Opioid Deprescribing in Emergency Medicine—A Tool in an Expanding Toolkit

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The opioid crisis has been a top public health priority for more than a decade. Although its latest evolution involves epidemic-level deaths from illicitly manufactured fentanyl and its analogues, the origin of the crisis can be definitively traced to the overprescribing of prescription opioids. Although broad-based efforts across all specialties have resulted in substantial reductions in opioid prescribing, the study by Smith et al demonstrates that efforts in their emergency department (ED) outpaced any secular trend. Their study evaluated opioid prescribing in an urban, academic ED and found a 66.3% decline between 2013 and 2018 for a variety of painful conditions, a rate substantially greater than those reported in previous studies and in national data.

When initial reports about opioid overprescribing emerged, government-derived data highlighted emergency medicine as a top-prescribing specialty based on the number of prescriptions written. However, later work demonstrated that, despite evaluating and treating substantial numbers of patients with pain, ED opioid prescriptions were typically for small quantities (eg, a mean of 17 tablets), highlighting that, even in earlier eras, emergency physicians were reticent to prescribe opioids for more than a few days. Although ED prescribing has not been the primary driver of the epidemic of opioid use disorder (OUD), hyperalgesia, overdose, and death associated with prescription and illicit opioids, there remain opportunities for improvement.

Perhaps because Smith et al are not emergency physicians, the process leading to their institution's success is not described in detail. It is worthwhile to highlight that the specialty of emergency medicine has addressed analgesia and its consequences and that many of these efforts generalize to other clinical departments and across the health care continuum.

Emergency departments function as 24/7 pain safety nets for those with a range of acute and chronic pain syndromes, including patients at the end of life from cancer or those experiencing complex pain, such as vaso-occlusive crises. Through the development of various (ie, institutional, state-based, specialty-wide, and national) guidelines, emergency physicians have been on the forefront of focused efforts to reduce opioid use while balancing the needs of individual patients with the sanctity of the public health. Unquestionably, the answer is not simply to stop prescribing opioids but rather to look critically at our practices and evaluate opportunities to improve.

As likely is operative in the study by Smith et al, ED analgesia guidelines have evolved from limiting indications for opioids in common conditions, such as headache and abdominal pain, to the current emphasis on the particulars of what is prescribed, to whom, and for what duration. It is important to note that Smith et al found the largest reduction in opioid prescribing for musculoskeletal pain, for which alternative medications, such as nonsteroidal anti-inflammatory drugs, have demonstrated superiority to opioids. They identified less benefit for conditions such as ureterolithiasis for which there was not a clearly superior opioid alternative.

Although there are no adequate risk prediction tools to help to identify individual factors associated with developing consequential opioid use, there is an indisputable fact: long-term opioid use cannot develop without exposure to an opioid. Therefore, as in the study by Smith et al, more attention needed (and still needs) to focus on avoiding unnecessary opioid exposure. Interestingly and supportive of current trends, data support that the duration of the initial opioid prescription may best predict adverse outcomes, and this finding has been robust across the spectrum of medical and surgical pain care.

New-era pain management guidelines typically recommend nonopioids or even nonpharmaceutical options to initially address pain, relegating the use of opioids to third-line agents.
for many patients. Not only are these alternatives effective analgesics for most patients, they also avoid the unintended messaging that opioids are the only effective pain management modality.

Other factors have influenced deprescribing. We have striven to reset expectations and clarify treatment goals, explaining that no pain may not be feasible and that improved functionality and quality of life should be the defined therapeutic goal. Pain assessments have shifted as well, from simply seeking to enumerate a subjective pain score to using objective signs of functional ability. In response, patients and clinicians have honed their understanding of risk and benefit and become more wary of opioids. However, programs that correctly highlight the poor risk and benefit of opioids, such as so-called opioid-free EDs, may unintentionally result in stigma and bias when these dictums are tightly applied.

The electronic health record is increasingly leveraged to integrate the prescription drug monitoring program as a decision support tool and to direct prescribing behavior through the use of default quantities and best-practice alerts. Review of these data can also help to identify problematic opioid use patterns, allowing referral to treatment from the ED when concern arises.

Notably, through the use of a stewardship model, EDs and health care systems have sought to address the spectrum of harms associated with opioid use. While the study by Smith et al focused on the success of 1 aspect of opioid stewardship (ie, deprescribing), stewardship programs also address harm reduction (eg, naloxone prescribing and distribution) and treatment engagement (eg, buprenorphine prescribing).

Increasingly, EDs are leading to treatment by credentialing a cadre of clinicians who are ready to engage patients in the treatable moment that may accompany an ED visit. This includes a focus on withdrawal management with buprenorphine, warm hand-off programs, bridge clinics, and direct initiation of buprenorphine therapy. No doubt, being face to face with this evolving crisis spurred ED thought leaders to develop these programs.

Data from the Centers for Disease Control and Prevention show that our extensive efforts to reduce mortality from prescription opioids are starting to show benefit, albeit too late for those who have developed OUD or transitioned to illicit opioids. The ED must continue to cast a wider safety net to accommodate this population, with real-time harm reduction through education and take-home naloxone to protect these patients from the ultrahigh potency and variability of fentanyl and related novel opioids.

While the study by Smith et al demonstrates the potential effectiveness of opioid deprescribing, emergency physicians must not solely address this isolated metric. The specialty, and the health care system overall, must continue to focus on rational and compassionate pain management using the existing toolkit of nonpharmacologic, nonopioid, and opioid therapies, while balancing the potential risks of OUD, hyperalgesia, and overdose. Now, we must further expand our toolkit to engage patients with OUD in treatment and help to overcome the stigma of this disease. Stewardship of all aspects of opioid use is critical to overcoming this personal and public health crisis.
REFERENCES:


