"Expert Monitoring for Safe Opioid Prescribing"

Presented by:
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Webcast Questions and Answers
*(Answers are in **bold**)*

Questions:

1. Will ritalin test +ve for amphetamine?
   a. Ritalin will test + for methamphetamine on an immunoassay, but on confirmatory testing the methamphetamine and amphetamine will be negative
   https://academic.oup.com/jat/article/36/7/538/828902#.Xv-lonFEVXs.email
2. Wouldn't the positive hydrocodone in the patient taking oxycodone be more likely from cross-reactivity of the test rather than impurities? Actual impurity levels tend to be much lower than allowed but if the test is an EIA then cross reactivity seems more likely.
   a. **Oxycodone metabolized to noroxycodone, oxymorphone, and their glucuronides, and is excreted primarily via the kidney.**
3. Do you have medical hypnosis available for non-pharma intervention?
   a. **Yes we do.**
4. If a patient takes only one pill that morning or day before, but sells the rest, will you know?
   a. **It depends on the pharmacogenetics . See Paice,J (2007)** *doi:10.1016/j.pmn.2007.04.001*
5. Can you comment on racial disparities in prescribing practices as it relates to pain control measures?
   a. **There are many articles that you might review with a google search of this topic. ASPMN® has a statement on our website that you can access at www.aspmn.org.**
6. What is the risk of becoming dependent on opioids from chronic opioid use for non-end-of-life pain?
   a. **Here is one summary of the findings you are asking about.**
   https://www.acpjournals.org/doi/full/10.7326/M14-2559?journalCode=aim
   Risk is evaluated and stratified by evidence based risk tools in practice.
7. How do patient-based risk factors compare to medication-based risk factors? For example, how does the risk of dependence or death from MEDD of 50 mg or more compare to risk from presence of mental illness or sleep apnea?
   a. **So you are asking if mental illness or OSA has a relationship to addiction and overdose different than MEDD? I don't have an answer to that nor do I see it in the literature. This might be a great question for your research study! And a good question to have discussion on our listserv.**

8. You don't rely a bit on rapid screen to prescribe then?
    a. **We did say that if the screen is what you expect that you might re-prescribe. However we also said that initial testing should include confirmation and any clinical evaluation should be considered to wait confirmation before continuing a prescription. You should not counsel a patient for unexpected results on a rapid screen- always send for confirmation.**
9. What about pt's use of THC during the evaluation process? Do you require patients to be clean from THC as well as heroin/cocaine? Do you make a referral to an addiction specialist if they use THC regularly?
    a. **Illicit marijuana use is looked at closely. Typically, we will prescribe for someone utilizing illicit marijuana, as long as they are cutting down to quit, or quit already. The normalization or creatinine/THC ratio is attained by taking the ng/ml THC result, dividing it by the creatinine level, then multiplying that by 100. That can give us a level that takes the hydration level of the urine into consideration and can better tell us whether a patient is actually discontinuing use over time. It's important to consider physical activity, THC is stored in fat cells and with increased activity can release into the body, thus causing a level to increase or show positive after a very long time since last used.**
10. How to differentiate between amphetamine and methamphetamine on confirmation in particular when amphe and meth levels are equal (say both are >3000 ng/ml) and when amphe and meth levels are 3000 and 1000 ng/ml, respectively?
    a. **Meth is metabolized to amphe, but amphe is not metabolized to meth. Meth d is script and street meth, while Meth l is OTC like Vicks. Many prescription meds for parkinsons and obesity will metabolize into meth or amphe. GS-MS or LC-MS testing can differentiate between meth d and meth l. On an immunoassay, many meds (sudafed, thorazine, buproprion, Ritalin, ma huang, Inderal) can throw a false + for meth on an immunoassay, but will not test + for meth or amphe on LC-MS/MS. So to differentiate meth vs amphe, and prescription vs illicit should take into consideration the confirmatory results, the prescription monitoring program, and physical assessment of the pt.**
11. What to do if somebody is opioid (suboxone) compliant, however, using methamphetamine too-do I need to refer to addiction specialist?
    a. **It depends if they are taking both drugs through a prescriber for a diagnosis based on a history and physical examination.**
12. As a new consulting doctor in a subacute rehab SNF, I discovered OxyCODONE is being given instead of OxyCONTIN to someone on chronic opiate therapy. He is symptomatic for Rx surges. I alerted nursing, but he was transferred off my service. Nothing has been changed to his orders. What do I need to do?
    a. **It isn't clear what you mean by "Rx surges" or if the patient was prescribed long acting chronically and then changed to IR when entering the SNF. If you have documented LA opioids chronically and the dosing is underdosed and decreasing function and quality of life as well as increasing pain, I would have documented this in my notes and alerted both nursing and administration/quality assurance for follow up.**

13. I am working in a suboxone clinic. I advise pts to AVOID known substances that give false positives (e.g. NO sudafed, phenylephrine) & I provide a list of holistic alternatives. My partner allows all these +'s if pt states they took these OTC's. What is the best approach?
    a. **If the holistic approach works for your patients, it provides the most clear evaluation. If there is any question on results, you or your partner should consult the toxicologist from the company confirming the results for guidance in moving forward.**
14. How long does it take to go from initial contact to appointment in the outpatient setting?
    a. **Multifactorial: depends on the availability of the practice, pt insurance, proximity of pt to the office, etc.**
15. Please provide the link referenced in slide 9 regarding Tennessee chronic pain guidelines (link was broken that was originally provided).
    a. **Link for 2020: https://www.tn.gov/content/dam/tn/health/healthprofboards/ChronicPainGuidelines.pdf**
16. Please provide the link to the article referencing the revised ORT from 7/20/2019.
    a. **Martin D. Cheatle, Peggy A. Compton, Lara Dhingra, Thomas E. Wasser, and Charles P. O'Brien (July 2019) Development of the Revised Opioid Risk Tool to Predict Opioid Use Disorder in Patients with Chronic Nonmalignant Pain *Journal of Pain* 20:7**