Questions from “The Prescription Opioid Abuse Epidemic: How It Happed and Solutions” presented at the Texas Department of State Health Services of Grand Rounds given April 12, 2017.

Can you explain a little more about what the Texas Drug Monitoring program is and how it works?

The Texas Prescription Drug Monitoring program is administered by the Texas State Board of Pharmacy using software from Appriss Health. The point of a PMP (sometimes called a PDMP) is to inform prescribers and pharmacists of a patient’s history with controlled (or scheduled) substances (prescription drugs classified by the Drug Enforcement Agency). When a pharmacist dispenses a controlled substance, electronic reporting of that event is sent to the PMP. Texas’ PMP has an approximately seven-day delay from reporting to appearance in the database. A potential prescriber can see the patient’s controlled substance use history for the last three years. Texas’ PMP communicates with 10 other states which is useful for patients who may be getting controlled substances from providers outside of Texas. At this point, 49 states and Guam have PMPs (Missouri and Puerto Rico do not).

Is gabapentin a viable option as an alternative to opioids?

For some patients, the answer is yes. Let me give you a short piece on acute vs chronic pain.

Acute pain is called nociceptive pain. This literally means pain from a noxious source. For example, a broken leg causes pain because the leaking blood is an irritant to tissues, physical trauma of inappropriate movement causes local nerve receptors to activate sending messages to the brain which is interpreted as pain. The point of nociceptive pain is to tell you to stop doing what you are doing to prevent further damage, it is a protective mechanism. Acetaminophen, NSAIDs and opioids are the mainstay of short-term therapy for acute pain. The real long-therapy is to heal the wound; the cause of the pain!

Long standing acute pain or long standing illness can damage the nerves leading up to the brain. These damaged nerves send inappropriate signals to the brain which are then interpreted as pain; I say inappropriate because the acute injury is no longer there or never was there. For this neuropathic pain, chemically stabilizing the nerve so that it no longer (or less frequently) fires is the goal. We typically use drugs that have also been used for other nerve dysfunctions, e.g., antidepressants and anticonvulsants. There is Gabapentin

is an anticonvulsant that is frequently used for this neuropathic pain. We also frequently use the antidepressant duloxetine for this type of pain as well. There are data showing tricyclic antidepressants are more effective, but they have significant adverse drug events associated with them. Please note that opioids will still block neuropathic pain, but since we cannot as yet heal the damaged nerves, (analogous to healing the wound in acute pain) we must settle for stabilizing the nerve.

Do we have any evidence that the written prescription for opioids vs. e-prescribing has been helpful to reducing the abuse rates as opposed to just inconveniencing the providers and the patients?

This is a bit of a loaded question; e-prescribing was not planned to inconvenience anyone. Evidence is slowly building that e-prescribing along with other electronic medical records decreases overall cost to the healthcare system, because of data mining possibilities. There is some old data that supports e-prescribing is decreasing drug diversion. Some actually find that once in place, e-prescribing makes prescribing and record keeping easier.

What role does insurance companies have with opioid addictions and what changes are needed?

Insurance companies are almost always trying to manage cost to maximize payoffs to stockholders. Many limit behavioral care to very short periods for inpatient care and sometimes even impose lifetime limits. Some states actually mandate insurers cover MAT and counseling. There is concern that Substance Use Disorders may be “pre-existing” disorders that may limit future care by the AHCA as currently passed by the US House. This is not my area of expertise, so I really can’t say what specific changes are needed.

I am in a school setting and would like more information on the disposal pouches. Are they for controlled substances only? How much medication can be placed in a pouch?

Disposal pouches can be used for any drug. The size of the pouch is the only determinate of how much can be placed in them; some are for very small amounts. They primarily work by mixing something that can adsorb the drug or neutralize it so it is safe for the landfill.

Why did they stop pharmacies from taking back old unused or out of date medications?

The DEA requires pharmacies to be registered to take back unwanted drugs. This means the pharmacy must have a disposal system which then costs them money. Not all are willing to pay for these services. You can search for a takeback site on the DEA webpage.

What does he mean by medication assisted treatment?

Medication assisted treatment (MAT) involves the use of methadone or buprenorphine in combination with behavioral counseling to help those with opioid use disorder reduce and eventually stop opioid use.

During the presentation, a comment was made that Texas has not caught up to the rate of prescription opiate abuse seen in other states. Is that truly the case or are there unique variables impacting Texas?

It is hard to say the real answer here. Texas has 254 counties and over 250,000 square miles with over 27 million people; reporting systems are not standardized. The comparison state of Tennessee has only 46,000 square miles and about 6-7 million people in 95 counties. Fewer people, less space, fewer counties all make data collection a little easier. The Centers for Disease Control only report nine (9) counties in Texas as having "reliable data".

Does DEA enforcement of opioid prescribing differ from state to state?

To my knowledge, there is no difference in various states, but there are likely differences in the way offices divide up resources.

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