Prescription opioid sales, deaths and treatment: 1999-2010

• An estimated 978 people died of opioid-related overdoses in Massachusetts in 2013 — a 46% increase

The source of the data is: Registry of Vital Records and Statistics, MA Department of Public Health
Heroin’s Toll
Heroin Surges as Kentucky Cracks Down on Pain Pills

Abuse-Deterrent OxyContin Shifted Patterns of Use, Introduced Heroin as Alternative

By Joe Elk

Edited by Susan Sadoughi, MD, and Richard Saltz, MD, MPH, FACP, FASAM

OxyContin abuse changed but didn’t end with the advent of an abuse-deterrent formulation in 2010, according to a JAMA Psychiatry study.

Researchers used data from an ongoing national survey of patients entering treatment centers before and after abuse-deterrent pills were introduced. They found that post-month abuse of OxyContin had occurred in roughly half the sample before the abuse-deterrent formulation, dropping to about 20% afterwards, where it has remained.

Continuing abusers of OxyContin switched in the following ways: about 45% changed from injecting or inhaling to swallowing; a third were able to defeat the deterrent safeguards and continued to inject or inhale; and about a quarter continued their previous pattern of swallowing the drug. Only about 3% stopped using opioids completely.

Abuse-deterrent formulations have been shown to reduce the risk of abuse and diversion. If properly implemented, these formulations could help stem the opioid epidemic.
Effect of Abuse-Deterrent OxyContin.


Figure 2. Standardized Overtone Rates and Segmented Regression Results Before and After Opioid Market Changes

A  Prescription opioid overdose

B  Rate of prescription opioid overdose to dispensing

C  Overtone overdose

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Overtone Rate (100,000 населения)</th>
<th>Predicted Overtone Rate (100,000 населения)</th>
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<tr>
<td>Q4 2012</td>
<td>0.24</td>
<td>0.22</td>
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<td>Q3 2012</td>
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<td>Q2 2012</td>
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<td>Q1 2012</td>
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Figure 2A: Prescription opioid overdose rates across quarters.

Figure 2B: Rate of prescription opioid overdose to dispensing across quarters.

Figure 2C: Overtone overdose rates across quarters.
Ethics Issues

• Beneficence vs. Non-maleficence
• Obligation to individual patient vs. society
• Role of physician and profession

CASE STUDIES
John is a 53-year-old mechanic who recently moved to MA. He had been relatively healthy since quitting drinking at 48. Due to his prior alcohol abuse, however, he had developed chronic pancreatitis, which caused him debilitating abdominal pain. He had modified his diet and had been taking pancreatic enzyme supplements faithfully, but needed long-acting daily morphine to carry on his normal work activities at the post office. To continue his care in MA, John went to a primary care clinic, where he was seen by Dr. Smith. Dr. Smith had 20 years of experience in prescribing opioid medications and required all his patients to sign opioid treatment contracts, which explicitly state the risks and benefits of treatment, prohibited behaviors, and criteria for termination of treatment. Dr. Smith approached John to discuss the terms by which he could continue to receive his prescriptions for long-acting morphine. As Dr. Smith explained the contract, John got increasingly upset. Finally he said, “Stop. Why are you treating me like a criminal when I have a legitimate medical condition?”

Dr. Li is an ED physician in Boston. One afternoon, he sees a young woman named Doris who has come to the ER because of extreme abdominal and knee pain over the past 12 hours. Doris says that she is in great distress and rates her pain at a 10 out of 10. She says that the pain resembles that of her previous sickle cell crises and that only Vicodin helped. She points to her abdomen and both of her knees as the sites of pain and refuses to allow Dr. Li to touch them. Dr. Li observes no overt swelling or redness. Looking at her chart, Dr. Li sees a long list of emergency department visits and admissions over the past 2 years. Doris, 25, has a diagnosis of sickle cell disease. On most ER visits, the peripheral blood smear reports were inconclusive for vaso-occlusive crisis. Notes from her hematologist comment that she is habitually noncompliant and that they have considered consulting psychiatry to help address her persistent chronic pain.
WM is a 38 yo patient of mine with a past medical history of heroin addiction and hepatitis C. He has a h/o incarceration for bank robbery. He is currently clean and sober and regularly attends AA meetings. He presented to the MGH ED after a fall off of a ladder at work twisting his ankle. The ankle was red and swollen, there was no fracture seen on xray. The ED attending made the diagnosis of cellulitis and admitted him to ED Obs for IV vancomycin. Because of his h/o heroin use, the ED physician refused to prescribe opioid medications for his pain. In frustration, the patient signed out AMA 6 hours later. He limped into my office the following day. He appeared to be in severe pain, the ankle was warm, red and diffusely swollen. The patient said to me, “Am I an effing animal”? Because I used to use heroin, does that mean I have to suffer?