Advocating for those Who Use Opioids for Non-Pain Conditions

Background

It is well recognized that the United States is in the midst of an opioid crisis. The use and abuse of both prescription and illegal drugs has dramatically increased in recent years. According to the Centers for Disease Control and Prevention, the number of overdose deaths involving opioids, both prescription and heroin, and the sale of prescription opioids have quadrupled since 1999[1]. On average, 130 Americans die everyday from an opioid overdose[2]. Addressing the opioid epidemic is a major public health concern on federal, state and local levels. Efforts include multi-faceted approaches with a focus on acute and chronic pain management including but not limited to promoting non-opioid medications as first-line therapy early in pain treatment and stricter laws controlling opiate drug prescriptions.

Issue

Some patients with an ileostomy, as well as patients with surgical short bowel syndrome with an ileostomy or continent fecal diversion, may develop a condition called High Output Stomas (HOS), which results in severe watery diarrhea often liters per 24 hours. This leads to dehydration, fluid and electrolyte imbalance, difficulty with maintaining an ostomy pouching system, requirements for costly intravenous fluid hydration, Emergency Room visits, and hospitalizations. These patients may need to be prescribed opioids such as diphenoxylate (Lomotil) loperamide (Imodium), codeine and distilled tincture of opium (DTO) at doses closely monitored by their physician to manage this condition. These drugs can be life-saving for these patients. There is a growing concern that new regulations and laws being enacted to address the opiate epidemic are restricting and/or prohibiting access to the prescription and coverage of opioids prescribed for control of significant uncontrollable diarrhea resulting in an increasing threat to our patients' quality of life and increasing medical costs by needing to resort to the aforementioned costly intravenous fluids, Emergency Room visits and inpatient hospitalizations. Opioids are usually the last line of defense against this difficult problem. However, for some low dose opioids are prescribed to better and more effectively manage this non-pain condition and restore the quality of life for these patients.

Position

UOAA recognizes and supports the need to address the opioid epidemic facing the country. Furthermore, regardless of the purpose of the drug-use (pain versus other medical treatment such as controlling refractory diarrhea) we also appreciate the necessity for careful monitoring for side effects and that the proper dosage is prescribed to minimize the risks associated with opioid use. However, any legislative and/or regulatory approach to control opiate prescriptions that will impact chronic pain treatment must ensure that patients who are already utilizing opioids for **non-pain treatments** in accordance with the recommendations of their physician are:

- protected;
- appropriately accommodated;
- not restricted access to their lifesaving treatment

For these difficult and life-threatening situations the goal is always for the physician to prescribe the lowest dose of opiate to control the patient's diarrhea and maintain their hydration. In reference to following pain protocols prescribing physicians should follow those used by pain management clinics which treat individuals with chronic pain and medically indicated opiate use. These include requiring physicians to check for potential abuse by accessing the state opiate reporting system or ordering random drug tests.

[1]"Opioid Overdose." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 19 Dec. 2018, www.cdc.gov/drugoverdose/epidemic/index.html.

[2]Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2017. Available at http://wonder.cdc.gov