Test Your Knowledge

What percent of patients with advanced cancer experience severe pain?

- 50%
- 70%
- 80%
- 90%

What percent of cancer pain patients receive inadequate analgesic treatment?

- 10-14%
- 15-41%
- 42-65%
- 66-100%

Commentary on "Drug Crime is a Source of Abused Pain Medications in the United States"

The opinions contained within this commentary are solely those of Dr. Steven Passik and are not supported or endorsed by ROI Media Group, Inc. or Cephalon, Inc. and its affiliates.

Dr. Passik received his doctorate in clinical psychology from the New School for Social Research in New York City, and subsequently completed his postdoctoral training as chief fellow in the psychiatry service of Memorial Sloan-Kettering Cancer Center. Dr. Passik is presently an associate attending psychologist at Memorial Sloan Kettering Cancer Center, as well as an associate professor of psychiatry at Cornell University Medical College, both located in New York City. Before accepting his current position, he was the director of symptom management and palliative care, and an associate professor of medicine and behavioral sciences at the University of Kentucky, Lexington.

Commentary:
re: Joranson DE, Gilson AM. Drug Crime is a Source of Abused Pain Medications in the United States. *Journal of Pain and Symptom Management* . 2005;30(4):299-301.

Introduction

The published research letter by Joranson and Gilson illuminates impressive drug diversion statistics obtained through Drug Enforcement Administration records via the Freedom of Information Act. Analyzable data was provided from 22 states, east of the Mississippi, representing approximately 53% of the total US population.

Data from years 2000-2003 showed:

• 28 million dosage units of all prescription controlled substances were diverted in 12,894 separate incidents, primarily involving illegal pharmacy supply network theft prior to prescribing

• In 2003, alone, an estimated 5.8 million doses of opioid pain medications were diverted through similar means

It is important to stress that these thefts occurred outside the medical environment of physician prescribing, local pharmaceutical dispensing, and consumer or patient use.
These opioid diversions occurred either as theft from local pharmacies or higher up within the pharmacy supply chain, in the manufacturing and distribution zones, by non-professional people who are not required to be monitored by federal and state mandated drug-prescribing detection programs. The Joranson research results are considered vital, as a first-step, in accurate and fair-balanced drug diversion reporting.

Dr. Passik, providing commentary on the published findings, is a proponent of appropriate pain management, including legally prescribed pain medications for

In The Know

Study Results: Silent Pain Sufferers

New study results published in the February 2006 Mayo Clinic Proceedings entitled “Silent Pain Sufferers ,” demonstrate a substantial population of chronic pain sufferers who are silent in regard to severity and intensity of their pain, and...

More ...

patients with intractable pain or chronic pain syndromes.

Steven Passik's Perspective

David Joranson and Aaron Gilson, from the University of Wisconsin, have been tireless in their continued efforts to shed light on the truth regarding the origins of drug diversion in our country. The results of their recent inquiry into pharmacy theft via the Freedom of Information Act represent critical missing pieces of information in a long-standing puzzle, namely: where are the diverted prescription opioids coming from?

By electing to submit their findings as a letter-to-the-editor, Joranson and Gilson have been able to bring these data to the attention of the pain management community and disseminate the news more rapidly than if they had chosen to submit a peer-reviewed article. The extent of drug diversion occurring at the pharmaceutical supply chain is extensive, as many of us have speculated about for years. It is important to note that the reported sources of diversion, via thefts from the neighborhood pharmacies and manufacturing and distribution centers, have been historically unrecognized, and almost exclusively ignored as a very real problem in understanding the growth of prescription drug abuse.

Prior to the Joranson and Gilson findings, this major stream of potential diversion has been solidly ignored, and the blame placed squarely on doctors who prescribe, and patients who take, pain medications. This limited understanding is in turn used to justify a campaign against doctors as the major remedy to prescription abuse. Worse still, it has facilitated an overreaction among some clinicians, who are worried about regulatory oversight as they prescribe; and in response they've adopted aspects of a policing or law enforcement attitude into their own practice. This attitude can translate into a punitive stance vis-à-vis patients. Patients' periodic noncompliance behavior is then dealt with more punitively than the results of some studies on aberrant drug-related behaviors might suggest is appropriate (because their behavior is not related to abuse or diversion but other causes), as is described below.

It's my opinion that in certain high-profile cases, the DEA and Department of Justice have misconstrued many key points related to pain management; such as opioid ceilings, the legality of prescribing opioids to pain patients with a history of known drug abuse, and the meaning of aberrant behaviors. My feeling is that these agencies consider aberrant behaviors as "red flags" translating to "do not prescribe"; and if prescribing continues in the presence of the aberrant behaviors, the clinician is then potentially acting in a criminal fashion.

My previous work and the work of my colleagues at the University of Kentucky found aberrant behaviors quite common; apparent in nearly 50% of patients with nonmalignant pain on opioid therapy. This statistic clearly indicates that aberrant behaviors are not indicators of addiction nor are they closely related to diversion.

We shouldn't ignore aberrant behaviors, but let's try to think of them as yellow, rather than red, flags. Practitioners should approach patients who display these behaviors with caution. Management strategies may include increasing the structure surrounding the pain management plan or referring the patient for consultation, or using some other tool to increase monitoring and decrease risk of abuse and diversion.

In other words, if we can act more like therapeutic agents and less like law enforcement agents, we can be thoughtful and helpful to patients who need pain relief and astute in using medications properly. This can only happen, though, if the fight against prescription drug abuse focuses more on criminals and less on doctors.

As long as the problem of prescription drug abuse continues to be focused on the doctor-patient relationship, I worry that doctors will feel compelled to discharge patients unfairly. Many clinics across the country have adopted a "one-strike-and-you're-out" policy. At least 45% of pain patients display at least one aberrant behavior. Does this mean that we must discharge half of our patient population who come to us for pain relief? Does it mean that if your patient runs out of medication early, just once, you discharge him? If patients ask for more medication

in ways that make you feel uncomfortable, do you stop prescribing? These policies are an attempt to keep pain practice safe in spite of the fact that practitioners don't *feel* safe practicing pain management.

The findings of Joranson and Gilson are particularly important in this context. Their results may inspire redirection of funds and manpower toward other sectors to combat the growing problem of diversion and prescription abuse. Clinicians collaborating with regulatory agencies at the federal and state levels may serve to re-establish balance and contain the problems of drug abuse and diversion. In order to attain this goal, all parties must have the facts and deal with them. David Joranson and Aaron Gilson remind us, through their efforts, that awareness of all sources of drug diversion, will aid in development of novel solutions designed to minimize risks of drug diversion and abuse. This goal is something we can all agree on.

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