Questions and Answers from the Opioid Workshop
September 7, 2017

Are the drug companies looking into opioid antidotes? Such as Contrave (Welbutrin/Nacan) as an appetite suppressant?

There are a number of naloxone type drugs available which are direct opioid antagonists. These include naloxone nasal spray (Narcan), naloxone auto-injector (Evzio), or a naloxone kit. Drug companies are also developing abuse-deterrent formulations by combining naloxone with an opioid. It prevents patients from crushing the tablet and injecting the content. There are several products available such as morphine/naltrexone (Embeda), buprenorphine/naloxone (Suboxone, Zubsolve, Bunavail) and oxycodone/naloxone (Targiniq).

Can Dr Franklin talk about the alternatives to opioids and the new acupuncture pilot program for low back pain?

The 2015 agency medical director’s opioid guideline (http://www.agencymeddirectors.wa.gov/files/2015amdgopioidguideline.pdf) has new sections on alternatives to opioids. The best evidence is for graded exercise and similar physical reactivation methods and for cognitive behavioral therapy.

The acupuncture pilot program is only for the department of labor and industries and only for low back pain. We have recruited over 200 acupuncturists for the 1-2 year pilot program.

Can I ask for clarification with regard to use of opioids in cancer pain and pain related to terminal illnesses?

We have not had any limitations on opioid use for cancer pain or end of life pain care.

Hi! Is there a universal protocol that primary care physicians can use to wean off their patients when they are already dependent on opioids like Dilaudid?

There is no universal protocol, but the 2015 Agency Medical Director’s Opioid Guideline has specific sections on how to taper and a case definition of when to taper.
I am not sure who or when it is most appropriate to ask this question, but I am wondering about data on Tramadol and if patients on Tramadol are/should be included in our office Chronic Pain Protocols? What is the State’s perspective on this?

Tramadol is a schedule IV opioid and is now being tracked in our state prescription monitoring program; we would recommend inclusion of these patients in your office protocols pertaining to opioids and chronic pain.

I have practiced emergency medicine for 14 years. The worst experience I have had to date was from a narcotic seeker, (I probably have PTSD from that patient). One of the troubles I've seen in the emergency department is "allergy to NSAIDS" by patients. What are the recommendations for acute pain treatment of these chronic pain patients?

This needs to be explored to clarify whether this is a true allergy with respiratory compromise or intolerance due to GI side effects. Unless there is a true allergy, these patients can use oral NSAIDs with PPI or use a topical NSAID. For true NSAID allergy, acetaminophen is an option.

Is there sincere research being conducted on the effectiveness of chiropractic care for treating chronic or acute low back pain? There's a seemingly inappropriately high amount of negative stigma against the practice held by medical practitioners but ample anecdotal evidence that supports the notion of efficacy that supports chiropractic care as a very effective method of treatment for spinal care.

There is abundant evidence on the efficacy of chiropractic care. Please see this reference for more information: Chou et al, Ann Intern Med. 2017 Apr 4;166(7):493-505.

My mom is 87 years old and she had been taking oxycodone for years for chronic pain. How do we assure that she doesn't suffer when they are taken away from her at this point in her life? Do we worry about addiction at this stage?

She should be reassessed to optimize therapy with a goal of lower doses. Recent data from WA State on opioid overdose events reveal that Oregon and Washington have had the highest rates of overdose among the elderly in the US, this should be of high concern.

SUD is a primary dx NOT a symptom of anything else. It may co-occur with the other things listed.

Thank you.
What percentage of young people with overdose were buying pills from others on the street as opposed to being prescribed the drugs by a provider?

As studies from Michigan have shown, even one opioid prescription in a high schooler is associated with a 33% increased risk of non-medical misuse between the ages of 18-23. Miech et al pediatrics 2015; 136: e1170.

According to the CDC, most people who abuse prescription opioids get them for free from a friend or relative. However, those who are at highest risk of overdose (using prescription opioids non-medically, 200 or more days a year) get them in ways that are different from those who use them less frequently. These people get opioids using their own prescriptions (27 percent), from friends or relatives for free (26 percent), buying from friends or relatives (23 percent), or buying from a drug dealer (15 percent).

Sources of Prescription Opioids Among Past-Year Non-Medical Users

Since drug diversion is also a crime, how does WHPS help nurses with criminal convictions, given that a criminal conviction might lead to loss of license?

Nurses with criminal convictions have a difficult time finding employment not only from stigma, but also from regulatory restrictions on practice. For example Washington State's Disqualifying List of Crimes and Negative Actions Chapter 388-113 WAC, automatically disqualifies those convicted of certain crime from providing service to certain populations (i.e. vulnerable adults and children), and the Medicare Exclusion List excludes individuals from providing services attached to Medicare/Medicaid dollars.

WHPS advocates for nurses in employment by monitoring and documenting their recovery, and partnering with employers to ensure a safe working environment for the nurse and
patients. Approximately 75% of nurses in the WHPS program are actively practicing at any given time. In order to graduate from WHPS all nurses must practice under their license for a defined period of time and while it does happen it is very rare that a nurse has not met his/her practice obligations at the time they are scheduled to graduate. Unfortunately nurses with felony convictions sometimes find the employment challenge so daunting that they end up giving up their license. There is still much work to do regarding the acceptance of substance use disorder as a defined medical disease and erasing the stigma. John Furman, WHPS Director

I was wondering, how can practitioners advise patients, especially elderly patients, to keep themselves safe from burglaries and related crimes, without coming off as alarmist?

I was wondering if there are any brochures or materials about this?

Unintentional poisoning death rates have risen by 395 percent over the past 16 years. Keep your medications secure in your home and while you travel. These medications are intended for you alone. You should never share them or take them from others. This is illegal. Do not discuss opioid medications that you are taking with others.

Practitioners should only prescribe what is needed, discuss this with your patient. Patients can choose to only partially fill their prescription if they feel they won’t use it all. Do no keep unused prescriptions around the house.

To dispose of unwanted medication, ask your pharmacy for a drop-off location near you. If you can’t drop off unused medication, put household waste or garbage in the bottle and throw it away in its original childproof and watertight bottle. Do not flush it down the toilet.