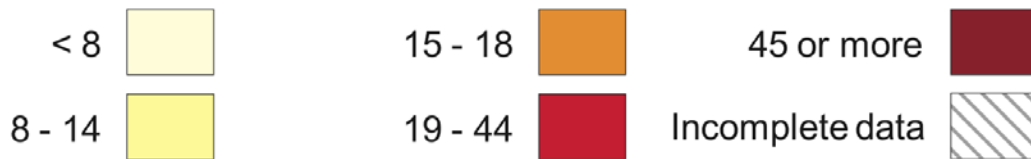


SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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

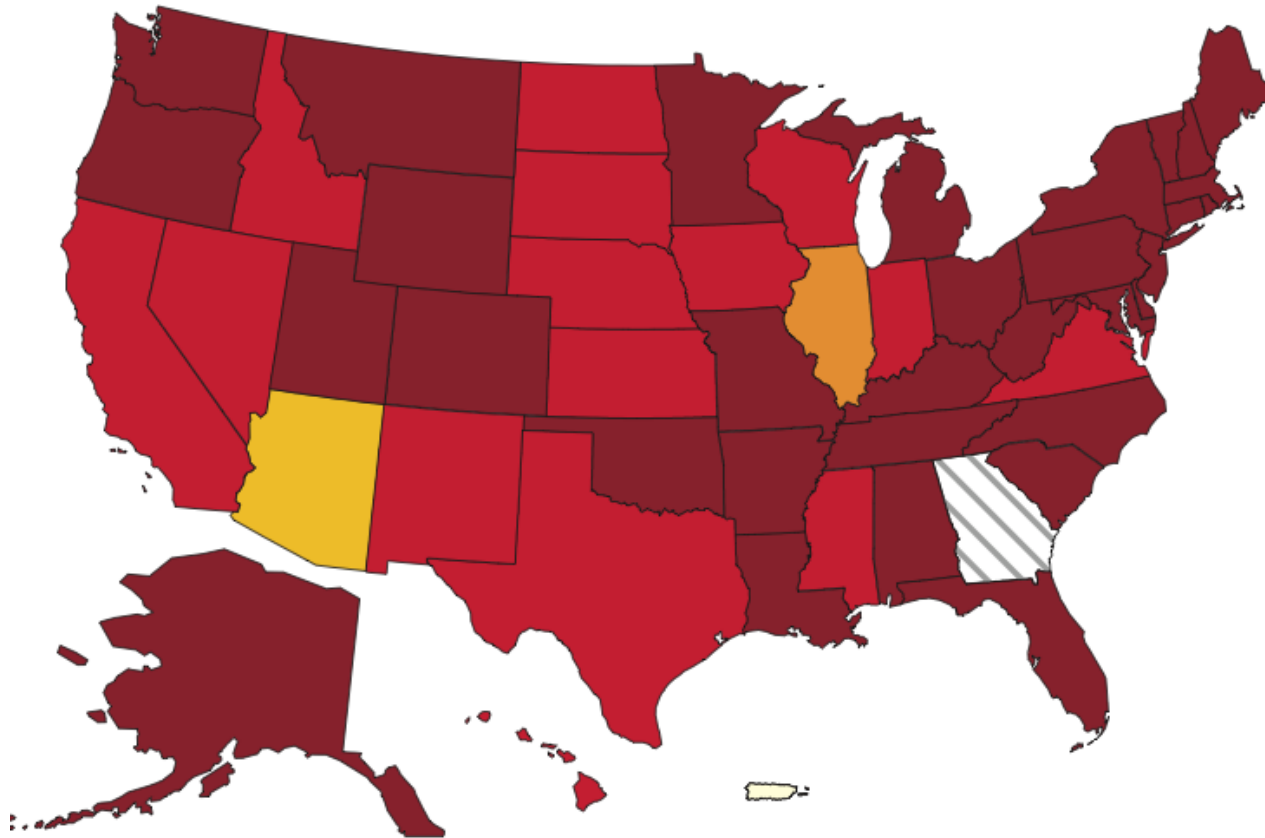


2007
(range 1 – 340)



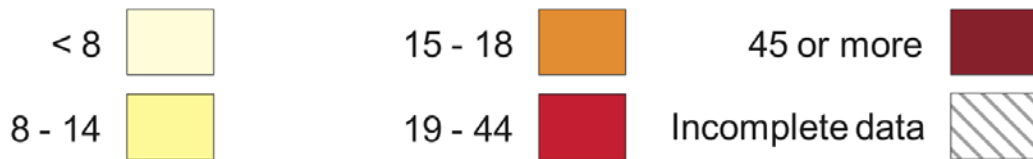
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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



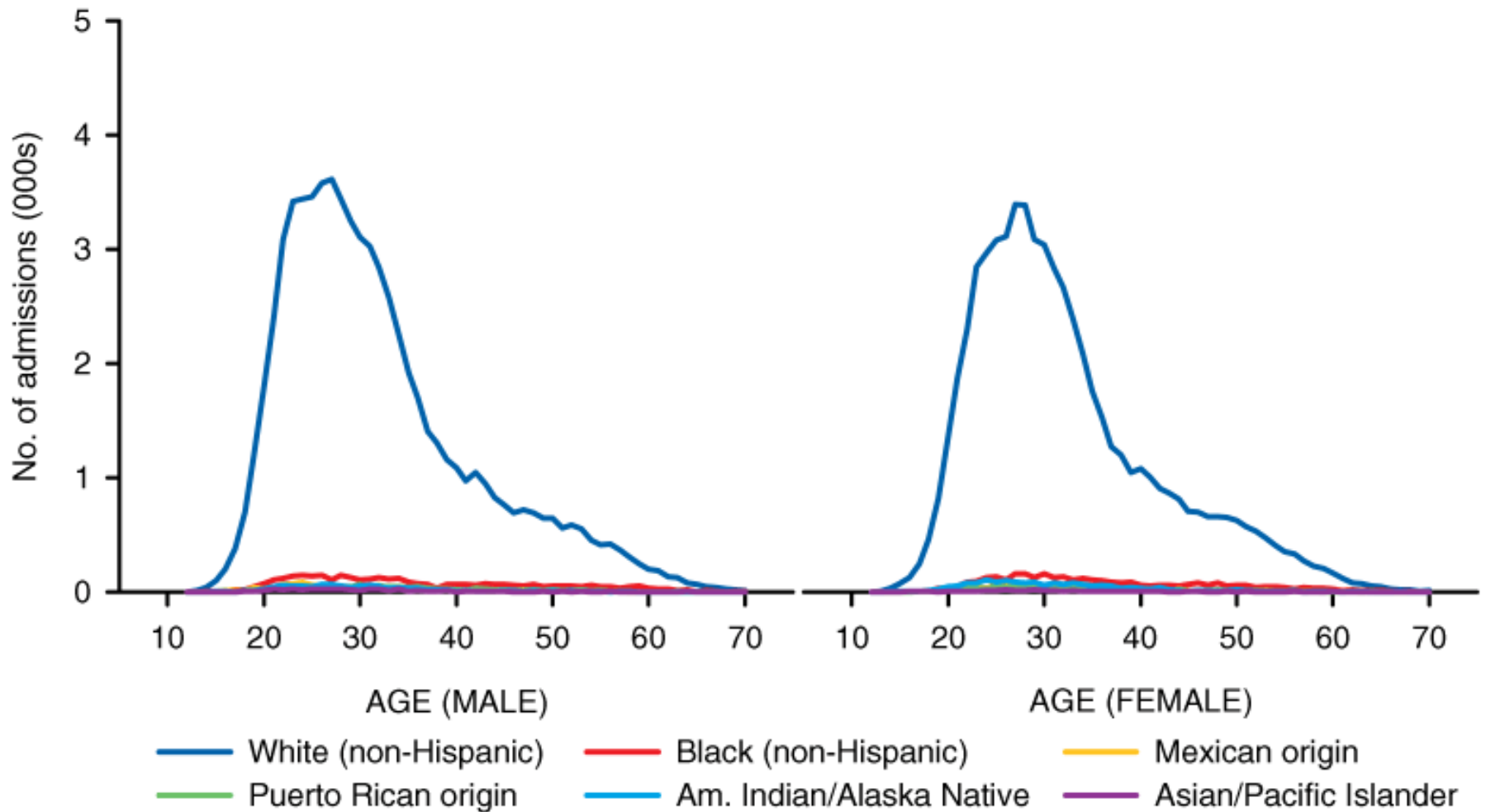
2009

(range 1 – 379)



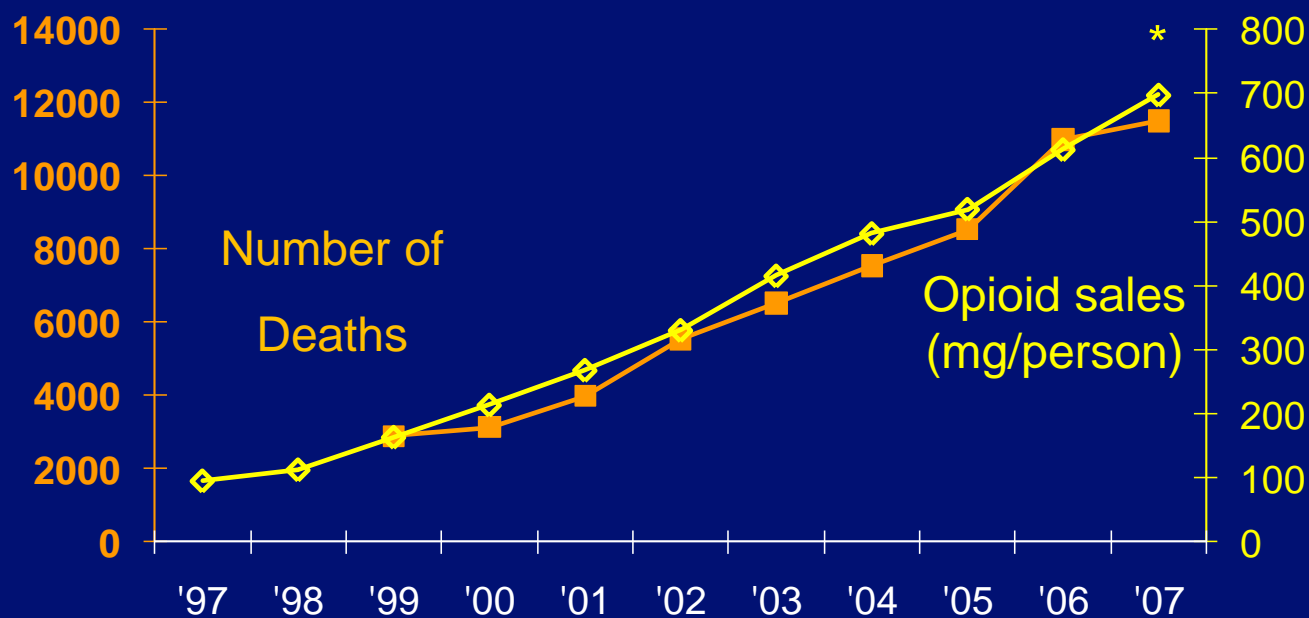
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Non-heroin opioid treatment admissions: 2013



SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 01.23.15.

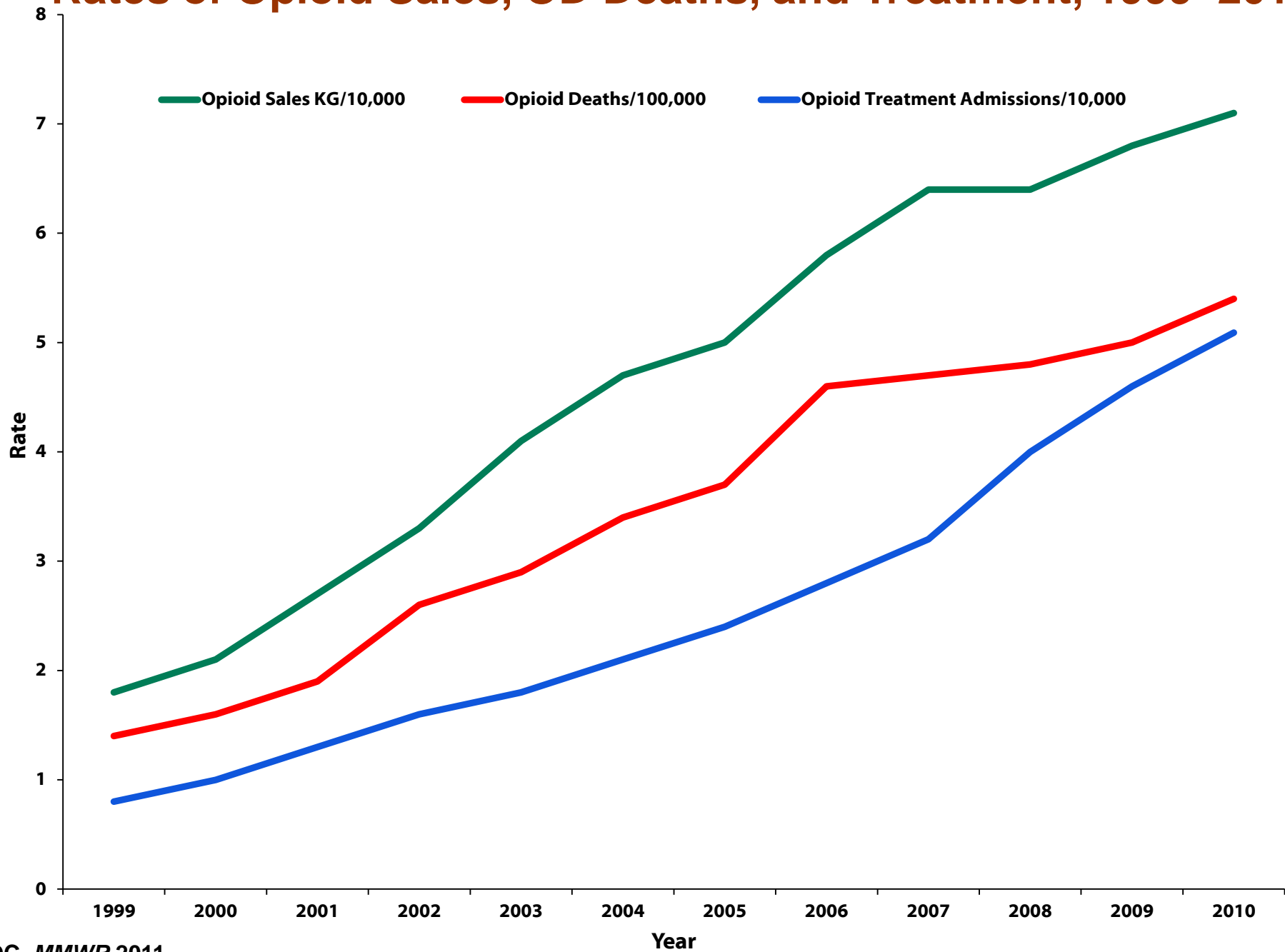
Unintentional overdose deaths involving opioid analgesics parallel per capita sales of opioid analgesics in morphine equivalents by year, U.S., 1997-2007



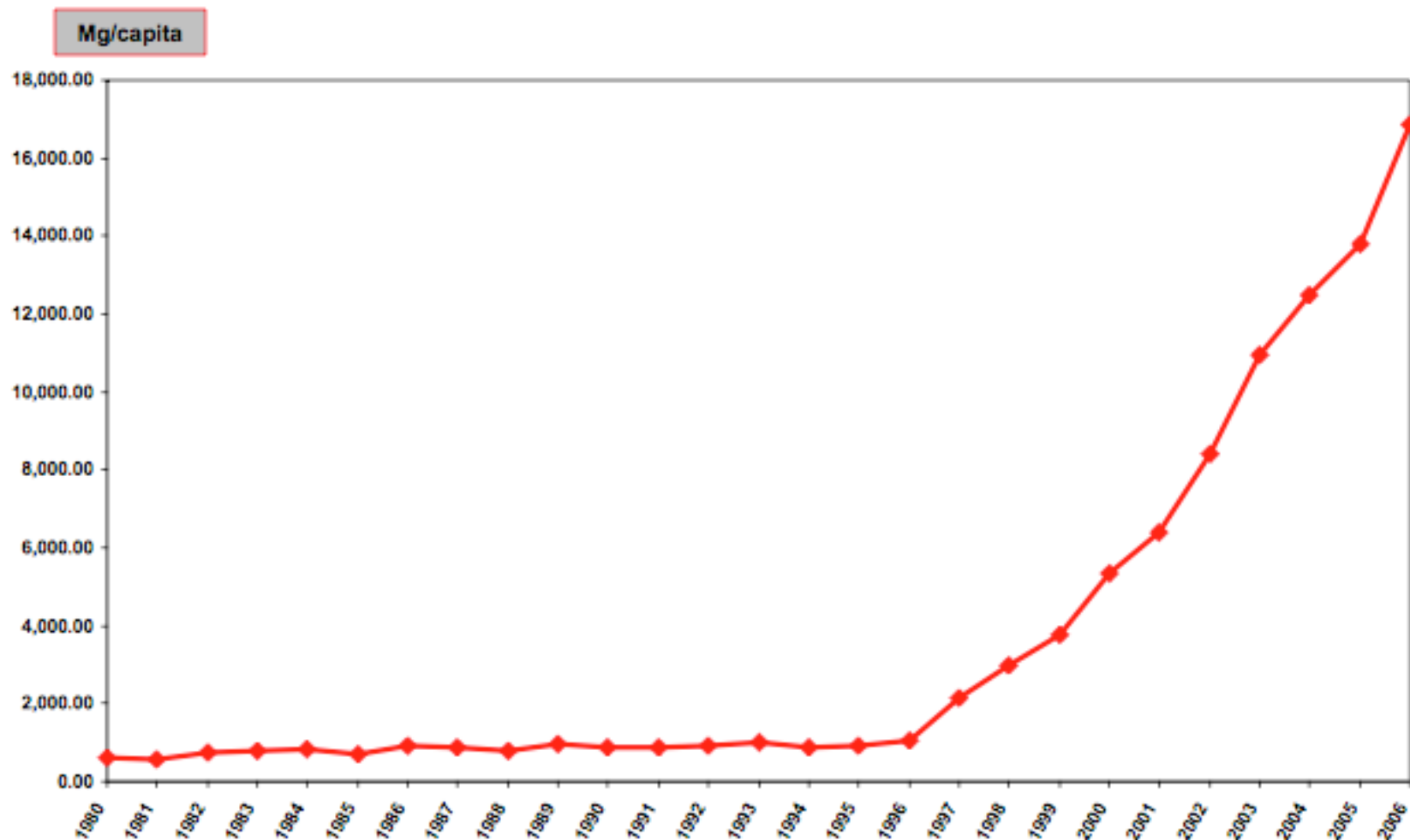
Source: National Vital Statistics System, multiple cause of death dataset, and DEA ARCOS

* 2007 opioid sales figure is preliminary.

Rates of Opioid Sales, OD Deaths, and Treatment, 1999–2010

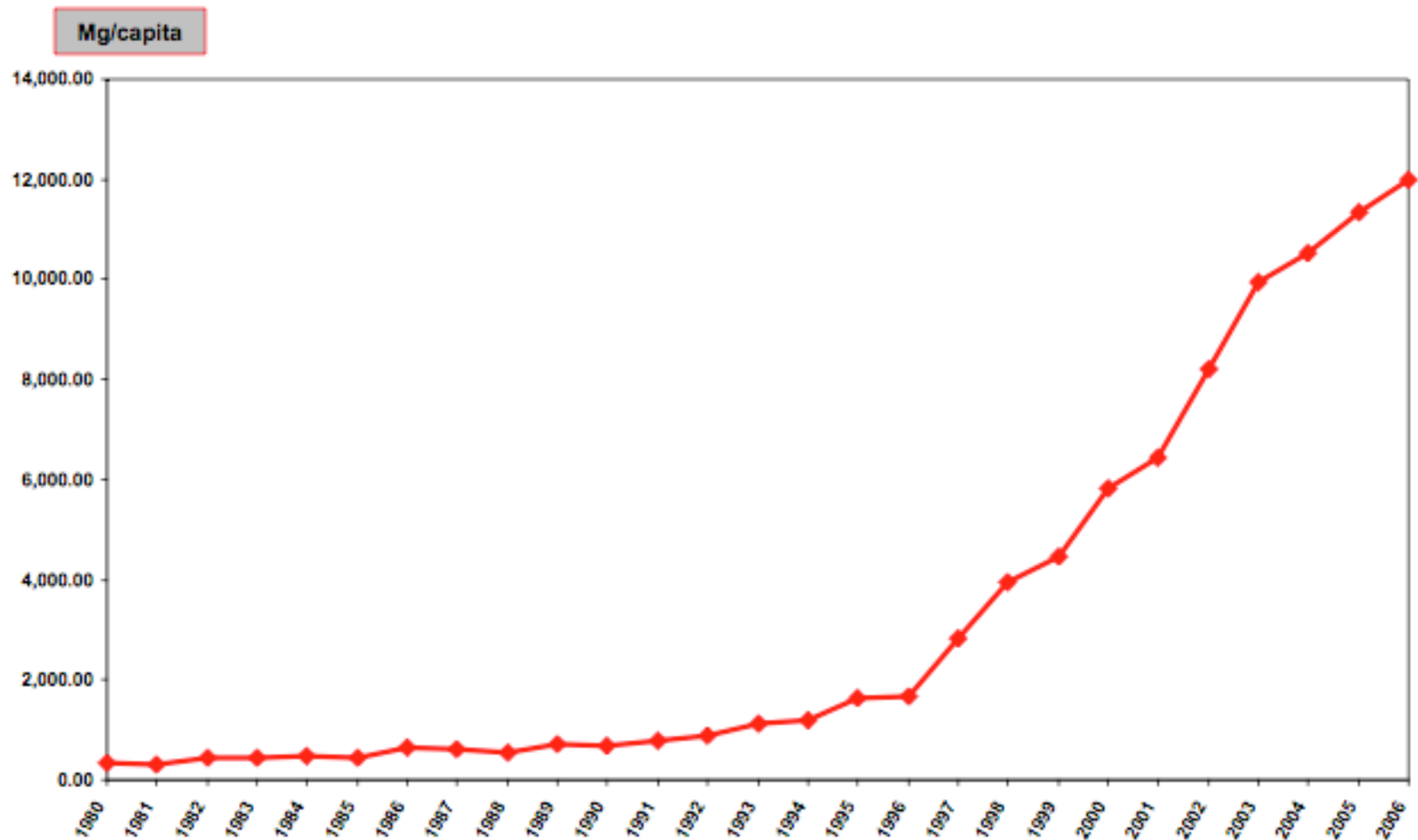


New York Consumption of Oxycodone 1980 - 2006



Sources: U.S. Dept of Justice, Drug Enforcement Administration, Office of Diversion Control

New York Consumption of Hydrocodone 1980 - 2006

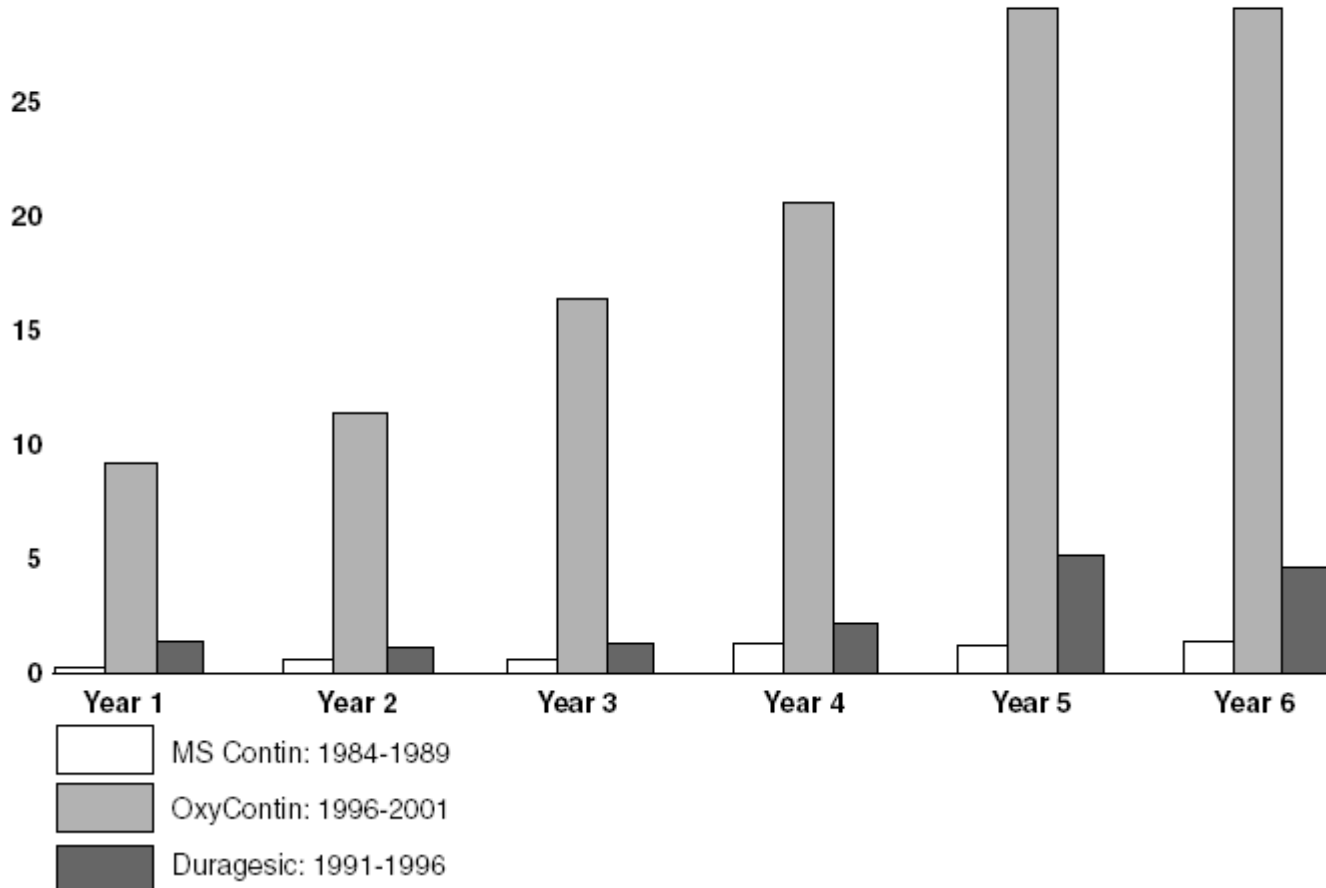


Sources: U.S. Dept of Justice, Drug Enforcement Administration, Office of Diversion Control

Dollars Spent Marketing OxyContin (1996-2001)

Figure 1: Promotional Spending for Three Opioid Analgesics in First 6 Years of Sales

Absolute dollars in millions
30



Source: United States General Accounting Office: Dec. 2003, "OxyContin Abuse and Diversion and Efforts to Address the Problem."

Industry-funded “educational” messages

- Physicians are needlessly allowing patients to suffer because of “opiophobia.”
- Opioid addiction is rare in pain patients.
- Opioids can be easily discontinued.
- Opioids are safe and effective for chronic pain.

Industry-funded organizations campaigned for greater use of opioids

- Pain Patient Groups
- Professional Societies
- The Joint Commission
- The Federation of State Medical Boards



“The risk of addiction is much less than 1%”

Porter J, Jick H. *Addiction rare in patients treated with narcotics*. N Engl J Med. 1980 Jan 10;302(2):123

Cited 824 times (Google Scholar)

N Engl J Med. 1980 Jan 10;302(2):123.

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 patients¹ 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

Waltham, MA 02154

Boston University Medical Center

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.

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

Background: Increases in prescriptions of opioid medications for chronic pain have been accompanied by increases in opioid overdoses, abuse, and other harms and uncertainty about long-term effectiveness.

Purpose: To evaluate evidence on the effectiveness and harms of long-term (>3 months) opioid therapy for chronic pain in adults.

Data Sources: MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL (January 2008 through August 2014); relevant studies from a prior review; reference lists; and ClinicalTrials.gov.

Study Selection: Randomized trials and observational studies that involved adults with chronic pain who were prescribed long-term opioid therapy and that evaluated opioid therapy versus placebo, no opioid, or nonopioid therapy; different opioid dosing strategies; or risk mitigation strategies.

Data Extraction: Dual extraction and quality assessment.

Data Synthesis: No study of opioid therapy versus no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction. Good- and

fair-quality observational studies suggest that opioid therapy for chronic pain is associated with increased risk for overdose, opioid abuse, fractures, myocardial infarction, and markers of sexual dysfunction, although there are few studies for each of these outcomes; for some harms, higher doses are associated with increased risk. Evidence on the effectiveness and harms of different opioid dosing and risk mitigation strategies is limited.

Limitations: Non-English-language articles were excluded, meta-analysis could not be done, and publication bias could not be assessed. No placebo-controlled trials met inclusion criteria, evidence was lacking for many comparisons and outcomes, and observational studies were limited in their ability to address potential confounding.

Conclusion: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

Primary Funding Source: Agency for Healthcare Research and Quality.

Ann Intern Med. 2015;162:276-286. doi:10.7326/M14-2559 www.annals.org
For author affiliations, see end of text.

This article was published online first at www.annals.org on 13 January 2015.



The NEW ENGLAND JOURNAL of MEDICINE

Reducing the Risks of Relief — The CDC Opioid-Prescribing Guideline

Thomas R. Frieden, M.D., M.P.H., and Debra Houry, M.D., M.P.H. March 15, 2016

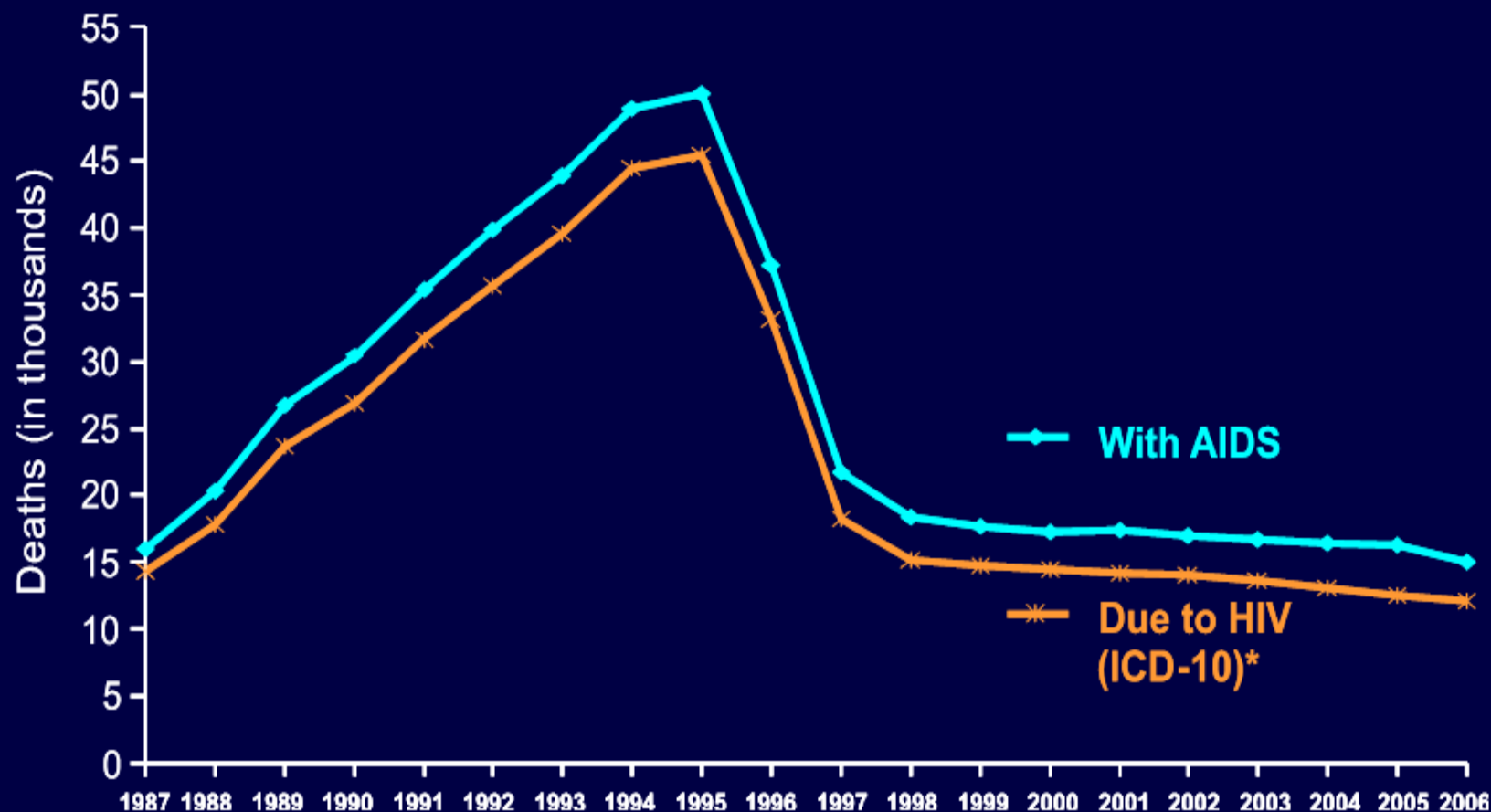
“The science of opioids for chronic pain is clear: for the vast majority of patients, the known, serious, and too-often-fatal risks far outweigh the unproven and transient benefits.”

Controlling the epidemic:

A Three-pronged Approach

- **Prevent** new cases of opioid addiction.
- **Treat** people who are already addicted.
- **Reduce supply** from pill mills and the black-market.

Comparison of Mortality Data from AIDS Case Reports and Death Certificates in Which HIV Disease Was Selected as the Underlying Cause of Death, United States, 1987–2006



*For comparison with data for 1999 and later years, data in the bottom (red) line for 1987–1998 were modified to account for ICD-10 rules instead of ICD-9 rules.



Summary

- The U.S. is in the midst of a severe epidemic of opioid addiction
- To bring the epidemic to an end:
 - We must prevent new cases of opioid addiction
 - We must ensure access to treatment for people already addicted