



Prescription Drug Abuse and Prevention

America is in the midst of a prescription opioid epidemic. It is estimated that in 2016, 11.8 million Americans, or 4.4 percent of the population, age 12 years and older were nonmedical users of opioids – defined as prescription pain relievers and heroin. Of these nonmedical users, and over the course of the previous year, 10.9 million reported the misuse of only pain relievers, 641,000 reported the misuse of pain relievers and heroin, and 948,000 reported the misuse of only heroin.¹

As oral and maxillofacial surgeons (OMSs) and lawful prescription drug prescribers, we know that when used as prescribed, prescription opiates enable individuals with acute and chronic pain to lead productive lives and recover more comfortably from invasive procedures. We also recognize, however, that acute pain medication prescribed following oral and maxillofacial surgery may frequently be the first exposure many American adolescents have to opioid prescriptions, and that roughly 12 percent of all immediate-release opioid prescriptions in the United States are related to dental procedures.² Dentists, including OMSs who primarily manage acute pain, have a responsibility to ensure we do not exacerbate a growing public health risk while ensuring our patients receive the relief they need following complex dental procedures.

Over the past decade, a number of approaches have been proposed to address this issue. AAOMS provides the following positions in response to several of these proposals.

Prescription Drug Monitoring Programs

Prescription drug monitoring programs (PDMPs) implemented and updated by dispensers – if properly funded – are valuable tools for detecting a practice known as “doctor-shopping” and preventing the diversion of prescription opioids. AAOMS believes federal and state efforts to develop these programs should be supported and properly funded. AAOMS further believes that in order to prove useful in preventing abuse and diversion, dispensers should enter data into a PDMP in real time. In addition,

if the prescription is for a period of less than seven days, it should not be mandatory to check a PDMP for acute pain patients who receive an opioid following an invasive surgical procedure, as the risk of abuse and diversion is low in these instances. Furthermore, because checking the PDMP is an administrative task, AAOMS believes approved auxiliary personnel should be authorized to access the system on the doctor’s behalf.

Continuing Education

The training received during their residencies implicitly qualifies OMSs to manage their patients’ pain – and, in particular, acute pain – following invasive procedures. Nevertheless, AAOMS encourages our members to be aware of public health trends that may impact patient care and also encourages voluntary provider participation in continuing education (CE) programs that focus on drug abuse and responsible prescribing practices. AAOMS worked with the National Institute on Drug Abuse (NIDA) to develop an educational course to help prescribers, including oral and maxillofacial surgeons, talk to adolescents about substance use and abuse. We also helped develop and encouraged our members to participate in the Substance Abuse and Mental Health Services Administration’s (SAMHSA) online training on “Safe Opioid Prescribing for Acute Dental Pain.” Prescribing, while important, is but a small part of the overall care that is provided to each patient. AAOMS believes that to be most effective, CE should be managed at the state level, be appropriately proportionate to other CE requirements and be customized so that it is relevant to each type of prescribing situation. AAOMS further believes provider specialty organizations such as AAOMS should be included as accepted practitioner training organizations for CE requirements. Finally, there remains a need beyond prescriber CE to educate patients and the public at large about opioid abuse and diversion. AAOMS supports such collaborative education efforts that include governmental agencies, non-profit organizations and prescriber organizations.

Prescribing Guidelines

AAOMS appreciates the development of prescribing guidelines, which may be helpful to practitioners as they determine the proper course of postoperative treatment for their patients. In 2017, AAOMS released the white paper “Opioid Prescribing: Acute and Postoperative Pain Management,” which provides recommendations for the prescribing of opioids for pain. AAOMS encourages all OMSs to consult this document for the management of acute and postoperative pain in their patients and to follow the recommendation that nonsteroidal anti-inflammatory drugs (NSAIDs) – rather than opioids – be utilized as a first-line therapy to manage a patient’s acute and post-surgical pain. AAOMS also recognizes and encourages our members who provide chronic pain management to consider the CDC Guideline for Prescribing Opioids for Chronic Pain.³ AAOMS further supports efforts currently underway by several OMS residency training programs and encourages all training programs to develop and utilize acute prescribing guidelines that instruct all practitioners to calculate the total morphine milligram equivalents prescribed to a patient to ensure safe prescribing. If government entities seek to develop prescribing guidelines, we encourage them to recognize the unique care provided by OMSs by involving them in the development process and to avoid a one-size-fits-all approach as pain management needs varies from patient to patient. AAOMS encourages provider and/or patient discretion by allowing them to partially fill a prescription with the option to acquire the remaining amount only when necessary. Implementation of such a practice will lessen the risk of diversion of unused medications.

Supporting Practitioner Judgment

Only the treating practitioner, not subjective policy, can determine a patient’s medical needs. It is the position of AAOMS that the patient-practitioner relationship must be upheld, allowing the practitioner to have the final say regarding the management of a patient’s pain including drug types, dosage and treatment duration. Practitioners should be informed of the latest public health trends, including possible alternatives to opioid pain treatment; but in the end, practitioners should be trusted to treat their patients according to their best professional judgment. As with any issue, should a practitioner be shown to be practicing contrary to the standard of care, the practitioner should be referred first for peer review, followed by prescription writing counseling/continuing education and then, if necessary, punitive remediation.

White Paper



References:

- 1 *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration. September 2017. Retrieved from www.sahmsa.gov/data/.*
- 2 *JADA. July 2011; 142(7): 800–810.*
- 3 *CDC Guideline for Prescribing Opioids for Chronic Pain. Recommendations and Reports. 65(1); 1-49. March 2016.*

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