Monday through Friday	Saturdays & Holidays	Sundays & Christmas
8:00 A.M. to 8:00 P.M.	9:00 A.M. to 1:00 P.M.	Noon to 4:00 P.M.

IT'S ABOUT PAIN

A monthly service of Kirkpatrick Family Care Vol 1, Number 8, August 2018

The Pendulum Strikes Back

In the history of medicine, policies and practices often swing back and forth from one extreme to another. For example, for high blood pressure, treatment in the '60s and 70s, was fixed combinations of two or three drugs. From the 1980s to around 2015, it was "maximize one drug before adding a second." Now, fixed dose pills are coming back.
In treatment of chronic pain, we've gone from "No Narcotics" in the 1970s to "whatever is needed" from about 1995-2014, and now it's back to "No." But some national experts are pointing out serious problems caused by "No."

Read the following piece from Wall Street Journal, 8/16/2018 by Dr. Sally Satel and Dr. Stefan Kertesz

Oregon overshoots on opioids

The Oregon Health Authority is contemplating a radical plan to end opioid coverage for many chronic-pain patients enrolled in the state's Medicaid program. Beginning in 2020, physicians would have one year to fully taper off doses of medications such as Percocet, Vicodin and OxyContin. OHA's chief medical officer says the agency believes "pain patients have been put at higher risk with regard to overprescribing."
Oregon's proposal is a more extreme version of increasingly common policies that position dose reductions as the key to patient safety. But the available evidence does not show a safety benefit from mandatory, across-the-board opioid tapers. Instead of targeting those most at risk of overdose, the mandate would needlessly exacerbate suffering for thousands of patients.
The risk of opioid overdose among chronic pain patients is real but low—less than 0.3% a year at typical doses, according to a 2011 study. It tends to occur among specific groups of opioid users: those who suffer from mental illness or other major medical problems, and those who mix opioids with alcohol or other drugs.
Researchers from Kaiser Permanente and the Denver Health Medical Center found that prescription dose didn't predict overdose risk once mental health and other factors were considered. This comports with our clinical experience: Prescription-related overdoses tend to occur among patients in the midst of chaotic personal situations involving other sedatives, alcohol and emotional distress. Forced dose reduction wouldn't end the disarray in these patients' lives. It could even make it worse.
There is no question that some patients have abused Medicaid to purchase fistfuls of opioids through illegal pill mills or to scam physicians into writing prescriptions for medication they resell. Medicaid needs to protect against such fraud, but Oregon officials should not swing a scythe where a scalpel will suffice.
The current climate has made physicians hypervigilant about breaking opioid-prescribing rules. This has led to needless suffering and even pushed some patients to commit suicide after having

their doses reduced. Increasingly, doctors urge patients to undergo addiction treatment or procedures—including spinal injections—regardless of whether clinically appropriate. “Opioid refugees” wander the country as the number of experts willing to care for them dwindles.
Opioids are rarely a first choice. They pose sometimes intolerable risks of dependency, sedation and, yes, overdose. But they also allow a significant number of people with neurological, inflammatory and musculoskeletal afflictions to function in situations where other treatments have failed.
Last week the OHA held a public meeting in Wilsonville to advance the proposal toward finalization. Pain patients protested outside the room. One sign read: “Death with dignity is a law: What about LIFE with dignity?”
Thanks to overwhelming dissent from physicians and pain-treatment advocates, the new policy’s progression has stalled. But the final vote on forced tapering is scheduled for October. Let’s hope respect for dignity prevails and this misbegotten plan dies.

Dr. Satel is a resident scholar at the American Enterprise Institute and a lecturer at Yale School of Medicine. Dr. Kertesz is a professor of preventive medicine at the University of Alabama.
Further, it appears that the cause of overdose death has shifted dramatically from prescription drugs to illegal fentanyl derivatives and heroin.

Turning the tide or riptide? The changing opioid epidemic

ABSTRACT—

The US opioid epidemic has changed profoundly in the last 3 years, in ways that require substantial recalibration of the US policy response. This report summarizes the changing nature of overdose deaths in Jefferson County (home to Birmingham, Alabama) using data updated through June 30, 2016. Heroin and fentanyl have come to dominate an escalating epidemic of lethal opioid overdose, whereas opioids commonly obtained by prescription play a minor role, accounting for no more than 15% of reported deaths in 2015. Such local data, along with similar reports from other localities, augment the insights available from the Centers for Disease Control and Prevention's current overdose summary, which lacks data from 2015–2016 and lacks information regarding fentanyl in particular. The observed changes in the opioid epidemic are particularly remarkable because they have emerged despite sustained reductions in opioid prescribing and sustained reductions in prescription opioid misuse. Among US adults, past-year prescription opioid misuse is at its lowest level since 2002. Among 12th graders it is at its lowest level in 20 years. A credible epidemiologic account of the opioid epidemic is as follows: although opioid prescribing by physicians appears to have unleashed the epidemic prior to 2012, physician prescribing no longer plays a major role in sustaining it. The accelerating pace of the opioid epidemic in 2015–2016 requires a serious reconsideration of governmental policy initiatives that continue to focus on reductions in opioid prescribing. The dominant priority should be the assurance of subsidized access to evidence-based medication-assisted treatment for opioid use disorder. Such treatment is lacking across much of the United States at this time. Further aggressive focus on prescription reduction is likely to obtain diminishing returns while creating significant risks for patients.

Stefan G. Kertesz , MD, MSc from Substance Abuse, January 2017