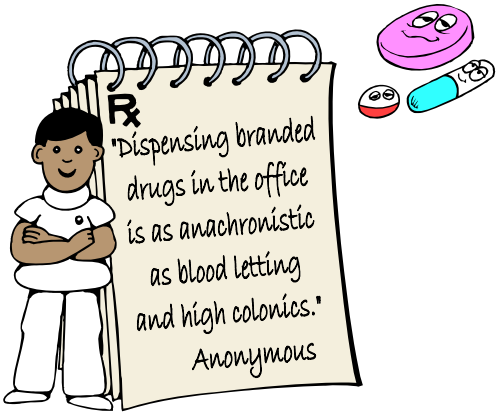
The Prudent Prescriber

Phil Mohler, M.D. • pmohler69@gmail.com
2775 Crossroads Blvd • P.O. Box 10600 • Grand Junction, CO 81502-5600



November 2017

Pharm Reps ≠ Rational Prescribing (PR) (RP)

My Contribution to the Opioid Crisis or How many pain pills should we be prescribing?

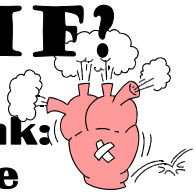
Over a 40 year career, how many hundreds of times did I respond to a fractured clavicle, a second degree burn or an ankle sprain with my standard prescription?

Tylenol #3, dispense #30
1 every 4-6 hours for pain
Refills: 1

Sure, I now know that codeine is a lousy pain medicine (cannot get the dose high enough without significant nausea) and has been associated with deaths in children who are rapid metabolizers. My real clinical mistakes, however, were
1) often choosing an opioid over an anti-inflammatory in these scenarios and
2) having no idea in the world how many pain pills the patient was going to need.

In 2017, there are significant data that demonstrate that opioids are not the most effective choices for either acute or chronic pain.

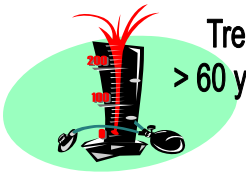
CHF?



Think:
Ace
Aldactone
B-blocker
Dig
Diuretic

Avoid these expensive "me-too" drugs:

Intermezzo
Vimovo
Livalo
Pristiq
Viibyrd
Edarbi
Daliresp



Treat patients > 60 years to 150/90

Antibiotics do NOT help acute bronchitis

ß-blockers in post-MI save lives

Pill splitters save BIG

NOW AVAILABLE ON THE GENERIC MARQUEE

Frova→frovatriptan
Voltaren gel→diclofenac Na 1% gel
Crestor→rosuvastatin
Nuvigil→armodafinil
Jalyn→dutasteride/tamsulosin
Ortho Tri-Cyclen Lo→Tri-Lo-Marzia, Tri-Lo-Sprintec, & others

Some illuminating results from a retrospective cohort study from Oregon (Deyo *et al* Journal General Internal Medicine 32 (1): 21–7).

- Of 536,967 opioid-naïve patients who filled an opioid prescription; 26,785(5.0%) became long-term users.
- Increased numbers of refills and morphine milligrams equivalents (MMEs) during the initiation month were associated with more long-term use. Even one additional refill after an initial prescription was associated with a 2.25 greater odds of long term opioid use.
- Patients started on long acting opioids have a higher risk of long-term use than those initiated on short-term opioids.

These are observational data, but probably the best insights we are going to get because of the ethical challenges that surround randomized controlled trials with opioids. The authors suggest that the probability of long-term opioid use can be minimized by initiation with
1) a single prescription of a short acting opioid
2) no refills
3) a cumulative dose of less than 120 morphine milligram equivalents.
These are essentially the CDC guidelines!

How many opioid pills should I prescribe?

- In a survey from the University of Utah (J Urol 2011:185 (2): 511) of 210 patients who underwent urologic surgery, 67% of patients had surplus medication after discontinuing opioid use, and 91% of them saved the pills. Hydrocodone was prescribed most commonly (63%), followed by oxycodone (35%). Eighty six percent of the patients were satisfied with pain control. Of the dispensed narcotics 58% was consumed and 12% of patients requested refills.

- A small survey study reported that 53% of patients who underwent cesarean delivery and 45% of patients discharged home after thoracic surgery took none or very few (<5 pills) of the opioid prescribed [PLoS One 2016:11(1)e: 0147972]. Only 17% of cesarean delivery patients and 29% of thoracic surgery patients used all or nearly all of their prescriptions. Leftover opioids were stored in an unlocked location in 77% and 73% of cases, following C-section and thoracic surgery, respectively.

- A study involving 250 patients who underwent upper extremity surgery reported that most patients received a prescription for 30 opioid tablets [J Hand Surg Am. 2012:37(4): 645.] Oxycodone, hydrocodone, and propoxyphene accounted for over 95% of the prescription medications. Patients undergoing bone procedures reported the highest medication use (14 pills), whereas patients undergoing soft tissue procedures reported the lowest use (9 pills). Seventy seven percent of patients took half or less of the prescribed pills, and 45% took less than five. The total number of unused tablets from these 250 patients was **4639**. Over half of the subjects reported taking the opioid medication for 2 days or less. Medicare patients consumed significantly less medication (7 pills) than patients covered by all other types of insurance. Overall, patients consumed a mean of 10 opioid pills.

❖One single center study of 642 opioid naïve patients who underwent one of five common outpatient procedures evaluated the number of opioid pills that were taken for postoperative pain [Ann Surg. 2017, 265: 709]. The number of pills necessary to supply the opioid needs of 80% of patients for each procedure was calculated, with doses converted to equal a 5mg oxycodone pill. Results were as follows:

- •Partial mastectomy: 5 pills
- •Partial mastectomy with sentinel lymph node biopsy: 10 pills
- •Laparoscopic cholecystectomy: 15 pills
- •Laparoscopic inguinal hernia repair: 15 pills
- •Open inguinal hernia repair: 15 pills

A substantial number of patients who underwent each of the surgical procedures took no opioids postoperatively, ranging from 22% after open inguinal hernia repair to 82% after partial mastectomy.

My Take:

Clinicians' role in the opioid crisis

Overprescribing opioids, in general (when anti-inflammatories will often work better) and the number of opioid pills, specifically

plus

patients not disposing of or storing leftover opioids appropriately (and our failure as clinicians to counsel about these behaviors)

and remembering

that among those who abuse opioids, that over 70% obtain opioids through diversion, and 40% to 50% obtain the drug from family members or friends.

Considerable attention has been focused on the high risk attributes of patients receiving opioids. Less attention has been given to the high-risk characteristics of initial opioid describing patterns.

Dowell *et al* (JAMA. 2013:309:2219-20) summarize the problem,
"Our data suggest the value of attention to high risk prescribing, over which clinicians have greater control. This in part, reflects the concern we are dealing with "risky drugs, not risky patients."