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Opioids on a blue prescription

INVITERT KOMMENTAR

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A growing number of patients are being prescribed high-dose opioids by their general practitioners. Discussion is needed on how we can reverse this trend and reduce the risk of overdose from prescribed medications.

In this edition of the Journal of the Norwegian Medical Association, Pedersen et al. present a study of opioid use in Norway during the period 2011–2019 (1). The prevalence of persistent high-dose opioid use was higher at the end of the period than at the beginning. The proportion who received the medications on a blue prescription (heavily subsidised prescriptions) also increased. However, the proportion with concurrent persistent use of benzodiazepines and z-hypnotics decreased.

The authors describe a development in which doctors with various roles have played a part. An increasing number of patients are being prescribed high-dose opioids on a long-term basis for chronic non-malignant pain. This occurs frequently, contrary to clinical recommendations (2). The results of the study are highly relevant for general practitioners (GPs) in Norway, who are largely responsible for the daily prescribing of opioids, benzodiazepines and z-hypnotics.

> *«The results of the study are highly relevant for general practitioners in Norway»*

Historically, the clinical recommendations for treating chronic non-malignant pain have been subject to change, while our patients remain the same. In 2019, the Regional Medicines Information Centre (RELIS) launched an opioids educational campaign – KUPP – for GPs in Norway. The campaign was launched at the same time the opioid epidemic in the United States gained widespread attention following a billion-dollar fine imposed on a major pharmaceutical company (3, 4). Highlighting the issue is beneficial, as it means many patients are now aware of the risks of long-term opioid use, which will aid collaborative decision-making when weighing the pros and cons of treatment.

According to the Trøndelag Health Study (HUNT), approximately 30 % of the adult population in Trøndelag suffer from chronic non-malignant pain (5). Although opioid treatment is not a good long-term solution, a patient's desire for immediate relief can be difficult to ignore, even for the most patient clinician. Equally important, a doctor's ethical duty to alleviate chronic, severe pain can feel pressing. Many would also argue that there has been a shift in the power dynamics between doctor and patient, making it more difficult to deny requests for prescriptions. Alternative treatment options to medications exist, but evidence on their effect is limited and availability tends to vary. How long does your patient need to wait to get an appointment with a psychomotor physiotherapist, and how far do they need to travel?

> ***«A patient's desire for immediate relief can be difficult to ignore, even for the most patient clinician»***

The number and proportion of overdose deaths attributed to opioids in prescription medications have increased (6). I believe that in many cases, GPs have a gut feeling about which patients they are prescribing analgesics for might be at risk of excessive use and abuse of opioids, or who may be supplementing their consumption with non-prescribed medications and substances, such as alcohol. Alcohol is a legal substance, and consumption can be defended as a private matter, but it is also associated with depression, injuries and a range of somatic conditions (7). Patients are rarely asked about their alcohol use by health service professionals, and older patients are asked less frequently than younger patients (8). Perhaps we should incorporate a discussion about alcohol use into our conversations with patients, including when prescribing opioids, to help normalise the topic? Where clinically relevant, drug testing after a medical appointment can be justifiable. Findings of phosphatidylethanol (PEth) in moderate concentrations (0.03–0.3 umol/L) confirms use of alcohol (9), and this could be a good opportunity to further assess the patient's alcohol habits and consumption. If your patient is prescribed oxycodone, but the medication does not show up in a high-quality drug test, this could potentially be a clinical game changer.

The study by Pedersen et al. found that prescribing opioids and benzodiazepines or z-hypnotics in parallel was relatively less common at the end of the study period compared to 2011. It would be interesting to explore

whether changes to the driving licence regulations during the study period impacted on prescribing practices in Norwegian general medicine, such as the combination of codeine/paracetamol and benzodiazepines.

> ***«Ethical considerations, medication choices and dosage matters must result in concrete decisions by the GP»***

Pedersen et al.'s study is based on old data. It is important to have more recent data in order to track current developments. If the blue prescription scheme contributes to increased opioid consumption, we need to discuss how to better balance the patient's medication costs with the associated health risks. Patients with complex symptoms, often accompanied by chronic pain, are treated by their GPs. Ethical considerations, medication choices and dosage matters must result in concrete decisions by the GP. GPs need effective tools to manage patients with complex issues and persistent high-dose opioid use, along with access to relevant expertise for discussion and support when the available solutions are not optimum.

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