

*Prescription Drug-Seeking
and Drug-Diversion
in Primary Care*

Giang T. Nguyen, MD, MPH, MSCE

Assistant Professor of Family Medicine & Community Health
University of Pennsylvania

Family Medicine Lecture Series

Thursday, May 28, 2008 – noon

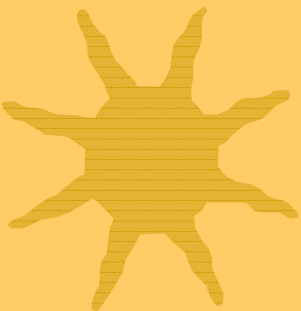
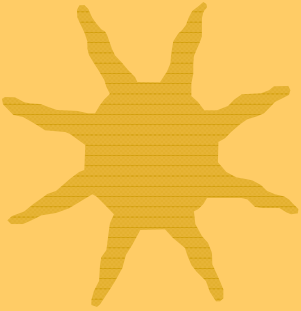


Case Presentation: “MM”

New Patient Visit Nov 28

55 y.o. female, new patient visit for “hepatitis”

- ★ Was once told that she had hepatitis B, but was later told by someone else that she didn't have it. Never went to see GI.
- ★ PMH: HTN, glaucoma, “borderline” DM, ?hepatitis B, B/L knee arthritis, ?hiatal hernia, anxiety (had a “nervous breakdown” after her mother's death in 1997).
- ★ Allergy: Sulfa.
- ★ Meds: glaucoma eye drops, MVI, Norvasc, Clonazepam, Hydrocodone/APAP q6 prn knee pain.
- ★ PSH: L. knee arthroscopy 1999, nml colonoscopy 1998, bladder cystocele 1983, D+C x3 for heavy vaginal bleeding.
- ★ FH: anxiety, DM, stroke, sz, ?MI, sibs with HTN, brother died age 43 with kidney dz.
- ★ SH: Social Security Insurance, smokes 1.5 ppd, no EtOH since '90.
- ★ Patient left before physical exam (had to catch her ride home). Labs ordered, follow-up in 1 week.





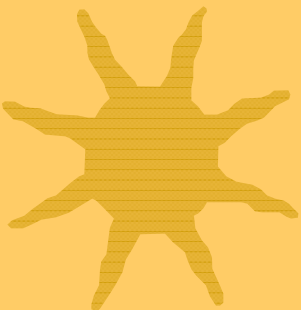
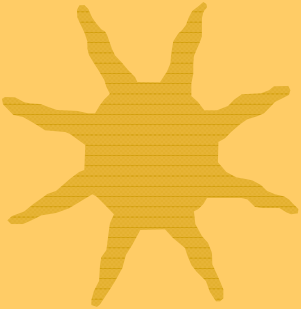
Dec 6 – Follow-up visit.

Complaint of abdominal pain, vomiting x1, increased anxiety.

- ★ Full exam shows soft abdomen with mild non-specific tenderness, b/l knee crepitus, heme neg, non-fasting glu 112, BP 120/76.
- ★ Lab tests show HBsAb(+), HBsAg(-), HAV(-), HCV(-), nml fasting glucose, sl high HgbA1c, nml CBC, nml LFT.
- ★ Reveals that she also gets Haldol IM q3wk at Horizon House, and is supposed to take Cogentin but doesn't.
- ★ Says her money was recently stolen.
- ★ Dx'd GERD → advised lifestyle change and OTC meds. Referral to GI and Ophthalmology.
- ★ Advised to f/u for full Gyn exam. Pt considering HIV testing.
- ★ No follow-up over the next month...



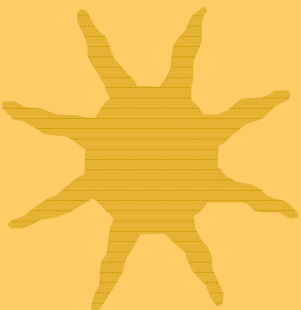
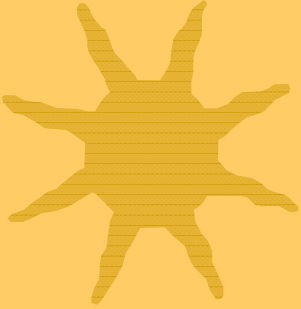
And then, the phone calls...



- ★ Jan 14 Mon – rec'd voice-mail from patient (left over weekend): Awaiting R knee surgery, ortho refused to Rx more Vicodin until surgery → Rx'd Tylenol #3, instructed to get surgery date ASAP.
- ★ Jan 17 Thu – Voice-mail from patient: Said she was given only #16 (Rx called in was “sixty”). Wants Vicodin. Surgery date 2/9/02 → Called Pharmacy and clarified original Rx, also Rx'd capsaicin topical. Advised pt: no additional narcotic Rx's until examined by me; left a message with ortho to confirm dates.
- ★ Jan 18 Fri – Ortho office returned my call: patient is not scheduled for 2/9 (Saturday) or any other day; they are trying to schedule sometime in Feb.
- ★ (Jan 18 Fri – office appointment: “No Show”)



More phone calls...



- ★ 2 days later: Jan 20 Sun – Voice-mail from patient: “The pain is worse. Tyl #3 not working. I made an appointment for 2/23 but I can’t wait that long. Please phone in Rx for Vicodin or Darvocet.” Left *different* pharmacy ph # → per computerized scheduling record, patient has no pending appointments at our office, left msg for RN to call patient to schedule appointment.
- ★ Jan 21 Mon
 - 3:11pm – Generic Tyl #3 not working, can’t wait. Please call in new Rx.
 - 4:15pm – Voice-mail from nurse: pt scheduled for 1/22.
 - 4:15pm – Voice-mail from patient: In a lot of pain. Tyl #3 not helping at all. Can’t get a ride tomorrow. Please call pharmacy (I’m allergic to motrin, ibuprofen, sulfa).
 - 4:30pm – Voice-mail from patient: “I’m in a lot of pain. Please phone in Rx. They gave me generic Tyl #3 and it’s not working” → Asked nurse to call patient back; she must come in to be seen. No exceptions.



The next day:

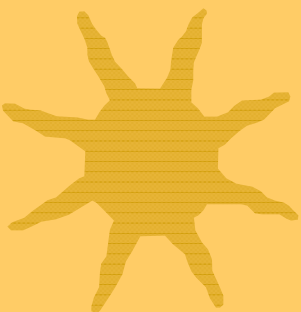
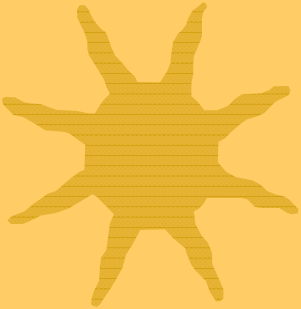
Jan 22 – acute visit for “leg pain”

Needs pain medicine.

- ★ When asked to list every medicine she’s tried: No success with naprosyn, ibuprofen, motrin, vioxx (“made me feel funny”), tylenol, tylenol #3, celebrex (“gave me bloody stools/hemorrhoids”).
- ★ Denies ever using recreational drugs. Prior EtOH problem but stopped in 1990.
- ★ Exam of knees was unremarkable. BP 132/80.
- ★ Suggest Ultram → “Oh, I tried that, too, and it didn’t help” (used neighbor’s pills). Must have Vicodin.
- ★ Pharmacy confirmed that the orthopedist gave last Vicodin Rx, and it should have run out by now → 30-day supply of Vicodin Rx’d, partially in an effort to establish some additional level of trust with patient. But no more refills after this: patient must f/u with Ortho.



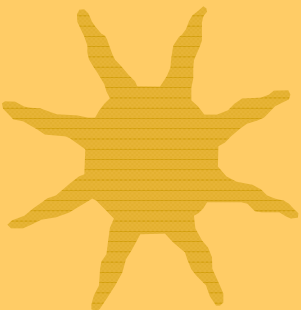
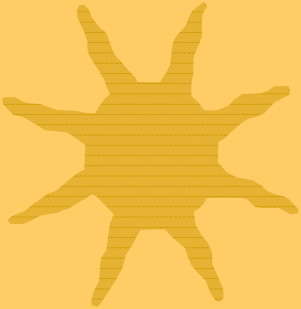
Even more phone calls... (1)



- ★ 7 days later: Jan 29 Tue – Voice-mail from patient: Wants form completed to get special housing.
- ★ Jan 30 Wed – Wants to move into special housing this Friday. Please complete form ASAP.
- ★ (Jan 31 Thu – I rec'd the housing form. Patient does not look like she qualifies based on physical “disability,” but I’ll fill it out accurately and fax it.)
- ★ Jan 31 Thu – Voicemail: Wants form completed.
- ★ Feb 1 Fri – Voicemail: “Did you fax the form?”
- ★ (Feb 1 Fri – No show to appointment).



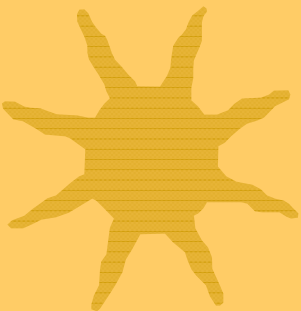
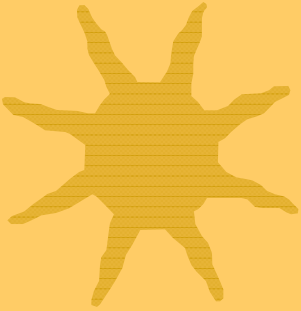
Even more phone calls... (2)



- ★ 3 days later: Feb 4 Mon, voice-mails from patient:
 - 8:14 am – Needs pain medicine. Ran out of meds. Surgery scheduled for Feb 20. Wants Darvocet. Left a *different* (3rd) pharmacy #.
 - 4:22 pm – Needs Darvocet.
 - 5:17 pm – Needs Darvocet.
 - (6:25 pm – I left a msg for the patient stating that, as previously agreed, NO more narcotic Rx's now. I can call in Ultram if she wants.)
- ★ No activity for over a month...
- ★ Mar 20 Thu, 5:50pm – Voice-mail from patient: Had surgery Feb 20 and still in pain, “can’t reach ortho”. Needs Vicodin. Left a *different* (4th) pharmacy # → Nurse to call patient to come in if needed.
- ★ (The next day: Mar 21 – Per ortho, the pt was scheduled for surgery 2/20 but didn’t show, hasn’t rescheduled.)



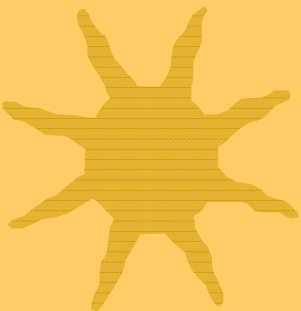
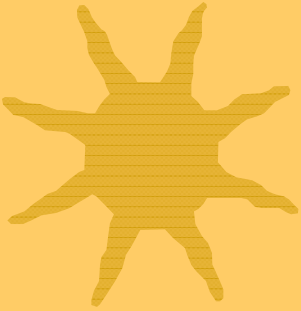
Even more phone calls... (3)



- ★ (Mar 22 – Patient no-showed to appointment. I called all 4 pharmacy phone #'s for narcotic history, able to speak to 3 pharmacists – Pharmacists knew her by name. Narcotics prescribed by 5+ providers.)
- ★ No activity for nearly 3 months...
- ★ June 15 Sat , voice-mail messages from patient:
 - 12:35 pm – “In pain”, wants Tylenol #3. Left pharmacy phone #1.
 - 4:06 pm – Wants Tyl #3. Voice-mail message electronically marked “URGENT”.
 - 6:04 pm – “I have an appointment on Tuesday. I’m in pain. I can hardly walk”. Voice-mail again marked “URGENT”. Left pharmacy phone #3.
- ★ June 17 Mon – I spoke to the patient on the phone regarding appropriateness of “URGENT” messages. She doesn’t have an appointment with me despite her last message. She must come to office if she wants these issues addressed.)



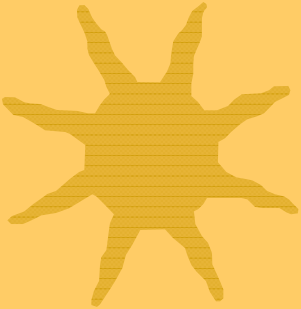
And...



★ (June 17 – One year later, she hasn't been back.)



Goals for this session...



★ Describe the problem of drug diversion in the US and locally.



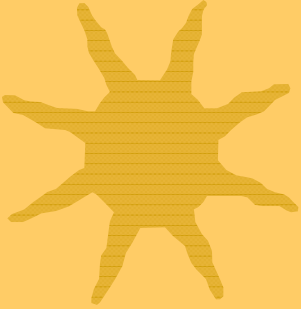
★ Review the characteristics of drug-seeking and drug-diverting patients.



★ Discuss practical methods for safely prescribing and documenting therapies with controlled prescription drugs.



Drug Enforcement Agency Scheduled Substances



★ 1: No accepted medical use.

– Heroin, marijuana, LSD

★ 2: High abuse potential with severe dependence liability.

– Morphine, methadone, oxycodone, amphetamines, secobarbital

★ 3: Less abuse potential than schedule 1 and 2 substances.

– Acetaminophen with limited quantities of certain narcotic drugs

★ 4: Less abuse potential than schedule 3 substances.

– Phenobarbital, benzodiazepines, propoxyphene, pentazocine, phentermine

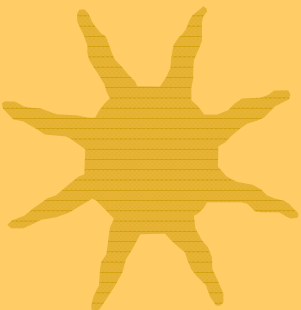
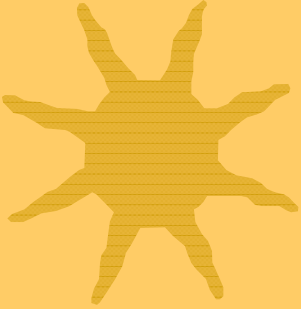
★ 5: Least abuse potential of scheduled substances.

– Buprenorphine, propylhexedrine
(Parran 1997).





DEA Licenses



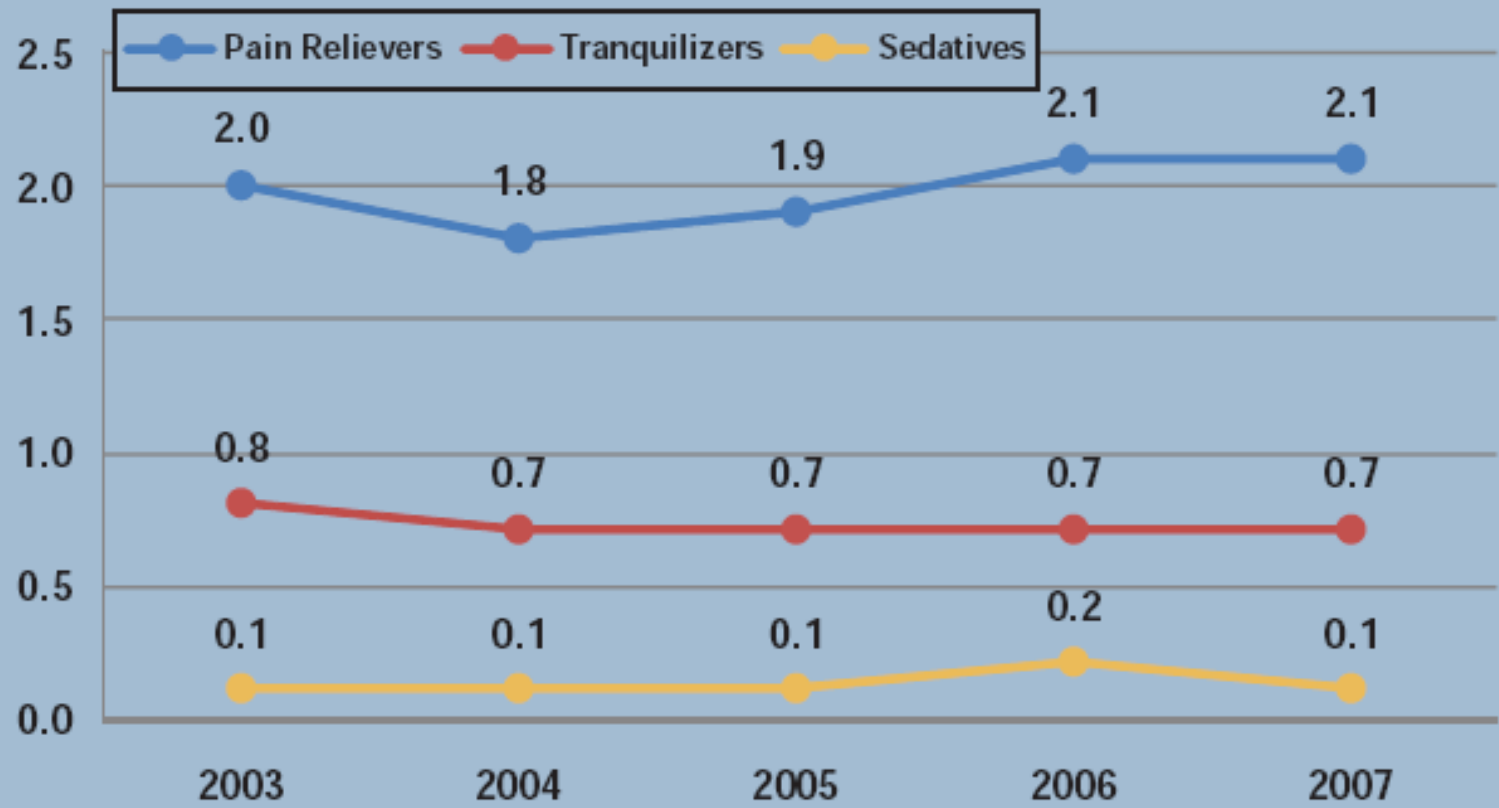
- ★ Required for prescribing controlled drugs
- ★ U.S. Dept of Justice, Drug Enforcement Agency, Office of Diversion Control
- ★ www.deadiversion.usdoj.gov
- ★ Difference License Types:
 - Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner
 - Manufacturer, Distributor, Researcher, Analytical Laboratory, Importer, Exporter
 - Narcotic Treatment Program
 - Domestic Chemical
- ★ Registration is national, but based upon state
 - Registration must be held in each state where a practitioner prescribes controlled drugs
 - Options for locum tenens: (1) apply for a separate DEA registration in each state; (2) use DEA license of the hospital if they agree to this; (3) contact Office of Diversion Control to transfer DEA registration to different state
 - Registration is also based upon place of practice within the state. However, if only prescribing (ie, not manufacturing/dispensing/etc) then a practitioner may use a single registration across multiple practice sites.



Is prescription drug abuse and diversion a problem?

DEA 2009 Prescription Drug Threat Assessment

Figure 2. Past Month Nonmedical Use of Psychotherapeutics by Individuals 12 or Older, by Percentage, Nationwide, 2003–2007



Source: National Survey on Drug Use and Health.

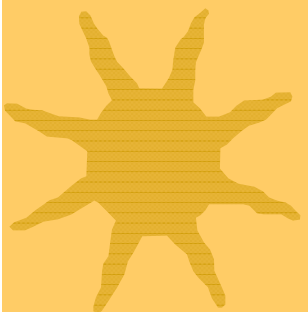
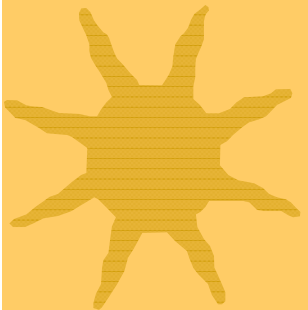
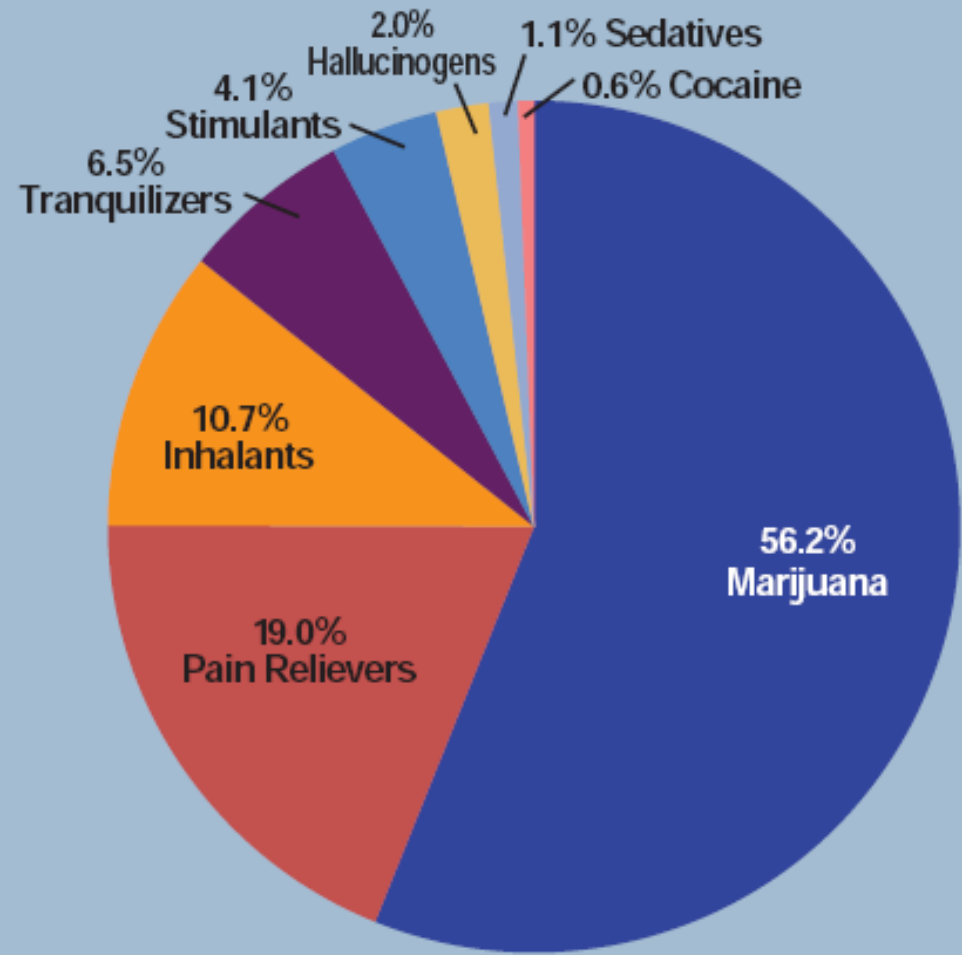


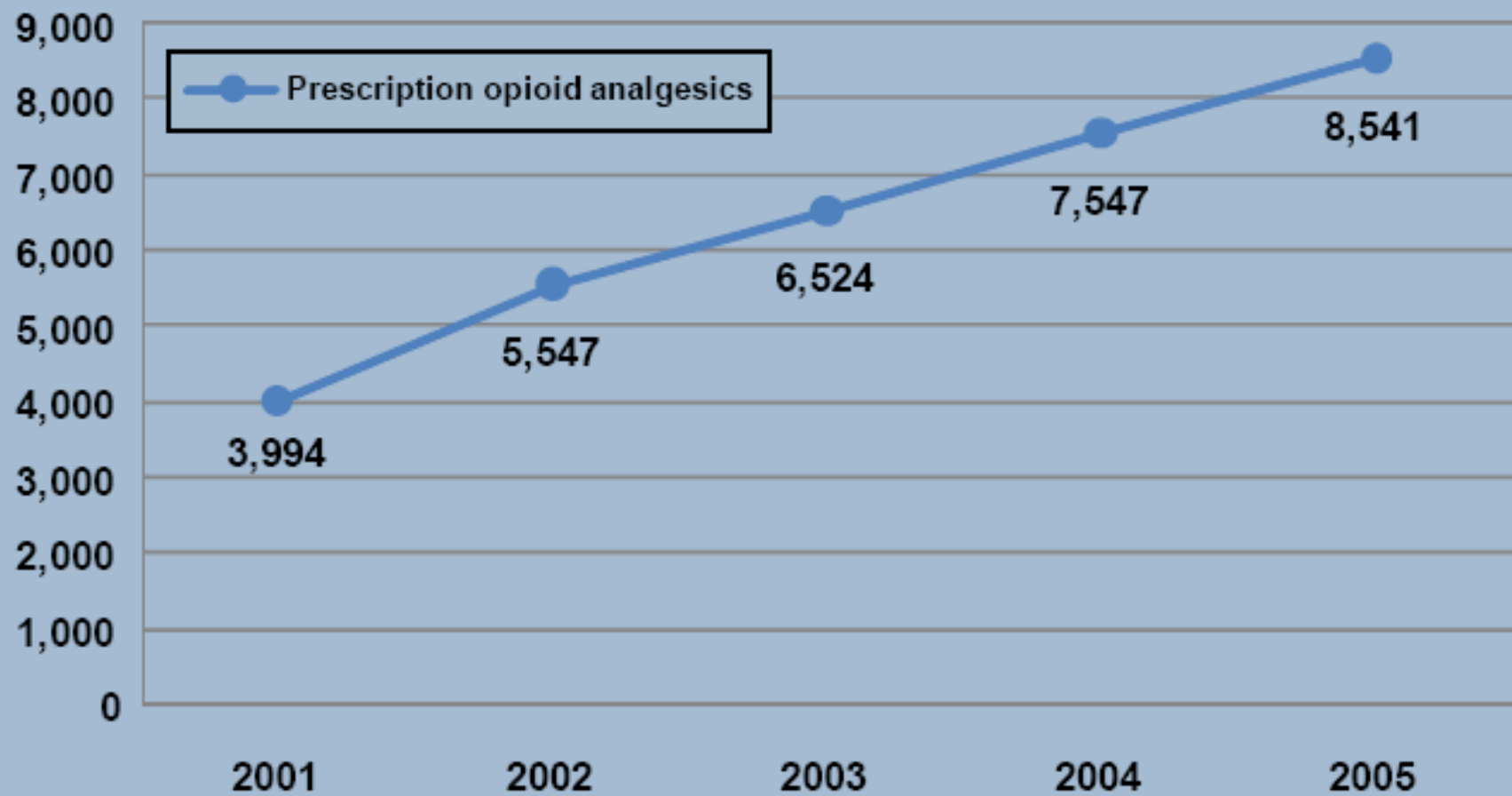
Figure 13. Specific Drug Used When Initiating Illicit Drug Use Among Past Year Initiates of Illicit Drugs, Aged 12 or Older, 2007



Source: National Survey on Drug Use and Health.



Figure 1. Prescription Opioid Analgesic Deaths Nationwide, 2001–2005

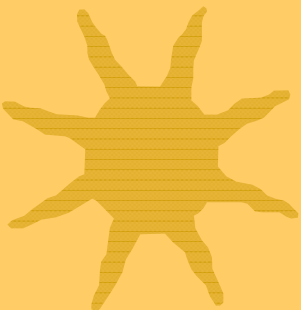
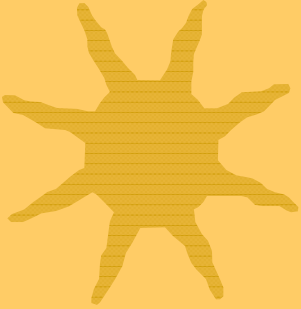


Source: Centers for Disease Control and Prevention.



But remember...

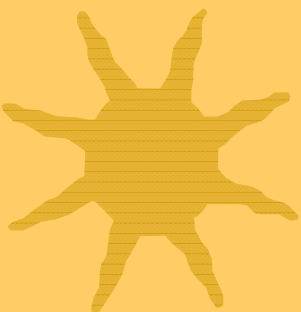
Pain requires treatment



- ★ Failure to provide relief from pain and anxiety disorders → enormous social cost due to lost productivity, needless suffering and excessive health care expenditures (Longo et al. 2000).
- ★ “Opiophobia” – Pain sufferers have become the victims of provider fears concerning addiction and drug diversion.
- ★ 6.6% of European physicians cited fear of turning patients into opioid addicts as a barrier (Zenz and Willweber-Strumpf 1993).
- ★ Codeine and oxycodone have been shown to be effective and safe treatment for well-defined chronic rheumatic disease pain in VA patients (Ytterberg et al 1998).



Be aware of Pseudoaddiction

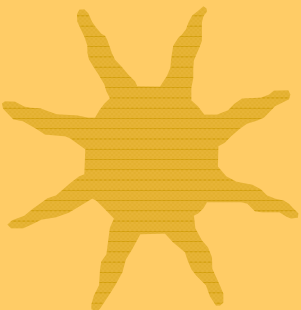
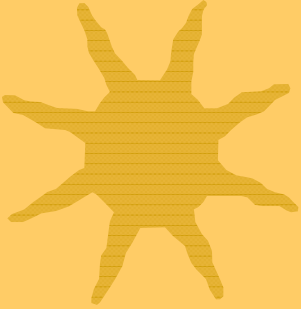


- ★ Apparent drug-seeking behavior in patients with severe pain that is not adequately treated. Distinguished from true addiction by its resolution with pain control.

(Savage 1999, Weaver 2002)

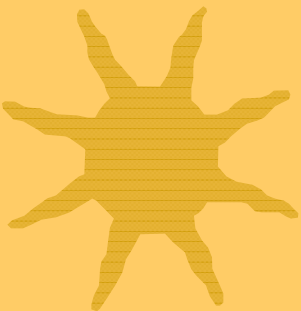
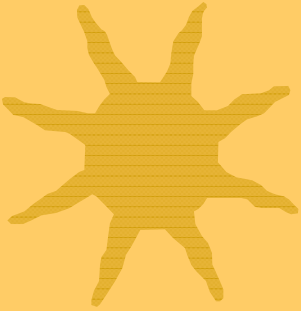


Signs Suggestive of Addiction During Opioid Therapy



- ★ Loss of control
 - Compulsive overuse, unable to take medications as prescribed
 - Frequently runs out of medication early despite dose agreement
 - Frequently reports lost or stolen prescriptions
 - Solicits multiple prescribers
 - Uses multiple pharmacies to fill prescriptions
- ★ Preoccupation with drug use
 - Noncompliant with other treatment recommendations
 - Misses other appointments, always arrives for opioid prescriptions
 - Uses street drugs, involved with street culture
 - Preference for short-acting or bolus dose medications
 - Reports no relief with other medications or treatments
 - Reports *allergies* to all other drugs
- ★ Adverse consequences of opioid use
 - Declining function despite apparent analgesia
 - Observed to be frequently intoxicated or high
 - Persistently oversedated

(Savage 1999)



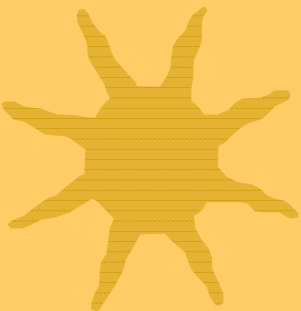
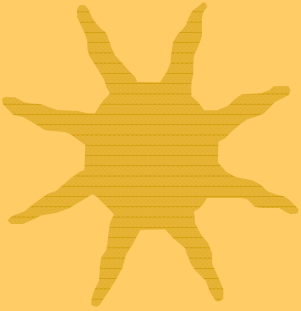
Drug Abuse and the Elderly: Poorly recognized by medical staff

- ★ A study in 3 hospitals in New South Wales, Australia.
- ★ Medical staff caring for 263 inpatients age 65 and over with problem substance use.
- ★ 88 problem users of benzodiazepines
 - Only 3 were identified by medical staff.
- ★ 76 smokers
 - Only 29 were identified by medical staff.
- ★ 99 problem drinkers
 - Only 33 were identified by medical staff.

(McInnes and Powell 1994)



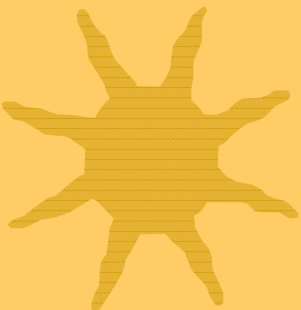
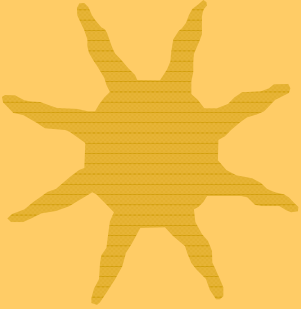
Diversion of Medications



- ★ Estimated 2.6M people in U.S. use prescription medications for “non-medical” reasons, surpassing the estimated number of users of heroin, cocaine and crack (Sajan 1998).
- ★ A 1999 study cited 4.0M people in the U.S. using psychotherapeutic medications for non-medical reasons (Cole 2001).
- ★ Even controlled-release medications are coveted on the street (Goldman 1998).
- ★ Street names: ac/dc, coties, demmies, dillies, hillbilly heroin, o.c., oxy, oxycotton, percs, vics, zannies
- ★ Drug diverters can be very resourceful (e.g., checking surgery schedules and obituaries in order to masquerade as patients).

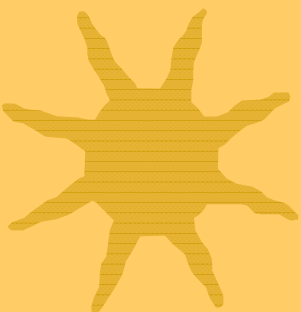


Sources of controlled prescription drugs (CPD) diversion



- ★ Avenues for diversion of opioid pain relievers:
 - Prescription fraud, theft, and exploitation of the Internet;
 - most diversion occurs when individuals with a prescription pass their drugs to family and friends
- ★ Rogue Internet pharmacies (95% of Rx's from these pharmacies are CPDs, compared to 11% in standard pharmacies)
- ★ Unscrupulous prescribers
- ★ Millions of dosage units are stolen or lost in transit, including armed robbery and pharmacy break-ins

In the U.S., CPD diversion is highest in eastern states



Prescription Drug Monitoring Programs (PDMPs) have been established legislatively in many states.

Data from the Mid-Atlantic Region

- ★ Deaths related to propoxyphene (Darvon, Darvocet, Balacet) have increased in Philadelphia over the past 5 years.
- ★ Many CPD abusers in Philadelphia seek a lower-dose formulation of Percocet® over OxyContin®.
- ★ Prescription drug rings often use global positioning systems (GPSs) to locate pharmacies at which they can fill fraudulent prescriptions. The drugs are traded or sold at the retail level, often for other illicit drugs, such as marijuana or cocaine.
- ★ Street dealers of marijuana, cocaine, and heroin in Pennsylvania also sell CPDs.
- ★ Diverted CPDs are sold from open-air drug markets located near narcotic treatment program (NTP) facilities in the District of Columbia.



Doctors who are at risk...

- ★ **Dated** – incomplete knowledge of current pharmacology, differential diagnosis, and management.
- ★ **Duped** – vulnerable to manipulative patients.
- ★ **Dishonest** – financial gain.
- ★ **Disabled** – medical or psychiatric disorder that hampers decision-making skills.

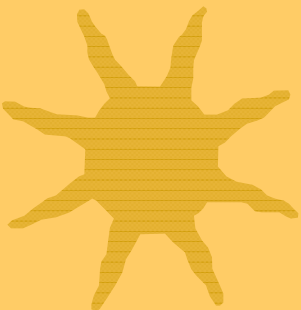
(Longo et al. 2000).

- ★ **“Medication Mania.”**
- ★ **“Hypertrophied Enabling.”**
- ★ **“Confrontation Phobia.”**

(Parran 1997).



Legal Implications (1)

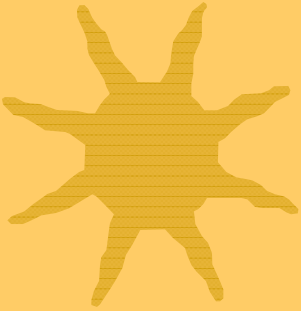


- ★ “A federal grand jury indicted a Virginia doctor on 95 counts, including 14 counts of illegally dispensing medication leading to death or bodily harm and 64 counts of prescribing medication without reason. The doctor was accused of contributing to seven deaths by overprescribing OxyContin and other painkillers. In October 2003, a federal jury failed to convict the doctor of 69 charges against him, with more than 30 of the charges being exonerated and deadlocked on the rest.”

(Online Lawyer Source.com 2004).



Legal Implications (2)



★ Both over-treatment and under-treatment of pain can give rise to **legal liability** and professional discipline.



★ Physicians who adhere to national guidelines and sound principles of medical practice are not at serious risk of malpractice litigation or discipline.



Rich BA (2003). Pain and the law: Civil and criminal cases. American Pain Society 2003 Scientific Meeting Syllabus. Session 314.



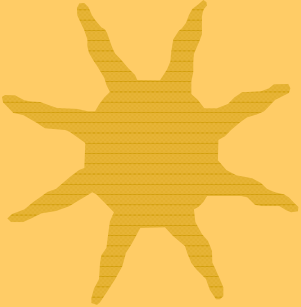
Legal Implications (3)

- ★ Informed Consent.
- ★ Documentation of the Decision-Making Process – including decision-making competence, discussion of alternatives, and evidence of voluntary action.
- ★ Duty to Warn / Third-Party Liability – based upon “driving cases” (driving while using medications).
- ★ Avoid prescribing in isolation from other therapies.

(Longo et al. 2000).



Determinants of Street Value



★ Rapid onset of action.

★ High potency.

★ Brief duration of action.

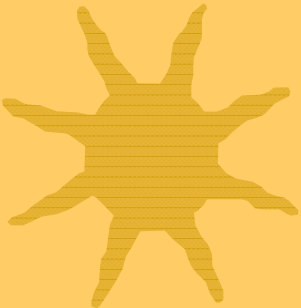


★ High purity.

★ Water solubility (for intravenous use).

★ High volatility (ability to vaporize if smoked).

★ Trade-name drugs: the “real thing”

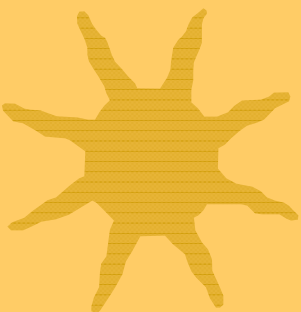
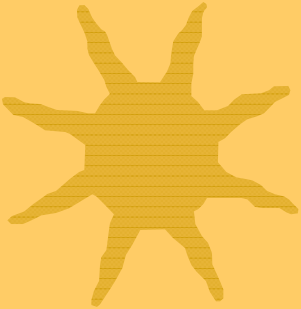


(Longo et al. 2000).



Street Value of Controlled Prescription Drugs, July 2008

DEA 2009 Prescription Drug Threat Analysis



- ★ Based on state and local law enforcement data and DEA field offices.
- ★ Many diverted CPDs have been stable at \$1 per mg for years, but some specific drugs have increased in street value.
- ★ The *average per-milligram* prices nationwide for the most commonly diverted CPDs are as follows:
 - Alprazolam (Xanax®) – \$3.50
 - Hydrocodone (Vicodin®, Lortab®) – \$1.90
 - Methadone – \$1.45
 - Oxycodone (OxyContin®, Percocet®, Roxicodone®) – \$1.15
- ★ How about Philadelphia?

Drug	City/County	Low \$	High \$	Quantity
Actiq® (fentanyl)	Philadelphia	\$25.00	\$25.00	1 lollipop
Alprazolam	Philadelphia	\$2.00	\$2.00	1 milligram
Ambien®	Philadelphia	\$2.00	\$2.00	1 dosage unit
Codeine	Philadelphia	\$15.00	\$15.00	1 ounce
Methadone	Philadelphia	\$5.00	\$5.00	5 milligrams
Morphine	Philadelphia	\$8.00	\$10.00	15 milligrams
Morphine	Philadelphia	\$25.00	\$25.00	30 milligrams
Oxycodone	Philadelphia	\$5.00	\$10.00	1 milligram
OxyContin®	Philadelphia	\$1.00	\$1.00	1 milligram
OxyContin®	Philadelphia	\$20.00	\$30.00	20 milligrams
OxyContin®	Philadelphia	\$10.00	\$15.00	30 milligrams
OxyContin®	Philadelphia	\$30.00	\$35.00	40 milligrams
OxyContin®	Philadelphia	\$40.00	\$75.00	80 milligrams
OxyContin® (liquid)	Philadelphia	\$100.00	\$100.00	5 milliliters
Percocet®	Montgomery County	\$10.00	\$10.00	5 milligrams
Percocet®	Philadelphia	\$3.00	\$5.00	5 milligrams
Promethazine/codeine	Philadelphia	\$20.00	\$30.00	1 ounce
Xanax®	Philadelphia	\$1.00	\$2.00	1 milligram



The word on the street...



- ★ White House Office of National Drug Control Policy issued a 38-page listing: “Street Terms: Drugs and the Drug Trade”



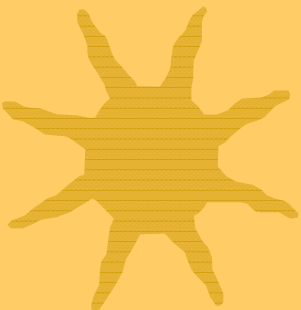
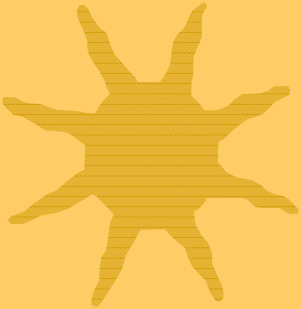
- ★ Available at
http://www.whitehousedrugpolicy.gov/pdf/street_terms.pdf



- ★ Sample terms for OxyContin
 - Blue, Cotton, Hillbilly Heroin, Kicker, Os, Ox, Oxy, Oxycotton, Pills, 40, 40-bar, 80
 - “Pill ladies” are female senior citizens who sell OxyContin



Common “Scams”

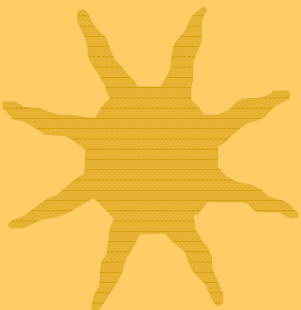
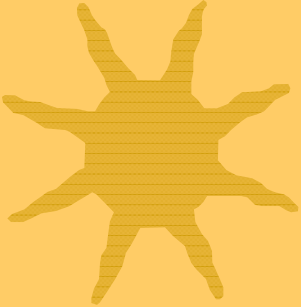


- ★ Spilled the bottle....
- ★ Lost the prescription....
- ★ Lost my luggage....
- ★ The dog ate it....
- ★ It is the only thing that works....
- ★ Multiple drug allergies....
- ★ Washed the prescription in the laundry....
- ★ Stolen from my home....
- ★ Only trade name will do....
- ★ Oh by the way....
- ★ But you filled it before....
- ★ You are the only one who understands....
- ★ Prescription stealing or altering....

(Parran 1997)



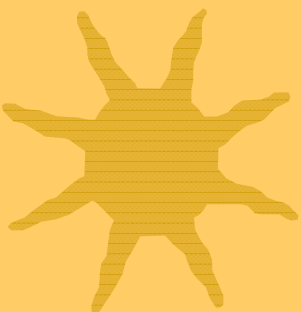
Drug Diverters: Red Flags (1)



- ★ Elaborate stories.
- ★ Claims that s/he is traveling through town or visiting friends or relatives.
- ★ Seeks appointment toward the end of office hours.
- ★ Calls or arrives outside of office hours.
- ★ Demands immediate action. Insists on being seen immediately. Claims to be in a hurry (to catch a plane, to make another appointment, etc.).
- ★ Declines physical examination, work-up, or referral. Wants Rx now.



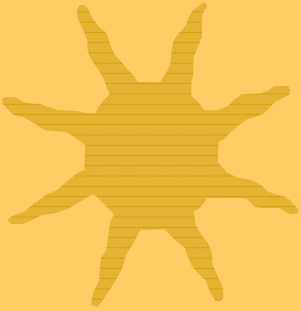
Drug Diverters: Red Flags (2)



- ★ Resists attempts to obtain old records.
- ★ Unable to provide specifics about prior healthcare providers/facilities, or states that they went out of business or burned down.
- ★ No regular healthcare provider. May claim to have no insurance.
- ★ Slovenly or over-dressed.
- ★ Lost Rx, stolen meds, or forgot to pack meds for trip.
- ★ Exaggerated or feigned medical problems.



Drug Diverters: Red Flags (3)



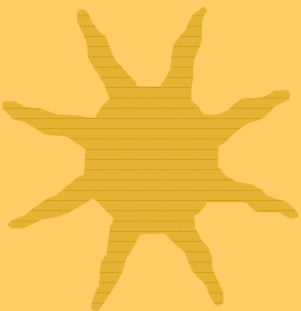
★ Recitation of textbook symptoms or very vague medical history.

★ Unusual knowledge of controlled substances.



★ Requests for a specific drug, unwilling to try anything else.

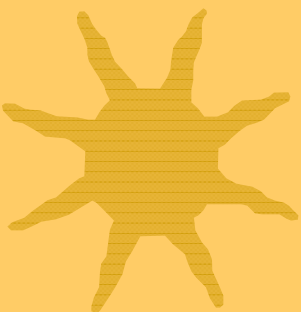
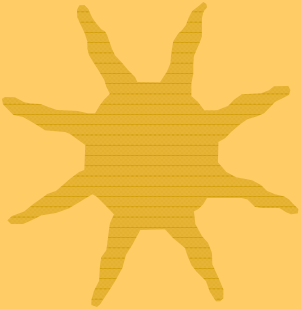
★ Insistence that specific non-opioid analgesics do not work (or cause allergic reaction).



Partners Against Pain (2001).



Aberrant Behaviors



- ★ Used additional opioids than those prescribed
- ★ Used additional opioids than those prescribed more than once
- ★ Forged prescription
- ★ Sold prescription
- ★ Admitted to seeking euphoria from opioids
- ★ Admitted to wanting opioids for anxiety
- ★ Overdose and death
- ★ Injected drug
- ★ Abnormal urine/blood screen
- ★ Abnormal urine/blood screen positive for 2 or more substances
- ★ Solicited opioids from other providers
- ★ Unauthorized ER visits
- ★ Concurrent abuse of alcohol
- ★ Unauthorized dose escalation
- ★ Resisted therapy changes/alternative therapy
- ★ Reported lost or stolen prescriptions
- ★ Canceled clinic visit
- ★ Requested early refills
- ★ Requested refills instead of clinic visit
- ★ Abused prescribed drug
- ★ Was discharged from practice
- ★ No show or no follow-up
- ★ Third party required to manage patient's medications

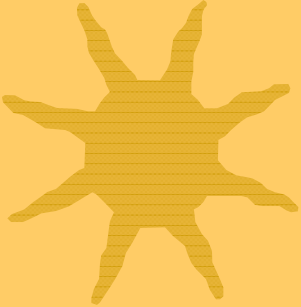


Opioid Risk Tool (ORT) – self-administered

Item	Mark Each Box That Applies	Item Score If Female	Item Score If Male
1. Family history of substance abuse			
Alcohol	[]	1	3
Illegal drugs	[]	2	3
Prescription drugs	[]	4	4
2. Personal history of substance abuse			
Alcohol	[]	3	3
Illegal drugs	[]	4	4
Prescription drugs	[]	5	5
3. Age (mark box if 16–45)	[]	1	1
4. History of preadolescent sexual abuse	[]	3	0
5. Psychological disease			
Attention deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia	[]	2	2
Depression	[]	1	1
Total		—	—
Total score risk category			
Low risk: 0–3			
Moderate risk: 4–7			
High risk: ≥8			



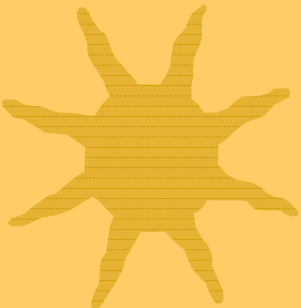
SOAPP-R (Screener and Opioid Assessment for Patients w/Pain, revision 2007) – self-administered



Never (0), Seldom (1), Sometimes (2), Often (3), Very Often (4)

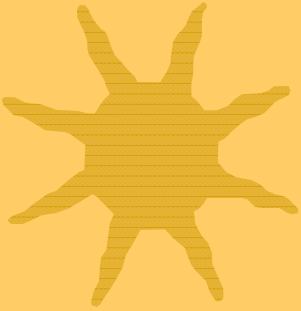


1. How often do you have mood swings?
2. How often have you felt a need for higher doses of medication to treat your pain?
3. How often have you felt impatient with your doctors?
4. How often have you felt that things are just too overwhelming that you can't handle them?
5. How often is there tension in the home?
6. How often have you counted pain pills to see how many are remaining?
7. How often have you been concerned that people will judge you for taking pain medication?
8. How often do you feel bored?
9. How often have you taken more pain medication than you were supposed to?
10. How often have you worried about being left alone?
11. How often have you felt a craving for medication?

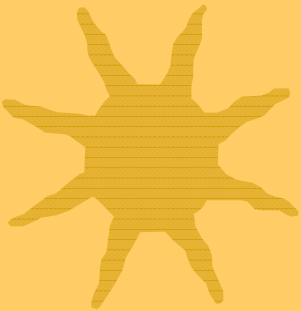




*SOAPP-R score of 18+
suggests high risk of aberrant behavior in 6 months*

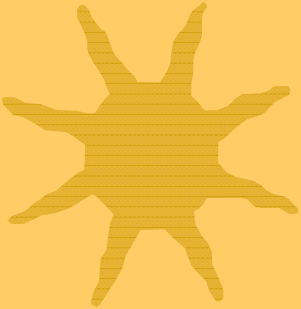


12. How often have others expressed concern over your use of medication?
13. How often have any of your close friends had a problem with alcohol or drugs?
14. How often have others told you that you had a bad temper?
15. How often have you felt consumed by the need to get pain medication?
16. How often have you run out of pain medication early?
17. How often have others kept you from getting what you deserve?
18. How often, in your lifetime, have you had legal problems or been arrested?
19. How often have you attended an AA or NA meeting?
20. How often have you been in an argument that was so out of control that someone got hurt?
21. How often have you been sexually abused?
22. How often have others suggested that you have a drug or alcohol problem?
23. How often have you had to borrow pain medications from your family or friends?
24. How often have you been treated for an alcohol or drug problem?





Other instruments

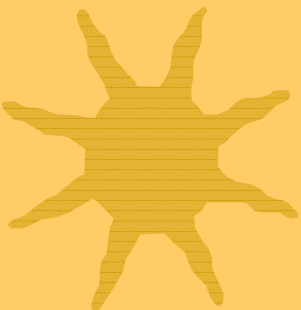


- ★ The Current Opioid Misuse Measure (COMM) – 17 items, self-administered
- ★ The Addiction Behaviors Checklist (ABC) – 20 items, staff administered
- ★ But there is no universally accepted gold standard to screen for risk of prescription drug abuse/ diversion





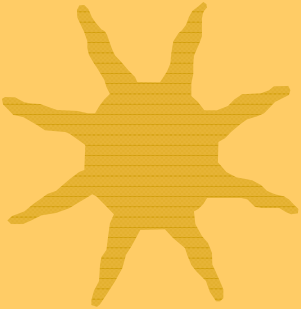
Urine Drug Screen (UDS)



- ★ To confirm compliance with therapy and to screen for use of non-prescribed substances.
- ★ Different providers have different policies
 - Randomly for all patients.
 - Patients with hx of addictive disorder.
 - Patients with pattern of management problems (non-compliance, lost Rx's, etc.).
- ★ Order *specific* tests as needed.
 - Short acting medications such as oxycodone often are not detected with standard UDS (Savage 1999, Levy 2006).
 - Fentanyl is also often not detected (Savage 1999).
- ★ Beware: chain of custody, purchased specimens.



Urine Drug Screen, cont'd



- ★ False positives:
 - Excessive ingestion of poppy seeds.
 - Pseudoephedrine or dextromethorphan, used as directed.
- ★ Alcohol used in cooking does not cause false positives.
- ★ Incidental marijuana exposure (not enough to cause intoxication) does not cause false positives (“hot-boxing” can show up on screening). Tests are positive 1-3 days after single exposure, 4-6 weeks in regular users.
- ★ What is not detectable on routine urine drug screening?
 - Inhaled nitrous oxide (must test serum or urine shortly after use, w/special techniques)
 - Ecstasy
 - Oxycodone
- ★ To test for diluted samples: check urine specific gravity and urine creatinine.
- ★ Federal guidelines: patient provides identification, empties pockets and uses bathroom without running water; blue dye is placed in standing water; specimen temperature is checked immediately)
- ★ Staff observation (direct observation/present in room); standing outside door ineffective
- ★ Mail-in survey of 359 pediatricians, family physicians, and adolescent medicine providers showed low knowledge and low compliance with guidelines.

(Levy, 2006)



- ★ “Clean” urine specimens are readily available for purchase on the Internet...

Whizzinator Drug Masking Kit



- ★ Kit with dried urine and syringe, heater packs (to keep the urine at body temperature), a false penis (available in several skin tones) and instructions.

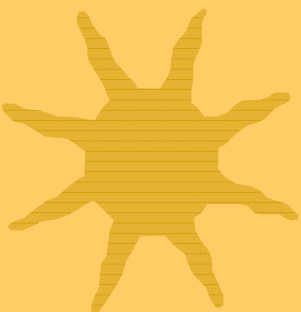
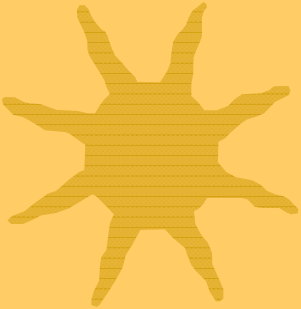
- ★ May 2005: Onterio Smith, a former Minnesota Vikings running back, was caught with one at Minneapolis-St. Paul International Airport, resulting in his suspension.



Kit contents



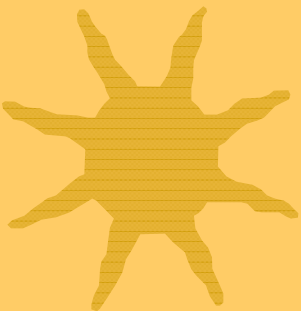
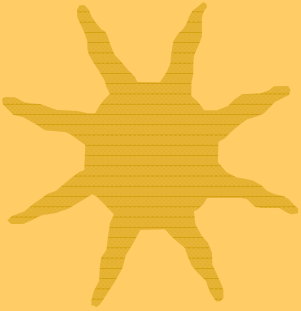
Other attempts to mask urine drug screens: Niacin



- ★ It doesn't work, but some took niacin's "flushing" qualities and metabolic effects out of context.
- ★ It was promoted for rapidly clearing the body of drugs of abuse, such as cocaine and cannabis, and is alleged to interfere with urine drug screening.
- ★ Mittal et al (2007) presented 4 cases of this use associated with significant adverse effects.
 - 2 with isolated skin manifestations
 - 2 with life-threatening manifestations, including nausea, vomiting, dizziness, hepatotoxicity, metabolic acidosis, and hypoglycemia evolving into hyperglycemia.
 - One also had profound neutrophilia and QTC-interval prolongation.
 - All improved after cessation of the drug use and supportive treatment.
- ★ Similar cases were reported in MMWR 4/20/07, 56(15);365-366



Beyond urine testing: Pill Counts

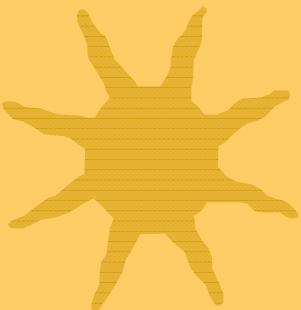
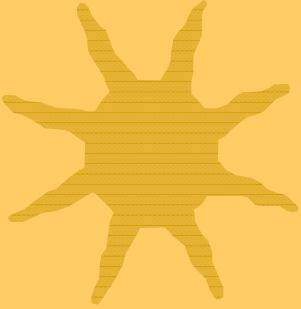


- ★ To confirm that patients are using medications as prescribed.
- ★ Have the patient bring all medications to the appointment to be sure that the expected number of pills remain.
- ★ Consider “unscheduled” pill counts (explain at the initiation of therapy that this might occur from time to time).

(Savage 1999)



Systematic Approach to Identifying Drug-Seeking Patients



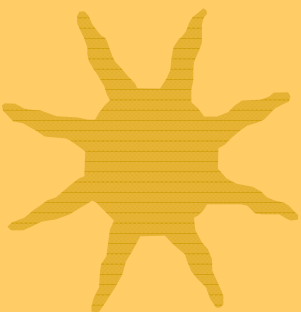
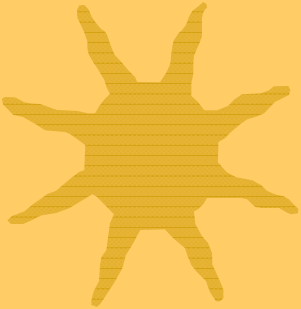
- ★ Involve your entire team (identify inconsistencies, get history from family, obtain info from previous providers and pharmacies).
- ★ Recognize suspicious behavior (obsessive, impatient, repeated calls, finding provider's home/pager numbers, lack of follow-up, flattery).
- ★ Obtain a thorough history.
- ★ Look for consistency in the exam. Consider distraction techniques.
- ★ Conduct appropriate tests.
- ★ Prescribe non-pharmacologic treatment.
- ★ Proceed cautiously.



Ten Tips for Prescribing Opioid Analgesics

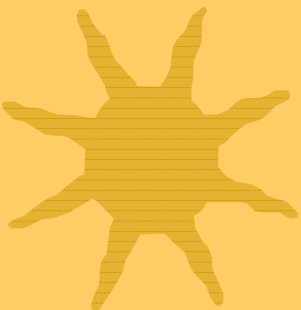
(Cole 1998)

1. Get a thorough history and physical examination.
2. Document everything you see, think, feel and hear about the patient in a manner that will be useful for subsequent readers.
3. Obtain informed consent for long-term opioid therapy.
4. Get a second opinion to verify your care plan if you feel at all uncertain.
5. Ask the patient to use only one pharmacy and to obtain opioid analgesics only from you.
6. See the patient regularly (at least every 30 to 90 days).
7. Prescribe controlled-release medications to stabilize the blood levels and limit the “buzz” associated with immediate-release medications.
8. Keep the dosages controlled to the amount necessary to provide comfort without unacceptable side effects.
9. Check the patient’s urine drug screen.
10. Learn as much as you can about the use of opioid analgesics.





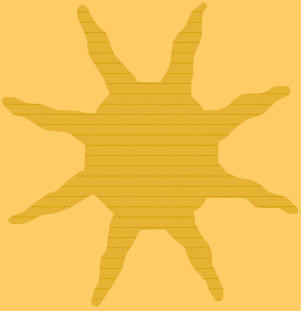
More specific recommendations concerning prescriptions



- ★ Guard your Rx pads.
 - ★ Never sign an incomplete Rx.
 - ★ Use tamper-resistant Rx pads that can't be photocopied
 - ★ Write dosages and quantities out in numbers and letters (e.g., “10 [ten] mg / Take 1 [one] bid for pain / Disp #10 [ten] / 0 [zero] refills”).
 - ★ Write on the Rx the exact pharmacy where it is to be filled.
 - ★ Consider faxing a copy to the pharmacist for authentication.
 - ★ Do not pre-print your license number on your Rx pad. Write it in when you complete the Rx.
- Partners Against Pain (2001).
- ★ Do not pre-date your prescriptions. If you have a good relationship with a patient on stable treatment, you may appropriately date your prescriptions and write “Do not fill until...” to specify that it will be used in the future.
 - ★ In the future, electronic prescribing of controlled drugs will be available and will likely reduce forgeries



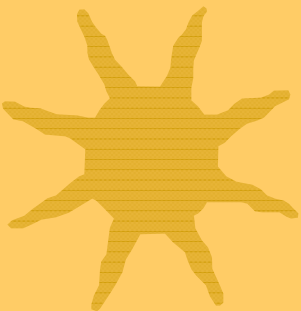
Sample Pain Contract from American Academy of Pain Medicine



NOTE: on Epic, use smartphrase .NARCOTICCONTRACT

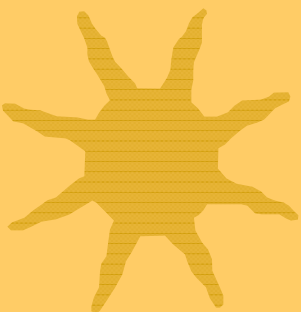


- ★ “The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.
- ★ The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide longterm benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.
- ★ Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.”





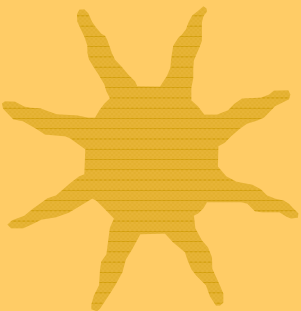
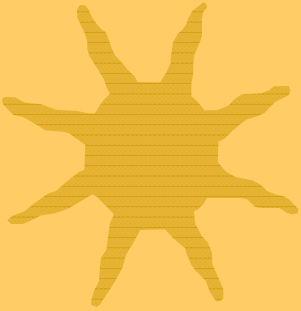
Pain Contract, continued



1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:
_____ phone: _____.
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.



Pain Contract, continued



8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
9. Original containers of medications should be brought in to each office visit.
10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
12. Early refills will generally not be given.
13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.



Pain Contract, continued



14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
18. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].
19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

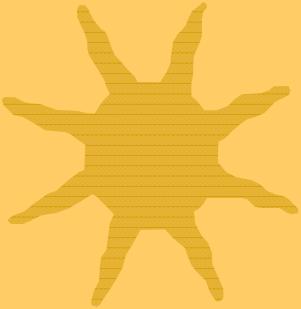


Physician Signature
Date

Patient Signature
Patient Name (Printed)



Remember: Pharmacologic Alternatives to Controlled Drugs in Patients with Addictions



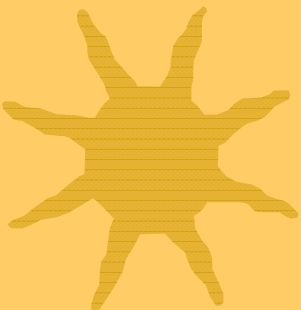
Pain

- NSAID's
- Acetaminophen
- Antidepressants
- Anticonvulsants
- Steroids
- Muscle relaxants



Anxiety disorders

- Antidepressants (most)
- Buspirone (Buspar)
- Anticonvulsants
 - Valproic acid [Depakene]
 - Gabapentin [Neurontin]
- Beta-Blockers
- Atypical neuroleptics
 - Olanzapine [Zyprexa]
 - Quetiapine [Seroquel]
 - Risperidone [Risperdal]



Insomnia

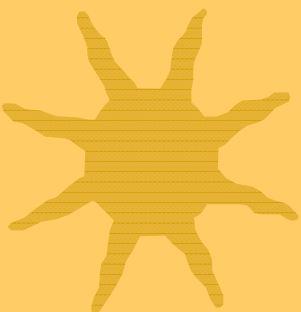
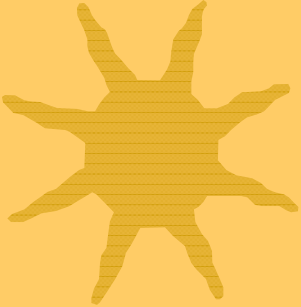
- Sedating antidepressants
- Trazodone (Desyrel)
- Doxepin (Sinequan)
- Amitriptyline (Elavil)
- Nefazodone (Serzone)
- Mirtazepine (Remeron)
- Zolpidem (Ambien)
- Antihistamines

Attention-deficit disorder

- Pemoline (Cylert)
- Bupropion (Wellbutrin)
- Desipramine (Norpramin)
- Venlafaxine (Effexor)
- Clonidine (Catapres)
- SSRI's
(Longo et al. 2000)



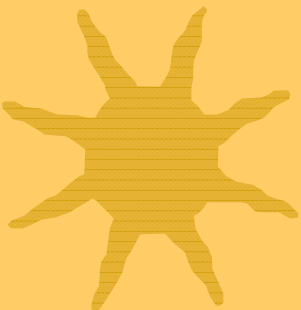
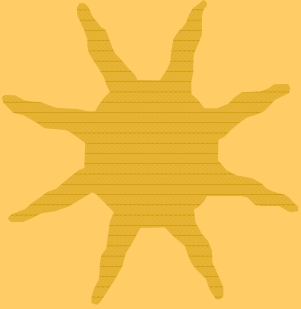
Emotional Responses to the Drug-Seeking Patient



- ★ Recognize **codependence** and **countertransference** (Longo et al. 2000).
- ★ Practice self-control.
- ★ “Difficult” patients have the potential to elicit strong negative emotions from their caregivers
 - Frustration
 - Despair
 - Anger
- ★ Know which situations and patients elicit these negative reactions and (when possible) prepare in advance for those interactions (Simon et al. 1999).



Ways to Combat Drug-Seeking Behavior

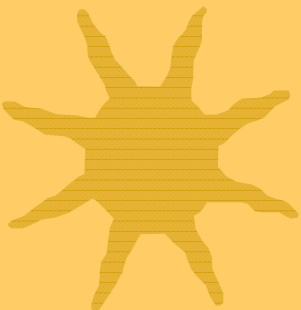
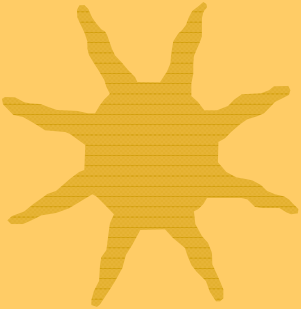


1. Acquisition and wide use of chemical dependence screening skills.
2. Early and firm limit setting regarding indications for controlled drug prescribing.
3. Careful documentation of a firm diagnosis and the ruling out of chemical dependence before initiating a controlled prescription.
4. Practice in "just saying no" and feeling comfortable in being firm without escalating into an argument with the patient.

(Parran 1997).



Education



★ Educate yourself.

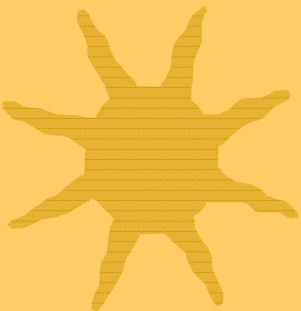
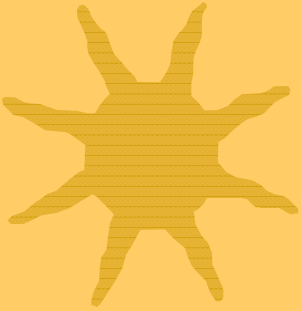
- PartnersAgainstPain.com – lots of downloadable docs
- American Pain Society (ampainsoc.org)
- American Academy of Pain Medicine (painmed.org)
- Substance Abuse and Mental Health Services Administration (samhsa.gov)
- For patients: American Pain Foundation (painfoundation.org)

★ Talk to patients and families.

★ Be involved in community education.



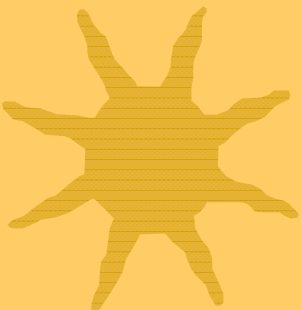
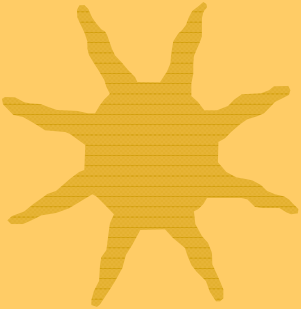
Recommendations



- ★ Educate your patients about medications, side effects, and potential for addiction and diversion.
- ★ Don't be afraid of using narcotics. They can be an important part of good care. Just do it intelligently and appropriately.
- ★ For chronic use, obtain informed consent/patient care contract. Keep this information in a highly visible part of the chart, rather than hidden within a single progress note (e.g, problem list, social history narrative).
- ★ Write prescriptions legibly and correctly.
- ★ Carefully document all prescriptions (consider photocopying).
- ★ Communicate concerns about drug-seeking behavior to other providers in the practice.
- ★ Trust your instincts. Be firm if you don't think prescription is indicated.
- ★ Consult with specialists if unsure.
- ★ But don't forget, drug-seeking patients get sick, too!



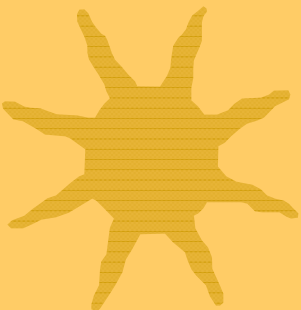
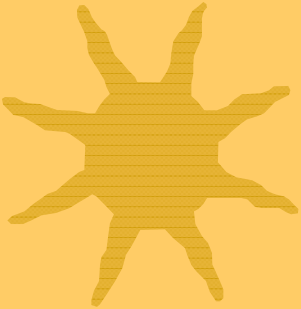
References (1)



- * Carlson MJ and Baker LH (1998). Difficult, Dangerous, and Drug Seeking: The 3D Way to Better Patient Care. *Am J Pub Health.* 88(8):1250-2.
- * Cole BE (1998). Ten tips to survive opioid prescribing. *The Pain Practitioner newsletter.* Sonora, CA: American Academy of Pain Management. Fall-Winter 1998:4.
- * Cole BE (2001). Recognizing and Preventing Medication Diversion. *Family Practice Management (American Academy of Family Practice).* October 2001:37-41.
- * Goldman B (1998). The news on the street: prescription drugs on the black market. *CMAJ.* 159(2):149-150.
- * Lapp T (2001). Two faces of OxyContin: AAFP concerned about abuse, diversion of drug. *FP Report.* 7(8).
- * Larson BS (2002). Medications through the Internet: what clinicians and patients need to know. *Journal of Pain & Palliative Care Pharmacotherapy.* 16(2):49-57.
- * Levy S et al (2006). Drug testing of adolescents in ambulatory medicine: Physician practices and knowledge. *Arch Pediatr Adolesc Med.* 160(2):146-50.
- * Longo LP et al (2000). Addiction: part II. Identification and management of the drug-seeking patient. *Am Fam Physician.* 61:2401-8.
- * McInnes E and Powell J (1994). Drug and alcohol referrals: are elderly substance abuse diagnoses and referrals being missed? *BMJ.* 308(6926):444-446.
- * Online Lawyer Source (2004). Doctor accused of contributing of OxyContin deaths (1/22/2004). [<http://www.onlinelawyersource.com/news/oxycontin.html>] accessed 3/9/2004.
- * Partners Against Pain (2001). How to stop drug diversion and protect your practice [pamphlet]. Perdue Pharma.
- * Parran T (1997). Prescription drug abuse: a question of balance. *Med Clin of North Amer.* 81(4):967-978.



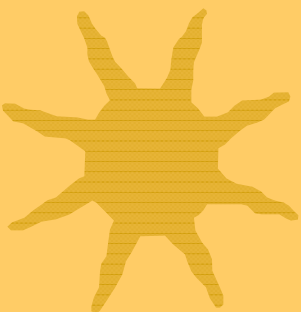
References (2)



- ★ Passik SD (2003). Guide to aberrant behaviors associated with analgesic use. *Essentials of Pain Management: Principles and Practice* (Syllabus for 2003 Conference).
- ★ Pope D et al. (2000). Frequent users of the emergency department: a program to improve care and reduce visits. *CMAJ*. 162(7):1017-1020.
- ★ PR Newswire (2003). Five more OxyContin lawsuits dismissed (9/18/2003). [http://www.legalnewswatch.com/news_261.html] accessed 3/9/2004
- ★ Rich BA (2003). Pain and the law: Civil and criminal cases. *American Pain Society 2003 Scientific Meeting Syllabus*. Session 314.
- ★ Sajan A et al. (1998). The street value of prescription drugs. *CMAJ*. 159(2):139-142.
- ★ Savage SR (1999). Opioid use in the management of chronic pain. *Med Clin of N Amer*. 83(3):761-786.
- ★ Simon JR et al. (1999). Ethical issues in emergency medicine: The difficult patient. *Emergency Medicine Clinics of North America*. 17(2):353-370.
- ★ Weaver M, Schnoll S (2002). Abuse liability in opioid therapy for pain treatment in patients with an addiction history. *Clinical Journal of Pain*. 18(4 Suppl):S61-9, 2002 Jul-Aug
- ★ Ytterberg SR et al. (1998). Codeine and oxycodone use in patients with chronic rheumatic disease pain. *Arthritis & Rheumatism*. 41(9):1603-1612.
- ★ Zenz M and Willweber-Strumpf A (1993). Opiophobia and cancer pain in Europe. *Lancet*. 341(8852):1075-1076.



Poppies!



Have a great day!