EDITORIAL

DANIEL G. TOBIN, MD, FACP
Assistant Professor, Department of Internal Medicine, Yale University School of Medicine, Yale-New Haven Hospital, Saint Raphael Campus, New Haven, CT

A rational approach to opioid use disorder in primary care

As a medical student, I understood that dealing with death was part of the practice of medicine. I was prepared to help my patients face the end of life from disease and old age and had steeled myself against the inevitable losses I would see from trauma and infection. However, I had no sense of the incredible burden that opioid addiction and death from unintentional overdose would one day cause.

See related article, page 377

MORE DEATHS FROM OVERDOSE THAN FROM MOTOR VEHICLE ACCIDENTS

To highlight the point, unintentional overdose deaths in 2008 exceeded motor vehicle accidents as the leading cause of accidental death in the United States.[1] Since then, the problem has only worsened; by 2014 the US Centers for Disease Control and Prevention reported that 78 Americans were dying each day from unintentional opioid overdose.[2]

Yet the scourge of deaths from opioid overdose is only the most obvious way that opioid use disorder destroys the lives of patients suffering from addiction, as well as their friends and family. Among many other heartaches, opioid use disorder is associated with severely impaired social function, increased rates of hepatitis C and human immunodeficiency virus (HIV) infection, and serious legal consequences and incarceration.[3] Sadly, opioid use disorder has torn apart countless families. Addiction may be a brain disease, but its scope of morbidity extends far beyond the individual with the affliction.

doi:10.3949/ccjm.84a.17030

PLENTY OF BLAME TO GO AROUND

To some extent, physicians are culpable in propagating this epidemic, and not just in their obvious role as opioid suppliers. To be certain, opioid overprescribing is a tremendous problem; in 2014, more than 240 million prescriptions for opioids were issued, enough for every American adult to have his or her own bottle of pills.[4]

However, there is plenty of blame to go around in the medical system for the problems of overprescribing and inappropriate opioid use. Among other factors, medical schools have historically failed to teach young physicians how to treat pain or prescribe opioids safely,[5] and pain specialists are often inaccessible to primary care providers.[6] Additionally, pharmaceutical companies have been found guilty of marketing opioids to prescribers in misleading ways,[7] and well-intentioned but misguided campaigns such as the "pain as a fifth vital sign" movement may have inadvertently contributed to opioid overprescribing as well.[8]

Treating addiction is quickly becoming part of primary care, and clinicians can no longer turn a blind eye

TACKLING THE CHALLENGE

Prescribers need to tackle these challenges by educating themselves about when and how to prescribe opioids for chronic pain. Breaking the cycle of overprescribing can be achieved by learning to prescribe opioids rationally, cautiously, and as part of a comprehensive multimodal pain management plan with a commitment to risk assessment and harm reduction. It also means having an exit strategy at the start of opioid therapy. This must include recognizing problematic opioid use when it occurs and having options to offer patients when opioid use disorder becomes the primary problem.

Recognizing the problem

Physicians are notoriously poor at predicting and detecting the presence of aberrant drug use behaviors and opioid use disorder. For example, in a study of patients clinicians thought were not at risk for misuse of medications, 60% had urine drug tests showing either the presence of illicit drugs or no evidence of the prescribed drug.[9]

The prevalence of problematic opioid use in patients on chronic opioid therapy for pain has been variably reported in the literature, but one systematic review found that misuse rates ranged from 21% to 29% (95% confidence interval 13%–38%) and addiction rates averaged 8% to 12% (3%–17%).[10] These numbers are alarming, and prescribers need to know how to screen for and diagnose opioid addiction when they see it.

Importantly, there is a wide spectrum of opioid misuse behaviors, and the wise prescriber will thoughtfully consider each circumstance before assuming a patient has a substance use disorder. For example, one patient may skip doses and "hoard" unused pills for fear that he or she will run out of medication during a pain flare, while another may use opioids for nonmedical reasons such as to get high. Both examples represent aberrant drug use, but in the first case patient education may sufficiently address the problem, while the second may herald a more dangerous and less correctable problem.

Responding with empathy

Simply recognizing that a problem exists is not enough. Once we identify problematic opioid use, we also need to know how to address it.

Managing opioid misuse behaviors requires empathy, and prescribers should consider a patient's motivation and emotive response to counsel. For instance, the patient who skips doses and hoards pills may fear that their well-controlled pain will suddenly worsen if their doctor's opioid prescribing becomes more restrictive as new guidelines are released.

The lesson is that safe opioid prescribing may require a more restrictive approach than was understood in prior years, but rational prescribing also means careful consideration before arbitrarily tapering or discontinuing opioids in a patient who has demonstrated benefit without evidence of harm, even if new guidelines now recommend against starting opioid therapy for similar pain syndromes. For example, the American College of Physicians released a guideline earlier this year that recommended against opioids to treat low back pain, but it did not recommend stopping opioids if patients were already taking them and benefiting from their use.[11]

Sometimes the best course of action is to discontinue opioid therapy. This decision may trigger a grief-like reaction in some patients and there can be distinct communication challenges during each coping phase.[12] The prescriber should frame opioid prescribing discussions on the changing balance of perceived benefits, risks, and harms; in some cases, the treatment may have "failed" or no longer be appropriate, but the patient may still be suffering from pain. Further, the patient may now need help with a newly recognized substance use disorder and may be particularly vulnerable during this time.

The wrong approach, in my opinion, is to discharge the patient from care because of addiction. This approach may seem justified to the provider who feels betrayed by a patient who has used a prescription differently than intended and has thus placed everyone at risk. However, providers should not take it personally; by definition, a patient with addiction has lost control over use of a drug and may have a stronger relationship with the drug than with you. Instead, we should attempt to intervene to protect a patient's health and chances of survival. It is critical that physicians learn to leverage treatment resources to provide the support patients need to start the long process of recovery. This may involve detoxification and rehabilitation programs, but in many cases opioid agonist therapy also has a role.

Medication-assisted therapy

Medication-assisted therapy with methadone or buprenorphine can be an extremely important part of this process and is a strategy that Modesto-Lowe et al explore in this issue of the *Journal*.[13] As they point out, patients and providers often misunderstand the use of opioid agonists to treat opioid use disorder; many perceive this as merely substituting one form of addiction for another. However, compel-

ling data support this approach. Studies have shown that opioid agonist therapy is associated with decreased illicit opioid use, better retention in substance use treatment programs, reduced hepatitis C and HIV seroconversion, reduced rates of criminal activity and incarceration, decreased overdose risk, and improved survival.[14]

Opioid agonists are not a cure-all and come with their own challenges, but for many patients they can "create the space" needed to do the real work of recovery—healing their damaged relationships with themselves, their family, and their society.

Providers need to educate themselves regarding the options available and when and how to use them. They should familiarize themselves with methadone and buprenorphine treatment programs in their community. Better yet, with only 8 hours of additional training, primary care physicians can become waivered to prescribe buprenorphine to treat opioid addiction right in the office. Treating addiction is quickly becoming part of primary care, and clinicians in practice can no longer turn a blind eye toward this problem.

REFERENCES

1. **Miniño AM, Murphy SL, Xu J, Kochanek KD**. Deaths: final data for 2008. Natl Vital Stat Rep 2011; 59:1–126.
2. **Rudd RA, Aleshire N, Zibbell JE, Gladden RM**. Increases in drug and opioid overdose deaths—United States, 2000–2014. MMWR Morb Mortal Wkly Rep 2016; 64(50–51):1378–1382.
3. **Hser YI, Evans E, Grella C, Ling W, Anglin D**. Long-term course of opioid addiction. Harv Rev Psychiatry 2015; 23:76–89.
4. **The opioid epidemic: by the numbers**. Department of Health and Human Services; 2016 [updated June 2016.] www.hhs.gov/sites/default/files/Factsheet-opioids-061516.pdf. Accessed April 18, 2017.
5. **Roehr B**. US needs new strategy to help 116 million patients in chronic pain. BMJ 2011; 343:d4206.
6. **Breuer B, Pappagallo M, Tai JY, Portenoy RK**. U.S. board-certified pain physician practices: uniformity and census data of their locations. J Pain 2007; 8:244–250.
7. **Morreale M**. Why Is the pendulum swinging? The opiate epidemic in the USA. Acad Psychiatry 2016; 40:839–840.
8. **Hirsch R**. The opioid epidemic: It's time to place blame where it belongs. KevinMD.com. April 6, 2016. http://www.kevinmd.com/blog/2016/04/the-opioid-epidemic-its-time-to-place-blame-where-it-belongs.html. Accessed April 8, 2017.
9. **Bronstein K, Passik S, Munitz L, Leider H**. Can clinicians accurately predict which patients are misusing their medications? J Pain 2011; 12(suppl):P3. Abstract 111.
10. **Vowles KE, McEntee ML, Julnes PS, Frohe T, Ney JP, van der Goes DN**. Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis. Pain 2015; 156:569–576.
11. **Qaseem A, Wilt T, McClean R, Forciea MA**. Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline from the American College of Physicians. Ann Intern Med 2017; 166:514–530.
12. **Tobin D, Andrews R, Becker W**. Prescribing opioids in primary care: safely starting, monitoring, and stopping. Cleve Clin J Med 2016; 83:207–215.
13. **Modesto-Lowe V, Sweizbin B, Cheplin M, Hoefer G**. Use and misuse of opioid agonists in opioid addiction. Cleve Clin J Med 2017; 84:377–384.
14. **Nielsen S, Larance B, Degenhardt L, Gowing L, Kehler C, Lintzeris N**. Opioid agonist treatment for pharmaceutical opioid dependent people. Cochrane Database Syst Rev 2016(5):CD011117.

***ADDRESS**: Daniel G. Tobin, MD, FACP, Yale-New Haven Hospital, Saint Raphael Campus, 1450 Chapel Street, Private 308, New Haven, CT 06511; daniel.tobin@yale.edu*