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The Opiate Epidemic: Can we Reverse the Trend?

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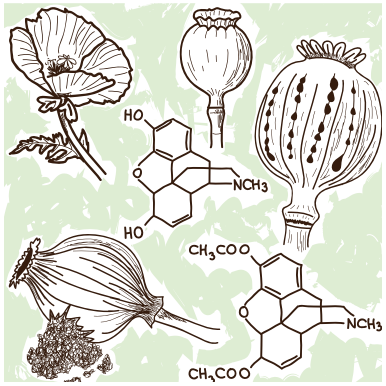
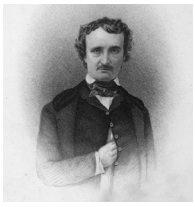
Opium derived from the condensed juice of the poppy, Papaver Somniferum, has been used as an analgesic, euphoric, and soporific for centuries. It was initially cultivated in 3400 B.C. in Mesopotamia, and has been used therapeutically and recreationally ever since.



In 1660 A.D., the English physician, Thomas Sydenham, compounded an opium tincture, which he called Laudanum. This was considered the medicinal “cure all” for most ailments. Numerous scientists have experimented since then by mixing opium with other agents including whiskey, rum, brandy, ether, and chloroform. Laudanum is now virtually extinct in the U.S., though still can be obtained in a number of European countries.

The two opium wars in the 19 century between England and China were fought over trade disagreements. The English had an insatiable appetite for tea and the private traders attempted to use opium obtained from India as the medium of exchange rather than the more precious gold and silver to obtain their favorite blend. Both wars were eventually won by the British resulting in Hong Kong and Kowloon being ceded to England.



In the late 1800s, numerous notables became addicted, including Edgar Allan Poe, Dr. William Halsted, Mary Todd Lincoln, and Samuel Coleridge.

Regulation of opiates began in the early 20th century. The Pure Food and Drug Act (1906) and the Harrison Narcotic Act (1914) required labeling and restricted the manufacture and distribution of opiates in the U.S. Paregoric (camphoratedtincture of Opium) was available in the U.S. without a prescription until 1970 and used to treat diarrhea and cough. Resourceful addicts modified the product to allow intravenous use frequently with contaminated needles resulting in inguinal, arm or neck abscesses.

There has never been a controversy when large doses of opiates were used to treat terminally ill patients. However the use of prescribed opiates for non malignant pain in the mid and late 20th century was relatively infrequent. State Medical Boards, empowered with enormous clout, adhered to the philosophy that "There was no indication to treat chronic nonmalignant pain with opiates." Physicians were threatened with license suspension and censorship when over-prescribing was perceived. This intimidation of physicians prevented them from properly treating even acute and subacute pain resulting in unnecessary suffering by their patients.

Things slowly began to change in 1986 when Portenoy/Foley, two renowned pain management physicians wrote an article in the Journal of Pain and concluded that "Opiate therapy can be a safe and humane alternative in patients with intractable, nonmalignant pain." Their study which included a mere 38 patients had a major impact on how chronic pain was viewed and treated in the US.

Prescribed opiates slowly became a commonly accepted and ethical form of pain management. Pain clinics owned and staffed by former anesthesiologists and physiatrists became widespread, and the opiate dike was opened wide. The social stigma of taking narcotics was largely removed when the intent was to treat pain and suffering in a humane manner designed to improve quality of life.

The number of opiate prescriptions in the United States since the late 1990s has skyrocketed. Some of the associated statistics are shocking:

- **Prescribed opiates resulted in greater than 16,000 accidental deaths in 2010. Frequently these victims also consume benzodiazepines and alcohol, contributing ultimately to their demise.**
- **Presently, 46 people die daily from an overdose of prescription narcotics.**
- **The United States has less than 5 percent of the world population, yet use greater than 85 percent of the available legitimate opiates.**

Once addicted, patients will use all means to sustain their habit including forging prescriptions, buying and selling street drugs, doctor shopping with several providers, using poly-pharmacies, and getting drugs from relatives. This incessant urge frequently results in criminal behavior.

Many primary care physicians have very busy office schedules with limited time to spend with their patients. The convenient approach for the physician who encounters a drug-seeking patient is to write the prescription and get on with his/her next patient. Pain contracts and urine screens have become quite popular as a method of monitoring the use of prescribed opiates. Pharmaceutical companies with a vested economic interest have contributed to the problem with ads suggesting the "safety and therapeutic benefit" to patients. All of us need to rein in our prescriptive pen. We can still provide compassionate care without over prescribing narcotics. More time needs to be spent on counseling and treatment of addiction.

The use of illegal substances including heroin, cocaine and methamphetamine will continue outside the purview of Medicine. Methadone clinics once quite popular to treat reformed heroin addicts have seen their societal benefit diminish as access to prescribed opiates have replaced their need.

Addictive behavior will always be with us. Our motivation should be to treat patients in a kind and caring manner without burdening them with a future problem of addiction that may supercede and be more devastating than the original diagnosis. We still have a chance to slow the "opiate train" that has left the station if all of the stakeholders will join in a cooperative effort that provides compassion and inherent reasonableness.