Dr Alistair Dunn

General Practitioner

Northland District Health Board

Whangarei

Addiction Issues Around Oxycodone - Concurrent Workshop Repeated

Sunday, 18 August 2013	Start 8:30am	Duration: 55mins	Lounge 1
	Start 9:35am	Duration: 55mins	Lounge 1

NORTHLAND DISTRICT HEALTH BOARD

Te Poari Hauora Ā Rohe O Te Tai Tokerau

Oxycodone

- Dr Alistair Dunn
- Addiction Medicine Specialist
- General Practitioner
- Whangarei , Northland .

Oxycodone

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- CRUSADER !

Oxycodone

- Pharmacology :
- Powerful synthetic opioid agonist

Oxycodone vs Morphine

- Approx half mg dose required
- Same side effect profile
- Safer in renal impairment

Oxycodone vs Morphine Cont'd

- Greater Abuse Potential :

- More euphoria
- More easily injected
- Easily smoked

Oxycodone “what's the problem ?”

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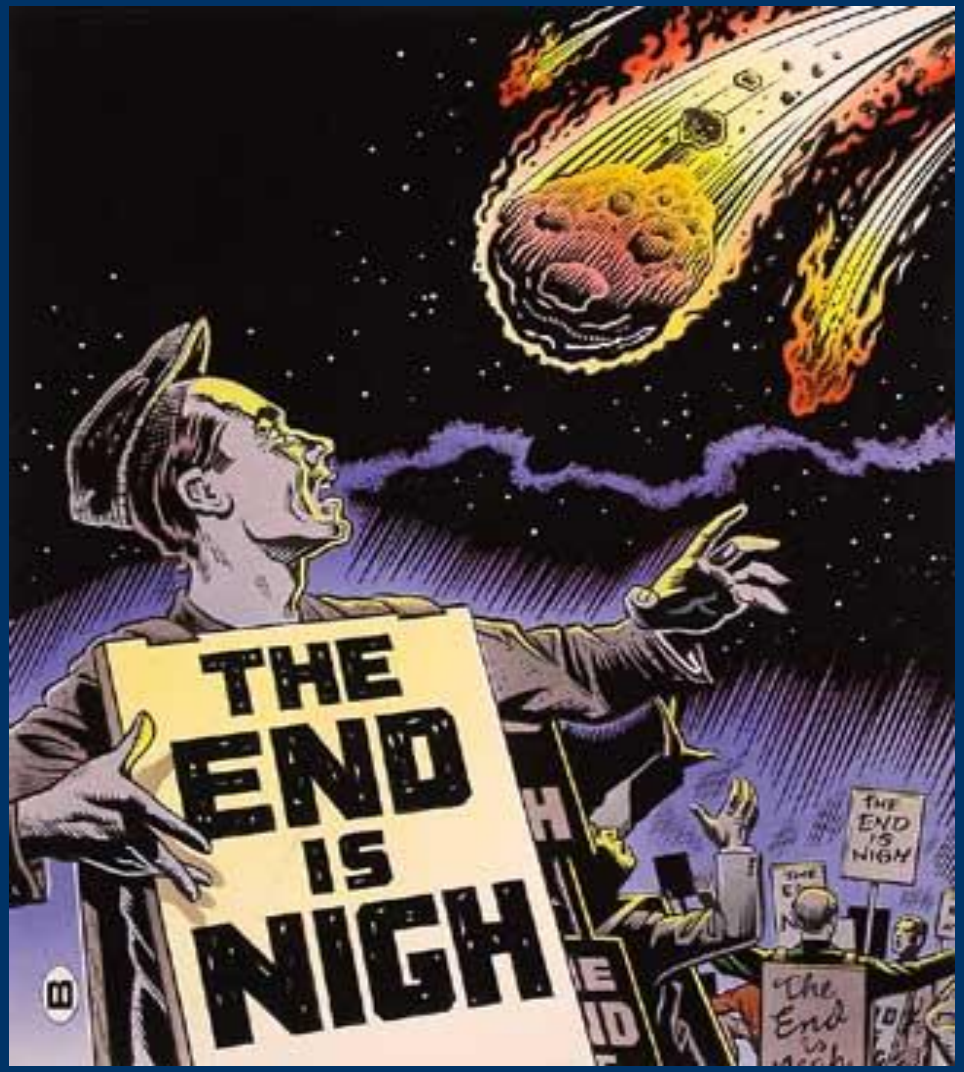
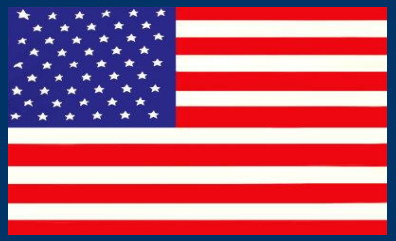
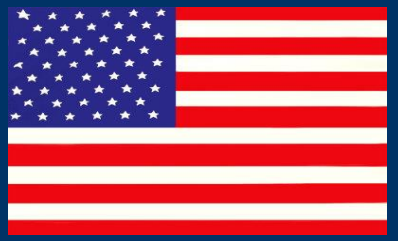


USA Experience



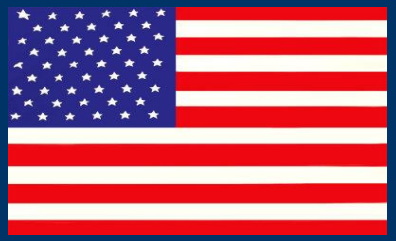
- Marked rise in Oxycodone prescribed

USA Experience



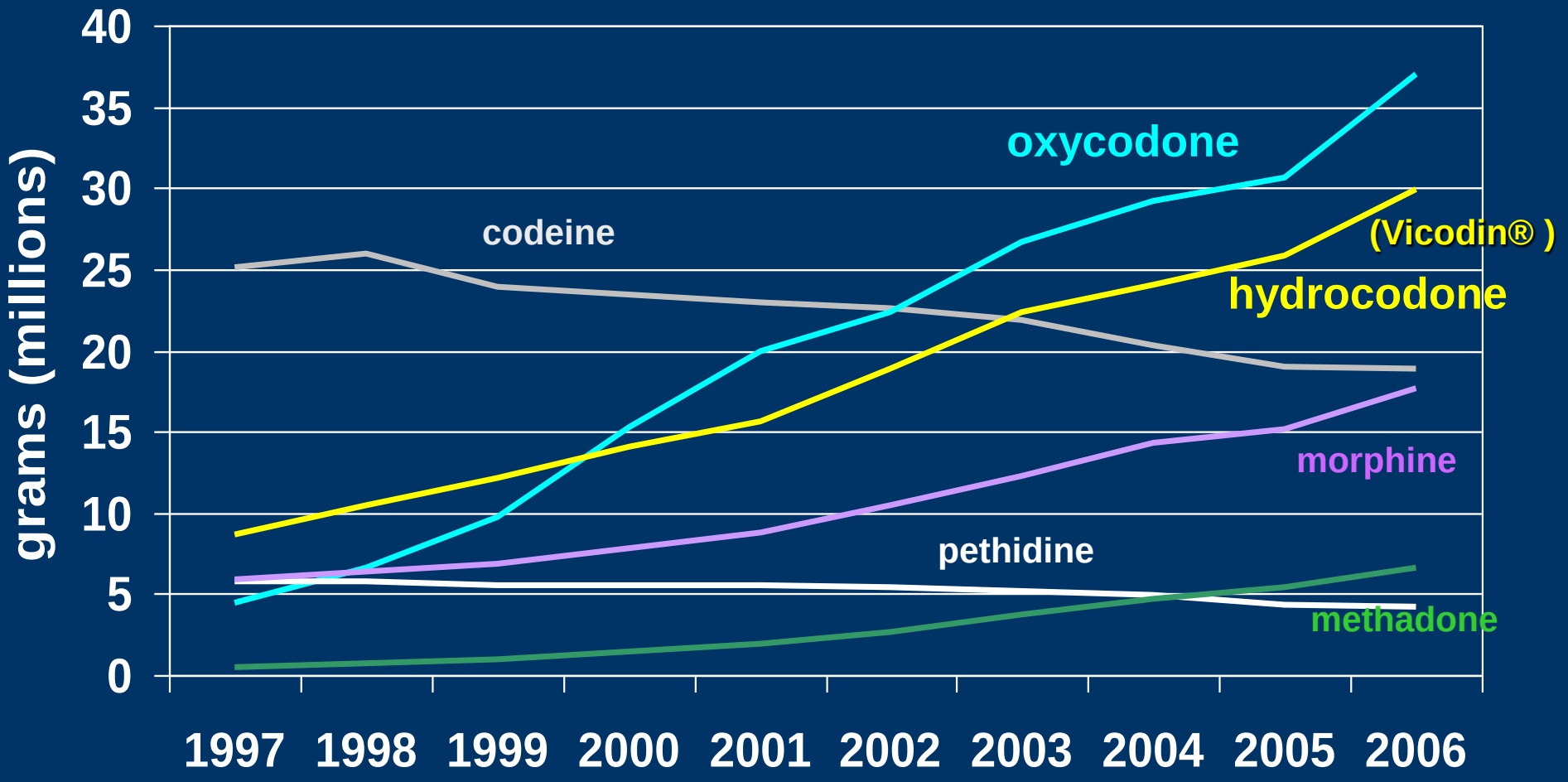
- Marked rise in Oxycodone prescribed
- Subsequent increase in ED presentations with overdose related to prescribed opioid analgesics

USA Experience



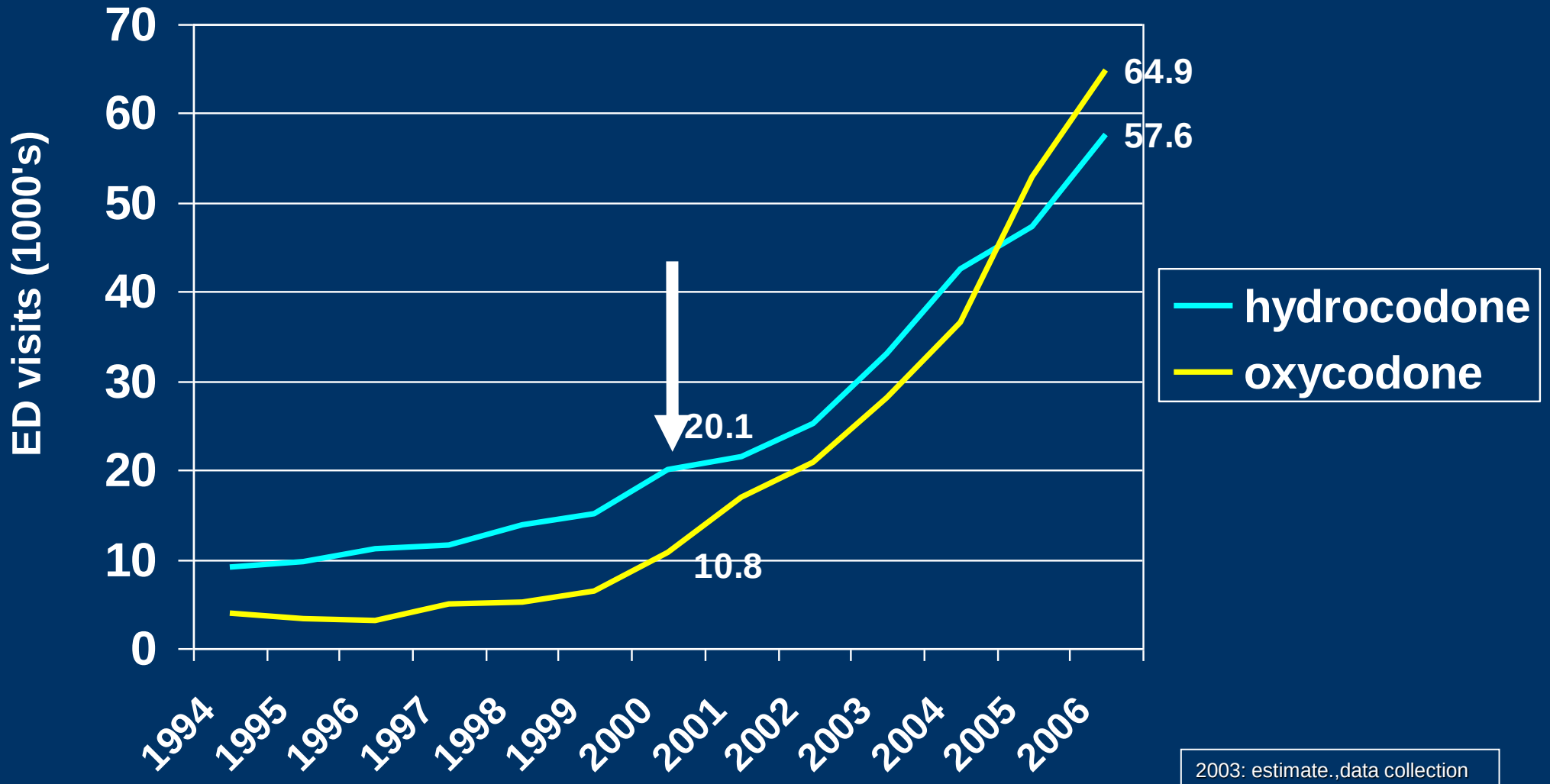
- Marked rise in Oxycodone prescribed
- Subsequent increase in ED presentations & overdose related to prescribed opioid analgesics
- Number of deaths from prescribed opiates now exceeds deaths due to cocaine & heroin

Opioid supply: USA 1997-2006



Source: ARCOS Automated Reports and Consolidated Orders. DEA, US DoJ.

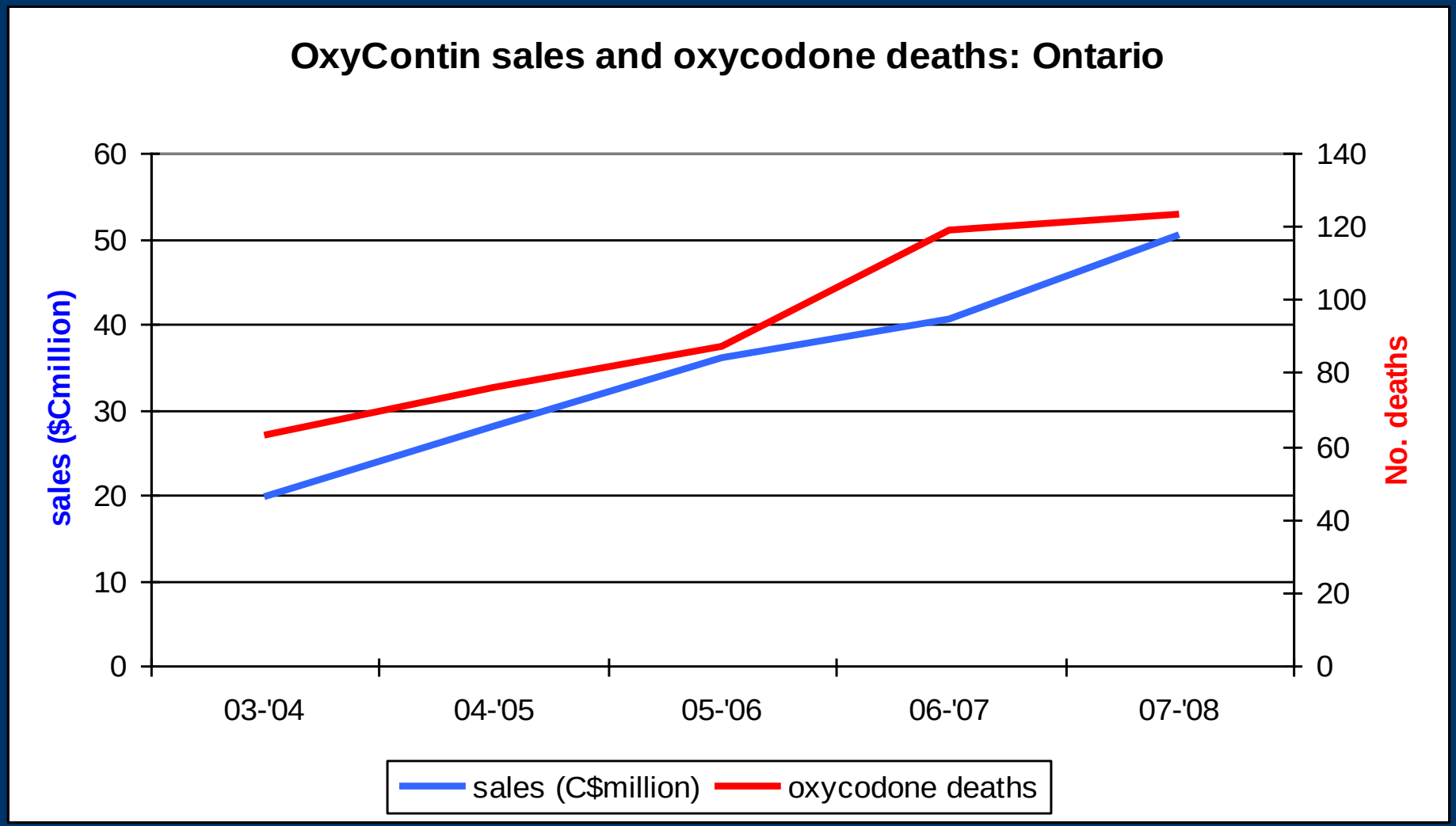
Emergency Department visits: USA 1994-2006



2003: estimate.,data collection method changed

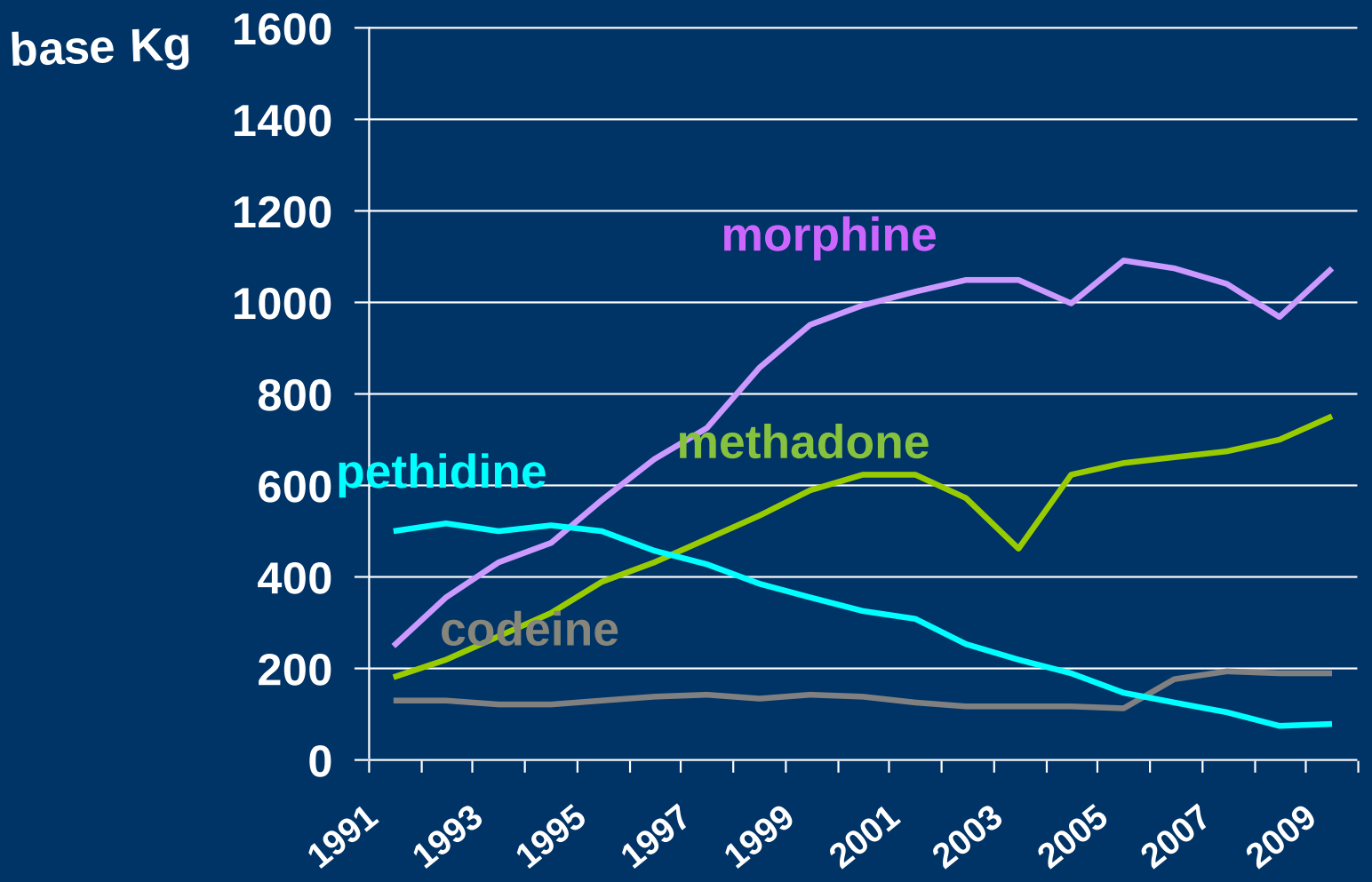
DAWN – **non-medical use**

Canada

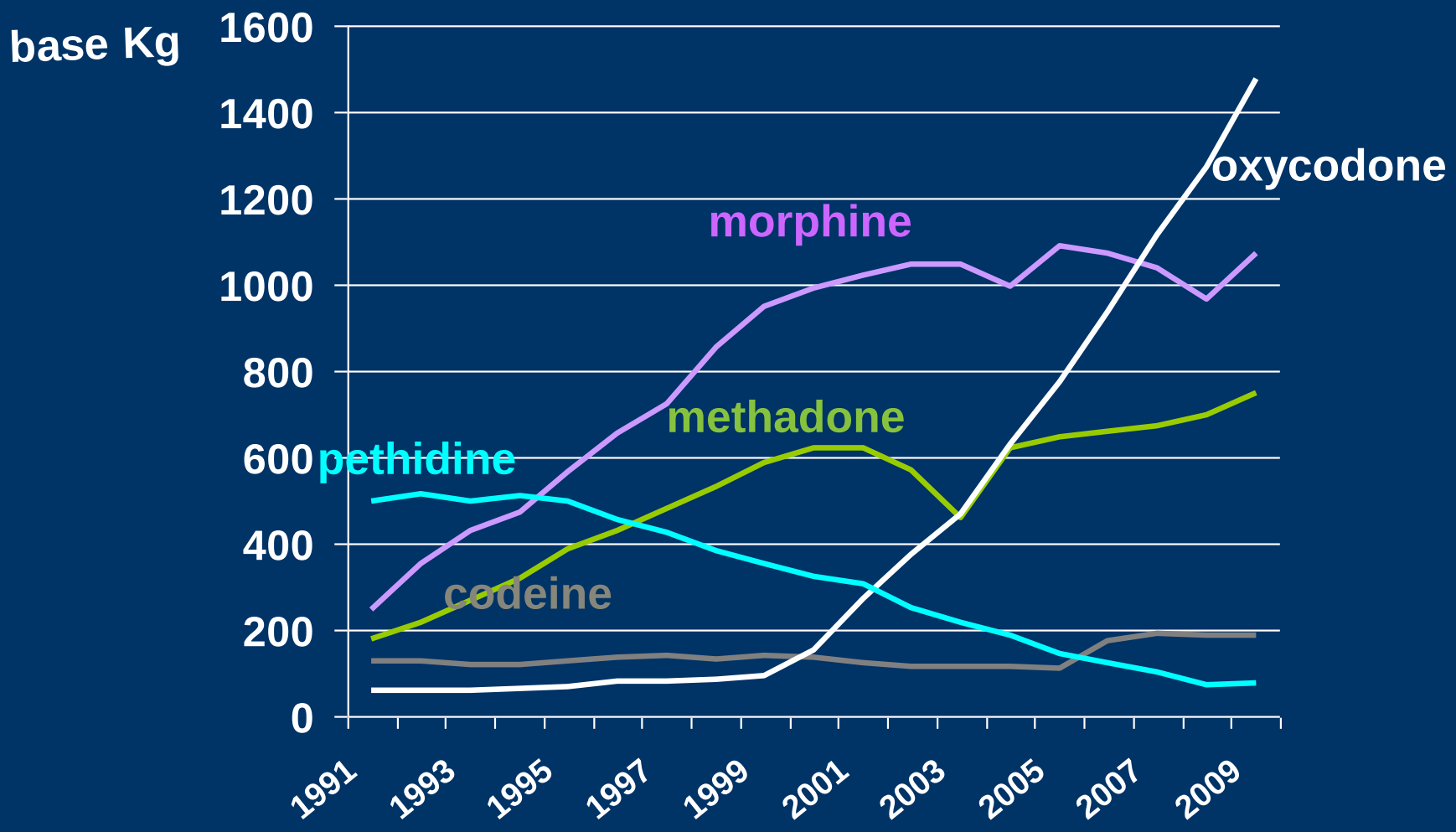

OxyContin sales and oxycodone deaths: Ontario
sales ($Cmillion)
No. deaths
60
50
40
30
20
10
0
140
120
100
80
60
40
20
0
03-'04
04-'05
05-'06
06-'07
07-'08
sales (C$million)
oxycodone deaths

Australia

Opioid base supply: Australia, 1991-2009



Opioid base supply: Australia, 1991-2009

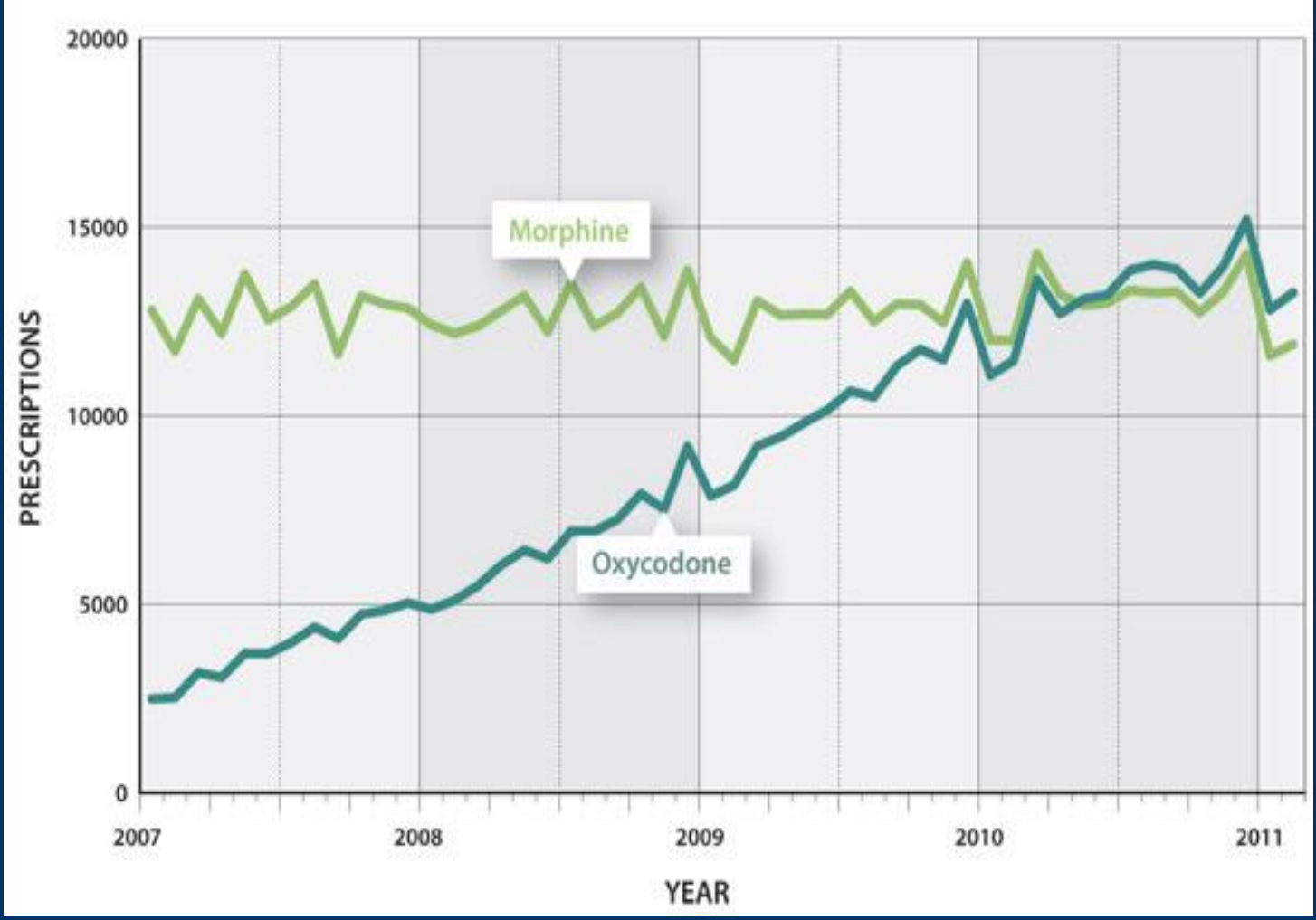


New Zealand ?

New Zealand 2006-2009

- Number of oxycodone prescriptions in NZ 2006 – 2009 (Pharmaceutical Wharehouse data)

New Zealand 2007- 2010



Don't Ignore the Early Warning !

The Men From the Ministry...

- MINISTRY OF HEALTH
- Dr Adrian Gray , Medicines Control

- *“Here in NZ Oxycodone is a relative newcomer , but in 2008 oxycodone prescribing was already on a par with DHC and diazepam . This dramatic increase is difficult to explain on any grounds other than successful marketing by the drug companies . It has no clinical advantage over other agents already available in NZ.”*

The Men From the Ministry...

- MINISTRY OF HEALTH
- Dr Adrian Gray , Medicines Control

- *Oxycodone should be considered a second line potent analgesic , for use only when morphine is not tolerated . The abuse potential is high : oxycodone is a potent analgesic with high dependence potential and is easily extracted from the long-acting formulation for intravenous use”*

BPAC – 2009

- Oxycodone use has been steadily increasing over the last three to four years
- .

BPAC – 2009

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- This trend is similar to patterns observed in other countries such as the UK and Australia and corresponds with a ***prominent marketing campaign*** suggesting that oxycodone should be the preferred opioid analgesic for the treatment of moderate to severe persistent pain.

BPAC – 2009

- Oxycodone use has been steadily increasing over the last three to four years
- This trend is similar to patterns observed in other countries such as the UK and Australia and corresponds with a prominent marketing campaign suggesting that oxycodone should be the preferred opioid analgesic for the treatment of moderate to severe persistent pain.
- Oxycodone is more expensive than morphine, has a similar side effect profile and there is no clinical evidence to support its use first-line.

BPAC – 2009

- Oxycodone is a strong opioid and is a second line option (after morphine) for use at step three on the WHO analgesic ladder
- Morphine remains the *first-line* strong opioid and oxycodone should be reserved for specific situations
- Oxycodone can be considered if morphine is poorly tolerated

Local experience - Whangarei

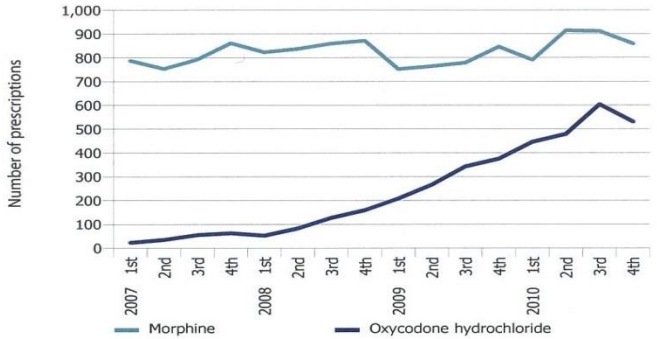
Local experience - Whangarei

- patients discharged from hospital Rx Oxycodone
- Patients arriving from Australia on high doses Oxycodone
- Hosp Rheum : “try simple analgesics such as tramadol / oxynorm / oxycontin”

Local experience - Whangarei

Personalised feedback for Manaia Health PHO

Your PHOs pattern of prescribing for oxycodone and morphine

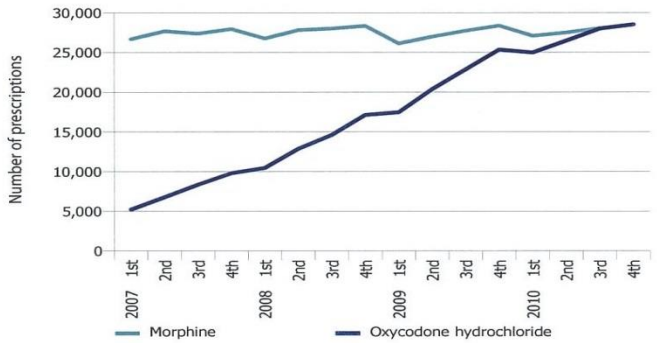


Over the last year

Your PHO has written **3,556** prescriptions for morphine

Your PHO has written **2,172** prescriptions for oxycodone

National pattern of prescribing for oxycodone and morphine



Note: As the graph shows, morphine use is unchanged but oxycodone use has increased dramatically.

Question: Is this because oxycodone is being used inappropriately in the place of a weaker opioid?

Notes:

Time period: 1 March 2010 to 28 February 2011.

Data is assigned to your PHO based on the recorded NZMC number for prescriptions. Data has been excluded where the NZMC number was not recorded.

Data excludes injectable forms of oxycodone hydrochloride and morphine.

Why is this happening ?

Why is this happening ?

- 1) “Honeymoon” phase of new medication
- Newer = better
- Long term effects less clear (Selegiline , HRT , Calcium)
- Keeping “up to date”

Why is this happening ?

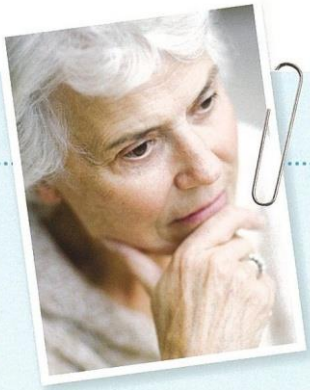
- 1) Honeymoon phase
- *2) Effective marketing*
- - perceived advantages
- - appeals to doctor's desire to alleviate suffering
- Target group ;
- 50-70 yrs Osteoarthritis
- (ref case examples Australia)

OxyContin® tablets

The Appropriate Patient

Osteoarthritis (OA) - associated pain contributes substantially to loss of function and disability.[1,3]

- OA is present in 80% of the population by age 75 years.[3]
- Pain associated with OA contributes substantially to disability and reduced function and has a negative impact on functional activities:[3]
  motor function, sleep, mood



CASE STUDY:

Name: Joan

DOB: 16/04/40

Diagnosis:
Confirmed significant degeneration of the right knee. Diagnosed 15/6/09.

Investigations:
Radiographic investigations confirm OA of right knee.

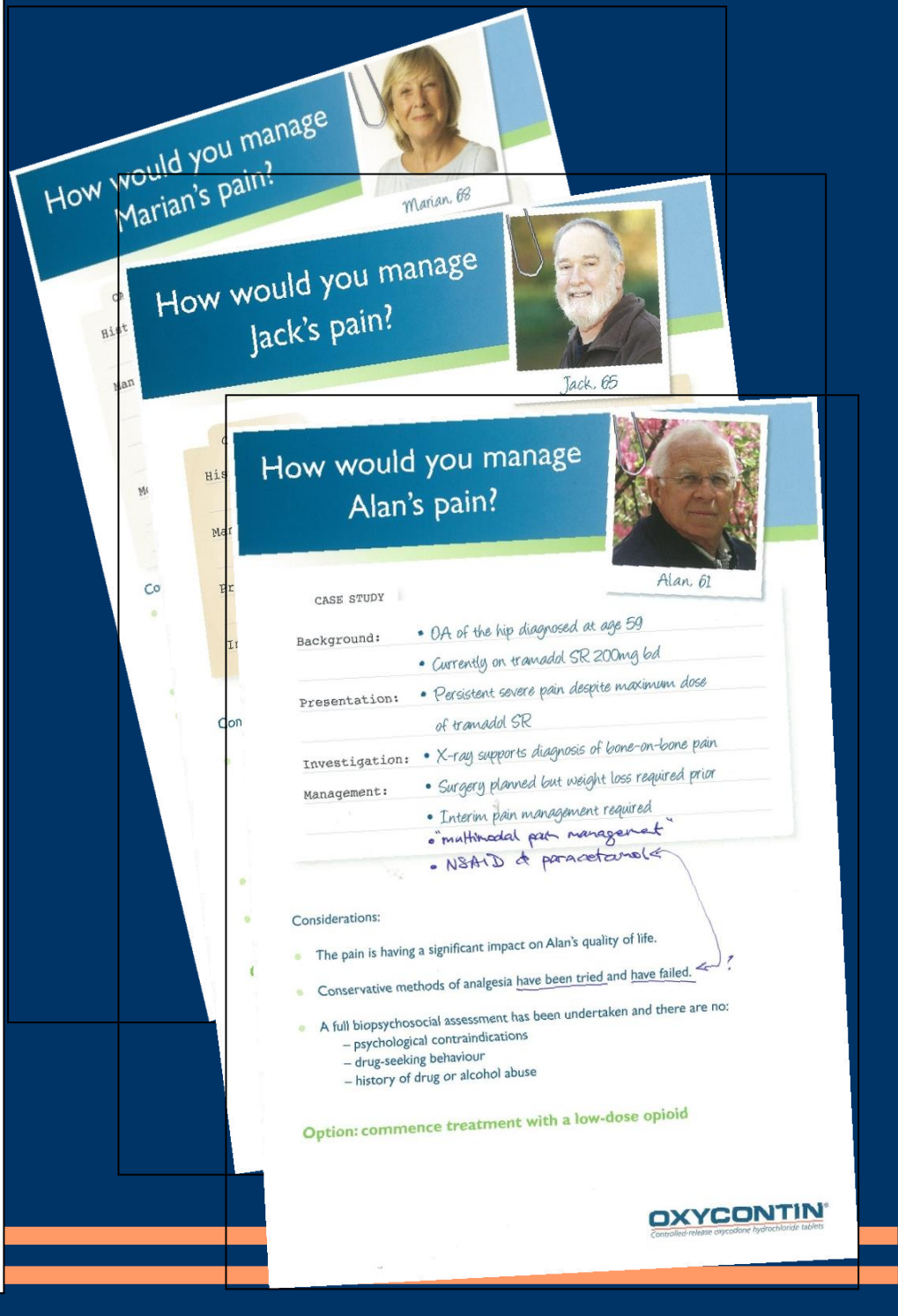
Management:
Joan is on the public waiting list for surgery.

Considerations:

- The pain is having a significant impact on Joan's quality of life
- Conservative methods of analgesia have been tried and have failed
- A full biopsychosocial assessment undertaken and there are no:
  - psychological contraindications
  - drug-seeking behaviours
  - personal and family history of drug or alcohol abuse
- Radiographic investigations confirm OA of right knee
- Renal function tests indicate renal impairment

5mg 10mg 20mg 40mg 80mg

OXYCONTIN®
Controlled-release oxycodone hydrochloride tablets



Addiction
EDITORIAL
doi:10.1111/j.1360-0443.2011.03395.x

Oxycodone poisoning: not just the 'usual suspects'

Oxycodone is a major public health problem for many countries. The focus to date, however, has been on illicit drug users. Many (perhaps the majority) who are dependent on oxycodone, however, have never used illicit drugs. These people have been forgotten in public health interventions, and require urgent attention.

Oxycodone is an opioid analgesic that is typically prescribed for moderate to severe chronic pain. Recent years have seen considerable concern about the abuse of this pharmaceutical, with substantial increases in both sales and deaths attributed to the drug [1–6]. Indeed, in the United States toxicity deaths due to oxycodone have grown to exceed those due to heroin. Despite the scale of the problem, surprisingly little research has been conducted on the characteristics, toxicology and circumstances of oxycodone-related death, or on how to counter the problem.

The most important questions to ask about such trends are: who is it that is dying, are these deaths accidental or deliberate and what is their toxicology? Cases appear to fall into two broad groups, injecting drug users (IDU) aged typically in their 30s and older chronic pain patients aged, on average, in their 50s [3,7]. While the media focus has been on IDU, whom we may characterize as the 'usual suspects' for opioid-related death, the majority of cases appear to belong to the latter group. Accidental deaths predominate, but suicide is prominent, particularly among chronic pain patients [3]. Finally, the toxicology of deaths is typical of opioid fatalities worldwide, with almost all being due to multiple drug toxicity [3,7]. Consistent with the toxicological patterns seen among other opioid toxicity cases [8], the major co-occurring substances are central nervous system depressants (CNS), specifically benzodiazepines, alcohol and opioids other than oxycodone.

What is to be done? Needless to say, there has been a great deal of discussion on responses to these trends [9]. The toxicology of cases provides us with one obvious approach. Over the course of the past decade or so, a great deal of effort has gone into educating heroin users about the dangers of polydrug use, particularly alcohol and the benzodiazepines, which substantially increase the risk of death. Indeed, opioid concentrations may well be sub-toxic in themselves, but result in overdose in the presence of other CNS depressants [10]. Illicit drug users are, however, only a proportion of cases. There is no reason to believe that older pain patients, most of whom have never used illicit opioids, have any such knowledge. In my own work, it was clear to me that many older pain cases used alcohol and benzodiazepines to aid in pain relief, or from sheer boredom and frustration at being incapacitated and/or unable to work. This group should receive the same information that heroin users already receive: do not use alcohol or benzodiazepines with opioids. They dramatically increase the risk of overdose and death. We have made headway in improving the knowledge of illicit drug users on such matters, but we must range far beyond this group. Such information is usually provided to illicit drug users through treatment programmes, outreach or needle exchange programmes. In the case of the older pain patient, the treating physician is the most obvious source for education. This may well require more direct education of doctors of the substantial dangers of poly-CNS use among their patients [5]. Doctors may also consider whether they should rather prescribe safer analgesics, such as buprenorphine, for the treatment of moderate to severe chronic pain, as has been occurring in maintenance treatments for opioid dependence [11].

Another possible response that arises from our experiences with illicit drug deaths is the provision of naloxone hydrochloride [9]. Naloxone is the opioid antagonist used to reverse opioid overdoses. It is easily administered and may be given intravenously or intramuscularly, with nasal sprays also in development [10]. The drug has no effects other than to reverse opioid toxicity. While this has been trialled successfully with heroin users, giving this life-saving drug to the older pain patients makes a good deal of sense. It may be stored at home and used by spouses, etc. if the patient does overdose. Again, this is a case of extending a proven intervention beyond the usual suspects to a far broader population.

The prominent role of suicide, particularly among older patients suffering great pain, suggests other approaches to those associated with accidental death discussed above. The risk of suicide for the chronic pain patient is serious. Two points arise here. First, doctors need to be aware of the risks of deliberate overdose for the chronic pain patient. This may well influence what drugs they choose to prescribe (e.g. buprenorphine). Secondly, in view of the risk, concomitant psychotherapy and/or the provision of serotonin selective reuptake inhibitors (SSRIs), which do *not* increase the risk of overdose, but *do* reduce psychological distress, may be warranted.

Finally, it appears to me to be very odd that drugs such as oxycodone are advertised widely in the United States, where the increase in sales and deaths has been most dramatic. This is a far broader issue than can be dealt with here. Suffice to say that increases in the sale of the

Renal Impairment ?

Renal Impairment ?

- Dr Jenny Walker , renal physician
- Accumulation toxic morphine metabolites
- GFR < 30
- Use methadone

Osteoarthritis ?

Osteoarthritis ?

- Dr Terry Macedo , Rheumatologist

Osteoarthritis ?

- Dr Terry Macedo , Rheumatologist

- Dear Alistair
- I agree that it is not desirable to use the opioids for chronic management of osteoarthritis or chronic non-malignant musculoskeletal pain. It is fairly likely that tolerance will develop.It is worrying to hear of ED admissions with overdose, both intentional but also unintentional. I much prefer to keep to simple analgesia, NSAIDs short term tramadol, and low dose amitriptyline for chronic pain.
- Regards
- Terry

Chronic non malignant pain ?

Chronic non malignant pain ?

- RCT Oxycodone & Gabapentin diabetic neuropathy

Chronic non malignant pain ?

- RCT Oxycodone & Gabapentin diabetic neuropathy

- 12 WEEKS !!

Chronic non malignant pain ?

- “There are ***no*** longitudinal RCTs on the long term effectiveness & consequences of opioid use in chronic non malignant pain”

- (Prescription Opioid Policy , Improving management of chronic non malignant pain and prevention of problems associated with prescription opioid use . RACP / RACGP / RANZP . 2009)

Chronic non malignant pain ?

- Dr Bob Large , Pain Specialist , TARPS

Chronic non malignant pain ?

- Dr Bob Large , Pain Specialist , TARPS
- *"I am convinced that it is best to avoid opioids as a treatment option for chronic non-cancer pain"*

Why is this happening ?

- 1)Honeymoon phase
- 2)Effective marketing
- 3)Lack of resources / alternatives
- - multidisciplinary pain service
- - access to psychologists , physio, O/T

Why is this happening ?

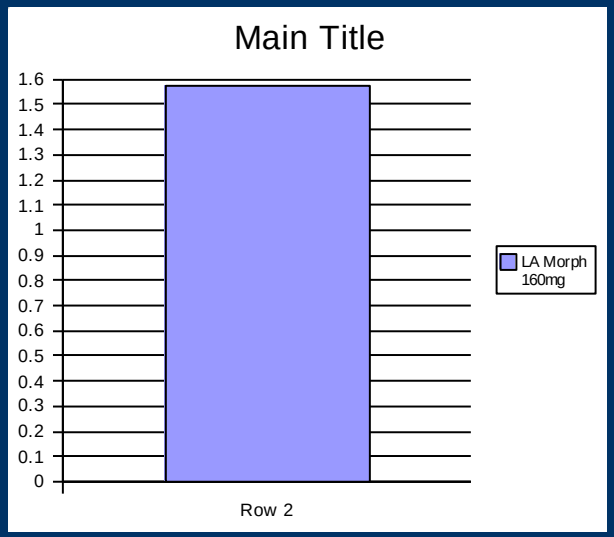
- 1)Honeymoon phase
- 2)Effective marketing
- 3)Lack of resources / alternatives
- 4)More appealing than “morphine”

- “it's morphine” vs “it's oxycodone”

And another thing ...

And another thing ...

LA Morphine 160 mg = $1.57



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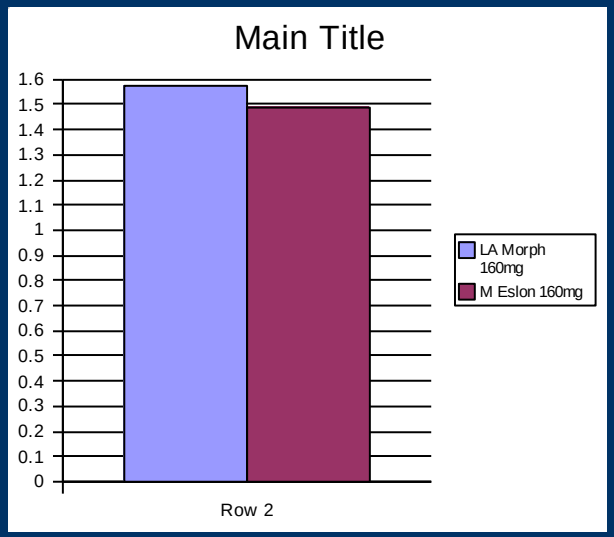
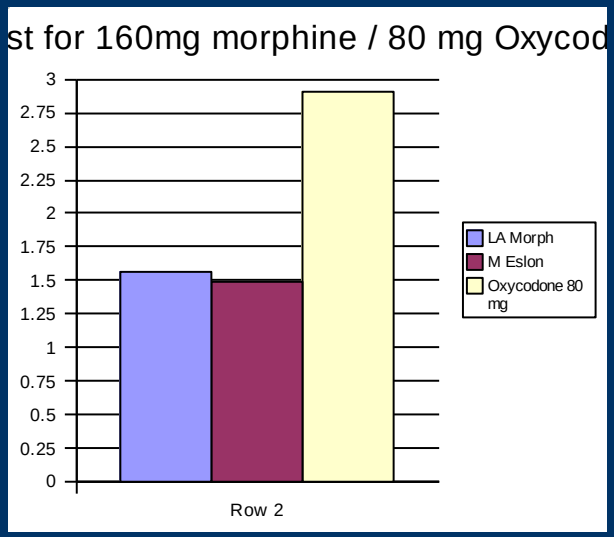


Oxycontin 80 mg = $2.49



Annual Expenditure

- Total expenditure on Oxycodone increased between 2009 to 2010 by more than
- 1 MILLION DOLLARS

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- Morphine 2010 $ 3,235,862

Annual Expenditure

- Total expenditure on Oxycodone increased between 2009 to 2010 by more than
- 1 MILLION DOLLARS
- Morphine 2010 $ 3,235,862
- Oxycodone 2010 $ 5,167,500

What to do ?

- Stop and think

Have I Exhausted Alternatives ?

- Non pharmacological measures
- Activity
- Referrals pain clinic / specialist
- Counselling / Education

Counselling / Education

- acceptance of pain , adjust & adapt thru self-management
-
- “Incurable” - like diabetes
- Change goal from being pain-free to “taking the edge off it” and promoting function

Counselling / Education

- Patient must first end their resentment and rejection of their damaged / new body
- Stress, anxiety, depression , guilt , frustration

Counselling / Education

- Illness Beliefs
- - I can't stand it / can't cope
- - No one believes me
- - I must be a bad person / punished

Counselling / Education

- Cognitive Errors
- I'm useless
- Nothing helps / no-one cares
- Passive recipient of relief ('bystanders' in own treatment) vs active participant in pain management

Non-Opiate Medication

- Paracetamol , NSAID , Tramadol , Codeine Amitriptyline , Gabapentin

Red Flags

- - past hx A&D
- - fam hx A&D
- - Hep C
- “aberrant” behaviour

If you must ...

“Universal Precautions”

- Not all risks are apparent
- (not the usual suspects)
- Diversion of medication to users
- (family members ,resale , theft)

Seek Advice

- Second opinion
- - multidisciplinary pain service
- - musculoskeletal specialist
- - addiction specialist
- - peers

Full Discussion

- Check patient expectations
- (no cure for chronic pain , goal is management and restoration of QOL / functional goals)

Clarify Plan

- Formalise contract
- - dose
- - dispensing
- - time-frame
- - exit criteria
- - urine drug screen tests

Consider other opiates

- Transdermal Buprenorphine (not subsidised)

Prescribe Morphine

- Rx Morphine

- Unless GFR < 30
- Unless not tolerated

If you do prescribe Oxycodone

- Don't advise the patient
  “it's like morphine”

If you do prescribe Oxycodone

Say

-

If you do prescribe Oxycodone

Say

- “it's like heroin”

Coming off Oxycodone …

- Convert short acting to long acting
- Set times rather than PRN
- Taper gradually

- Rx TCA or Gabapentin

Coming off Oxycodone …

- Assess for red flags / co-morbidities

Coming off Oxycodone …

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- Educate re opiates in CNMP – they suck !

Coming off Oxycodone …

- Assess for red flags / co-morbidities
- Educate re opiates in CNMP – they suck !
- Contract / Consent (dose , dipsensing etc)

Coming off Oxycodone …

- Assess for red flags / co-morbidities
- Educate re opiates in CNMP – they suck !
- Contract / Consent (dose , dipsensing etc)
- ref Pain Team

Coming off Oxycodone …

- Assess for red flags / co-morbidities
- Educate re opiates in CNMP – they suck !
- Contract / Consent (dose , dipsensing etc)
- ref Pain specialist
- Monitor :
  watch for aberrant behaviour
  Consider dependency criteria and ref to A&D service ? OST