

PRESIDENT'S MESSAGE

Eight Principles for Safer Opioid Prescribing

Deaths from prescription medications have been at a crisis level for several years [1]. Evidence as to the etiology of deaths has been slowly accumulating [2]. Unfortunately, the evidence has not led to a national reversal of this tragic trend. It is unclear what percent of all the decedents are people who received opioids for pain vs people who died after ingesting diverted drugs. What is clear is that people with pain who are prescribed opioids are among the decedents, suggesting the need for an educational remedy for clinicians who prescribe opioids.

With this in mind, the American Academy of Pain Medicine (AAPM) Board of Directors has endorsed the following principles, presented with supporting references, and is asking members to promote them in their communities. The principles have appeared previously on the website of the LifeSource Foundation [3] and in various scientific presentations. Follow-up to assess impact on practice change is planned similar to surveys performed in Utah to assess academic detailing containing a version of these principles [4].

If the following focused, national, medical-education program were adopted by most prescribers, it could possibly reverse the opioid-related unintentional overdose trend, meeting the 60-month goal of a 15% reduction in the death rate set by the White House Office of National Drug Control Policy [5]. This contention is based on the reversal of the death rate in Utah that was associated with the physician and public educational program offered by the Utah Department of Health [6].

1. Assess patients for risk of nonmedical use or medical misuse before starting opioid therapy and manage accordingly.

Providers may use one of several available tools before prescribing for opioids to assess patients for their risk of developing problematic drug-taking behaviors [7–9]. These are based on biological, social, and psychiatric risk factors associated with misusing opioids prescribed for pain [10–12]. Implement a plan according to the level of risk: e.g., for high-risk patients, this might include referral for further psychiatric evaluation and comanagement with a chemical dependency expert prior to initiating an opioid trial.

Periodic monitoring for effects on analgesia, daily activities, adverse effects, aberrant drug-related behaviors, cognition, function, and quality of life can be assisted by tools such as the Pain Assessment and Documentation Tool and the Current Opioid Misuse Measure [13,14]. Cli-

nicians should use checks of the state prescription-monitoring database and measures, such as urine drug monitoring, to ensure adherence to the medication regimen [15]. All patients should be taught safe usage, storage, and disposal methods.

2. Watch for and treat comorbid mental disease when it occurs.

The frequent co-occurrence of mental-health disorders, including depression and anxiety, with chronic pain place patients at high risk for misuse, mixing, drug–drug interactions, and overdose [1,16–18]. Assess for the presence of mental-health disorders before initiating opioid therapy and, when indicated, consult with experts in mental-health fields to coordinate care.

3. Conventional conversion may cause harm when rotating (switching) from one opioid to another.

Equianalgesic conversion tables provide insufficient guidance to determine the equivalent doses of different opioids [19,20], and individual consideration is necessary for every patient. When rotating from one opioid to another, consider slowly decreasing one opioid while slowly titrating the new opioid to effect [21]. This process takes time but may be safer than switching all at once. If you are not experienced in switching opioids in patients on long-term opioid therapy, seek expert consultation.

4. Avoid combining benzodiazepines with opioids, especially during sleep hours.

Benzodiazepines will enhance the respiratory-depressant effects of opioids [22,23]. Consider using an alternative to benzodiazepines for anxiety disorders. When a sleep aid is indicated, use alternative treatments, like an anticonvulsant or a low dose of trazodone. For a patient with a neuropathic pain disorder, a low dose of a tricyclic anti-depressant at bedtime may be dually beneficial. Use caution in older patients, monitoring for excessive anticholinergic effects.

5. Use methadone as a secondary or tertiary agent, starting with a low dose and titrating very slowly.

Methadone's half-life averages from 8 to 59 hours but can last up to 130 hours in some people; compare this with its analgesic effect, which usually lasts only 4 to 8 hours [24,25]. This unusual pharmacokinetic profile can contribute to an unpredictable accumulation of methadone. Consider starting patients (whether or not they are opioid

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naïve) on 15 mg or less per day [26] in divided doses (q8h) and increase total daily dose by no more than 25% to 50% no more frequently than weekly. If you are not experienced prescribing methadone, consult with a clinician who is.

6. Assess for sleep apnea in patients on high daily doses of methadone or other opioids and in patients with a predisposition.

Research has shown a high prevalence of sleep apnea in patients on chronic opioid therapy [22,27]. The data suggest a dose relation, and the sleep apnea can be life threatening on moderate-to-high doses of opioids [22]. Patients who require greater than 50 mg of methadone or greater than 150 mg morphine equivalent of other opioids should be referred for formal sleep apnea evaluation. So should those with a predisposition or risk factors for sleep apnea. At-risk patients may require inpatient evaluation to monitor for and determine safety of opioid therapy.

7. Tell patients on long-term opioid therapy to reduce opioid dose during upper respiratory infections or asthmatic episodes.

Because of a decreased margin of safety [28], patients should be advised to reduce their daily opioid doses, particularly their evening doses, by at least 30% during events with acute respiratory tract compromise. These include flu, pneumonia, and upper respiratory infections.

8. Avoid using long-acting opioid formulations for acute, postoperative, or trauma-related pain.

Most long-acting opioids, including transdermal patches [29], should be reserved for patients who have developed tolerance to opioids.

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