Opioid Stewardship Series, Season 1, Episode 7:
Double Trouble: Benzos and Opioids / Harm Reduction With Naloxone

Speaker 1 (00:03):

So, now I'm really excited to introduce you to one of our local opioid heroes, Dr. Steven Dudley. Dr. Dudley's a board certified clinical toxicologist, and he's also the director of the Arizona Poison and Information Drug Information Center. Shortly after graduating from U of A College of Pharmacy, he completed a toxicology fellowship at the Arizona Poison and Drug Information Center. In addition to his clinical and director duties, Dr. Dudley is Clinical Toxicology fellowship director, as well as a preceptor and course instructor for pharmacy and medical students and residents. So, his work also includes overseeing Arizona opioid assistance and referral line.

Speaker 2 (00:46):

Today, you know, we're gonna talk about double trouble benzos, benzos, an opioids harm reduction with Naloxone. So, basically we're just going to compare the risk of benzo opioid overdose and their co-involvement, characterize the approaches of reducing the opioids and benzo's co-prescribing, and identify some best practices for discharge naloxone. All right, so I'm pretty sure we've all seen or heard in some way this statement, in some form or manner, but this is from the CDC guideline for prescribing opioids or chronic pain, back in 2016. And basically, this recommendation came out that clinicians should avoid prescribing opioid pain medication and benzodiazepine concurrently whenever possible. And I think two of the big points I want to talk about today is, one, whenever possible, you know, clearly there are some specific times and needs where you may need to co-prescribe those, you know, palliative of care, things like that.

Speaker 2 (01:35):

But, uh, whenever possible, we definitely want to try to avoid that. And the second part of this is, you know why, and, and I think we all know now because of the risk of overdose and death, specifically when you combine these two medications. So, as a poison center person, I want to give some poison center statistics. And so this is from our all the poison centers, all 55 of us from last year, 2021, the data for exposures or calls to us. And so, if you look here nationally, we, the poison center received, almost 18,000 cases of a benzo exposure reported to us. And, and this is a single substance. So, what that means is that these were the calls we had where it was just the benzo involved, nothing else, at least nothing else that was known or reported to us.

Speaker 2 (02:23):

And so, of those nearly 18,000 cases, we had eight deaths. So, we're about a rate of a little under 0.05%. When you look at just opioid exposures, we had little over 26,000 of those, again, just opioids, single substance, and not combined any other category or class of medication that was known to us. 439 deaths are, you know, a little over one and half percent of the time, those internet fatalities. And then, when you look at the combination of benzos plus opioids exposures to us together about 22,000 cases, 469 deaths and that rate increased to 2.09%. Now, the poison center data is a little skewed. You know, again, we get these exposure calls. These can be accidental ingestions. They could be self-harm attempts, so definitely take it with a grain of salt. But, you know, we're absolutely seeing this in our world, and a big part of what we're also seeing is not just the prescription of opioids, but also illicit in streets, opioids who are being contaminated with fentanyl and fentanyl analogs, et cetera.

Speaker 2 (03:29):

And so, you know, definitely something to keep in mind there. But looking at data from elsewhere... So, this is one study done from the VA looking at the benzodiazepine-prescribing patterns and deaths in the VA population with opioids. This was a systematic retrospective review looking at over, 420,000 randomly sampled patient records that had an opioid prescribed. And then of that 420 thousand reviews, we had a little over 112,000 who were co-prescribed benzos. And so, they specifically looked at that population and the subset of the 2,400 patients who unfortunately died from an overdose. But again, the take home point that they found, without, without doubt, was increasing the frequency, increasing the amount of opioids and benzos taken together led to a higher risk of death from drug overdose. All right, so, you know, we talk about, and I'm sure everyone's here, heard probably ad nauseum about the risk that exists here, but what can we do about it?

Speaker 2 (04:32):

And so one of some things we can make of the interventions is clinicians checking the prescription drug monitoring program for concurrent control medications prescribed by other clinicians. That's a big, and I want to say easy one, you know, with, with tongue-in-cheek there, because, you know, sometimes there are barriers implementing that into, you know, your EHR or having, you know, consistent access or, you know, getting people, nurses, technicians, et cetera, as authorized viewers for, for physicians to look at that. I know there's can't be some barriers there, but that is a pretty relatively low-hanging fruit to try to reduce the incidents that that's happening. But a big part of it, it's gonna be taking the patient history and being cautious about OTC opioids. And what I mean by OTC opioids are the two big ones we're seeing, especially in the poison center world, are Kratom, depending on how you wanna pronounce it.

Speaker 2 (05:22):

And this one is a plant that is from, from originally from Southeast Asia. It's the mitragyna speciosa plant. And what's interesting is that in low doses, it's actually more of a stimulant, kind of like caffeine, and that's what it's used for in the fields for, you know, field laborers, things like that. But in high doses, it does act on the myopia receptor, and it, it through and through is an opioid. The big thing here in Arizona is that, you know, how are we gonna regulate this? And this was a big talk for years, and, you know, where we're going to make it illegal, make it a controlled substance, and we sort of, you know, kicked the can down the road. And right now it's, you can get it online, you can get it, we've seen it in vending machines around Tucson.

Speaker 2 (06:04):

So it, it is definitely accessible to patients, and it's becoming known as an opioid, sort of substitute for, for patients who, who may need it for any purpose. And so, you can see it's the CDC report from the MMWR about the increase in drug overdose deaths. The other one we're, we're seeing here as well is the generic loperamide, is the anti-diarrheal. And this one we've seen as well, unfortunately, in the poison center, rare and the normal doses you get over the counter, it has no opioid effect in the brain whatsoever. But in high doses, you're talking hundreds of, of capsules a day, you can actually penetrate the blood-brain barrier. And again, this is another sort of OTC opioid, and unfortunately, it's, it's been linked to overdose of deaths as well as torsades as no of the unfortunate adverse effects.

Speaker 2 (06:50):

Okay, so what else can we do, right? We know this is the big issue. What can we do to actually do something about it, considered non-pharmacologic and non-opioid pharmacologic treatments. And so, you know, what

does that, what does that mean? There have been studies looking at, if we see opioids and we know that they're not working there, or we want to reduce the risk, what else can we do? So, cognitive behavioral therapy has been a big one that's been gained a lot of steam in the last few years. Exercise therapy and biopsychosocial rehabilitation. The biocycle social model is really looking at, you know, three different things. So, I think as clinicians, everyone's pretty familiar with the, the physical model, right? The bio pathway, but also looking at the psychological impact, and social impact of chronic pain, and how to address those different things to sort of cultivate this better patient-centric patient care model to improve outcomes.

Speaker 2 (07:41):

And there have been some, some evidence that, that does have pretty modest increases or improvements in chronic pain. So, as part of your, your pharmacologic therapy, this can be a pretty important tool to improve chronic pain without having to rely heavily on opioids and especially opioids and benzos. And then your non-opioid therapies, your acetaminophens, NSAIDs, your SNRIs, your serotonin, norepinephrine reuptake inhibitors, uh, your tricyclics. Again, trying to target the, the chronic pain, the neuropathic pain, you know, from a different non-opioid based mechanism against evidence showing that there is, you know, modest improvement as well as part of a treatment plan, can definitely lead to better outcomes and improve quality of life. Okay. And then the last thing, you know, consider involving pharmacists and pain specialists as part of the management team. And when opioids are co-prescribed with other central nervous system depressants.

Speaker 2 (08:32):

And so, it's kind of a twofold argument here. One, you know, pain specialists, I say that because obviously it's nice to have somebody who specializes in that area for these, for these patients, as, as someone who runs the OR line, being here in Tucson and covering the state, especially in these rural areas, that is way easier said than done. I think in 2016, you know, in a good effort, you know, there was all these new updated guidelines that came from Arizona and that says, yeah, you know, just have a pain specialist and you recruit them all and consult them. Easy peasy. And then you have to try to find one, and there were essentially none, right? So, definitely easier said than done for that matter, but involving pharmacists can definitely be an easier way to, to get an extra set of eyes on these prescriptions and these prescribing patterns and to make interventions.

Speaker 2 (09:16):

All right, so the first one. So there's some, some evidence that's out there. So, there are medication therapy management programs that offer pharmacists, delivered, you know, direct-to-provider interventions. And so, this one was just kind of looking at, retrospective review, looking at about 58,000 subjects. And they found that, you know, when there was a pharmacist involved in trying to make an alert or a change to a benzo and opioid co-prescription, that the, the change was actually approved roughly like 66% of the time. And that led to some out of, you know, 22—23,000 prescriptions being changed. De-combining the two prescriptions there. So, definitely a good intervention. From a VA standpoint, again, this one's looking at academic detailing program done by pharmacists to look at and effect the co-prescribing trends and the VA system.

Speaker 2 (10:06):

And they found that once academic programming was done, uh, by pharmacists, the rate of co-prescribing of benzos and opioids dramatically decreased. And they had about a third of reduction after the first month of the interventions of the two there. So again, another sort of example of how you can have a multidisciplinary approach to help reach the goals there. You know, for all the things that we're talking about with the, the strain

on the healthcare system and, you know, physician time with patient, and all these metrics that we have to hit it, it is nice to have a separate set of eyes and a backup there to kind of help reach our goals, so to speak. And then, finally just another example, another study done about implement, implementing the pharmacy console service to reduce the co-prescribing opioids and benzos.

Speaker 2 (10:56):

And again, same thing after the implementation, you know, the co-prescription rates dropped dramatically. Okay, so then a big part just to kind of wrap up the Quickinar session here, is naloxone and discharge. So, I think we all know Naloxone saves lives. You know, it's not the end all, be all. We definitely need to approach the problem from a prevention standpoint, an education standpoint to prevent an overdose. But should this happen, Naloxone is definitely one of the first tools we want to make sure we have, you know, with the patient to prevent a death. And so, naloxone should be offered to patients at an increased risk for overdose. And what does that mean, right? So, if they had a history of overdose in the past of any substance, that would be a reason to have Naloxone there. History of a substance use disorder, if they're co-prescribed benzos and opioids, again, we know by now the increased risk of overdose death.

Speaker 2 (11:44):

Their reduced tolerance or return to a high dose. This is a big one that we see in the poison center world. And you may have seen any, you know, your own experiences, but patients who are incarcerated, who have been using opioids in any manner, illicitly or through prescription, you know, and they, they don't have access to that, they lose that tolerance over time, and then they returned to their home dose and effectively it's an overdose because they've lost a tolerance. That becomes a whopping dose for them. And really, anyone who's being prescribed more than 50 morphine milligram equivalents a day, you do see some, some variation that's number 50, or is it 90? Again, I think it's definitely better to, you know, be safe than sorry. And, and I think that the important point here is you want to reduce those barriers, right?

Speaker 2 (12:27):

High-risk patients should leave with Naloxone in hand. You know, in Arizona we have the standing order, so any patient can go to a pharmacy and get Naloxone, but you want to reduce that barrier. You want to reduce the chance they get there and, you know, pharmacy's out of stock, or they don't go to the pharmacy whatsoever, know at all. Um, anything that we can do to make sure they leave with Naloxone, it's directly going to impact their chances of survival should and overdose occur. And the big thing too is addressing the stigma. You know, this is, I think we work with a lot of people who use drugs. I know this is not necessarily the focus of this talk, but it does spill over with patients who are using opioids again, for, for any reason. There is that stigma that we have in society about, oh, well there, there are a drug user and what does that mean?

Speaker 2 (13:10):

And so, you know, there's a lot of evidence that, you know, there's a perception is that they feel less, less, less appreciated, that they feel like they're, they're, you know, not really respected as your, your typical patient would be. And so, because of that, they don't get the same sort of opportunities, same education, things like that. And so, we want to make sure that, you know, we're not blowing these patients off. We're addressing provider stigma, patient stigma, to making sure the patient care comes first. And a big part of that too is making sure that the patients feel comfortable taking the Naloxone and having that conversation with people they live with, of close ones nearby, about how to use Naloxone, how to recognize the signs of the opioid overdose,

because if they suffer from an overdose, they're not going to be able to administer Naloxone to themselves, more often than not. And so it's gonna be somebody else with them. And we know that, people who are with these people who live with them at home are the best chance for these patients surviving an overdose, far greater than EMS getting there, because again, there's that time delay there. So, addressing stigma goes a long way into improvement outcomes, and that's really what it's all about. You know, what's the point of giving a lifesaving drug if they never use it or tell 'em to use a lifesaving drug if they never get it?

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