Responding to the Prescription Opioid and Heroin Crisis: An Epidemic of Addiction

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Conflict of Interests

I have no relevant financial relationships to disclose.
Unintentional Drug Overdose Deaths
United States, 1970–2007

52,404 drug overdose deaths in 2015

Year

Death rate per 100,000

Heroin

Cocaine

Drug Overdose Deaths by Major Drug Type, United States, 1999–2010

Opioid Related Overdose Deaths
United States, 1999-2014

Heroin treatment admissions: 2003-2013

Non-Hispanic White

Non-Hispanic Black

Percent of all heroin admissions aged 12 and over

2003 2005 2007 2009 2011 2013

12 to 19 years
20 to 34 years
35 to 44 years
45 years or older

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 01.23.15.
Death rates from overdoses of heroin or prescription opioid pain relievers (OPRs), by age group

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

1999 (range 1 - 50)

- < 8
- 8 - 14
- 15 - 18
- 19 - 44
- 45 or more
- Incomplete data

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2001
(range 1 – 71)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2003
(range 2 – 139)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2005 (range 0 – 214)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2007
(range 1 – 340)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2009
(range 1 – 379)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Non-heroin opioid treatment admissions: 2013

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 01.23.15.
All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH).

Mortality by cause, white non-Hispanics ages 45–54

Unintentional overdose deaths involving opioid analgesics parallel per capita sales of opioid analgesics in morphine equivalents by year, U.S., 1997-2007

Source: National Vital Statistics System, multiple cause of death dataset, and DEA ARCOS
* 2007 opioid sales figure is preliminary.
Rates of Opioid Sales, OD Deaths, and Treatment, 1999–2010

CDC. MMWR 2011
New York Consumption of Oxycodone
1980 - 2006

Sources: U.S. Dept of Justice, Drug Enforcement Administration, Office of Diversion Control
New York Consumption of Hydrocodone
1980 - 2006

Sources: U.S. Dept of Justice, Drug Enforcement Administration, Office of Diversion Control
Dollars Spent Marketing OxyContin (1996-2001)

Figure 1: Promotional Spending for Three Opioid Analgesics in First 6 Years of Sales

Industry-funded “educational” messages

• Physicians are needlessly allowing patients to suffer because of “opiophobia.”

• Opioid addiction is rare in pain patients.

• Opioids can be easily discontinued.

• Opioids are safe and effective for chronic pain.
“The risk of addiction is much less than 1%”


Cited 824 times (Google Scholar)
ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients, Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

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Long-term Opioid Treatment of Nonmalignant Pain
A Believer Loses His Faith
(REPRINTED) ARCH INTERN MED/VOL 170 (NO. 16), SEP 13, 2010 1422
WWW.ARCHINTERNMED.COM

Chronic Noncancer Pain Management and Opioid Overdose: Time to Change Prescribing Practices

BMJ

Facing up to the prescription opioid crisis
Deaths resulting from prescription opioids tripled in the United States between 1999 and 2007 and are also increasing in many other countries, including the United Kingdom. Irfan A Dhalla, Navindra Persaud, and David N Juurlink describe how this situation developed and propose several ways to reduce morbidity and mortality from opioids.

BMJ 2011;343:d5142 doi: 10.1136/bmj.d5142

Long-Term Opioid Therapy Reconsidered

The NEW ENGLAND JOURNAL of MEDICINE

A Flood of Opioids, a Rising Tide of Deaths
Susan Okie, M.D.

Viewpoint
Patient Satisfaction, Prescription Drug Abuse, and Potential Unintended Consequences
Aleksandra Zgierska, MD, PhD; Michael Miller, MD; David Rabago, MD
The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

**Background:** Increases in prescriptions of opioid medications for chronic pain have been accompanied by increases in opioid overdoses, abuse, and other harms and uncertainty about long-term effectiveness.

**Purpose:** To evaluate evidence on the effectiveness and harms of long-term (>3 months) opioid therapy for chronic pain in adults.

**Data Sources:** MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL (January 2008 through August 2014); relevant studies from a prior review; reference lists; and ClinicalTrials.gov.

**Study Selection:** Randomized trials and observational studies that involved adults with chronic pain who were prescribed long-term opioid therapy and that evaluated opioid therapy versus placebo, no opioid, or nonopioid therapy; different opioid dosing strategies; or risk mitigation strategies.

**Data Extraction:** Dual extraction and quality assessment.

**Data Synthesis:** No study of opioid therapy versus no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction. Good- and fair-quality observational studies suggest that opioid therapy for chronic pain is associated with increased risk for overdose, opioid abuse, fractures, myocardial infarction, and markers of sexual dysfunction, although there are few studies for each of these outcomes; for some harms, higher doses are associated with increased risk. Evidence on the effectiveness and harms of different opioid dosing and risk mitigation strategies is limited.

**Limitations:** Non-English-language articles were excluded, meta-analysis could not be done, and publication bias could not be assessed. No placebo-controlled trials met inclusion criteria, evidence was lacking for many comparisons and outcomes, and observational studies were limited in their ability to address potential confounding.

**Conclusion:** Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

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For author affiliations, see end of text.

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“The science of opioids for chronic pain is clear: for the vast majority of patients, the known, serious, and too-often-fatal risks far outweigh the unproven and transient benefits.”
"OIC is a different type of constipation"
Controlling the epidemic: A Three-pronged Approach

• **Prevent** new cases of opioid addiction.

• **Treat** people who are already addicted.

• **Reduce supply** from pill mills and the black-market.
Comparison of Mortality Data from AIDS Case Reports and Death Certificates in Which HIV Disease Was Selected as the Underlying Cause of Death, United States, 1987–2006

*For comparison with data for 1999 and later years, data in the bottom (red) line for 1987–1998 were modified to account for ICD-10 rules instead of ICD-9 rules.
Buprenorphine Experience in France

• Introduced in the mid 90s

• 79% decline in OD deaths in 6 years

• Use of mono product (not formulated with naloxone) associated with diversion and injection use

Heroin treatment admissions with planned medication-assisted opioid therapy 2003-2013

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 01.23.15.
Clinical Pearls

1. Opioids are highly addictive. Except for palliative care, prescribe sparingly.

2. Physiological dependence occurs in all patients on daily opioids and is not a benign condition.

3. Opioids are not proven safe or effective for daily, long-term use.

4. Pain patients with difficulty coming off opioids may do better if switched to buprenorphine.

5. Opioid use disorder can be effectively treated in primary care with buprenorphine.
Summary

• The U.S. is in the midst of a severe epidemic of opioid addiction

• To bring the epidemic to an end:
  – We must prevent new cases of opioid addiction
  – We must ensure access to treatment for people already addicted