

The Narcotic Prescription Problem: Prisoners of Our Own Design

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Editorial

Prescribing excess opioid medications is currently a contentious topic for our nation. Prescription drugs are essential for improving the quality of life for millions of Americans living with acute/chronic pain; but misuse, abuse, addiction, and overdose of these therapeutic medications, especially opioids for chronic non-cancer pain, have become a serious health problem in the United States [1]. Evidence suggests that opioid analgesics are now responsible for more deaths than motor vehicle accidents [1]. Currently, the Centers for Disease Control and Prevention (CDC) has stated that the U.S. is in the midst of an opioid overdose epidemic [2]. In 2014, more than 60% of drug overdose deaths were caused by opioids, furthermore in that same year prescription opioids and heroin deaths were responsible for a record high of 28,647 deaths [3]. Dependence or misuse of prescription opioids is the biggest risk factor for heroin use worsening the prescription drug epidemic.

A significant relationship exists between the sales of opioid pain relievers and mortality. According to the CDC, the prescriptions for narcotics have increased fourfold since 1999; however, there has not been an overall change in the amount of pain Americans report [3]. Also, of interest to note, there is evidence that non-steroidals and gabapentin are more effective at treating certain types of pain than opioids are (European Data) [4]. This leads one to question why are we prescribing more narcotics if the amount of reported pain has not increased, and how did we get into this situation? These questions cannot be answered simply.

Over the past 20 years, the liberalization of laws governing the prescribing of opioids for the treatment of chronic non-cancer pain by the state medical boards has led to a dramatic increase in therapeutic opioid use [1]. This along with the introduction of new pain management standards by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in 2000, has led to increased awareness of the right to pain relief, and increased aggressive marketing by pharmaceutical companies [1]. These changes have contributed to the current crisis which we now face.

Patients with acute or chronic pain demand immediate and complete pain relief and physicians while trying to "heal" often turn to prescribing narcotics. This in addition to increased implementation of patient satisfaction surveys, such as the Press Ganey for emergency room physicians, and more emphasis on pain scores such as the "Faces Pain Scale" to quantify pain [5], have fueled the desire to medicate patients to improve pain scores and satisfaction [6]. Then we, as physicians, become bound to prescribing pain medications, and patients, in turn, become imprisoned by taking them. However, we now need to pause and scrutinize our prescribing habits.

The CDC is leading the way by promoting clinical practice guidelines that help health care providers offer safer, more effective treatment while reducing opioid-related abuse and overdose. We, as pediatricians, are in a special position to help curtail the epidemic by providing education, and assistance to pediatric patients so that we don't add to the growing population of adults with drug habits. Also, we serve a crucial role in helping parents of children with acute/chronic pain understand that pain relief medications, in the short term are associated with serious risks and potential complications—and we must prescribe them carefully. Habituated patients may feign pain obtaining narcotic prescriptions to divert (sell) them to others. In prescribing narcotics, we must remain cognizant that higher doses of prescribed narcotics are associated with an increased risk of overdose [3]. The risk of overdosing on narcotic prescriptions is not necessarily limited to the patient that it is prescribed for. For example, if an adult is prescribed a topical pain patch, and has an infant on their chest. The medicine could inadvertently be absorbed through the child's skin or the infant may ingest the topical patch [7,8]. We as pediatricians must be vigilant in family education concerning pain management. Another important aspect of prescribing pain medications to consider is the actual dosing regimen. According to the CDC, we must be careful of prescribing narcotics for chronic non-cancer related pain in doses greater than 50 morphine milligram equivalents (MEE) per day [3]. If the patient is requiring a higher dose, we must consider a referral to a pain specialist [3].

To help stop this epidemic, a shift in the concept of pain management is required by patients, parents, and physicians. The target should not be complete relief of pain, and parents / physicians need to come to terms with the fact that their child / patient may have to live with a tolerable amount pain. While patients may want a pain pill to relieve their pain, it is not always in their best interest [6]. We must recognize that prevention is the key to curtailing this epidemic by recognizing that there are alternatives to narcotics for pain management. Physical therapy is probably one of the most underutilized alternate pain management strategies in both the adult and pediatric worlds. Physical therapy has been shown in some studies to help relieve pain especially musculoskeletal and to help reduce hospitalization for pain [9-11]. Other effective strategies are cognitive behavior therapy, acetaminophen, non-steroidal anti-inflammatories (ibuprofen) [4,11], topical preparations (lidocaine patches), gabapentin [4], pregabalin, antidepressants (tricyclic antidepressants and selective serotonin reuptake inhibitors) [12]. Also, important adjuncts to pain management are the medicines that help with withdrawal such as clonidine [13], and dexmedetomidine [14].

Listed below are possible interventions that we should consider while treating patients with acute/chronic non-cancer related pain:

1. Alternative pain management strategies should be first line therapy in a patient with acute/chronic pain.
2. Short-term, low dose narcotics should be considered for pain relief only if the first line agents fail.
3. Physicians should educate themselves on morphine milligram equivalents (MME) and not prescribe greater than 50 MME/day.
4. Referral to pain specialists.
5. Parental education on narcotic abuse, recognizing symptoms, and more importantly recognizing signs of narcotic overdose.
6. Parental education for safe keeping of prescribed narcotics to help prevent potential accidental and intentional overdoses.
7. Reducing availability of narcotics through reduced inappropriate utilization and community exchange narcotic programs.
8. Providing easy access to treatment for narcotic addiction.
9. Improve state prescription monitoring systems to identify recent and multiple narcotic prescriptions filled for the same patient.
10. Consider education and funding for naloxone for use by public servants (ex: police officers, firefighters, etc.) to help treat narcotic overdoses prior to asphyxia.

In conclusion, a paradigm shift is needed in the area of pain management. What we is needed first and foremost is education. This includes educating physicians, nurses, parents, and patients about the expectations of pain relief. We must use narcotics appropriately to improve but not eliminate pain. This type of attitude, along with using alternative approaches to narcotics, implementing state narcotic monitoring systems, and other prevention strategies will help stop the current narcotic epidemic. This will in effect release both our patients and us from the prison system which we ourselves have created.

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