Opioid Addiction and the Dental Patient

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Deadly Epidemic: Rx Drug Overdoses

• In the past 11 years, deaths from overdose increased more than 400 percent among women, compared with a 265 percent rise among men.

• Americans consume 80 percent of opiate painkillers produced in the world, according to the American Society of Interventional Pain Physicians.
Millions of Opioid Prescriptions Go to 'Doctor Shoppers'

- Nearly 2% of all US opioid prescriptions, totaling an estimated 4.3 million prescriptions each year and 4% of all opioids by weight, are purchased by patients presumed to be "doctor shoppers," according to a new study. In the first national estimate of opioid medications obtained in the United States by the doctor shoppers — patients who receive painkiller prescriptions from multiple doctors without informing the doctors of their other prescriptions — researchers found that they obtained, on average, 32 opioid prescriptions per year from 10 different prescribers.
"But Doc! I Really Hurt! "
Dopamine Pathways – Pleasure pathways

- Frontal cortex
- Nucleus accumbens
- Striatum
- Hippocampus
- Substantia nigra/VTA

Substances:
- Cocaine
- Heroin
- Nicotine
- Amphetamines
- Opiates
- THC
- PCP
- Ketamine
- Alcohol
- Benzodiazepines
- Barbiturates
Many Things Are Happening During the Transition Between Voluntary Drug Use and Addiction…
Compulsive Drug Use (Addiction)

Voluntary Drug Use
What is the switch for addiction?

What are the adaptive changes that occur in the brain that turn on addiction?
Events...It’s Likely That the Transition Involves Both Learning and Memory

Drug Use

Addiction

...and Cellular Adaptations
Pain Management vs. Patient Management

• Acute Pain
• Chronic Pain
• The Patient with the Pain
The International Association for the Study of Pain

• "an unpleasant sensory and emotional experience associated with actual or potential tissue damage...“

• **Pain is subjective in nature and is defined by the person experiencing it**

• Understanding of chronic pain now includes the impact that the mind has in processing and interpreting pain signals.
WHO 3-step ladder

1 mild
- ASA
- Acetaminophen
- NSAIDs

2 moderate
- A/Codeine
- A/Hydrocodone
- A/Oxycodone
- A/Dihydrocodeine

3 severe
- Morphine
- Hydromorphone
- Methadone
- Levorphanol
- Fentanyl
- Oxycodone
± procedures
Mark Twain:

"It ain't what you don't know that gets you into trouble. It's what you know for sure that just ain't so."
Things we “know” that aren’t so

- If there is real pain, developing opiate dependence is rare- Not True!
- If is a legitimate Prescribed Drug it is safe- Not True!
- Even if they had past issues with drugs (or alcohol) if they need it then they ought to get it, just be careful- Haven’t seen this work too well
Risk Factors for opiate abuse

• History of alcohol or drug abuse
  – History of physical/sexual abuse
  – History of depression/anxiety
  – Current chaotic living environment
  – History of criminal activity
Risk Factors for opiate abuse

– Prior failed treatment at a pain management program
– Regular tobacco use
– Regular alcohol use
– Multiple injuries or surgeries
– Family history of drug abuse
“It is more important to know what kind of patient has a disease... than what kind of disease a patient has”
Definitions

Acute Pain

– Acute pain is the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It is generally time-limited.
Acute Pain

- Broken bones
- Dental “issues”
- Incisions
- Burns
- Kidney Stones
- Childbirth
- Damaged or disrupted tissue
SOMETIMES YOU THINK...

• You are darned if you do and
• You are darned if you don’t
• Write that Rx
As a healthcare professional

• You have a legal and ethical responsibility to uphold the law and to help protect society from drug abuse.

• You have a professional responsibility to prescribe controlled substances appropriately, guarding against abuse while ensuring that your patients have medication available when they need it.
And...

- You have a personal responsibility to protect your practice from becoming an easy target for drug diversion. You must become aware of the potential situations where drug diversion can occur and safety guards that can be enacted to prevent this diversion.
Not easy!

• While stereotypes from popular culture might suggest that a drug seeker would be easy to recognize, the truth is that regardless of income, race, gender, or employment status, a potential abuser or "doctor shopper" may be difficult to identify. As a dentist, a health care provider, what is the best way to guard against this behavior?
Office staff training also:

• Train staff to recognize and alert you to questionable patient demeanor. The first person to address a patient is usually the receptionist. By knowing the drug seeking characteristics, he or she should be able to identify a patient who exhibits drug-seeking behavior.
Common Characteristics of the Drug Abuser:

• Unusual behavior in the waiting room;

• Assertive personality, often demanding immediate action;

• Unusual appearance - extremes of either slovenliness or being over-dressed;

• May show unusual knowledge of controlled substances and/or gives medical history with textbook symptoms OR gives evasive or vague answers to questions regarding medical history;
Common Characteristics of the Drug Abuser:

• Reluctant or unwilling to provide reference information. Usually has no regular doctor and often no health insurance;

• Will often request a specific controlled drug and is reluctant to try a different drug;

• Generally has no interest in diagnosis - fails to keep appointments for further diagnostic tests or refuses to see another practitioner for consultation;
Common Characteristics of the Drug Abuser:

- May exaggerate medical problems and/or simulate symptoms;
- May exhibit mood disturbances, suicidal thoughts, lack of impulse control, thought disorders, and/or sexual dysfunction;
- Cutaneous signs of drug abuse - skin tracks and related scars on the neck, axilla, forearm, wrist, foot and ankle. Such marks are usually multiple, hyper-pigmented and linear. New lesions may be inflamed. Shows signs of "pop" scars from subcutaneous injections.
What You Should Do When Confronted by a Suspected Drug Abuser

• **DO:**
  • perform a thorough examination appropriate to the condition.
  • document examination results and questions you asked the patient.
  • request picture I.D., or other I.D. and Social Security number. Photocopy these documents and include in the patient's record.
What You Should Do When Confronted by a Suspected Drug Abuser

• Do:
  • call a previous practitioner, pharmacist or hospital to confirm patient's story.
  • confirm a telephone number, if provided by the patient.
  • confirm the current address at each visit.
  • write prescriptions for limited quantities.
What You Should Do When Confronted by a Suspected Drug Abuser

DON'T:

• "take their word for it" when you are suspicious.
• dispense drugs just to get rid of drug-seeking patients.
• prescribe, dispense or administer controlled substances outside the scope of your professional practice or in the absence of a formal practitioner-patient relationship.
How to Discuss Drug Issues with a Patient

Suggestions from Greg Jones, MD
Medical Director at the KY Physicians Health Foundation
Educational Need/Practice Gap

Many Healthcare Professionals are uncomfortable discussing alcohol and drug use with their patients. Optimal healthcare requires this information for good clinical decisions.

We all need to improve our comfort and skill set in having these discussions. And in recognition of pertinent findings.
Why bother?
The patient is the one With the problem
Usual Way of Discussing Addiction Issues

• Never ask- Probably most common way
• Do you have a drinking or drug Problem?
• Or You don’t have a drinking or drug problem do you?
• How much do you drink?
• How much drug do you use?
“I’ve never had a problem with drugs. I’ve had problems with the police.”

Keith Richards
Dr. J’s 1st law of Addiction Medicine

The level of Denial is proportional to the obvious and measurable damage done by their drinking or drug use.

*Corollary- Denial increases if confronted with the evidence
Dr. J’s 2\textsuperscript{nd} law of Addiction Medicine

There is an inverse and proportional relationship between the degree of conviction a patient has in their dx and the likelihood it exists.
So what on Earth am I supposed to do!

- Ask the questions
- And in the course of your usual Hx taking
- Any hint of judgmental or disapproving attitude and the useful conversation is over
How to Ask It

• Don’t make a **Big Deal** out of it. It is very important, but so are many things we routinely discuss with our patients.

• Include it as part of the overall conversation.

• Make sure the person understands you are not judging you just need accurate information to care for them.
Which drugs are we talking about?

- Tobacco
- Alcohol
- Opiates
- Benzodiazepines/ Z-drugs
- Cannabis
- Cocaine
- Amphetamines (includes Rx’d and other stimulants like Ritalin)

(Tramadol, Lyrica, Provigil...don’t forget)
Willingway Drug Rule

When old drugs become addictive, they are replaced with new non-addictive drugs. When the new drugs become addictive and are replace by new non-addictive drugs.

Adapted from the *Recovery Book*
What to Ask

• Ask do you drink? Or use drugs?
• Ask when was the last time you ....
• Are you concerned about your drinking or drug use?
• Have you considered doing something different with your drinking or drug use?
• Ever have times you drank or used more than you intended too?
Then….

• Do you recall how old you were when you first used alcohol or another drug?
• Do you recall any of your family members having issues with alcohol or other drugs?
• “How many times in the past year have you had X or more drinks in a day?”, where X is 5 for men, 4 for women
• Used to get high?
What if they complain of Pain?

• Ask what is the pain preventing them from doing? Not – How bad is the pain?
• Pain scales are not helpful.
• Ask about things they are able to do.
• Ask how they first came to have the pain.
• Ask how long the pain has been present.
• Ask about prior evaluations.
• Ask about prior treatment.
Red Flags

• The “Call Brand”
• Anytime they mention or ask for a specific drug by name...
• Having more than one doctor.
• Having more than one pharmacy.
• Being on more than one class of controlled substance.
• They brought their films.
• Work or disability related.
Get A KASPER i.e. Use your PDMP!

- How many classes of drugs
- How many prescribers
- Overlapping?
- How many Pharmacies?
- Amount and frequency?
Prescription Painkiller Prescribing Dropped After New Kentucky Law Implemented

• The law requires prescribers to register with the state’s prescription drug monitoring database, and gives law enforcement easier access to it.

• Rates of prescribing for oxycodone and hydrocodone have dropped.

• Between August 2012 and May 2013, the number of hydrocodone doses decreased by 9.5 percent, and oxycodone doses dropped by 10.5 percent.
So you are fixin’ to Rx a controlled substance – eyes OPEN!
Michael Osswald

Photo: Louisville Metro Police Department, December, 2012
Michael Osswald

• Police believe Michael Osswald had a good con going for a while: He would visit a dentist, complain of tooth pain, and receive a prescription for painkillers.

• According to arrest warrant Osswald visited 28 dentists in four months and received 541 hydrocodone during three of those months.

• As a result of HB1, the targets of Osswald’s alleged scams were able to see the Louisvillian had received prescriptions from other dentists, and at least one alerted police, said Sgt. John McGuire of the Louisville Metro Police Department’s prescription drug diversion unit.

• Osswald charged with 22 counts of obtaining a controlled substance by fraud.

Story: Mark Vanderhof, Louisville Courier-Journal, December 10, 2012
And....

• Utilize your local pharmacists
• Thank you!
Questions?

For further information:
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Providers’ Clinical Support System for Opioid Therapies (PCSS-O)

Providers’ Clinical Support System for Opioid Therapies (PCSS-O) is a collaborative project led by American Academy of Addiction Psychiatry with: American Dental Association, American Medical Association, American Osteopathic Academy of Addiction Medicine, American Psychiatric Association, American Society for Pain Management Nursing, and International Nurses Society on Addictions.

Goal: To develop evidence-based educational resources (webinars, online modules and listserv) offered at no cost to health professionals in the treatment of chronic pain and/or opioid related addiction.

For more information, please visit: www.pcss-o.org