Opioids

a presentation for the Northlake Dental Association

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Objectives

- Marvel at the opioid epidemic in this county.
- Recognize that we were part of the problem that created this mess.
- Differentiate between acute pain and chronic pain; understand that opiates are not first-line for chronic pain.
- Discuss strategies for acute pain treatment in the dental setting.

Nomenclature

- For the purposes of this talk:
- Narcotic is generally considered “out of favor” when discussing opioids.
  - Narcotic in police settings used to encompass non-opioid drugs as well, and is not exact.
- Opioids include everything from poppy plants to morphine to synthetic fentanyl and heroin to the endogenous opioids we all contain (endorphins).

Nomenclature

- Acute Pain
  - Around the time of tissue injury.
  - In the dental setting, most tissue healing should have occurred by 3 weeks, at the most.
- Chronic Pain
  - Typically occurring for > 3months.
  - Beyond the time of normal tissue healing.

Some Opioids We Rx

- Morphine: the original
- Dilaudid (Hydromorphone): 5-7x as potent
- Hydrocodone – Vicodin/Lortab: 1.5x as potent
- Oxycodone – Percocet/Oxycontin: 1.5x as potent
- Fentanyl: patch, also IV, tabs (& more): 25mcg/patch a day = 50-100 oral morphine a day, so very potent.
- Codeine: Tylenol #3, cough syrup - weak
- Tramadol: Ultram - weak

All conversions approximate and for oral doses (excepting fentanyl patch) – IV is different and stronger for all.

How bad is it, really?

- 2 million in the US have an opioid use disorder.
- At any one moment in time, there is a bottle of narcotics for every American…
  - In 2013, 249,000,000 opiate Rxs were written.
- One in 4 chronic pain pts on opioids in primary care also has an addiction disorder.
- Pain reports, nationwide, remain unchanged.

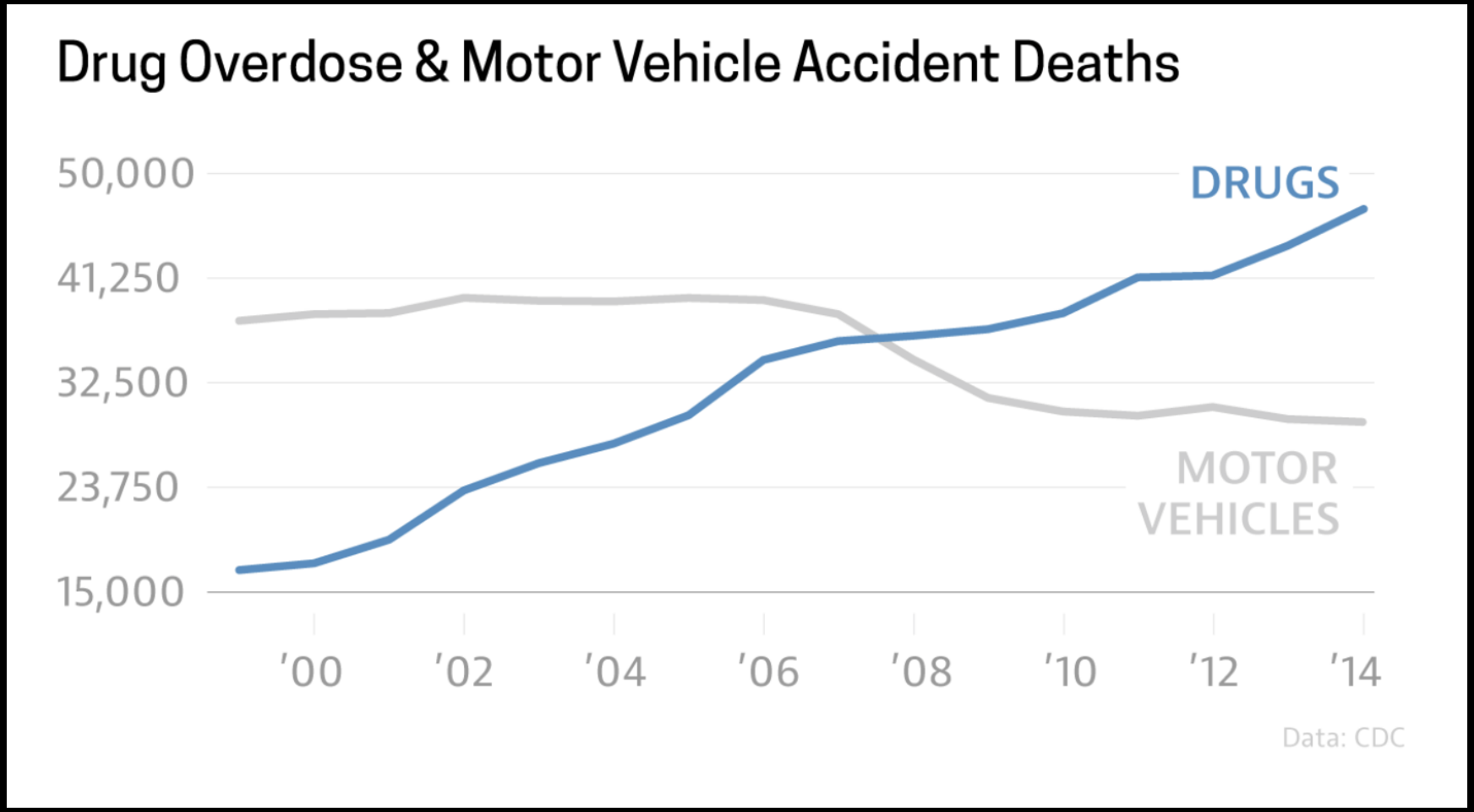
Source: CDC.gov

How bad is it, really?

- In the last 20 years, opioid deaths have quadrupled.
- Currently, about 27,000 die a year from opioid and heroin use in the US.
- The US makes up 5% of the worlds population, and uses 80% of it’s opioids.

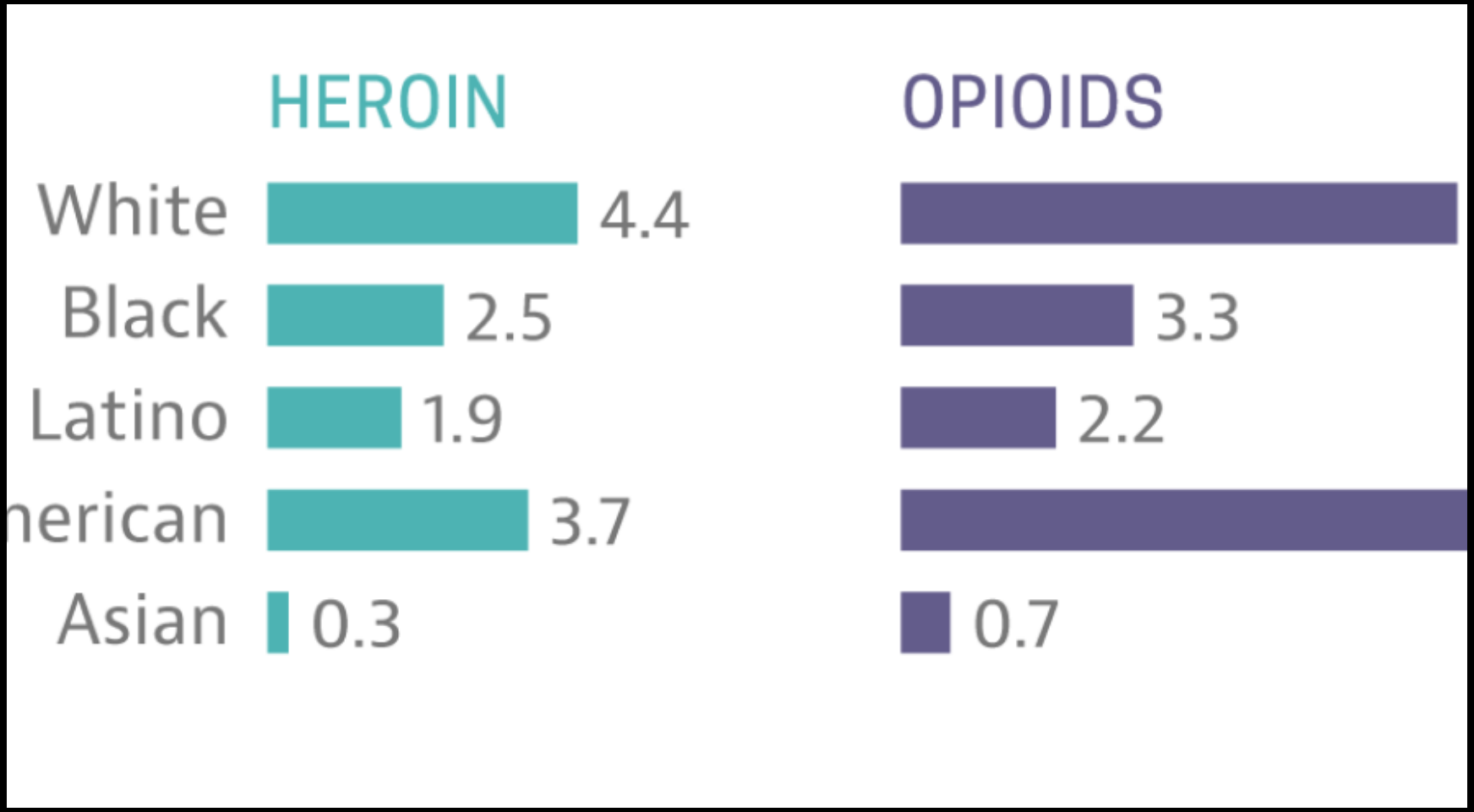
Source: CDC.gov

Today: Drugs Kill More Than Cars



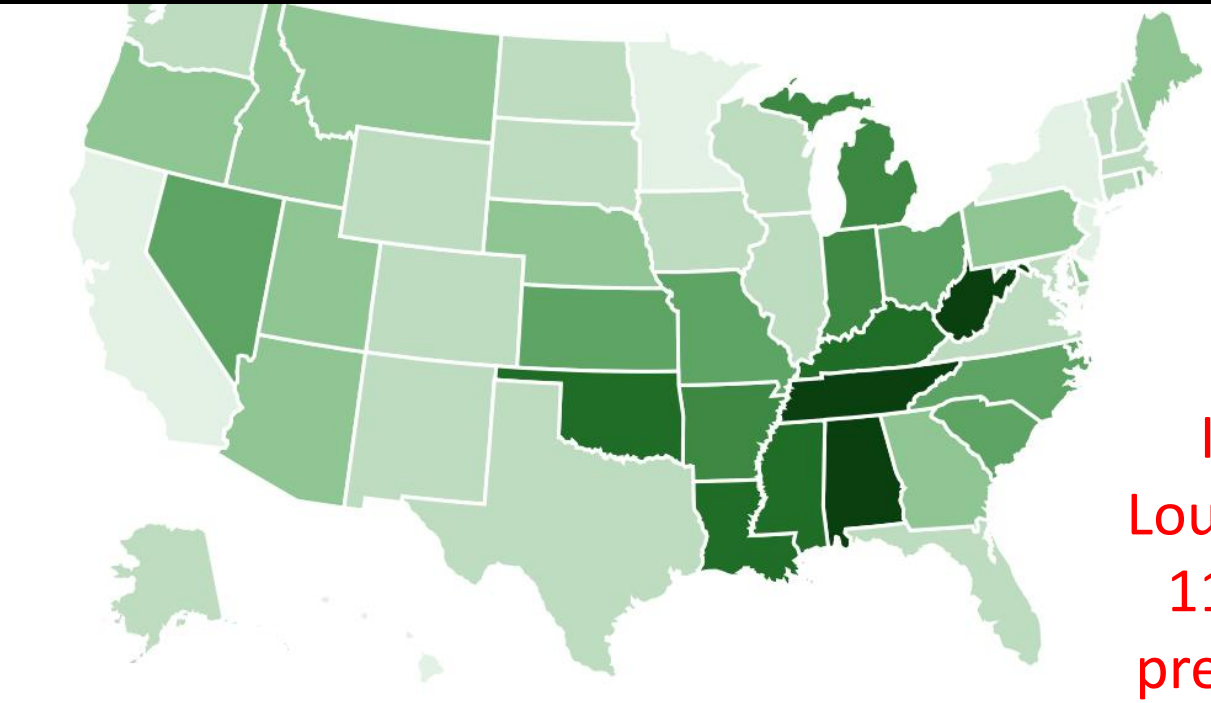
Source: CDC.gov via Frontline, PBS

Whites and Native Americans Particularly Affected



Deaths per 100,000 people, Source: CDC.gov via Frontline, PBS

But Not in Louisiana, Right?



In 2012, Louisiana had 118 opioid prescriptions per 100 people.

*thank God for Alabama, Mississippi and West Virginia

Source: CDC.gov via Frontline, PBS

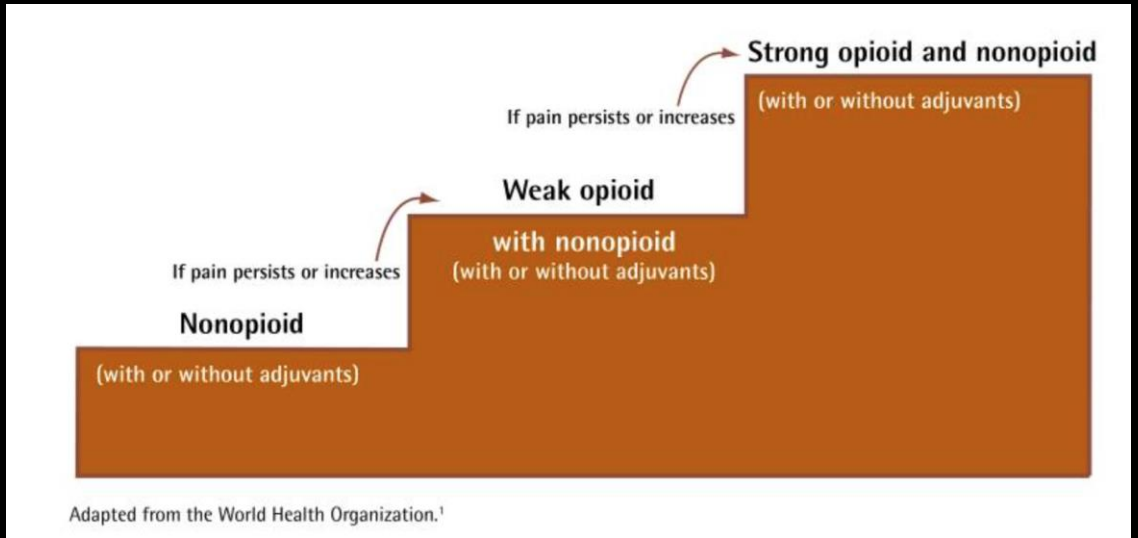
How Did This Happen?

- Pain as the Fifth Vital Sign?
  - Movement started in the mid 1990s.
  - Pressure to improve pain scores → VA standard → "Joint Commission Standard."
  - Medicare requires patient satisfaction surveys- pressure to treat pain at any cost? Evidence suggests yes!
- No Medical Education on Treating Pain
  - How many of you remember the course on treating pain? But yet we spent months on chemistry, calculus, pharmokinetics…

Source: JAMA network, Personal Insight, Jena et al.

How Did This Happen?

- World Health Organization Pain Ladder
  - Developed in 1986 by an expert panel.
  - What I was taught!
  - “The correct dose of opioid is the dose that reaches the desired pain relief.”



Source: JAMA network, Personal Insight

How Did This Happen?

- We were taught misinformation.
  - "Opioids, when used for pain, are not addictive and rarely cause respiratory depression."
  - "If pain is chronic, start with a long acting opioid."
  - "If pain is not to a 0-3/10, increase the opioid."
  - Prescribers → False sense of safety.
  - AND OUTRIGHT WRONG!

How Did This Happen?

- Pill Mills
  - Doctors we know…
  - Making millions a year prescribing thousands of opiates (and xanax, suboxone, and soma…).
  - Typically cash payments; no services rendered…
  - One doctor prescribed, in a year, more opioids than the entire staff at John Hopkins Hospital.
  - In 2016, for the first time, a pill mill prescribing doctor was convicted of murder. Many since.

Or, is it is all oral surgeon's fault?

Today

- The onus is on us as prescribers.
- We must know the dangers of what we Rx.
- Law Enforcement is not coming after us… but still, we would hate to create even one pain addict – or be the first step in that chain.
- If you are treating chronic pain with opioids, I suggest you refer these patients to pain specialists in your town.

So What Do We Do?

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VERTISEMENT

Home > About the ADA > ADA Positions, Policies, and Statements > **Statement on the Use of Opioids in the Treatment of Dental Pain**

Statement on the Use of Opioids in the Treatment of Dental Pain

1. When considering prescribing opioids, dentists should conduct a medical and dental history to determine current medications, potential drug interactions and history of substance abuse.
2. Dentists should follow and continually review Centers for Disease Control and State Licensing Boards recommendations for safe opioid prescribing.
3. Dentists should register with and utilize prescription drug monitoring program (PDMP) to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse and diversion of these substances.
4. Dentists should have a discussion with patients regarding their

Suggestions for Practice

- The following slides are a compilation of suggestions from the ADA, US Surgeon General, CDC, and Louisiana State Board.
- I have attempted to organize the suggestions into a manner of approach.

The Order

- Patient History.
  - Consider addiction risk assessment
  - Consider Louisiana Pharmacy Monitoring
- Consider your pain pill options.
- Know why your are choosing an opioid, when you chose one (be able to chart a reason).
- Consider which opioid to use, if using.
- Consider your opioid duration, if using.
- Refer to a specialist if pain persists > 4 weeks (or so) or aberrant behaviors arise.

Patient History

- Your history, if you may be prescribing opioids, needs to include questions about history of active/prior substance use (both legal and illegal).
  - I typically ask (or have in a form):
    - How many drinks a day? Were you a heavy drinker before?
    - How much do you smoke? Did you smoke before?
    - Are you on pain pills or pills off the street?
    - Do you use heroin, cocaine, crack, speed or other drugs? Have you in the past?
    - Do you use marijuana now or in the past?

Addiction Risk Assessment

- 1) Use a tool (next slide).
- 2) Does your patient have a standing pain contract with another provider?
- 3) Run the Louisiana Prescription Monitoring Program.
  - Some boards are making this required before every opioid script… this is not the case here.
  - https://louisiana.pmpaware.net/login/
    - Joining is easy!

Opioid Risk Tool (ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Rx drugs	☐ 4	☐ 4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Rx drugs	☐ 5	☐ 5
AGE BETWEEN 16–45 YEARS	☐ 1	☐ 1
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐ 3	☐ 0
PSYCHOLOGIC DISEASE		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
SCORING TOTALS		

ADMINISTRATION

- On initial visit
- Prior to opioid therapy

SCORING (RISK)

0–3: low

4–7: moderate

≥8: high

Question: Can you give opioids to a high risk or prior addict or current addict?

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“The first line treatment of dental pain is…

..the diagnosis and the treatment.”

Some Acute Pain Pill Options

- Tylenol
- NSAIDS
- Opioids
- Antidepressants, anticonvulsants and other “adjuvant” pain meds are often used in chronic pain and are beyond the scope of this talk.

NSAIDS

- Some great NSAIDS (*I prefer nonspecifics*):
  - Ibuprofen/Advil – 400mg dose is fine!
  - Naprosyn/Aleve
  - Diclofenac – nice for some as it requires the "Rx" and thus may have a stronger placebo effect (AEL opinion)
- Consider these "first line" for the treatment of acute dental pain. Relative contraindications to NSAIDs
  - Very elderly (>75?)
  - Renal impairment
  - On oral anticoagulants (generally avoid) – okay w asa 81mg
  - Heart failure
  - On cyclosporine, phenytoin, another big NSAID (celecoxib)

I Think I Have to Rx an Opioid

- Principle: The LOWEST effective dose for the SHORTEST amount of time possible
  - 3 days typically sufficient.
  - More than 7 days should RARELY be needed.

TurnthetideRx.org, CDC.gov

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Some Reasons Opioids May be OK

- Elderly, renal issues, heart failure, tylenol not enough.
- On oral anticoagulants, feel tylenol not enough.
- Pain may be more than you feel tylenol or an NSAID can handle.
- *Don’t prescribe for your convenience!*

Personal opinion

If You Rx an Opioid…

- SHORT ACTING
  - I can think of no reason you should need a long acting in dentistry for acute pain…
  - Long actings greatly increase the risk of sudden death. In my field they require extra training…

Some Nice Opioid Short Actings

- Tramadol/Ultram
  - Weak, 50mg = 5mg morphine = 3mg hydrocodone/oxycodone
  - Comes in 50mg, 100mg.
  - I like 50mg, q6 hours as needed.
  - Can combine with tylenol, or NSAID…
  - Avoid if <17 years old (FDA investigating if respiratory depression worse in kids than others)
  - Avoid if on serotonin agents (SSRIs), seizure history
  - Maximum daily dose (there is a ceiling!!!) = 300mg

Some Nice Opioid Short Actings

- Hydrocodone/Acetaminophen = Lortab/Vicodin
  - comes in 5mg, 7.5mg, 10mg
  - each pill also contains 325mg tylenol/acetaminophen
  - maximum daily dose of tylenol allowed (acetaminophen) is 3000mg – so care with combining with tylenol!
  - Hydrocodone is 1.5x as potent as morphine.
  - cleaner than tramadol – so no serotonin/seizure issues.
  - Consider hydrocodone 5/325 q4h prn pain #12.

Some Nice Opioid Short Actings

- Oxycodone/Acetaminophen = Percocet
  - Comes in 5mg, 7.5mg, 10mg
  - Each pill also contains 325mg of acetaminophen
  - No reason to chose this over hydrocodone, or hydrocodone over this… sometimes if people have had nausea/itching with one they can still tolerate the other.
  - Oxycodone = 1.5x as potent as morphine
  - Consider Oxycodone 5/325 q4 hours prn pain #12.

Some Nice Opioid Short Actings

- What if we are trying to avoid tylenol?
  - The rare cirrhotic (though frankly a little tylenol…) or an allergy, not unheard of…
- Consider plain oxycodone
  - Not the same as oxycontin – oxycontin is LONG ACTING oxycodone.
  - Oxycodone is a short acting, like percocet, but without the acetaminophen.
  - Comes in 5, 10, 15, 20... (frankly too many options).
  - Consider Oxycodone 5mg q4 prn pain #12

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Why Only 12 pills, Alex?

- Many addictions start with treatment for acute pain.
- When total doses of opioids are kept to <100mg of morphine equivalents, the odds are less…
- Lortab 5 q6 for 3 days
  - = morphine 7.5mg q6 = morphine 30 a day = morphine 90mg total

Recommendations from CDC.gov

When to Refer…

- Concern that pain is no longer due to acute dental issue.
- Concern that pain scores and need are out of proportion to dental exam.
- Concern for neuropathic pain that cannot be addressed with dental diagnosis/treatment.
- Concern that your patient is addicted to substances.

Questions?

Few More Things…

Are there any reporting requirements for dentists to the LA PMP?

- Only if you are “dispensing” controlled substances (like a pharmacy does).
- Administering is not equivalent to dispensing.

Just FYI – What are the Long Actings?

- Morphine comes in a long acting.
  - MS Contin or Morphine Sulfate ER
- Oxycodone has a long acting.
  - Oxycontin
- Fentanyl Patch is a long acting.
  - Again, a fentanyl patch 25mcg/hr = morphine 50mg a day – so they are ALL STRONG!
- Methadone is a long acting, don't use it.

Just FYI –Long Actings

- The reason we avoid long actings…
- Increased risk of sudden death.
- Even the lowest dose of available long actings. requires a patient be VERY opioid tolerant…
  - typically, for instance, a patient would be on around-the-clock pain short acting opiates before we even consider these.
- Consult an expert, PLEASE!

If You Rx an Opioid…

- Discuss safe practices of the opioid storage
  - Away from children.
  - Out of medicine cabinets in bathrooms and bedside tables (obvious places “guests” look)
  - Never share.
  - Take as Rxed!!!
  - Discard in coffee grounds or kitty litter
    - Law Enforcement Drug Boxes
    - DEA Take-back days

Opioid Short Term Side Effects

- Constipation (never fails)
- Nausea
- Itching
- Confusion/Delirium
- Respiratory depression, aka not breathing well
  - Especially if drinking
  - Especially if on a benzodiazipine
    - BE very very wary of Rxing opiates in anyone on alprazolam/xanax, lorazepam/ativan, klonazepam/klonopin
  - Especially if untreated Sleep Apnea!

Resource – ADA.org

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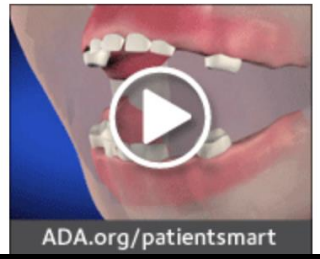

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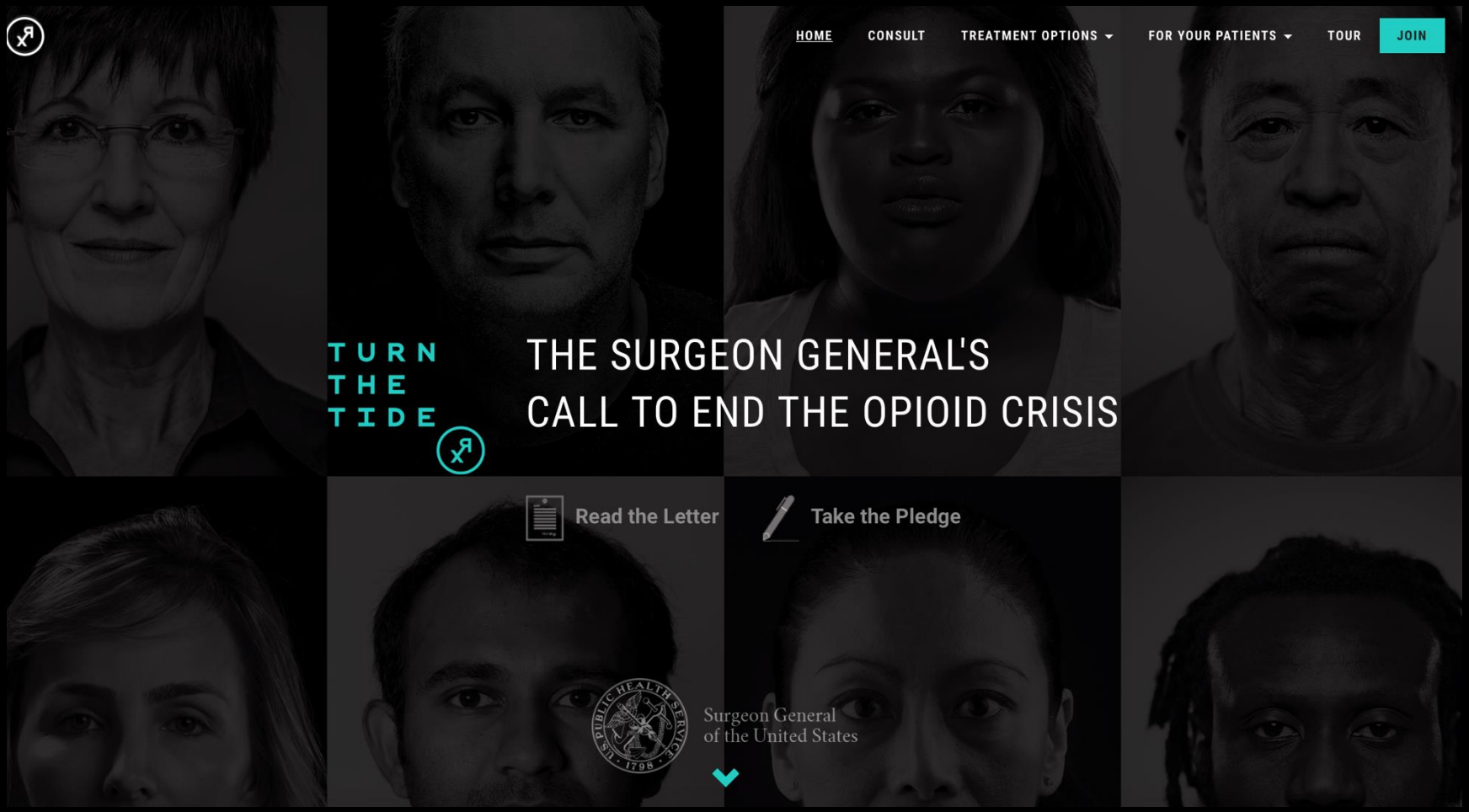
Prescription Opioid Abuse

The misuse and abuse of opioid pain relievers—such as hydrocodone (Vicodin® and Lortab®) and oxycodone (OxyContin® and Percocet®)—has reached epidemic proportions. As prescribers of opioid pain medications, dentists are well positioned to help keep these drugs from becoming a source of harm.

- Statement on the Use of Opioids in the Treatment of Dental Pain
- Prevention of prescription opioid abuse: The role of the dentist (JADA July 2011)
- ADA president urges dentists to renew commitment to prevent opioid abuse (ADA News 7/5/16)

Resource – TurnTheTideRx.org



How Has Your Practice Changed?

Who Have You Referred To?

- Which pain specialists in this area have been helpful to your patients?
- Which addiction specialists?

Thoughts?

References

- Frontline, pbs.org, “Chasing Heroin” aired February 2016.
- TurnthetideRx.org, accessed February 1, 2017.
- CDC.gov, Injury Prevention and Control, Opioid Overdose, accessed February 2, 2017.
- ADA.gov
- Jena et al. **Hospital Prescribing of Opioids to Medicare Beneficiaries** *JAMA Intern Med.* 2016;176(7):990-997.
- JAMA Forum: August 9, 2016. The Pain and Opioid Epidemics: Policy and Vital Signs,
- Ozy.com How Wisdom Teeth are Fueling the Opioid epidemic. Accessed February 1 2017
- ORT from prescriberesponsibly.com, accessed Feb 7, 2017.
- Perspective: Reducing the Risks of Relief — The CDC Opioid-Prescribing Guideline, Thomas R. Frieden, M.D., M.P.H., and Debra Houry, M.D., M.P.H., N Engl J Med 2016; 374:1501-1504