Ups and downs with painkiller prescriptions

It's widely accepted that over-prescription of opioid painkillers, and associated addiction, is a deadly problem in many countries throughout the world, notably the US. But just how bad are things here in Godzone? How aware are our medical professionals of the dangers of doling out opioids, and are we doing anything to curtail overzealous prescribing? **Matt Black** talks with some medical professionals to find out.

MATT BLACK

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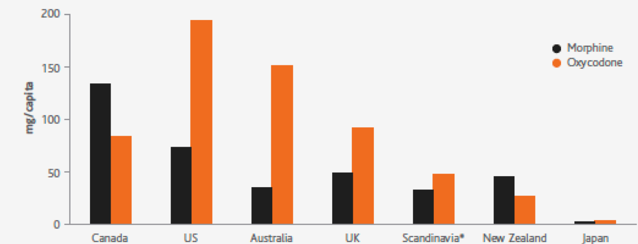
>
> JOHNNY DOW



Corporate America is no stranger to malfeasance in the pursuit of profit, but by any standard, the US$634 million judgment handed down against Purdue Frederick in 2007 for the misrepresentation of its opiate painkiller OxyContin remains a milestone.

In the judgment against three of the company's top executives, a federal judge extraordinarily bemoaned his inability to jail the plaintiffs for substantial periods as they had already arrived at the multimillion dollar plea deal, but he did additionally sentence them to three years probation and 400 hours community service each – all to be served in drug prevention or rehabilitation. A US Department of Justice media statement from 10 May 2007 reads:

"Even in the face of warnings from health care professionals, the media, and members of its own sales force that OxyContin was being widely abused and causing harm to our citizens, Purdue, under the leadership of its top executives, continued to push a fraudulent marketing campaign that promoted OxyContin as less addictive, less subject to abuse, and less likely to cause withdrawal," said United States Attorney John Brownlee.

"In the process, scores died as a result of OxyContin abuse and an even greater number of people became addicted to OxyContin; a drug that Purdue led many to believe was safer, less abusable, and less addictive than other pain medications on the market."

The early and widespread availability of OxyContin is now considered to be the root catalyst of America's current heroin epidemic, a nationwide disaster and the worst drug crisis in the country's history. Of the 52,000 American overdose deaths since 2015, some two-thirds have been attributed to heroin or prescription painkillers such as Percocet, OxyContin and fentanyl – more deaths than car crashes and gun homicides combined. More than 165,000 Americans have died from opiate overdoses between 1999 and 2014. To provide some New Zealand perspective, that's 30,000 more people than the population of Tauranga.

For a time, New Zealand looked like it was following the American model of oxycodone distribution. Between 2007 and 2011, oxycodone prescriptions rose 249 percent. But in 2014, disturbed by international reports of the drug's potential for addiction and abuse, the Health Quality and Safety Commission and New Zealand's district health boards (DHBs) launched a collaborative initiative to reduce the prescription of oxycodone, clinically championed by Dr Peter Moodie.

"We got a dramatic decrease in the usage of it. Unfortunately, when a drug is still under patent, it tends to be heavily promoted. If you take a drug like morphine, which is now a generic drug that has been around for hundreds of years, it's not actively promoted by any particular company, whereas things like oxycodone were being heavily promoted by the company that was selling it."

"If you've got a new drug, you want to promote it as much as you can to get the sales up." He says drug sales reps have been banned from his medical centre in Karori for a long time. "We just stopped them coming ages ago."

The campaign to make the New Zealand medical profession aware of the perils of oxycodone has been largely successful. Pharmac data shows prescriptions dropped from 180,830 in 2012 to 151,134 in 2016. But prescriptions of other strong opiates across the same period went up, with morphine rising from 161,229 to 203,690 and fentanyl almost doubling from 28,623 to 57,132.

The increase in fentanyl is largely attributed to prescribing in aged residential care, where it has also nearly doubled. Strong opioid prescribing rates for people over 80 are six to seven times higher than for those under 65. There is no hard data to indicate why that is, but one assumption is that there are increased needs for pain relief from operations, arthritis, cancer or other common causes of pain in the elderly.

Despite these seemingly large increases in strong opioid prescription, New Zealand's black market for prescription opiates remains tiny compared to other countries, indicating that the medications are mostly being used by their intended patients as prescribed. Data from the National Drug Intelligence Bureau put 2015 seizures of heroin at 38 grams (across 14 incidents), oxycodone at only 549 tablets and fentanyl powder at 1.6 grams, with most of these drugs seized at the border. Morphine and codeine remained the most seized opioids, with 2,184 codeine tablets seized in 2015.

Presentations at treatment organisations for opiate addiction in New Zealand are also very low. Johnny Dow, Clinical Director at Higher Ground, a residential facility with

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52 beds, says only one of his current patients used opiates as their drug of choice.

"Methamphetamine makes up 70 percent of our admissions. GHB and meth are driving us insane. Some of our patients would dabble in it a little bit, but it's not their drug of choice. We used to have a lot of people coming off methadone. It was really hard for them. They needed a lot of clonidine patches, and we'd take them to the sauna just for the last detox of it. I can't remember the last person who was coming off methadone. I think the population is just getting smaller and smaller."

Dow suspects much of the medical profession have become cautious of reaching for the controlled drugs pad.

"They're pretty worried about what happened in America, aren't they? The medical profession must be aware they over-prescribed, which has caused this latest heroin epidemic."

Robert Steenhuisen, Regional Manager for the Community Alcohol and Drug Services (CADS) in Auckland, is responsible for admitting addicts to the region's methadone and Suboxone programmes. He also says the number of people presenting with opiate addiction are static or decreasing.

"The current caseload is around 1,200. Each year, around 100 people come off and another 100 enrol, so there's a very slow churn."

But he says within the population seeking treatment, a significant number are users of prescription opiates, before adding he isn't seeing any transfer from prescription drugs to street drugs like heroin.

"It's probably the [lack of] availability. You go to Amsterdam or Sydney or New York, and you can go into areas, neighbourhoods where the dealing is physical in the street. I can't take you anywhere in Auckland to show you that."

He does suggest that New Zealand may have a group of people using prescription opiates recreationally.

"Most of these people will be fairly reluctant to seek treatment with a DHB-operated alcohol and drug rehab programme. They wouldn't think they have a problem with it."

Given the relatively insignificant seizures of prescription opiates by the Police and the lack of presentations at rehab clinics, are these increases in strong opiate prescribing really a problem?

Dr Julie Hancock, a GP at CityMed in Auckland who has recently returned from the International Medicine in Addiction Conference in Sydney, says sometimes the lack of alternatives can make prescribing painkillers problematic.

"There's codeine, tramadol, and if people can't tolerate anti-inflammatories, then you really are quite stuck. I find that since useful medicines like Paradex went off the market, there isn't really very much between paracetamol, codeine and the strong opiates."

Hancock points to a cultural and educational change among her colleagues about the hazards of strong opiates, and oxycodone in particular, as a result of the American experience.

"When we were at medical school, we were taught, as were doctors in America and everywhere else, that if people had real pain, opiates were blocking the pain perception with very little risk of addiction, so everyone felt comfortable socking in large doses and didn't give much thought to withdrawing people. But now we have much greater knowledge of chronic pain, that the body has its own natural systems of painkilling – both an opioid one and a cannabinoid one – and that if you use painkillers for too long, it shuts down the body's own mechanisms, ultimately increasing pain perception."

Echoing Dow's comments about a newfound caution among the medical profession, Hancock expresses concern that doctors in general practice have swung too far the other way and become afraid to prescribe strong opiates when they might actually be appropriate.

"I think some doctors have taken that to an extreme degree where they just use paracetamol and ibuprofen, and that's meant to be adequate for all forms of pain. But everybody has a different level of pain tolerance and perhaps a different severity of muscular-skeletal pain.

"In the case of severe pain, we should have the confidence to introduce, monitor and wean off a medication and inform the patient fully of what the whole process is about. Nobody should have to suffer pain because we're too scared of getting them addicted. We're also so terrified of using benzodiazepines that we give them out two at a time. It's subjecting people to more anxiety and discomfort than is necessary."

Moodie sees things differently.

"I don't think that's the case. I think there's been a heavy pressure that, if you want to give somebody something, start off with morphine. That gives you a clear internal message that you're using a potent drug. And if you feel that's justified, well that's fine. I've got no indication that people are underusing these medications at all."

He says the explosion in oxycodone prescribing in New Zealand may have been due to a misunderstanding about the power of the drug, which is nearly twice as strong as morphine and has a far higher bioavailability (15–20mg of oxycodone is approximately equivalent to 30mg of morphine).

Dr Peter Moodie

Photo credit: Fairfax Media NZ

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DR PETER MOODIE

"I think what was happening was that people were thinking it wasn't as powerful as morphine."

Moodie's next comment might have come directly from a transcript of the case against Purdue in 2007:

"Because of the name, you thought it was just a strong form of codeine."

He's also worried about the rise in fentanyl scripts.

"We have to be careful with drugs like fentanyl, which again seem like an easy way out. It has the supposed advantage that you just put a patch on, so you don't have to take the medicine regularly. But again, we have to be careful. That's a seductive message, and I think people are easily being put on it too much and for too long."

New Zealand has reasonably rigorous safeguards in place designed to prevent over-prescribing, either intentionally or through people 'doctor shopping' or otherwise exhibiting drug-seeking behaviour, including peer, clinical and Ministry of Health Medicines Control reviews.

There is also a system called Test Safe, where doctors can see all the prescriptions that have been filled, with the prescriber, dates and quantity of drugs. Nevertheless, Hancock and Moodie agree there is still a danger of prescribing too freely and of becoming known for it among drug users.

Moodie: "The moment you give narcotics to someone who is a drug seeker, that message will go through their networks like wildfire. It happens on occasions, and sometimes they will target out new associates, because they think there's a new doctor in town. In this practice, we're always keeping a watch to see how many narcotics we're using, just to make sure someone hasn't slipped in and become a drug seeker without us recognising it."

Hancock: "We're regularly told how many scripts of this and that we prescribe of various medications compared to our peers. If someone comes in and they have needle tracks all over their arms, you tend to be a little more careful about what they are asking for. We've got our eyes out for the devil incarnate, but anyone can get addicted. It's not a respecter of class, race or intellect. It's a part of human nature."

She worries that, once someone is considered a drug seeker or addict, they get substandard care on every level. "Even if they're seriously ill, all the doctors will see is 'drug addict'. We don't want to deal with you, out on the pavement thanks. And I don't think that's fair. We haven't got any right as medical practitioners to judge. That happens right across the board – judgements are made about addiction on whether you should be 'that type' of sick."

She says in the context of prescribing painkillers and other narcotics, despite every one of us having the potential for addiction, it is important to identify some groups that may be particularly predisposed.

"People with a conduct disorder in childhood, AD disorders – and in particular if they had both – they are susceptible. People who come from broken homes, who haven't had a lot of attention or support and other groups. I think we need to acknowledge every one of us has the potential for addiction, an internal war going on between our impulses to indulge and out impulses to control. As a profession, we need to be advanced and honest enough to embrace addiction as a sickness, recognise the risks of our prescribing but above all not turn our backs on the problem so that it otherwise manifests in preventable deaths and infection."

New Zealand's current drug problem with prescription opiates appears to be pretty minor. It seems likely that the action taken by Dr Moodie and New Zealand's DHBs has prevented a similar situation to the addiction statistics in America and possibly now facing Australia.

"I'm very pleased that the campaign we ran some years ago is still having an effect," Moodie says. "It means there's less drugs available for the black market." ■

Matt Black is an Auckland-based freelance writer.