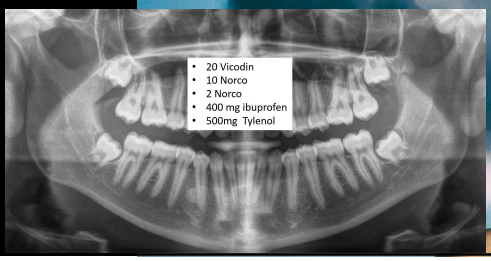
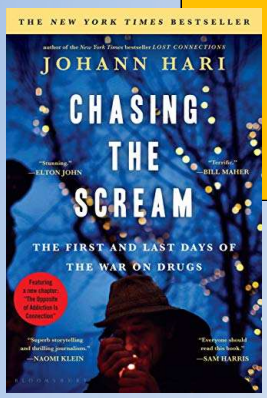
Once Upon A Time



In the US, 1 person dies every 5 minutes from opioid overdose

The OPIOID Zeitgeist

Use and Misuse
How did we get here?
Where are we going?



Short term use
5 – 7 days,
Non-hospital
Immediate release only

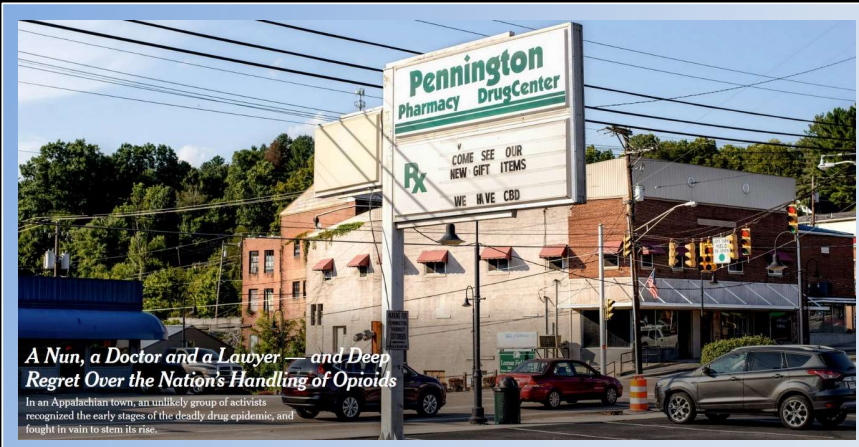
Bosack, Spring, 2023

ADA®

ADA Releases New FAQ About DEA Continuing Education Requirement

Mar 13, 2023

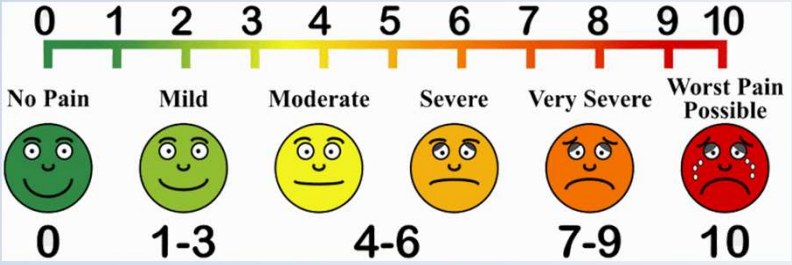
8 hour, one-time training on safe, controlled substance use by July 1, 2023.




Sr. Beth Davies


Dr. Art Van Zee

Pain



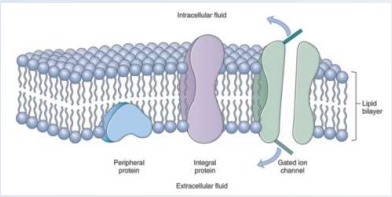
- Subjective
- "is an opinion"
- Cannot be measured

5

Acute Pain

normal, predictable, protective, psychologic response

- An unpleasant sensory (biologic) and emotional (psychologic) experience associated with actual or potential **tissue damage**
- Usually easily localized
- "nociceptive"
- Somatic vs. Visceral
- Perception vs. Tolerance
  - Attitudes, beliefs, personalities, culture
  - Anxiety, depression, sleep deprivation, substance use disorder



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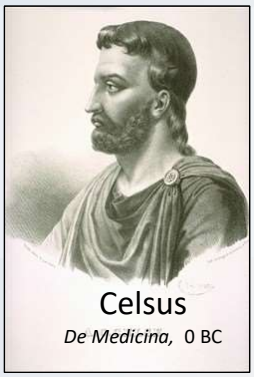
Inflammation

- Normal process to protect and promote healing
  - Vascular – 5 cardinal signs of inflammation
    - Calor, Rubor, Tumor, Dolor, Functio Laesa
    - Vasodilation and increased vascular permeability
      - Histamine, bradykinin, prostaglandins
  - Cellular - diapedesis



Celsus
De Medicina, 0 BC

7

Chronic Pain

- Pain without apparent biological value that has persisted beyond normal tissue healing time, usually 3 months.
  - Chronic back pain
  - Fibromyalgia
  - Headaches, migraines
  - Post-traumatic, post viral

8

Neuropathic pain

- Burning, freezing
- Lesion or disease of the nervous system
- Can be chronic (> 3 months duration)
- Central “sensitization”
- Usually responds to TCA’s, anti-convulsants

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Pain responses

- Genetics
- Gender
- Culture
- Psychological factors
- Social factors
- Past experiences

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Pain Catastrophizing

- A heightened emotional response to anticipated or actual pain
- "exaggerated" pain experience causes the patient to "feel" more pain
- Or….. Does more pain trigger a heightened response????

Quartana PJ, et. al. Pain catastrophizing: a critical review. Expert Rev Neurother 9:745-58, 2009.

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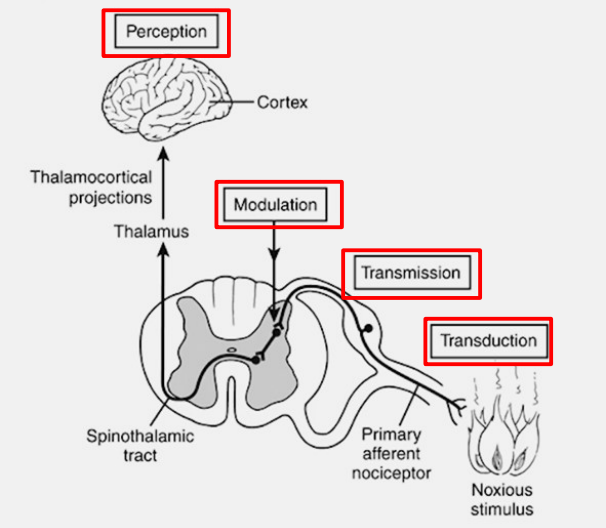
Pain mechanisms

- Nociceptive
  - Tissue damage stimulates specialized receptors
  - Usually acute, limited in duration, ends with tissue healing
  - Responds well to NSAIDs and APAP



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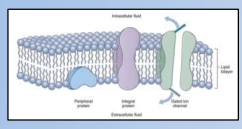
Disrupt cell membrane



Phospholipase A2

Arachidonic Acid

COX 1

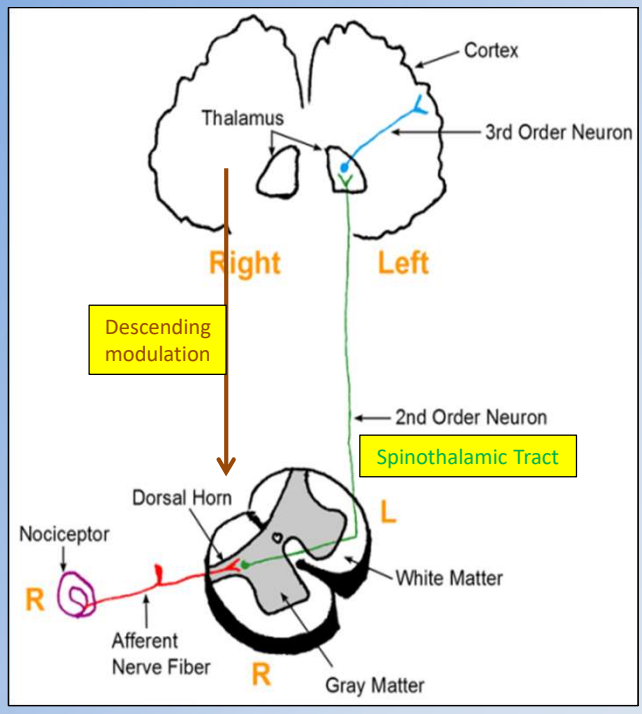
Prostaglandins, etc.

- Protect GI mucosa
- Maintain RBF
- **CLOTS**

COX 2

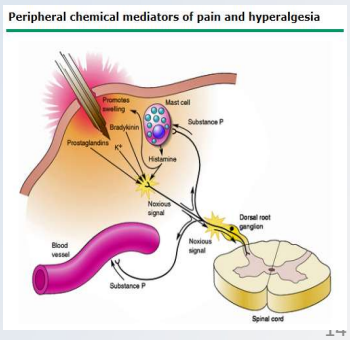
Prostaglandins, etc.

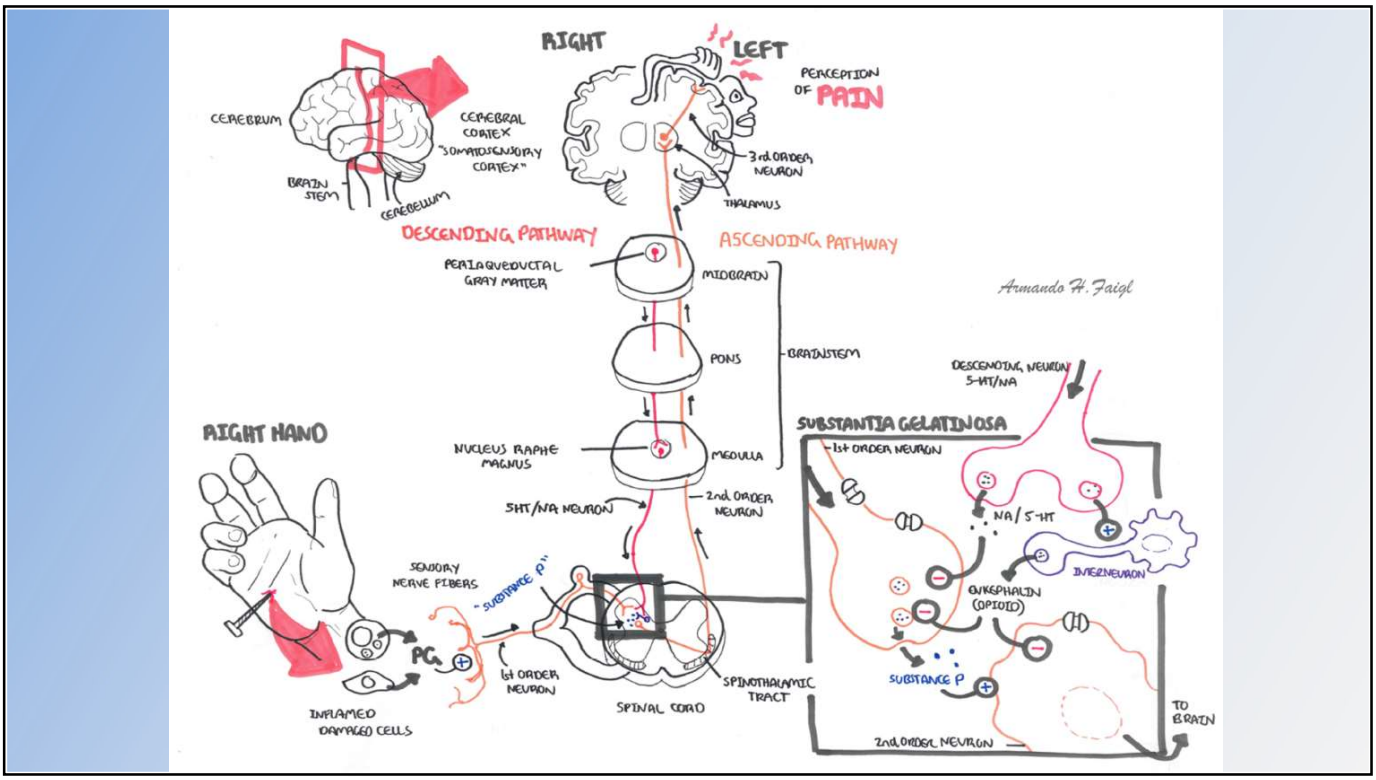
- Pain, swelling, fever
- Maintain RBF
- **BLEED**



Nociceptor

- Specialized nerve endings of
  - **Aδ** – fast, localized, low threshold, myelinated nerves
    - Neurotransmitter – glutamate
  - **C** – slow, poorly localized, unmyelinated
    - Neurotransmitter – substance P
- Sensitive to **heat** and **pressure** and..
- Pro-inflammatory **chemicals** released with tissue damage
  - Arachidonic acid
  - Prostaglandins
  - K^+
  - 5-HT (serotonin)
  - Bradykinin
  - Lactic acid
  - Substance P
  - AcH





Definition of terms

analgesia – diminished pain sensation without LOC

- **Preventive Analgesia (preferred term vs. pre-emptive)**
  - Any anti-nociceptive regimen that will attenuate pain-induced sensitization
  - Before pain starts and continuous until pain stops (?)
  - Round the clock dosing
  - NSAID's inhibit PG formation, no effect on PG already there
- **Multimodal Analgesia – target different sites in pain pathway / synergy**
  - Reduce opioid requirements, better analgesia, less side effects
  - Analgesics – opioid, non-opioid
  - Long acting local anesthesia
  - Gabapentinoids
  - Avoid inflammation – cold packs, steroids, keep head elevated
  - Careful manipulation / antibiotics when indicated

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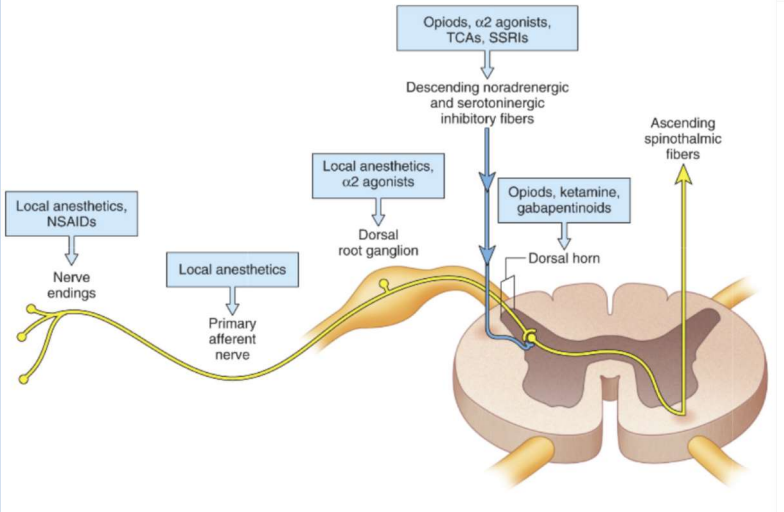
Non-Opioid Approach

(multimodal) – different agents, different sites of action

- NSAID's – ASA*
- Acetaminophen
- Anticonvulsants
  - Gabapentin*
  - Pregabalin*
- Anti-inflammatories
  - Temperature therapy
  - Steroids*
- Long acting local anesthetics

* pre-emptive



Analgesic drug options for pain management

interrupt impulses / depress CNS interpretation

- <u>Non-opioids</u>
  - interrupt prostaglandin synthesis by inhibiting COX
    - NSAIDs (reversible)
    - Acetaminophen (APAP)
    - Aspirin (ASA) (irreversible)
  - enhance descending inhibitory neural traffic – modulate ascending traffic
    - Gabapentinoids / Tricyclic anti-depressants / Tramadol
- <u>Opioids</u>
  - activate specific receptors - Mu

Prostaglandins

- Inflammation, pain, fever (COX2)
- Protect stomach mucosa (COX1)
- Maintain kidney function (COX 1 / 2)
- Stop bleeding (constriction, enhance P.) COX1
- Enhance blood flow (dilation, inhibit P.) COX2

Non-drug related options for pain management (post-op)
"multi-modal"

- Minimize inflammation
  - RICE – rest, ice, compression, elevation
  - Steroids – dexamethasone, methylprednisolone
    - Decadron™, Medrol Dose-pak™
      - Avoid with active fungal or viral infection
      - GI upset, sleep disturbance, psychiatric challenge, diabetes
  - Careful surgical manipulation
- Adequate / long acting local anesthesia

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Multi-modal Analgesia
NNT

- Number Needed to Treat

A measure of efficacy of a specific dose of an analgesic: the # of patients needed to get a 50% reduction in maximal pain for 4-6 hours.

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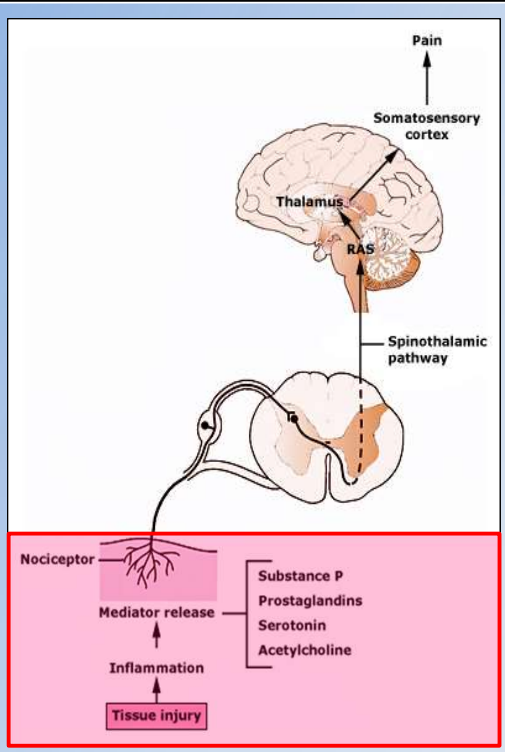
CENTRAL



Opioids
Acetaminophen
Gabapentinoids
TCA

PERIPHERAL

NSAID's
Steroids / Cold compress
Bupivacaine

Acetaminophen (20% opioid sparing)

APAP = N-acetyl-para-aminophenol

- COX-3 inhibition - central
- Analgesia, antipyretic
- No effect on inflammation
- Minimal GI irritation
- "safer" than ASA

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	Ibuprofen	Acetaminophen
Analgesia	*Peripheral* PG blockade (inhibit Cox 1 Cox 2)	*Central* PG blockade (inhibit Cox 3)
Anti-pyretic	+++	++
Anti-inflammatory	++	-
Toxicity	Renal, HTN, clots (< 10 days duration)	Liver toxicity Large or prolonged dosing
Side Effects	GI upset, bleeding (?)	few

NSAIDs

30% opioid sparing

ibuprofin (Advil™, Motrin™)
naproxen (Aleve™, Anaprox™)
ketoprofen (Orudis™)
flurbiprofen (Ansaid™)
celecoxib (Celebrex™)

- Inhibit cyclooxygenase, prevent formation of PG, which sensitizes nociceptors
  - Inhibit gastroprotective PG – ulceration
  - Inhibit platelets – bleeding
  - Ceiling effect for analgesia
  - No ceiling for side effects
  - Decrease renal blood flow

COX 2 NSAIDS spare these side effects, may enhance thrombosis

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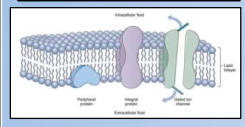
Pain mechanisms

Disrupt cell membrane



Phospholipase A2

Arachidonic Acid

COX 1

Ketorolac (Toradol™)
Aspirin

Prostaglandins, etc.
- Protect GI mucosa
- Maintain RBF
- **CLOTS**

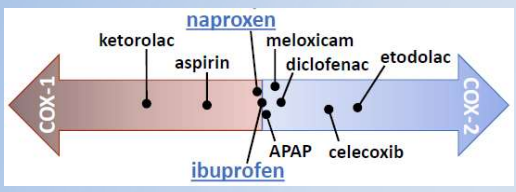
Block Cox 1
- TUMMY ACHE
- BLEED

Meloxicam (Mobic™)
Etodolac (Lodine™)
Celecoxib (Celebrex™)

COX 2

Block Cox 2
- ↓ PAIN, INFLAMM
- CLOT

Prostaglandins, etc.
- Pain, swelling, fever
- Maintain RBF
- **BLEED**



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Acetaminophen + EtOH

paracetamol

Popularity surged in the 80's after ASA linked to Reyes Syndrome

- **Analgesic, anti-pyretic**
  - 96% hepatic metabolism (became aware of hepatotoxicity in 1966)
    - 80% metabolized
    - 16% - converted by CYP2E1 to toxic **NAPQI**
    - Limited endogenous supplies of glutathione bind / reduce NAPQI, excrete
    - If supplies exhausted, NAPQI accumulates, hepatotoxicity results
  - Chronic ethanol induces CYP2E1, and "could" increase NAPQI
  - Co-ingestion could consume the CYP2E1 and be protective
  - Sudden EtOH cessation might be worrisome
  - "Keep drinking when you take Tylenol™"

Non-opioids
summary

- NSAID should be first line Rx
  - Anti-inflammatory component : dose
  - Use before pain - PREVENTIVE
- NSAID and acetaminophen are synergistic and should be used together
- Unlike opioids, there is a ceiling effect for analgesia
  - 400mg for ibuprofen
  - 1000mg for acetaminophen

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Analgesic Use According to Acute Pain Level

Mild	Ibuprofen 200-400mg prn q4-6º
Mild to Moderate	Ibuprofen 400-600mg q6º x 4 fixed doses, Then Ibuprofen 400mg prn q4-6º
Moderate to Severe	Ibuprofen 400-600mg PLUS acetaminophen 500mg q6º x 4 fixed doses, Then Ibuprofen 400mg + acetaminophen 500mg prn q6º
Severe	Ibuprofen 400-600mg PLUS acetaminophen 650mg with hydrocodone q6º x 4-8 fixed doses, Then Ibuprofen 400-600mg + acetaminophen 500mg prn q6º

Moore, PA, Hersh, EV. Combining ibuprofen and acetaminophen for acute pain management after third-molar extractions: translating clinical research to dental practice. J AM Dent Assoc 144:898-908, 2013.

Contraindications - review

absolute / relative

- **Acetaminophen**
  - Allergy / intolerance / lack of efficacy
  - **LIVER DISEASE**
- **Ibuprofen**
  - Allergy / intolerance / lack of efficacy
  - **PEPTIC ULCER DISEASE or RENAL DISEASE**
  - Coagulopathy – disease or medications
  - Relative contraindications (if Rx > 5 days)
    - Patients taking sulfonylureas for type II DM – glipizide, glyburide
    - Poorly controlled HTN
      - Prolonged use can interfere with anti-hypertensive medication (except CCB)
    - Cardiovascular disease
    - Lithium, high dose methotrexate
  - Pregnancy

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Clinically Significant Drug Interactions with NSAIDs

Diuretics, anti-HTN	Antagonized by NSAID	↑ Na^+, H_2O retention with increased BP
Alcohol	Enhanced by NSAID	↑ GI irritation
Warfarin	Enhanced by NSAID	↑ bleeding risk
Anti-platelet drugs	Enhanced by NSAID	↑ bleeding risk, competes with ASA, ↑ clot risk
DAOC	Enhanced by NSAID	↑ bleeding risk
K^+ sparing diuretics, K^+ suppl. Triamterene, Spironolactone, Amiloride	Enhanced by NSAID	Possible hyperkalemia
Chemotherapeutic Agents	Enhanced by NSAID	↑ risk of GI ulceration
SSRI's Fluoxetine, sertraline, paroxetine	Enhanced by NSAID	↑ risk of GI ulceration and bleeding
Corticosteroids	Enhanced by NSAID	↑ Na^+, H_2O retention with ↑ BP, ↑ risk of GI ulceration

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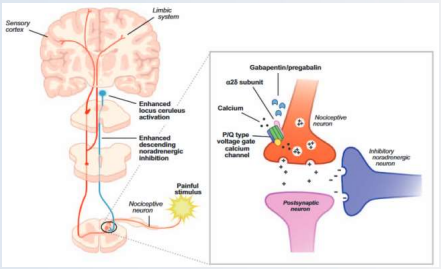
Perioperative Gabapentinoids

"membrane stabilizers" (off label for post-op pain control)

Pregabalin - Lyrica™
Gabapentin - Neurontin™

- Modulate release of excitatory glutamate from activated nociceptors
- Indications
  - Post-herpetic neuralgia, seizure, fibromyalgia, diabetic neuropathic pain
- Can reduce immediate post-op pain and opioid use
- Oral absorption of pregabalin > gabapentin
  - Pregabalin elimination T 1/2 ~ 5 hours
  - Pregabalin side effects
    - Sedation, dizziness, HA, visual disturbance
- Pregabalin oral dose 75-150 mg – pre or post-op



Schmidt PC, et al. Perioperative Gabapentinoids. Choice of Agent, Dose, Timing, Effects on Chronic Postsurgical Pain. Anesthesiol 119: 1215-21, 2013.

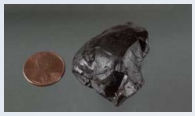
Steroids

- Anti-inflammatory and immunosuppressive
- Decrease nociceptive input
- Single dose does not increase wound infection

Narcotics:

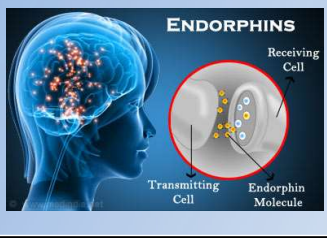
- Opioids – all drugs that act at mu receptor
  - Partially derived from poppy
  - Synthetic – in the lab
  - Codones, morphones, fentanyls
  - There is no ceiling effect
- Opiate – natural derivative of poppy
  - Morphine, heroin, codeine

Papaver somniferum



Opium

Heroin



- Released during exercise, eating, socializing, panic, fight for flight
  - runner's high, frantic parent
- Attach to same receptors
  - Suppress pain / calm / slow breathing

Tylenol #3 = 300 mg acetaminophen
- Codeine 30mg

NORCO – all tablets have 325mg acetaminophen
- 5, 7.5 OR 10mg hydrocodone

LORTAB – liquid
- 15ml = 7.5mg hydrocodone + 325mg acetaminophen

VICODIN – all tablets have 300mg acetaminophen
- 5, 7.5 or 10mg hydrocodone

PERCOCET - 325mg acetaminophen
- Oxycodone 5mg

CYP2D6

enzyme deficiency – in 7% of patients
inhibited by SSRI

- Codeine – a "pro-drug"
  - Analgesia mostly dependent on CYP converting to morphine
  - Prodrug can cause nausea and constipation
- Hydrocodone – parent drug has some innate analgesia
  - Some activity due to conversion to hydromorphone
- Oxycodone – parent drug provides most analgesic activity
  - Conversion to oxymorphone not that important
  - Can be given in lesser dose

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Codeine > hydrocodone are pro-drugs

% of activity depends on conversion of parent drug to active drug by CYP2D6

- CYP activity is variable –
  - **Increased CYP activity (1-7% of general population) – TOO MUCH**
    - Especially children – AVOID CODEINE IF < 12 YEARS
    - Concomitant dexamethasone – induces CYP2D6
  - **Decreased CYP activity – NOT ENOUGH**
    - 10%+ of general population cannot convert
    - Concomitant SSRI's
      - Prozac™ (fluoxetine)
      - Paxil™ (paroxetine)

- Codeine (converts to morphine)
- Tramadol = Ultram™ (converts to M1 opioid metabolite)
- Hydrocodone – Vicodin™, Norco™ (converts to hydromorphone)
- Oxycodone = OxyContin™, Percodan™ (converts to oxymorphone)
- Hydromorphone = Dilaudid™
- Morphine

Tramadol

- Tramadol – also a pro-drug requiring CYP conversion
  - 50mg tablet ~ 60mg codeine
  - Norepi and serotonin reuptake inhibitor
    - Like TCA's – interrupts nociceptive impulses
  - Mood elevation
  - Centrally acting analgesic, used for chronic pain
  - Tremors / Seizures at high doses

Tricyclic Antidepressants
Amitriptyline (Elavil™)
Imipramine (Tofranil™)
Doxepin (Sinequan™)
Desipramine (Norpramin™)

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Pain control in children < 12 yrs.

Avoid codeine and tramadol in children < 12 years due to variability in metabolism (CYP2D6) that could result in fatal overdoses.

(Caution in children > 12 who have respiratory disease or obesity.)

Pediatric Analgesic Dosing

	Dose	Maximum Dose	Not to Exceed
Acetaminophen	10 – 15mg/kg q4-6h	5 doses / 24 hours Or 75mg/kg/day	4,000mg
Ibuprofen	4 – 10 mg/kg q6-8h	40mg/kg/day	3,200mg
Hydrocodone Always with APAP 5/325	0.25ml/kg	6 doses / day	
Lortab Elixir 7.5/500mg/15 ml	0.25ml/kg q4-6h	6 doses / day	
Oxycodone	0.1 – 0.2mg/kg q4-6h		

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Oral Drug	Dose (mg)	Half-life (h)	Onset (h)	Analgesic action (h)	Peak Duration (h)
Codeine [1]	15-60	4	0.25-1	0.5-2	3-4
Hydromorphone	1-4	2-3	0.5-1	1	3-4
Hydrocodone	5-7.5	2-3	0.5	1.5	3-4
Oxycodone	5	3-5	0.5	1-2	4-6
Tramadol [2]	50-100	5-6	0.5-1	1-2	4-6

1 Codeine not recommended for post-op analgesia due to genetic variable metabolism
2 Tramadol not classified by FDA as an opioid; however, tramadol possesses naloxone partial reversal analgesia

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Federal Schedules of Opioid Medications

II	***Codeine***
	Hydrocodone combos Vicoden™, Norco™, Lortab™, Vicoprofen™
	Hydromorphone - Dilaudid™
	Morphine - MSContin™
	Oxycodone combos OxyContin™, Percocet™, Percodan™ (+ASA)
III	Codeine Combos – Tylenol #3™
	Buprenorphine / naloxone: Suboxone™, Subutex™
IV	Tramadol - Ultram™
V	Codeine Cough Suppressant

Schedule II rules
- Require signed prescription
- Must be filled in 30 days in Illinois (no federal law)
- emergency situation ?

Schedule III rules
- Oral or fax
- Can be refilled only 5 times in 6 months

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Opioid Analgesics

therapeutic considerations

Hydromorphone	1.5mg
Oxycodone	4 mg
Hydrocodone	6 mg
Morphine	6 mg
Codeine	40 mg

- Equipotent doses are equi-analgesic
  - Successful pain control depends on dose, not drug
- Oral doses are attenuated by
  - Gastric degradation
  - First pass metabolism

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Morphine equivalent doses

Hydromorphone	1.5mg
Oxycodone	4 mg
Hydrocodone	6 mg
Morphine	6 mg
Codeine	40 mg
Tramadol	60 mg

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Are “weak” opioids safer?

codeine, tramadol

- Not necessarily
  - May not work
  - Can still be a substrate for addiction
  - Side effects present
  - Might trigger withdrawal with opioid dependence

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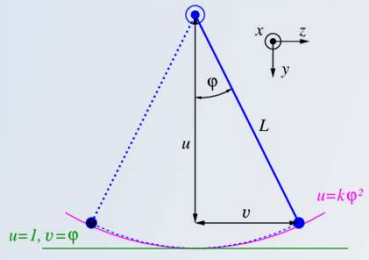
Goals of perioperative pain management

- Relieve suffering
- Achieve early mobilization after surgery
- Achieve patient satisfaction



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Pain levels

Mild
- Simple extractions
- Sub-gingival procedures
- Routine endo
- Implants

Moderate
- Minor flap surgery
- Surgical extraction
- *Fractured tooth*
- *Acute pulpitis*
- *"Dry socket"*

Severe
- Full flap surgery
- Boney impactions
- *Abscess pressure*

Some Predictors of Postoperative Pain

- Anxiety
- Psychological stress
- Pre-operative pain
- Younger Age
- Type of surgery
- Gender / culture

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WHO Analgesic Ladder
modified

Non-opioid
- ASA
- APAP
- NSAID

Non-opioid +
- codeine
- tramadol

Non-opioid +
- hydrocodone
- oxycodone
- hydromorphone

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Analgesic regimens

- Mild to moderate pain – round the clock dosing, NOT prn
  - Ibuprofen 400-800mg (or other equivalent NSAID)

    AND / OR
  - Acetaminophen 1000mg (<4g/day)

Maximal daily doses
- Ibuprofen – 3200mg
- Acetaminophen – 3000mg

Table 6. Number Needed to Treat (NNT)*

Drug	*NNT*
Ibuprofen 200 mg/acetaminophen 500 mg	1.6 (1.4–1.8)
Naproxen 500 mg	1.8 (1.6–2.1)
Codeine 60 mg/acetaminophen 1000 mg	2.2 (1.8–2.9)
Oxycodone 10 mg/acetaminophen 650 mg	2.3 (2.0–2.6)
Ibuprofen 400 mg	2.3 (2.2–2.4)
Acetaminophen 600 mg	3.2 (2.9–3.6)

* The number of patients that are treated with the medication before 1 patient experiences 50% pain relief over 4 to 6 hours.[27] Adapted from Moore PA, Hersh EV. Combining ibuprofen and acetaminophen for acute pain management after third-molar extractions: translating clinical research to dental practice. *J Am Dental Assoc*. 2013;144(8):898–908.

49

Analgesic regimens

- Add opioid COMBINATIONS for breakthrough pain
  - Hydrocodone 5 – 10mg
    - Norco™ Lortab™ Vicodin™
  - Oxycodone 5 – 10mg
    - Percocet™ 5/325; 7.5/325; 10/325
- Tramadol 50-100mg

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Opioid

short term risks and adverse side effects

tolerance, dependence, hyperalgesia

- **Common**
  - N/V, sedation, constipation, urinary retention, sweating
  - Pruritis (itching) – histamine release
  - Respiratory depression, loss of upper airway tone
- **Rare**
  - Allergy
- **Serious**
  - Overdose and death
  - When combined with other sedatives
  - Opioid use disorder
- **In elderly**
  - Drug-drug interaction
  - Fall risk
- **Collateral risks**
  - Young children ingestion
  - Adolescent experimentation

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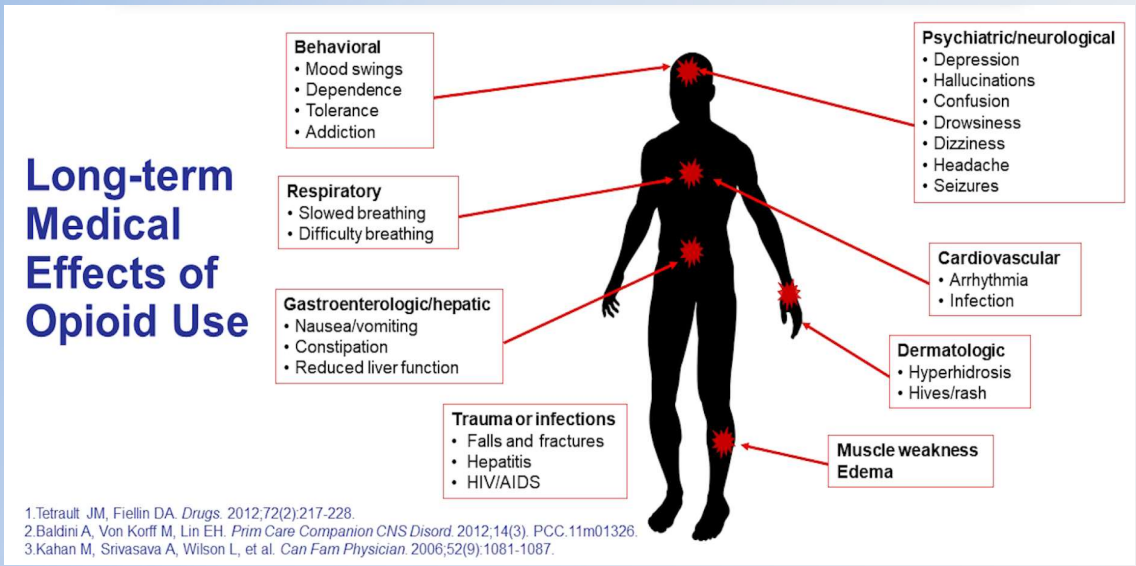
Opioid

long term risks and adverse side effects



1.Tetrault JM, Fiellin DA. *Drugs*. 2012;72(2):217-228.
2.Baldini A, Von Korff M, Lin EH. *Prim Care Companion CNS Disord*. 2012;14(3). PCC.11m01326.
3.Kahan M, Srivasava A, Wilson L, et al. *Can Fam Physician*. 2006;52(9):1081-1087.

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REMS

Risk Evaluation and Mitigation Strategy

- FDA drug safety program required for certain medication with serious safety concerns to help ensure benefits outweigh risks
- Reinforce medication use behaviors and actions that support the safe use of the medication

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Opioid Analgesic REMS

- Drug makers must avail training to prescribers
- Boxed label warnings must appear
  - Overdose
  - Death
  - Neonatal opioid withdrawal
  - Drug interactions

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Types of REMS Requirements

REMS include a risk mitigation goal, and are comprised of information communicated to and/or required activities to be undertaken by one or more participants (e.g., health care providers, pharmacists, patients) who prescribe, dispense or take the medication. Together, the goal, communications and/or activities make up the safety strategy.

Each REMS is designed to help one or more of the key participants in a REMS address a specific safety concern. The most common role(s) of each of these key participants in a REMS are further described elsewhere. These roles may be similar across programs, but the specific requirements and risk messages of each REMS is tailored to each medication, the nature of its risks, and the likely setting in which the drug will be, or is being, used.

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Original Contributions

Is it time US dentistry ended its opioid dependence?

Martin H. Thornhill, MBBS, BDS, PhD; Katie J. Suda, PharmD, MS; Michael J. Durkin, MD, MPH; Peter B. Lockhart, DDS

Thornhill MH, et. al. Is it time US dentistry ended its opioid dependence? JADA 150:883-889, 2019.

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MEDPAGE TODAY's KevinMD.com
Social media's leading physician voice

Are teenagers more vulnerable to the effects of opioids?

MYLES GART, MD | CONDITIONS | NOVEMBER 24, 2019

1. The younger you are when first exposed to opioids, the more likely the addiction in later life.
2. Perhaps due to alterations in the "feel good" neurotransmitters: dopamine in a not fully developed prefrontal cortex (internal reward systems).
3. Teenagers have overactive impulse to seek pleasure and less ability to consider the consequences.
4. Technology induced social isolation
5. Max out on non-opioid multimodal approach…..therefore no combo meds – Rx straight oxycodone 5 – 10 mg (OcyContin™)

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Safe opioid prescribing

- Check IPMP
- Screen patients for opioid misuse risk
  - Current or hx of substance abuse disorders
  - Rx Opioid Misuse Risk factors
    - Personal or family hx of substance use disorder
    - Age between 16 – 45 years
    - Legal hx (DUI, incarceration)
    - Caucasian
    - Mental health challenges
- Do not mix with other sedatives, EtOH
- Minimize risk of diversion by educating patients about
  - Safe storage – "locked box"
  - Proper disposal of unused medication

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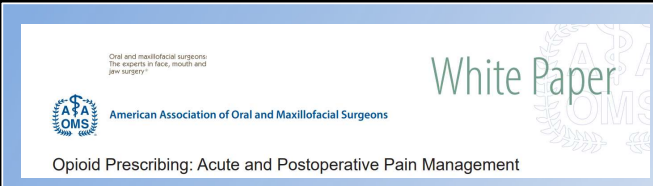

Ibuprofen – < 3,200mg/day
Acetaminophen - < 3,000 mg/day
No codeine to patients < 12 years

- Document everything
- Responsible Prescribing, uphold Dr-patient relationship
- Educate your patients
- Pre-op NSAID, steroid
- Long acting local
- Avoid extended release opioids
- NSAID / acetaminophen – paired or sequential, round the clock
- Short acting, lowest effective opioid dose for shortest duration for breakthrough pain
  - Access PDMP – state Prescription Drug Monitoring Program
  - Document need, safe storage and disposal

Pain control agreement

- Before treatment
- Goal is to reduce, not eliminate pain
- Alternatives to opioids – what the studies show
- Discuss risks vs. benefits
  - Abuse, addiction, diversion, overdose
  - Hyperalgesia, sexual dysfunction
- How to take opioids
- Expectations from Rx
- 1 prescriber, 1 pharmacy
- Safe storage and disposal

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Is refilling an opioid prescription without seeing the patient legal?

- "a prescription for a controlled substance must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his/her professional practice."

- "the responsibility for the proper prescribing and dispensing of controlled substances rests on the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription"

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Is refilling an opioid prescription without seeing the patient legal?

- Common themes
  - A valid provider-patient relationship must exist
  - The prescription must be issued for a valid medical purpose
  - The prescription must be therapeutic for the patient's condition

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Universal Prescribing Precautions

1. Document patient history – medical, social, drug
2. Document diagnosis that justifies prescription
3. Non-opioid, multimodal approach
   a. Long acting local anesthesia, ice/steroid to control inflammation
   b. Preemptive "around the clock" dosing NSAIDs + acetaminophen
4. Keep tamper-proof Rx pads in a secure location
5. If opioids are needed use consistent/standardized application of opioid prescribing precautions
   a. Document all discussions
   b. Educate patients about opioid risks/dangers – alleviate not eliminate pain
   c. Develop an opioid AGREEMENT prior to any intervention
   d. Estimate/predict opioid misuse risk FOR ALL PATIENTS
      - Check online prescription monitoring program, document this action
      - White, < 45; any hx of EtOH, tobacco, illicit drug use
      - Criminal history
      - Mental health challenges
      - Escalating use, drug seeking behavior, doctor shopping, scamming
   e. Lowest dose and quantity of immediate release opioids to reduce, NOT eliminate discomfort
   f. Avoid phone refills, request in-person evaluation to justify opioid refill Rx
   g. Refer to MD/pain specialty clinics to coordinate / manage chronic pain
   h. Explain safe storage
   i. Educate patient on immediate disposal of unused opioids

Summary

- Patients deserve pain relief
- Recognize that opioids have limited efficacy when used alone
- Prior to prescribing opioids, assess patients for opioid misuse risk
- Use universal precautions but individualize pain management based on risk
- Prescribe opioid in limited amounts with clear directions
- Educate patients on safe storage and disposal
- Use risk-benefit framework to guide clinical judgement.

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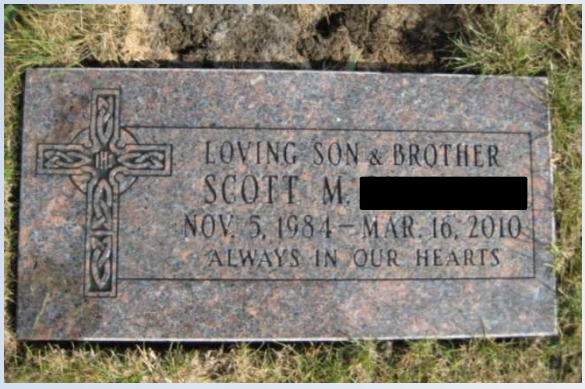

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ADVOCACY UPDATE

Sept. 16, 2022: Advocacy Update spotlight on 2022 Overdose report

SEP 16, 2022 • 2 MIN READ

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CONTENTS

AMA 2022 Overdose Report shows worsening epidemic, need for all-hands approach | More articles in this issue | Essential Tools & Resources

AMA 2022 Overdose Report shows worsening epidemic, need for all-hands approach

The AMA last week issued its 2022 Overdose Epidemic National Report, which showed a worsening epidemic and called for an all-hands approach—physicians, policymakers, public health experts, educators, faith leaders and employers—to help save lives.

The report highlighted that while physicians and other health care professionals have decreased opioid prescribing by nearly 50% nationally since 2012, used state prescription drug monitoring programs (PDMP) more than 1.1 billion times in 2021, and have increased prescriptions for medications to treat opioid use disorder and naloxone—more than 107,000 Americans died of a drug-related overdose in 2021, mainly due to illicitly manufactured fentanyl, methamphetamine and cocaine. At the same time, health insurers continue to violate state and federal mental health and substance use disorder parity laws, individuals are unable to access treatment for substance use disorders or mental illness and patients with pain continue to suffer by the misapplication of the 2016 CDC opioid prescribing guideline. Health inequities also continue to worsen.

How can we manage this epidemic?

- Education
- Improved Rx practices
- Address risk factors
- Better SUD treatment - MAT
- Collaborate with law enforcement
- **Take a good look at society**

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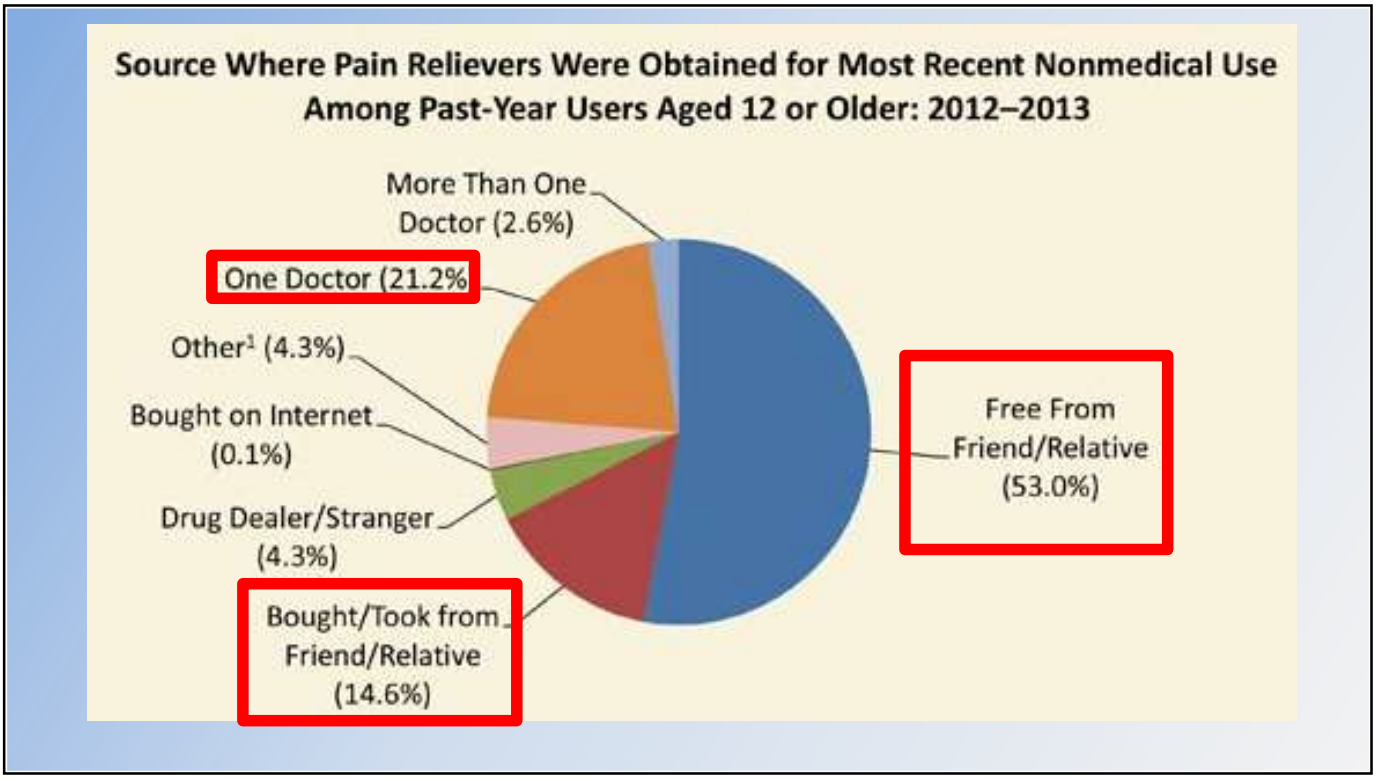

Opioid epidemic burden

- Diversion, dependence, addiction
- Progression to heroin
- Overdose (death)
- Neonatal addiction / withdrawal
- Infection HIV; Hep B, C; staph
- Lost work, social failure

- Health insurance expenditures
- ER visits
- Treatment of addiction
- Autopsies
- Treatment of related disease
- Payment for fraudulent / unnecessary Rx
- Loss of productivity in the work force
- Police / EMS

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Dependence, Tolerance, Addiction

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Dependence, Tolerance, Addiction

- Physical dependence
  - A state of adaptation such that abrupt substance cessation triggers a withdrawal syndrome, generally reactions opposite to those produced by the drug. Can occur in 7 days of active intake. Abrupt cessation is more symptomatic than gradual tapering.

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Acute withdrawal (continuum)

Mild	Moderate	Severe
Anxiety	Irritability / Agitation	Delirium, Violence
Nausea	Vomiting / cramping	Diarrhea / Incontinence
Wet runny eyes and nose sneezing, sweating		
Tremors	Muscle Cramping	Muscle Spasm
Loss of appetite		Dehydration
Piloerection	Hot and cold flashes	
Yawning	Hypertension / Tachycardia / Tachypnea	

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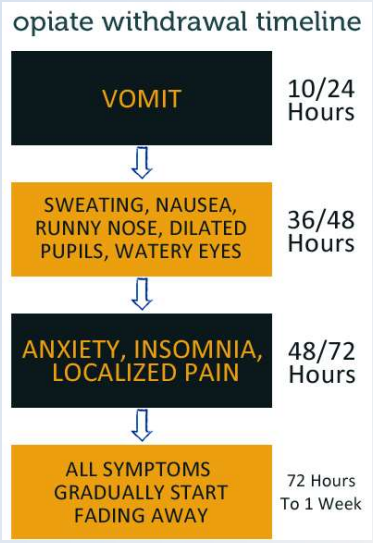
Natural Withdrawal

not triggered by an antagonist

- Is not life-threatening
- Will develop in ~ 12 hours after last dose of short-acting opioid
- Persist for 3 – 5 days, *OR LONGER*



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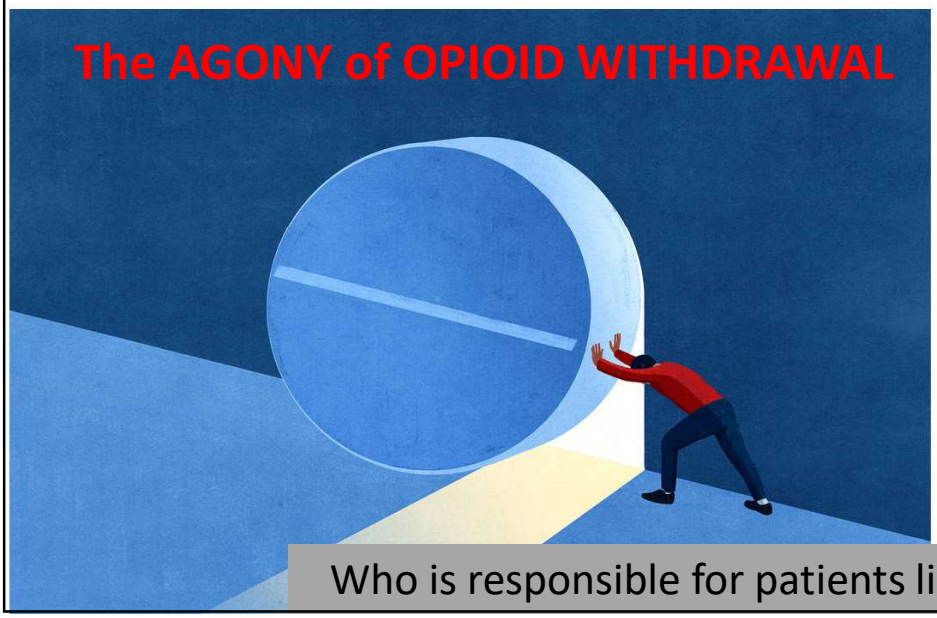
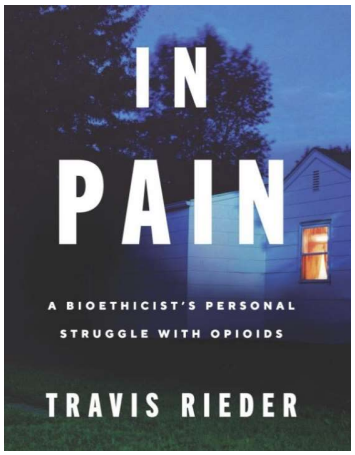
IDEAS | ESSAY

The Perilous Blessing of Opioids

An injured bioethicist learned firsthand how desperately patients with severe pain need the relief of powerful drugs—and how little support they get to stop taking them.





Who is responsible for patients like me?

Dependence, Tolerance, Addiction

- Tolerance
  - Increasing amount of substance needed to achieve desired effect, attained by smaller doses in the past.
  - Occurs with analgesia, sedation and respiratory depression, but not constipation or miosis.
  - Gradually diminishes over time during abstinence

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Physical dependence ≠ addiction

- Tolerance and physical dependence are inevitable consequences of chronic opioid exposure
- Addiction is NOT an innate pharmacologic property of opioids.

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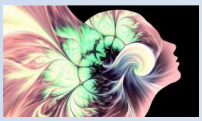


1. Characterize
2. Define
3. Manage

A dynamic, chronic, neurobiologic, relapsing disease with genetic, psychosocial and environmental factors influencing its development and manifestation.

In SOME patients, a pathologic hijacking of the reward-related learning and memory areas of the brain

DSM -5 – OUD – a problematic pattern of opioid use leading to significant impairment or distress.

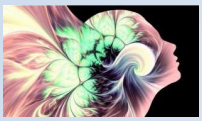
Addiction

dynamic

- A chronic, neurobiological, relapsing disease with genetic, psychosocial and environmental factors influencing its development and manifestations
- DSM-5 OPIOID USE DISORDER
  - A problematic pattern of opioid use leading to significant impairment or distress
- 3 **C's**
  - Impaired **c**ontrol over use / compulsive
  - **C**ontinued use despite harm
  - **C**raving

- Compulsive drug seeking behavior
- Inability to limit use on your own
- Difficulty in functioning without the drug

Is addiction a disease ?

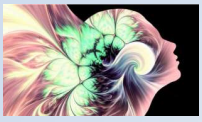


1. Characterize
2. Define
3. Manage

1. Why are addicts filled with shame / guilt
2. Why are family members filled with shame / blame / disappointment
3. Why did Nancy Reagan say – “Just Say No”
4. Why do we put addicts in JAIL
5. Why the STIGMA

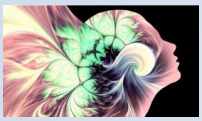
“you did this to yourself, you miserable person”
“ you are now officially ostracized”

- Disorders of feeding
- Tobacco ravaged lungs
- Sedentary lifestyle
- DUI trauma



1. Characterize
2. Define
3. Manage

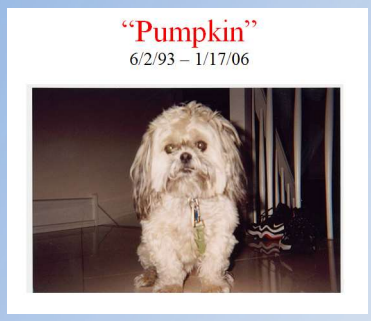
Stupid
Weak



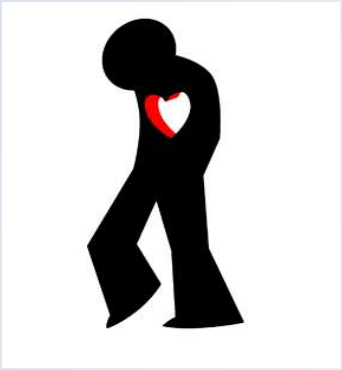
1. Characterize
2. Define
3. Manage

Human behavior is regulated by a combination of need and control

↑ need or ↓ control = exaggerated behavior



ISM – inside of me



"ISM" – InSide of Me

Need and Control : Human Behavior

And, either ↑ need or ↓control – lead to "exaggerated behavior"

Objects of addiction: False Gods

- Alcohol
- Drugs
- Food
- Work / struggle
- Sex
- Gambling
- Relationships
- Pornography
- Cell phones
- amazon





"Necessary, but insufficient"

3 things in common:

1. They make you feel better
2. Pursuit of them develops ego strength
3. Inevitable disillusionment

"The first time I ever used an opioid, I felt the most confident and powerful I'd ever felt"……."So I said, this is it. I want to do this for the rest of my life"

"I didn't need 20 Vicoden when I got my wisdom teeth out," he says. "So I just saved them."

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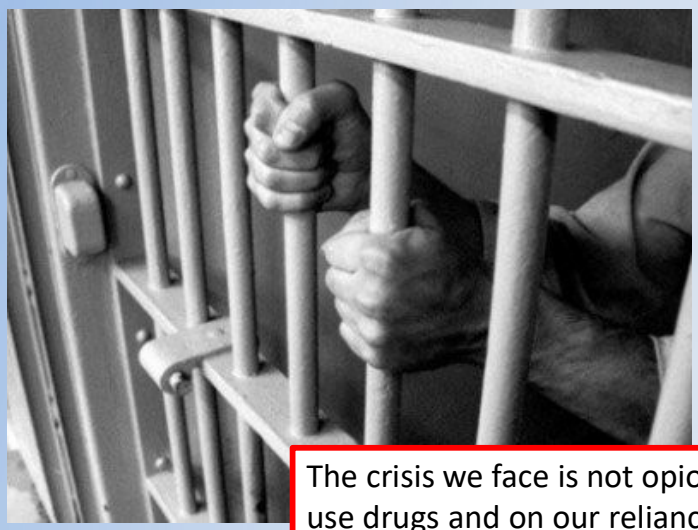
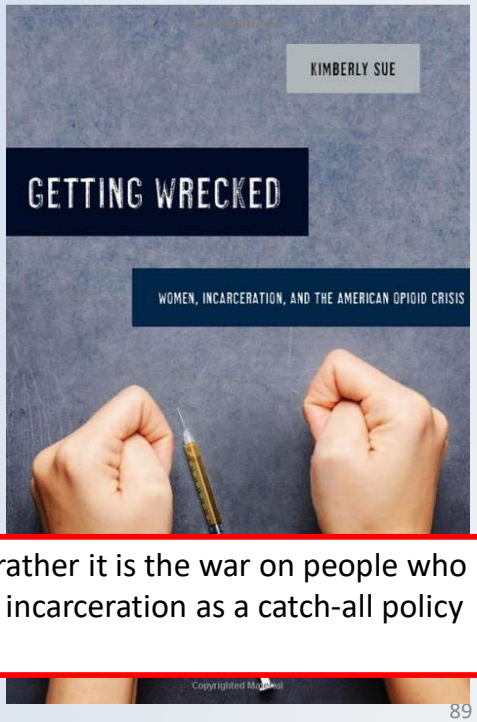
"The notion that people become addicted to drugs because they initially chose to take these drugs for pleasure is a belief that stems from a different time, in which we believed addiction to be a moral issue rather than a medical one."

L.A.B. Leknes Affective Brain lab

Is alcohol good for you?

- McGill University Study in the 50's
- Alcohol does something FOR the addict
  - It fills a void,
  - They feel better, but they do not get better
- Alcohol does something TO the non-addicted
  - They drink to get high, loosen inhibitions





The crisis we face is not opioids, rather it is the war on people who use drugs and on our reliance on incarceration as a catch-all policy solution.

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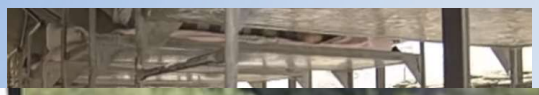

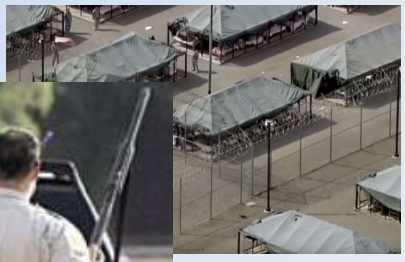

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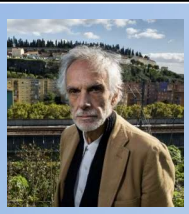

Dr. Nuno Felix da Costa

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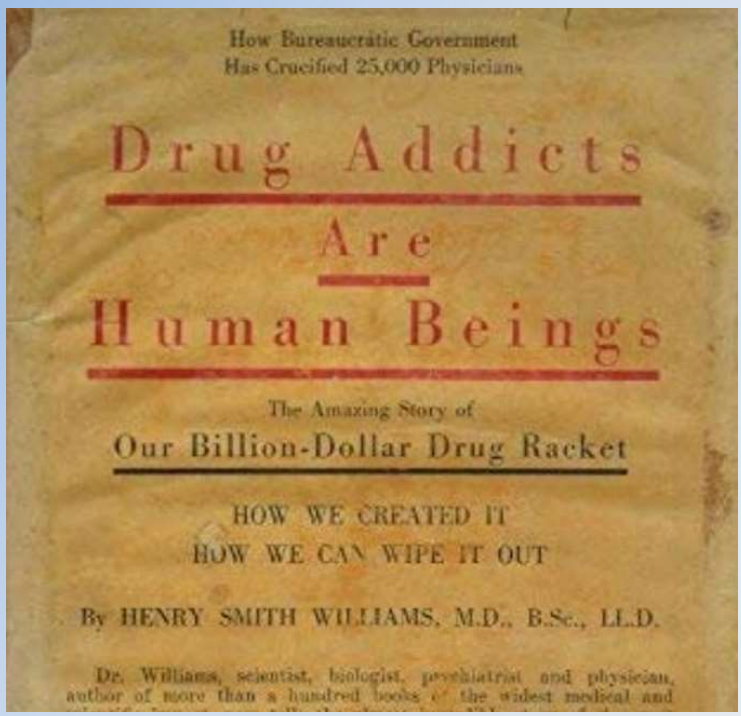
How Bureaucratic Government
Has Crucified 25,000 Physicians

Drug Addicts
Are
Human Beings

The Amazing Story of
Our Billion-Dollar Drug Racket

HOW WE CREATED IT
HOW WE CAN WIPE IT OUT

By HENRY SMITH WILLIAMS, M.D., B.Sc., LL.D.

Dr. Williams, scientist, biologist, psychiatrist and physician, author of more than a hundred books of the widest medical and

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CHANGING THE NARRATIVE

Avoid stigmatizing language
- Addict
- Junkie
- Drunk
- Drug habit
- Abuse

The Tired Narratives of Drug Policy

"Addict" *Stigmatizing Language about Substance Use*	**"Trading One Addiction for Another"** Medication to Treat Opioid Use Disorder	**"Hooked on Opioids"** *The Difference Between Addiction and Dependence*	**"Filling Parks & Playgrounds with Hypodermic Needles"** *Misconceptions about Syringe Service Programs*
"Legal Shooting Galleries" *Misinformation about Supervised Consumption Sites*	**"Addicted Babies"** *Stigmatizing Language about Neonatal Abstinence Syndrome*	**"Helping is Enabling"** *The myth of co-dependency*	**"Cut Them Off"** *Tough love doesn't work*
"Doctor Shopping and Drug Seeking" *Punishing vulnerable patients is counter-productive*	**"Prescription Fentanyl is Driving Overdoses"** *Distinguishing between Illicit and Pharmaceutical Fentanyl*	**"Junkie"** *Stigmatizing Language about Substance Use*	**"Narcan Parties"** *Misinformation about Naloxone*

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Vice Ad. Jerome Adams breaks the stigma at Purdue

BY AMBER PEREIRA Staff Reporter Nov 18, 2019

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November 13, 2019

'Hope Stems' to bloom at Purdue, raising awareness on addictions, substance use

The "Hope Stems" Brain Flower will be on display from Nov. 18-21 at Purdue University. (Photo provided)

Download Image

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Related Web site

Web video series aims to help educate community about opioids, substance abuse and resources

Research News

- Technology shown to reduce cancer-causing contaminants in drinking water, airports, military sites receives millions in funding
- New antenna tech to equip ceramic coatings with heat radiation control
- Study: Leaders educated in economics spur faster economic growth
- Availability of drugs as implants could expand, thanks to MRI maps

- Stigma is the biggest killer
- Keeps people in the shadows
- Remove Rx opioids, patients will switch to another substance
- SUD requires support
- "Better health through better partnerships"

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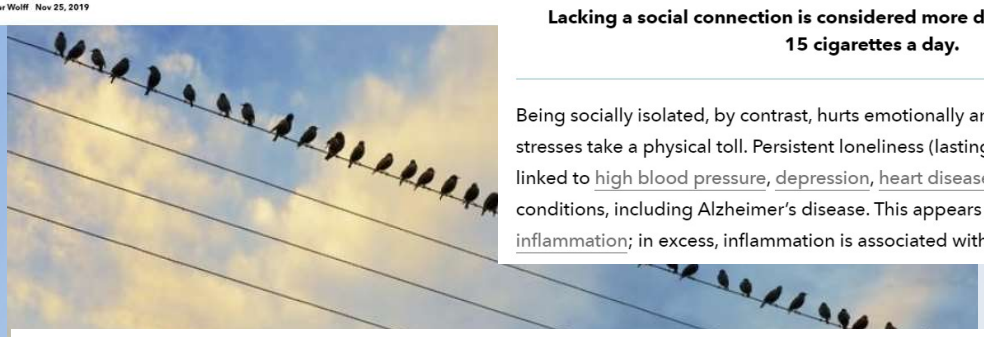
Loneliness Is the Quiet Health Epidemic Impacting Your Heart, Brain, and Longevity

Here's what to know to protect ourselves, and one another.

By Jennifer Wolff Nov 25, 2019



Lacking a social connection is considered more dangerous than smoking 15 cigarettes a day.

Being socially isolated, by contrast, hurts emotionally and psychologically, and its stresses take a physical toll. Persistent loneliness (lasting longer than two weeks) is linked to high blood pressure, depression, heart disease, and stroke among other conditions, including Alzheimer's disease. This appears to be due to increased inflammation; in excess, inflammation is associated with chronic disease.

Why we're lonelier than ever

If loneliness is a disease, it's one that's reached pandemic proportions. A growing number of Americans now live by themselves, which is one reason we're experiencing greater loneliness than ever before. Another factor is the lightning-fast evolution of technology. "We have had more change in the last 24 years than we

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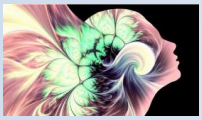


1. Characterize
2. Define
3. Manage

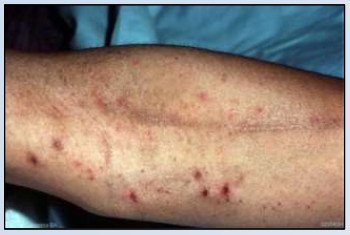
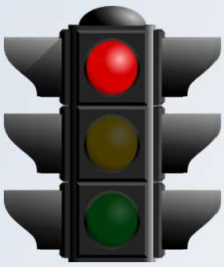
Persistent use despite adverse consequences

In SOME patient, a pathologic hijacking of the reward-related learning and memory areas of the brain. Stimulate dopamine, down-regulate, lose interest in normally pleasurable activity.

DSM -5 – OUD – a problematic pattern of opioid use leading to significant impairment or distress.

Can you identify the addict?



- Soft calls
- Suspicion clinches diagnosis

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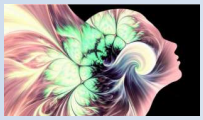
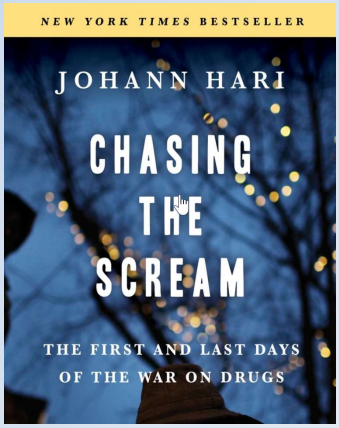
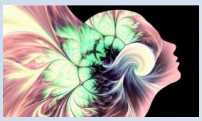
- Genetics
- Younger age
- Male gender
- Lower educational level
- Lower income
- Unemployed
- Concomitant psychiatric disorders



1. Characterize
2. Define
3. Manage





1. Characterize
2. Define
3. Manage

www.brucekalexander.com

“Rat Park”

Professor Peter Cohen

www.cedro-uva.org/cohen/

THE OPPOSITE OF ADDICTON IS CONNECTION.

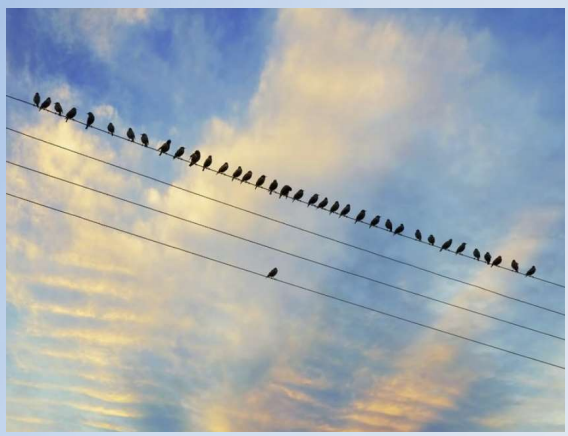
Loneliness Is the Quiet Health Epidemic Impacting Your Heart, Brain, and Longevity

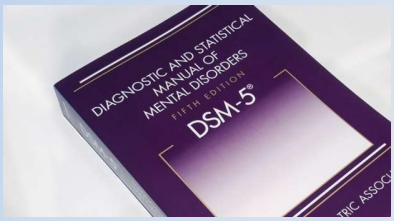
Here's what to know to protect ourselves, and one another.

By Jennifer Wolff Nov 25, 2019

Lacking a social connection is considered more dangerous than smoking 15 cigarettes a day.

Being socially isolated, by contrast, hurts emotionally and psychologically, and its stresses take a physical toll. Persistent loneliness (lasting longer than two weeks) is linked to high blood pressure, depression, heart disease, and stroke among other conditions, including Alzheimer's disease. This appears to be due to increased inflammation; in excess, inflammation is associated with chronic disease.





Substance abuse disorder

A cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues to use the substance despite significant substance-related problems.

There exists an underlying change in brain circuits co-existent and possibly contributory to repeated relapse and/or craving.

1. Impaired control over substance use
2. Compulsive _____-seeking behavior
3. Inability to stop on your own
4. Social impairment – difficulty in functioning without_____
5. Continued use despite harm

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SUD, addiction, in general

pandemic? Undetected?

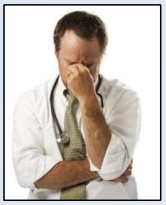
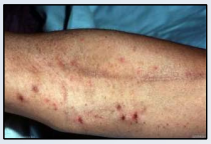
All socio-economic strata, age, race

- ER physicians, dental sedation providers, anesthesiologists, psychiatrists
- DENIAL is UNIVERSAL

Concomitant

- Psychiatric disorders
- Infectious disease
- Criminal behavior



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SUD, addiction, in general

- Prevalent, ***epidemic ?*** , but largely undetected
  - All socioeconomic strata, age, race
    - ER physicians, anesthesiologists, psychiatrists,
    - Denial is **UNIVERSAL**
    - Stigma, shame, failure of will
  - Concomitant
    - psychiatric disorders
    - infectious disease
    - criminal behavior

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4 common characteristics of patients with drug use disorders

- **Escalating use**
- **Drug-seeking behavior**
- **Doctor shopping**
  - a routine of visiting several doctors complaining of similar symptoms in order to receive multiple prescriptions for the same condition
- **Scamming**
  - coercion or manipulation of the doctor in order to obtain medication.
  - Patient pressures dentist to Rx EVEN AFTER REQUEST DENIED, esp. when specific drug names is requested.

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"Yet" disease

- RELAPSE – OVERDOSE – IMPRISONMENT - DEATH

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Opioid use disorder

- Signs and symptoms that reflect compulsive, prolonged self-administration of opioid substances that are used for no legitimate medical purpose, or in doses greatly in excess of the amount needed for a medical condition.

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OUD – at least 2 of these observed within 12 month period.

problematic pattern of opioid use leading to significant impairment distress

DSM-5 Criteria for Opioid Use Disorder

Check all that apply	Criteria (within a 12-month period)
☐	Opioids are often taken in larger amounts or over a longer period than was intended
☐	There is a persistent desire or unsuccessful efforts to cut down or control opioid use
☐	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects
☐	Craving, or a strong desire or urge to use opioids.
☐	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home
☐	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
☐	Important social, occupational, or recreational activities are given up or reduced because of opioid use
☐	Recurrent opioid use in situations in which it is physically hazardous
☐	Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
☐	Exhibits tolerance*
☐	Exhibits withdrawal*

Total checked: _____

If OUD is diagnosed (≥ **2 criteria met**), assess severity as **mild (2-3 criteria met), moderate (4-5 criteria met) or severe (≥ 6 criteria met).**

*Not considered to be met for individuals taking opioids solely under appropriate medical supervision.

Source: American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. 2013.

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Treatment options for opioid use disorder

to reduce HIV, death, etc.

- **Long term out patient treatment**
  - Medication-assisted treatment
    - Usually includes psychosocial intervention
    - Opioid agonists – methadone, buprenorphine
    - Opioid antagonists – naltrexone
- **Inpatient/residential care**
  - Supervised detoxification
- **Psychosocial intervention (non-medication treatment)**

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Treatment options: Opioid Use Disorder

- **Psychosocial Treatment (no meds)**
  - Abstinence-based therapy – dismal long term results
  - Urine testing; incentives, group dynamics
  - ↓treatment----↑relapse
- **Maintenance medication: opioid agonists**
  - Methadone; buprenorphine
  - "medication-assisted treatment"
- **Opioid antagonist treatment**
  - Naltrexone

Treatment of opioid use disorder

Psychosocial Intervention

- "Contingency Management" – 12 weeks
  - Behavioral intervention – incentivize target behavior
    - Abstinence / reduction in drug use
    - Medication compliance
    - Treatment attendance
- Motivational Interviewing
  - Explore and resolve ambivalence to behavior change
  - Rapport / collaboration to effect change
- Cognitive-Behavioral Therapy
- Family Therapy
- 12 step facilitation
- Addiction counseling
- Mutual help groups

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Treatment of opioid use disorder

- Maintenance medication
  - *Agonists -- "medication-assisted treatment"*
    - **Methadone** – SLOW, full μ opioid receptor agonist , NMDA antagonist
      - 80-160mg
      - Don't need or want other opioids, no euphoria, no withdrawal
      - Physiologic dependence persists
      - Regain societal productivity, safely drive a car
      - Monitored administration of liquid – methadone clinics
    - **Buprenorphine** – Sticky, partial μ opioid receptor agonist (weak), κ opioid receptor antagonist
      - Blocks all other drugs
      - Ceiling respiratory depression
      - 8-24 mg, sublingual

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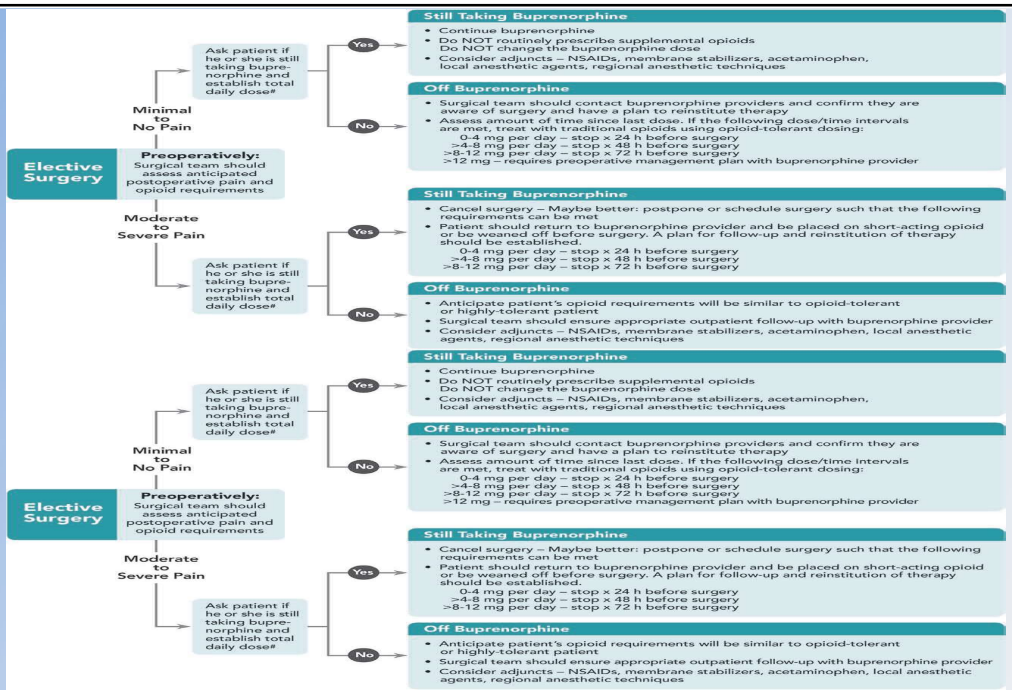
- **Maintenance medication: opioid agonists**
  - Methadone; buprenorphine
  - "medication-assisted treatment"

Methadone (analgesic effect)
- Don't need or want other opioids
- Full agonist, no "dopamine buzz"
- Prolonged onset, prolonged offset
- No craving, no withdrawal
- Physiologic dependence persists
- Can function in society
- MMT – witnessed administration of liquid
- Prolonged QT interval with higher doses (300mg/day)
  - Elderly, $\downarrow K^+$, bradycardia, female, structural heart disease, arrhythmia
- Naloxone will reverse

Buprenorphine (little analgesia)
- Other opioids won't work
- High affinity for mu receptor
  - Prevents other opioids/naloxone binding
- Partial (weak) agonist – ceiling respiratory depression
- Overdose possible
- Less restriction on prescribing
- Suboxone™ sublingual film (4:1 with naloxone)

Medications for OUD

	Methadone	Buprenorphine	Naltrexone
Trade Name	Dolophine; Methodose	Subutex; Suboxone	Depade; Revia; Vivitrol
Class	Full agonist	Partial agonist	Antagonist
Use and Effects	Once daily, monitored P.O. liquid administration. Reduce craving and withdrawal, facilitate ADL.	Once daily, film tab, reduce craving and withdrawal, block effect of other opioids	P.O.; IM q 1 month, blocks mu receptor, diminish reinforcing effect of opioids
Advantage	Slow drug, careful and consistent dosing reduces euphoria	Greater availability, less risk of IV use with Suboxone	Not addictive or sedative
Disadvantage	"approved clinic", daily visits	Measurable abuse liability	Must achieve complete abstinence prior to use, patient compliance issues



Anderson TA, et al. To Stop or Not, That Is the Question: Acute Pain Management for the Patient on Chronic Buprenorphine. Anesthesiology 126:1180-6, 2017.

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Buprenorphine

- Subutex™ = buprenorphine
- Suboxone™ = buprenorphine + naloxone
- Sublocade™
  - Buprenorphine extended release injection SC
  - 100-300mg
  - Once a month dosing
- Probuphine implants – 6 months

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Buprenorphine Prescribing Restrictions have been relaxed….

Telehealth allowed

no need for 8 hour federal education requirement

- New Rx have remained flat from 2019 to 2022
- Only 20% of patients managed with bup have stayed on it for > 6 months
- The new DEA 8 hour requirement may ↓ the number of eligible prescribers
- 50% of patients presenting to ED with anaphylaxis get Rx for epi injection device
- 10% of patients presenting to ED with opioid overdose get Rx for buprenorphine

Chua, K., et. al. Trends in Buprenorphine Initiation and Retention in the United States, 2016-2022. JAMA 329:1402-1404, 2023.

Opioid antagonist treatment

- Naltrexone
  - Requires total withdrawal prior to initiation
  - Prevents users from experiencing opioid intoxication
  - Prevents physiological dependence

Treatment of opioid use disorder

- Maintenance medication
  - *Antagonists*
    - Need to withdraw first
  - Naltrexone
    - Blocks opioid receptors, nothing works
    - Prevents physiological dependence

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Recovery – 3 choices

- Drunk
- Dry
- Spiritual Recovery
  - “get better, not feel better”

Recovery is not only possible, but it is assured if patients accept and apply themselves to the 12 step program.

Recovery requires a certain amount of character and pain

Willingness to take direction

Willingness because he(she) has suffered enough pain

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12 STEPS

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

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12 step program……

- Turn over control to a “higher power”

The Human Brain Evolved to Believe in Gods

- 84% of world population
- Believe in higher power, spiritual force
- God (with a capital G)
- 20% of “atheists” accept higher power or spiritual forces

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12 step program……

- Turn over control to a “higher power”
- Admit to ourselves and others the exact nature of our wrongs
- List people we have harmed and make amends
- “spiritual awakening”
- Etc…..

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12 step program……

1. Admit you are powerless over the substance and that your lives have become unmanageable.

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How to address a patient with suspected drug abuse disorder

- Non-judgmental
- Avoid confrontation
- Express empathy

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Can you reliably identify patients with OUD?

- Regularly taking opioids more than prescribed doses for non-prescribed reasons, such as to improve mood or play better golf
- Taking opioids for fear of withdrawal
- Either high, craving or withdrawing
- Mood swings: agitated, skittish, exciting, euphoric
- Seeking opioids from multiple doctors
- Request a specific drug
- Losing interested / disengaging – people, activities
- Engaging in high risk behaviors
- Generally, not interested in finding the "root of the problem"
- Doctor shopping
- Missed appointments
- Using more than 20 MME / day

- Unusual behavior in the waiting room
- Assertive personality, demanding immediate action
- Must be seen immediately
- Wants appointment at the end of the day
- Calls after regular business hours
- Claims non-opioids are not working
- Rx is lost
- Unusual appearance – slovenliness or overdressed
- Fully clothed on hot weather, arms covered
- Pop-scars from subQ injections
- Needle tracts – linear, hyper pigmented marks
- Raccoon eyes, yawning, fidgety – withdrawal signs
- Unusual knowledge of controlled substances or disease entities, may exaggerate Sx
- No regular MD, no health insurance

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How to address a patient with suspected drug abuse disorder

- Open ended questions
- 3 step interventional counseling
  - Feedback – I am concerned about your Vicodin™ use, may cause harm to body, work and social relationships
  - Advice – try to cut dosage and use alternatives
  - Establish goals

Table 4. The "7 Es" to Remember When Engaging a Patient in Conversation About Their Substance Use[25]

7 Es	*Example*
Express empathy	"I understand that you are in pain and that this is causing you significant anxiety and distress."
Elicit functional goals	"What activities would you like to do that your pain is preventing you from doing?"
Educate	"For some patients, continuous use of opioids can actually result in more pain by lowering the pain threshold.
Endorse an alternative plan	"A lower dose of opioids may make you less sedated and allow you to actually improve your ability to do the activities you want to do."
Enlist patient buy-in	"Would you be willing to try a lower dose of opioids or switch to a combination of nonopioid options?"
Enact follow-up plan	"Would you be willing to meet every 2 weeks to discuss your progress?"
Equanimity	Be calm, even-tempered, and nonjudgmental throughout the conversation

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Thank You