What they didn’t teach you in residency about Diagnosing & Treating Prescription Opioid Abuse

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American Psychiatric Association
Annual Meeting
May 20, 2007
Prescription Opioids

• Fastest growing drug abuse
• Usually used orally but may be crushed & snorted or injected
• Injection less likely with combo products, more likely with Oxycontin
• Schedule III products available via Internet but not Schedule II
• More frequent source: medicine cabinets & prescriptions
• Believed to be safer than illicit street drugs
Epidemiology

- In 2001, 8 million persons abused prescription pain relievers at least once during previous 12 months
- In 2004, this had jumped to 11.4 million
- Between 1994-2001, narcotic analgesic abuse more than doubled
- In 2002, prescription drugs were second only to marijuana as most commonly abused drugs
Figure 1. Annual Numbers of New Nonmedical Users of Prescription-Type Drugs, by Drug Category: 1965–2000
Evolving Landscape of Drugs of Abuse

Farming

Pharming
Changing Methods of Distribution

Hand commerce → E commerce
Potential subpopulations of prescription Opioid Abusers

- Persons who abuse or are dependent on only prescription opioids
- Abusers of other opioids, e.g., heroin, when they cannot get their drug of choice
- Polydrug abusers
- Pain patients who develop abuse or dependence problems on these drugs in the course of legitimate medical treatment
Why Has the Abuse of Prescription Drugs Been Increasing?

- Increasing numbers of prescriptions (greater availability)
- Attention by the media & advertising (television and newspaper)
- Easier access (e.g. internet availability)
- Improper knowledge & monitoring (adverse effects go unrecognized)
As Prescriptions Increase, Emergency Room Reports Have Increased at the Same or Faster Rate

Number of Prescriptions (in 1000s)

Source: IMS Health for Prescriptions and SAMHSA (DAWN) for Emergency Department Mentions

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Prescription Opioid Abuse Historical Aspects

1990 - Current

- Through the efforts of pain control advocates, organized medicine, scientific journals, & malpractice suits, prescribing opiates for pain became more common during the last decade of the 20th Century.

- Opioid therapy became accepted (although often inadequately) for treating acute pain, pain due to cancer, & pain caused by a terminal disease.

- Still disputed is the use of opioids for chronic pain not associated with terminal disease.
Increased Media Attention
Easy Access: Role of the Internet?

“Delivered in the Privacy of your Home”

Some reasons why you should consider using this pharmacy:

- No consultation fee
- No prescription required
- Free Worldwide delivery
- Discrete packaging
- Mail order to your door
- Drugs at low prices

No prescription required!
Improper Knowledge & Monitoring?

• Primary care has become the major source for most prescription opioids.

• Risks for abuse and addiction not well understood. Except for prior history of addiction.

• Does pain protect individuals from addiction? Possibly.

• Is addiction a side effect of chronic use of opioids? Yes, in a small but significant number of patients.
Commonly known Mechanisms of Diversion

- Illegal sale of prescriptions by physicians;
- Illegal sale of prescriptions by pharmacists;
- “Doctor Shopping” by individuals who visit numerous physicians to obtain multiple prescriptions;
- Illegal substitutions or “shorting” by pharmacists;
- Theft, forgery, or alteration of prescriptions
- Robberies & thefts from pharmacies & thefts of institutional drug supplies
- Internet sales
Less Often Discussed Mechanisms

- Residential Burglaries
- “Obituary Shopping”
- Hotel & residential “sneak thefts”
- Supply-chain theft
  - In-production losses
  - In-transit losses
  - Returns/reverse distributors
  - Employee pilferage
Mechanisms of Diversion by Middle & High School Students

- Thefts from family medicine cabinets
- Drug “switching” at home
- Drug trading at school
- Thefts & robberies of medications from classmates
Is pain associated with opioid disorders?

Opioid Disorders According to Different Levels of Past 4 Week Interference Due to Pain

Nearly Linear Relationship of Pain & Opioid Use Disorder

Source: NESARC Study
Prevalence of Co-Morbid Chronic Pain & Substance Abuse

- 10-30% of adult population has chronic pain
  - 10-15% background rate of substance abuse
    - 2-9 million in US with both conditions
- 2 million adults have opioid addiction
  - 30-60% have chronic pain
    - 0.6-1.2 million with pain & opioid addiction
- Cost of care is approx. 10 times that of average pt, 3 times major depression
Initial Assessment

• Categories
  – Patient in stable recovery
  – Patient on maintenance therapy
  – Patient actively abusing

• Covariates
  – What is the substance of abuse?
  – Co-morbid mental illness?
  – Social supports
Universal Precautions

-OR-

How to Structure a Program

• Clinical Assessment
  – Physical exam, including skin
  – Pill counts
• Lab tests
  – LFTs, CBC, HIV
  – Urine toxicology
• Prescription monitoring program data
• Significant other reports, medical records
Treatment Issues

Who is the Patient

- **Age**
  - Adolescent
  - Adult
  - Elderly

- **Drug History**
  - New onset of drug abuse
  - Relapser
  - Chronic poly substance abuser

- **Route**
  - Oral
  - Intranasal
  - Injector

- **Comorbidity**
  - Psychiatric
  - Chronic pain
Treatment Options

• Detoxification
  – To antagonist maintenance (naltrexone, nelmefene, depot naltrexone)
  – To residential therapeutic community
  – To abstinence-oriented programs (counseling, 12 step programs)

• Maintenance
  – Methadone
  – Buprenorphine
Opiate Addiction
Pharmacotherapy

- **Agonists**
  - Methadone, LAAM

- **Partial Agonists**
  - Buprenorphine

- **Antagonists**
  - Naltrexone

- **Anti-Withdrawal**
  - Methadone; Buprenorphine
  - Clonidine: rapid detox using Buprenorphine, Naltrexone, & Clonidine

- **Anti-Craving**
  - Clonidine or Lofexidine
Advantages of Buprenorphine

• Buprenorphine binds more tightly to the receptor than any other opiate

• It is a partial mu agonist, occupying that receptor only 70%—also kappa antagonist

• Ceiling effect protects against overdose—but also limits degree of agonist effect—ceiling effect approximately 32 mg

• Withdrawal easier than from methadone or heroin

• Maintained patients describe:
  – “Clear headedness”
  – Increased energy
  – Improved sleep & mood stability
  – Easier to engage in therapy