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THE PRESCRIPTION OPIOID EPIDEMIC IN DEVELOPED VERSUS UNDERDEVELOPED COUNTRIES: IS THERE A HAPPY MEDIUM?

Prescription opioid abuse-related deaths are in excess of 16,000 yearly and add more than 50 billion dollars to the healthcare costs in the United States.[1] This is a real problem to the healthcare system. However, the magnitude of this problem seem to vary widely among countries.

The World Health Organization (WHO) ladder for the treatment of cancer pain was extended to the management of acute and chronic non-cancer pain and the WHO urged governments to act to facilitate the use of strong opioids to treat severe pain. Despite the availability of the guidelines and the translation into 22 languages, pain remained undertreated for decades and some countries are still struggling with very strong barriers to access to controlled medications such as limited medical knowledge, overly restrictive regulations, lack of enabling policies, and supply challenges. Subsequently, outpatient treatment of severe pain is still almost nonexistent in most countries. North America unchained opioid prescription from most of its restrictions. Therefore, there is currently a severe discrepancy between North America on one side, and Africa, Europe, the Middle East and Gulf areas, on the other side in their respective consumption of opioids. The US population represents 4.6 percent of the world's population and consumes 80 percent of the global opioid supply.[2] After many years of focus on pain undertreatment, it is clear that we are facing now a new challenge. The challenge of finding a balance between good pain control and limiting prescription addiction.

The use of potent opioids has dramatically increased after the liberalization of laws governing opioid prescribing for chronic non-cancer pain by state medical boards in the late 1990s, and the introduction of pain management standards by the Joint Commission (previously JCAHO) in 2000,[3] which required pain assessment at every initial patient visit, making pain the "fifth vital sign."[4] The total morphine equivalent consumption in the United States was 693 mg/capita in 2010 and the increase in opioid consumption was paralleled by a sharp increase in abuse and addiction.[5] While patients in pain and their treating anesthesiologists, pain specialists or general practitioners benefited from the lenient prescribing laws, the United States witnessed a two-fold increase in opioid prescriptions over two decades (from 120 to 210 million), a four-fold increase in unintended deaths caused by opioid analgesia with reported past-year abuse rates of 9 to 12 percent and 12 million Americans reporting recreational prescription opiate use in 2010.[6] Emergency Departments (ED) physicians on the other hand were flooded with 500,000 visits annually for misuse and abuse of prescription opioid which amounts up to 20 percent of all ED visits in the United States.[7] In the ED, shift work, 24 hour availability, brief physician-patient interactions and limited access to medical records, contribute to creating a susceptible environment for misuse and abuse by patients. This demonstrates the challenge of controlling prescription opioid abuse in busy emergency departments where continuity of care is lacking. Furthermore, identifying drug-seekers with certainty is challenging, although multiple studies have attempted to describe signs of drug seeking behavior. Common presentations are easily feigned and often difficult to objectively assess, including back pain, dental pain and headache. Other behaviors associated with drug seeking include asking for analgesics by name, claiming allergies to non-narcotic analgesics, requesting parenteral narcotics, reporting greater than 10 out of 10 pain, aggressive behavior, return visits for the same complaint though these are not very specific.[7] Physicians are thus left struggling with trying to curb misuse on the one hand and the risk of denying pain medications to legitimately suffering patients and being non-compliant with hospital pain management policies on the other hand. The public health community in high consumption countries like the United States is now struggling to balance the need for good pain control with prescription drug abuse.

In underdeveloped countries however public health officials are challenged with problems that are at the other end of the spectrum with pain undertreatment being way more prevalent than prescription opioid abuse. In Lebanon for instance, the opioid consumption per capita is 5 mg. Severe opioid prescription restrictions limit access to opioids. Only pain specialists and oncologists are allowed to

deliver opioid prescriptions. However, what complicates the situation even more is the lack of availability of strong opioids and opioid formulations. Morphine immediate release is not available which makes treatment of breakthrough pain a very challenging endeavor. Morphine and fentanyl are the only long-acting formulations that are available. In addition, methadone is only available for patients undergoing detoxification programs and not for pain treatment, which makes it impossible for treating physicians to use the strategy of opioid rotation to control pain. Health care providers engaged in pain treatment in Lebanon tend to agree that the lack of availability of opioids and opioid formulations is by far a more restraining problem than prescription restrictions of opioids.

In European countries with moderate opioid consumption rates including France, Germany, and Italy, where total morphine equivalent use is 220, 376 and 144 mg per capita respectively, there are dose limits and special forms in place for opioid prescriptions. In addition, in France, patients are required to register to receive opioid prescriptions and in Italy patient permit requirements exist for outpatient opioid use.[8] Regulations in other countries include requiring physicians to receive special opioid prescribing licenses, limiting prescribing privileges to specific specialties, limitations on dispensing privileges, provisions for opioid prescribing for emergency situations and limitations on formularies available to patients. Many of these have been criticized for limiting access to good pain control. It is clear that physicians and the public health community have to accept some compromise solution that would help strike a better balance between the opioid prescribing abuse problem and ensuring pain control.

The answer to opioid prescription abuse is not obvious. Approximately 60 percent of fatalities originate from opioids prescribed within the guidelines, with approximately 40 percent of fatalities occurring in 10 percent of drug abusers. Furthermore, 20 percent of fatalities occurred while prescribing low-dose opioid therapy of less than 100 mg of morphine equivalent per day.[9] The data also shows that 40 percent of deaths occur in individuals abusing the drugs obtained through multiple prescriptions, doctor shopping, and drug diversion.[9] Is it reasonable then to say that some restrictions on opioid prescriptions should be re-established. For instance, patients with high opioid consumption or with drug-seeking behavior should have their opioids prescribed by specialists only where continuity of care is secured. Hospital admission for complex cases might be needed where strict monitoring is available. Also, since patients on long-term opioid use have been shown to increase the overall cost of healthcare, disability, rates of surgery, and late opioid use[2] and since chronic use of opioids lacks evidence of efficiency, maybe another approach is to limit the number of days/weeks of strong opioid prescriptions to treat noncancer pain. The public has started to take notice of this complex problem. In January 2013, Mayor Bloomberg of New York City announced opioid prescribing guidelines that include recommendations on careful consideration of need for opioid analgesia, limiting duration of prescriptions and more disclosure of risks of opioid analgesia to patients.[10] This has created some public outcry over perceived bureaucratic interference in medical care. Yet, the medical community is facing the challenge of ending the madness of the opioid epidemic in the United States, in huge discrepancy to the rest of the world where regulations have been the solution.

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