

THE OPIOID CRISIS: A CASE FOR SHIFTING FROM TERTIARY TO PRIMARY PREVENTION

To the editor: The Special Advisory Committee (SAC) on the epidemic of opioid overdoses, a committee struck by the federal, provincial, and territorial governments, recently released the most up-to-date and complete quantification of the Canadian opioid crisis; a staggering 2,458 apparent opioid-related deaths were reported across the country in 2016.¹

Unsurprisingly, there has been a dramatic upstroke in emergency department (ED) visits related to opioid intoxication, overdose, and withdrawal.² Plus, with pain being one of the most common presenting complaints to the ED, managing patients with acute pain, as well as patients suffering from chronic pain exacerbations (albeit less common) are a daily reality. No other practitioners have born better witness to this crisis as it unfolded or, more importantly, are better positioned to address it.

The risks of under-treating pain are well documented and with the limited non-opioid pharmacological analgesic options; categorically, not prescribing opioids is unreasonable, whereas prescribing them safely by assessing risk is reasonable. It is important to note, however, that, per capita, Canada is one of the highest opioid consumers in the world, so there is clearly room to expand the use of non-opioid options.

Most physicians likely perform some sort of personal risk assessment, but the rates of opioid-prescribing among ED physicians are extremely heterogeneous with the risk of long-term use in naïve patients being much higher if their original prescription was from a high-intensity prescriber.³

Thankfully, there exists several validated opioid prescribing tools that, at least anecdotally, are underused. The Opioid Risk Tool (ORT), for example, is a validated set of 10 patient-reported questions that literally takes a minute and is conveniently available on MDCalc.⁴ Many others exist; none are perfect. Some are more elaborate, like the Acute Pain Assessment and Opioid Prescribing Protocol.⁵ Even the single question: “How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?” has been validated and shown to be 100% sensitive and 73.5% specific for the detection of a drug-use disorder.⁶

Of course, risk assessment is only one aspect, and addressing this developing crisis from the ED requires a multi-pronged approach. Experts at treatment with naloxone drips and kits are getting better at harm reduction with ED-initiated buprenorphine/naloxone programs followed by referrals to addiction services; however, it is time to move as hastily as departmentally possible from tertiary to primary prevention. The balance between the professional responsibility of treating pain and striving to avoid

creating opportunities for misuse is a delicate one; however, evidence-based risk assessment, before any opioid prescription, is essential for safe prescribing.

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