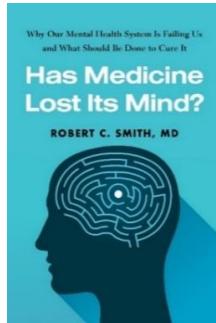


HAS MEDICINE LOST ITS MIND?



Newsletter 20: The New Opioid Dilemma

September 2025

Dear (name),

There's at least some good news on the opioid front. Prescribing rates have declined from 2012 to 2023: for long acting drugs, from 22.8 million to 9.3 million (41%); for short-acting medications, a 49% decrease (1). Tempering this success, though, is an increase in street drug use, the nature of the epidemic changing as a result of greater regulation of professional prescribing (2).

A couple rigorous studies documented the risks of opioids (1). More than 1 in 5 took opioids for non-prescribed reasons (get high, sell them, give to someone else) and 1 of 8 met criteria for Opioid Use Disorder (an addiction problem). And 27.1% of patients met Opioid Use Disorder criteria in another study where 4.1% of Medicaid patients using chronic opioids overdosed.

Here's the dilemma. We know the risks, but there's no good data supporting the use of opioids in chronic pain (1). The few studies evaluating benefits lasted only about 12 weeks, and showed no benefit. Another investigation, reported small but clinically insignificant improvement for both pain and functioning from opioid use in chronic pain (3); many believe assessing function is more important than the pain level because the latter is so subjective (4).

One part of the dilemma is clear, at least to me. Don't initiate opioids for chronic pain (and don't use them more than a few days in acute pain, lest refilling prescriptions leads to chronic use, which fosters chronic pain). But this advice doesn't help much. Most chronic pain patients already take opioids, so what about them, that's the new and evolving dilemma, patients on long-term prescribed opioids?

Guidelines from the Veterans Administration (3) have proven useful, and my textbook provides evidence-based guidelines based on the key patient-centered and motivational interviewing practices (4). My clinical experience and that of many others indicates that doctors have difficulty in discontinuing or even tapering opioids in chronic users. To have the best chance for success, doctors negotiate this non-prescriptively with the patient in a respectful, understanding, and caring way. If patients agree, recent data indicate that clinicians can conduct a monthly reduction of 10-40% safely without increases in overdosing or mortality (5). But greater reductions over a month led to an increased risk of death. Further worrisome, because many

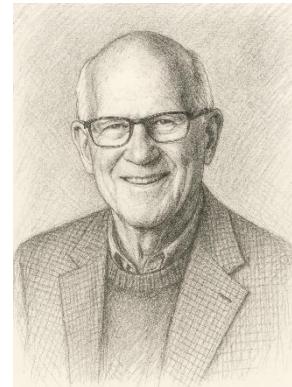
patients aver that they need just a slight increase in their dose to control their pain, when clinicians increased the dose by more than 10% per month, the risk of death, overdose, and addiction increased. For a skilled clinician, tapering with buprenorphine, an opioid with a different chemical structure that's less addicting, produces much better success (6). Another use of this medication is for maintenance in those who cannot reduce or discontinue their opioids. Substituting buprenorphine for the patient's usual opioid is much safer and causes less euphoria, but there's little data, like that for other opioids, on its actual benefit (5).

The long and short is that many patients will remain on opioids for a lifetime, and we must gracefully accept and manage that.

Sadly, our lack of training in opioid use and chronic pain led not only to the opioid crisis in deaths and overdoses but also to the now troublesome opioid addiction problem. I address the more definitive measures to counter this in Has Medicine Lost Its Mind?

I'm greatly honored that Dr. Charles (Chaz) Hong, our new Department Chair in Medicine, created this picture electronically to use as our department's first entry on its new Wall of Fame.

Take care, get your Covid and other shots, and be well,



Bob

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