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EDITORIAL

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The New Opioid Epidemic and the Law of Unintended Consequences

In this issue of *EM*, EP-toxicologists Rama Rao, MD, and Lewis Nelson, MD, review the salient features of the current opioid epidemic in the United States. The authors differentiate this epidemic from prior patterns of heroin and opioid abuse partly by the clinical features that now make timely diagnosis and treatment in the ED more difficult.

According to the CDC, between 2000 and 2015, the number of opioid overdose deaths in this country quadrupled to half a million, or 91 deaths a day (http://bit.ly/2jEOHfs). We know now that prescription opioids have been driving this 15-year increase. Since 1999, both the amount of opioids prescribed and the number of opioid deaths in the US have quadrupled. Ironically, during that same period, the amount of pain reported has not changed overall (http://bit.ly/2jEOHfs). In 2015 alone, opioids were involved with 33,091 deaths, of which more than 15,000 were due to prescription opioid overdoses—most commonly methadone, oxycodone, and hydrocodone (http://bit.ly/2jZ1TfO and http://bit.ly/2iwagAI). Adding to the misery has been a sharp increase in deaths due to heroin since 2010, and a similar increase in deaths due to fentanyl, tramadol, and other synthetics since 2013. Currently, more than 1,000 people are treated in EDs each day for misusing prescription opioids (http://bit.ly/2iwagAI).

The road to the current epidemic began to be paved with good intentions in the late 1990s when, soon after the FDA approved the controlled-release form of oxycodone (Oxycontin), the American Pain Society introduced the phrase "pain as the fifth vital sign." In 1999, the Department of Veterans Affairs embraced the statement, as did other organizations. The Joint Commission standards for pain management in 2001 stated "pain is assessed in all patients" (*all* was dropped in 2009) and contained a passing reference to pain as the fifth vital sign. In 2012, CMS added to its ED performance core measures timely pain treatment for long bone fractures, emphasizing parenteral medications.

By 2010, the problems created by emphasizing effective pain management had become evident, and measures began to be introduced to restrict the prescribing and availability of pharmaceutical opioids. The restrictions sent many patients to EDs seeking pain meds. Others sought substitutes on the street and ultimately ended up in EDs as overdoses from very potent synthetics. Many EPs began to limit opioid prescriptions to 3 days for acute painful conditions, though not all patients were able to obtain follow-up appointments with PCPs within that time period.

In April 2016, the Joint Commission issued a statement claiming it was not responsible for "pain as the fifth vital sign" or for suggesting that pain be treated with opioids. In June 2016, the AMA urged dropping "pain-as-the-fifth-vital-sign" policies, and in 2014, CMS modified its core measure emphasis on parenteral medication in the timely treatment of long bone fractures. But the damage has been done, leaving many people requiring help managing their pain and others suffering the consequences of opioid dependence.

EPs must continue to deal with victims of overdoses without denying pain treatment to those with acute, acute-on-chronic, and recurrent pain. Increased use of effective non-opioid pain meds such as NSAIDs may help, although not everyone can tolerate them and there are long-term risks. For large, overcrowded, urban EDs where treatment of pain is not always timely or consistent, 24/7 ED pain management teams working with EPs could be a tremendous asset, just as 24/7 ED pharmacists have proven to be. Until both effective pain treatment and the resultant opioid dependence and overdoses can be successfully addressed, regulatory agencies should deemphasize, without completely eliminating, pain treatment questions in scoring patient satisfaction. ■

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