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Review Article

Opioid Crisis

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ABSTRACT
Treating cancer patient is crucial method. Sometimes there is the need for medical persons to identify non cancer patient and cancer patient. This identification is done by the method called chronic opioids therapy (COT). In this paper assessment to the therapeutic goals are discussed.

KEYWORDS: cancer patient, COT.

INTRODUCTION

In most cases, opioids are prescribed for pain. Chronic opioid therapy (COT) has been observed to be effective in situations where patients experience non-cancer pain are monitored and selected carefully (Ault, 2017). Notably, COT has been associated with serious harms such as the abuse of potential opioids and opioid-related adverse effects (Højsted, Ekholm, Kurita, Juel and Sjøgren, 2013). This challenge has led to guidelines aimed at specifying risk stratification and patient selection. Notably, COT is used to treat chronic pains persisting beyond the normal tissue healing time of three months. However, the chronic pain disorders with which COT is applied ought to involve pain outside of the pain at the end of life,or outside of cancer pain. The eventuality is that the chronic pain disorders cause chronic non-cancer pain (CNCP). According to the National Academies of Sciences, Engineering, and Medicine (2017), some of the conditions to which COT proves applicable, relevant, and targeted include back pain, osteoarthritis, fibromyalgia, and headaches. Regarding the standards for COT initiation and maintenance, one of the areas concerns risk stratification and patient selection. According to Rudd, Aleshire, Zibbell and Gladden (2016), the initiation of COT needs to be preceded by appropriate testing and physical examination, conducting a history, and assessing risks of substance addiction, misuse, and abuse. The use of COT is also expected to be applied when CNCP is severe or moderate and when the pain poses adverse effects on the quality of life and function of the patient, as well as when the perceived therapeutic benefits outperform possible harms (Ault, 2017). Apart from risk stratification and patient assessment, an additional area contained in COT guidelines concerns opioid management plans and informed consent. Also, there is a need to obtain informed consent before starting COT (Højsted, Ekholm, Kurita, Juel and Sjøgren, 2013). Discussions with patients ought to focus on alternatives to COT, potential risks, expectations, and goals. Also, Ault (2017) asserted that clinicians ought to consider written COT management plans with the aim of specifying the responsibilities of clinicians and patients, with the plan culminating into patient education. Another area associated with the standards of initiating and maintaining COT involves COT initiation and titration. As affirmed by Rudd, Aleshire, Zibbell and Gladden (2016), patients and clinicians ought to consider the initial treatment using opioids as a therapeutic trial for purposes of determining the appropriateness of COT. The titration, initial dosing, and selection of opioids are also expected to be individualized based on the health status of the patient, the observed or predicted harms and previous exposure to opioids. Another area entails monitoring. As avowed by Højsted, Ekholm, Kurita, Juel and Sjøgren (2013), the role of clinicians lies in the periodic reassessment of patients on COT to document the level of functioning and pain intensity, assess progress towards the realization of therapeutic goals, and determine any adverse events; as well as establish the patients' therapy adherence. In situations, where it is confirmed that a given patient is likely to have aberrant drug-related behaviors, monitoring implies further that the clinicians engage in urine drug screening (periodically). This step is crucial because it aids in predicting the level of COT adherence (Ault, 2017). It is also worth noting that when there are cases of repeated dose escalations in patients undergoing COT, clinicians ought to reassess benefits versus harm, as well as potential causes of

the escalations. For patients in need of high doses of COT, there is a need to consider more frequent follow-up visits, emphasize adherence to the treatment plan, evaluate changes in health status on an ongoing basis, and examine unique opioid-associated adverse effects. In case of intolerable adverse effects (or situations where patients experience no progress towards the realization of therapeutic goals – or engage in drug diversion or abuse and repeated aberrant drug-related behaviors), it is expected that clinicians wean or taper them off of COT (Ault, 2017).

References

1. Ault, A. (2017). *Opioid Crisis in America: Experts Call for Action*. Medscape: LLC, New York
2. Højsted, J., Ekholm, O., Kurita, G. P., Juel, K., and Sjøgren, P. (2013). Addictive behaviors related to opioid use for chronic pain: a population-based study. *Pain*, 154, 2677-2683
3. National Academies of Sciences, Engineering, and Medicine (2017). *Pain and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Opioid Use.*The National Academies Press: Washington, DC
4. Rudd, R. A., Aleshire, N., Zibbell, J. E., and Gladden, R. M. (2016). Increases in drug and opioid overdose deaths–United States, 2000-2014. *MMWR Morb Mortal Wkly Rep.,*64, 1378-1382