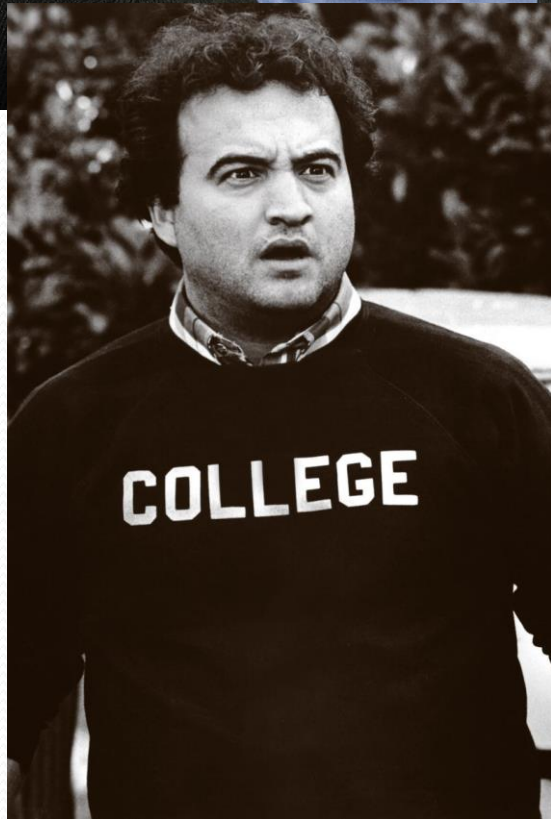


# A multifaceted approach to opioids with PPP (Police, Patient, and Physician)

Charles Opperman, MD  
Grand Rounds – 5/20/16











*You don't want your name on this pill bottle.*

# Interesting statistics

- The US makes up less than 5% of the world population. We utilize 80% of the world's prescription opiates.
- 3 people will die of opiate overdose in the US during this lecture (every 19 minutes)
  - The majority from prescription Rx (Oxy, Vicodin, etc)
- 80% of heroin users start by using prescription Rx
- **91% of people who experienced an overdose were still able to get another opioid Rx (usually from same doctor)**

# How did we get here?

- Until the latter part of the 1990s, use of long-term opioid therapy for chronic noncancer pain (CNCP), or pain lasting beyond 3 months, was effectively prohibited in most states.
- **Chronic use of opioid analgesics in non-malignant pain: report of 38 cases (1986)**
  - Portenoy and Foley – *Pain*
  - Led to pain as the 5<sup>th</sup> vital sign initiative



# Portenoy study

- **Chronic use of opioid analgesics in non-malignant pain: report of 38 cases.**
- ***Pain* – May 1986**
- **38 patients with non-malignant pain were evaluated retrospectively**
  - 12 – oxycodone
  - 7 – methadone
  - 5 - levorphanol
  - Others - propoxyphene, meperidine, codeine, pentazocine, or some combination of these drugs
  - 19 patients – treated for >4 years at evaluation
  - 6 patients – treated for > 7 years at evaluation
- **2/3rds of patients required <20 morphine equivalents mg/day**
- **Only 4 patients in study took >40mg/day**

# Portenoy study - results

- 38 patients
  - 24 (63%) - partial but acceptable or fully adequate relief of pain
  - 14 (37%) – inadequate relief
  - 2 (5%) – “management became a problem. Both had a history of drug abuse.”
- “Few substantial gains in employment or social function could be attributed to the institution of opioid therapy”
- “**We conclude** that opioid maintenance therapy can be a safe, salutary and more humane alternative to the options of surgery or no treatment in those patients with intractable non-malignant pain and no history of drug abuse.”
  - Interpreted in other words (mine) – We provided a drug that caused destruction to 5% of the people, helped “*a few*,” failed to help nearly 40%.

“We conclude that hot dogs DO  
NOT cause cancer.”



# Pain as the 5<sup>th</sup> vital sign



- Dr. Portenoy
  - American Pain Foundation – director
  - American Pain Society- President
    - Established pain as a 5<sup>th</sup> vital sign
- Late 1990's
  - “Epidemic of untreated pain”
  - Should be monitored alongside HR, BP, RR, and Temp
- 1998 – Federation of state medical boards
  - MD’s wouldn’t face regulatory action for prescribing even large amounts of narcotics, as long as it was in the course of medical treatment
- Effective Jan 1<sup>st</sup>, 2001 - Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
  - all patient care organizations accredited by JCAHO must address a patient’s pain
- 2004 - called on state medical boards to make under-treatment of pain punishable for the first time.
  - Policy drawn up with help by Purdue Pharma (makers of OxyContin)

# Pain as the 5<sup>th</sup> vital sign

- “Vital Signs are taken seriously. If pain were assessed with the same zeal as other vital signs are, it would have a much better chance of being treated properly. We need to train doctors and nurses to treat pain as a vital sign. Quality care means that pain is measured and treated.”

- James Campbell, MD

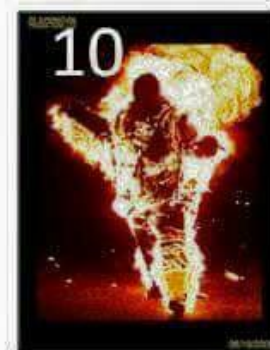
Presidential address, American Pain Society

November 11<sup>th</sup>, 1996

# Pain as a 5<sup>th</sup> vital sign

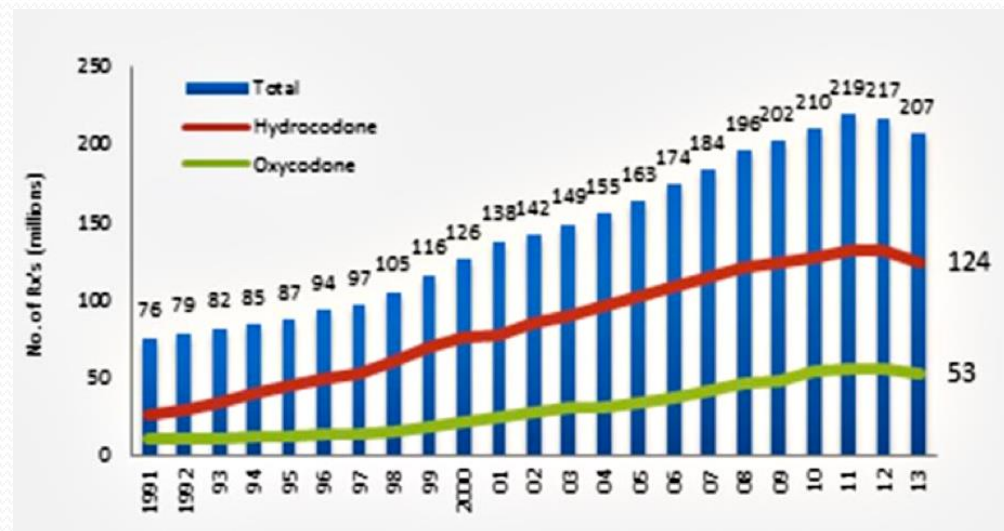
- Excerpt from VA Pain as a 5<sup>th</sup> Vital Sign Toolkit:
  - Under FAQ's – potential scripts the MD can use for certain responses:
- Q. *My Pain is a 15.*
- A. You must be in a lot of pain to select 15 on a 10 point scale. We like to use the scale to measure progress in the pain medications and treatment you receive. Let's look at the scale again and think of the number 10 as the worst pain imaginable and 0 as a time in your life when you had not pain at all. Now, try the scale again.

# The Larsen Pain Scale



# Opiate Rx then and Now

- 76 million total Rx in 1991, 207 million in 2013
- Hydrocodone products in 2014 = 119.2 million Rx
  - #2 prescribed drug (#1 was levothyroxine at 120 million)
- Suboxone in 2014 = #17 prescribed non-generic (#1 = Synthroid)
  - Viagra = #16, Novolog products = #35,36





# Purdue Pharma

- 1996-2001
  - national pain management and speaker-training conferences at resorts in Florida, Arizona, and California.
  - More than 5000 physicians, pharmacists, and nurses attended these all-expenses-paid symposia
- Numerous studies showing OxyContin to be equal and not superior to other opiates
- 2004- OxyContin was #1 abused drug
  - Claimed addiction rate was negligible
  - Perry and Heidrich = 0/10,000 burn patients
  - Porter and Vick = 4/11,882
    - Both studies done on acute pain, not chronic long-term therapy
- Other studies show...
  - Fishbain et al. = 3-18%
  - Hoffmann et al. = 23%
  - Kouganou et al. = 12%
  - Chabal et al. = 34%
  - Katz et al. = 43%
  - Reid et al. = 24-31%
  - Michan et al. 45%
- General consensus is lifetime addiction rate on chronic opioids is between 3-16% (NIMH epidemiologic Catchment Area Program)
- **May 2007 – 3 company executives plead guilty to criminal charges of misbranding OxyContin by claiming it was “less addictive” than other opioids**



# Dr. Portenoy

“I gave innumerable lectures in the late 1980s and '90s about addiction that weren't true”

Dr. Portenoy said it was “quite scary” to think how the growth in opioid prescribing driven by people like him had contributed to soaring rates of addiction and overdose deaths.

“Did I teach about pain management, specifically about opioid therapy, in a way that reflects misinformation? Well, against the standards of 2012 goes, I did”

“we didn't know then what we know now.”

# JACHO Standards

- Recognize the right of patients to appropriate assessment and management of pain
- Screen for the presence and assess the nature and intensity of pain in all patients
- Record the results of the assessment in a way that facilitates regular reassessment and follow-up
- Determine and ensure staff competency in pain assessment and management (e.g., provide education), and address pain assessment and management in the orientation of all new clinical staff
- Establish policies and procedures that support the appropriate prescribing or ordering of pain medications
- Ensure that pain does not interfere with a patient's participation in rehabilitation
- Educate patients and their families about the importance of effective pain management
- Address patient needs for symptom management in the discharge planning process
- Incorporate pain management into performance review activities (i.e., establish a means of collecting data to monitor the appropriateness and effectiveness of pain management)


# Clarification of the Pain Management Standard

Provision of Care, Treatment, and Services Standard PC.01.02.07 addresses the assessment and management of pain. The Joint Commission has always held the position that pain may be managed by using pharmacologic and/or nonpharmacologic strategies. Following an extensive literature review, Joint Commission staff enhanced Standard PC.01.02.07 by revising or adding the rationale and adding a note to element of performance (EP) 4. These clarifications affirm that organizations' treatment strategies may consider both pharmacologic and nonpharmacologic approaches, as well as the benefits and risks to patients, when determining the most appropriate intervention. They also note to include the risks of dependency, addiction, and abuse of opioids when considering the use of medications to treat pain.

Staff convened conference calls with clinical experts and stakeholders in pain management to acquire feedback on this clarification as well as information on the future direction of

pain management. The experts recommended some editorial changes and affirmed that the note and rationale add to the strength of the requirements.

The revised (or added) rationale and the revised EP 4 are shown in the box below. The revisions are **effective January 1, 2015**, and appear in the *2014 Update 2* to the *Comprehensive Accreditation Manuals* for the **ambulatory care, critical access hospital, home care, hospital, nursing care centers, and office-based surgery programs**. Similar revisions are also scheduled for the behavioral health care program (in the "Care, Treatment, and Services" chapter) with a July 1, 2015, effective date and will be published closer to that date.

For more information, please contact Emi Datuin-Pal, associate project director, Department of Standards and Survey Methods, The Joint Commission, at [bdatuin-pal@jointcommission.org](mailto:bdatuin-pal@jointcommission.org). 

Joint Commission



Requirement

## Clarification to Standard PC.01.02.07

**Effective January 1, 2015**, for Ambulatory Care, Critical Access Hospital, Home Care, Hospital, Nursing Care Centers, and Office-Based Surgery Practice Programs

**Standard PC.01.02.07:** The [organization] assesses and manages the [patient's] pain.




### Revised Rationale for PC.01.02.07 (New for Ambulatory Care and Office-Based Surgery Practice)

The identification and management of pain is an important component of [patient]-centered care. [Patients] can expect that their health care providers will involve them in their assessment and management of pain. Both pharmacologic and nonpharmacologic strategies have a role in the management of pain. The following examples are not exhaustive, but strategies may include the following:

- Nonpharmacologic strategies: physical modalities (for example, acupuncture therapy, chiropractic therapy, osteopathic manipulative treatment, massage therapy, and

physical therapy), relaxation therapy, and cognitive behavioral therapy

- Pharmacologic strategies: nonopioid, opioid, and adjuvant analgesics

**C EP 4:** The [organization] either treats the [patient's] pain or refers the [patient] for treatment.   

### New Note for EP 4 (Additional Note for Nursing Care Centers)

**Note:** *Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect a [patient]-centered approach and consider the patient's current presentation, the health care providers' clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.*

# Chronic Pain definition

Pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three continuous months.

# The data for prescription opioids

- Efficacy of opioids for chronic pain: a review of the evidence
  - **Ballantyne JC**, Shin NS. *Clin J Pain*. 2008
  - “existing evidence suggests that analgesic efficacy, although initially good, is not always sustained during continuous and long-term opioid therapy (months to years).”
  - “Mechanisms for loss of analgesic efficacy proposed are pharmacologic tolerance, opioid-induced hyperalgesia, subtle and intermittent withdrawal, and a number of psychologic factors including loss of the placebo component.”

# The data for prescription opioids

- Medications for Acute and Chronic Low Back Pain: A Review of the Evidence for an American Pain Society/American College of Physicians Clinical Practice Guideline
  - **Chou** and Huffman. *Annals of Internal Medicine*. 2007
  - Review of systematic reviews
    - “We found good evidence that NSAIDs, skeletal muscle relaxants (for acute low back pain), and tricyclic antidepressants (for chronic low back pain) are effective for short-term pain relief.”
    - “We found fair evidence that acetaminophen, tramadol, benzodiazepines, and gabapentin (for radiculopathy) are effective for pain relief.”
    - “good evidence that systemic corticosteroids are ineffective for low back pain with or without sciatica”
    - “For **very severe, disabling pain**, a trial of opioids in appropriately selected patients may be a reasonable option to achieve adequate pain relief and improve function, despite the potential risks for abuse, addiction, and other adverse events”

# What does Up-to-date say?

**OPIOIDS** — The role of opioid therapy in the more severe forms of acute pain and in cancer pain is well established, but opioid administration in chronic noncancer pain remains controversial [29,102,103]. Evidence of benefit with long-term treatment of chronic pain with opioids is lacking [104]. A 2014 systematic review of 39 studies in patients with chronic pain treated with opioids found no evidence of long-term benefit, but found increased risk of serious harm (eg, increased risk of overdose) that was dose dependent [105,106].

Opioid prescriptions for the management of noncancer pain have increased over the last 10 to 20 years, and opioids are the most commonly prescribed class of medication in the United States [107]. In a 2000 to 2001 representative survey of households in the United States, approximately 2 percent of the respondents reported opioid use for at least one month; arthritis and back pain were the most prevalent conditions for which opioids were prescribed [108]. (See "[Cancer pain management: General principles and risk management for patients receiving opioids](#)" and "[Cancer pain management with opioids: Optimizing analgesia](#)" and "[Subacute and chronic low back pain: Pharmacologic and noninterventional treatment](#)".)

**Indications** — For patients with chronic nonmalignant pain, the decision to begin long-term opioid therapy must be weighed carefully. Opioid therapy should be reserved for patients with moderate to severe chronic pain that is having an adverse impact on function or quality of life. (See "[Choice of therapy by type of pain](#)" above.)

- Patients with nociceptive pain syndromes may require opioid therapy if they do not respond to nonopioid analgesics or if their pain is severe at the outset. However, a systematic review and meta-analysis found that the use of opioids in patients with chronic back pain, compared to placebo and non-opioid analgesics, did not result in significant improvement in pain scores [109]. In addition, there was no significant reduction in pain from baseline in an efficacy comparison of different opioids.
- Patients with neuropathic pain may require opioids, but other medications (anticonvulsants and antidepressants) are considered first and second-line, and should be initiated prior to opioid therapy [110].

**Evaluation prior to initiation of opioids** — Before initiating chronic opioid therapy, an assessment of the risks and benefits of therapy for the individual patient should be based upon the history, physical examination, and assessment of the risk of substance abuse, misuse, or addiction [111]. Principles of risk management during opioid treatment for pain are shown in a table (table 6). Screening to identify drug abusers is discussed separately. (See "[Substance use disorder: Principles for recognition and assessment in general medical care](#)".)

A personal or family history of alcohol or drug abuse is the most strongly predictive factor for aberrant drug-related behaviors related to chronic opioid therapy [112]. A personal history of past drug abuse may be considered a contraindication to long-term opioid therapy, although this remains controversial. Guidelines from the American Pain Society and the American Academy of Pain Medicine recommend that patients at high risk be evaluated by a mental health or addiction specialist, and be willing to comply with more frequent and stringent monitoring [113]. The benefit-to-harm evaluation of chronic opioid therapy should be considered and documented on an ongoing and periodic basis during treatment with chronic opioids.

Guidelines that have been established for opioid therapy should be followed closely [113]. Patients should be closely monitored, especially after initiation of opioid therapy as the risk for an adverse event is greatest shortly after initiation [114]. Additionally, patients receiving higher doses are at increased risk for overdose. Doses should be adjusted in a goal-directed manner, with increases dependent upon clearly demonstrable functional improvement [115].

Prior to initiating chronic opioid therapy, patients should be assessed by their clinician for the psychological impact that pain is having on their lives, for possible psychological comorbidity that may be interfering with treatment, and for the risk of opioid addiction. Referral to a trained mental health professional should be considered, and is a component of routine evaluation prior to initiating chronic (>three months) opioid therapy in several pain center programs. Ongoing psychologic support should be available to all patients requiring chronic opioid therapy. The dispensation of drugs and associated follow-up should be performed by a single clinician and pharmacy, allowing maximum consistency and continuity of treatment.

It is important for clinicians to understand the difference between the terms "physical dependence," "tolerance," and "addiction" when prescribing opioids.

- Physical dependence means that the rapid discontinuation of opioid following prolonged administration, usually one month or longer, will result in withdrawal symptoms such as dysphoria, anxiety, and volatility of mood, as well as physical findings such as hypertension, tachycardia, and sweating.
- Tolerance is present when increasing amounts of opioid are required to produce an equivalent level of efficacy.
- Addiction is a form of psychological dependence and refers to the extreme behavior patterns that are associated with procuring and consuming the drug.

None, any, or all of these factors may present in patients who take opioids for prolonged periods of time. A discussion of prescription drug abuse is presented separately. (See "[Prescription drug misuse: Epidemiology, prevention, identification, and management](#)".)

The US Food and Drug Administration is under a Congressional mandate to create Risk Evaluation and Mitigation Strategies (REMS) for abusable prescription drugs in an effort to reduce the rising prevalence of prescription drug abuse [116]. REMS require that the company marketing targeted opioids develop prescriber training and medication guides to reduce the potential for serious adverse outcomes [117]. REMS addressing long-acting and extended-release opioid analgesics have been approved [118].



# Opioids for chronic noncancer pain

A position paper of the American Academy of Neurology



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MPH

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## ABSTRACT

The Patient Safety Subcommittee requested a review of the science and policy issues regarding the rapidly emerging public health epidemic of prescription opioid-related morbidity and mortality in the United States. Over 100,000 persons have died, directly or indirectly, from prescribed opioids in the United States since policies changed in the late 1990s. In the highest-risk group (age 35–54 years), these deaths have exceeded mortality from both firearms and motor vehicle accidents. Whereas there is evidence for significant short-term pain relief, there is no substantial evidence for maintenance of pain relief or improved function over long periods of time without incurring serious risk of overdose, dependence, or addiction. The objectives of the article are to review the following: (1) the key initiating causes of the epidemic; (2) the evidence for safety and effectiveness of opioids for chronic pain; (3) federal and state policy responses; and (4) recommendations for neurologists in practice to increase use of best practices/universal precautions most likely to improve effective and safe use of opioids and to reduce the likelihood of severe adverse and overdose events. *Neurology*® 2014;83:1277–1284

## GLOSSARY

**AAN** = American Academy of Neurology; **CNCP** = chronic noncancer pain; **COAT** = chronic opioid analgesic therapy; **FDA** = Food and Drug Administration; **MCID** = minimum clinically important difference; **MED** = morphine equivalent dose; **PDMP** = Prescription Drug Monitoring Programs; **RCT** = randomized controlled trials; **REMS** = Risk Evaluation and Mitigation Strategies; **VA** = Veterans Affairs.

Until the latter part of the 1990s, use of long-term opioid therapy for chronic noncancer pain (CNCP), or pain was no ceiling on dose, may have been too permissive (e.g., “No disciplinary action will be taken against a prac-

# AAN position paper

“All of this activity emerged in the absence of any clear evidence from clinical trials that opioids could be safely and effectively used in patients with chronic non-cancer pain (CNCNCP).”

## Five Things Physicians and Patients Should Question

1

### Don't perform electroencephalography (EEG) for headaches.

EEG has no advantage over clinical evaluation in diagnosing headache, does not improve outcomes and increases cost. Recurrent headache is the most common pain problem, affecting 15% to 20% of people.

2

### Don't perform imaging of the carotid arteries for simple syncope without other neurologic symptoms.

Occlusive carotid artery disease does not cause fainting but rather causes focal neurologic deficits such as unilateral weakness. Thus, carotid imaging will not identify the cause of the fainting and increases cost. Fainting is a frequent complaint, affecting 40% of people during their lifetime.

3

### Don't use opioid or butalbital treatment for migraine except as a last resort.

Opioid and butalbital treatment for migraine should be avoided because more effective, migraine-specific treatments are available. Frequent use of opioid and butalbital treatment can worsen headaches. Opioids should be reserved for those with medical conditions precluding the use of migraine-specific treatments or for those who fail these treatments.

4

### Don't prescribe interferon-beta or glatiramer acetate to patients with disability from progressive, non-relapsing forms of multiple sclerosis.

Interferon-beta and glatiramer acetate do not prevent the development of permanent disability in progressive forms of multiple sclerosis. These medications increase costs and have frequent side effects that may adversely affect quality of life.

5

### Don't recommend CEA for asymptomatic carotid stenosis unless the complication rate is low (<3%).

Based on studies reporting an upfront surgical complication rate ranging from 2.3% (ACAS) to 3.1% (ACST) among patients undergoing carotid endarterectomy (CEA) for asymptomatic stenosis of >60%, and an absolute risk reduction for stroke or death of roughly 5–6% in the surgical group at 5 years, several specialty societies (Goldstein et al, 2011; Brott et al, 2011; Chaturvedi et al; Ricotta et al) have recommended that surgery for asymptomatic patients should be reserved for those with a perioperative complication risk of <3% and a life expectancy of greater than 3–5 years. The cited 3% threshold for complication rates may be high because more recent studies have reported lower stroke rates with improvements in both surgical (Brott, 2010) and medical (Marquardt) management. However, there are no recent randomized trials comparing these treatments. Given this, the more recent AHA guidelines (Brott 2011) state that it is "reasonable" to perform CEA for asymptomatic patients with >70% stenosis if the surgical complication rate is "low."

Reported complication rates vary widely by location (Kresowik), and are dependent on how complications are tracked (self-report vs. neurologist's evaluation vs. administrative data (Wolff T). Despite calls for rigorous monitoring 15 years ago (Goldstein), most patients will likely need to rely on

# Recent publications regarding opioids

- CDC
  - “CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016” (Mar 2016)
- NEJM
  - “Intensity of Chronic Pain — The Wrong Metric?” (Dec 2015)
  - “Opioid Prescribing for Chronic Pain — Achieving the Right Balance through Education” (Jan 2016)
  - “Trends in Opioid Analgesic Abuse and Mortality in the United States” (Jan 2016)
  - “Relationship between Nonmedical Prescription-Opioid Use and Heroin Use” (Jan 2016)
  - “Opioid Abuse in Chronic Pain — Misconceptions and Mitigation Strategies” (Mar 2016)
  - “A Proactive Response to Prescription Opioid Abuse” (April 2016)
- JAMA
  - “Preventing Prescription Opioid Abuse” (Mar 2015)
  - “Addressing the Opioid Epidemic” (Oct 2015)
  - “Effect of Mindfulness-Based Stress Reduction vs. Cognitive Behavioral Therapy or Usual Care on Back Pain and Functional Limitations in Adults With Chronic Low Back Pain” (Mar 2016)
  - The CDC Guideline on Opioid Prescribing: Rising to the Challenge (April 2016)
- Annals of Internal Medicine
  - “The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop” (Feb 2015)
- Cleveland Clinic Journal of Medicine
  - “Prescribing Opioids Safely” (Mar 2016)
- ACP Hospitalist
  - “The Revolving Door of Opioid Overdose” (Mar 2016)

# CDC guidelines (March 2016)

1. **Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain**
2. Before starting opioid therapy, establish treatment goals. **Only continue if meaningful improvement**
3. Before starting and during therapy, discuss realistic risks and benefits
4. When starting opioids, prescribe immediate release instead of extended release
5. When opioids started, use lowest effective dose
6. **3 days of treatment for acute pain is often enough. More than 7 days is rarely needed.**
7. Should see patient in 1-4 weeks after starting. For continued therapy, every 3 months or more frequently
8. Evaluate risk factors for opiate-related harm. Consider giving naloxone if substantial risk present (>50MME/day, benzo use, hx of OD)
9. Review PDMP prior to starting and every 3 months
10. Use UDS before starting and at least annually for continuation
11. Avoid co-administering benzos
12. Arrange for evidence based treatment (Suboxone, methadone) for opioid use disorder

# Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain  $\geq 3$  months, excluding cancer, palliative, and end-of-life care

## CHECKLIST

### When CONSIDERING long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

### If RENEWING without patient visit

- Check that return visit is scheduled  $\leq 3$  months from last visit.

### When REASSESSING at return visit

**Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.**

- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
  - If  $\geq 50$  MME/day total ( $\geq 50$  mg hydrocodone;  $\geq 33$  mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid  $\geq 90$  MME/day total ( $\geq 90$  mg hydrocodone;  $\geq 60$  mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals ( $\leq 3$  months).

## REFERENCE

### EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

### NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

### EVALUATING RISK OF HARM OR MISUSE

**Known risk factors** include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

**Urine drug testing:** Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

**Prescription drug monitoring program (PDMP):** Check for opioids or benzodiazepines from other sources.

### ASSESSING PAIN & FUNCTION USING PEG SCALE

**PEG score** = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

- Q1:** *What number from 0–10 best describes your **pain** in the past week?*  
0 = “no pain”, 10 = “worst you can imagine”
- Q2:** *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*  
0 = “not at all”, 10 = “complete interference”
- Q3:** *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*  
0 = “not at all”, 10 = “complete interference”



# The data against prescription opioids

- The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention Workshop
  - **Chou** et al. *Annals of Internal Medicine*. 2015.
    - Systematic review of 39 studies
    - >3 months opioid therapy for chronic pain
      - Studies of parental opioids and tramadol excluded
      - Included studies with cancer pain not at end of life
  - “the lack of scientific evidence on effectiveness and harms of long-term opioid therapy for chronic pain is clear and is in striking contrast to its widespread use for this condition and the large increase in prescription opioid-related overdoses”
  - “Accumulating evidence supports the increased risk for serious harms associated with long-term opioid therapy, including overdose, opioid abuse, fractures, myocardial infarction, and markers of sexual dysfunction; for some harms, the risk seems to be dose-dependent.”

# The data against prescription opioids

- Prescription opioid use among patients seeking treatment for opioid dependence.
  - Canfield et al. *Journal of Addiction Med.* 2010
  - Survey of 75 patients admitted for opiate withdrawal
    - Had to meet DSM-IV criteria for opiate dependence
    - Mean age = 32
    - Asked how their opiate “addiction” started
      - 31/75 (41%) – addiction from well-intended pain medication
      - 24/75 (32%) – diverted prescription medication
      - 20/75 (27%) – “street drugs”
        - 90% had purchased “street drugs” at some point in their life
  - “Many treatment-seeking opioid dependent patients first began using licit prescription drugs before obtaining opioids from illicit sources. Later they purchased heroin, which they would come to prefer because it was less expensive and more effective than prescription drugs; however patients who begin taking opioids from the illicit market tend to prefer heroin to a greater extent.”

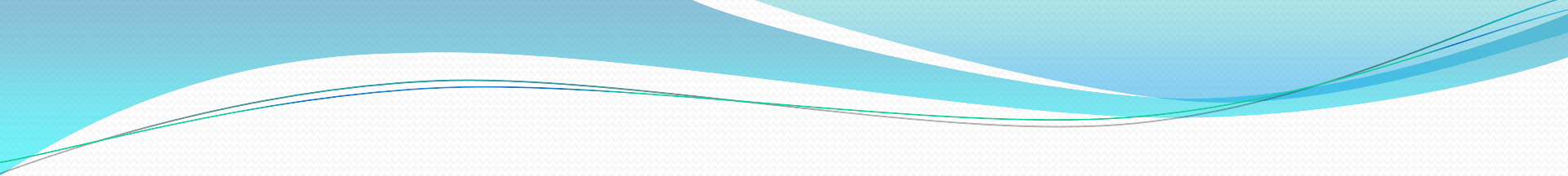


# Participant comments

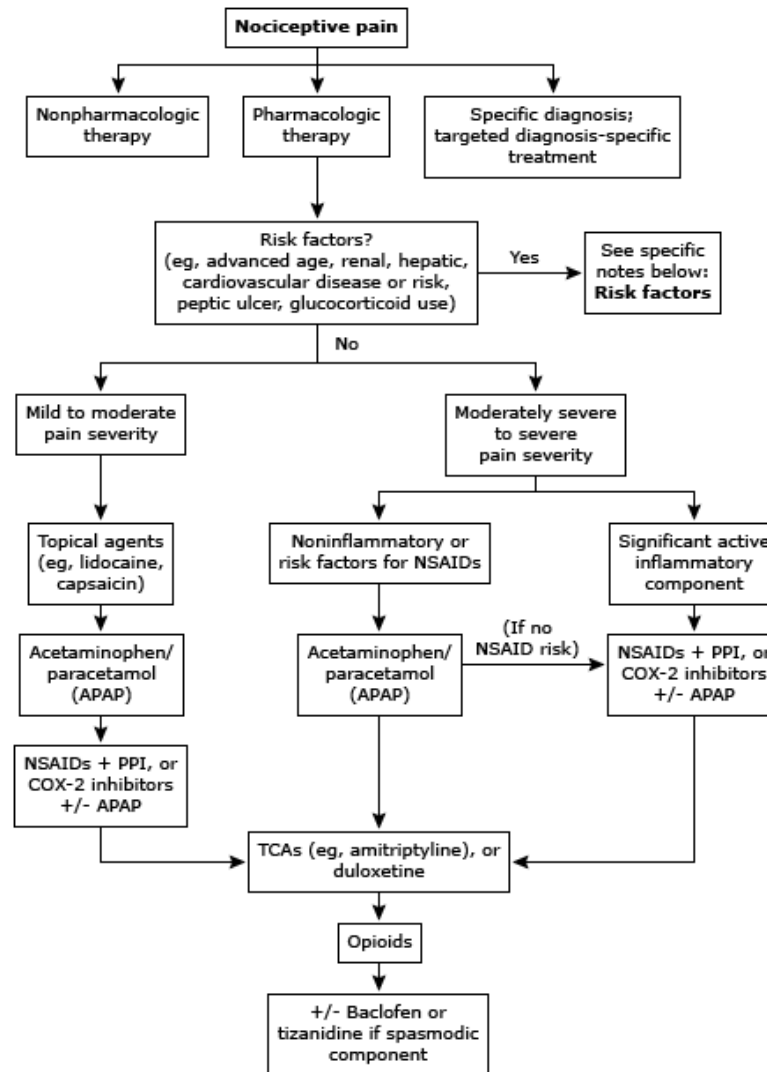
- “Pill parties” – a common source (49%) of trying.
- “kids are using it like Viagra”
- Opiates available “at the prom.”
- Athletes in high school used to “make it through a game” and later used to “get high.”
- “I used them to feel normal”
- “It helped take away my emotional pain and stress”
- “made me feel like a better person”
- Often obtained from “parent’s prescriptions”
- “The best way to get opiates is to look for the dying person who will give [them] up”
- Prefer prescription opiates to heroin because “they know they’re pure”

# The data against prescription opioids

- Intensity of Chronic Pain – The Wrong Metric?
  - Ballantyne JC and Sullivan M
  - Perspective article – NEJM, November 2015
  - “For three decades, there has been hope that more liberal use of opioids would help reduce the number of Americans with unrelieved chronic pain. Instead, it produced what has been termed an epidemic of prescription-opioid abuse, overdoses, and deaths – and no demonstrable reduction in the burden of chronic pain.”

- 
- Opioid Abuse in Chronic Pain — Misconceptions and Mitigation Strategies
    - Volkow and McLellan
    - Review article – NEJM, March 31<sup>st</sup>, 2016
    - “It is no longer possible to simply continue previous practices with respect to the management of chronic pain. The associated risks of opioid diversion, overdose, and addiction demand change.”

# Up-to-Date algorithm



Home

Opioid Painkillers

Side Effects

Lawsuits

News

Contact

Contact us to start your claim today

First Name	Last Name
Email	
(Area Code) Phone Number	
City	State
Type of Overdose	
Year	
Who suffered from the overdose?	

Drug that caused the overdose:

- Fentanyl (Duragesic)
- Methadone
- OxyContin (oxycodone)
- Vicodin (hydrocodone)
- Dilaudid (hydromorphone)
- Other

Please describe how the overdose occurred.

Type the characters you see in the image:

6 P Q 6

Yes I agree to the Terms & Conditions

## Painkiller Litigation

Patients who were treated with a prescription opioid painkiller and experienced complications from the drug—including overdose or addiction—may be eligible to file a class action lawsuit against the manufacturers of these drugs or the doctors who prescribed them.

Opioid class actions have already been filed on behalf of users of a number of prescription painkillers—including oxycodone (OxyContin) and propoxyphene (Darvon, Darvocet). These lawsuits were filed seeking compensation and medical monitoring costs for patients who were injured after using these prescription painkillers.

Lawsuits involving prescription opiates may be filed against the companies that make these drugs or the doctors who prescribe them to patients. Despite the health risks associated with using opioid painkillers, many drug companies have continued to promote opioid painkillers for off-label uses, putting the health of patients at risk. Doctors may also improperly prescribe painkillers to their patients, increasing their risk of addiction, overdose, or other complications.

The attorneys at Heygood, Orr & Pearson are the nationwide leaders at trying cases involving side effects from opioid medications. Our lawyers have interviewed hundreds of expert witnesses and reviewed millions of legal and scientific documents for our painkiller lawsuits. Juries have awarded our clients tens of millions of dollars in verdicts against the drug companies who manufacture opioid painkillers.

If you or a loved one has been the victim of serious complications caused by the use of opioid painkillers, you may be eligible to file a lawsuit. For a free consultation, contact our law firm by calling toll-free at 1-877-446-9001, or by filling out the free case evaluation form located on this page.

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JUNE 16, 2015

## Addicts Can Now Sue Doctors, Pharmacies for Enabling Addiction

By **Pintas & Mullins Law Firm**



The West Virginia Supreme Court recently ruled that narcotic addicts can sue pharmacies and doctors that prescribed and dispensed painkillers. The lawsuit was filed by dozens of pain center patients who were treated with narcotics and became addicted. **Dangerous drug lawyers** at Pintas & Mullins detail this case and its implications below.

The plaintiffs in this case were patients of the Mingo County Mountain Medical Center, who were treated mostly for injuries suffered on-the-job or in auto accidents. They claim they were

criminally prescribed narcotic pain killers by four physicians at Mountain Medical and negligently given the pills by three pharmacies: B&K Pharmacies, Strosnider Drug Store, and Tug Valley Pharmacy.

Plaintiffs claim they were prescribed and became addicted to the pills, causing them to engage in criminal activity to support their addiction. It is worth noting, however, that the vast majority of plaintiffs abused controlled substances before seeking help at Mountain Medical. Most if not all of the plaintiffs were likely “doctor shopping,” or seeking out physicians who were known to loosely write prescriptions for narcotics.

Mountain Medical was raided and shut down by the FBI in 2010 after investigators found evidence of improperly prescribed pharmaceuticals. One of the doctors, Katherine Hoover, was accused of recklessly and illegally writing hundreds of thousands of pain killer prescriptions. Dr. Hoover never faced criminal charges and now lives in the Bahamas. Two other Mountain Medical doctors and the office manager pled guilty to criminal charges and were sentenced to six months in federal prison.

### Ask Your Question Now

FREE CONSULTATION  
800-994-9032

In order to help you more quickly, please fill out the quick form and submit or call 800-994-9032. A representative of the firm will call you ASAP.

SUBMIT



### Topics

**Birth Defects** (21)

**Class Action Lawsuit** (29)

**Contaminated Drugs** (33)

**Dangerous Side Effects** (216)

# List of most abused drugs – 2013

1. OxyContin
2. Suboxone
3. Concerta (methylphenidate)
4. Ambien
5. Ritalin
6. Zoloft
7. Lunesta
8. Adderall XR
9. Opana ER (oxymorphone)
10. Xanax
11. Klonopin
12. Fentora (Fentanyl)
13. Percocet
14. Ativan
15. Soma (carisoprodol)
16. Valium
17. Vicodin (No 2012 sales data available otherwise likely ranked higher)

Source: Drug Enforcement Agency (DEA)

# The rules

## Schedule II

- Schedule II prescription orders must be written and signed by the practitioner
- May not be telephoned into the pharmacy except in an emergency.
- No refills

## Schedule III, IV

- Written or oral (phoned to pharmacy) order
- Refills up to 5 times anytime within 6 months from the date the Rx was issued.
- Schedule V – must be 18 y/o



# Schedule of controlled substances

- **Schedule 1** - have high abuse potential, no medical use, and severe safety concerns
  - Illegal drugs
  - Ex: Heroin, LSD, marijuana, ecstasy
- **Schedule 2** - high potential for abuse and dependence, an accepted medical use, and the potential for severe addiction
  - Ex: cocaine, high dose codeine, Fentanyl, **Oxycodone**, Morphine, Methamphetamine, **Adderall**, Ritalin, **hydrocodone based opiates (reclassified)**
- **Schedule 3** - lower potential for abuse than drugs in the first two categories, accepted medical use, and mild to moderate possible addiction
  - Anabolic steroids, low dose codeine, **Tylenol #3**, ketamine, testosterone, **Fioricet**
- **Schedule 4** - even lower abuse potential than Schedule 3 Drugs, accepted medical use, and limited addiction potential.
  - **Benzodiazepines**, Sedatives, **sleeping agents**, **Tramadol**, **Soma**
- **Schedule 5** - low abuse potential, accepted medical use, and a very limited addiction potential.
  - preparations containing limited quantities of narcotics or stimulant drugs for cough, diarrhea, or pain.
  - **Lyrica**, **Imodium**, **Robitussin AC**
- “If a drug does not have a potential for abuse, it cannot be controlled.”
  - DEA – Drugs of Abuse publication (2015)

To start off, please, please, please don't lecture me. I'm well aware of the risks involved with this and I have assessed them at length. Also, I'm aware that just getting some pills isn't nearly as much trouble. This isn't about trouble. It is for science.

Disclaimer: Try this at your own risk. It is kind of stupid. I probably wouldn't do it if I were you. I'm not responsible for your decisions or well being.

I figured I would post this TEK because there seems to be a lot of controversy and doubt regarding this on other forums. I tried it, you know, for science, to see if I could make it work. It worked.

Supplies:

You will need:

- Loperamide. AKA Imodium AD I will get to how much later.
- Tagamet
- Grapefruit Juice [GFJ]
- Tonic Water

The TEK

**Step 1.** Take the tagamet. Give it time to work, I usually wait about an hour.

**Step 2.** During this hour, drink as much tonic water and GFJ as you reasonably can. I find mixing them makes two pretty gross drinks pretty tasty. Mixed half and half, I usually get down about 16 - 24 ounces.

**Step 3.** Eat some loperamide. Some people say they eat like 200 mg but they have a tolerance. I usually eat about 50. [to give you an idea of tolerance, I don't really have one, I use maybe once a week. When I was shooting up, I would load about 45 mg of morphine for a serious nod. 30 was perfectly acceptable and the same goes for OC's. My tolerance is roughly the same now. I take about 20 mg of methadone orally for a really good nod.] They are 2 mg a pill here so that is roughly a 24 pack pack of pills which costs me about anywhere from 3 - 4 dollars if I get store brand at a wal-mart or something.

50 mg doesn't █████ my whole world up, but it is a damn good buzz.

This stuff lasts a long time so I take it easy because, it would suck pretty hard to over-do it and these days, I don't have 48 hours to puke in a toilet or really even nod hard. Be careful re-dosing, it takes a good 2 hours to kick in.

The question most people inevitably ask is, "█████ how are you not constipated for the rest of your life?" I have pretty regular movements. Make sure you eat enough fiber and you'll be fine. You probably won't █████ for a couple days, but I don't really find it to be that much worse than your average long-acting opiate. I wouldn't binge out on it or anything

There are better buzzes out there. I would say this is somewhere between m-done and bupe. [I am currently opiate naive but am well aware how █████ bupe can be with tolerance.] It is a little dirty, but better than tramadol or some █████ like that.

The main reason I thought this would be useful is for people who are in withdrawal. If you have some money but no access to your drugs, this could be a potential life saver.

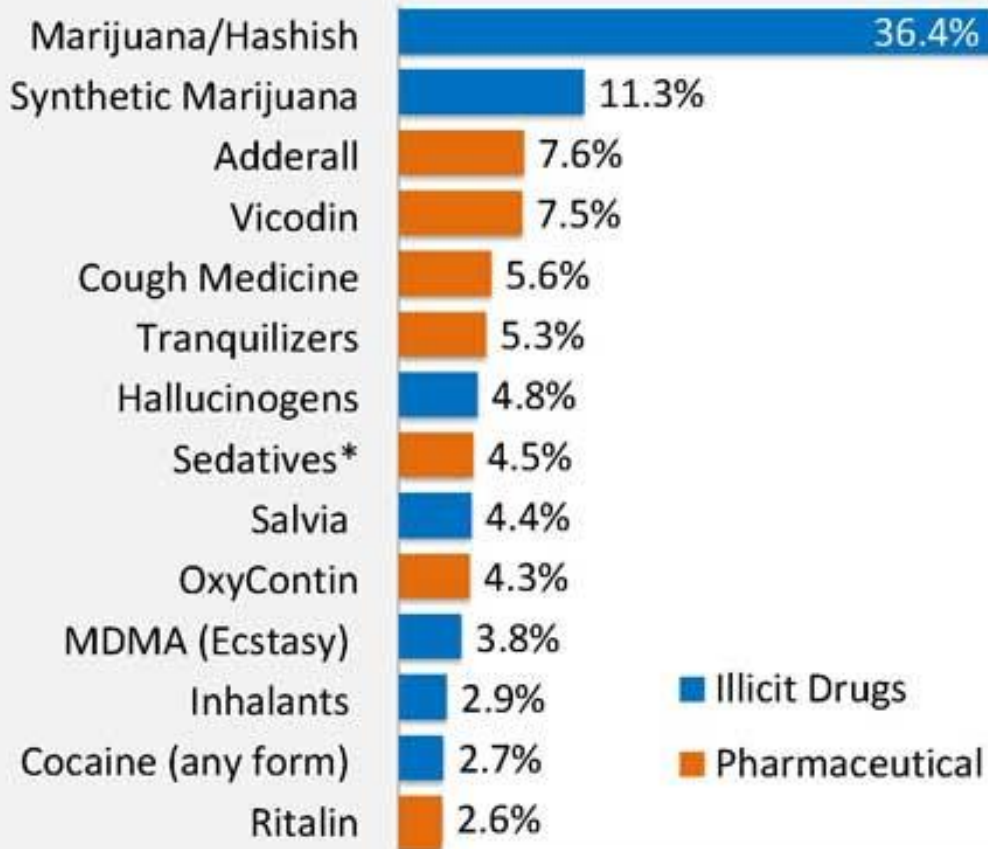
It is also worth noting that people lacking in the CYP450 enzyme don't actually have to mess with all of the extra stuff. They just take lope and get high.

### **Why does this work and why am I able to buy it OTC?**

Loperamide, is indeed an opiate, but it usually can't cross the blood brain barrier [BBB]. This means it all attaches to the opioid receptors in your intestines, thus slowing them down and making you █████ less. Tonic water has quinine; tagamet and GFJ are PGP-inhibitors. Basically, they cause less of the drug to be broken down by the liver during the 1st pass metabolism and IIRC, allow for higher blood-plasma concentrations thus letting more into your brain.

There are better ways to get high, but not all of us have access all the time. If you find yourself dopesick, or in a great deal of pain and have no access to regular opiates, this is something to consider.

## Past-Year Use of Illicit Drugs and Pharmaceuticals among 12th Graders



SOURCE: University of Michigan, 2012 Monitoring the Future Study

# Interview with police

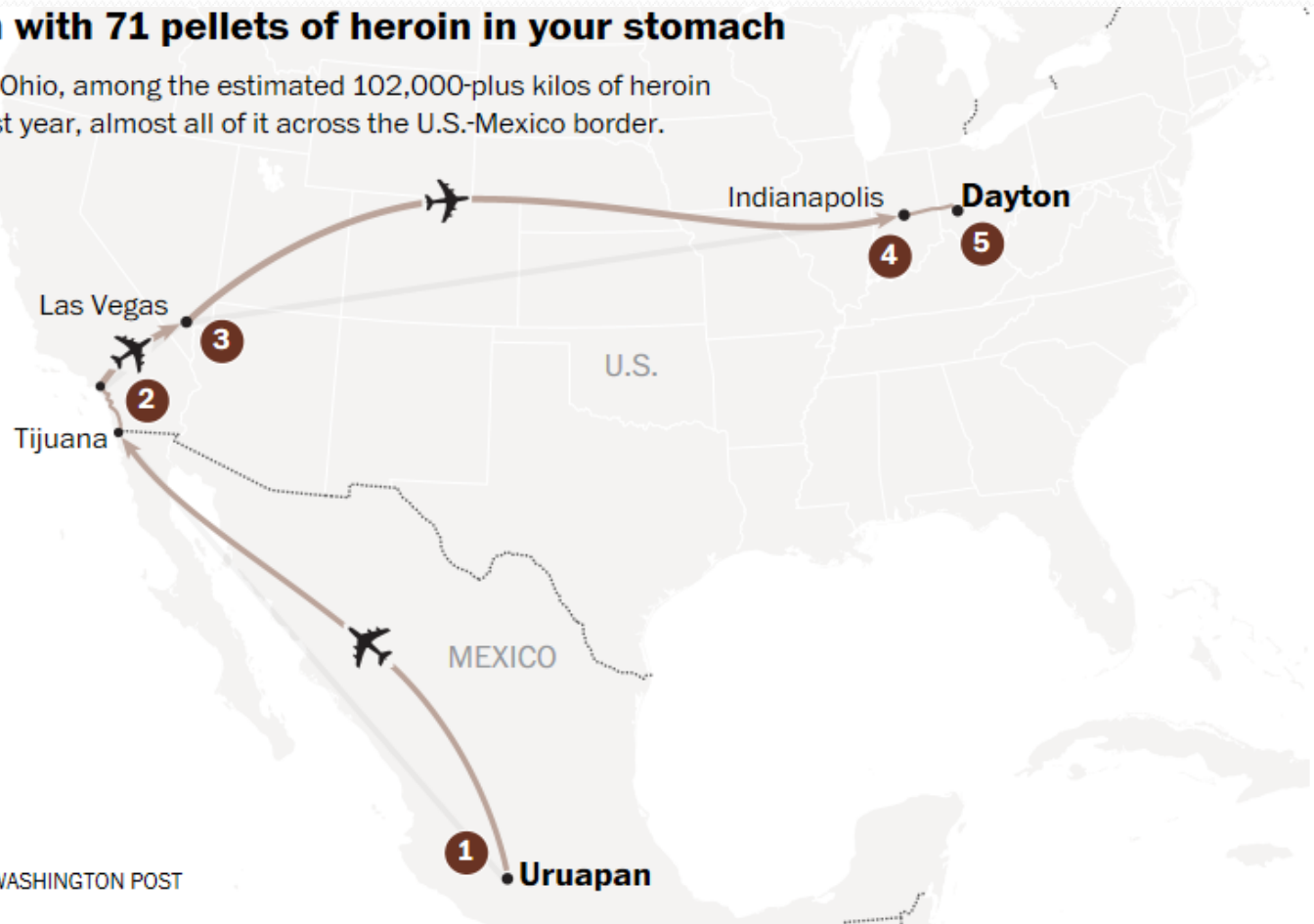
- “You know how Miami, FL is the hub of cocaine for the US? Well, Dayton is the hub for heroin.”
- “When they hear someone has died from heroin, they flock to the person that sold that heroin”
  - Capt. Thompson (Miamisburg)
- DEA: July 2015 press release
  - “The strongest risk factor for a heroin use disorder is a prescription opioid disorder”
- “Definitely, greater than 50% of the heroin addicts we interview start with prescription opiates.”
  - Capt. Brem (Mont County Sherriff office)
  - 4 out of 5 report first using prescription opioid from medical literature
- Undercover patient – pill mills
  - \$1/mg of Rx pill.
    - #120 pills of 10mg Oxy = \$1,200
  - \$5/cap of heroin



## A 37-hour trip to Dayton with 71 pellets of heroin in your stomach

How one kilo (2.2 pounds) came to Ohio, among the estimated 102,000-plus kilos of heroin smuggled into the United States last year, almost all of it across the U.S.-Mexico border.

- 1** A courier takes the 2:05 p.m. flight from Uruapan to Tijuana.
- 2** He walks across the San Ysidro border pedestrian bridge and travels by vehicle to John Wayne Airport, in Santa Ana, Calif.
- 3** He takes the 3:39 p.m. flight to Las Vegas.
- 4** He takes the 6:05 p.m. flight to Indianapolis, which arrives at 1:19 a.m.
- 5** A taxi takes him to the Dayton Motor Motel. The 129-mile ride cost \$250.



Source: DEA

TODD C. FRANKEL AND LARIS KARKLIS/THE WASHINGTON POST

# What to do before I prescribe

## SYCAMORE PRIMARY CARE GROUP

### NARCOTICS POLICY

- Trial other agents
  - **“Health care providers are not obligated to use opioids when a favorable risk-benefit balance cannot be documented” ---CDC**
- Query NARx (OARRS)
- Check UDS
  - Send out confirmatory if unexpected results
- Document current pain, functional status and set goals for therapy
  - Being pain-free not a reasonable goal
  - Document the 4 A’s with every visit:
    - Activities of daily living
    - Adverse effects
    - Analgesia
    - Aberrant behavior
- Sign narcotic agreement
- Start lowest effective dose
  - **Should refrain from co-administering with BZD or sedative hypnotics**

State and federal laws require strict monitoring of controlled substances through the Drug Enforcement Agency. Failure to comply with these laws by either medical personnel or Patients puts both at risk for criminal activity. In order to protect both physicians and patients from inappropriate use of controlled substances, all patients being prescribed such medications on a chronic basis will be required to adhere to the following policy.

1. Only one doctor will prescribe controlled substances for a patient. This physician will be the identified primary care physician of the patient. All other doctors caring for the patient are advised of this plan.
2. Only one pharmacy can be used. The pharmacy name and telephone number is identified in the chart as specified below.
3. Under **NO** circumstances will a controlled substance prescription be written again, after the patient leaves the office. This includes, but is not limited to, loss, theft, or destruction of any kind once it has been given to the patient. It is the patient’s responsibility to keep the prescription safe. No one else can do this.
4. Those who are taking narcotics on a daily basis will be required to see their primary doctor EVERY month. At these scheduled visits, the prescription may be written for a full month with no refills. The patient **MUST** come to the next month’s appointment to receive the next prescription. There will be no events in which a prescription is renewed early.
5. Narcotics or other controlled substances **will not be refilled by telephone.**
6. The goal will be to wean the medication to the **LOWEST EFFECTIVE DOSE**, and when appropriate, stopped.
7. In the event that a patient requires chronic use of a controlled substance, further evaluation and/or testing at the discretion of the physician may be required, which may also include consultation with a specialist.
8. Patients transferring from another practice, who are currently on controlled substances, will be required to provide appropriate documentation within one month’s time that a previous evaluation was done to warrant the continued use of such medical medications.
9. Patients receiving narcotics may be required, at the physician’s discretion, to have periodic and random drug testing. Failure to comply may jeopardize further prescriptions for controlled substances.

**My doctor and I have talked about these rules, and I agree to follow them.**

_____	_____	_____
Date	Patient’s Signature	<u>PRINT</u> Name
_____	_____	_____
Your Physician	Pharmacy	Pharmacy Phone Number
_____	_____	_____
	Date of Birth	

# Monitoring and compliance

- Check NARx/OARRS
  - Know what you're looking at
- Obtain random UDS
  - At least 2x/year (more if compliance in question)
  - **IMPORTANT:** you must document last ingestion time!!!
  - Send confirmatory for abnormal
- No early refills
- Utilize random pill counts
- 80 MED (morphine equivalency dosing) = trigger threshold
  - Re-evaluate therapy
- 120 MED = should see pain management specialist

**Ohio Automated Rx Reporting System**  
 77 South High Street, Room 1702; Columbus, OH 43215-6126  
 Equal Opportunity Employer and Service Provider  
 TEL: 614/466-4143 E-MAIL: Info@ohioicrmp.gov Fax: 614/644-8556  
 TTY/TDD: Use the Ohio Relay Service: 1-800/775-0750 URL: http://www.ohioicrmp.gov

---

**Patient Rx History Report**

**BETTY TESTPATIENT** Date: 9/9/2013 1:41:12 PM

13576182  
 Search Criteria: (Last Name = 'Testpatient' And First Name = 'Betty') And D.O.B. = '1/1/1970' And Gender = 'F' And Street = '' And Zip = '' And Phone = '' And Request Period = '8/14/2011 to 9/9/2013'

**Patients included in report that appear to match search criteria**

1286 BETTY TESTPATIENT, DOB 01/01/1970, 123 BROADWAY, COLUMBUS, OH 43215  
 1289 BETTY TESTPATIENT, DOB 01/01/1970, 234 WEST ST, WESTERVILLE, OH 43081  
 1142 BETTY TESTPATIENT, DOB 01/01/1970, 123 BROADWAY, COLUMBUS, OH 43215

**Active Cumulative Morphine Equivalent**  
 \*\*See explanation provided at the end of the report\*\*  
59.6

---

**Prescriptions**

Fill Date	Product, Str, Form	Qty	Days	Patient	Prescriber	Written	Rx #	Daily MED <sup>1</sup>	Active <sup>2</sup>	Pharm	Pay <sup>3</sup>
9/4/2013	PERCOCET 325 MG-5 MG TAB	15	15	1286	BR HEA 2	5/27/2013	33324113	7.5	Y	REAL1	M2
9/3/2013	PERCOCET 325 MG-5 MG TAB	30	7	1286	BR HEA 2	6/26/2013	33324113	32.1	Y	REAL1	M2
8/30/2013	APAPHYDROCODONE BI 325 MG-10 MG TAB	30	15	1286	BR HEA 2	5/22/2013	33321714	20	Y	REAL1	M2
8/23/2013	ALPRAZOLAM 1 MG TAB	120	30	1289	GO DOC 5	5/15/2013	0676157	-	Y	WERX	C
8/20/2013	AMBIEN CR 12.5 MG TER	23	23	1286	BR HEA 2	5/12/2013	33321714	-	Y	REAL1	M2
8/15/2013	CLONAZEPAM 0.5 MG TAB	90	30	1289	BA DOC 8	4/9/2013	06558738	-	Y	DRUG	C
7/21/2013	CARISOPRODOL 350 MG TAB	30	15	1286	FA HOS 0	10/1/2011	505570	-	N	FAKE1	C
7/19/2013	CLONAZEPAM 0.5 MG TAB	90	30	1289	BA DOC 8	4/9/2013	06558738	-	N	DRUG	C
7/2/2013	AMBIEN CR 12.5 MG TER	12	2	1289	DO OH1 8	3/24/2013	06555037	-	N	SCRIPT	C
6/24/2013	CLONAZEPAM 0.5 MG TAB	90	30	5142	BA DOC 8	2/19/2013	1058176	-	N	DRUG	CI
5/30/2013	CLONAZEPAM 0.5 MG TAB	90	30	5142	BA DOC 8	2/19/2013	1058176	-	N	DRUG	CI
4/9/2013	ALPRAZOLAM 1 MG TAB	120	30	1286	JO P L 1	12/24/2012	0358797	-	N	FAKE2	M2
1/9/2013	ALPRAZOLAM 1 MG TAB	120	30	5142	GO DOC 5	10/1/2012	04077535	-	N	STUFF	CI
1/8/2013	ALPRAZOLAM 0.5 MG TAB	60	30	1289	CA FAM 3	9/30/2012	064233	-	N	REAL2	CI

Disclaimer: The State of Ohio does not warrant the above information to be accurate or complete. The Report reflects the search criteria entered by the requester, the data entered by the dispensing pharmacy, and the frequency at which the data is reported. For more information about any prescriber, please contact the dispensing pharmacy or the prescriber.

As always, use the OARRS report as an additional tool when determining the appropriate treatment for your patient. The OARRS report should not be the ONLY tool used. You must use other tools available to you to verify the information presented on the OARRS report. OARRS data is not reported in "real-time". Therefore your patient may have prescriptions that do not appear on the OARRS report. Additionally, Daily MED values and Active Morphine Equivalent values are produced based on the days supply reported by the pharmacy. If the patient is consuming the prescription medication at a faster or slower paced than is indicated by the days supply, the patients actual Active Cumulative Morphine Equivalent may be higher or lower than the value on the report.

The "Patient Details" box shows detailed information regarding the patient records matched to your request. Use this to ensure that all prescriptions on this report belong to your patient.

The "Daily MED" column indicates the Morphine Equivalent Doses per day for this prescription. The Daily MED values of the active prescriptions are added together to produce the Active Cumulative Morphine Equivalent.

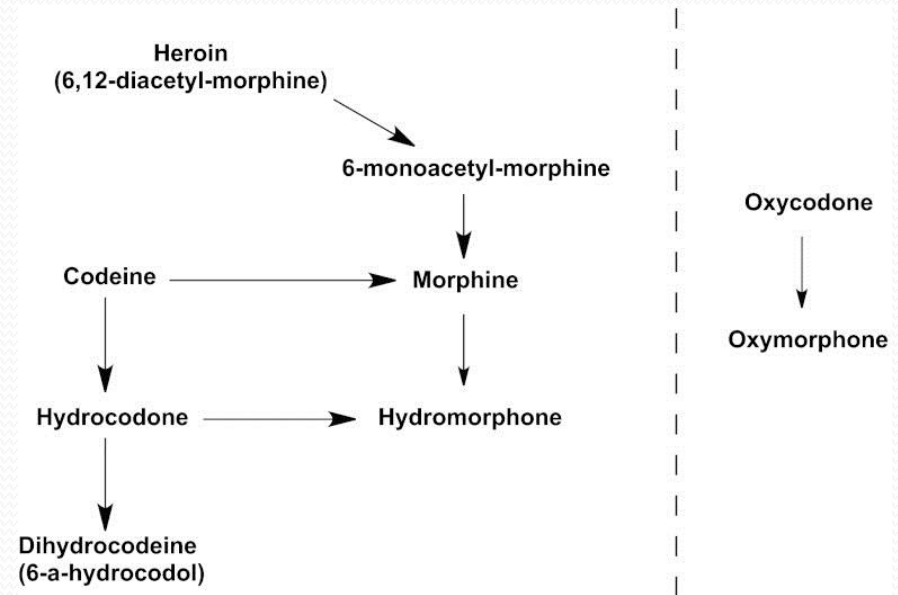
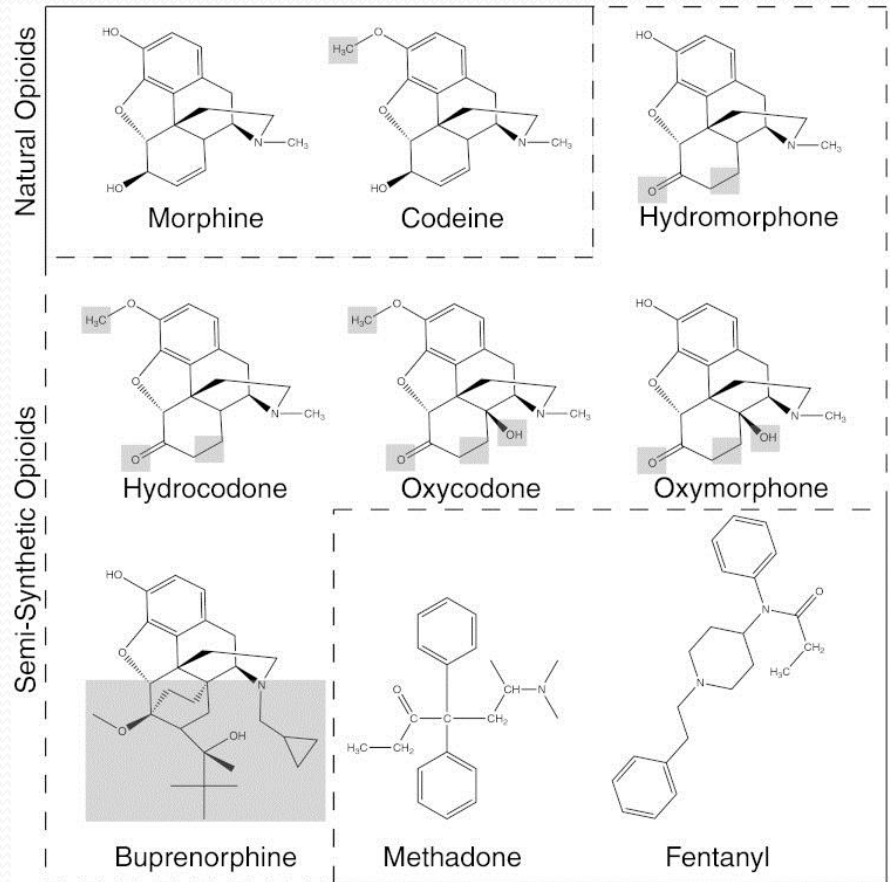
The "Active Cumulative Morphine Equivalent" represents the amount of opioid prescription drugs, converted to a common unit, that your patient currently has access to based on the prescriptions that have been reported to OARRS at the time the OARRS report was run.

The "Active" column shows which prescriptions are currently active and thus included in the calculation of the Active Morphine Equivalent. In addition, all active prescriptions appear in bold.

AMPHETAMINES	BARBITURATES	METHADONE	PHENCYCLIDINE (PCP)
Amantadine (Symmetrel) [Parkinson's dz]	Ibuprofen, Naproxen [Anti-inflammatories]	Chlorpromazine (Thorazine) [Antipsychotic]	Dextroamphetamine (Dexedrine) [ADHD; Stimulant]
Bupropion (Wellbutrin, Zyban) [Antidepressant; Smoking cessation]	Phenytoin (Dilantin) [Seizures]	Clomipramine (Anafranil) [Antidepressant]	Dextromethorphan (Delsym, Robitussin) [Anti-tussive]
Chloroquine (Aralen) [Anti-malaria]	Primidone (Mysoline) [Seizures]	Diphenhydramine (Benadryl) [Antihistamine]	Diphenhydramine (Benadryl) [Antihistamine]
Chlorpromazine (Thorazine) [Antipsychotic]	BENZODIAZEPINES	Doxylamine (Unisom) [Insomnia]	Doxylamine (Unisom) [Insomnia]
Desipramine (Norpramine) [Antidepressant]	Oxaprozin (Daypro) [Arthritis]	Ibuprofen (Advil) [Anti-inflammatory]	Ibuprofen (Advil) [Anti-inflammatory]
Dextroamphetamine (Dexedrine) [ADHD; Stimulant]	Sertraline (Zoloft) [Antidepressant]	Quetiapine (Seroquel) [Antipsychotic]	Imipramine (Tofranil) [TCA antidepressant]
Ephedrine (Ephedra, Ma Huang) [Stimulant]	CANNABINOIDS	Thioridazine (Mellaril) [Antipsychotic]	Ketamine [General anesthetic]
Labetalol (Trandate) [Hypertension]	Dronabinol (Marinol) [Nausea; Appetite stimulant]	Verapamil [HTN; Anti-arrhythmic]	Meperidine (Demerol) [Pain]
Mexiletine [Anti-arrhythmic]	Efavirenz (Sustiva) [HIV]	OPIATES / OPIOIDS	Tramadol (Ultram) [Pain]
Procainamide [Anti-arrhythmic]	Hemp seed oil, Cannabis seed, Hemp oil, Hemp food	Dextromethorphan (Delsym, Robitussin) [Anti-tussive]	Venlafaxine (Effexor) [SNRI Antidepressant]
Phentermine (Adipex, Suprenza) [Obesity]	NSAIDs (ibuprofen, naproxen, ketoprofen, piroxicam, etc)	Diphenhydramine (Benadryl) [Antihistamine]	LSD
Promethazine (Phenergan) [Nausea]	Pantoprazole (Protonix) [GERD; Peptic ulcer dz]	Fluoroquinolones (Levaquin, Avelox, Cipro, Floxin)	Amitriptyline (Elavil) [TCA antidepressant]
Propranolol (Inderal) [HTN; Migraines; Anti-arrhythmic; Essential tremor; Stage fright]	Promethazine (Phenergan) [Nausea]	Poppy seeds and oil [Yummy bagels and bread]	Dicyclomine (Bentyl) [Anticholinergic for IBS]
Pseudoephedrine (Sudafed) [Nasal decongestant]	COCAINE	Quinine [Antimalaria]	Ergotamine [Migraines]
Ranitidine (Zantac) [GERD; Peptic ulcers]	Amoxicillin (Amoxil) [Antibiotics]	Rifampin [Tuberculosis]	Promethazine (Phenergan) [Nausea/Vomiting]
Selegiline (Zelapar, Eldepryl) [Parkinson's disease]	Coca leaf teas	OXYCODONE	Sumatriptan (Imitrex) [Migraines]
Trazodone (Desyrel) [Antidepressant; Insomnia; Migraines]	Tonic water	Hydrocodone, Oxycodone, Hydromorphone, Codeine,	
Vick's inhaler [Congestion]			



# What is positive in UDS?



Oxycodone will show up in UDS screening if elevated (cross-reactivity) 5-fold (1500 ng/dl) compared to 300 ng/dl of morphine

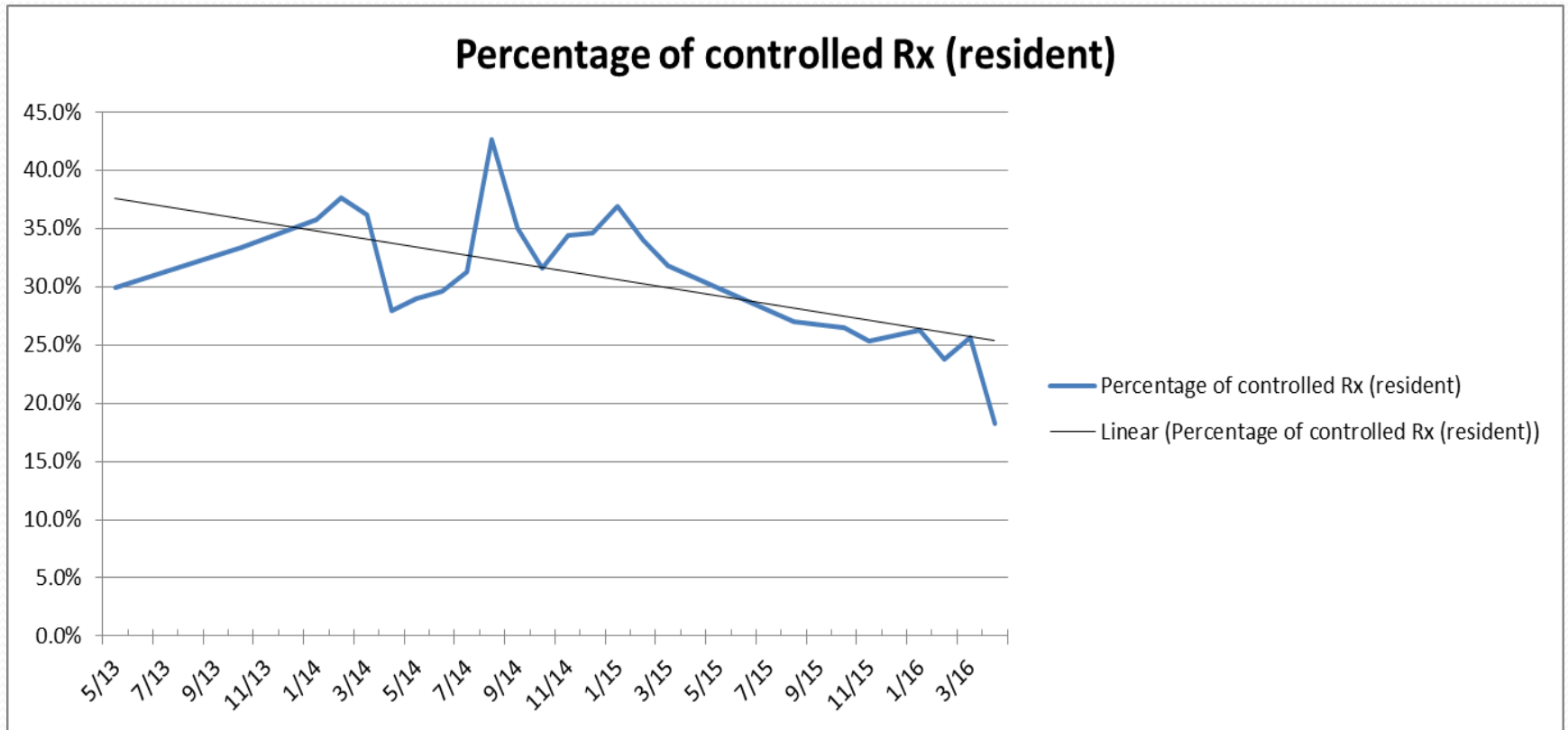
# “Average” time for positivity

Length of Time Drugs of Abuse Can Be Detected in UrineDrug	Time
Alcohol	7-12 h
Amphetamine	48 h
Methamphetamine	48 h
Barbiturate	
Short-acting (eg, pentobarbital)	24 h
Long-acting (eg, phenobarbital)	3 wk
Benzodiazepine	
Short-acting (eg, lorazepam)	3 d
Long-acting (eg, diazepam)	30 d
Cocaine metabolites	2-4 d
Marijuana	
Single use	3 d
Moderate use (4 times/wk)	5-7 d
Daily use	10-15 d
Long-term heavy smoker	30 d
Opioids	
Codeine	48 h
Heroin (detected as morphine)	48 h
Hydromorphone	2-4 d
Methadone	3 d
Morphine	48-72 h
Oxycodone	2-4 d
Propoxyphene	6-48 h
Phencyclidine	8 d

# Fun facts about UDS (Siemens EMIT)

- Antibodies that attach themselves to the drug in urine sample. Then use light emission to determine levels.
- Essentially zero false positive results
- False negative result 2-4% (if near lower limit of cutoff)
- Levaquin can cause false + opiate
- Passive marijuana inhalation WILL NOT turn THC test positive. Don't buy into their lies!
  - Light users = 2-8 days
  - Heavy users = 6-19 days

# Sycamore Primary Care Data



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