

The 56th Dr. Daniel Labby Senior Clinicians' Seminar

Monday, September 25, 2017: 10:00 am – 11:30 am

The Opioid Crisis:

Finding a Path between Chronic Pain, Addiction, and Death

Case #1:

John is a 62 year old truck driver. In the middle of a cross-country haul, he pulls his 18-wheel rig into a hospital parking lot in Akron, Ohio. He brings his 5'10", 216 lb. frame to the Emergency Department where he informs the physician that he accidentally spilled his pain medication into the toilet during his last rest stop. He goes on to say that his regular physician in Montana is on vacation and her office is closed for the weekend with no covering physician on call. The trucking company expects him to get his truck and its cargo to New Jersey by the next day. He wants a refill of his pain medication to avoid developing intolerable back pain as well as narcotic withdrawal symptoms. Both of these will occur if the opioid is stopped for more than twelve hours.

He is taking a very high dose of an opioid, the equivalent of 220 mg of morphine daily in a long-acting extended release tablet. His only other medication is Ambien, a valium relative he uses for sleep. He drinks beer but never while driving. Helpfully, he has a recent report of the MRI images of his lumbar spine which showed minor but definite lumbar disc protrusions at two levels.

Case #2:

Opioid (morphine-related) pain medication is the leading cause of accidental death in the United States with 33,000 deaths from all opioids in 2015 and half of these from prescribed opioids. This is comparable to the number of deaths related to motor vehicle crashes (38000) and much greater than cocaine (7000). Nearly 92 million U.S. adults, or about 38 percent of the population, took a legitimately prescribed opioid in 2015.

Dr. Benson is a well-established clinician researcher who is looking for an answer to America's pain management crisis. As a laboratory scientist, he makes a breakthrough discovery.

Using mice, he showed that a drug called Methyl-naltrexone appears to dramatically reduce the following major unwanted side effects of opioid medication:

1. A paradoxical increased sensitivity to pain (opioid induced hyperalgesia)
2. Loss of effective pain relief from opioids over time. This is called developing a

tolerance to the medication and it leads to requiring escalating doses of opioids for the same degree of pain relief.

Methyl-naltrexone is unable to circulate within the brain and spinal cord so it blocks only those pain receptors located elsewhere in the body. Because pain is perceived in the brain, and Methyl-naltrexone cannot get there, it does not affect pain control with opioid medications, which do reach the pain receptors in the brain and spinal cord. But by blocking pain receptors outside these areas, Methyl-naltrexone limits side effects and does not cause withdrawal symptoms (at least in mice).

Dr. Benson is very excited about the results of his mouse study and is hopeful that this drug can become a standard for any patient on long-term opioid treatment.

Interestingly, the drug is already FDA approved for the treatment of opioid-related constipation. He wonders if it would be reasonable to prescribe this drug as a way to combat the accelerating opioid epidemic among his patients.

Case #3: Involuntary Commitment

Mr. Hern arrived at the emergency department in the middle of the night after being found unconscious on the living room floor by his wife. The paramedics reported that they found a bottle of OxyContin (an opioid pain reliever) on the dining room table near him. Mr. Hern's wife reported that he suffers chronic pain from three herniated disks and two pinched nerves. Mr. Hern is treated by a pain management specialist who has prescribed opioids for him for several years. His wife said "I think he takes too much," and "I have been trying to get him to cut back for at least a year, since the last time he was hospitalized for the same thing." "I've tried everything, even Narcotics Anonymous, but nothing works. I am worried he is going to end up dead."

Dr. James, the hospital psychiatrist, was equally concerned. He believed that Mr. Hern would benefit from more specialized care. He arranged to talk about the advantages of long-term hospitalization for substance abuse with Mr. Hern later the next day when his wife could be present. Mr. Hern, however, was uncooperative, strongly denying that he had any problem at all. Mrs. Hern was visibly stressed. She begged Dr. James to commit her husband (involuntarily if necessary) to the substance abuse treatment center located adjacent to the hospital.

Background:

Many states, including Florida where Mr. Hern lives, have recently passed laws that allow individuals with substance abuse problems to be held for up to 90 days against their will. A petition can be filed in cases where the individual is at risk of serious harm to themselves or others or has "lost the power of self-control with respect to substance abuse" and are "incapable of making a rational decision regarding his or her need for care."

Dilemma:

Although a judge ultimately would need to determine whether or not Mr. Hern could be involuntarily committed for substance-abuse treatment, Dr. James is unsure whether it is appropriate for him to petition the court for such an order. On the one hand, Mr. Hern had come to the emergency department twice already, both times unconscious after having taken too much OxyContin. On the other hand, Dr. James was a strong proponent of patient autonomy. And Mr. Hern, while he had taken too much medication in the past, seemed at present to have decision making capacity. Further, Mr. Hern's conduct seemed to pose no threat of harm to anyone else. Dr. James also wondered if mandating inpatient treatment for substance abuse is in Mr. Hern's best interests, given his strong opposition to it.