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GUEST EDITORIAL

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# Balancing needs and risks as the opioid pendulum swings

Recently, my family had a conversation about the volume of news reports on overdose deaths from the illicit use of opioid drugs—a phenomenon that is complex and stems from many factors. We decided, as a family, that we could have a small impact on the problem. How? By carrying naloxone with us and administering it if we encounter a person with potential opioid overdose. Our decision was made possible by the recent US Food and Drug Administration (FDA) approval of naloxone nasal spray for over-the-counter use.[1] At a cost of about $50 for 2 nasal sprays, we decided it would be a reasonable price to pay to potentially save a life.

Prescribing opioids in clinical practice is a different side of the problem. The Centers for Disease Control and Prevention (CDC) reports that prescription opioids account for about one-quarter of opioid overdose deaths.[2] This is not trivial, and much effort has gone into addressing how clinicians can do better by their patients. There are training programs and risk-mitigation strategies for opioid prescribing. States have developed prescribing registries to identify patients who receive controlled substances from multiple prescribers, at higher-than-recommended doses, and too early in the pain management process. These efforts have reduced the number of opioid prescriptions and rates of high-dose prescribing (> 90 morphine milligram equivalents). However, that hasn't translated into a reduction in the number of deaths.[2]

**The CDC encourages clinicians to find a balance of the potential benefits and harms and to avoid inflexibility.**

The article by Posen et al[3] in this issue further reminded me how trends in health care, including opioid prescribing, are like a pendulum—swinging from one extreme to the other before eventually centering. I recall conversations with colleagues about how often we undertreated pain—and then later, how relieved we were when new approaches to pain management, using newer opiates, emerged and were reported to be much safer, even for long-term use. We now know the rest of that story: more prescriptions, higher doses, longer duration, addiction, death, and deception by manufacturers.

In our efforts to prevent addiction and decrease opioid deaths, we tried to get patients off opioids completely, thereby increasing demand for addiction therapy, including medication-assisted recovery. This also drove many of our patients to seek opioids from nefarious suppliers, resulting in even more deaths from fentanyl-laced drugs.

At least one positive has arisen from the "no more opioids" movement: We have re-evaluated their true effect on managing pain. Initially, we were told opioids were safe and highly effective—and, having few tools to help our patients, we were Pollyanna-ish in accepting this. But many recent studies have demonstrated that

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### Putting recommendations into best practice

Given the time constraints in primary care practice, the most efficient way of providing high-quality, clinical preventive services is by implementing USPSTF "A" and "B" recommendations, being very selective about who receives an intervention with a "C" recommendation or "I" statement, and avoiding interventions with a "D" recommendation. JFP


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using opioids for pain is no more effective than using other analgesics.[4-9] In addition to overdose deaths and addiction, these studies show significantly higher rates of opioid discontinuation due to adverse effects.

We certainly can manage most patients' pain effectively with other approaches. For some, though—patients whose pain is not adequately controlled and/or interferes with their ability to function, and those who are terminally ill—opioid nihilism has had unintended consequences. Recognizing these issues, the CDC updated its guideline for prescribing opioids in 2022.[10] Four areas were addressed: whether to initiate opioids; opioid selection and dosing; duration of therapy and need for follow-up; and assessing risk and addressing potential harms of opioid use. The CDC encourages clinicians to find a balance of the potential benefits and harms and to avoid inflexibility. Finally, the CDC encourages clinicians to identify and treat patients with opioid use disorders.

Clearly, opioid overuse and overdose result from complex medical, economic, and societal factors. Individual clinicians are well equipped to manage things "in their own backyards." However, what *we* do can be perceived as a bandage for a much larger problem. Our public health system has the potential for greater impact, but the "cure" will require multimodal solutions addressing many facets of society and government.[11] At the very least, we should keep some naloxone close by and vote for political candidates who see broader solutions for addressing this life-and-death crisis. JFP


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