Caring for people with opioid use disorders

Nicholas Pimlott MD CCFP FCFP, SCIENTIFIC EDITOR

Although the world is full of suffering, it is also full of the overcoming of it.

Helen Keller

In Canada in 2017, there were almost 4000 opioid-related deaths, most involving illicit fentanyl or fentanyl analogues.[1] A third of deaths and more than half of opioid-related hospitalizations in Canada were in people with a medical opioid prescription.[2,3] In 2016, 1 in 8 Canadians received an opioid prescription,[4] and a single 5-day prescription from a physician might increase the likelihood of long-term opioid use.[5,6] A new guideline in this issue of *Canadian Family Physician* on the management of opioid use disorder (OUD) in primary care opens with these startling statistics (**page 321**).[7]

I belong to a generation of family physicians who were indoctrinated during their training into the overreliance on opioids for the treatment of people with chronic pain. In the early 1990s, when I was in the midst of my family medicine residency, the use of short-acting medications for patients with chronic pain was panned, and long-acting opioids were promoted by experts and opinion leaders as effective, safe, and with low risk of dependence and harm. Failure to prescribe them for suffering patients was considered to be substandard practice. Two and a half decades later, Canada and the United States are in the midst of an opioid crisis, the complexity of which is hard to disentangle and for which a solution will be equally complex.

In an important commentary published in the *American Journal of Public Health,* Dasgupta and colleagues described 3 phases of an intertwined opioid epidemic.[8] The first phase occurred at about the time my generation of family physicians was in training, with a rise in the prevalence of chronic pain (owing to greater patient expectations for pain relief, musculoskeletal disorders of an aging population, rising levels of obesity, increased survivorship after injury and cancer, and increasing frequency and complexity of surgery)[8]; the development and aggressive marketing of innovative, extended-release formulations of opioids; and a corresponding withdrawal from the market of nonopioid analgesics owing to concerns about safety.[8]

Dasgupta et al argue that while opioid overprescribing by physicians is a key factor in the epidemic, it has also been fueled by economic and social upheaval, and opioids have become a refuge from trauma, socioeconomic disadvantage, social isolation, and hopelessness.[8] Some would argue that these forces are more of a factor in the United States, but similar social factors and transformations have occurred in Canada too.

While family physicians can advocate that we address the opioid crisis through the kind of structural-determinants lens called for by Dasgupta et al, in the near term it is crucial that we are far more judicious in prescribing opioids, identify patients in our practices with OUD, and work collaboratively with them. To assist family physicians with this challenging task, this issue of the journal features another clinical practice guideline developed by the PEER group at the University of Alberta in Edmonton entitled "Managing opioid use disorder in primary care. PEER simplified guideline" (**page 321**).[7] Like previous guidelines from the PEER group, this OUD guideline meets the Institute of Medicine's criteria for *Clinical Practice Guidelines We Can Trust*[9] and was specifically developed to support family physicians and their patients. Furthermore, the guideline is supported by a rigorous systematic review of the evidence (**page e194**).[10] The PEER guidelines show that there is good evidence for the effectiveness of treatment of OUD in primary care compared with treatment in more specialized settings.[7,10] Research in this issue (**page 343**) also finds that, while rates of chronic disease prevention and management in patients with OUD receiving opioid agonist treatment (OAT) are low, those receiving OAT in a medical home setting are more likely to receive such care than those treated in specialized OAT settings.[11] Although it can sometimes be difficult to identify patients with OUD, the guidelines provide some promising tools that can make the task easier and more accurate. Finally, they provide good evidence that we should be offering OAT to patients with OUD and offer approaches to caring for such patients in a supportive, not punitive, way.

Cet article se trouve aussi en français à la **page 312.**

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