Detecting Misuse of Prescription Opioids: Easier Said Than Done?

To the Editor: A recent *Journal* article by Han et al[1] investigated the prevalence and clinical manifestations of prescription opioid use disorder (POUD) among adults with prescription opioid use, classified by opioid misuse status. POUD refers to the loss of control over opioid use, inability to stop, and organization of daily activities around opioid use despite impairment. In this nationally representative sample, only 38% of POUD patients admitted to misuse, indicating that most POUD patients had a secretive relationship with their opioids. The authors emphasize the need for clinicians to screen for POUD in all patients taking prescription opioids irrespective of their opioid misuse status.[1] However, this is easier said than done. One question of interest is how to uncover this "hidden" relationship in a patient-centered fashion.[1]

Guidelines suggest that all long-term opioid therapy (LTOT) patients be monitored for opioid misuse (using opioids in a way that differs from how it was prescribed) with a universal precautions approach.[2] Broadly, these strategies include opioid agreements, clinical screening, urine drug toxicology (UDT), and prescription drug monitoring programs (PDMPs).[2] Misuse is common and may lead to risk of overdose or progression to POUD.[1] Approximately, 4.8 million Americans have POUD, and 24% of opioid overdoses in the US involve prescription opioids.[3] Thus, tackling POUD remains a public health priority.

One screening tool is the Current Opioid Misuse Measure (COMM), which has 77% sensitivity and specificity.[4] However, as indicated by recent research, self-report is not always accurate.[1] Objective data to detect aberrant behaviors include the use of PDMPs and UDTs. PDMPs are useful to identify patients seeking opioids from several prescribers and pharmacies while uncovering risky drug interactions.[5] UDTs can help to monitor adherence and undisclosed substance use. UDTs are recommended at least annually for low-risk patients for opioid misuse.[6] However, implementation of this guideline is variable. A retrospective study in a sample of 5,690 LTOT patients showed that only 39.6% of them had UDTs completed at least once a year.[7] Discussions regarding the need for UDT as well as the results require good patient-prescriber rapport. In addition, interpretation of UDT requires some expertise and complicates the process.[4]

In one Australian study, primary care providers were fearful of conversations about POUD, felt uncomfortable prescribing opioids, and were worried about LTOT. They perceived discussions about misuse, and the need for urine testing to be difficult, leading to avoidance of diagnosing POUD.[8] The hesitancy surrounding diagnosis may reflect the stigma that permeates these discussions. While primary care providers in the US appear somewhat comfortable diagnosing POUD, effective pharmacotherapy (eg, buprenorphine) is underutilized and is viewed as too "onerous, complex, or difficult."[9]

In sum, prescription opioids continue to contribute to opioid overdose and much misuse goes undetected. Providers need to feel comfortable initiating difficult discussions to understand the experiences of LTOT patients. Provider confidence in this skill can improve risk mitigation strategies and lead to the implementation of universal precautions in a patient-centered manner.

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