



COMMENT: Morphine Milligram Equivalents: Current Applications and Knowledge Gaps, Research Opportunities, and Future Directions; Public Workshop;

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CONFLATION AND COLLATERAL DAMAGE:

THE DANGERS OF MME LIMITS FOR CHRONIC PAIN PATIENTS' ACCESS TO CARE

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INTRODUCTION

headsUpmigraine is a volunteer patient organization dedicated to improving access to care for patients. As such, we seek to provide accurate, evidence-based, interdisciplinary information about migraine and chronic pain.

Morphine milligram equivalents (MME) is currently being used in ways not supported by science. The misuse has been devastating for chronic pain patients. The main points I would like to make in this comment are the following:

1. The current use of MME conflates pain with disease, ignoring the wide array of diseases and conditions that cause chronic pain.

2. The use of MME by law enforcement to limit overdose deaths by tracking medical users and their physicians is destined to fail because the vast majority of overdose deaths are polypharmacy and associated with street drugs. MME has become a way to harass physicians.
3. Medical fragile patients and their physicians are the collateral damage of this misapplication of MME.

1. PROBLEMS IN MEASURING AND USING MME

MME was designed for titration of dose for an individual patient. The MME would take into account the wide variations in patients: level of pain, response to medication, weight, and so forth. Ethically, MME can be used to determine the optimal outcome for the individual patient. It should have no role to play in aggregating statistics. That is, however, exactly what the CDC did in its now notorious 2016 Guideline for Prescribing Opioids for Chronic Pain (Guideline).¹

Once the CDC provided that number, far too many agencies, federal and state, have grabbed on the 90 MME as a hard cap, even though the Guideline said nothing of that sort. 90 MME, and even 50 MME became the magic numbers. The CDC's judgement replaced that of the physician. There was no allowance for the vast variety in complex medical conditions, metabolism, response to medication and multitude of other factors.

The current use of MME pressures treating physicians to treat patients as identical in their response to opioids, to their great detriment. Different diseases, conditions, weights, all should be factors in determining a treatment plan. A universal 90 MME, or 50 MME, severely limits the physician's ability to formulate a care plan.

¹ Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm. Rep 2016;65(No. RR-1):1–49. DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>

adversely affected care of medically complex patients. What is truly troubling is that care of millions of patients has been disrupted over a measure that lacks scientific consensus.²

2. THE MISUSE OF MME IN AGGREGATES

The other misuse of MME is by law enforcement, and state agencies tracking physicians by MME. Certain kinds of physicians, by the nature of their specialties, will write more opioid prescriptions. Reliance of MME by law enforcement fails to account for this. The resulting raids can disrupt care for thousands of patients.

Opioid prescriptions, whether written by physicians or veterinarians³, are entered into the state Prescriptions Drug Monitoring Program databases. Law enforcement can track opioid prescriptions using MME, by both patient and prescriber. In many states, law enforcement does not need a warrant to conduct a search in the PDMP. This is often without context – in that law enforcement cannot necessarily distinguish between, say, a palliative care physician, and a family medicine physician, who will have widely divergent opioid prescribing needs. Just high MME prescribing numbers alone might be enough to trigger a visit by the DEA.⁴ With the threat of asset forfeiture always present, it was safer for physicians to either taper to 90MME or even 50 MME, or simply decline to treat pain patients entirely.⁵ Millions of seriously sick

² Dasgupta, Nabarun PhD; Wang, Yanning MS; Bae, Jungjun BS; Kinlaw, Alan C. PhD, Chidgey, Brooke A. MD, Cooper, Toska MPH; Delcher, Chris PhD, Inches, Centimeters, and Yards, *The Clinical Journal of Pain*: August 2021 - Volume 37 - Issue 8 - p 565-574
doi: 10.1097/AJP.0000000000000948

³ As a personal anecdote, my dog's comfort care opioid prescription was included in my PDMP report. There was no way to distinguish it as being written by a DVM.

⁴ Oliva, Jennifer, Dosing Discrimination: Regulating PDMP Risk Scores (January 18, 2021). 110 *California Law Review* __ (forthcoming 2022), Available at SSRN: <https://ssrn.com/abstract=3768774> or <http://dx.doi.org/10.2139/ssrn.3768774>

⁵ Lagisetty PA, Healy N, Garpestad C, Jannausch M, Tipirneni R, Bohnert ASB. Access to Primary Care Clinics for Patients With Chronic Pain Receiving Opioids. *JAMA Netw Open*. 2019;2(7):e196928.
doi:10.1001/jamanetworkopen.2019.6928

Americans, with chronic and progressive diseases have been medically abandoned.⁶

3. THE MANY TYPES OF CONFLATION

The very term “opioid” is a conflation: the vast majority of overdose deaths, some 85% in 2019, are the result of alcohol and polypharmacy, mostly street drugs like illicit fentanyl analogs.⁷ Prescription opioids trail in fourth. There is also considerable evidence that medical users are an almost separate population from non-medical users.⁸ Pain patients are not the population where the bulk of the overdoses are occurring. Overdose deaths have increased, even as opioid prescription numbers have fallen steadily since 2012.⁹ The actual numbers of patients who have a prescription who overdose are very low, from about 0.25% in North Carolina, to just over 1% in Massachusetts.¹⁰

Conclusion

There is no evidence that using MME to persecute treating physicians and pain patients will significantly reduce overdose deaths. Wider naloxone availability would be far more effective. Pain patients and their physicians are collateral

⁶ Brian Goldstone, The Pain Refugees, Harper’s Magazine, April 2018, <https://harpers.org/archive/2018/04/the-pain-refugees/>

⁷ Pat Anson, Nearly 85% of Overdose Deaths Linked to Street Drugs, Pain News Network, September 4, 2020, <https://www.painnewsnetwork.org/stories/2020/9/4/nearly-85-of-us-overdose-deaths-blamed-on-street-drugs>

⁸ Singer, J. A., Sullum, J. Z., & Schatman, M. E. (2019). Today's nonmedical opioid users are not yesterday's patients; implications of data indicating stable rates of nonmedical use and pain reliever use disorder. *Journal of Pain Research*, 12, 617–620. <https://doi.org/10.2147/JPR.S199750> (finding that medical and non-medical users of opioids are largely distinct populations);

⁹ Ghei, Nita, Pain Patients: Collateral Victims of the War on Drugs (February 11, 2021). Available at SSRN: <https://ssrn.com/abstract=3783560> or <http://dx.doi.org/10.2139/ssrn.3783560>;

¹⁰ Minozzi S, Amato L, Davoli M. Development of dependence following treatment with opioid analgesics for pain relief: a systematic review. *Addiction*. 2013 Apr;108(4):688-98. doi: 10.1111/j.1360-0443.2012.04005.x. Epub 2012 Oct 18. PMID: 22775332; Alexander Y. Walley, MD, MSc; Dana Bernson, MP ; Marc R. Laroche, MD, MPH ; Traci C. Green, PhD, MSc3; Leonard Young, MS, MA ; and Thomas Land, PhD, The Contribution of Prescribed and Illicit Opioids to Fatal Overdoses in Massachusetts, 2013-2015, PUBLIC HEALTH REPORTS 2019, Vol. 134(6) 667-674 (just over one percent of fatal overdose victims had an opioid prescription).

damage in the opioid crisis. Returning MME to its scientific, evidence backed role would be a step in the right direction.