

# OPIOID PRESCRIBING: SAFE PRACTICES AND SAVING LIVES 2018 UPDATE

ARTHUR OHANNESSIAN, MD  
DEPARTMENT OF FAMILY MEDICINE  
DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA  
AMERICAN ACADEMY OF FAMILY PHYSICIANS  
SEPTEMBER 29, 2018



**UCLA** Health



# Disclosures

- **American Academy of Family Physicians,**  
Executive Committee, Commission of Education
- **California Academy of Family Physicians,**  
Board of Directors, District IV
- **University of California Los Angeles**  
Family Medicine Department,  
Residency Associate Program Director  
Assistant Clinical Professor
- **I have no commercial or private interests to declare**

# PUBLIC HEALTH CRISIS OF OPIOID OVERDOSES IN THE UNITED STATES

- Drug overdose deaths in the US have more than **quadrupled** since 1999
- **63,632** = total overdose deaths in 2016, a **21% increase** from 2015
- Worst addiction epidemic in the U.S. Every day, **44 people in the U.S. die from opioid OD. Nearly 2 deaths/hr**
- Prescription **opioids, heroin, and synthetic opioids (fentanyl)** are the major causes of the drug overdose deaths



# PUSH FOR PAIN CONTROL IN 80's and 90'S

- Under-treatment of pain
- Pain as a human rights issue
- Early data that opioid risks were low
- Pain as 5<sup>th</sup> vital sign
- Porter J., Jick H., et al, *New England Journal of Medicine*, Jan 1980
  - “the development of addiction is rare in medical patients with no history of addiction”
- Portenoy R., 1986
  - “opioid maintenance therapy can be a safe, salutary and more humane alternative to surgery or to not treating a patient with chronic pain”
- The Joint Commission, 2000
  - “there is no evidence that addiction is a significant issue when persons are given opioids for pain control.”





# MARKETING FOR PAIN CONTROL IN 1990'S

## FREEDOM FROM PAIN!

Extra strength pain relief  
free of extra prescribing  
restrictions.

- Telephone prescribing in most states
- Up to five refills in 6 months
- No triplicate Rx required

### Excellent patient acceptance.

In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.<sup>1</sup>

COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Cotalano R2. The medical approach to management of pain caused by cancer. Semin. Oncol. 1975; 2: 379-92 and Fleisher JB, et al. The chronic pain syndrome: misconceptions and management. Ann. Intern. Med. 1980 98:95.

### The heritage of VICODIN<sup>®</sup> over a billion doses prescribed.<sup>2</sup>

- VICODIN ES provides greater central and peripheral action than other hydrocodone/acetaminophen combinations.
- Four to six hours of extra strength pain relief from a single dose
- The 14th most frequently prescribed medication in America<sup>2</sup>

**vicodin ES**

(hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg)

Tablet for tablet, the most potent analgesic you can phone in.

<sup>1</sup> (hydrocodone bitartrate 5 mg) (Warning: May be habit forming) and acetaminophen 500mg)

<sup>2</sup> Data on file, Knoll Pharmaceuticals  
Standard industry new prescription audit

Please see brief summary of prescribing information on adjacent page

## Maintain control of your patient's therapy.

**Rx Specify**  
*Do not substitute*

**vicodin ES**  
(hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg)

**It's your prescription – not a suggestion.**

**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain. **CONTRAINDICATIONS:** hypersensitivity to acetaminophen or hydrocodone. **WARNINGS:** Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression. **Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS:** Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. **Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. **Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anxiolytics, sedatives, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAOI inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Usage in Pregnancy:** Teratogenic Effects: Pregnancy Category C: Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Neonatal/Infant Effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, vomiting, and fever. **Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more pronounced in ambulating than in nonambulating patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, loss of appetite, psychic dependence and mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives may be anticholinergic and increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** Urteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule II). **Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. OVERDOSEAGE:** Acetaminophen Signs and Symptoms: In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised March 1992

5890

Knoll Pharmaceuticals  
A Unit of BASF K&F Corporation  
Whippany, New Jersey 07981



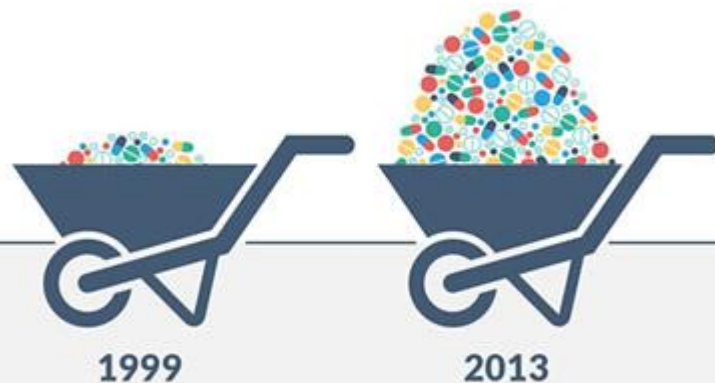
# 1996: THE BIRTH OF OXYCONTIN





# PUBLIC HEALTH CRISIS OF OPIOID OVERDOSES IN THE UNITED STATES

From 1999 to 2013,  
the amount of prescription painkillers prescribed  
& sold in the U.S. nearly **QUADRUPLED.**

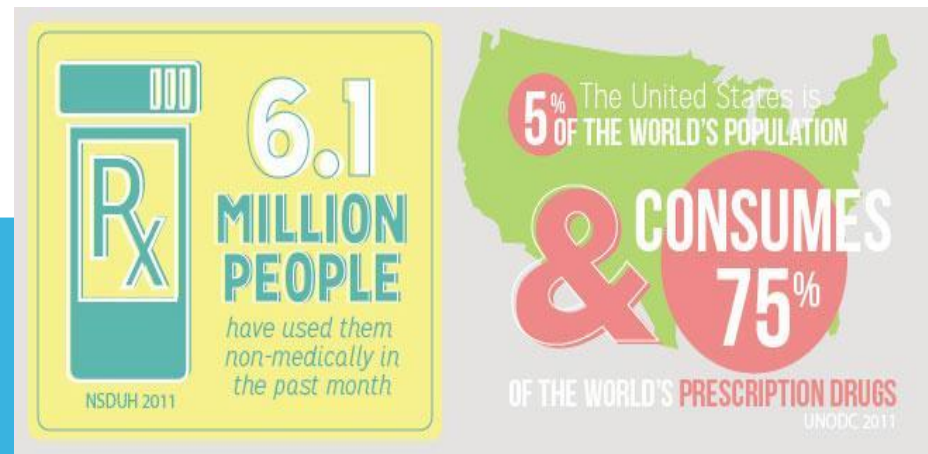


Yet there has not been an overall change in  
the amount of pain that Americans report.

CDC.gov

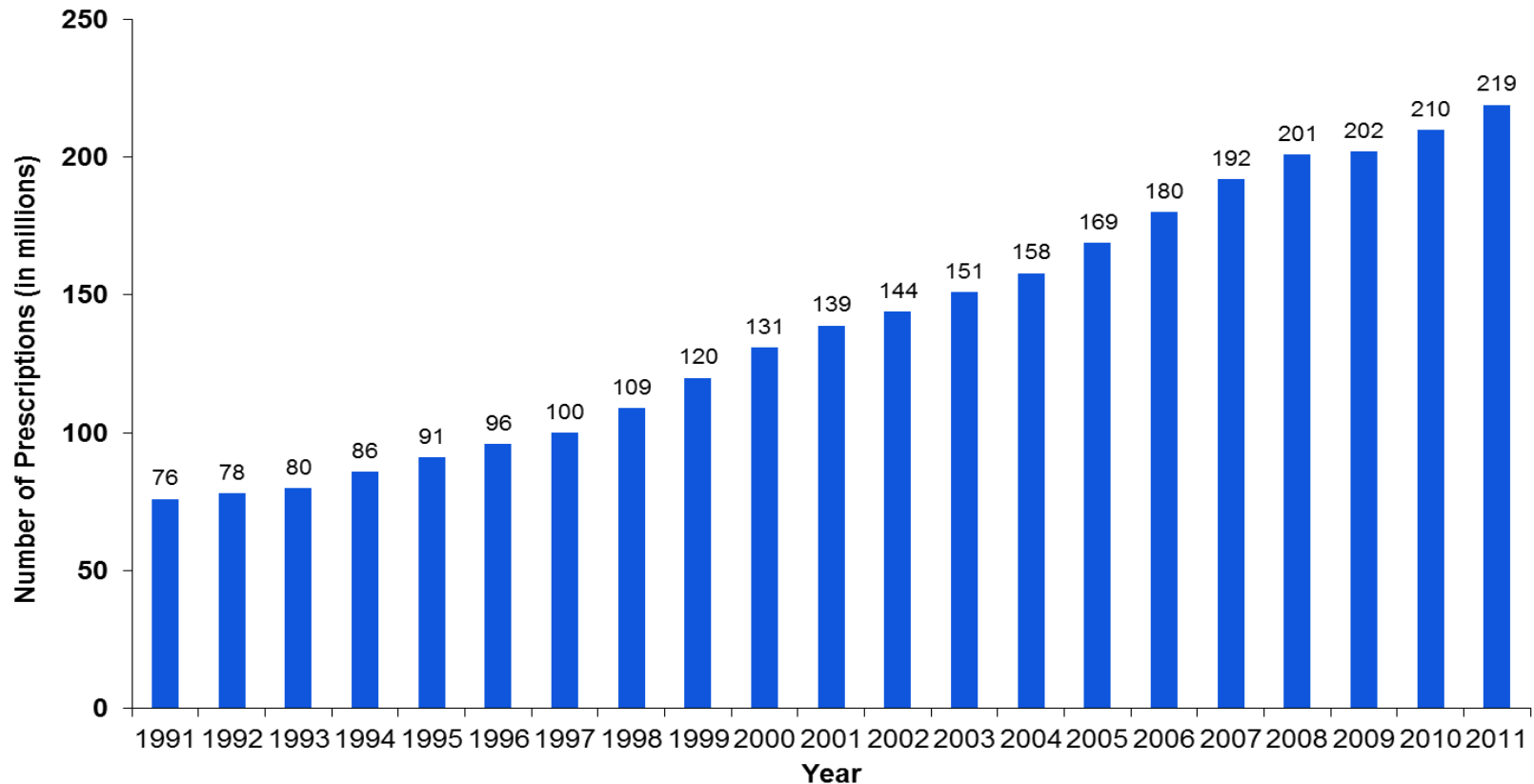


TIME Magazine, June 15, 2015



CDC.gov

# Opioid Prescriptions Dispensed by Retail Pharmacies- United States 1991-2011



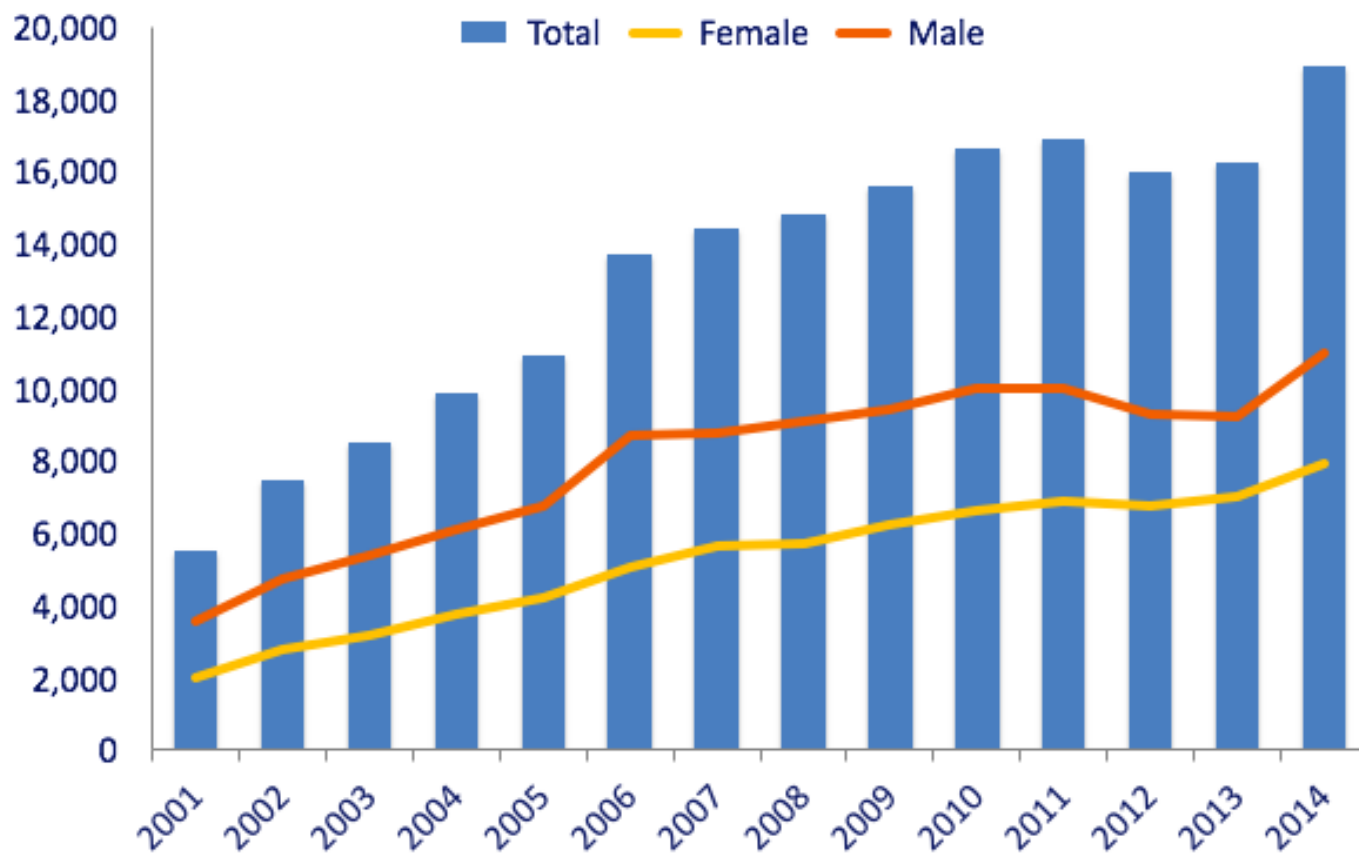
*IMS Vector One. From "Prescription Drug Abuse: It's Not what the doctor ordered." Nora Volkow National Prescription Drug Abuse Summit, April 2012.*





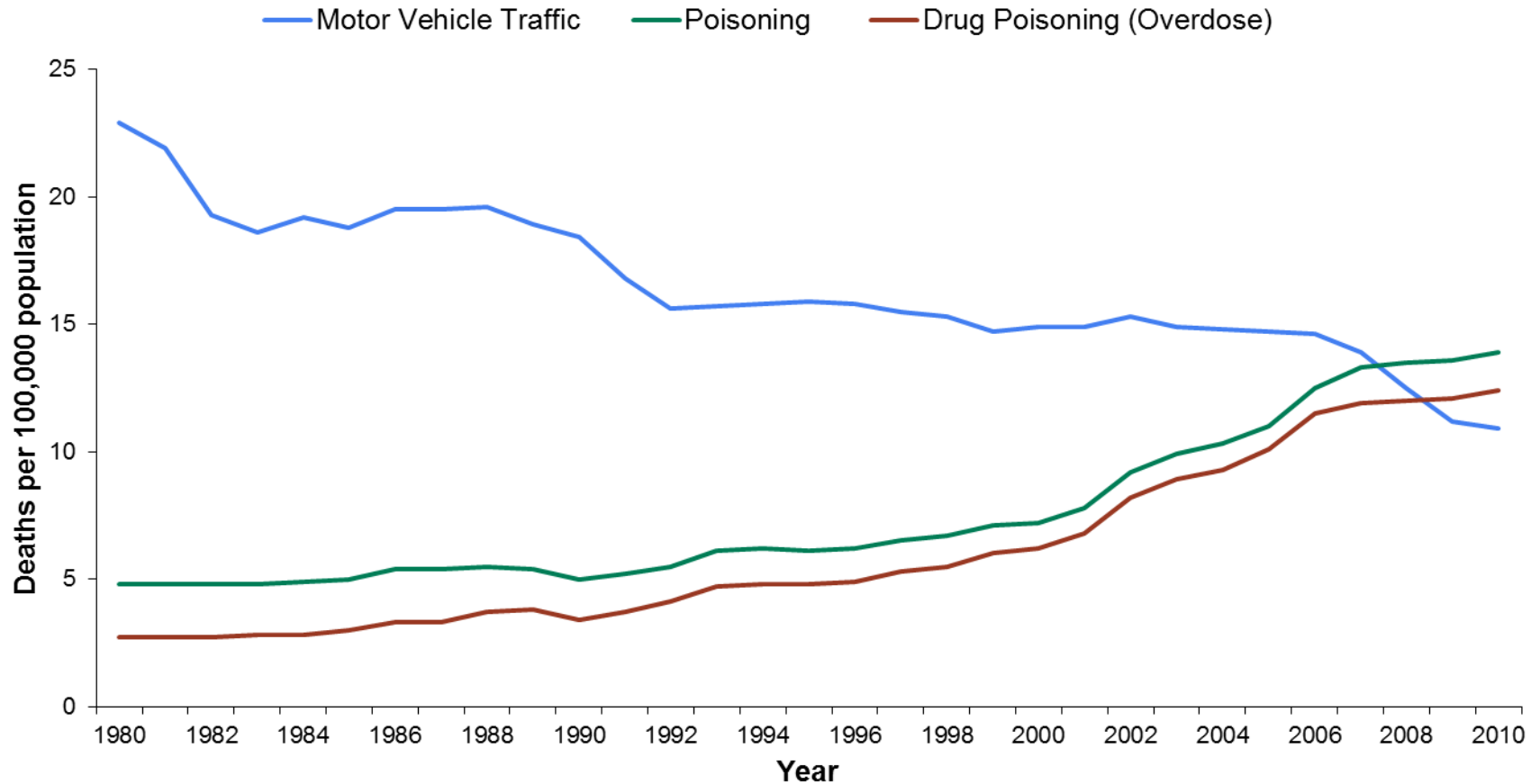
# National Overdose Deaths

## Number of Deaths from Prescription Opioid Pain Relievers



Source: National Center for Health Statistics, CDC Wonder

# Motor Vehicle Traffic, Poisoning, and Drug Overdose Death Rates, US 1980-2010

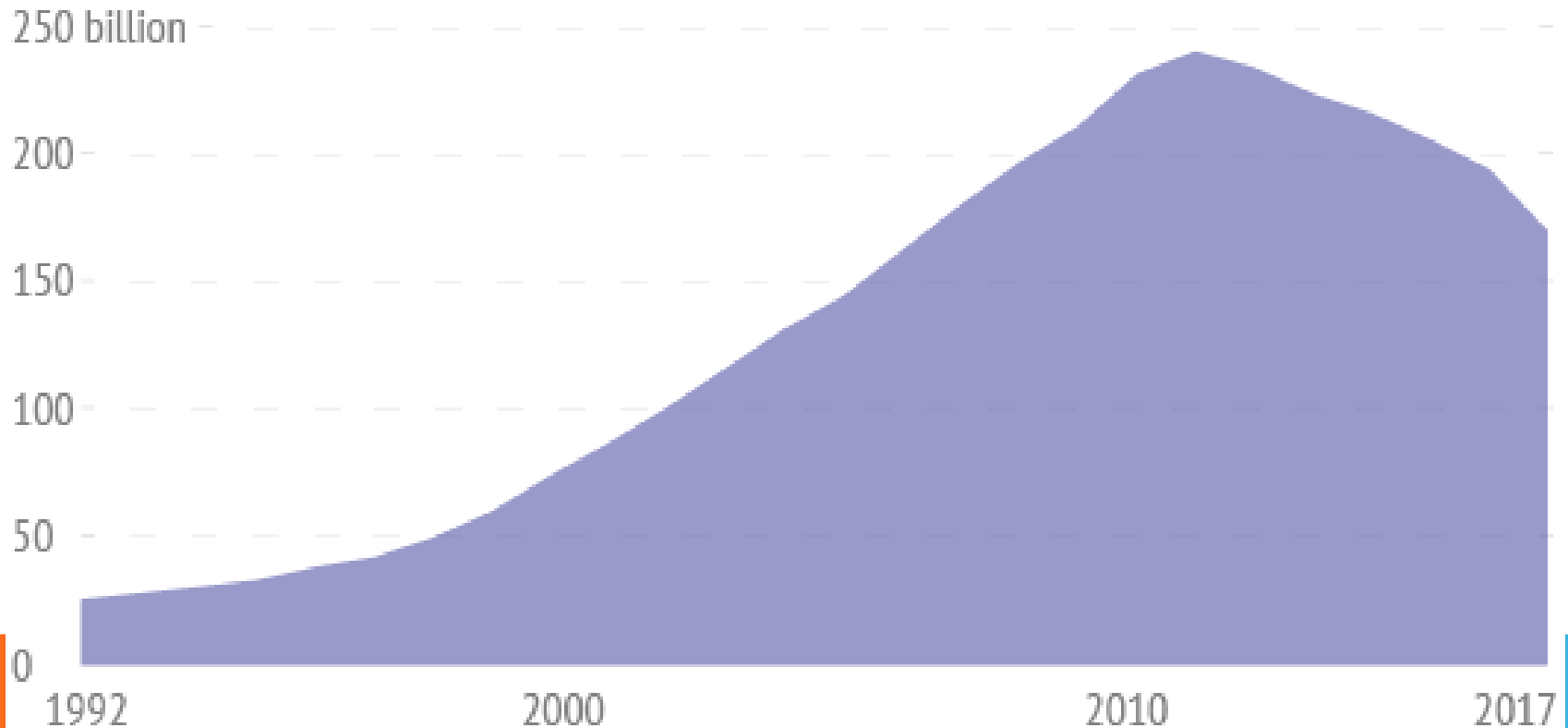


NCHS Data Brief, December, 2011. Updated with 2009 and 2010 mortality data.

# Providers starting to prescribe less opioids

## Opioids of the masses

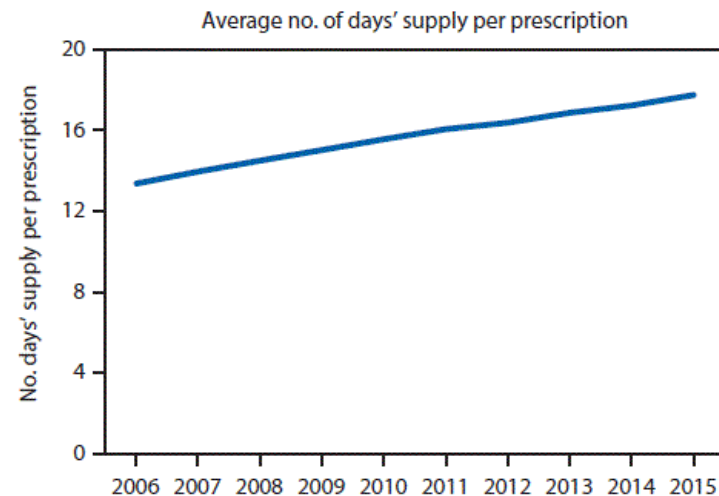
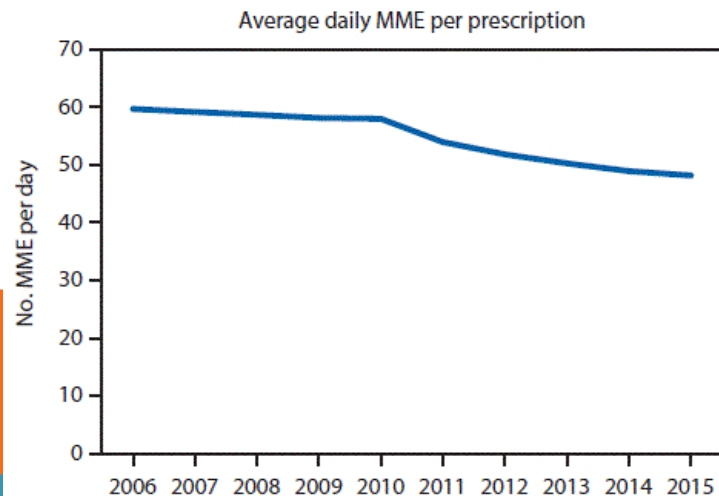
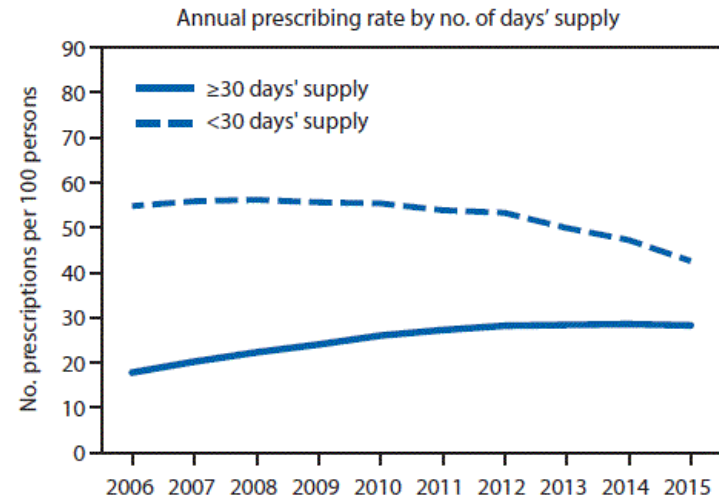
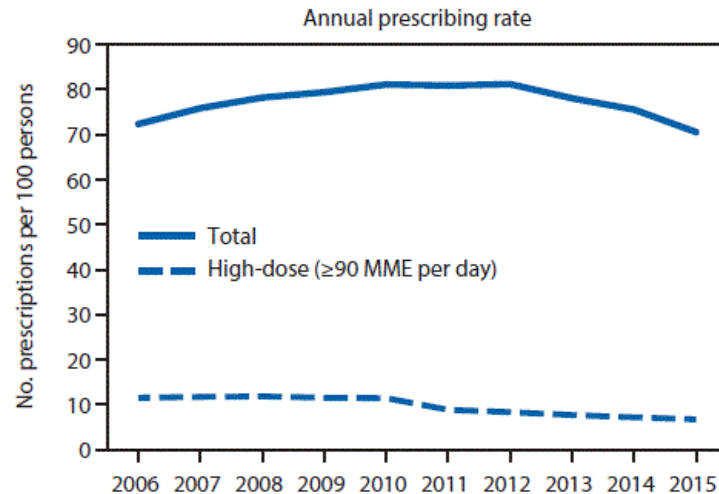
Narcotic analgesic dispensed volume in morphine milligram equivalents (MME)



Source: IQVIA National Prescription Audit

**CNBC**

# Providers starting to prescribe less opioids



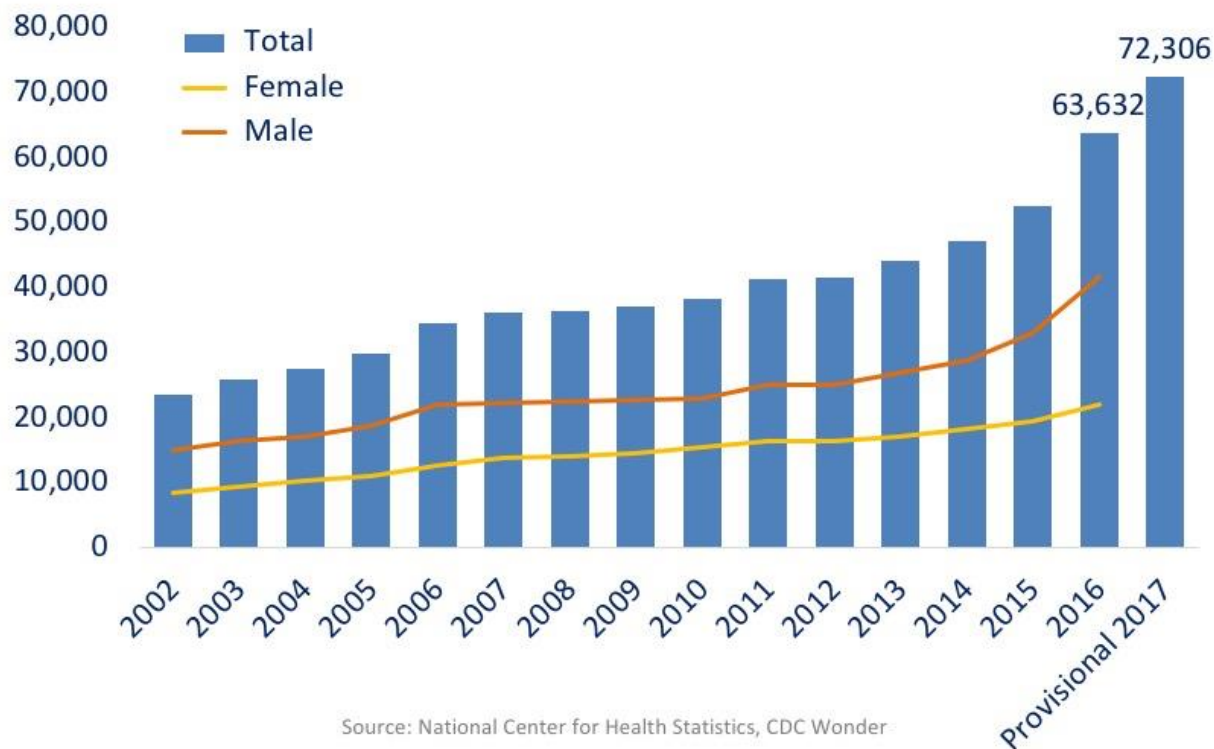
*CDC Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:697–704.*





# National Overdose Deaths

## Number of Deaths Involving All Drugs

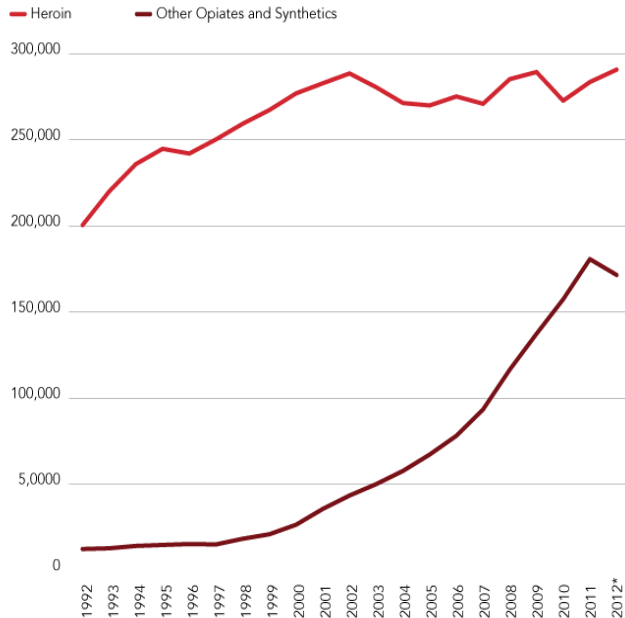


# Opioid prescribing is now decreasing, but many patients are switching to heroin

## Painkillers And The Heroin Market

A growing number of people are using heroin in recent years, in part because it can be cheaper and easier to find than opioid painkillers purchased on the black market. Most heroin users were first hooked on prescription opioids, which generated \$11 billion in 2010 for the pharmaceutical industry.

Substance abuse treatment facilities admissions by primary drug



\*2012 data for Mississippi, Pennsylvania, and West Virginia are not available.

Sources: SAMHDA, Los Angeles Times, Frost & Sullivan

4 out of 5  
new heroin users have  
abused painkillers.

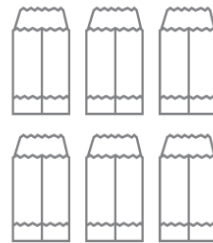


### A Cheaper High

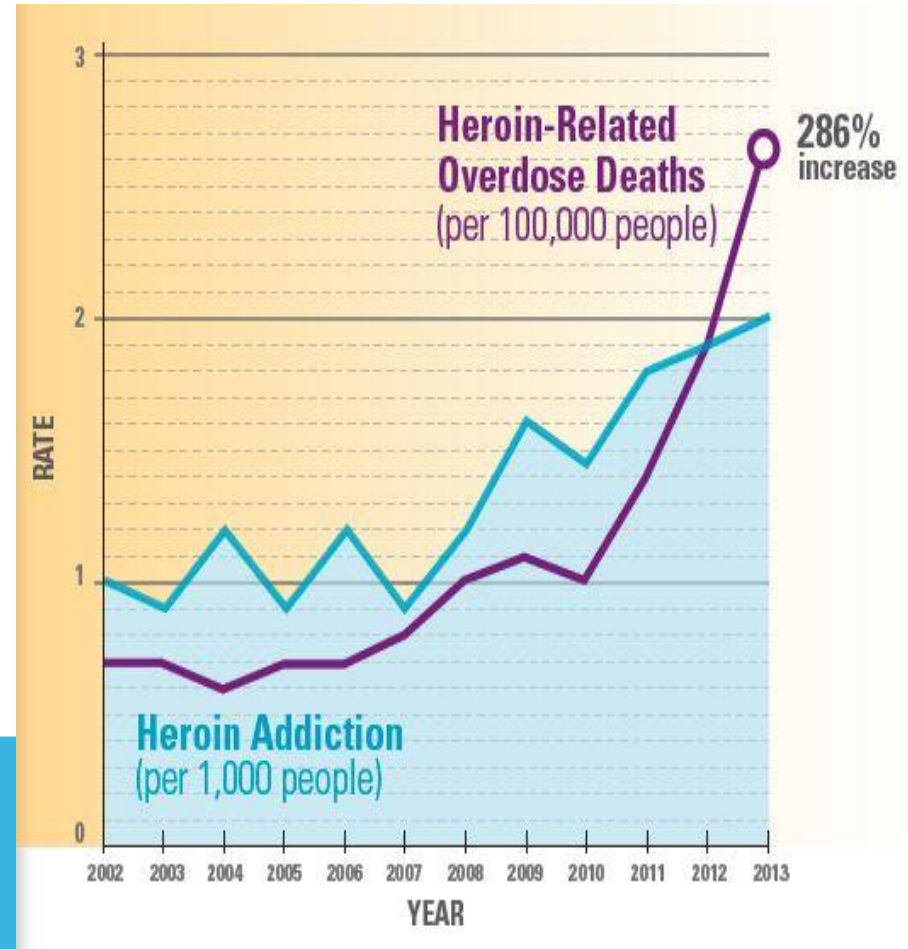
\$30 can buy one oxycodone  
pill on the street in New York...



or six hits of heroin.



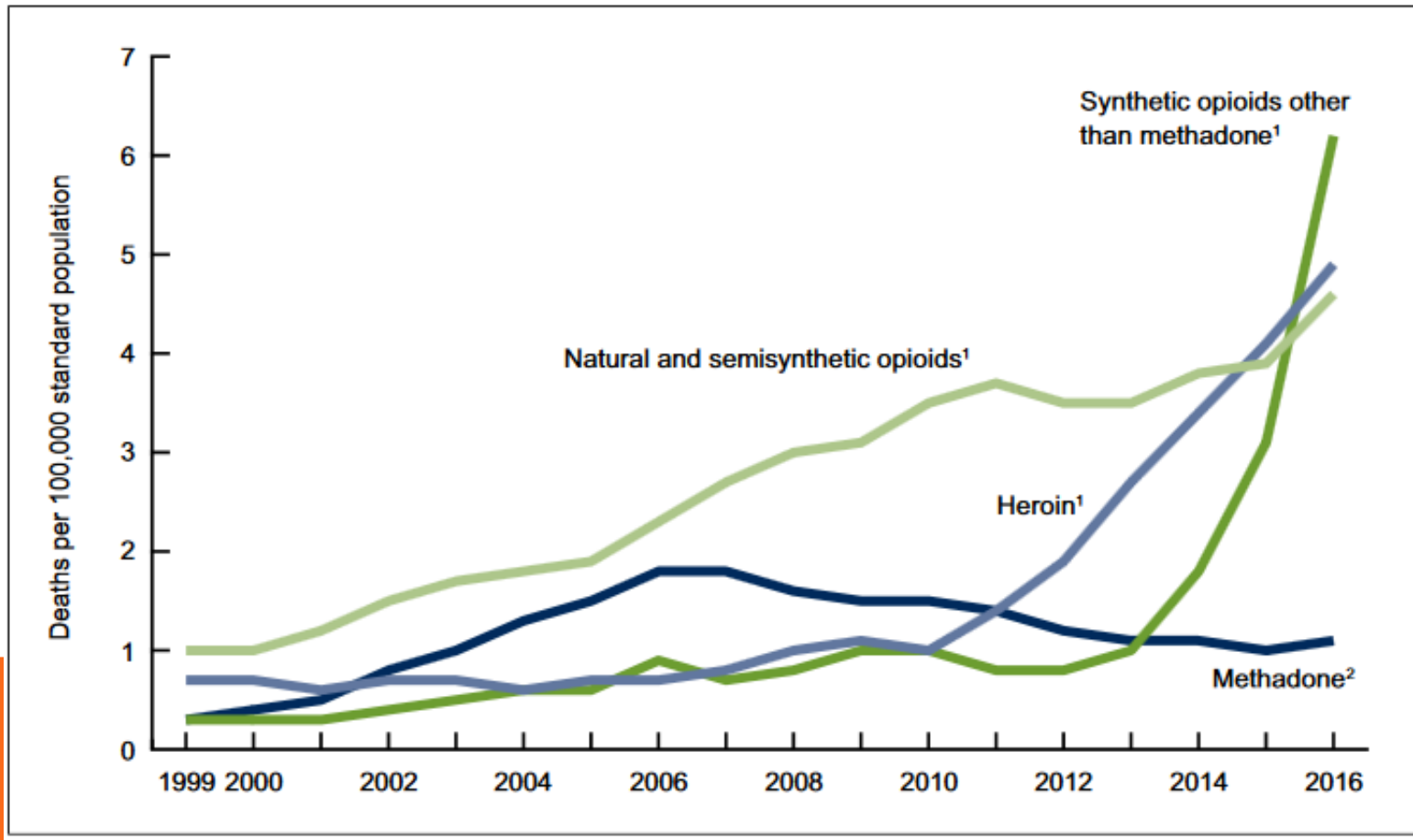
THE HUFFINGTON POST



NCHS Data Brief, December, 2011. Updated with 2009 and 2010 mortality data.

# Most recent sharp rise due to fentanyl

Figure 4. Age-adjusted drug overdose death rates, by opioid category: United States, 1999–2016



# UNITED STATES DEPARTMENT OF JUSTICE

## OFFICE OF PUBLIC AFFAIRS

**February 21<sup>st</sup> , 2011**

CDC declares a opioid addiction epidemic in US

**April 9<sup>th</sup> , 2013**

States start passing legislation allowing lay persons to administer naloxone

**March 10<sup>th</sup> , 2014**

Attorney General Holder, Calling Rise in Heroin Overdoses 'Urgent Public Health Crisis,' Vows Mix of Enforcement, Treatment

**August 8<sup>th</sup> , 2016**

Surgeon General, Dr. Vivek Murthy, asks all health care provider to take "The Pledge", launches [Turnthetiderx.org](http://Turnthetiderx.org), releases CDC Opioid Prescribing Guideline

**October 26<sup>th</sup> , 2017**

Trump declares opioid crisis a "public health emergency", but does not declare it a "national emergency" => thus no new funds are requested or allocated



# Turnthetiderx.org

- Pocket Guide
- MME Calculator
- PDMP's



## PRESCRIBING OPIOIDS FOR CHRONIC PAIN

### ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

**IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN** (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

### BEFORE PRESCRIBING

- ASSESS PAIN & FUNCTION**  
 Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).  
 Q1: What number from 0 – 10 best describes your PAIN in the past week? (0 = "no pain", 10 = "worst you can imagine")  
 Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = "not at all", 10 = "complete interference")  
 Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY? (0 = "not at all", 10 = "complete interference")
- CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE**  
 Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.
- TALK TO PATIENTS ABOUT TREATMENT PLAN**
  - Set realistic goals for pain and function based on diagnosis.
  - Discuss benefits, side effects, and risks (e.g., addiction, overdose).
  - Set criteria for stopping or continuing based on diagnosis.
  - Set criteria for regular progress assessment.
  - Check patient understanding about treatment plan.



### Calculating Total Daily Dose & MME Conversions (2 pages)

#### CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dose, Higher Risk.

Higher doses of opioids are associated with higher rates of overdose and death, are relatively less effective, and are more costly. Higher doses also increase the risk of addiction, tolerance, and physical dependence. Higher doses also increase the risk of respiratory depression, which can be fatal.



**NOTE: IT IS IMPORTANT TO CALCULATE THE TOTAL DAILY DOSE OF OPIOIDS.**  
 When converting multiple oral doses to a total daily dose, use the following formula:  
 (Dose x Frequency) x 24 = Total Daily Dose

**NOTE: IT IS CRITICAL TO CALCULATE THE TOTAL DAILY DOSE OF OPIOIDS.**  
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SOURCE: [Centers for Disease Control and Prevention, 2016](#)



### Prescription Drug Monitoring Programs (PDMPs) (2 pages)

#### PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

Checklist for the PDMP: An Important Step in Improving Patient Safety

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## Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

### CHECKLIST

#### When CONSIDERING long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

### REFERENCE

#### EVIDENCE ABOUT OPIOID THERAPY

- Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
- Short-term benefits small to moderate for pain; inconsistent for function.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

#### NON-OPIOID THERAPIES

- Use alone or combined with opioids, as indicated:
- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

#### EVALUATING RISK OF HARM OR MISUSE

- Known risk factors include:
- Illicit drug use; prescription drug use for

AN INITIATIVE OF



Surgeon General of the United States

WEBSITE CREATED IN PARTNERSHIP WITH



Public Health Foundation Enterprises

100 Million Healthier Lives

CONVENED BY H Institute for Healthcare Improvement

# SO WHEN DO YOU PRESCRIBE OPIOIDS?

## CDC Opioid Prescribing Guidelines

### *Acute pain*

- ⇒ lowest effective dose of immediate-release opioids
- ⇒ => 3 days or less, rarely more than 7 days

### *Chronic pain*

- ⇒ No restrictions for active cancer, palliative, and end-of-life
- ⇒ Line between acute pain and initial chronic pain not always clear
- ⇒ Pain lasting longer than 3 months or past the time of normal tissue healing is generally no longer considered acute



# LONG-TERM OPIOID TREATMENT

- ⇒ Set realistic goals regarding pain and function based on dx
- ⇒ Check that non-opioid therapies tried and optimized
- ⇒ Discuss benefits and risks
- ⇒ Set criteria for stopping or continuing opioids
- ⇒ Assess baseline pain or function (PEG scale)
- ⇒ Schedule initial reassessment in 1-4 weeks
- ⇒ Evaluate risk of harm or misuse
  - ⇒ Check prescription drug monitoring program (PDMP) data
    - ⇒ In California CURES 2.0
    - ⇒ Check urine drug screen



# Assessing Pain & Function Using PEG Scale

**PEG Score = average 3 individual question scores**

=> 30% improvement from baseline is clinically meaningful

**Q1:** What number from 0-10 best describes your ***pain in the past week?***

**Q2:** What number from 0-10 best describes how during the past week, pain has ***interfered with your enjoyment of life?***

**Q3:** What number from 0-10 best describes how during the past week, pain has ***interfered with your general activity?***

The PEG Scale

In the past week, how much:

**Pain on average?**

0 1 2 3 4 5 6 7 8 9 10

No pain As bad as you can imagine

**Pain interfered with Enjoyment of life?**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

**Pain interfered with General activity?**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

Wells JE, et al. J Gen Intern Med. 2009;24(6):703-8.



# WHEN REASSESSING AT RETURN VISIT

- ⇒ Assess baseline pain or function (**PEG scale**), and compare to baseline
- ⇒ Observe patient for signs of over-sedation/overdose risk
- ⇒ **Check PDMP**
- ⇒ Determine with to continue, adjust, taper, or stop opioids
- ⇒ Calculate opioid dosage morphine milligram equivalent (MME)
  - ⇒ If  **$\geq 50$  MME/day total ( $\geq 50$ mg hydrocodone;  $\geq 33$ mg oxycodone)**
    - ⇒ Increase freq of f/u; consider offering naloxone
  - ⇒ If  **$\geq 90$  MME/day ( $\geq 90$ mg hydrocodone;  $\geq 60$ mg oxycodone)**
    - ⇒ Carefully document justification; consider specialist referral
- ⇒ Schedule reassessment at regular intervals (<3months)

# Calculating MME

## 50 MME/day:

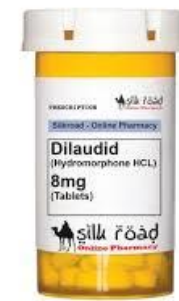
- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

## Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

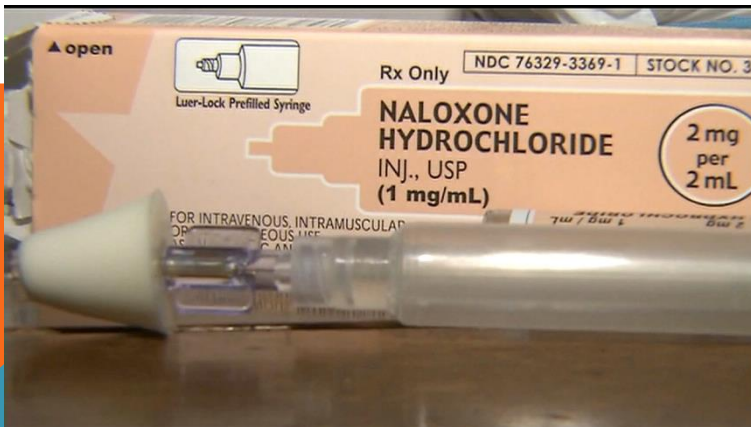
## 90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)



# NALOXONE (NARCAN)

- reverses the effects of opioids including respiratory depression, sedation and hypotension
- pure opioid antagonist
- antagonizes opioid effects by competing for the  $\mu$ ,  $\kappa$  and  $\delta$  opiate receptor sites in the CNS
- does not possess the "agonistic" or morphine-like properties characteristic of other opioid antagonists
- in the absence of other opioids it exhibits essentially no pharmacologic activity



# LEGISLATIVE CHANGES IN CALIFORNIA

## AB 635, Ammiano. Drug overdose treatment: liability.

legislation that supports and provides legal protections for health care providers to prescribe naloxone to be administered by non-medical personnel in cases of suspected life threatening opioid overdose

## AB 1535, Bloom. Pharmacists, Naloxone Hydrochloride:

legislation that supports and provides legal protections for pharmacists to prescribe naloxone to patients in accordance with standardized procedures and protocols developed and approved by the Medical Board of California and California State Board of Pharmacy





# New Regulations from CA Medical Board

Starting October 2<sup>nd</sup>, 2018, all California providers who prescribe controlled substance (Class II to IV) are required to check the state's Controlled Substance Utilization Review and Evaluation System (CURES) website.

- Rule applies to ALL schedule II to IV substances: includes opioids, benzodiazepines, and stimulants
- Prescriber only one should check the CURES report by logging into website.
- Prescriber is not allowed to share password to CURES website with anyone

*\*Prescriber may designate a delegate to search for a patient in the CURES database but cannot review the search result, can only forward the search result to the prescribing provider\**

<https://oag.ca.gov/cures/faqs>

*California Health and Safety Code section 11165.4(a)*

# New regulations from CA Medical Board

## Acute Rx:

- mandatory to check CURES before 1<sup>st</sup> prescription, unless less than 5 day supply
- CURES can not be check no earlier than 24hrs (or previous business day) before prescribing

## Chronic Rx:

- every patient needs a face-to-face visit AT LEAST every 3 months
- check CURES at least every 4 months – now MANDATORY
- Urine Tox screen AT LEAST annually

<https://oag.ca.gov/cures/faqs>

*California Health and Safety Code section 11165.4(a)*

# New Regulations

## CA Assembly Bill 2760 (Wood):

- Signed by Gov. Brown just 2 weeks ago
- Requires all providers to offer a prescription of Naloxone with any opioid Rx if:
  - 90MME /day or above
  - opioid is prescribed concurrently with a benzodiazepine
  - Patient has increased risk for opioid overdose
- Requires provider to provide education and caution regarding overdose symptoms and reversal agents

If prescriber fails to offer naloxone Rx or provide use information  
=> shall be referred to the licensing organization for  
administrative action

# CASE 1

## History:

31 y/o M presents to urgent care for acute knee pain. Pt reports falling off ladder and hitting his knee while working in his garage last night. He reports being in 9/10 pain and is having difficulty ambulating and bending his knee. He has a history of peptic ulcer disease and reports being intolerant to NSAID's. He also has a history of anxiety that is currently well controlled with Sertraline 100mg Qday and Lorazepam 1mg BID. "I need something strong to ease the pain doc."

## Pexam:

large ecchymosis over R patella, +TTP over patella, ROM with flexion and extension limited by pain to 110 degrees, no ligamentous laxity noted, minimal joint line tenderness

## Imaging:

R knee Xray -neg for acute fracture, minimal degenerative changes

# CASE 1

- ⇒ Would you prescribe opioids for this patient?
- ⇒ If yes what type? How many days supply?
- ⇒ What else are you required to do for regulatory compliance?



# CASE 1

⇒ Rx Hydrocodone/APAP 5mg/325mg 1 tab PO Q8H prn severe pain

⇒ 3 tabs x 5mg = 15mg hydrocodone/day = 15MME/day

⇒ #12 (3 day supply)

⇒ 1<sup>st</sup> time you are prescribing opioid to this patient  
need to check CURES Patient Activity Report

⇒ Pt is on both opioids and benzodiazepines  
required to offer Rx for naloxone

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3



# CASE 2

## History:

55 y/o F presents to your primary care office for acute on chronic back pain. Pt is well known to you. She a h/o of severe spinal stenosis, s/p multiple ESI. She goes to acupuncture and does home physical therapy. Is currently taking Naproxen 500mg bid, Gabapentin 800mg tid, Dialudid 4mg po q4h.

## Pexam:

patient in significant discomfort, standing in room because sitting exacerbates her pain, significant pain with flexion and extension of low back, 5/5 motor strength in b/l LE, sensation intact, normal rectal tone

MRI L-spine: significant spinal stenosis L1-L4

## CASE 2

- ⇒ Is the opioid regimen appropriate for this patient?
- ⇒ If not, how would you change it?
- ⇒ What else are you required to do for regulatory compliance?



## CASE 2

- ⇒ convert short acting opioid to long-acting opioid for better pain control, and less risk of abuse
- ⇒ Dilaudid (Hydromorphone) 4mg q4h = 24mg Dilaudid/day
  - ⇒  $24\text{mg} \times 4 = 96\text{MME/day}$
- ⇒ MS Contin 30mg q8h (90MME)
- ⇒ #90 (30 day supply)
- ⇒ Document PEG scale score
- ⇒ Utox now
- ⇒ need to check CURES Patient Activity Report
- ⇒ Provide naloxone prescription, review overdose risks, refer to pain management specialist to co-manage patient

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
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Methadone	
1-20 mg/day	4
21-40 mg/day	8
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≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

# Take Home Points

- Opioid overdose death rates have dramatically risen and the opioid epidemic in the US is worsening
- Maximize non-opioid therapies for pain management first, make opioids your last option
- CDC guidelines for opioid treatment
  - Treat acute pain for 3 days, rarely more than 7 day
  - If treating pain longer than 3 months then likely chronic pain
  - When treating chronic pain the hallmarks for dosing are  $\geq 50\text{MME/day}$  and  $\geq 90\text{MME/day}$
- CURES 2.0 database checks are required for controlled substance prescribing starting October 2<sup>nd</sup>, 2018
- CA Prescribers are required to offer naloxone Rx and counseling for high risk patients starting January 1<sup>st</sup>, 2019
- Use CDC resources: [Turningthetide.org](https://turningthetide.org)

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# QUESTIONS? AT THE END

