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Time to confront iatrogenic opioid addiction

by Dr. Jan Klimas (PhD)
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In recent years, the public health system has had to come to grips with the prescription opioid epidemic. Simply put, diverted pharmaceutical opioids now contribute to a massive burden of disease across Canada and internationally.

In fact, deaths from unintentional drug overdoses related to opioid analgesics have far outstripped deaths related to cocaine and heroin.

In Canada, the emergence of the prescription opioid epidemic has been attributed to OxyContin, the slow-release form of oxycodone. The drug's availability and ease of abuse made it a source of so many opioid-related deaths that most provinces stopped funding it, as well as its tamper-resistant successor OxyNEO, in 2012. However, this only resulted in a "substitution effect," with increased prescriptions for more potent opioids such as fentanyl and hydromorphone.

British Columbia recently declared the province's drug overdose situation a public health emergency in the wake of 474 apparent illicit drug overdose deaths in the province in 2015—a 30% increase from 2014. An estimated 31% of those deaths involved fentanyl, versus only 5% of overdose deaths in 2012. In Ontario, fentanyl accounted for one in four opioid fatalities in 2014 (173 deaths). And over 270 Albertans died from fentanyl overdoses last year—more than double the 2014 death toll.

The implications of this shift are remarkable, and few in the public health or medical communities are considering how and why it has occurred. Specifically, Canada has been grappling for decades in a largely ineffective attempt to keep heroin—produced in Asia and increasingly Central America—out of our borders. Now, instead of grappling with a drug produced thousands of miles away, the unsafe prescribing of opioid medications in Canada has created such a large market for these pills that organized crime groups are turning their attention to "customers" whose addiction to opioids started in the doctor's office. They are even going so far as to press fentanyl into oxycodone look-alike pills. Why would they sell expensive heroin from Afghanistan if they could sell relatively cheap fentanyl that looks the same as their potential customers' drug of choice?

The time to swiftly address this crisis is now. Research has shown that a number of factors influence opioid-related mortality and morbidity. They can be broadly classified into prescriber and user behaviours and systemic/environmental characteristics. Targeting many of them at the same time can help curb the opioid epidemic, if tailored to the specifics of the area of concern. Several measures can be taken immediately: prescription monitoring programs, better education for prescribers and early treatment and intervention for those with opioid addiction.

However, even in British Columbia, which has one of the nation's most robust prescription monitoring systems, most physicians are not signed up to use those systems and there is no mandatory requirement that physicians check the systems to ensure their patient does not have multiple opioid prescribers or other evidence of addiction or diversion. Physicians are going to have to face the tough conversations that involve what one U.S. pain clinic director called two of the hardest words in a doctor's vocabulary: "enough" and "no."

In sum, unsafe prescribing practices, the emergence of false packaging of fentanyl and the overall lack of action created a "perfect storm" where casualties are to be expected. Fentanyl

itself is neither good nor evil. It has been around in powdered form since 1959. Its dangers lie in the intricate interplay of how the drug is used, regulated by laws, prescribed by doctors and distributed in the illicit drug market. Doctors, prescribe safely!

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