Government rules aimed at curbing opioid prescriptions may have backfired

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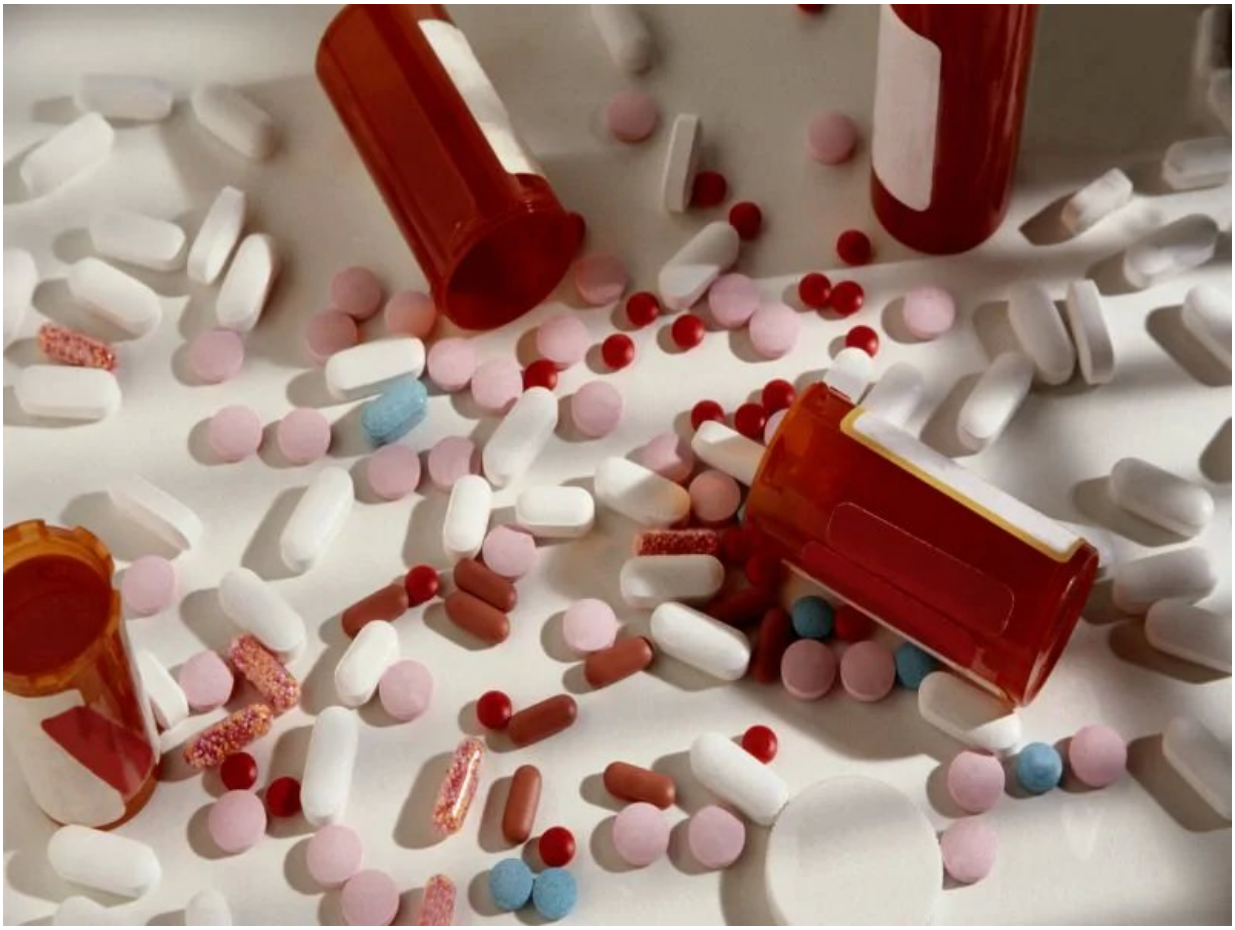

(HealthDay)—As the U.S. opioid addiction epidemic widened, the

federal Drug Enforcement Agency (DEA) placed the prescription painkillers in a tougher-to-refill category.

Many states also mandated monitoring programs to spot overprescribing by doctors.

But two new studies suggest these steps, while well-intentioned, may have led to more opioids—not fewer—being given to patients by surgeons after routine operations.

In the case of the DEA's 2014 action to move opioid painkillers to a more restricted class, this "may inadvertently motivate surgeons to prescribe greater amounts to ensure adequate pain treatment," said Dr. Jennifer Waljee, lead author of one of the studies. She codirects the Michigan Opioid Prescribing Engagement Network.

Her team believes that once prescription refills became tougher under the new DEA rules, surgeons who worried about a patient's longer-term pain control simply ordered a larger number of pills so the patient had a "stockpile" of opioids to use at home.

Opioid use for postoperative pain control is thought to be a major "gateway" to addiction, experts note.

The findings made sense to one physician.

While more prescribing after a tightening of rules seems "counterintuitive," Dr. Joseph Conigliaro said he "agrees with the findings.

"In the case of someone having surgery, they are in acute pain, meaning it shouldn't last long," said Conigliaro, who is chief of internal medicine at Northwell Health in Lake Success, N.Y.

"But because there are limits on prescriptions postsurgery, sometimes physicians can prescribe someone twice to four times as much to ensure they will ultimately have what they need," explained Conigliaro, who wasn't involved in the new study.

In their research, Waljee and her colleagues tracked opioid prescription patterns before and after the DEA's new rule, which moved the opioid hydrocodone (Vicodin) from schedule III to the more restrictive schedule II.

The change meant that doctors could now only prescribe a 90-day supply, and couldn't prescribe over the telephone or by fax.

Data on nearly 22,000 privately insured patients in Michigan—all of whom underwent common elective surgeries—found that far from hydrocodone prescription rates dropping, the number of prescriptions actually rose after the new rule.

Although there was a reduction in the prescription refill rate, there was an overall average 7-tablet-per-patient rise in hydrocodone prescribing after the DEA change, Waljee's group noted.

Why the unexpected trend?

"Our main thought was that since surgeons were more limited in their ability to prescribe extra pain medications after the patient left the hospital, they prescribed more up front to avoid the risk of patients running out," said study co-author Dr. Joe Habbouche. He's a surgery resident at Michigan Medicine, the academic medical center at the University of Michigan.

In a second study, researchers at Dartmouth-Hitchcock Medical Center in Lebanon, N.H., looked at changes in opioid prescribing after New

Hampshire mandated "prescription drug monitoring programs." These programs exist in many states and track doctors' opioid prescribing patterns.

The New Hampshire program went into effect Jan. 1, 2017, and the Dartmouth team looked at opioid prescription patterns for more than 1,000 patients who'd undergone an elective surgery in the six months before or after the change.

Researchers led by the hospital's Dr. Richard Barth found that "the percentage of patients prescribed opioids after surgery did not decrease significantly" after the monitoring program came into effect.

In fact, the average number of opioid pills dispensed after surgery was already decreasing before the implementation of the new program, but that decline actually *slowed* "in the six months after the legislation," Barth's group reported.

Dr. Harshal Kirane directs addiction services at Staten Island University Hospital in New York City. Reading over both studies, he said they point out the hazards of well-intentioned policies implemented "in the absence of adequate physician and patient engagement."

There's no "one-size-fits-all" method to curbing excess opioid use, Kirane said.

"Physician prescribing practices are a major contributor to the ongoing opioid crisis," he said. "Yet, even the most well-intentioned prescriber is confronted by an increasingly complex calculus, in which the goals of pain management and patient satisfaction must be balanced with eliminating the risks of opioid misuse."

The real solution may lie in a more nuanced, "evidence-based" approach

to opioid prescribing, and better education of doctors and patients alike, Kirane said.

Habbouche agreed.

"Different types of physicians and health professionals should be involved in the policymaking surrounding opioid prescribing—especially for prescribing in different settings," he said. "Our work suggests patient and physician education about opioids is critical."

Both studies were published online Aug. 22 in *JAMA Surgery*.

More information: Joe Habbouche, M.D., surgery resident, Michigan Medicine, University of Michigan; Jennifer Waljee, M.D., M.P.H., plastic surgeon, Michigan Medicine, and co-director, Michigan Opioid Prescribing Engagement Network; Harshal Kirane, M.D., director, addiction services, Staten Island University Hospital, New York City; Joseph Conigliaro, M.D., chief, internal medicine, Northwell Health, Lake Success, N.Y.; Aug. 22, 2018, *JAMA Surgery*, online.

For more about opioids, visit the U.S. National Institute on Drug Abuse.