



Overview of the Opioid Addiction Epidemic

Presenter: Dr. Andrew Kolodny

Moderator: Cindy Rodgers

Audio will begin at 3:00PM ET.

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Meeting Orientation

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Our Speaker

Andrew Kolodny, M.D.
Chief Medical Officer
Phoenix House
Foundation





Overview of the Opioid Addiction Epidemic

Children's Safety Network Webinar
October 16, 2013

Andrew Kolodny, M.D.
Chief Medical Officer
Phoenix House Foundation
New York, NY

The Opium Poppy

Papaver Somniferum



Papaver somniferum

Photo by Eric Clausen, © 2000 Erowid.org



Crude Opium Latex on Poppy Head



Opioids

- Morphine
- Codeine
- Heroin
- Hydrocodone (Vicodin, Lortab)
- Methadone
- Oxycodone (Percocet, Oxycontin)
- Hydromorphone (Dilaudid)
- Meperidine (Demerol)

Winslow's Soothing Syrup for infants

Active Ingredient: Morphine





BAYER
PHARMACEUTICAL
PRODUCTS.

Send for
 samples and
 Literature to

ASPIRIN
The substitute for the salicylates

PROTARGOL

QUINALGEN

EUROPHEN

HEROIN
The sedative for coughs

LYCETOL
The uric acid solvent

SALOPHEN
The antirheumatic and antineuralgic

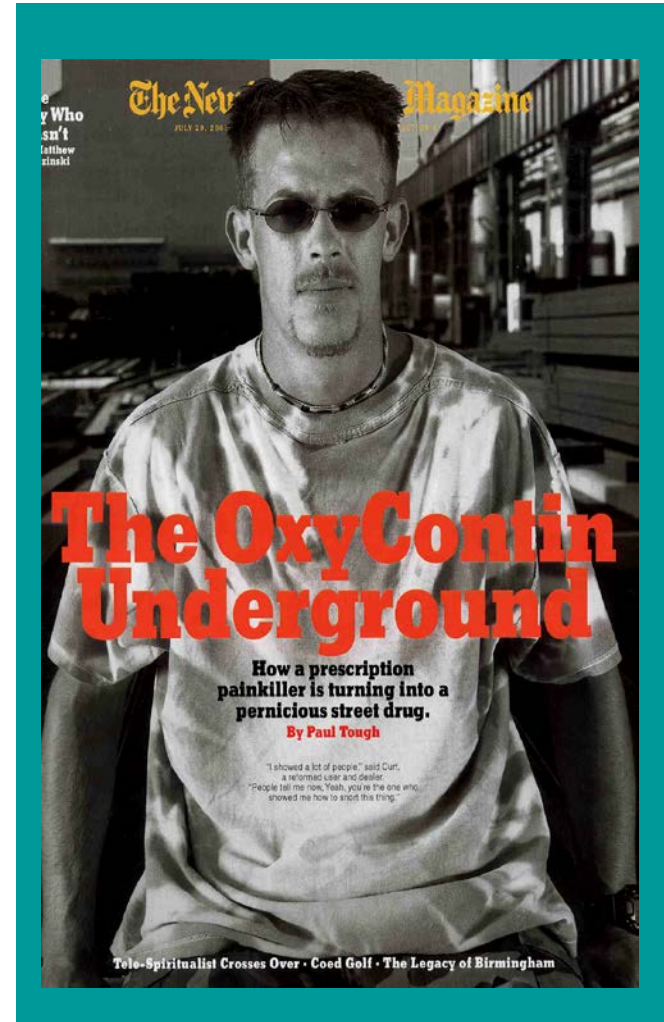
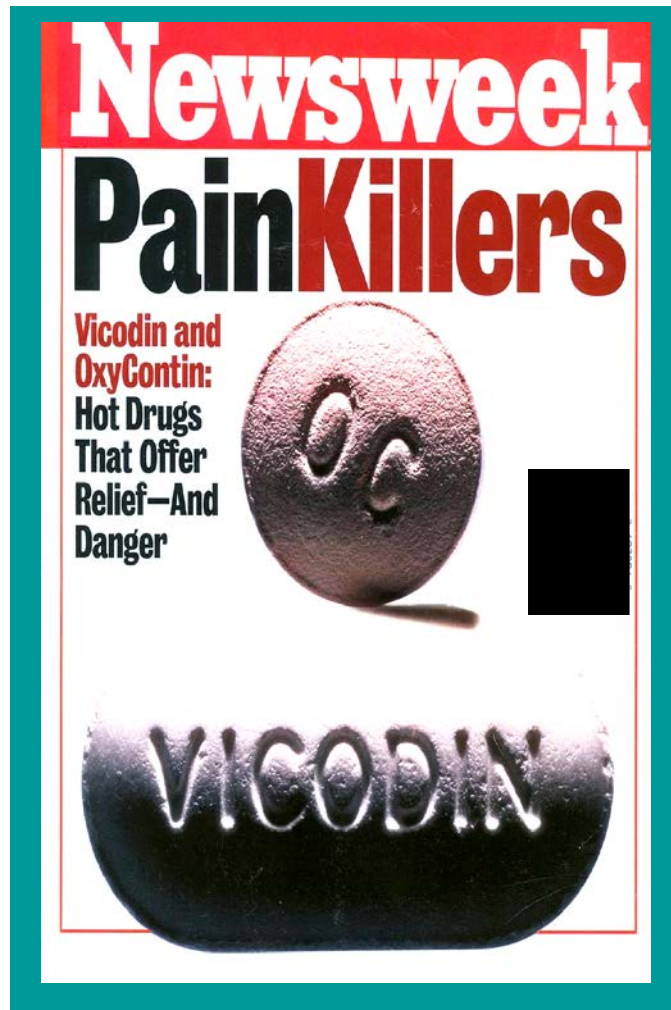
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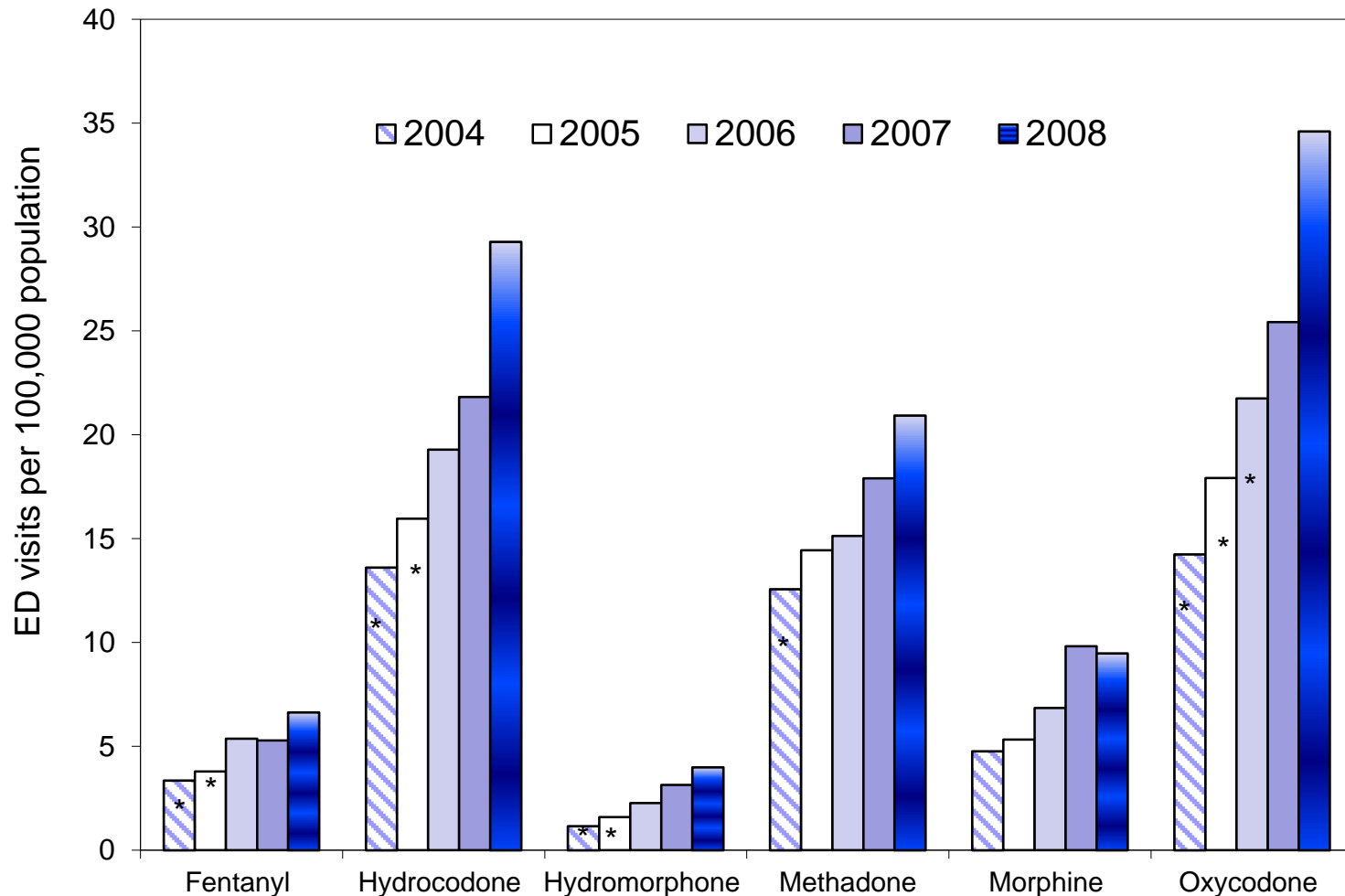
**40 STONE ST
 NEW YORK.**



Source: The New York Times Magazine, June 5, 1977



Rates of ED visits for nonmedical use of selected opioid analgesics increased significantly in the US

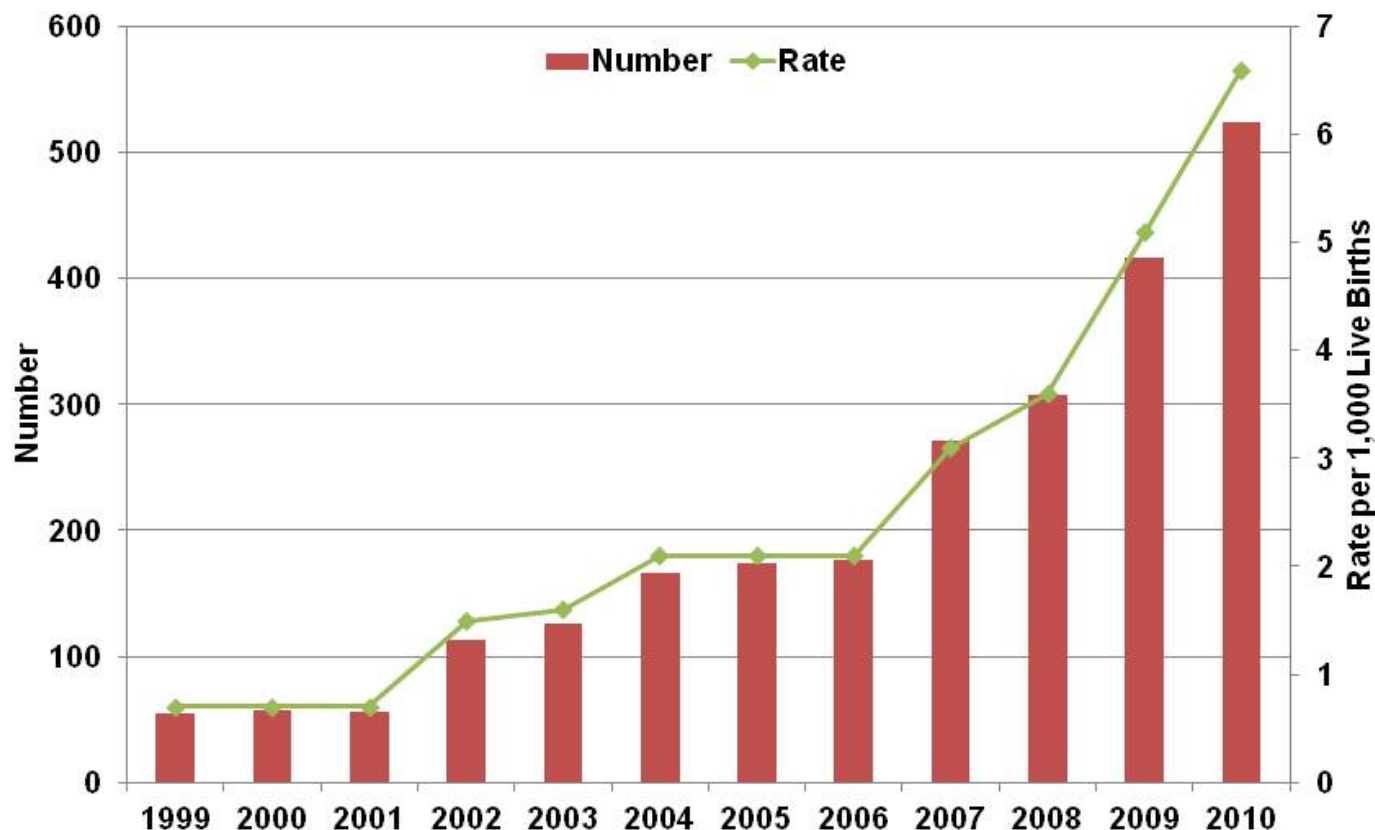


* Indicates a rate that was significantly less than the rate in 2008.

Note: Drug types include combination products, e.g., combinations of oxycodone and aspirin.

Opioid-Dependent Infants in Tennessee

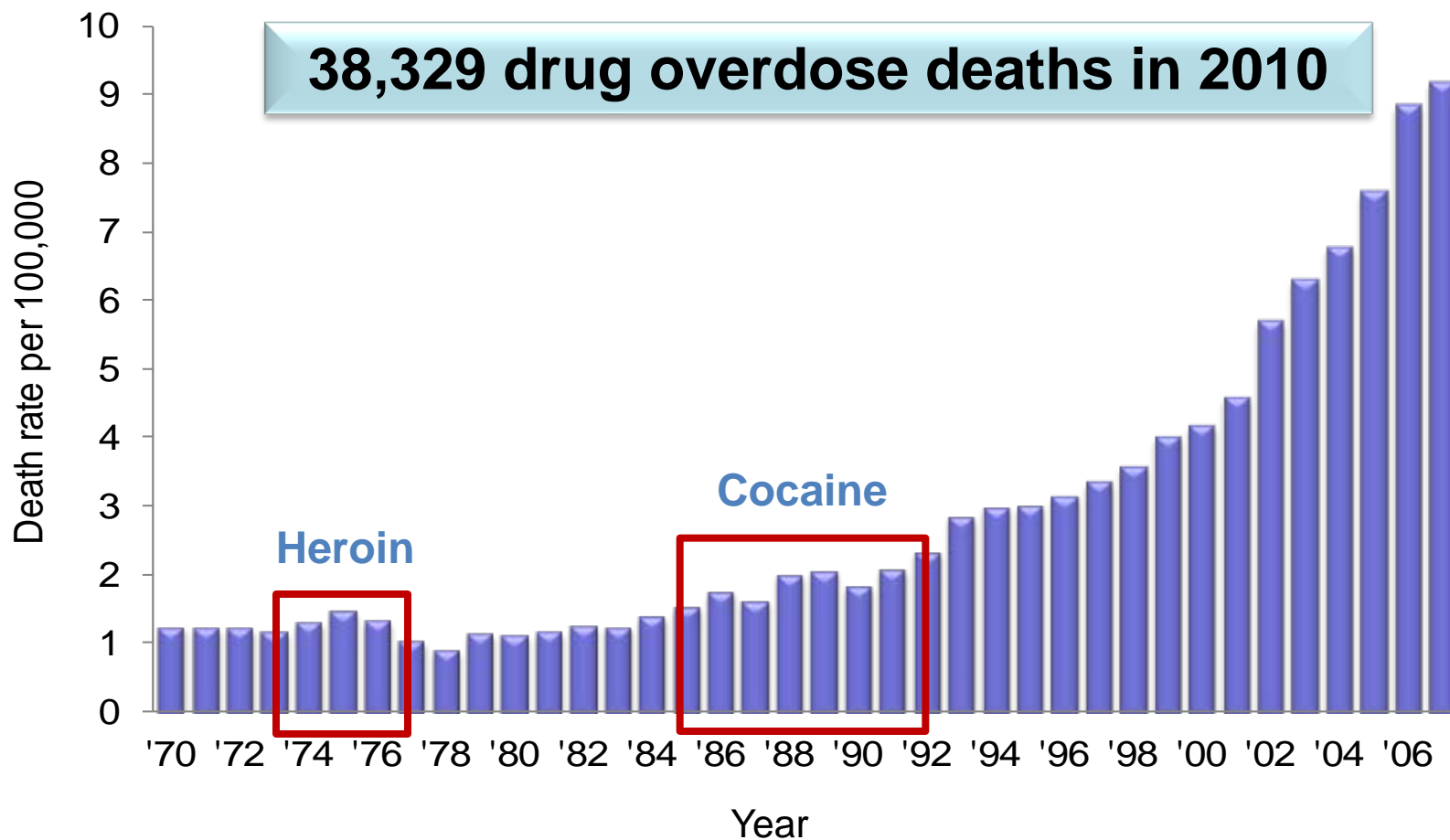
NAS in TN: 1999-2010



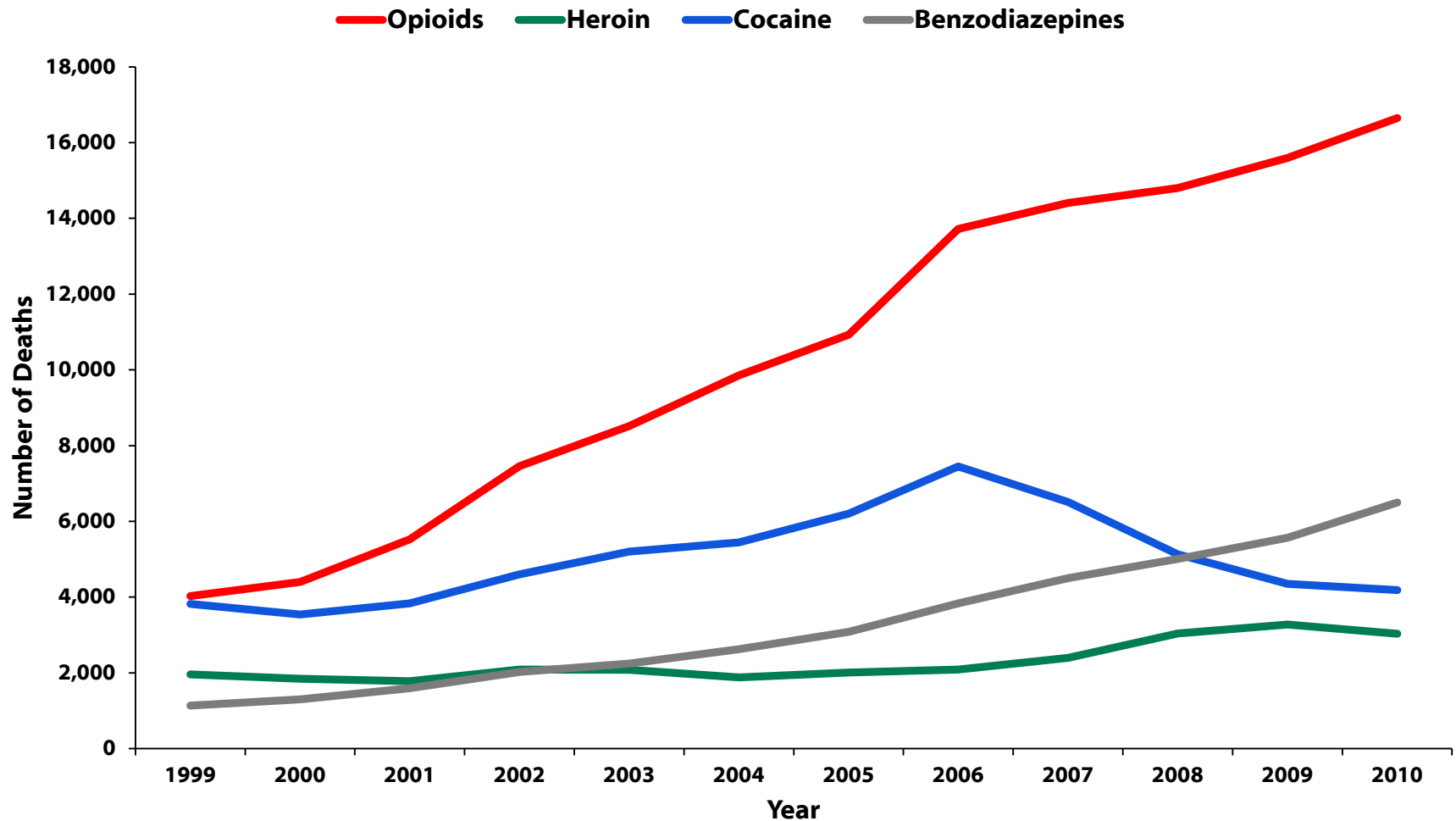
Data sources: Tennessee Department of Health; Office of Health Statistics; Hospital Discharge Data System (HDDS) and Birth Statistical System. Analysis includes inpatient hospitalizations with age less than 1 and any diagnosis of drug withdrawal syndrome of newborn (ICD-9-CM 779.5). HDDS records may contain up to 18 diagnoses. Infants were included if any of these diagnosis fields were coded 779.5. Note that these are discharge-level data and not unique patient data.



Unintentional Drug Overdose Deaths United States, 1970–2007



Drug Overdose Deaths by Major Drug Type, United States, 1999–2010



CDC, National Center for Health Statistics, National Vital Statistics System, CDC Wonder. Updated with 2010 mortality data.

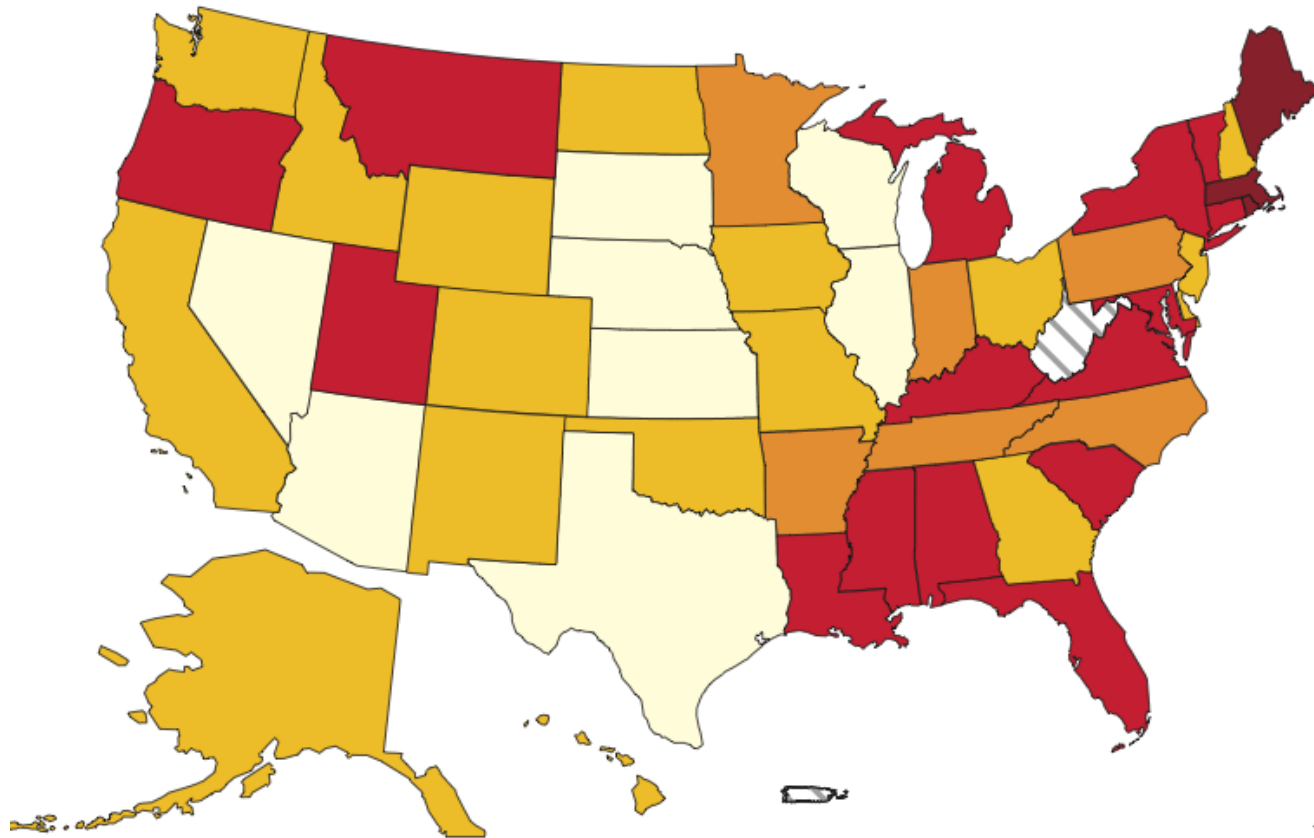
1999

(range 1 - 50)

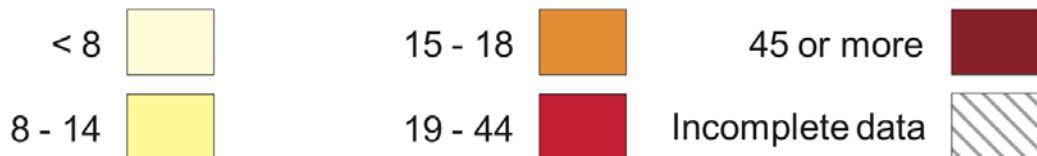


SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

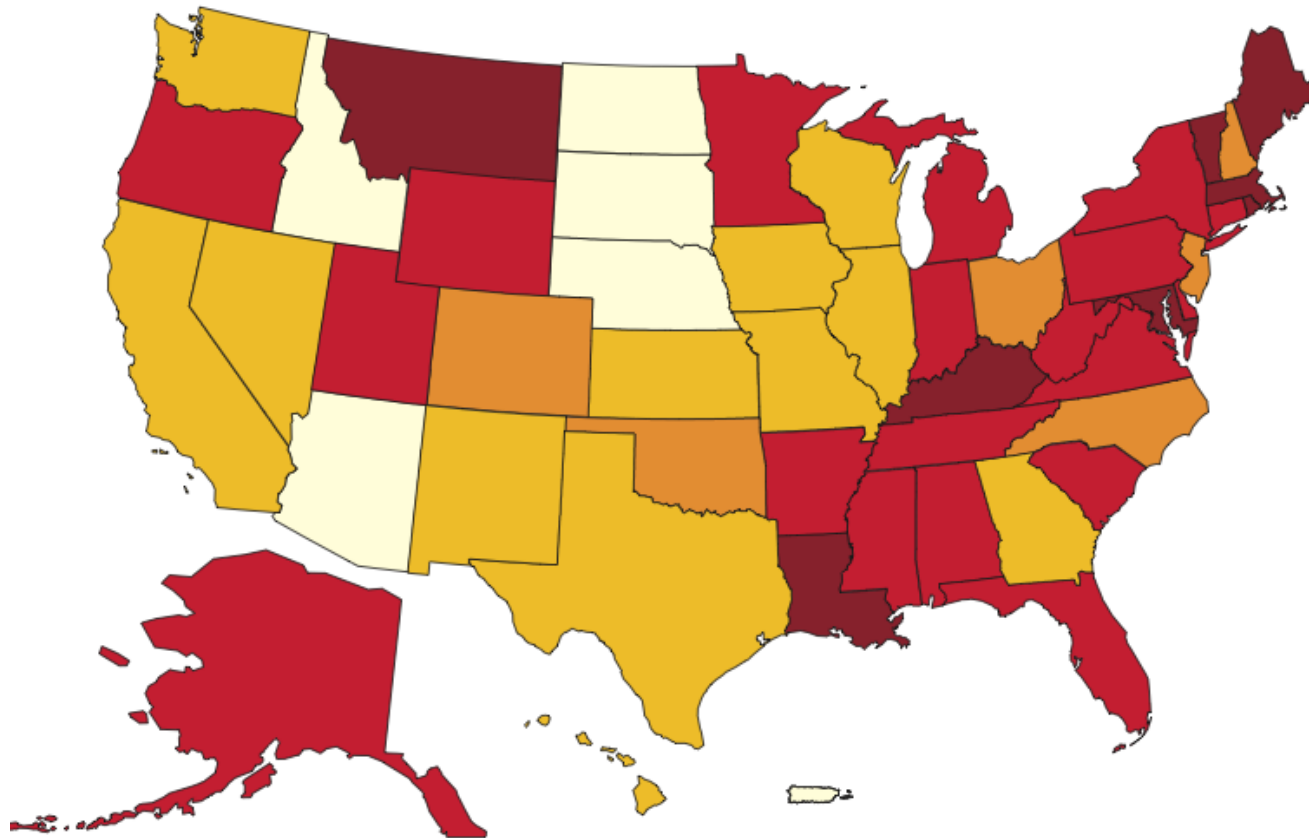


2001
(range 1 – 71)



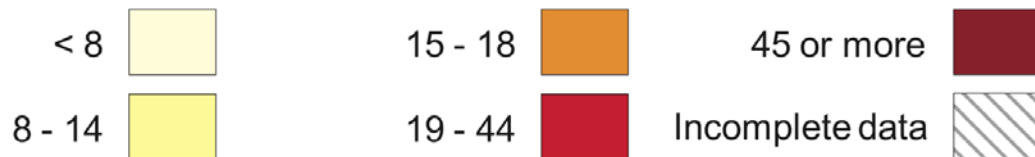
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



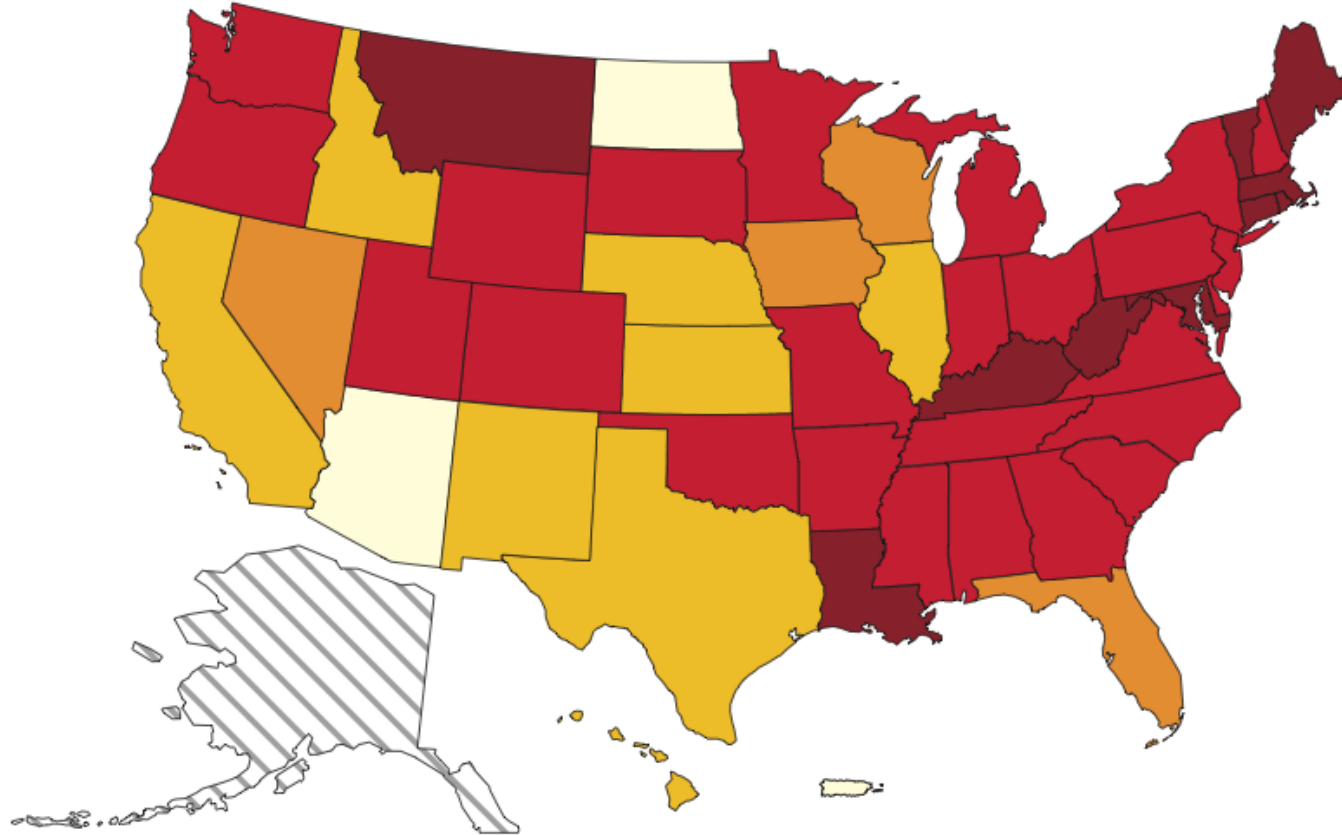
2003

(range 2 – 139)



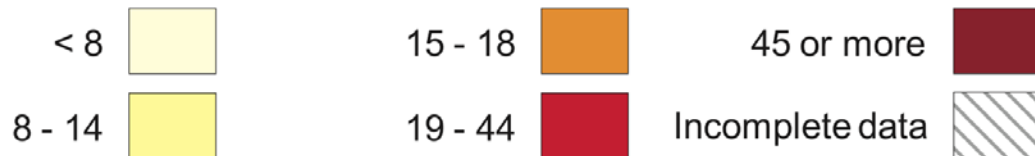
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

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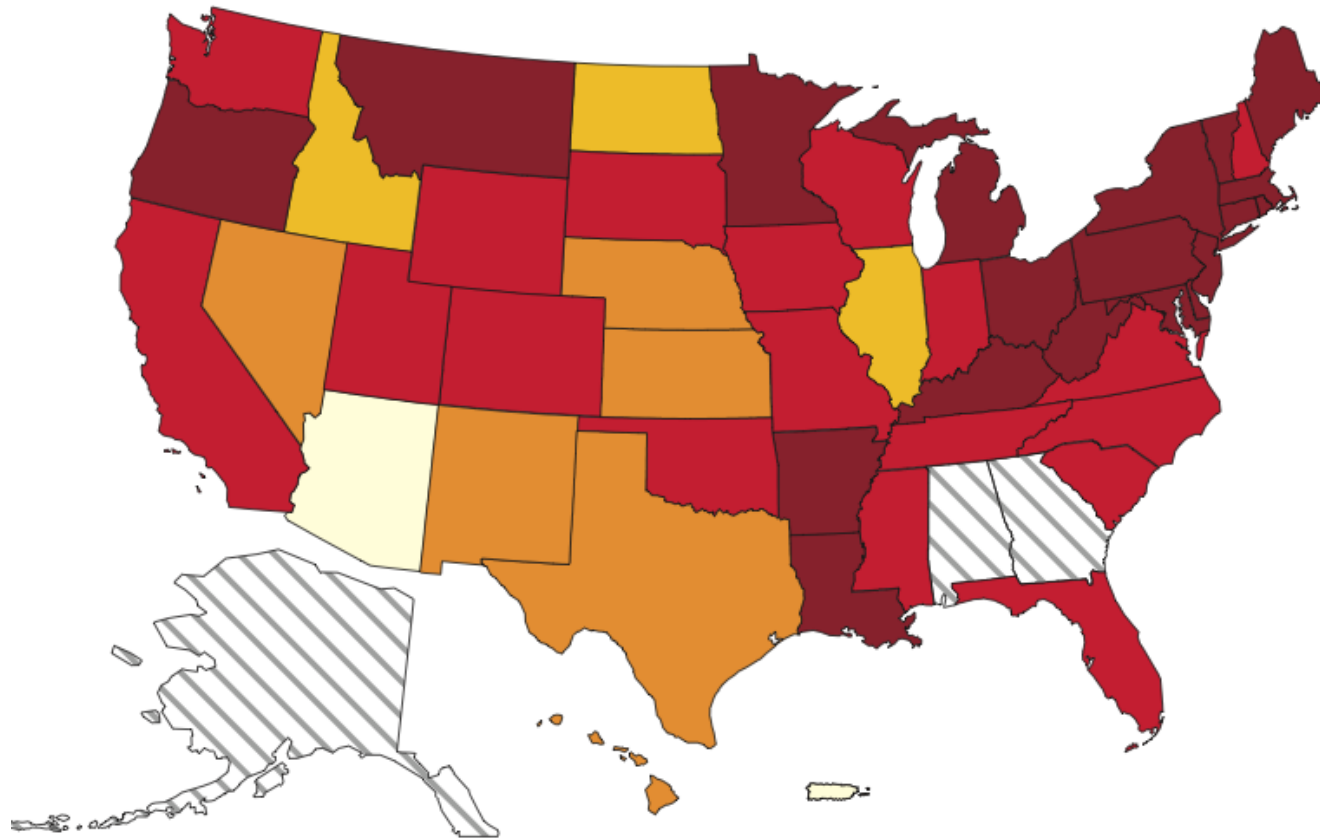
2005

(range 0 – 214)



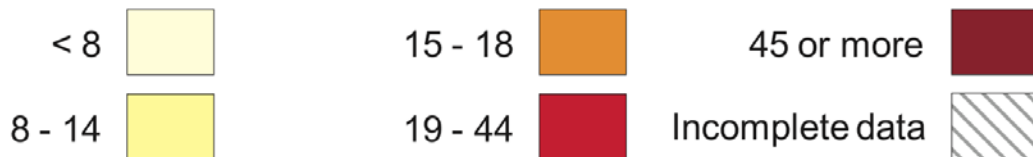
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



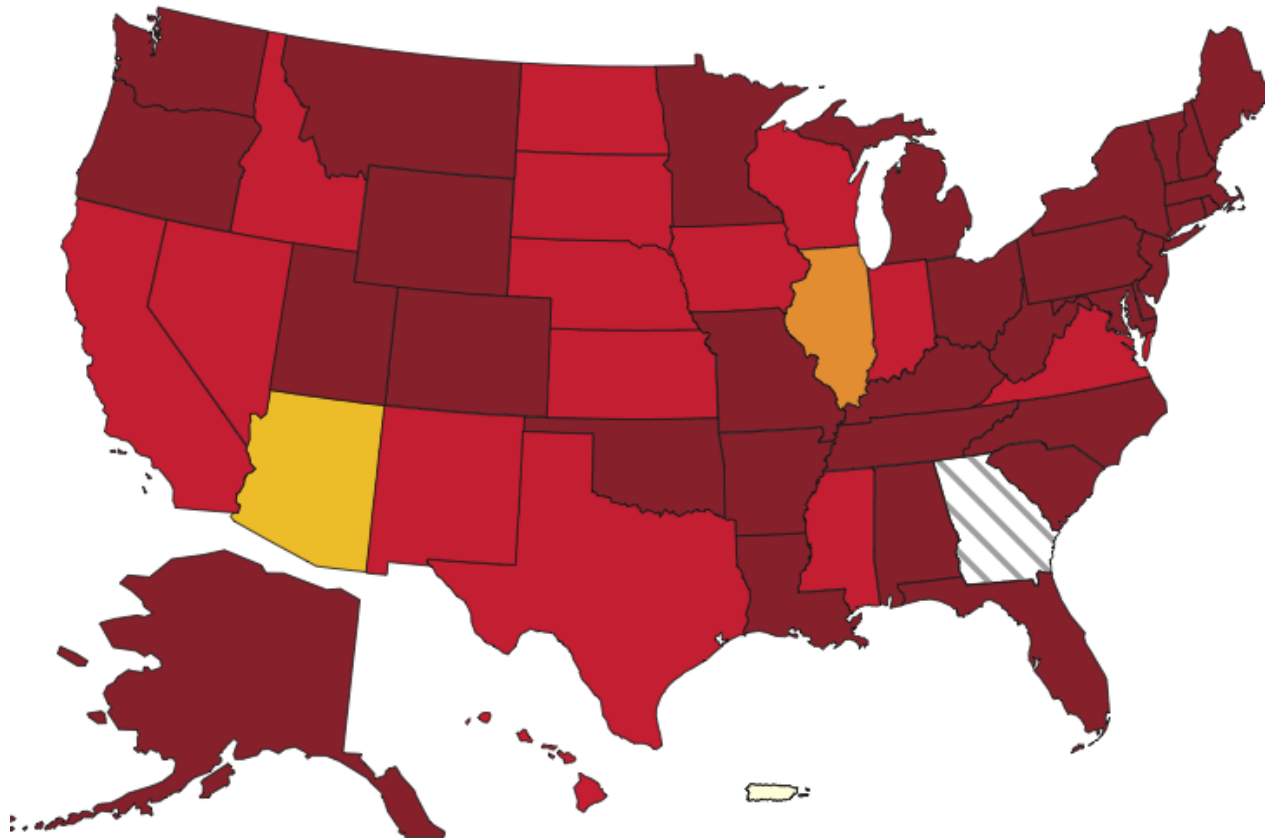
2007

(range 1 – 340)



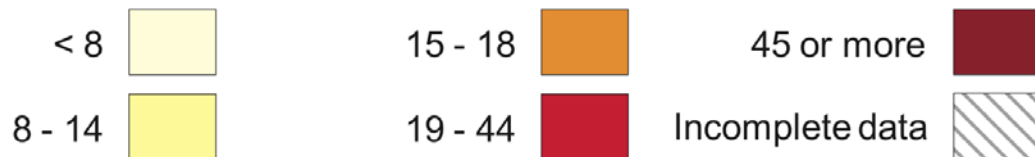
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)



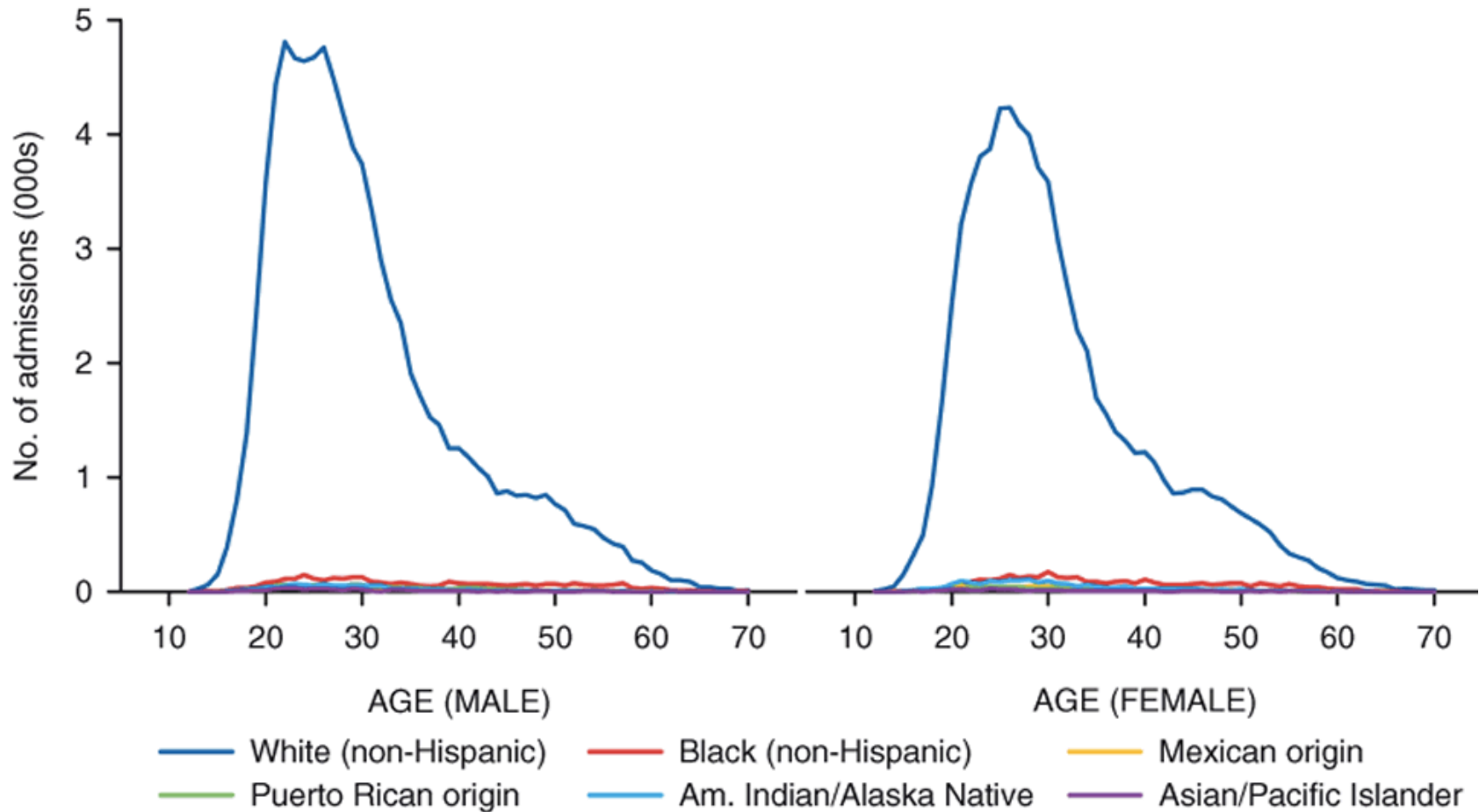
2009

(range 1 – 379)



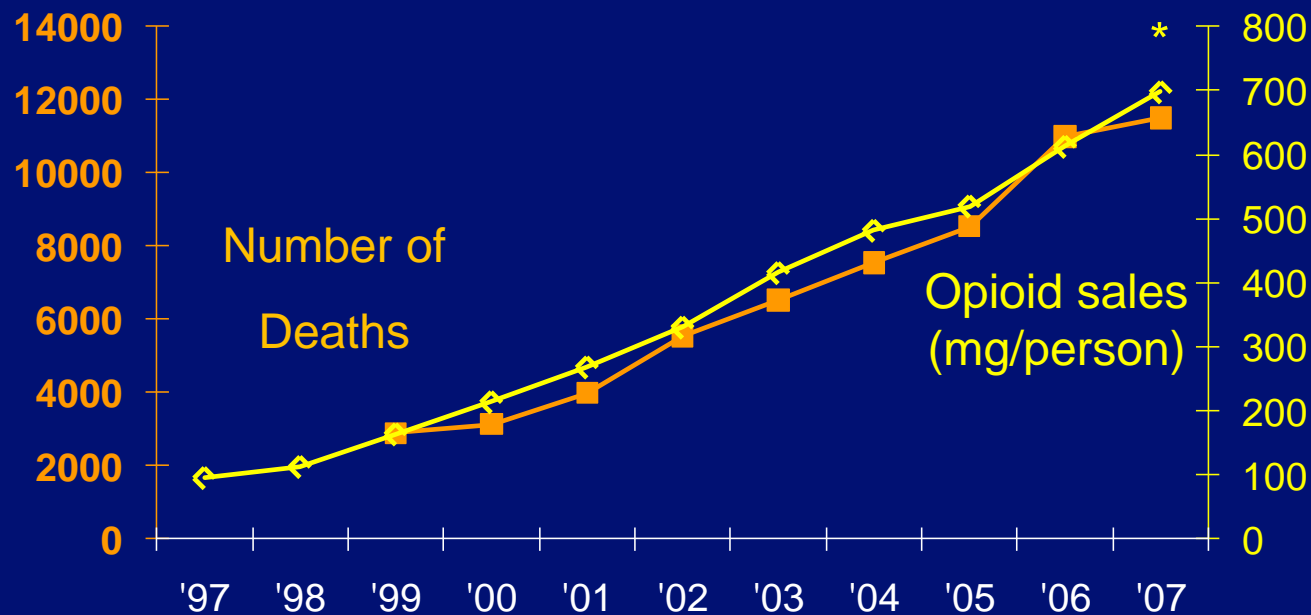
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.

Figure 9. Non-heroin opiate admissions, by gender, age, and race/ethnicity: 2011



SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.10.11.

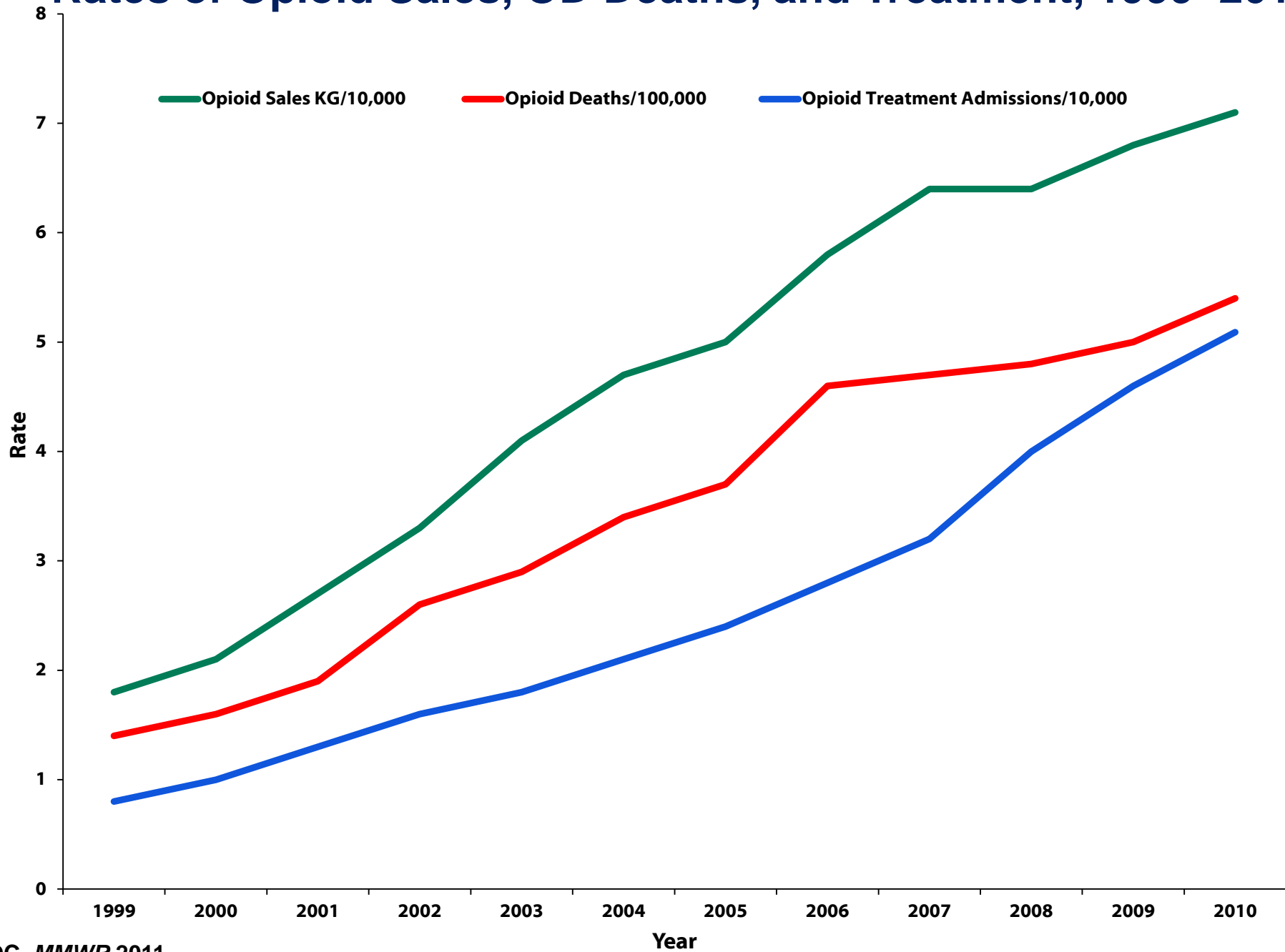
Unintentional overdose deaths involving opioid analgesics parallel per capita sales of opioid analgesics in morphine equivalents by year, U.S., 1997-2007



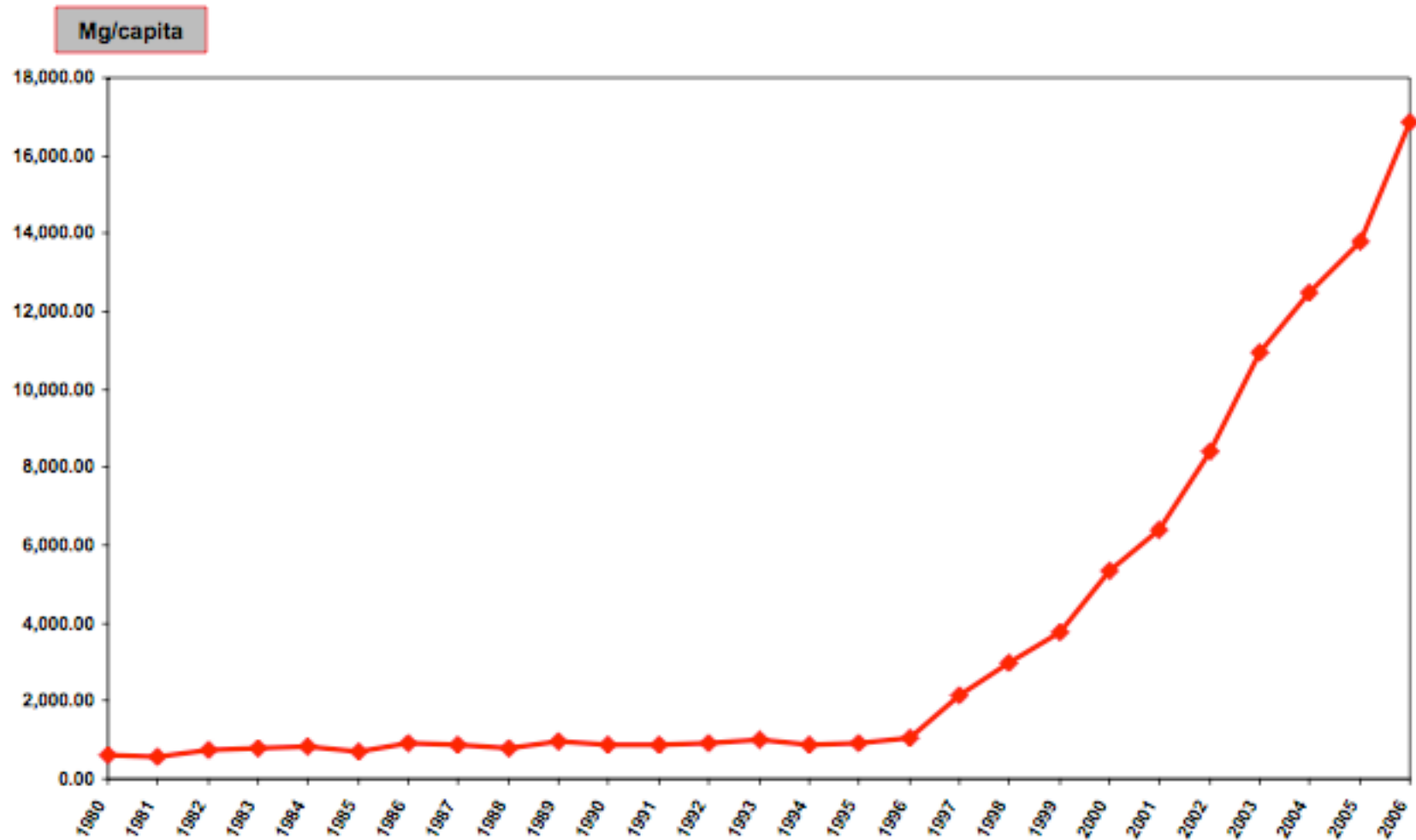
Source: National Vital Statistics System, multiple cause of death dataset, and DEA ARCOS

* 2007 opioid sales figure is preliminary.

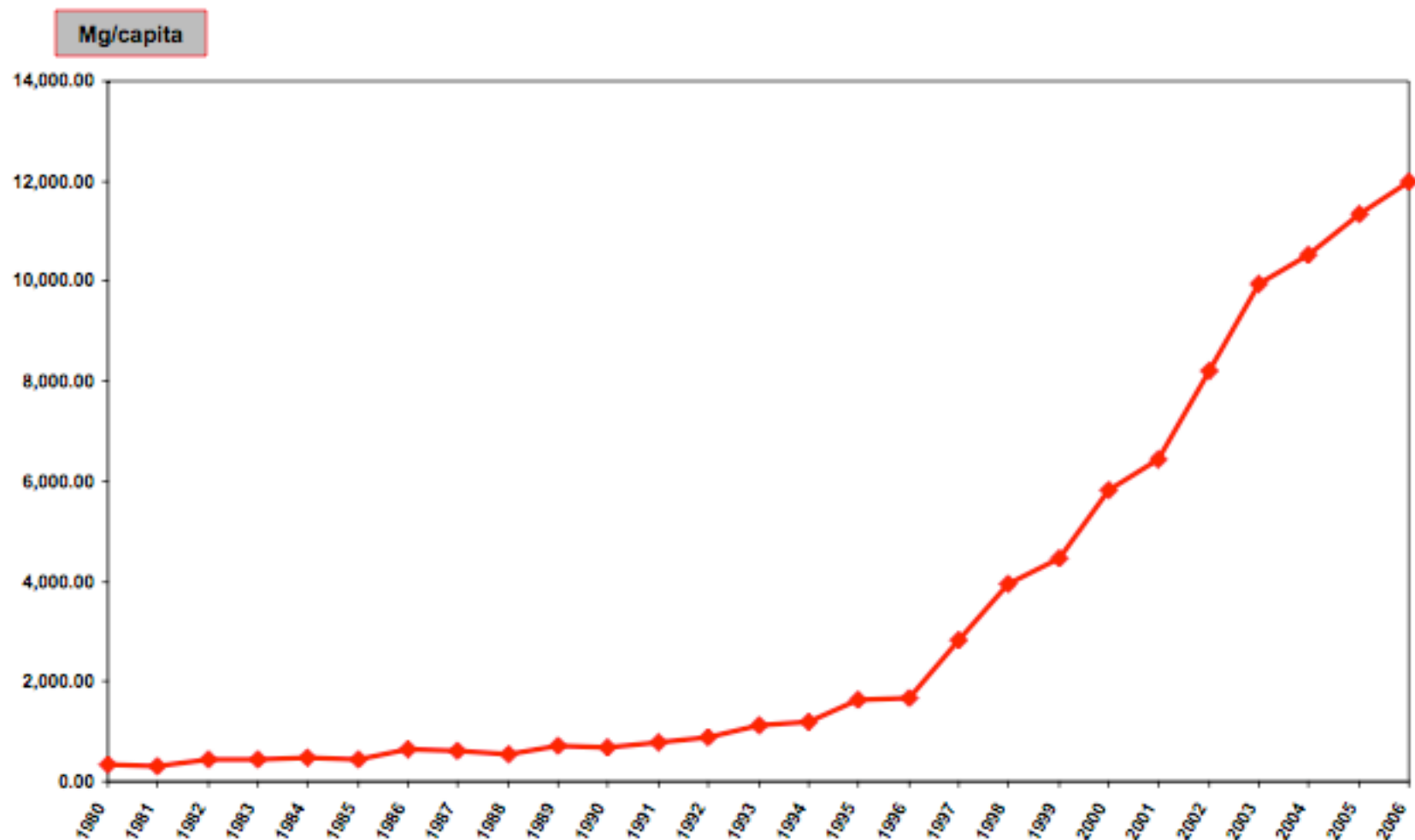
Rates of Opioid Sales, OD Deaths, and Treatment, 1999–2010



New York Consumption of Oxycodone 1980 - 2006



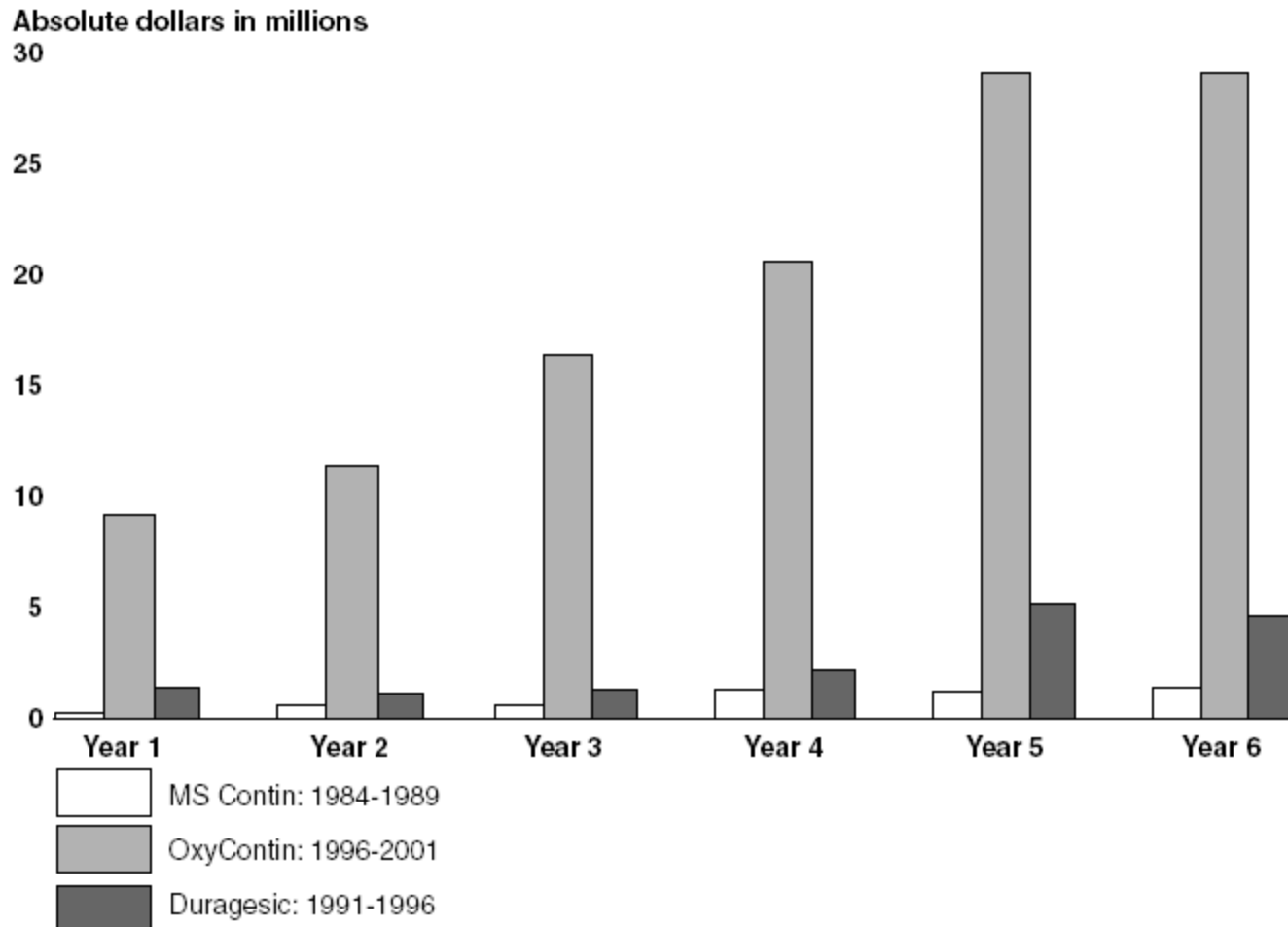
New York Consumption of Hydrocodone 1980 - 2006



Sources: U.S. Dept of Justice, Drug Enforcement Administration, Office of Diversion Control

Dollars Spent Marketing OxyContin (1996-2001)

Figure 1: Promotional Spending for Three Opioid Analgesics in First 6 Years of Sales



Source: United States General Accounting Office: Dec. 2003, "OxyContin Abuse and Diversion and Efforts to Address the Problem."

Industry-funded organizations campaigned for greater use of opioids

- Pain Patient Groups
- Professional Societies
- The Joint Commission
- The Federation of State Medical Boards



Industry-funded “education” emphasizes:

- Opioid addiction is rare in pain patients.
- Physicians are needlessly allowing patients to suffer because of “opiophobia.”
- Opioids are safe and effective for chronic pain.
- Opioid therapy can be easily discontinued.

*“Only four cases of addiction among
11,882 patients treated with opioids”*

Porter J, Jick H. *Addiction rare in patients treated
with narcotics*. N Engl J Med. 1980 Jan
10;302(2):123

Cited 677 times (Google Scholar)

N Engl J Med. 1980 Jan 10;302(2):123.

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients¹ who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,² Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER

HERSHEL JICK, M.D.

Boston Collaborative Drug
Surveillance Program

Waltham, MA 02154

Boston University Medical Center

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

Long-term Opioid Treatment of Nonmalignant Pain

A Believer Loses His Faith

(REPRINTED) ARCH INTERN MED/VOL 170 (NO. 16), SEP 13, 2010
1422

WWW.ARCHINTERNMED.COM

Annals of Internal Medicine

EDITORIAL

Chronic Noncancer Pain Management and Opioid Overdose: Time to Change Prescribing Practices

BMJ

Facing up to the prescription opioid crisis

Deaths resulting from prescription opioids tripled in the United States between 1999 and 2007 and are also increasing in many other countries, including the United Kingdom. **Irfan A Dhalla**, **Navindra Persaud**, and **David N Juurlink** describe how this situation developed and propose several ways to reduce morbidity and mortality from opioids

BMJ 2011;343:d5142 doi: 10.1136/bmj.d5142

Annals of Internal Medicine

IDEAS AND OPINIONS

Long-Term Opioid Therapy Reconsidered

Michael Von Koff, ScD; Andrew Kolodny, MD; Richard A. Davis, MD, MPH; and Roger Chou, MD



The NEW ENGLAND JOURNAL of MEDICINE

A Flood of Opioids, a Rising Tide of Deaths

Susan Okie, M.D.

Viewpoint

EXPAND

Patient Satisfaction, Prescription Drug Abuse, and Potential Unintended Consequences

Aleksandra Zgierska, MD, PhD; Michael Miller, MD; David Rabago, MD

JAMA®

The Journal of the American Medical Association

“I think that after 20 years of a failed experiment that there are not many people supporting this except for the die-hards and the pharmaceutical industry.”

**Jane C. Ballantyne, MD FRCA
Professor, Univ. of Washington**

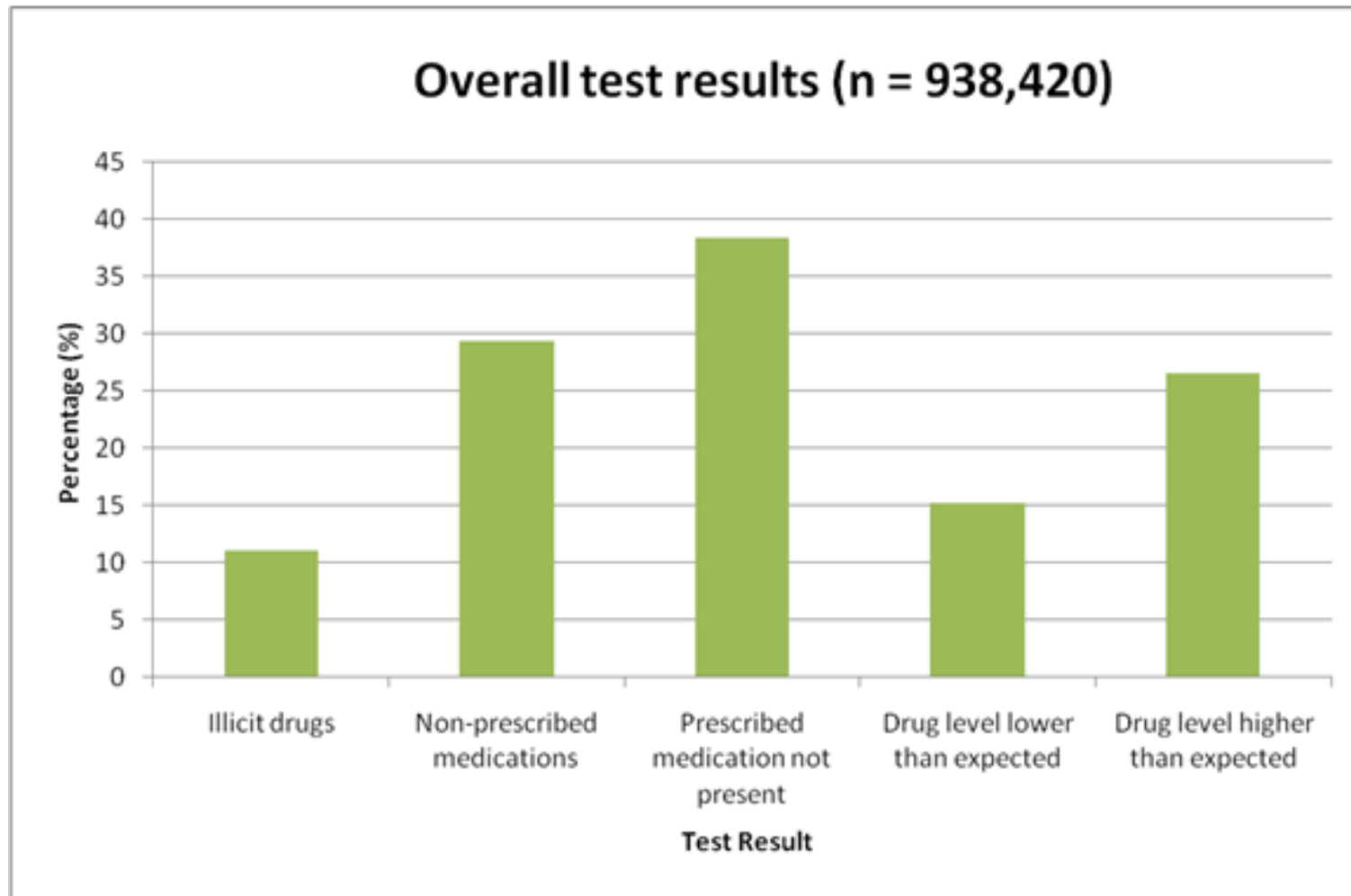
Source: *New York Times*, April 9, 2012. *“Tightening the Lid on Pain Prescriptions”*.

The Emperor's New Paradigm:

Patient Selection, Risk Stratification & Monitoring



Urine Tox Results in Chronic Pain Patients on Opioid Therapy



Source: Couto JE, Goldfarb NI, Leider HL, Romney MC, Sharma S. High rates of inappropriate drug use in the chronic pain population. *Popul Health Manag.* 2009;12(4):185–190.

Controlling the epidemic:

A Three-pronged Approach

- Primary Prevention- prevent new cases of opioid addiction.
- Secondary Prevention- provide people who are addicted with effective treatment.
- Supply control- Medical board & law enforcement efforts to reduce over-prescribing and black-market availability.

Opioid manufacturers continue to advertise opioids as safe and effective for chronic pain.

FREEDOM FROM PAIN!

Extra strength pain relief free of extra prescribing restrictions.

- Telephone prescribing in most states
- Up to five refills in 6 months
- No triplicate Rx required

Excellent patient acceptance.
In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.¹

COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalog 192. The medical approach to management of pain caused by cancer. Series. Clinol. 1975; 2: 379-92 and Fleisher JL, et al. The chronic pain syndrome: mechanisms and management. Ann. Intern. Med. 1980; 93: 95.

The heritage of VICODIN[®] over a billion doses prescribed.²

- VICODIN ES provides greater central and peripheral action than other hydrocodone/acetaminophen combinations.
- Four to six hours of extra strength pain relief from a single dose
- The 14th most frequently prescribed medication in America²

vicodin ES[®]

hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg

Tablet for tablet, the most potent analgesic you can phone in.

* (hydrocodone bitartrate 5 mg (Warning: May be habit forming) and acetaminophen 500mg)
1. Data on file, Knoll Pharmaceuticals
2. Standard industry new prescription audit

Please see brief summary of prescribing information on adjacent page.

Maintain control of your patient's therapy.

Rx Specify
Do not substitute

vicodin ES[®]

(hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg)

It's your prescription – not a suggestion.

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain. **CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone. **WARNINGS:** Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression. Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions:** The administration of narcotics may also obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PREGCAUTIONS: Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hyperplasia or urethral stricture. **Cough Reflex:** Hydrocodone suppresses the cough reflex, as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. **Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anxiolytics, sedatives, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAOI inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Usage in Pregnancy:** Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic Effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, vomiting, yawning, and fever. **Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Warning Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more pronounced in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above). However, some phenothiazine derivatives seem to be antianalgesic, and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** Urinary spasm, spasm of vesical sphincter and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be relieved and approximated by the use of sodium hydroxide. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substances Act (Schedule II). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. **OVERDOSEAGE:** Acetaminophen Signs and Symptoms: In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemia, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised March 1992

Knoll Pharmaceuticals
A Unit of BASF K&F Corporation
Whippany, New Jersey 07981

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This is a false dichotomy

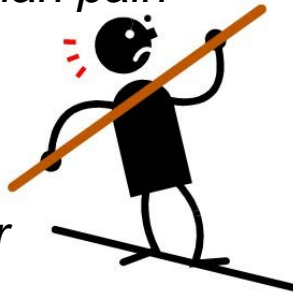
Aberrant drug use behaviors are common in pain patients

Pain Patients

35% met DSM V criteria for addiction²

63% admitted to using opioids for purposes other than pain¹

92% of opioid OD decedents were prescribed opioids for chronic pain.



“Drug Abusers”

1. Fleming MF, Balousek SL, Klessig CL, Mundt MP, Brown DD. Substance Use Disorders in a Primary Care Sample Receiving Daily Opioid Therapy. J Pain 2007;8:573-582.

2. Boscarino JA, Rukstalis MR, Hoffman SN, et al. Prevalence of prescription opioid-use disorder among chronic pain patients: comparison of the DSM-5 vs. DSM-4 diagnostic criteria. J Addict Dis. 2011;30:185-194.

3. Johnson EM, Lanier WA, Merrill RM, et al. Unintentional Prescription Opioid-Related Overdose Deaths: Description of Decedents by Next of Kin or Best Contact, Utah, 2008-2009. J Gen Intern Med. 2012 Oct 16.

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