ANNALS OF CLINICAL PSYCHIATRY 2017;29(1):1-2

GUEST EDITORIAL

The opioid epidemic and us

Richard Balon, MD
Departments of Psychiatry and Behavioral Neurosciences and Anesthesiology
Wayne State University School of Medicine
Detroit, Michigan, USA

The opioid epidemic is a sad reality that is threatening to destroy the basic fabric of society in some areas of the country. More Americans die of drug overdose than car accidents or firearms. In 2014, in the United States, 47,055 people died of drug overdose, more than one-half of these deaths due to prescription painkillers or heroin, while 33,756 Americans died in motor vehicle crashes and 33,599 died by firearms.[1] Approximately 450,000 emergency room visits per year are related to opioids. These are staggering numbers.

The disturbing and sad reality is also that medicine, "Big Pharma," and the government played an important, large role at the beginning of this epidemic and contributed to its rapid expansion. Some of us may remember the brilliant, but ultimately deadly (for patients), marketing of OxyContin by its maker, Purdue Pharmaceuticals. The company claimed that the addiction potential of OxyContin was small (one claim was that it was <1%),[2] although in reality it was high. Some physicians believed or wanted to believe the company's claim and prescribed OxyContin widely. Purdue Pharmaceutical targeted physicians who were prescribing OxyContin frequently for additional marketing, based on company's analysis of the physician's prescribing pattern. This is not the entire story of the recent opioid epidemic; for more, read Sam Quinones' book *Dreamland: The True Story of America's Opiate Epidemic*.[3] In addition, during the 1990s various medical organizations pushed the standards of pain management too high, for example, pain actually was declared the "fifth vital sign" (which the American Medical Association recently recommended removing) and demanded aggressive pain management. Together with many stories of physicians prescribing tens of thousands of painkillers a year, this evidence is illustrative of the role of physicians, Big Pharma, and various organizations' role in this epidemic.

Can physicians undo their role and help to defeat this epidemic? I believe and hope we can. Not just by referring patients who use opioids to addiction specialists—although we do not have enough of them—or

CORRESPONDENCE
Richard Balon, MD
Department of Psychiatry
Tolan Park Building, 3rd floor
3901 Chrysler Service Drive
Detroit, MI 48201 USA

E-MAIL
rbalon@wayne.edu

by prescribing buprenorphine, or by leaving pain management solely in the hands of pain specialists. I am not suggesting that we prescribe painkillers. On the contrary, I believe psychiatrists should not prescribe painkillers at all (sadly, I have encountered cases of psychiatrists prescribing methadone and benzodiazepines for pain). I am advocating for participation of every clinical psychiatrist in integrated management of pain and addiction. In 2016, the Centers for Disease Control and Prevention released a "Guideline for Prescribing Opioids for Chronic Pain."[4,5] We all should carefully review this guideline and realize that non-opioid therapy is preferred for treating chronic pain, and that concurrent opioid and benzodiazepine use should be avoided. Furthermore, Frieden and Houry[6] outlined where and what our role in pain management could be. They wrote, "Nonpharmacological therapies can ameliorate chronic pain while posing substantially less risk to patients. In some instances, other therapies result in better outcomes than opioids. These therapies include exercise therapy, weight loss, psychological therapies such as cognitive behavioral therapy, interventions to improve sleep, and certain procedures. The evidence review conducted in developing the guideline revealed that exercise therapy helped improve and sustain improvement in pain and function in patients with osteoarthritis. It did not find evidence that opioids were more effective for pain reduction than non-opioid treatments, such as nonsteroidal anti-inflammatory drugs for low back pain or antidepressants for neuropathic pain, but it did find that non-opioid treatments could be better tolerated and superior for improving physical function while conferring little or no risk of addiction and substantially lower risk of overdose and death."[3] I would add that we can better educate our patients about the risks of opioid use. How many of us tell patients about how opioids interfere with the hypothalamus-pituitary-gonadal axis (opioid-induced endocrinopathy), with subsequent reduction of cortisol and androgen production and increased morbidity and mortality risk during major surgeries? I think we all can find something to do among these suggestions.

However, as I hope for medicine's big turnaround, 2 of my colleagues were given prescriptions for ≥30 opioid pills after a minor surgery. ■

REFERENCES

1. Rudd RA, Aleshire N, Zibbell JE, et al. Increases in drug and opioid overdose deaths—United States, 2000-2014. MMWR Morb Mortal Wkly Rep. 2016;64:1378-1382.
2. Van Zee A. The promotion and marketing of oxycontin: commercial triumph, public health tragedy. Am J Public Health. 2009;99:221-227.
3. Quinones S. Dreamland: the true story of America's opiate epidemic. New York, NY: Bloomsbury Press; 2015.
4. Dowell D, Haegrich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2016. MMWR Recomm Rep. 2016;65:1-49.
5. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2016. JAMA. 2016;315:1624-1645.
6. Frieden TR, Houry D. Reducing the risk of relied—the CDC opioid-prescribing guideline. N Engl J Med. 2016;374:1501-1504.