PALLIATIVE CARE CASE OF THE MONTH

"Identifying and Managing Diversion of Prescription Medication in the Outpatient Setting"

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Case: Ms. L is a 60 year old woman with a history of stage IIIb lung cancer who underwent resection and adjuvant chemotherapy five years ago. She has pain related to her previous lung cancer surgery and chemotherapy, as well as chronic lower back pain and osteoarthritis. Her current physician, Dr. J, assumed her care six months ago when her previous physician retired. This physician had prescribed 30 milligrams of oxycodone, four times a day, for the past five years. Dr. J does not typically prescribe such high doses of opioids, and she reluctantly agreed to continue prescribing these with a hope that she could eventually wean the patient down on her dose. The urine drug screen Dr. J ordered on her first visit with Ms. L showed only her prescribed medications, including the oxycodone. The medical records available showed no indication of a history of a substance use disorder. The patient lives with her daughter, who is the one who calls every month and requests a refill on the oxycodone. Recently, the clinic received an anonymous phone call stating that Ms. L's daughter has been selling most of the patient's oxycodone tablets. How should Dr. J handle this case of suspected drug diversion?

Discussion: One definition of diversion is "the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber."2 The most commonly-diverted medications include benzodiazepines and other central nervous system depressants, opioids, and stimulants. Certain prescription drugs are in greater demand on the street, particularly 30 milligram oxycodone tablets ("Perc 30s") and fentanyl patches, from which the fentanyl can be extracted and then snorted or injected; among benzodiazepines, alprazolam 2 milligram tablets are popular ("Xanny bars"). Prescription medications are perceived as a safer alternative to non-prescribed drugs such as heroin, which have uncertain potency.

Diversion is more common than most prescribers realize. In one study, fifteen percent of patients with HIV who had been prescribed opioids for chronic pain admitted that they had sold or shared their opioids. 3 Another study reported that, of college students who had used opioids non-medically, the most common way of obtaining opioids was from a parent (28%), and the second most common (27%) was from a friend at the same college – while only 3.5% purchased them from a drug dealer.4 An individual's risk of being diagnosed with an opioid use disorder has been found to be higher if a relative had been prescribed opioids.5

How and Why Diversion Occurs

There are a number of ways that diversion of prescription opioids can happen. Perhaps the most common phenomenon is the patient who may simply not realize that they should not occasionally share a pill with a family member who has a headache.

A substance use disorder in either the patient who is prescribed the medication, or a friend or family member, is another common reason. Prescription opioids sell for more on the street than non-prescribed opioids – oxycodone, for example, typically can be sold for a dollar a milligram. So, a patient who has a substance use disorder may sell their oxycodone or fentanyl patch to obtain a larger quantity of a non-prescribed drug such as heroin, or a non-opioid substance such as cocaine or methamphetamine. A friend or family member with a substance use disorder may steal (or be given) medication from the patient to take themselves. Of course, patients or a family member may sell their medication as a way of paying their bills. "Pill brokers" maintain a list of patients, often elderly individuals, from whom they buy medications and then sell them to a street dealer. These brokers even create sophisticated systems for tracking when a patients' medications prescriptions will run out and help to arrange for patients to get refills.6,7

Prevention of Diversion

Fortunately, some mechanisms already are in place to prevent drug diversion. Before prescription drug monitoring programs (PDMPs) were in widespread use, it was common for individuals to "doctor shop", obtaining prescriptions from multiple clinics or emergency rooms. Alteration or forging of paper prescriptions has been another way of illicitly obtaining prescription drugs – before the advent of electronic prescribing for controlled substances. Health care systems such as hospitals have mechanisms in place to prevent diversion, including secure storage for controlled substances, and protocols such as witnessing of the wasting of partial doses.8,9

Outpatient prescribers can implement further preventative measures. Some of these are inseparable from general guidelines for initiating and managing opioid therapy. For example, the decision to prescribe opioids or other controlled substances should be accompanied by screening for risk factors for a substance use disorder (SUD)10,11, with heightened attention to safety strategies if prescribing is initiated in the context of a SUD. Clinicians should also prioritize non-opioid and non-pharmacologic methods of treating pain and use the lowest effective opioid dose possible.12 Of course, when prescribing a controlled substance, clinicians should check their state's PDMP, as well as that of neighboring states or a state in which the patient has lived recently.

More directed prevention strategies can be employed at the time of an initial prescription. Clinicians should explicitly state that the medication prescribed is for the patient's own use only, and that it is very risky (and illegal) to share it with a friend or relative. Though there is limited data supporting the effectiveness of treatment agreements, clinics that use one should incorporate this caution to patients.

Personal details in the case published have been altered to protect patient privacy.
For palliative care consultations please contact the Supportive and Palliative Care *programs at PUH/MUH, 412-647-7243, pager # 8511, Shadyside, 412-647-7243, pager # 8513, Perioperative/ Trauma Pain, 412-647-7243, pager # 7246, UPCI Cancer Pain Service, pager 412-644-1724, Magee Women's Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 412-688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children's pager 412-456-1518*
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Discussion Continued

Prescribers should also ask who lives in or comes into the home to raise the patient's awareness that they should be particularly careful to keep their medications secure when they live with teenagers, young adults, or individuals with a substance use disorder. Strategies to keep medication secure, such as the use of a lockbox, should also be discussed. In addition, some clinics in which opioids are frequently prescribed may require such patients to bring in their remaining medication at every visit for a count.

Addressing Suspected Diversion

There are no guidelines or data to guide prescribers to detect and manage suspected diversion – the following advice is based on expert opinion and current clinical practice with high risk populations. Routine or random urine drug screens may show the absence of a prescribed substance. However, this may also occur when a medication is ordered to be taken as needed, and the patient doesn't take it every day – or when the patient takes more of the medication than directed and runs out several days before clinic visit. In addition, a urine drug screen cannot detect how much of the prescription medication the patient is taking, so the possibility of diversion of part of a prescription still exists, even if it is present in the urine sample. Regardless, urine drug screens are still generally recommended when pain is managed with opioids.12 When obtaining a urine drug screen, the clinician should ask the patient when their last dose of the prescribed medication was and document the answer.

In cases where there is a strong concern for diversion, based on a urine drug screen result or a report from an individual in the community, the first step should be to discuss this concern, and the reasons for it, with the patient. Clinicians should offer the patient an opportunity to explain what has been going on. A question that normalizes the behavior can make it easier to answer honestly: "It can be tempting to share your medication, or even sell some pills if there is someone who is asking to buy them. Is this something you have done?" However, a patient who has been intentionally diverting their medication will typically not share this with their provider. In this situation, the only way to confirm or refute diversion is to require the patient to come into the clinic for a random count of their medication, and to provide a urine sample at that time (a "callback"). 13 A callback should be timed midway through the prescribing period, i.e., enough time that, if the patient is in fact diverting their medication, they would have had time to do so, but not towards the end of the interval, when the patient may have taken all of their medication. The clinic should also have a plan for how to respond when the patient says they are unable to come in, or when they are unreachable. This might involve reiterating the concern for diversion and setting an expectation that if they do not appear for the next random callback, the clinician will stop prescribing.

Return to Case: Ms. L was receiving monthly oxycodone prescriptions. Therefore, Dr. J called her two weeks after she had last filled her prescription and asked her about diversion, which the patient denied. She then told the patient that she would be required to come to the clinic within 24 hours with the remainder of her oxycodone. The patient agreed. However, she did not come to the clinic within the required time frame, and she did not appear for subsequent scheduled appointments. She received no further opioid prescriptions from Dr. J.

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