

Addiction Therapy-2014

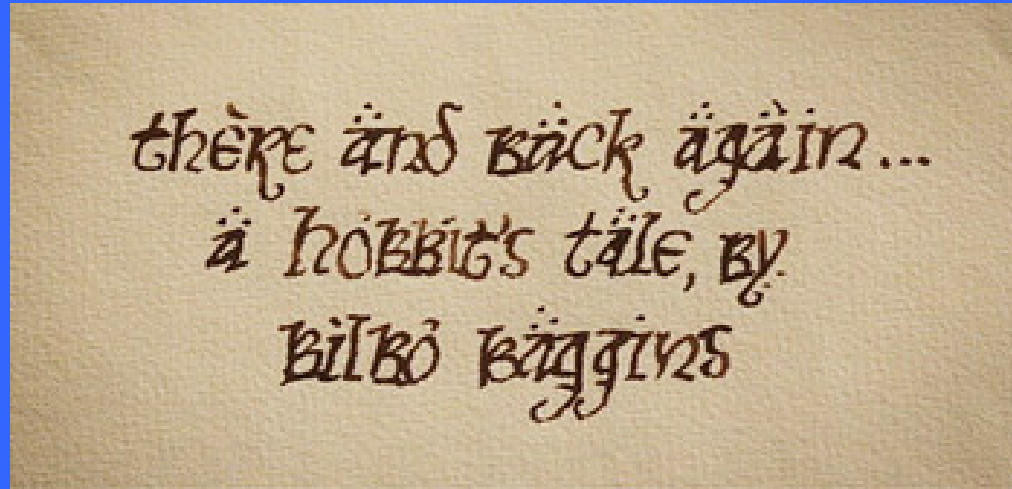
Chicago, USA

August 4 - 6, 2014



William S. Jacobs

Pain & Addiction



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Prior to the 1990s, “chronic pain” was not a broadly recognized concept in medicine.



Pain: Definition

- ◆ An unpleasant sensory experience associated with actual or potential tissue injury, or described in such terms.
 - IASP 1989

By the mid 1990s I was told that I was doing an inadequate job of treating pain. I was being needlessly stingy with opioids.

Esteemed speakers at medical conferences preached for more “appropriate” (liberal) use of opioids in pain management.



in 1996, Purdue Pharmaceuticals introduced Oxycontin as a “safe, long-acting opioid that would avoid the euphoric rush of short-acting opioids, and thus could be used chronically without fear of addiction or misuse”.

A new wonder drug had been developed “just in time” to meet our new needs and with new pressures to aggressively treat all forms of pain.

Oxycontin became the best selling opioid in the world by 2001.



UF | College of Medicine
Department of Psychiatry

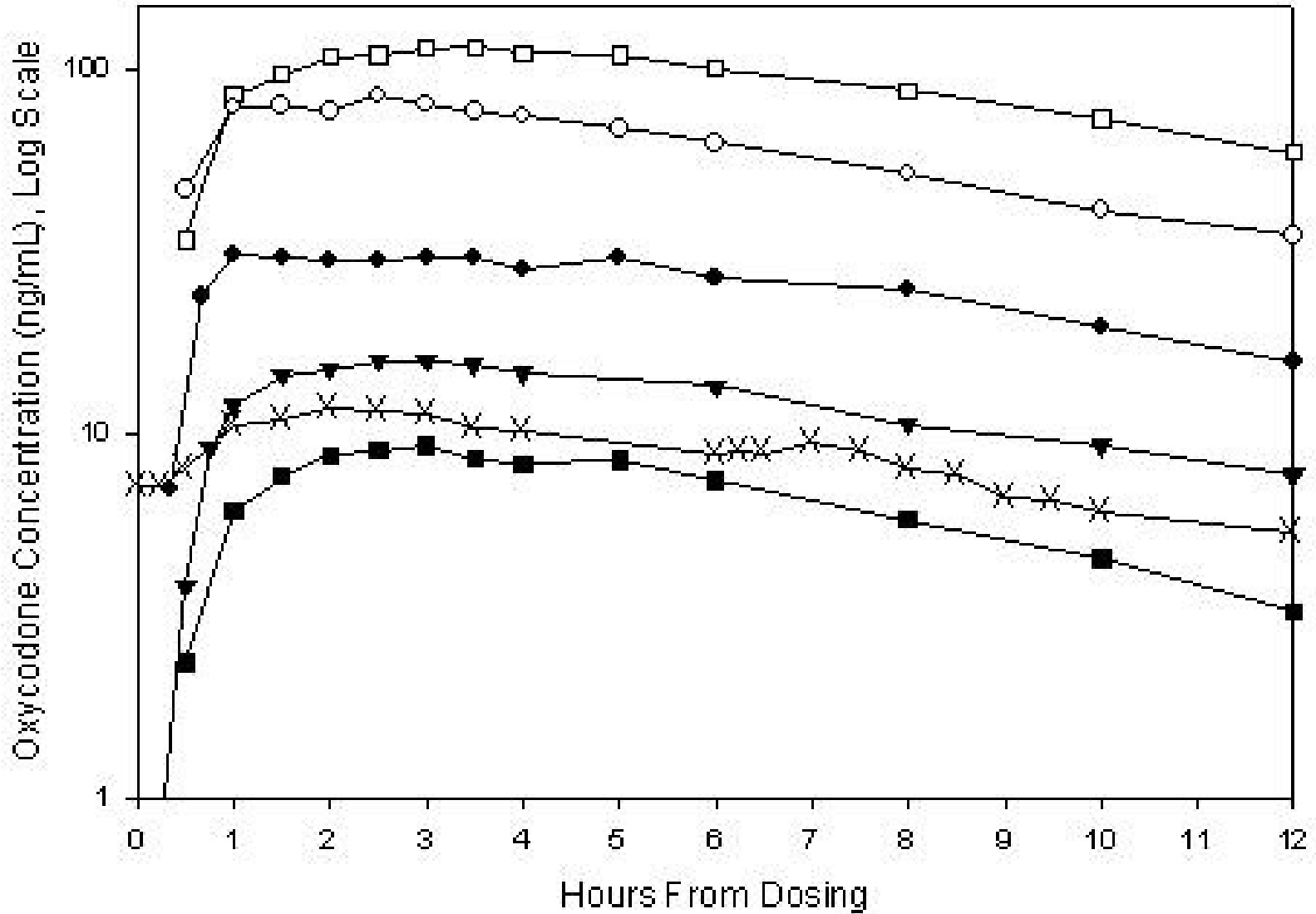
Help is a phone call away.
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At UF, several factors led to the creation of the Department of Psychiatry Chronic Pain Clinic. We were early adopters of this newly recommended practice.

We treated patients whom others refused to treat.

Though I knew the dangers of Oxycontin, which by this time had proven to be easily crushed and injected by those seeking to abuse it, I championed the concept that a long-acting opioid ought to be safe for chronic use.











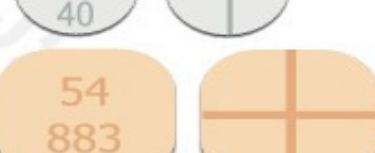
Plasma Oxycodone By Time



■ 10 mg ▼ 20 mg ◆ 40 mg ○ 80 mg □ 160 mg Single Dose
x 10 mg q12h Steady-State

We were also early adopters of methadone in the management of chronic non-malignant pain. It was generic, cheap, had been around forever, and was used to treat opioid addiction. And I was also an addictionologist who had worked in a not-for-profit Methadone Maintenance Program.

Methadone Appearances *

	Strength: 5 mg Manufacturer / Distributor: Roxane Laboratories Inc
	Strength: 10 mg Manufacturer / Distributor: Roxane Laboratories Inc
	Strength: 5 mg Manufacturer / Distributor: Mallinckrodt Pharmaceuticals
	Strength: 10 mg Manufacturer / Distributor: Mallinckrodt Pharmaceuticals
	Strength: 40 mg dispersible Manufacturer / Distributor: Mallinckrodt Pharmaceuticals
	Brand: Dolophine Strength: 5 mg Manufacturer / Distributor: Roxane Laboratories Inc
	Brand: Dolophine Strength: 10 mg Manufacturer / Distributor: Roxane Laboratories Inc
	Brand: Methadose Strength: 5 mg Manufacturer / Distributor: Mallinckrodt Pharmaceuticals
	Brand: Methadose Strength: 10 mg Manufacturer / Distributor: Mallinckrodt Pharmaceuticals
	Brand: Methadose Strength: 40 mg dispersible Manufacturer / Distributor: Mallinckrodt Pharmaceuticals
	Brand: Diskets Strength: 40 mg dispersible Manufacturer / Distributor: Cebert Pharmaceuticals Inc

* NOT TO SCALE OR A COMPLETE LIST. GENERIC UNLESS OTHERWISE NOTED. IMAGES ARE A REPRESENTATION ONLY. ACTUAL APPEARANCES MAY DIFFER. Copyright © 2009 PrescriptionDrug-Info.com

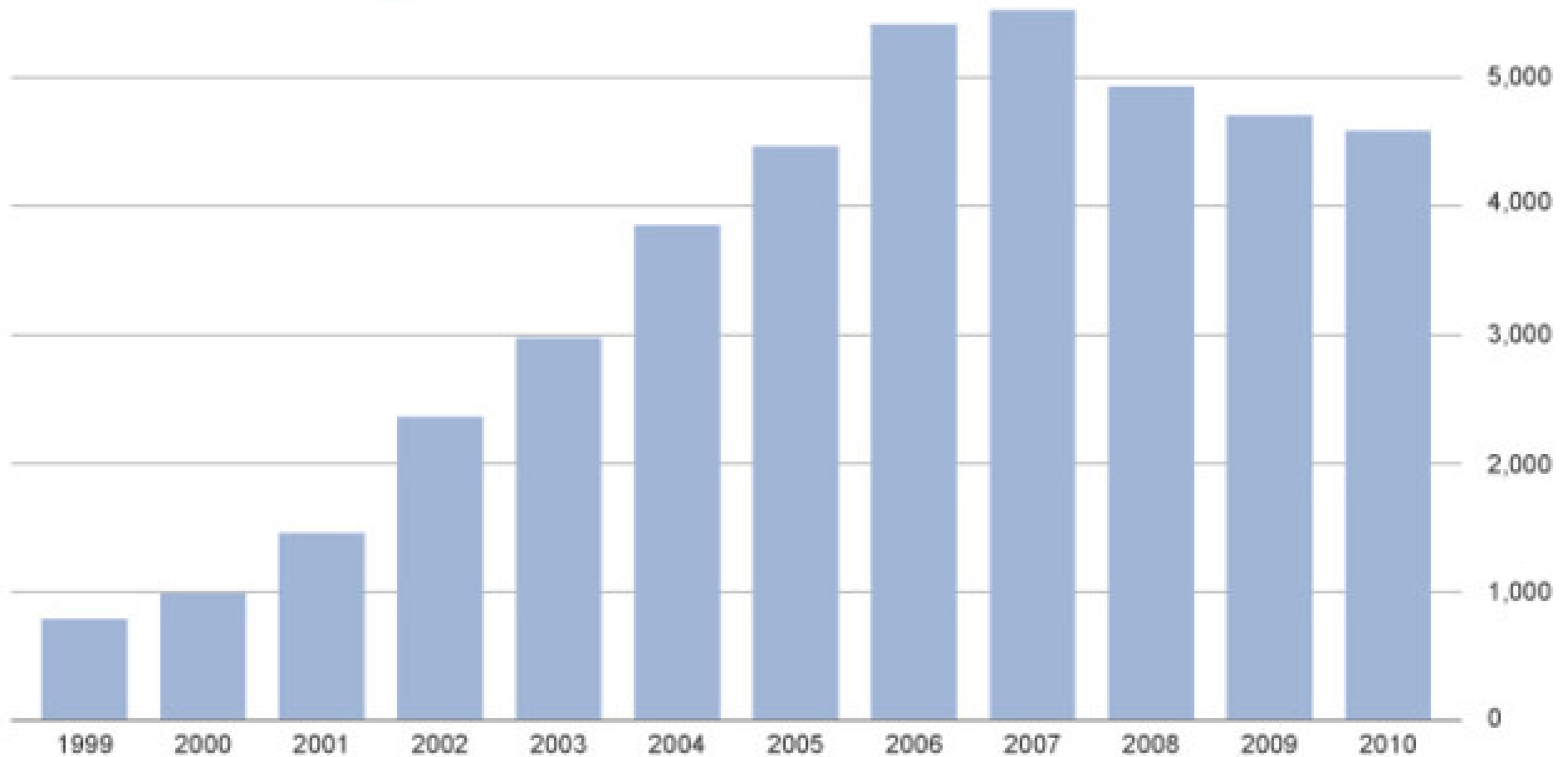
I believed that patients with chronic pain deserved to have a background dose of a long acting opioid like methadone, and then some short-acting opioids on hand for breakthrough pain.

A “controller” medication and a “rescue” medication is a pharmaceutical model widely used in the treatment of asthma, rheumatoid arthritis, and diabetes, so I embraced that concept for treating chronic pain.



While the number of U.S. overdose deaths involving methadone peaked in 2007, it was still almost six times higher in 2010, the most recent year for which data are available, than in 1999. The data don't reflect the source of the methadone — whether it's addiction clinics or pain prescriptions. More than one drug might be involved in each death.

U.S. Deaths Involving Methadone



Source: U.S. Centers for Disease Control and Prevention

Bloomberg

This movement toward more aggressive pain management was so strong that the Joint Commission (the accrediting body for quality medical practice) created a standard:



Excerpts From JCAHO Standards

- ◆ Patients have the right to appropriate assessment and management of pain
- ◆ Pain is assessed in all patients
- ◆ Policies and procedures support safe medication prescription or ordering
- ◆ The patient is monitored during the post-procedure period
- ◆ Patients are educated about pain and managing pain as part of treatment, as appropriate
- ◆ The discharge process provides for continuing care based upon the patient's assessed needs at the time of discharge
- ◆ The health care organization addresses care at the end of life
- ◆ The organization collects data to monitor its performance

Go to <http://www.jcaho.org> for these standards, explanations of their intent and examples of implementation.

every patient must be asked about their pain at every visit so that it could be appropriately addressed.

We put visual analog pain scales on the paperwork for every visit, so the “pain scales” became a **vital sign** just like heart rate, blood pressure, respiratory rate and temperature.

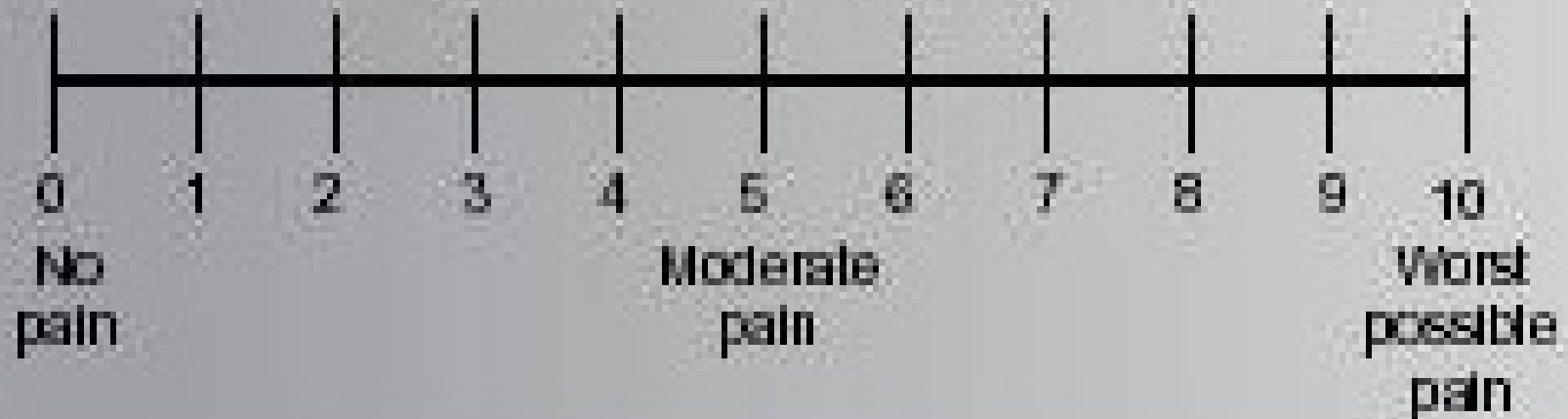


Pain Intensity Scales

Simple Descriptive Pain Intensity Scale



0-10 Numeric Pain Intensity Scale



MODERATE

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

	0	1	2	3	4	5	6	7	8	9	10
Verbal Descriptor Scale	NO PAIN		MILD PAIN		MODERATE PAIN		MODERATE PAIN		SEVERE PAIN		WORST PAIN POSSIBLE
WONG-BAKER FACIAL GRIMACE SCALE											
ACTIVITY TOLERANCE SCALE	NO PAIN		CAN BE IGNORED		INTERFERES WITH TASKS		INTERFERES WITH CONCENTRATION		INTERFERES WITH BASIC NEEDS		REST REQUIRED
SPANISH	NADA DE DOLOR		UNPOQUITO DE DOLOR		UN DOLOR LEVE		DOLOR FUERTE		DOLOR DEMASIADO FUERTE		UN DOLOR INSOPORTABLE
TAGALOG	Walang Sakit		Kanting Sakit		Katamtamang Sakit		Matinding Sakit		Pinaka-Matinding Sakit		Pinaka-Matandang Sakit
CHINESE	不痛		轻微		中度		严重		非常严重		最严重
KOREAN	통증 없음		약간 통증		보통 통증		심한 통증		아주 심한 통증		최악의 통증
PERSIAN (FARSI)	بدون درد		درد کم		درد متوسط		درد شدید		درد بسیار شدید		بدترین درد ممکن
VIETNAMESE	Không Đau		Đau Nhẹ		Đau Vừa Phải		Đau Nặng		Đau Thật Nặng		Đau Đến Tột Cùng
JAPANESE	痛みがない		少し痛い		いくらか痛い		かなり痛い		ひどく痛い		ものすごく痛い

Our clinic became very busy. We had patients seeking out our compassionate, forward thinking care, coming from hundreds of miles. These turned out to be some tough and very needy patients - lots of workman's comp cases, lots of patients with multiple prior back surgeries, lots of permanently disabled low functioning depressed unemployable patients.

To the point where it became overwhelming.

I noticed that no matter how much I listened and empathized and cared, and no matter how many opioids I prescribed, most never got better.

Many cheated and lied to me and got more opioids & other drugs from different doctors. They sold their drugs on the street. They lost them and demanded more.

Around 2003 “chronic pain syndrome” was recognized with its own ICD-9 diagnostic code.

ICD-9 338.4

Disease Synonyms

Chronic pain associated w psychosocial dysfunction

Chronic pain associated with psychosocial dysfunction

Psychosocial dysfunction due to chronic pain

Applies To

Chronic pain associated with significant psychosocial dysfunction

TABLE 1. Ten steps of universal precautions in pain medicine

1. Make a diagnosis with appropriate differential.
2. Perform a psychological assessment including risk of addictive disorders.
3. Obtain informed consent
4. Obtain a treatment agreement (also called a medication contract).
5. Perform pre- and postintervention assessment of pain level and function.
6. Initiate appropriate trial of opioid therapy \pm adjunctive medication.
7. Reassess pain score and level of function.
8. Regularly assess the “four A’s” of pain medicine:
 - a. Analgesia
 - b. Activity
 - c. Adverse effects
 - d. Aberrant behavior (Affect was later proposed as a fifth “A”).
9. Periodically review pain diagnosis and comorbid conditions, including addictive disorders.
10. Maintain complete documentation.

Adapted from Gourley DL, Heit HA, Almahrezi A. Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. *Pain Medicine*. 2005;6(2):107–112.

We did recognize these aberrant behaviors so we created a structured, standardized program for our patients who we thought needed opioids to manage their pain.

Every patient prescribed opioids signed a consent/treatment agreement which explained the dangers of opioids and the “rules” of our program. We required them to participate in educational group visits. We had them see psychiatrists and psychologists for the psychiatric symptoms.



We required Urine Drug Screens to ensure they were not using other drugs, and even more importantly, to ensure they were actually taking the drugs we were prescribing.

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We prescribed opioids only in a 28-day supply, to ensure that refills never came due on a weekend.

We never refilled opioids by phone or on the weekend.

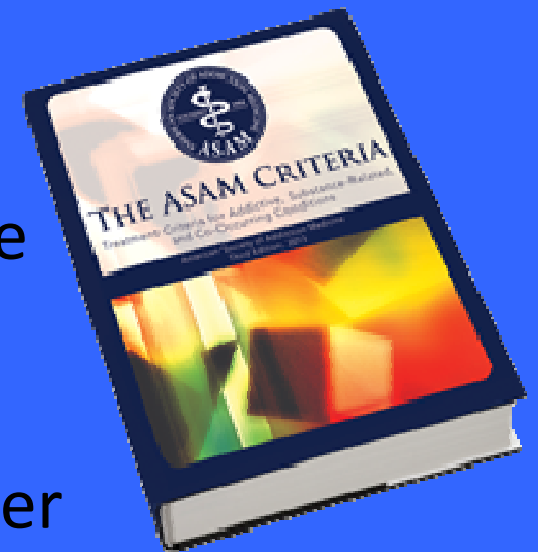
We did a substance abuse evaluation for all the patients we were considering starting on chronic opioids.

We tightened the boundaries whenever aberrant behavior was identified.

If a patient ran out early when would bring them back in 2 weeks instead of 4.

If a patient tested positive for unprescribed or illicit substances (or negative for prescribed ones), we counseled them and told most they could have one and only one more chance.

we re-evaluated their substance use disorder diagnoses and used ASAM criteria to recommend appropriate levels of treatment.



Yet even with our carefully structured pain program,
even with a program which exceeded published recommendations for cautious opioid prescribing,
our patients were not getting better.

I still found these pain patients to be the the most challenging patients I had ever treated.

I saw physicians across the state build up huge numbers of pain patients on massive doses of opioids, and then close their clinics and disappear, releasing hundreds of opioid-dependent patients onto the streets in search of a compassionate provider.

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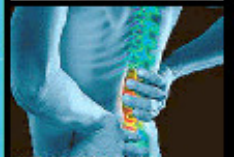
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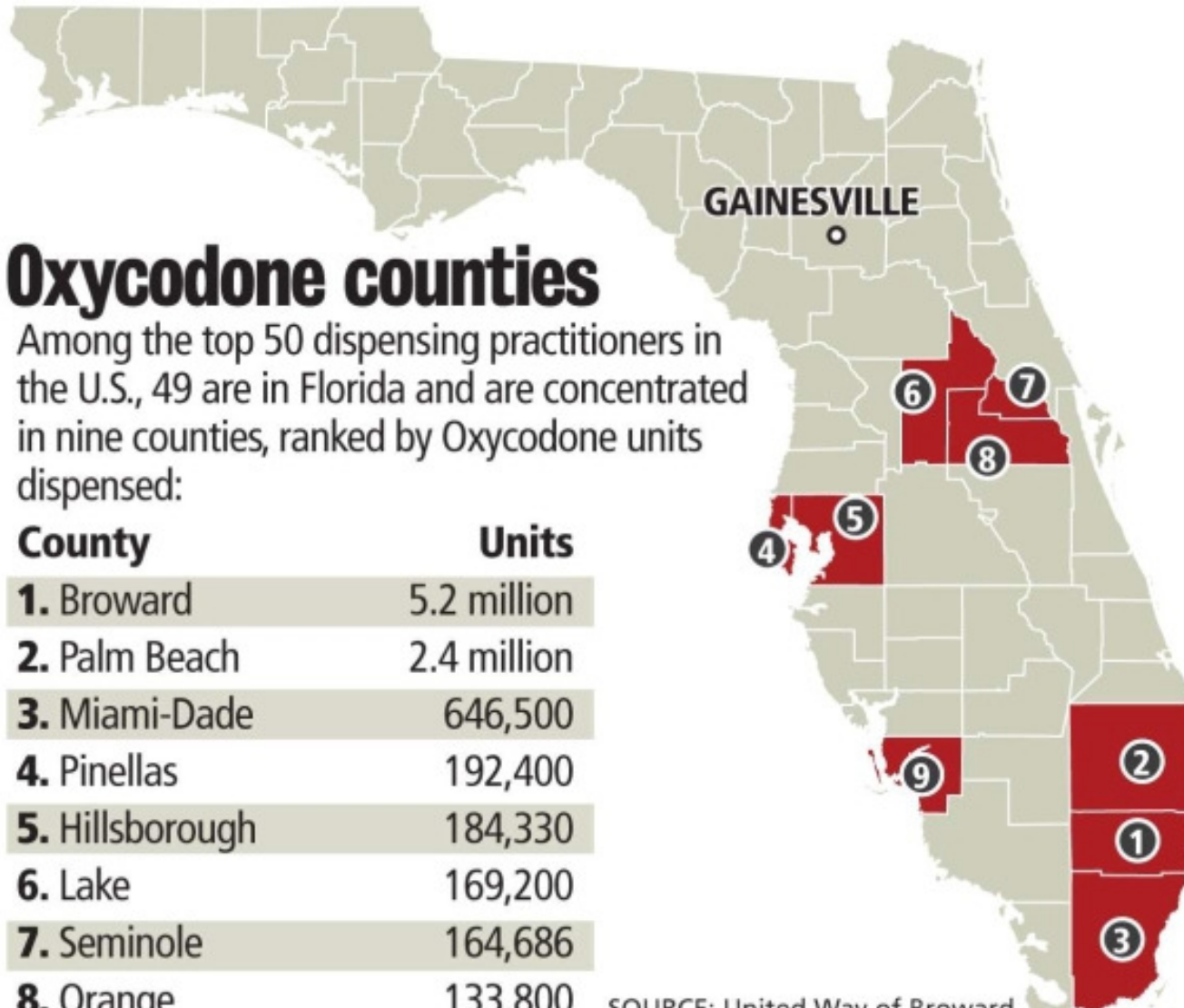
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SOURCE: United Way of Broward County and U.S. Drug Enforcement Administration
 ROB MACK/Staff graphic

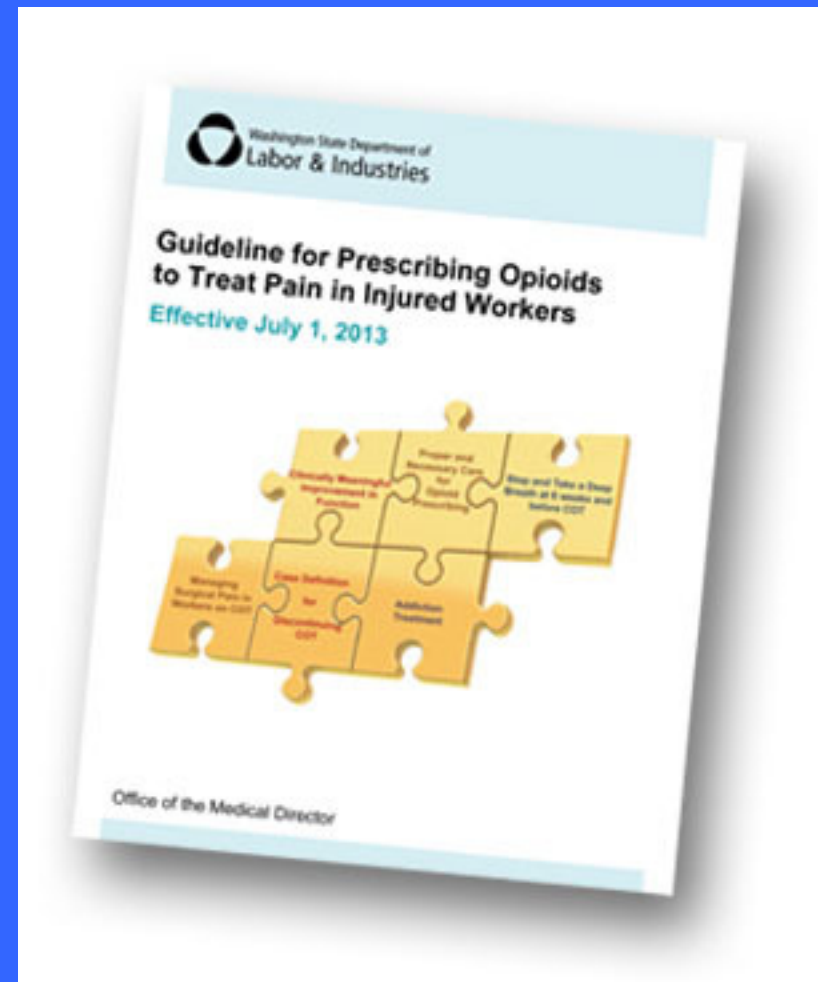
Some patients were admitted to the hospital for unrelated problem (out of control diabetes or HTN...) and were placed on the dose which they had been prescribed and were supposed to have been taking.

Many became somnolent and stopped breathing, because in fact they had not been taking anything close to that dose, but rather had been selling most of their opioids.

Now I became “the bad guy”, explaining that although I was willing to try to help, I could prescribe only a fraction of the dose their prior physician was prescribing, especially with the benzodiazepines and sedatives.

In 2007 after I returned to private practice, the State of Washington published guidelines for the use of opioids in the management of chronic pain.

The pain and addiction practice I created in Jacksonville already met or exceeded all of these standards.



John B. Hunt, M.D.
William S. Jacobs, M.D.



I thought I had one of the most advanced pain programs in the state.

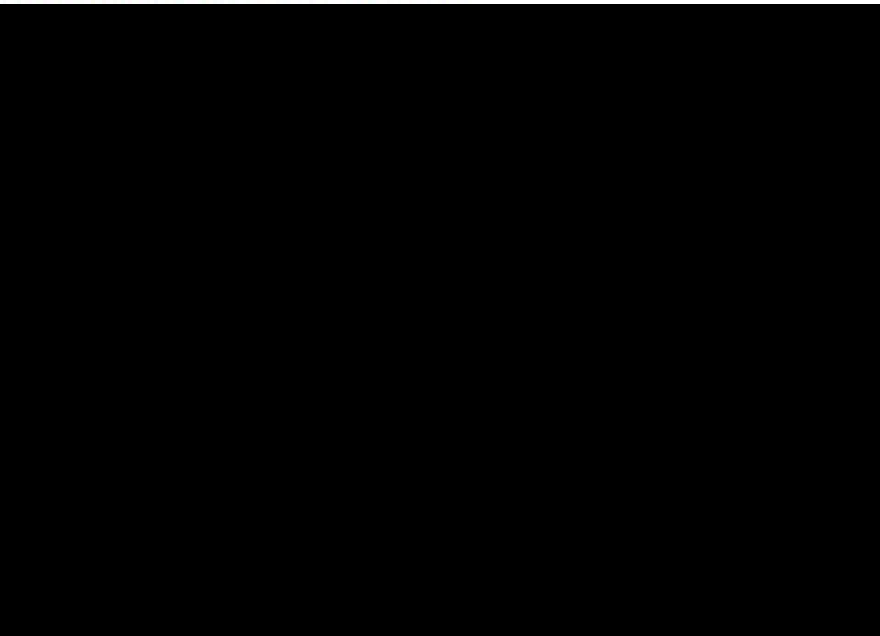
When Florida passed legislation requiring licenses for pain clinics, I trained their first set of inspectors.



OxyContin Maker Pleads Guilty

Manufacturer, execs
admit misleading
public about risky
painkiller

May 10, 2007 12:01 PM CDT



A TALE OF TWO OXYCONTINS

Addicts seeking the drug on the black market pay far less for the tamper-resistant OxyContin than the old version, suggesting that the new version is harder to crush and abuse.

OXYCODONE STREET PRICES, MONTHLY

\$2.50 per milligram



Source:

<http://features.blogs.fortune.cnn.com/2011/11/09/oxycontin-purdue-pharma/>



The Florida Prescription Drug Monitoring Program, known as E-FORCSE[®] (Electronic-Florida Online Reporting of Controlled Substance Evaluation Program), was created by the 2009 Florida Legislature in an initiative to encourage safer prescribing of controlled substances and to reduce drug abuse and diversion within the state of Florida.

Prescription for Change | Florida's efforts to tackle 'pill mills' have paid off

From March 2011, when Gov. Rick Scott announced new strike forces aimed at pill mills, through Feb. 13, 2012, there were:

2,040 arrests statewide related to alleged pill mills

446,000 pills seized

56 vehicles seized

390 weapons seized

\$4.6 million in currency forfeited

The number of pain-management clinics registered with the state health department has fallen 38% from its peak.



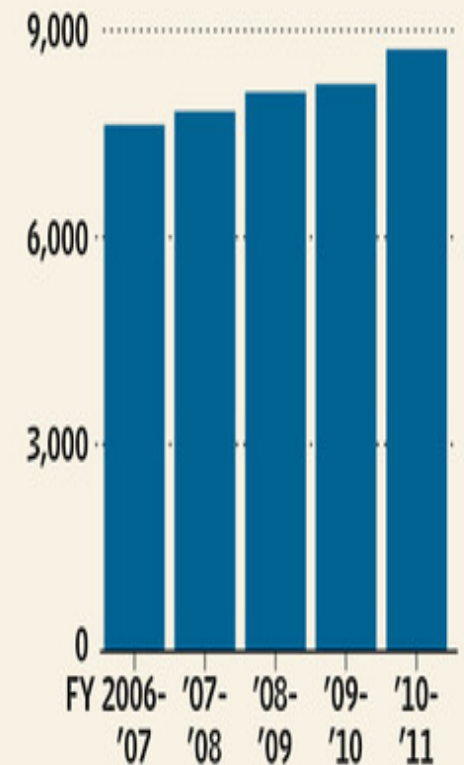
In 2010, 90 of the top 100 oxycodone-purchasing physicians in the nation were in Florida...



...by 2011, only 13 of the top 100 purchasers were in Florida.

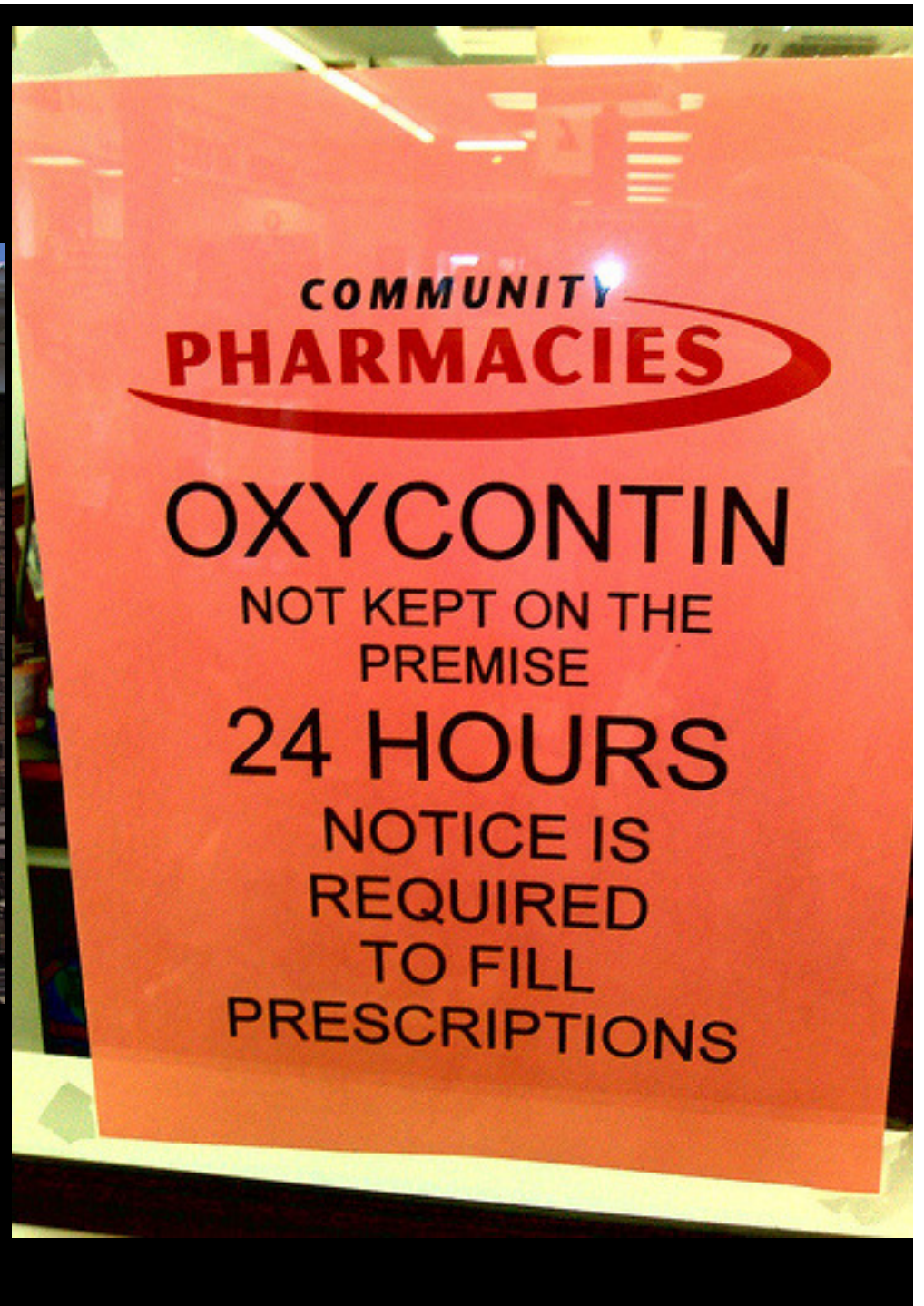
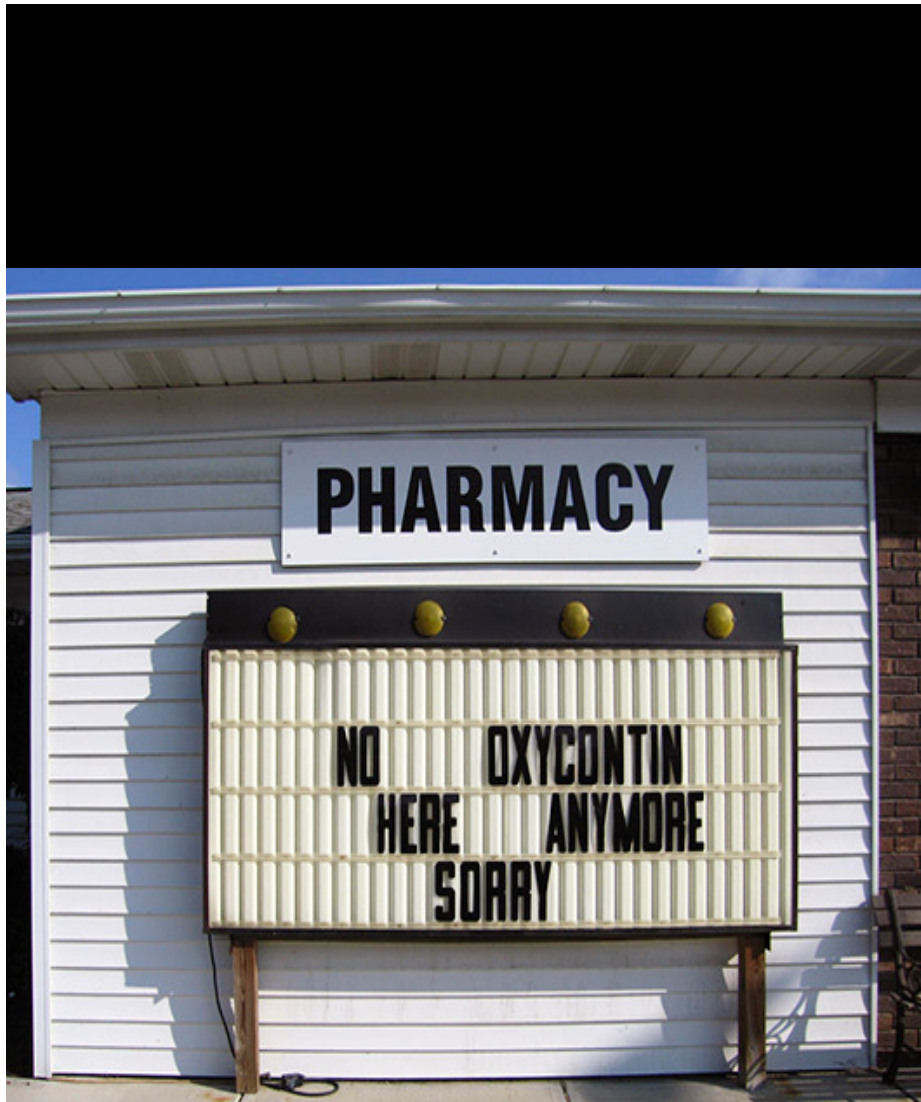


However, the number of pharmacies has risen, which officials worry may be linked to unscrupulous operators.



Note: Fiscal year ended June 30 Sources: Florida Department of Health; Florida Department of Law Enforcement; Drug Enforcement Administration

The Wall Street Journal



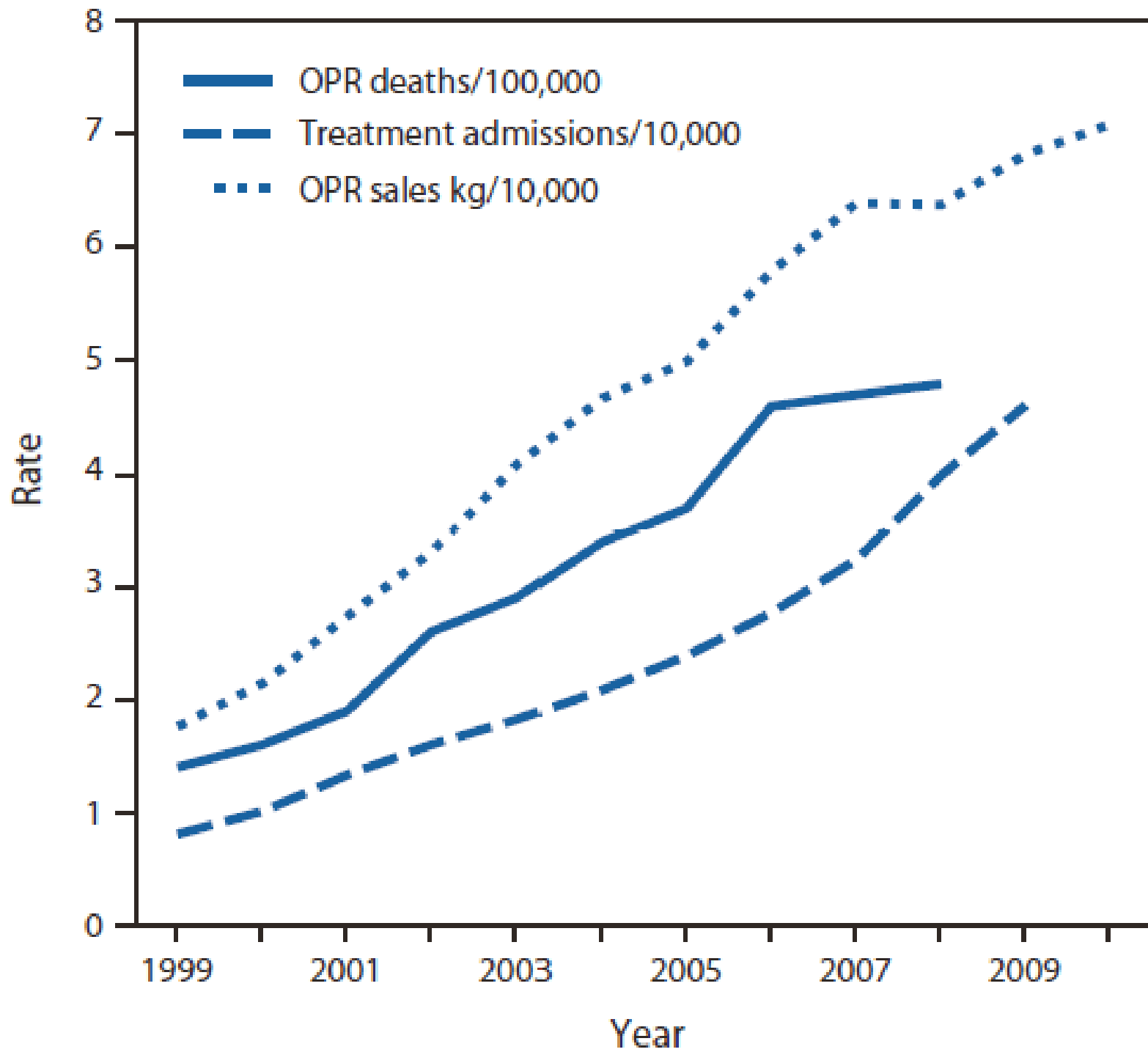


I was continuing to do Forensic work as an Expert Witness and was being bombarded with cases of overdose deaths from around the state.

I reviewed patient mortality in our practice. I had not had any deaths but my partner had a couple.

They were all listed by the Medical Examiners as “Accidental death related to the combined effects of . . .”

and listed all of the drugs discovered on a post mortem toxicology screen, at least one of which was an opioid.



The US has **5%** of the world's population, yet consumes **85%** of the world's prescription opioids.

Accidental opioid overdoses are now the leading cause of death in adults between the ages of 35 and 55 (above cancer, suicide, car accidents, heart attacks, smoking, HIV).

Emergency Departments see more cases related to prescription drug abuse than to illegal drug abuse.

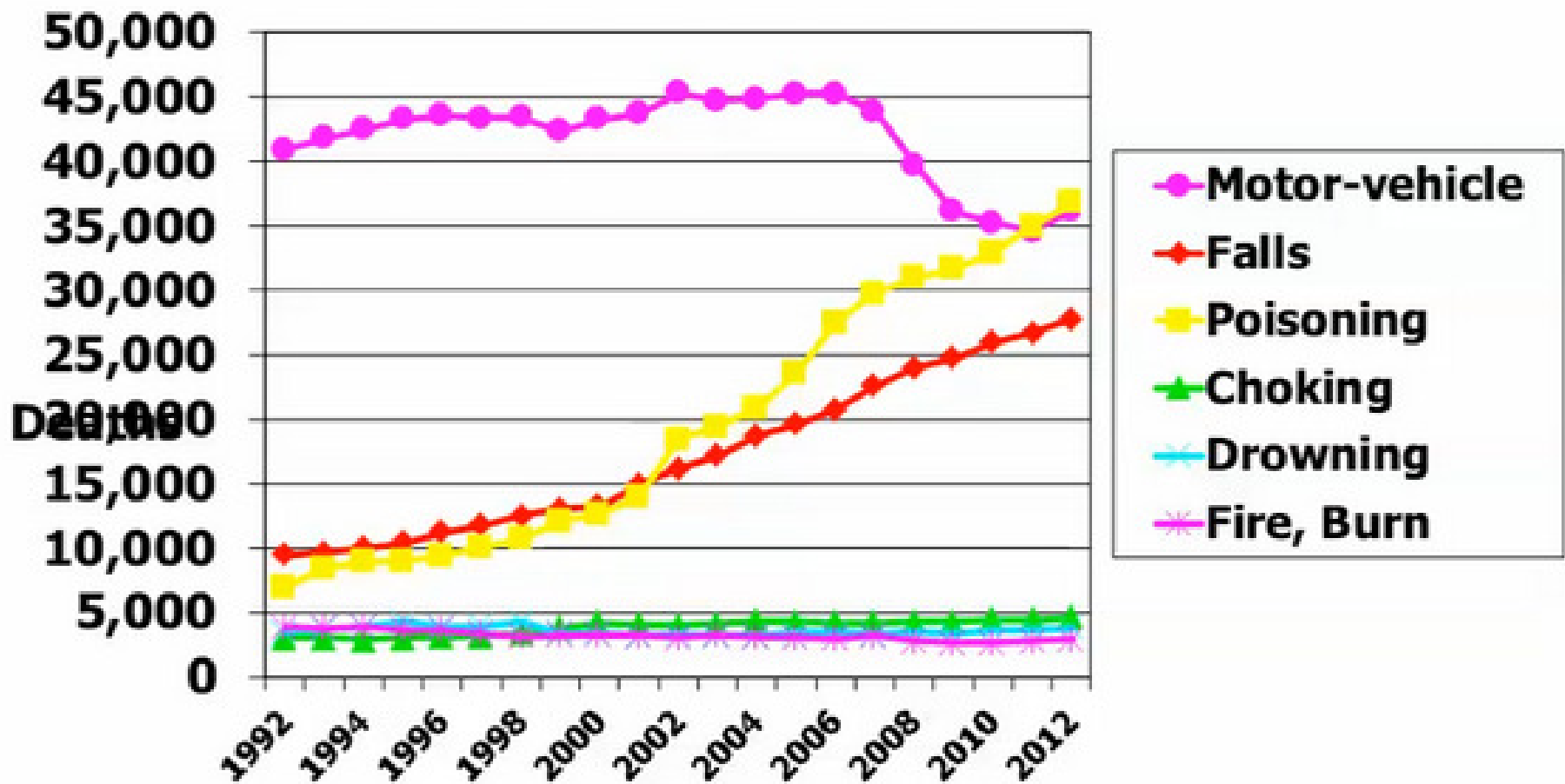
One quarter of high school students have used prescription opioids to get high.

High school students now look forward to having their wisdom teeth taken out because they know they will get a prescription for opioids.





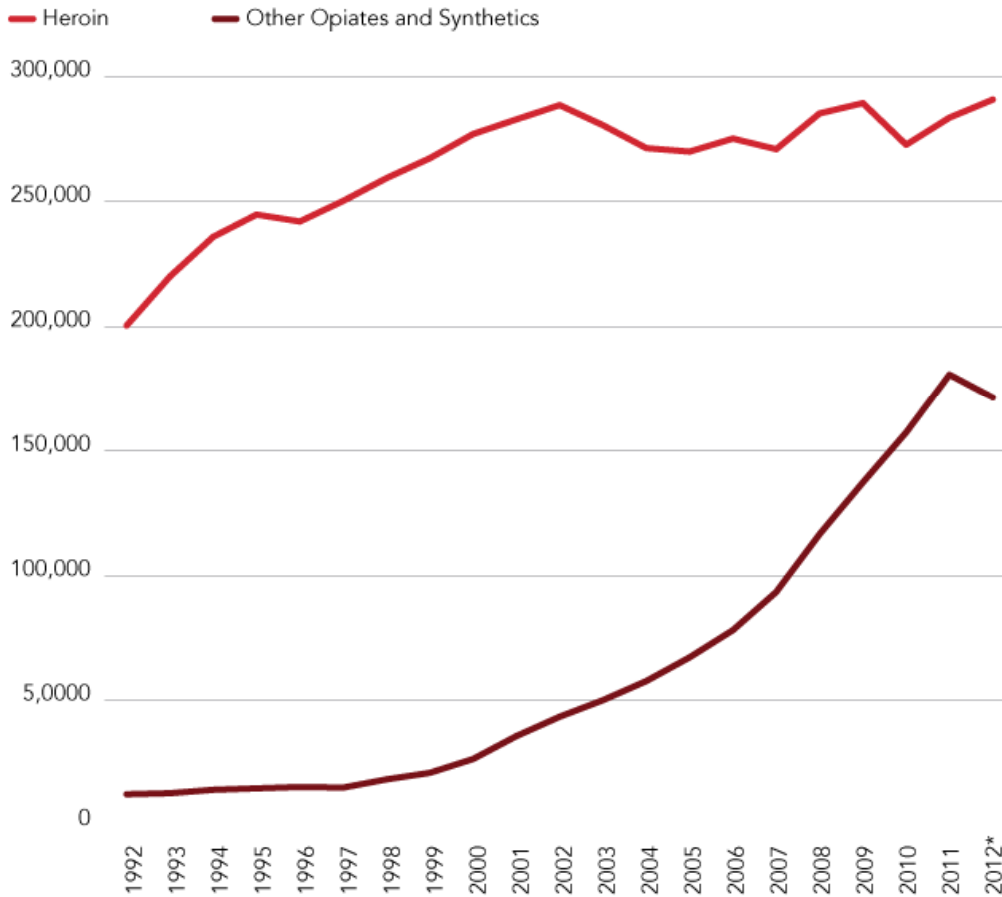
Trends in Leading Causes (p. 45)



Painkillers And The Heroin Market

A growing number of people are using heroin in recent years, in part because it can be cheaper and easier to find than opioid painkillers purchased on the black market. Most heroin users were first hooked on prescription opioids, which generated \$11 billion in 2010 for the pharmaceutical industry.

Substance abuse treatment facilities admissions by primary drug



*2012 data for Mississippi, Pennsylvania, and West Virginia are not available.

4 out of 5

new heroin users have abused painkillers.

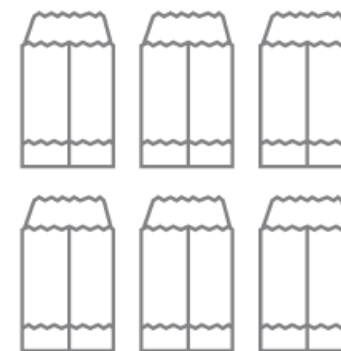


A Cheaper High

\$30 can buy one oxycodone pill on the street in New York...



or six hits of heroin.



This is a public health issue. It is about keeping patients safe. It is NOT about which providers are the nicest or most compassionate. In fact, in this instance, the best practice is the hardest practice – the one that sets limits and tells patients what they don't want to hear.

There are no published guidelines around the recommended amount of opioids for acute pain.

There is no easy method to dispose of opioids that are no longer needed.

It is illegal to return them to your doctor or your pharmacist.

It is unsafe to flush them down the toilet.

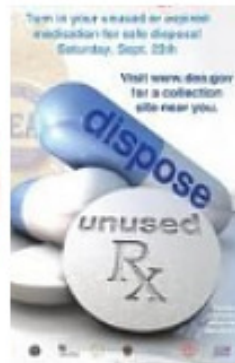
The Drop Boxes that do exist are few and far between.

CLEAN OUT YOUR CABINET!

WORLD'S MOST DANGEROUS LEFTOVERS



Disposal of Unused Medications



ERROR: stackunderflow
OFFENDING COMMAND: ~

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