SAFE OPIOID PRESCRIBING FOR ACUTE DENTAL PAIN

TRANSCRIPT

Slide 1
Welcome to Safe Opioid Prescribing for Acute Dental Pain.

This program is designed to assist clinicians in their treatment of patients with acute dental pain, using non-opioid and opioid analgesics as appropriate. Using the case of Melanie Stokes, it will guide clinicians through safe prescribing practices, including risk assessment and patient education.

At the conclusion of the program, if you wish to receive Continuing Dental Education credits, you must register in order to take a post-test and complete an evaluation. With a passing score of 70% or great, you'll be able to print your certificate.

Slide 2
Boston University Henry M. Goldman School of Dental Medicine is an ADA CERP recognized provider.

The program is supported by an unrestricted educational grant from the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services.

Slide 3
At the conclusion of this program, participants should be better able to:

- Practice safe and competent opioid prescribing for acute pain
- Prescribe opioids using universal precautions while individualizing care based on level of risk
- Educate patients and families about the safe use of and risks associated with opioid analgesics
- Communicate to patients and/or family members about how to properly store and dispose of unused medications

Slide 4
The reasons for taking this online course include use of all prescription opioids has dramatically increased in this country. Opioid use disorder, overdose, and deaths associated with misuse of prescription opioids have also dramatically increased. And in 2009 dentists prescribed 8% or 6.4 million prescriptions of opioid analgesics in the United States. Clinicians have the difficult task of balancing the relief of pain with the need to prevent adverse outcomes for their patients, families, and community.

Slide 5
This graph comes from a Journal of American Medical Association paper in 2011, using a national pharmacy database looking at prescriptions for opioids in 2009. As

mentioned before, dentists overall prescribed 8% of the opioids during this time. When looking at specific age groups, in particular patients age 10 to 19, dentists prescribed the most opioids or 31%. When looking at older patients, age 20 to 39, dentists prescribed the second highest amount of opioids only second to primary care providers.

Slide 6
This training covers the safe and competent use of opioids for managing acute moderate to severe dental pain. This training does not cover an extensive review of non-opioid management of acute pain or management of chronic pain.

Slide 7
This is the case study of Melanie Stokes. Ms. Melanie Stokes is 31 years old with a past medical history that is not contributory. She has not had routine dental care for over three years. This is her first appointment with Dr. Gunderson. She has told the dental assistant that she is in severe pain. She has requested a prescription for Vicodin. Should you be concerned about her request for opioids and in particular her specific request for Vicodin by name?

Slide 8
We know that acute pain is complex. It has been defined as the normal predicted physiologic response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, and acute illness.

We know that attitudes, beliefs, and personalities also strongly affect the immediate experience of acute pain, and that not all patients experience pain in the same way. We also know that there are factors that increase the painful experience, including anxiety and depression, sleep disruption, and substance use disorders.

Slide 9
So now let's talk about opioids and their benefit in treating acute pain.

Slide 10
We know that pharmacodynamically opioids turn on the descending inhibitory pathway in the midbrain. They also prevent the ascending transmission of pain signals and inhibit the terminals of the C fibers in the spinal cord in the dorsal horn. They inhibit activation of the peripheral pain receptors or nociceptors. However, we also know that opioids activate the opioid receptors in the midbrain or the reward pathway, which is a dopaminergic system that results in reward and euphoria.

Slide 11
Now, reflecting on this patient's request for a specific opioid by name, although requests for specific opioids may be concerning for opioid misuse, for example, diversion, they may also represent an innocent report on which opioid the patient tolerated or found beneficial in the past.

Slide 12
All patients who receive opioid medications for pain have different responses to specific opioids and doses. So it may make sense for a patient to ask for a specific opioid that worked in the past. And the reason for this variability in response includes differences at the Mu opioid receptor. We know that there are greater than 100 polymorphisms in the human Mu opioid receptor gene, and that there are Mu opioid receptor subtypes.

But we also know that patients metabolize opioids differently in terms of pharmacokinetics, and that opioid metabolism differs by individual opioid and by individual patient. For example, patients with an impaired cytochrome 2D6 metabolism do not respond to codeine.

Slide 13
So prescription opioids come in two major categories: immediate-release/short-acting and extended-release/long-acting. And we put them side by side on this slide to remind everybody that the molecules are essentially the same. Extended-release/long-acting opioids are that way because of their formulation. That is, that they're slow release if they're ingested orally. But we also know that if people disrupt that formulation by crushing it and sniffing it, that they become and immediate-release/short-acting opioid.

Slide 14
Now, due to the slow onset of action and high-dose formulations of extended-release/ long-acting opioids, they should not be prescribed for acute pain in opioid-naïve patients. And a patient who presents to you who is already on an extended-release/ long-acting opioid for chronic pain, well, refills for that opioid should come from the provider who's managing his or her chronic pain.

Slide 15
Now, let's look at comparative efficacy of medications for acute dental pain. Because most cases of postoperative dental pain include an inflammatory component, non-steroidal anti-inflammatory drugs are, therefore, a rational first-line agent. And they are often more effective than conventional doses of opioids. Mild to moderate pain can generally be managed by using optimal doses of non-opioids such as ibuprofen or acetaminophen or a combination of the two.

Slide 16
I am now going to show four slides from four different manuscripts that tried to elucidate the comparative numbers of different medications for the treatment of acute dental pain. The first slide here was taken from a Cochrane review in 2011, where they looked at studies where the primary outcome was the number needed to treat for at least 50% maximal pain relief over 4 to 6 hours compared to a placebo.

And what you can see here is that the top six medications or medication combinations that did the best in terms of the fewest number of patients needed to reach that 50% maximal pain relief were either combination medications, like acetaminophen with a non-steroidal anti-inflammatory drug, combination with acetaminophen and an opioid or

an NSAID alone, followed by what I would say is a second-tier group. And what you note is the last medication listed, which is codeine alone, fared the worst. That is, 21 patients needed to be treated before 1 patient got 50% maximal pain relief. You're starting to see a pattern here where NSAIDs can be extremely effective for acute dental pain, and a combination therapy seems to also hold some advantages.

Slide 17
This study looks at the concept of rational polypharmacy. Are combination medications better than medications alone? And what you can see here on the Y axis is main pain relief. Zero is no pain relief. Four is complete pain relief. What you can see here over an 8-hour period is that the combination of ibuprofen 400 milligrams with acetaminophen 1,000 milligrams did the best, followed by ibuprofen 200 milligrams with 500 milligrams of acetaminophen, which did better than acetaminophen alone, ibuprofen alone, or placebo.

Slide 18
This third study highlights the rational polypharmacy again. This involved 498 subjects who had third molar extraction and they followed them over five hours after their extraction. And they compared oxycodone with ibuprofen versus ibuprofen alone versus oxycodone alone versus placebo. And what they found was the combination of oxycodone with ibuprofen did the best, and actually oxycodone alone was no better than placebo.

Slide 19
And then finally, this study which was published in 2015 looked at the following outcomes, again, in patients who had just had third molar surgery. And this was a systematic review and meta-analysis. These were all randomized placebo-controlled trials. And they looked at sum of pain intensity difference in six hours, which essentially is the pain intensity score at baseline minus the pain intensity score hourly for six hours. The higher the score, the more analgesia.

The other outcome was total pain relief in six hours, which is a summation of pain relief scores on each hour in the first six hours. Again, a higher score represents more effective analgesia. And what you can see here is that when you looked at different combination medications comparatively, ibuprofen 400 milligrams with oxycodone 5 milligrams performed the best, followed by acetaminophen with oxycodone, acetaminophen with hydrocodone, acetaminophen with codeine, and acetaminophen with ibuprofen.

Slide 20
We need to individualize treatment based on the severity of pain and medical history, and we really need to maximize non-opioids before adding an opioid. And when you're using NSAIDs, be aware of NSAID-related adverse effects that involve the kidneys, the GI tract, and cardiovascular effects including increase in hypertension. And when you're using acetaminophen, be aware of liver adverse effects especially when prescribing high doses for extended periods of time.

You should also consider using preemptive analgesia. There have been studies that have looked at preemptive long-acting anesthetics as well as preemptive NSAID use, and there seems to be a decrease in postoperative pain. So considering preoperative dose, loading dose, but also prescribing around the clock initially when the person's pain is not going to be fluctuating very much. Remember to reduce the dose and duration of any NSAID or opioid when prescribing to the elderly.

Slide 21
Let's move on to opioid risks.

Slide 22
Care needs to be used when prescribing opioids for dental pain, and that includes checking the Prescription Drug Monitoring Program before writing a prescription for an opioid, screening patients for prescription opioid misuse risk, such as current or a history of a substance use disorder, developing a referral network for the treatment of substance use disorders for those patients identified with a substance use disorder, and then minimize the risk of diversion by educating patients about how to store opioids safely, including having a lockbox, and proper disposal of unused opioid medications.

Slide 23
The reason why we're focusing on opioid risks are because of data like these. Over the last decade, there's been an increase in opioid prescribing or opioid sales. But associated with that increase has been an increase in unintentional opioid overdose deaths. Also associated is an increase in people seeking addiction treatment for prescription opioid addiction. So although these lines are not showing causation, they are showing an association, and they're all trending in the exact same direction over the last decade.

Slide 24
Over the last decade drug poisoning deaths have overtaken motor vehicle crashes as the number one cause of accidental death in this country.

Slide 25
When you look at which drugs are causing these overdose deaths, by far it's prescription opioids more than benzodiazepines, cocaine, as well as other illicit drugs.

Slide 26
When those individuals are asked where they're getting those prescription opioids, over two thirds are getting them from a family or friend.

Slide 27
Allergies to opioids are rare. However, adverse effects are common including nausea, sedation, constipation, urinary retention, and sweating. There's also itching that some patients get or pruritus from a histamine release. The one we worry about the most is respiratory depression especially in our patients with sleep apnea. And we worry about

overdose especially at high doses, and those are patients usually on extended-release/ long-acting formulations; when combined with other sedatives, for instance, benzodiazepines; and drug-disease interactions, as I'd mentioned, patients with sleep apnea. And then lastly we worry about people developing an addiction or an opioid use disorder.

Slide 28
In terms of respiratory depression, opioids depress the medullary respiratory center. They decrease tidal volume and minute ventilation. They shift the CO2 response curve to the right, resulting in hypercapnia, hypoxia, and decreased oxygen saturation. This is immediately life threatening. However, sedation occurs before significant respiratory depression. And, therefore, sedation is a warning sign. Because of the possibility of respiratory depression, patients should be counseled not to increase doses to get better pain control, especially at night when respiratory rates are normally decreased.

Slide 29
There are specific opioid risks in our elderly patients because of drug-drug interactions and drug-disease interactions, especially in our patients with CHF, COPD, sleep apnea, chronic liver disease, and renal disease. Opioids can also worsen someone's dementia. And we know that as we age, there's a decline in therapeutic index, and there's an age-related predisposition to adverse drug effects. And then finally when you're prescribing an opioid, which is a sedative, there's a fall risk.

Slide 30
Prior to entering the exam room, Dr. Gunderson reviews the online state Prescription Drug Monitoring Program. The patient has received two prescriptions for hydrocodone with acetaminophen, ten tablets each, from two different doctors over the past two weeks. Dr. Gunderson notes the date each prescription was filled. How should you use this PDMP information when responding to the patient's request for opioids?

Slide 31
Prescription Drug Monitoring Programs or PDMPs are statewide electronic databases on dispensed controlled substance prescriptions. Prescription data available for the past year including information on date dispensed, patient, prescriber, pharmacy, medicine, and dose are included. Many states now mandate use before writing prescriptions for controlled substances. And several studies suggest an association between PDMP use and positive outcomes related to improving prescribing and reducing prescription drug abuse.

So how should a clinician discuss PDMP information with their patient? Well, it should be open and nonjudgmental. You could say, I see that you've received multiple opioid prescriptions from multiple providers filled at multiple pharmacies. Can you tell me about this?

Slide 32
Ms. Stokes explains that she developed severe right-sided tooth pain two weeks ago and went to two different emergency departments. Each time she was prescribed a small number of Vicodin pills, as shown in the PDMP, and was instructed to follow-up with a dentist. She says she heard great things about Dr. Gunderson from a friend. She also says that she has a hard time caring for her two young children because of the pain.

Slide 33
During the exam Dr. Gunderson found a large cavity in Number 30, the first molar on the right side, that extends to the pulp. The tooth is tender to percussion. There is mild swelling in the lateral cheek vestibule which is tender to palpation. There is evidence of mild periodontal disease, and Miss Stokes has a temperature of 100 degrees. Though there is a periapical pathology, the tooth is restorable. Dr. Gunderson recommends a root canal and crown.

Slide 34
Ms. Stokes tells him that she does not have insurance that will cover the cost of that work. Therefore, Dr. Gunderson recommends extraction. She says that she cannot have the extraction done today, and that the Vicodin she got from the emergency room worked pretty well on the pain, but she ran out. She asks for more Vicodin to tide her over. How would you assess her for prescription opioid misuse?

Slide 35
So assessing for risk of prescription opioid misuse starts with universal precautions in pain medicine, which should be part of an office controlled substance policy. We know that predicting prescription opioid risk and misuse is imprecise. So by using universal precautions it protects all patients and protects the public and community health. Part of universal precautions is the consistent application of opioid-prescribing precautions. This reduces stigma of individual patients and standardizes systems of care, and it's resonant with expert guidelines.

Slide 36
Universal opioid prescribing precautions for dentists should include checking the state Prescription Drug Monitoring Program data to corroborate patient history of opioid use; talking to all providers, both primary care, other dentists, other surgeons, as appropriate; assessing prescription opioid misuse risk including substance use history. Prescribe minimal amounts of opioids based on the expected duration of severe pain; give specific opioid-prescribing directions, for example, no more than four tablets in a day; and if pain is more severe or lasts longer than expected, reassess the patient before prescribing additional opioids; and then explain to patients how to store opioids safely and talk to them about how to properly dispose of unused opioids.

Slide 37
We know that the following are risk factors for prescription opioid misuse. A personal history of substance use disorder, whether it be illicit drugs, prescription drugs, alcohol, or nicotine; being younger, that is less than 45 years; a family history of substance use disorders; a legal history; and mental health problems.

Slide 38
According to an American Dental Association survey, more than half of dentists do not ask their patients about alcohol use. And of those who do not ask, more than half were either somewhat uncomfortable or not at all comfortable asking patients about their alcohol use.

Slide 39
According to that same ADA survey, over half of dentists do not ask their patients about the use of illegal substances. And of those, most dentists, almost two-thirds, either feel somewhat uncomfortable or not at all comfortable about asking these questions.

Slide 40
So a quick screen for unhealthy tobacco, alcohol, and drug use a dentist could use before prescribing an opioid could be, do you currently use tobacco? And then for alcohol, do you sometimes drink beer, wine, or other alcoholic beverages. And if yes, how many times in the past year have you had five or more drinks in a day? That would be four or more for women. And anything other than never would be considered positive on the alcohol screen.

In terms of the drug screen, how many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? Again, anything other than never would be considered positive.

Slide 41
So in terms of interpreting the answers to those screening questions, it's helpful to look at this pyramid, because what we're screening for is unhealthy alcohol and drug use, which not only includes substance use disorders but also includes individuals that are using substances in a risky way.

Slide 42
There is a specific screener that you may use called the Screener and Opioid Assessment for Patients with Pain, or the SOAPP Short Form. And it's scored as zero never, one seldom, two sometimes, three often, and four very often to the following questions. How often do you have mood swings? How often do you smoke a cigarette within an hour after you wake up? How often have you taken medications other than the way it was prescribed? How often have you used an illegal drug, such as marijuana or cocaine, in the five past years? This screener is considered positive when responses equal four or more.

Slide 43
Ms. Stokes screens positive on the SOAPP. Her score is four because she smokes very often. The substance use screen was negative for drug use and prescription opioid misuse but positive for unhealthy alcohol use because she's a binge drinker. She admits to heavy daily marijuana use in the distant past, but she says she has not used marijuana in more than ten years. How would you counsel Ms. Stokes about her prescription opioid misuse risk and unhealthy alcohol use?

Slide 44
Brief counseling for unhealthy substance use can be done in a dental practice, and it would include the following: giving the patient feedback, providing personalized feedback in stating your concern. For example, concern about increased prescription opioid misuse risk due to her smoking history or the health risk associated with binge drinking such as an increased risk of accident and trauma, or an overdose risk of combining alcohol with opioid pain medications.

Slide 45
After feedback you would give advice. Make a nonjudgmental yet explicit recommendation for change in behavior, such as cutting down to a lower risk amount to protect his or her health, or no drinking while taking opioid medications to avoid over sedation. And then finally would be goal setting, discussing with the patient his or her reaction to what you've said and discuss a plan for behavior change. For example, what do you think about these recommendations? Are you ready and able to make a change? How will you make this change?

Slide 46
In patients with a substance use disorder history, I think it's important to frame the substance use disorder as a challenging health issue and express admiration for the patient's recovery and acknowledge the patient's desire to never go there again. We also know that a history of substance use disorder is associated with increased pain sensitivity. That is, decreased pain tolerance. So we need to reassure the patient that his or her pain will be managed regardless of that substance use disorder history.
As with all patients, manage patients with non-opioids if appropriate. Due to increased opioid misuse risk, we need to increase the structure of care. And that includes giving smaller supply of medications in these patients and closer follow-up.

Slide 47
For those patients with a substance use disorder history that are on medications like opioid agonist therapy, for example methadone and buprenorphine, they can and should receive analgesia concurrently. That includes continuing opioid agonist treatment and providing aggressive pain management that combines effective communication with the patient, but also their addiction treatment provider, monitoring patients closely, and using appropriate medications for the treatment of that patient's pain.

Slide 48
For those patients that are on medications that are opioid antagonists like naltrexone, whether it be the oral form or the injectable depot form, these antagonists will block the effects of co-administered opioid analgesics. So if surgery is elective, discontinue the naltrexone. And if it's oral naltrexone, 50% of the blockade effect is gone after 72 hours. But if it's the injectable IM depot naltrexone, if possible delay elective surgery for a month after the last dose. If the acute pain is current or the surgery is urgent or emergent, use non-opioids and aggressive nerve block therapy.

Slide 49
Ms. Stokes is surprised that her drinking is considered risky. She says she is willing to cut down. Dr. Gunderson schedules the extraction in three days. For pain, he prescribes a limited supply of hydrocodone with acetaminophen, nine tablets, and ibuprofen. He also prescribes penicillin and Periogard. He educates Ms. Stokes about safe storage of opioid medication and the risk of pediatric exposure. Ms. Stokes agrees not to drink while she's taking these prescriptions, and she says she will store the opioids out of reach of her children.

Slide 50
Educating patients about collateral opioid risks is important. And this includes young children ingesting and overdosing and adolescents experimenting leading to overdose and opioid use disorders. How do we mitigate that risk? Again, educating patients about safe storage including a lockbox, educating family members about risk, having poison control numbers readily available, and naloxone distribution when available, and then finally proper disposal of unused medications.

Slide 51
It's important to tell patients to dispose of any unused opioids by providing information about local take-back programs if available, DEA authorized collection sites, for example, pharmacies, hospitals, and law enforcement locations, disposal in household trash by mixing pills with kitty litter or coffee grounds and sealing in a plastic bag and putting in the trash, and flushing down the toilet if appropriate.

Slide 52
On the day of the scheduled extraction, Ms. Stokes calls to cancel her appointment because her son is sick and needed to stay home from school. She says her tooth pain is killing her, and that the Vicodin helped but that she has run out. She is requesting a refill over the phone. How would you address her request for an opioid refill over the phone?

Slide 53
In determining whether refilling an opioid prescription without seeing the patient is legal, we need to be knowledgeable of state and federal laws and regulations. One is a prescription for a controlled substance must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice, and the responsibility for the proper prescribing and dispensing of controlled

substances rests on the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription.

Slide 54
There are some common themes in these laws and regulations: that there must be a valid provider-patient relationship, that the prescription must be issued for a valid medical purpose, that the prescription must be therapeutic for the patient's condition, and that the provider and pharmacist have a corresponding responsibility to determine the validity of that prescription.

Slide 55
So in this case refilling the opioid prescription without seeing the patient would be legal. However, you could then ask, is refilling an opioid prescription without seeing the patient good clinical practice? Well, it wouldn't be for a new patient who you're not certain can take the opioids safely, and not if the patient has been non-adherent with treatment instructions in the past, and then not if the patient's pain is persisting longer than anticipated.

Slide 56
We also need to understand the opioid schedules as laid out in the Controlled Substance Act. And really what we're prescribing here are either Schedule II opioids or Schedule III opioids. The only one that falls within Schedule III is acetaminophen with codeine. The vast majority of opioids that we'll be prescribing for acute pain fall within Schedule II. And that includes morphine, codeine that is not a combination product, hydromorphone, hydrocodone, and oxycodone.

Slide 57
The rules for prescribing Schedule II opioids include the requirement for a prescription that is signed by the practitioner. There is no federal time limit within which a Schedule II prescription must be filled after being signed by the practitioner. Some states and many insurance carriers limit the quantity of controlled substances dispensed to a 30-day supply. There are no specific federal limits to quantities of drugs dispensed via a prescription. An oral order is only permitted in an emergency situation.

Slide 58
This is opposed to Schedule III opioids where a prescription may be communicated either orally, in writing, or by fax to the pharmacist, and may be refilled if so authorized on the prescription or by call-in. The prescription may only be refilled up to five times within six months after the date on which the prescription was issued.

Slide 59
Dr. Gunderson explains nonjudgmentally and empathically that he does not feel comfortable prescribing additional opioids over the phone. He recommends that Ms. Stokes continue taking acetaminophen and ibuprofen for pain until she can reschedule her extraction. He explains that her pain is not going to be properly treated without an extraction. He reschedules the extraction for the following day.

Slide 60
Dr. Gunderson performs an uncomplicated extraction of Tooth Number 30. He prescribes ibuprofen, hydrocodone with acetaminophen every six hours for pain, and he specifically writes a maximum of four tablets per day on the prescription. Ms. Stokes becomes angry and complains that eight tablets is not enough to treat her pain, and that she is very sensitive to pain and needs more. She says she will not be able to take care of her children if she is in severe pain.

Dr. Gunderson explains to Ms. Stokes that the usual duration of postoperative pain is a couple of days, and she will need to return for another visit if the pain persists beyond that. He tells her ibuprofen and acetaminophen are as effective for acute dental pain as opioids, and he says the best pain control is with combination therapy.

Slide 61
Two days later Ms. Stokes calls the office. She's crying, and she says that she was beginning to feel better. Then last night she woke up in excruciating pain that is now causing ear and jaw pain on the right side of her face. She thinks she has an infection as she has a foul odor and taste in her mouth. She doesn't have a fever or chills. She says this pain is worse than the original pain. When asked to return to the office, she says she does not think she can, and she asks Dr. Gunderson to call in prescriptions for more Vicodin.

How would you interpret Ms. Stokes' request for additional opioids? Is she drug seeking or pain relief seeking?

Slide 62
There's a differential diagnosis for concerning behaviors around opioids. And determining whether the patient is pain relief seeking or drug seeking can be quite complex. For instance, pain relief seeking, does the patient have worsening pain due to an infection or a dry socket? Or maybe the patient has an exaggerated perception that opioids are the most effective treatment for acute dental pain and, therefore, if pain relief is not complete, more opioids are needed.

In terms of drug seeking, has the patient developed an opioid use disorder? Is the patient medicating other psychiatric diagnoses like anxiety? Or is the patient actually diverting, selling or giving away the opioids that you're prescribing with criminal intent?

It's possible that a patient could have both. That is pain relief seeking and drug seeking. For example, the patient has acute pain with comorbid opioid use disorder, taking some of the medication for pain but diverting some of the medication for income.

Slide 63
So in determining whether or not the patient has developed or has an opioid use disorder, we go to the DSM-5. The criteria of tolerance and withdrawal are not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

But the other criteria include use in larger amounts or duration than intended, persistent desire to cut down, giving up interests to use opioids, and a great deal of time spent obtaining, using, or recovering from opioids…

Slide 64
…craving or a strong desire to use opioids, recurrent use resulting in failure to fulfill major role obligations, recurrent use in hazardous situations, continued use despite social or interpersonal problems caused by or exacerbated by opioids, and then continued use despite physical or psychological problems. Opioid use disorders are categorized as mild if people have two to three criteria, moderate – four to five criteria, and severe – greater than or equal to six criteria.

Slide 65
What do you do if you have concerns that a patient is misusing the prescription opioids? Well, it's recommended to check the Prescription Drug Monitoring Program and then discuss your concerns openly with the patient giving specific examples of the observations that you've seen that concern you for risk or harm.

How to handle suspected diversion or opioid use disorder? First of all, you need to have the difficult conversation, but be specific as to why you're concerned. What are the behaviors that you've witnessed or observed that make you think the person is diverting or has an opioid use disorder? And for those with an opioid use disorder, counsel the patient, including giving a brief intervention similar to what we talked about before, which includes feedback, advice, and goal setting, and then always offer referral to substance use treatment if available.

Slide 66
In implementing these strategies in your clinical practice, it's important to remember to stay in the clinician role. You are not a police officer, a judge, or a DEA agent. You're a clinician, and we need to balance the risks and benefits of our prescribing based on what we're observing with any given patient.

Slide 67
Dr. Gunderson says he needs to examine her, and that prescribing more Vicodin over the phone without seeing her would not be appropriate. He schedule an urgent visit for today. Ms. Stokes arrives with her son, and she is in distress, crying and demanding pain medications. There is evidence of a dry socket without infection.

Slide 68
Dr. Gunderson starts to irrigate the extraction site to remove food particles and necrotic material. However, she is unable to tolerate the irrigation due to severe pain. Dr. Gunderson performs a nerve block, then irrigates and packs the socket with dry socket paste. He prescribes hydrocodone with acetaminophen, ten tablets, and ibuprofen. Ms. Stokes returns for daily follow-up assessment and treatment, and her symptoms continue to improve.

Slide 69
One week later Ms. Stokes calls the office, and she says that while her pain is better, she still has some pain and needs more pain medication, and she requests a Vicodin refill. She's worried that without the Vicodin her pain will become so severe that she will not be able to care for her children. Dr. Gunderson tells her that her pain will now be treated with non-opioids, such as ibuprofen and acetaminophen, and that if her pain gets worse, she can call the office and make an appointment as she will need to be re-examined. Dr. Gunderson does not hear from Ms. Stokes again.

Slide 70
So overall when prescribing opioids, it's helpful to use a health-oriented risk/benefit framework. It's not is the patient good or bad? Does the patient deserve opioids? Should this patient be punished or rewarded? Or should I trust this patient? It's really rather are opioids indicated and safe for this specific patient? So we're judging the opioid treatment, not the patient.

Slide 71
And we need to stay in this risk-benefit framework. We need to use clinical judgment in determining the indication and safety of opioid prescribing, to understand the complexities of an individual patient's pain, and then to identify worrisome behavior as to whether or not it's pain relief seeking or drug seeking or both.

Slide 72
So in summary we should use universal precautions but individualize pain management based on risk, recognize that opioids have limited efficacy when used alone, and that combined medications for synergistic effect is standard of care, prescribe opioids in limited amounts with clear directions, and prior to prescribing opioids assess the patient for opioid misuse risk. And we should be educating patients about safe storage and disposal. And finally we should use a risk/benefit framework to guide our clinical judgment.

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