

POINT OF VIEW | PENDING LEGISLATION NEEDS WORK

With pain meds, safety, effectiveness can jibe

BY BLAKE CHRISTENSEN, M.D.

Specialists in pain management use a comprehensive approach developed with specific goals to improve the quality of life and restore normal function while decreasing the need for addictive pain medication. While prescription drugs have been used effectively and appropriately to treat medical and psychiatric illness in the majority of patients, rates of abuse have escalated at alarming rates in the past decade.

The increase of availability of prescription drugs has contributed to a dramatic rise of nonmedical use and abuse of these medications. This is partly due to the paradigm shift within the medical community to how pain is treated.

Following a comprehensive evaluation, the use of narcotic analgesics for chronic pain management should be based on the need for long-term chronic opioid therapy, a trial of non-narcotic medications, and awareness of potential risks for abuse, dependence and diversion. Physicians are then required to check the state's Prescription Monitoring Program online to ascertain whether the patient has been getting prescriptions from other physicians and when they were last filled.

Since every patient is uniquely different and has medical conditions that affect their body in different ways, there isn't one single opioid that can be safely prescribed to help all individuals. It's important for physicians who prescribe controlled substances to be certain their patients get the

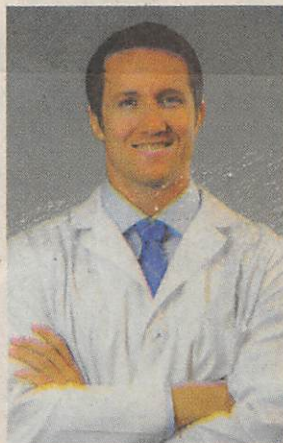
medications as prescribed.

Today's technology has offered doctors treating chronic pain opportunities to limit the risk of abuse by the patient or others. Newer medications have been designed with abuse-deterrent formulations that make pills difficult to crush, grind or melt, thus deterring those seeking nonmedical highs. Other medications provide abuse-deterrent capabilities through extended release formulations or by combining an opioid with an opioid antagonist, which is released when the pill is crushed.

Because the source of prescription drugs starts with the physician, we must be vigilant, use the skills we have been taught and use all resources available to prevent harm to our patients and others. Fully comprehending the patient and their unique prior history, family dynamic and social networks are key. We must recognize valid treatment opportunities when

opioids with abuse-deterrent properties yield maximum benefit. And we must be certain our patients will get the specific opioids prescribed to them that will provide the most benefit at the least risk.

Currently in the Legislature, Senate Bill 1499 must be amended to include language prohibiting insurance companies from making a patient have to "fail first" on a non-abuse-deterrent opioid before an abuse-deterrent opioid can be prescribed. Safety and effectiveness can go hand in hand.



Blake Christensen



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