Background

Current estimates show the United States uses 80 percent of the world’s narcotic supply. We are in the midst of an opioid epidemic in terms of use, misuse and abuse. What’s most concerning is physicians are accountable for much of it. According to the U.S. Food and Drug Administration, there has been nearly a 100 percent increase in narcotic pain medication prescription from 2008 to 2011. This increase in opioid prescription medication corresponds to an increase in opioid transfer to nonmedical users as well as a resurgence in heroin use. Opioid overdose is now the leading cause of accidental death in young adults. Opioids are associated with a higher risk of postoperative death and also increase the risk of fall/fracture in the elderly.

As an orthopedic surgeon, I continue to see patients presenting to my clinic for musculoskeletal pathology treated inappropriately by their primary care provider with narcotic medication. These patients are much more difficult to treat as a result and often times are no longer candidates for treatment as a result of their narcotic use. Their pain is difficult to treat postoperatively and their outcomes are altered making many surgeons feel they can no longer treat the underlying pathology due to the inappropriate administration of narcotic use.

PROPOSED TREATMENT STRATEGIES:

1. **Develop a Protocol:** Physicians can more effectively depersonalize discussions about opioids by using standardized opioid protocols to control opioid use.

2. **Limit the Amount of Narcotic:** A prescription should only include the amount of pain medication that is expected to be used/appropriate, based on the protocol established. For patients who live longer distances from their surgeons, two prescriptions for smaller amounts of opioids with specific refill dates should be considered rather than a single large prescription. **PATIENTS WITH ACUTE SEVERE TRAUMA (FRACTURE, KNEE LIGAMENT INJURY, HIGH ENERGY INJURY, ETC…) CAN BE GIVEN ENOUGH NARCOTIC MEDICATION TO LAST NO MORE THAN A WEEK.** This allows for adequate pain control prior to being seen by their specialist. If they cannot be seen within a week, they still need to be off of the narcotics by then to minimize abuse/dependence. No one with a rotator cuff tear, meniscal tear, low-energy injury, etc should be given these medications for more than a day or two. Tylenol and NSAIDS need to be employed to manage their pain.
3. **Limit Use of Extended-Release Narcotics**: Orthopaedic surgeons most often treat acute pain following injury or surgery. Such acute pain typically improves over hours to days, rather than days to weeks. Extended-release opioids are not FDA-approved for the treatment of acute pain. These medications are not intended for treatment of acute injuries.

4. **Restriction of Opioid Use for Preoperative and Nonsurgical Patients**: Pain from acute trauma or chronic degenerative diseases can usually be managed without opioids prior to surgery. Surgical patients using opioids preoperatively have higher complications rates, require more narcotics postoperatively, and have lower satisfaction rates with poorer outcomes following surgery. The effectiveness of opioid use for the treatment of chronic pain other than cancer is debatable. Policies/protocols that limit use of opioids in patients with non-acute conditions can help limit patients’ soliciting opioid prescriptions from more than one physician. Policies/protocols that restrict opioids for preoperative, nonsurgical, and chronic pain patients should be considered.

5. **Monitor Patient Use**: Patients at risk for greater opioid use should be identified (eg, using the opioid risk tool [http://www.mdcalc.com/opioid-risk-tool-ort-for-narcotic-abuse/](http://www.mdcalc.com/opioid-risk-tool-ort-for-narcotic-abuse/)). Patients with symptomatic depression and ineffective coping strategies should be identified and treated by their physician prior to elective surgery.

6. **Collaboration**: Partnerships need to be established among hospitals, pharmacies, law enforcement, physician groups, insurers, and others. Patients need to understand that opioid medications should be used only as directed and to practice safe storage and disposal. Handouts should be given to the patient for further “home education” to better understand the dangers of misuse.

7. **Improved Tracking**: It should be possible for a surgeon and pharmacist to see all prescriptions filled by a single patient. Opioid use is best coordinated through a single prescribing physician. Doctors in emergency departments should give patients enough pills to treat their pain until they are seen in referral but no longer (one week max). Referral for alternative pain management strategies should be considered for atraumatic musculoskeletal pain. Evidence is available that ongoing pain after injury or surgery is most often associated with symptoms of depression, posttraumatic stress disorder, and ineffective coping strategies—all of which are responsive to cognitive behavioral therapy.

8. **Opioid Culture Change**: Making opioids the focus of pain management has created many unintended consequences that often put both patients and their families at increased risk of addiction and death. A new approach to pain management is needed to effectively change the cultural expectations of patients with pain. Patients with similar injuries and surgeries experience varying amounts of pain. The differences in pain for a given injury or surgery are largely explained by individual patient circumstances, characteristics, and mindset. Stress, distress, and ineffective coping strategies create greater pain. Peace of mind is the strongest pain reliever. Studies have found that opioids are associated with more pain and lower satisfaction with pain relief. Opioids are potentially dangerous medications for all patients; they are highly addictive and can cause death.
GOAL:

My hope is to minimize the overprescribing of narcotic medication for musculoskeletal pathology. Educating patients and referring providers on the dangers of this is imperative. Having a better understanding of what injuries require narcotic use for short duration can help better treat the patient’s injury and minimize risk. The following injuries are examples of appropriate and inappropriate use of narcotics:

Narcotics are appropriate for one week (should be seen by specialist by then or off of narcotics and using non-narcotic medication for pain control):
- Fracture of any kind
- Ligament/tendon rupture of the knee
- Joint dislocation
- Severe crush injury (NOT a finger being slammed in a door)
- Other high-energy trauma

Inappropriate use:
- Finger being slammed in a door
- Rotator cuff tear (acute or chronic). Instead give steroid injection and use Tylenol and NSAIDS
- Ankle sprain
- Wrist pain without fracture
- Low back pain
- Arthritis pain. Instead give steroid injection and use Tylenol and NSAIDS