"A disaster in the making": it's time to take action against misuse of oxycodone

Dr Jeremy McMinn is a consultant psychiatrist and addiction specialist at Capital & Coast DHB. He is also the Co-Chair of the National Association of Opioid Treatment Providers and the New Zealand Branch Chair of the Australasian Chapter of Addiction Medicine. We invited Dr McMinn to answer a series of questions about the role of oxycodone, both as a legitimate option for pain control, and a medicine with a serious potential for misuse. The time for debating who to blame has passed. Oxycodone, and opioid prescribing in general, is already out of hand and we need to collectively take action before it is too late.

How would you describe the current situation in New Zealand in terms of misuse of oxycodone?

With due heed to hyperbole, we are looking at a disaster in the making. We have been complacent about the warnings from the rest of the western world, with harms arising from pharmaceutical opioids overtaking those from heroin. This has reached epic proportions in the United States, with oxycodone particularly over-represented. Pharmaceutical opioids in the United States now kill more people than firearms or road traffic accidents, and more than the combined death rates from heroin and cocaine overdoses. This is shocking and shameful – how can it be possible?

In New Zealand, we have had the good fortune to be last off the starting line, with oxycodone coming to us later. Even so, it is clear from [national dispensing] data that our prescribing of oxycodone has followed comparable trajectories to that seen in Australia and the United Kingdom. There is no good reason for this – oxycodone is more expensive than morphine and more addictive, and is no safer in renal [impairment] or other conditions. And it is not as if we are even prescribing it for the right reasons – the literature on chronic pain increasingly indicates that opioids are harmful long term, not beneficial. Chronic pain is not acute pain – the "benefits" of opioids in chronic pain may be limited to a brief reduction in subjective pain, before tolerance and hyperalgesia negate this, leaving the patient neuro-adapted to a higher dose.

> ***"New Zealand's problem prescribing pharmaceutical opioids, with the predictable onslaught of oxycodone, is a national scandal that should be stimulating profound professional soul-searching."***
>
> *— Dr Jeremy McMinn*

How does oxycodone compare to other prescription drugs of misuse, e.g. morphine?

The appalling aspect of this is that New Zealand has had three decades already of seeing pharmaceutical opioid abuse and dependence rather than heroin addiction – we, as prescribers, have significant responsibility for these harms.

In New Zealand, patients that end up on opioid substitution treatment [i.e. the methadone programme] mainly initiate and maintain their pre-treatment addiction with morphine and methadone. The morphine mainly comes from pain specialists, general practitioners and palliative care physicians, and the methadone comes from opioid substitution treatment (OST). In recent years, OST services have recognised this, and increasingly adopted greater treatment supervision, more restrictive dispensing, and more explicit adherence to evidence-based dose ceilings. Other prescribers need to catch up.

What advice can you give to general practitioners for identifying patients who are drug-seeking? i.e. no legitimate reason for requiring oxycodone

General practitioners need to take control, and use their knowledge of health conditions, prescribing risks and clinical concern appropriately. Patient choice is not the primary reason to prescribe a drug (although it may be a factor in which drug is chosen). But if the condition presented is not sensibly treated with the drug requested, do not prescribe it. Opioids are very likely not to provide a true benefit in pain conditions lasting over a month – just as benzodiazepines are not justified in cases of anxiety lasting more than two weeks.

Worry about a complaint to the Health and Disability Commissioner should not influence the decision – drug-seeking patients know that implying they will complain makes doctors fold. If the patient is likely to move on to a different, "softer touch" doctor, general practitioners can protect their colleagues by making an application for a Restriction Notice and making sure any documentation reflects the doubts about the legitimacy of the drug request.

General practitioners may know the background history and social/family environment better than any other doctor involved. It is likely that most people abusing oxycodone, benzodiazepines, etc, are using medications that were prescribed originally for someone else. *Primum non nocere* (first do no harm) extends to society, not just the patient in the room.

Any patient that insists on an abusable drug by name, without sufficient diagnostic justification, without supporting documentation, with stories of lost prescriptions or stolen medications should not receive a prescription. Medical Council guidance allows for a three day prescription to ease a threatening patient out of an office, but then preparations for the next consultation must be made. This may include talking with colleagues, arranging a chaperone, and applying for a Restriction Notice. Overt threats of violence should be reported to the police. Threats of suicide can be discussed with local emergency psychiatric services.

Chronic pain, current or past addiction to any substance, current or past mental illness, childhood sexual abuse and family history of addiction are all important risk factors for addiction.

"Many GPs already know that we are fighting to retract an opioid tsunami" *— Dr Jeremy McMinn*

What advice can you give to general practitioners for identifying patients who may be addicted to oxycodone? i.e. a legitimate need for pain relief which has turned into a dependency

Oxycodone is highly addictive – between 25–33% of regular users will experience features of dependence. With this risk, all patients with courses lasting longer than one month should be examined for signs of addiction. Requests for increasing doses and early (or replacement) prescriptions are obvious warning signs. It is essential to consider appropriate urine drug testing and examining for injections sites. The perceived stigma of these can be reduced by making this a standard condition of Controlled Drug prescribing.

General practitioners will be alert to treatment that does not achieve a net improvement. Emerging addiction is a powerful, but sometimes opaque, reason that treatment is not as effective as originally predicted.

Are there any safeguard practices for prescribing oxycodone which can help to avoid inadvertently contributing to drug misuse or addiction?

Prescriptions of any abusable medications that may last longer than a month should be subject to the 10 Universal Precautions*[to be discussed in the next edition of Best Practice Journal]. The gist of these precautions is an explicit contract covering treatment duration, dose parameters, outcome measures, side effect safeguards and defined review dates.

Patients (and doctors) should be aware of the relative lack of good evidence that oxycodone is genuinely effective after one month, contrasted with the wealth of evidence of harm. Oxycodone dose ceilings in primary care should be no more than 60 mg per day (broadly the equivalent of morphine 100 mg per day). After this, specialist review or re-thinking is required. Outcome measures should be measurable change in function, not subjective pain score – the pain always eases with a dose increase, but temporarily, just as it always flares with a dose decrease, temporarily. Safeguards for oxycodone prescribing include universal use of urine screens, examination for injection sites and regular discussion with the dispensing pharmacist.

A key advantage of some degree of treatment contract is that it allows the prescriber to back out of prescribing that is getting out of hand. The subsequent re-think can include seeking specialist advice for pain and addiction.

* Gourlay D, Heit H, Almahrezi A. Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. Pain Med 2005;6(2):107-12.

What issues are you seeing among patients as a result of oxycodone addiction?

I am seeing patients who tell me how easy it is to get oxycodone – and it is cheap. My impression is that most people find it straightforward to convince a doctor to prescribe for them, although clearly some doctors (and some regions) are easier than others. For the ones that do not go directly to a doctor, they can buy from other individuals or from doctor-shopping rings. These rings can include older women, who may not trigger the same suspicions. I have been surprised how much oxycodone seems to travel by New Zealand Post between regions. It is just a matter of time before the street oxycodone "market share" becomes evident.

People presenting voluntarily for treatment are still mainly presenting with morphine addiction, with methadone a close second. Virtually everyone has added some oxycodone into the mix of what keeps them going, but addictions driven only by street oxycodone are infrequent so far. However, I am not reassured by this – presentations for OST are usually very late: most people struggle with their own attempts to manage before they resign themselves to the restrictive rigours of OST.

I am also seeing a new cohort of patients, who are coming semi-voluntarily. These are the people who have received a long term prescription for pain which has tipped over into problematic use. Most have to see me because the original prescriber has become aware of problems and has wisely, if often belatedly, made further opioid prescription contingent on addiction assessment. Frequently, the problems arise from the short acting nature of the "pain", opioid-on/off effects, tolerance, aberrant use, etc. A transition to a longer acting opioid, i.e. methadone or buprenorphine (in the form of Suboxone) is usually required. Frequently these patients do not wish to characterise themselves as "addicts", but do nonetheless have features of opioid dependence. There may be some good prognostic factors present in this cohort, but a prolonged period of opioid substitution and related counselling still seem to be required.

It surprises me how often general practitioners seem to feel committed to continue a course of opioids started in hospital or recommended by a pain specialist – even though the use of opioids is clearly starting to go wrong. General practitioners usually have the best overall knowledge of the patient – in my opinion, this may trump the often more narrow and frequently time-limited recommendations of specialist care.

"General practitioners should not hesitate to bring their own knowledge to bear, even if this can be challenging initially to align with the specialist recommendations."

— Dr Jeremy McMinn

What advice can you give to a general practitioner managing a patient with an oxycodone addiction who wishes to withdraw?

The best advice is unhelpfully retrospective – do not get there in the first place. In opioid dependence, prevention is absolutely better than cure, as the opioid withdrawal failure rate without a period of substitution is nearly 100% - even if we had the best addiction resources, which we patently do not. Opioid substitution is the mainstay of managing opioid dependence, but funding exists for only around 5400 patients (with an expected need of at least 10 000 New Zealanders).

What is the recommended withdrawal regimen?

Withdrawal requires realism, compassion and determination on both the patient and doctor's part. Most people will require a stabilisation phase of two to four weeks to clarify the daily amount, which may include swapping to a longer acting opioid of the same equivalence. Given the Misuse of Drugs Act, general practitioners will have limited scope to use methadone or buprenorphine, but consolidating an Oxynorm and Oxycontin regimen into a set twice daily regimen of oxycodone as sensible pain management will be required.

After this stabilisation, a steady reduction should be agreed within a reasonable timescale. Factors such as prior treatment duration, size of total daily dose and important upcoming events, come into play when considering the rate of reduction. However, a reduction contained within one to three months should be agreed, with the reduction increments calculated back from this date setting.

Larger dose drops may be easier at the start of the reduction, with smaller drops later reflecting a larger proportion of the total daily dose. Neuro-adaptation plateaux, where the reduction is held for one to two weeks, may be sensible periodically, especially if the patient is struggling. Putting the dose back up is rarely sensible – a hold in reduction to allow the easing that comes with neuro-adaptation is more realistic than an oscillating rising and dropping dose.

What supportive treatments may be required?

The main support is one of compassion whilst maintaining a focus on the prize. Delaying a reduction restart, or providing unwise courses of other abusable drugs (benzodiazepines, zopiclone) will promote a sickness role and treatment failure. Patients need reminding that the discomfort is temporary and will abate. Levels of underlying distress need monitoring, and involving the educated support of family members may be useful. Excessive use of other substances from other sources (e.g. alcohol, cannabis, Nurofen Plus [containing codeine], a family member's opioids) should be addressed.

Loperamide for diarrhoea and non-opioid analgesics for withdrawal aching may be useful. Off-label use of clonidine may be considered for the hot/cold feelings and aching, but will require blood pressure monitoring: courses should be limited to two weeks. Quinine is no longer recommended.

What issues are there in terms of prescribing legitimate pain relief in the future?

Opioids are only part of the treatment of pain, and probably a much smaller part of chronic pain treatment than previously thought. Earlier problems with opioids mean that all potentially abusable future prescriptions may present risks, such that they should be avoided altogether or only provided within closely monitored parameters.

Patients who have experienced problems with opioids need more care, although commonly feel they receive less. A pain condition for which opioids were problematic could be framed as a "treatment resistant" condition and it may be legitimate to seek other less available treatments. In particular, access to non-pharmacological pain strategies may need to be emphasised.

Patients and prescribers should be explicitly discouraged from equating the removal of opioids with the removal of all pain management.

What other support systems are available for patients who have a prescription drug addiction?

Prescription drug addiction is a double act – both the patient and the doctor have, to some extent, entered into drug dyscontrol, drug salience (exclusive importance) and dysfunction. These need to be addressed, and prescription monitoring, dispensing restrictions, and use of the 10 Universal Precautions are good ways to achieve this. In particular, solid external controls on abusable medication availability are the keystones to preventing and managing prescription drug addiction.

For those who have ongoing opioid problems, the mainstay of opioid management will involve the local specialist Opioid Treatment Service, often with some degree of shared care with the general practitioner. Input from specialist Chronic Pain Services may also be required: in many regions there is regular liaison between Addiction and Pain services already in place.

Addiction support can also be available through non-government organisations, including the Alcohol & Drug Helpline, Salvation Army, CareNZ, 12-Step Programmes (e.g. Narcotics Anonymous, Alcohol Anonymous & Al-Anon) and Tranx.

The Alcohol & Drug Helpline (0800 787 797) and local DHB Addiction Services will usually be able to advise on local availability of addiction supports.

We would like to thank Dr McMinn for his willingness to speak out on these issues. We hope that this interview has challenged your thinking in terms of your own prescribing of oxycodone. We plan to publish a follow-up series of articles, expanding on some of the issues Dr McMinn has touched on, including examining the role of oxycodone in acute, short-term and long-term pain management and strategies for safe and rational prescribing of strong opioids.

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