The Pharmacist Activist

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Editorial

ADDICTION

Pharmacy Should Assume a Leadership Role in Addressing this Devastating Problem!

Last month I received an email message from Jeff Baldwin, a faculty member at the University of Nebraska College of Pharmacy and the recently-installed President of the American Association of Colleges of Pharmacy (AACP). He noted that he had looked over the topics that I have addressed in *The Pharmacist Activist* since I started publishing it in 2006 but had not found anything about pharmacist and pharmacy technician addiction issues. I responded as follows:

> "You are correct that I have not written an editorial about addiction issues. This has not been because of a failure to recognize the importance of these issues, but probably reflects a frustration of not having ideas/recommendations that will be helpful in addressing them. However, this is not a valid reason to remain silent on this matter."

Jeff Baldwin is a leader in addressing addiction issues. In his presidential address on July 19 at the AACP annual meeting in Boston he declared his passion for "…how we educate our students and practitioners about substance abuse and provide prevention services and assistance to those who are impaired." He announced that he was appointing a Special Committee on Substance Abuse that:

> "...will be charged to examine and recommend how pharmacy colleges should prepare all pharmacy students to appropriately assist those who are addicted or affected by others' addiction and help support addiction recovery with an emphasis on public safety. The Committee is directed to include recommendations on core curricular content and delivery, both for pharmacy students and continuing education for pharmacists, and of prevention and assistance processes within our colleges."

This is an important initiative that deserves the active support and involvement from pharmacists throughout our profession.

Recent Events

Several recent events and observations that are connected by their link to drug abuse come quickly to mind as I consider this issue.

Michael Jackson's death – The drug abuse horror story that resulted in the death of Michael Jackson continues to evolve. In many respects his circumstances are similar to those responsible for the early death of Elvis Presley more than 30 years ago. Very few individuals have experienced the adulation, fame, and fortune that these two individuals attained, and at an early age. However, very clearly, their remarkable "success" did not result in a contented life or escape from the trap of drug abuse and early death. If it was possible for Michael Jackson or Elvis Presley to send a message from the beyond, I have to think it would be "Don't do drugs! Just say no!"

"Drugs Won the War" – It was 40 years ago this year that President Nixon declared the war on drugs. "Drugs Won the War" is the title of the

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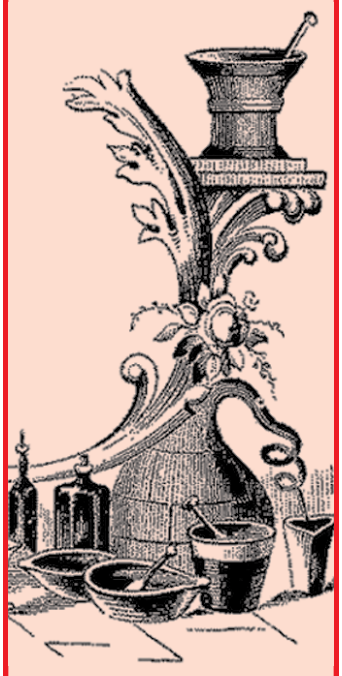

op-ed column by Nicholas Kristof in the June 14, 2009 edition of *The New York Times*. In his thought-provoking commentary he identifies the following consequences of the war on drugs:

> "We have vastly increased the proportion of our population in prisons;"
>
> "We have empowered criminals at home and terrorists abroad;"
>
> "We have squandered resources."

It is very clear that the war on drugs has not been anywhere close to being as effective as it needs to be. Some of its programs have the potential to be more effective, but our best thinking and planning must be devoted to the identification of new strategies that will be much more effective in discouraging/preventing the misuse of drugs and in helping those who are already trapped in addiction. Such initiatives should be primarily characterized by compassion, encouragement, and support.

Observations

My long-term experience has made me acutely aware of the often tragic consequences of addiction to drugs including alcoholic beverages. Deaths of students and pharmacists from accidental or intentional overdoses, DUI accidents resulting in serious injuries and deaths, revocation of licenses, and destruction of family relationships are among these consequences. Even one such situation is too many but I don't even want to try to count the number of these situations in which I personally know/knew the individuals who experienced these tragedies. With the individuals whom I knew better than others, I struggle with the question of whether there was something that I could have said or done that might have prevented the consequences.

The following discussions with my students come to mind:

- When I am discussing medications that have the potential for abuse, impairment, and addiction, I sometimes ask the students to raise their hands if they personally know someone who has died or experienced serious injuries from an accident caused by someone who was under the influence of drugs/alcohol. I am no longer surprised but it is still very disheartening to see a large percentage of the students with their hands raised. The students themselves seem surprised by the extent of the response;

- In my Ethics classes, I have my students discuss the question, "What is my personal responsibility when I become aware that a friend, or fellow student, or pharmacist co-worker, is misusing and/or stealing drugs?" We have had some excellent discussions that I hope have helped some students resist the temptation of misusing drugs or drinking excessively;

- In my Professionalism and Leadership in Pharmacy elective course I ask my students whether our group could provide the leadership that would result in our college of pharmacy becoming a drug-free campus. There is very little discussion. One student says "No" and the others quickly agree. It is not that these students misuse or condone the misuse of drugs themselves, but rather what they know about the attitudes and behaviors of some of their fellow students and what they view as the impossibility of changing those behaviors. When I ask the follow-up question, "Why not?' we have a much more active discussion, but the realistic recognition that we are not even close to being a drug-free campus continues as a major source of frustration and challenge for me.

Pharmacy's Role

What can we do as individual pharmacists and as a profession to address much more effectively the devastating problem of addiction? I admit that I have not come up with meaningful answers and solutions, and must further admit that I have been too passive in not doing more. But Jeff Baldwin has demonstrated an exemplary commitment to help others who need our assistance and we should view this as a challenge to increase our personal support and involvement in this direction. I offer the following observations and recommendations for your (and my) consideration and action.

1. We must never let our guard down. We must never let ourselves think that we are somehow immune from the temptations and issues that have resulted in others becoming addicted;

2. We must not use drugs in a recreational or casual manner, and not drink excessively. Completely avoiding alcoholic beverages incurs the least risk, is acceptable, and should be encouraged;

3. We must evaluate our attitude toward those who experience addiction. Our attitude and actions should be characterized by compassion, empathy, and support, and should not be condescending or critical;

4. We must not be silent when we recognize that a family member, friend, co-worker, or others of our acquaintance have a drug abuse problem. We should personally address the situation with the individual in a concerned and supportive manner. Often the voicing of our concern will be rejected or ignored but we will have done the right thing. If the individual rejects our concern and offer of support, we must report the situation to someone who is in a position to exert more influence or authority. This is one of the most difficult things to do because no one wants to get someone else in trouble. However, it is something we should do. The consequences of drug abuse and addiction are not limited to just the individual who is impaired. Others are often the victims of a dispensing error or accident caused by an individual who is abusing drugs. What if such an event occurred when we knew of the risk but did not intervene? To make it personal, what if the innocent victim was a member of our family?;

5. Programs should be available that will encourage individuals who are addicted to voluntarily acknowledge the problem and seek assistance in addressing it. Such programs should be supportive and not punitive, and should not jeopardize the licensure of a pharmacist or the opportunity for a student to

complete his/her pharmacy education. These programs should, however, include appropriate safeguards to prevent the premature return of individuals to responsibilities in which access to drugs of abuse can be a temptation that cannot be resisted and places the individual and others at risk. Many states have developed excellent programs to assist impaired pharmacists and pharmacy students, and, for those states that do not currently have such a program, this should be given priority attention;

6. Individuals who are engaged in illegal activities (e.g., theft of drugs for personal use or sale) should be reported to the appropriate authorities. If a pharmacist is identified as having a drug problem and rejects intervention, it is not enough to fire him or permit him to resign. He will find employment in another pharmacy and perpetuate the problem and risk to himself and others;

7. The profession of pharmacy has an essential role in assuring optimal drug therapy and preventing drug-related problems. Our profession should make a commitment to assume a leadership role in addressing drug abuse, addiction, and related problems;

8. Educational programs regarding drug abuse, addiction, and the pharmacist's role in addressing these problems should be developed and readily available. These problems are so important and pervasive that pharmacists should be required to complete two hours of continuing education programs on these topics every two years;

9. Colleges of pharmacy should include a one semester credit course on the topics of drug abuse and addiction as a required part of the professional curriculum. These topics should also be addressed in other pertinent courses (e.g., an Ethics course). To the extent possible, students should be provided opportunities to speak with/interview individuals who have addiction problems (e.g., in recovery programs, in shelters for the homeless). Although it is extremely difficult to attain, colleges of pharmacy should have a goal of having a drug-free campus;

10. Pharmacists and pharmacy students should be the experts in their communities regarding drug abuse and addiction issues. They should be provided with instruction and materials that will facilitate their giving presentations in schools, to civic groups, and to other organizations. I commend the many pharmacists who are already doing this. However, we need many more!

Daniel A. Hussar

New Drug Review

Tapentadol hydrochloride (Nucynta – PriCara)

Analgesic

New Drug Comparison Rating (NDCR) = 3

(no or minor advantages/disadvantages) in a scale of 1 to 5, with 5 being the highest rating

Indication:

For the relief of moderate to severe acute pain in patients 18 years of age and older.

Comparable drugs:

Oxycodone (e.g., OxyIR), tramadol (e.g., Ultram).

Advantages:

- Relieves pain by more than one mechanism of action (compared with oxycodone);
- Has a stronger analgesic action (compared with tramadol);
- Is less likely to cause gastrointestinal adverse events (compared with oxycodone);
- May be less likely to cause seizures and serotonin syndrome (compared with tramadol);
- Is less likely to interact with other medications (compared with tramadol).

Disadvantages:

- Labeled indication is limited to the relief of acute pain and is not indicated for use over extended periods (e.g., for chronic pain);
- Greater risk of dependence and abuse and is classified in Schedule II (compared with tramadol that is not a controlled substance);
- Is not available in a controlled-release formulation and must be administered more frequently than the controlled-release formulations of oxycodone and tramadol.

Most important risks/adverse events:

Contraindicated in patients with impaired pulmonary function or paralytic ileus, or concurrently with or within 14 days of a monoamine oxidase inhibitor; respiratory depression (risk is increased in elderly, debilitated patients); elevated intracranial pressure (e.g., increased risk in patients with head injuries); potential for dependence and abuse (classified in Schedule II); central nervous system depressant (CNS) effects (patients should be advised to exercise caution when engaged in potentially hazardous activities, and of the additive effects of other CNS depressants, including alcoholic beverages); seizures (must be used with caution in patients with a history of seizures); serotonin syndrome (in patients also being treated with serotonergic medications); must be used with caution in patients with biliary tract disease, including acute pancreatitis; should not be used during or immediately prior to labor and delivery; should not be used by a nursing mother.

(Continued on Page 4)

New Drug Review (cont.)

Most common adverse events:

Nausea (30%), vomiting (18%), dizziness (24%), somnolence (15%).

Usual dosage:

Initiate treatment with a dosage of 50 mg, 75 mg, or 100 mg depending upon pain intensity; second dose may be administered as soon as one hour after the first dose if adequate pain relief is not attained with the first dose; subsequent doses are administered every four to six hours; daily doses greater than 700 mg on the first day of therapy and 600 mg on subsequent days have not been studied and are not recommended; in patients with moderate hepatic impairment, the recommended initial dosage is 50 mg with the interval between doses no less than eight hours; in elderly patients, consideration should also be given to starting treatment with a dose of 50 mg.

Products:

Tablets – 50 mg, 75 mg, 100 mg.

Comments:

Tapentadol is a centrally-acting analgesic that, like the opioid analgesics (e.g., oxycodone), is a mu-opioid receptor agonist, but it also inhibits norepinephrine reuptake. Its pharmacological actions are most similar to those of tramadol that has an opioid agonist action and also inhibits norepinephrine and serotonin reuptake. However, the opioid agonist action of the new drug is stronger than that of tramadol, and the analgesic benefit of a dose of 100 mg of tapentadol is similar to that provided by a 15 mg dose of oxycodone. Tapentadol also has a greater potential for dependence and abuse than tramadol and is classified in Schedule II, whereas tramadol is not a controlled substance.

In contrast to tramadol, tapentadol is metabolized to only a limited extent via cytochrome P450 metabolic pathways and is not likely to interact with other medications via pharmacokinetic mechanisms.

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