The Inhumane and Dangerous Game of Forced Opioid Reduction

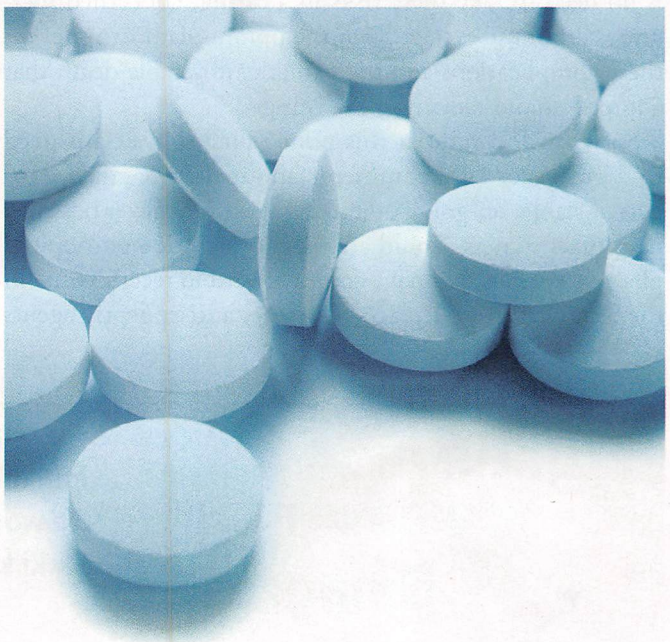
A colleague who I highly respect just informed me of a woman with intractable angina who had multiple, inserted coronary splints and required a high daily dose of morphine. Without warning, her insurance company arbitrarily decided she did not need opioids. As one might expect, the forced cessation of opioids led to her death.

The forced reduction and/or cessation of daily opioids in stabilized patients has, in some corners of our country, reached the point of unscientific and inhumane hysteria. The craze to fight opioid abuse and force opioid dosages below 100 to 120 mg of morphine equivalents a day (MEQ) is now harming some patients who have been doing quite well on stable, daily opioid dosages. Some of the rhetoric and tactics being used to force opioid reduction are farcical if they weren't so tragic in their consequences.

First, who is doing the forcing? There are multiple culprits: insurance companies, state legislators, regulators, and suppliers. Some of the tactics to force opioid reduction are indirect, such as limiting the amount of opioids a pharmacy can stock. Others are blatant, such as states that require physicians to seek a pain consultation if they continue to prescribe over a threshold MEQ level, even to patients who have been well maintained for a considerable time period. For example, in Washington State, a 120 mg/d MEQ threshold will trigger the prescribing physician to conduct, or refer the patient for, a pain consultation (exceptions and exemptions do exist).[1] As noted by Stephen J. Ziegler, PhD, JD, "in some states, these thresholds appear in regulations, making the actions required actions, while in other states the thresholds appear in guidelines, making the actions merely recommended."[2]

Insurance companies are currently the most dangerous "forcers." Neither patient, pharmacist, nor physician is prepared when a stable, opioid-maintained patient goes to fill a long-standing opioid prescription only to be told their insurance company has suddenly decided the patient should immediately cut their opioid daily dose by 30% to 70%, or even stop it altogether. The saddest aspect of this dangerous practice is that the motive is clearly greed, although the reduction may be accompanied by an "out-of-the-blue" statement that the forced reduction is for the patient's safety. For example, insurance companies have recently informed long-standing, opioid-maintained patients that they have suddenly and capriciously decided they will no longer cover brand name opioids, injections, patches, compounded formulations, or a daily dosage above a specific level.[3]

Insurance companies and some state guidelines are spitting out two illogical excuses for the forced reduction of opioids. One is that opioids dosages above 120 mg or so of MEQ are unsafe. Show me a study that indicates tissue toxicity of opioids at dosages over 120 mg in patients who have been maintained at a stable dosage for over 1 year. Patients who have been titrated up to dosages above 120 mg of morphine and periodically monitored by competent physicians almost



always experience improved health and function, not the reverse. I have several patients who have been safely maintained on high opioid dosages and led quality lives for more than 20 years!! Why force these folks into sickness, suffering, and possibly death by suddenly and capriciously claiming their life-saving medication is dangerous?

The other straw-dog is "hyperalgesia." Would someone please tell me how I'm to define and diagnose hyperalgesia in a patient who has been well maintained on a stable opioid dosage—high or low—for over a year? Hyperalgesia has become a label and excuse to force down opioid dosages. Reputable and credible pain practitioners are not even sure it exists in a human who is well maintained on opioids. Whenever I see a patient who is on opioids and claims his or her opioids aren't working as well as they used to, I take a hormone profile. Once I replace any deficient hormones, the patients' opioids resume working.

My demand is for someone to send me the consensus document that tells me how to objectively diagnose hyperalgesia in patients who have been well maintained on opioids over 90 days. What's more, if hyperalgesia exists, what harm does it do? If we really believe that hyperalgesia is a problem with high-dose opioids, we must remove all intrathecal opioid pumps because these devices deliver a MEQ directly to the CNS receptors that is far in excess of any dosage we can achieve by peripheral administration!!

Readers of *Practical Pain Management* well know that severe, constant pain has far more risks than any stable, daily opioid dosage. Severe pain adversely affects the cardiovascular, endocrine, immune, and neurologic systems. It sends patients to bed in agony to lead a short, suffering life. There is no need to take these risks in a caring, concerned society, as a minute extract from the opium plant can prevent these complications and the pathetic, miserable death that a forced opioid reduction can bring.

So what do we do at this point? First, physicians need to correct any false comments about the imagined dangers of stable, on-going opioid dosages. Whenever possible, pain practitioners should attempt to prescribe non-opioid pharmaceuticals that have come forward in recent years. In the latter category, I place ketamine, anti-epileptic agents (gabapentin, pregabalin, etc), and neurohormones (oxytocin, human chorionic gonadotropin, and progesterone). I've cut my patients' opioid use by about 50% over the past 5 years by use of these agents. I also recommend obtaining an opioid serum level in patients who take more than 100 mg of MEQ. The presence of a reasonable opioid serum level indicates that the patient is ingesting opioids and is functioning well with a high opioid dosage.

Lastly, and most important, families of patients who must take a high daily opioid dosage need to become publicly active as advocates for their loved one. Unfortunately, but realistically, patients who must take a high opioid dosage always have a debilitating condition such as arachnoiditis, CRPS, traumatic brain injury, post-encephalitis headache, or facial neuropathy, and are too ill to fend for themselves. But their family can. It's time families demand the right of their suffering loved ones to obtain opioids, and their direct and blunt communication should go to State Medical Boards, insurance companies, wholesale suppliers, and their elected representatives.

Also, pain patients and family members should start joining the emerging nationwide organizations that are now forming to fight back. While we physicians have little public voice left, families of pain patients can, should, and will be heard.

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References

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