Drug-monitoring programs needed to cut dangers linked to 'pharmaceuticalization' of 21st century

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Individual use of prescription opioids has increased four-fold since the mid-1990s, in part due to increased awareness of pain control for chronic conditions such as low back pain and fibromyalgia and a Joint Commission mandate that hospitals assess patients' pain as a "vital sign" along with their blood pressure and temperature. During the same timeframe, however, the number of people using these drugs recreationally, becoming addicted to them, and dying of overdoses has also shot up. Today, nearly three quarters of all fatal drug overdoses in the United States are due to prescription drugs -- far outnumbering deaths from cocaine and heroin combined, and often outpacing car accidents as the top cause of preventable deaths.

A Perspective piece published online today in the New England Journal of Medicine outlines a plan for an "ideal" prescription-drug monitoring program that would enable doctors, dentists, pharmacists, researchers and law enforcement officials to access real-time data on patients' prescription drug histories. The authors, medical toxicologists Jeanmarie Perrone, MD, an associate professor of Emergency Medicine in the Perelman School of Medicine at the University of Pennsylvania, and Lewis S. Nelson, MD, a professor of Emergency Medicine at the New York University School of Medicine, say that such programs would allow physicians to take better care of patients with legitimate pain issues as well as identify and intervene to help potential drug abusers, and cut the number of opioids in circulation for illegal sale.

"As the number of deaths associated with prescription-drug use surpasses the number of fatalities from motor-vehicle crashes in many states, we can learn from the success of auto-safety innovations that have mitigated mortality despite increased automobile use over the past three decades," the authors write. "We should initiate active safety measures to address the growing rates of illness and death associated with the pharmaceuticalization of the 21st century."

The idea of state-run prescription-drug monitoring programs dates back to federal legislation authored in 1993 -- long before robust internet use and the development of electronic medical records or e-prescribing systems. Today, 42 states have programs, another six have enacted legislation to develop them, and federal agencies including the Centers for Disease Control and Prevention and the Food and Drug Administration have called for broadening the efforts. But clinician awareness about the tools is poor, and some states, including Pennsylvania, restrict physician access, opening the databases only to law enforcement officials.

The authors note that mounting attention regarding abuse potential of painkillers such as oxycodone and hydrocodone has impaired physician-patient relationships in cases of genuine chronic pain issues. For instance, some recommendations suggest obtaining samples from patients for urine drug screens, or asking them to sign so-called "pain contracts" in which they must agree not to sell or give their drugs away.

To avoid these unintended consequences and improve opportunities to identify and help drug abusers, Perrone and Nelson call for a drug-monitoring system to better inform physician prescribing. Among their recommendations: standardization of the type of information submitted to the databases, and a move toward the use of bar-coded prescription paper to more quickly log entries, or a robust e-prescribing system that would eliminate paper and the resulting prescription fraud and "doctor

shopping" that contributes to illicit use of these controlled substances. They also suggest that the programs include tracking of drugs ranging from those with the most potential for abuse and addiction (oxycodone, for instance) to codeine cough suppressants and stimulant drugs that may be sold or misused for cognitive enhancement.

The authors cite several benefits to more robust drug-monitoring program, including the potential to provide clinicians with an early warning that a patient may need drug counseling or treatment -- and an opportunity to intervene while the patient is still in the medical setting. In addition, they believe these programs could help identify patients who are receiving multiple legitimate prescriptions from different prescribers and pharmacies and may be at risk of polypharmacy complications. As an added benefit, they note that prescribers could use the databases to monitor use of their own Drug Enforcement Administration number to detect forged or stolen prescriptions.

"Although updating an existing prescription-drug monitoring database to incorporate these 'ideal' goals would require additional support and money, the potential to protect the public health is substantial," Perrone says.

Perrone and Nelson will speak this week at the Harold Rogers Prescription Drug Monitoring Program National Meeting in Washington, D.C., where lawmakers will convene to discuss ways to make existing prescription-drug monitoring programs more user-friendly and compliant with health care privacy laws, and strategies to ensure that the data can be shared between states.

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