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Opioid prescribing in the UK: can we avert a public health disaster?

Cathy Stannard

For many of us working in the field of pain medicine, 2003 represented a turning point. For a decade a more liberal approach to opioid prescribing, supported in part by a steady stream of short-term, randomised controlled trials and facilitated by a tide of educational initiatives sponsored by pharmaceutical companies selling the next best thing, had put pain specialists ahead of the pack. We thought we had at our fingertips the newly acquired knowledge to open the floodgates and deploy our most potent weapon, strong opioids, in the battle to manage persistent pain. But then a distant warning bell was heard. Jane Ballantyne and Jianren Mao published a paper in the *New England Journal of Medicine* in which they sounded a number of cautionary notes.[1] They pointed out that opioids are not all good news when used in the long term and, in particular, the way that opioids are used in clinical practice cannot be justified from the information we derive from clinical trials. A year later there were more loud noises off. An editorial in *Pain* described a developing epidemic of opioid misuse in parallel with the marked and progressive rise in opioid prescribing.[2] The debate shifted from 'Why not prescribe opioids?' to 'Why not to prescribe opioids?'

Data from the USA are unambiguous. The increase in prescription of opioids for pain has been accompanied by an increase in prescription drug misuse and additional risk of morbidity and mortality.[3–10] The prescribing statistics from other developed countries, including the UK, show a similar rate of rise in opioid use, so it is no surprise to read dire warnings of the storm of misuse and opioid-related deaths that is about to hit us.[11–13] It is also unsurprising that the mix of a good story about the man in the street becoming addicted and a dig at doctors has made its way into our daily newspapers.[14–16]

For certain, every patient who becomes an addict as a result of irresponsible prescribing or marketing is a patient too many. Addiction destroys the lives of sufferers and their families and is a barrier to successful pain management. Support groups representing patients who have run into trouble with opioids and other drugs have recently found a voice in the UK, and this has led to both a parliamentary inquiry and a coordinated Department of Health work stream to address the problem.[17,18] As part of this work stream, the situation with regard to addiction and mortality in the UK is becoming clearer. There may be limitations in the way that data regarding addiction to prescribed and over-the-counter (OTC) drugs are collected and it is likely that addiction to medicinal opioids is somewhat under-reported. The National Drug Treatment Monitoring System data show that addiction to prescribed and OTC opioids does occur but the numbers of patients presenting for support in relation to addiction to prescribed opioids has remained stable over a 5-year period.[18]

The Office for National Statistics records data on all drug-related deaths. A review of the 2010 data show unchanged or falling death rates in relation to co-codamol, co-dydramol and dihydrocodeine; a steady increase in deaths from tramadol since 2003 (87 tramadol-related deaths in 2009 and 132 deaths in 2010); and a rise in codeine-related deaths from 2006 to 2009, which now seems to have stabilised.[19]

So what does all this mean? As far as we know, we do not, in the UK, have an epidemic of addiction and opioid-related mortality as a result of increased opioid prescribing – or at least not yet. We have only really just started looking properly. We might speculate that the inability of pharmaceutical companies to market opioids directly to patients, the current primary care set-up in which most patients still have a family doctor who has a pretty good grip on who, apart from themselves, is giving what to patients, and a culture in which patients, on the whole, believe that doctors know best,

Frenchay Hospital, Bristol, UK

Corresponding author:
Cathy Stannard, Frenchay Hospital, Bristol, BS16 1LE, UK
Email: cfstannard@aol.com

might act as brakes on the addiction and mortality juggernaut. However, this is no time for complacency. What the addiction and mortality data do not tell us is the enormous clinical challenge and healthcare burden in relation to patients with persistent pain on unhelpful and very-high-dose opioids who, in some cases for years, are burdened by all the harms and none of the benefits of opioid treatment. We do not know what the scale of the opioid-related harms is, but all of us see patients in this trap in almost every clinic.

We must remain vigilant and diligent in our efforts to improve what we know about safe prescribing of opioids and opioid-related harms. Cautionary guidance exists, but given the lack of a large enough data set to give us the answers we so badly need in relation to long-term opioid therapy, such guidance is still heavily weighted by professional opinion. It may be that we have a real opportunity here in the UK to somehow head off the impending storm by getting the message about safe prescribing to everyone who needs to know it, and to support the victims who have been already hit by the opioid problem with improved recognition and management of opioid burdens. If we could get it right it would be a public health triumph. If we do not, and the UK ends up in the undoubted opioid chaos seen in the USA, it will be as bad for those who do not need opioids as for those who do.

Conflict of interest

The author declares that they do not have any conflict of interest.

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