Trends in Medical Use and Abuse of Opioid Analgesics

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Unrelieved pain, whether due to trauma, surgery, cancer or noncancer conditions, and including pain occurring at the end of life, continues to be a major public health concern. Although numerous nonpharmacologic treatments can be used to relieve pain, the use of opioids in the class of morphine is the cornerstone of pain management.

However, because opioids have the potential to be abused, they are regulated under international and national narcotics and controlled substances laws. International and US federal drug laws embody a dual imperative to ensure the availability of controlled substances for medical and scientific purposes, while at the same time to prevent their diversion and abuse.

Concerns related to drug abuse permeate efforts to treat pain with opioids. Patients are concerned about becoming addicted to opioids. Health care professionals may be reluctant to prescribe, administer, dispense, or stock controlled substances for fear of causing addiction or contributing to the drug abuse problem. There are few studies of the extent to which prescription opioid analgesics contribute to the national drug abuse problem. In this descriptive study, we examine the abuse of opioid analgesics in relation to their medical use.

See also Patient Page.
clude amounts used for other major indications (such as codeine for cough and diarrhea, and drugs used for treatment of opioid addiction such as methadone).

**Data on Drug Abuse Trends**

We used the Drug Abuse Warning Network (DAWN) as the source for data on opioid abuse. DAWN, sponsored by the Substance Abuse and Mental Health Services Administration in the US Department of Health and Human Services, provides estimates of the health consequences of the nonmedical use of individual drugs. It is a large-scale, ongoing retrospective survey of medical records that is used to monitor national drug abuse trends. The system collects information from DAWN-affiliated hospital emergency departments (EDs) to identify substances that are abused; monitor drug abuse patterns and trends and detect new drug entities and combinations; assess health hazards associated with drug abuse; and provide data for national, state, and local drug abuse policy and program planning.

Data are collected on patients 6 years and older from the EDs of approximately 500 US hospitals in 21 metropolitan and other nonmetropolitan areas. Hospitals eligible to participate in DAWN are nonfederal, short-stay general hospitals with 24-hour EDs that are located in the coextensive United States. DAWN has been in existence since 1972, and began collecting data from a nationally representative sample of EDs in 1990.20,21 For our analysis, we used data from the 7-year period from 1990 to 1996 (the most recent year for which data were available at the time this study was begun).

Each hospital has a designated reporter, usually a member of the ED or medical records department, who is responsible for obtaining information from medical records each time a patient visits the ED with a presenting problem related to drug use; each visit is defined as an episode. Reported episodes typically involve drug overdoses, but also may be the result of long-term drug use and adverse reactions. The reporter collects information for each episode, including gender, ethnicity, age, concomitant use of other drugs, motive for use, reason for ED contact, source of substance, dosage form, and route of administration. The national estimates of abuse are derived from these data. Standardized procedures are used to collect DAWN data; however, there may be some variability from facility to facility.20

Drug abuse in the DAWN system is defined as the nonmedical use of a substance for psychic effect, dependence, or suicide attempt or gesture. Drug abuse can involve the use of illicit drugs or any other substance (eg, heroin, marijuana, peyote, glue, aerosols); prescription drugs in a manner inconsistent with accepted medical practice; and over-the-counter drugs contrary to approved labeling.20

For each episode of drug abuse, as many as 4 different substances, in addition to alcohol, can be recorded. Each is referred to as a drug mention. More than half of DAWN episodes involve multiple drug mentions.20 If DAWN reporters are not able to classify a drug, these mentions are classified as other/unspecified. DAWN reports do not include information about drugs for which the frequency of annual mentions is less than 200. However, for our study, the Substance Abuse and Mental Health Services Administration performed a special data run to extract annual abuse mentions for one of the study drugs, fentanyl, for which the number of mentions is consistently less than 200 per year.

We renamed several drug categories and reclassified a number of drugs to reflect current medical terminology and pharmacology. The categories designated as narcotic analgesics and nonnarcotic analgesics were renamed as opioid analgesics and nonopioid analgesics. Some drugs were reclassified: codeine combinations were recategorized from other drugs to opioid analgesics. Hydrocodone was reclassified from other/unspecified narcotic analgesics to opioid analgesics. Ibufrofen and naproxen were transferred from other drugs to nonopioid analgesics. Methamphetamine and methaqualone, originally classified as amphetamines and nonbarbiturate sedatives, respectively, were moved to the category of illicit drugs. Other/unspecified drugs listed within each subcategory of DAWN reports were aggregated into 1 “other drugs” category.

DAWN reports routinely combine heroin and morphine mentions into a single category, making it impossible to distinguish between the abuse of an illicit drug and an essential pain medication. We requested that the Substance Abuse and Mental Health Services Administration separate morphine from the heroin-morphine category for the period from 1990 to 1996. Morphine mentions accounted for an annual average of 1.9%, and never exceeded 2.5%, of the combined heroin-morphine category.

**Data on Medical Use of Opioids**

We obtained data on medical use of opioids from the US Drug Enforcement Administration’s Automation of Reports and Consolidated Orders System (ARCOS) for the years 1990 to 1996. ARCOS is a federal, computerized data system, required by the 1970 Controlled Substances Act.10 ARCOS monitors the lawful distribution of controlled substances in Schedules I and II and narcotic substances in Schedule III from manufacturers to the retail level of consumption, including hospitals, pharmacies, and licensed practitioners. The Drug Enforcement Administration makes reports on ARCOS data, providing information on individual states and national totals.22 Information is provided for each drug in total grams and grams per 100 000 population.23,24 ARCOS is the only nonproprietary source of information on medical use of opioids.

**RESULTS**

The percentage of 1996 total DAWN ED mentions represented by each of the 5 drug categories is shown in Table 1. Mentions for opioid analgesics account for less than 4% of total DAWN...
mentions, mentions for nonopioid analgesics account for 8.6%, and mentions for illicit drugs account for 33.2%. Table 2 presents the abuse levels for the same drug categories as number of mentions and as a percentage of total DAWN mentions for the period 1990 to 1996. From 1990 to 1996, the number of mentions for drug abuse in DAWN increased from 635,460 to 907,561 (42.8% increase), with an increase in total mentions for all drug categories. For opioid analgesics, the total number of mentions increased from 32,430 in 1990 to 34,563 in 1996 (6.6% increase), but declined as a percentage of total mentions from 5.1% in 1990 to 3.8% in 1996. Illicit drugs is the only category of drug abuse that exhibited a continual increase in both number of mentions and percentage of total mentions over the study period.

Trends in the medical use of the 5 selected opioid analgesics from 1990 to 1996 are shown in Table 3. Substantial increases were observed in use of fentanyl and morphine, which occurred in both total use and use adjusted for population. Table 4 presents trends for the abuse of the 5 selected opioid analgesics for the same 7-year trend. The number of abuse mentions, as measured by DAWN, for fentanyl, hydromorphone, meperidine, and oxycodone declined during the study period, whereas abuse mentions for morphine increased by 3.2%. The abuse levels for each of the 5 opioid analgesics, as a percentage of total DAWN mentions, were less than 1% and declined during the study period despite substantial increases in medical use.

**COMMENT**

Official Drug Enforcement Administration data indicate that the amounts of fentanyl, oxycodone, hydromorphone, and morphine distributed to the retail level have increased substantially. According to the World Health Organization, increasing medical use of opioids is one indication that progress is being made to improve pain management. Despite these increases, pain is still inadequately treated due to numerous barriers to pain management. In the future, as these barriers are addressed, the medical use of opioid analgesics may be expected to increase further.

In this study, meperidine was the only opioid that decreased in medical use over the study period. This decrease may reflect increasing awareness of the shortcomings of the use of meperidine for chronic pain, which includes short duration of action and accumulation of a long-lived toxic metabolite.

These data suggest that opioid analgesics, including the 5 study drugs, are a relatively small part of drug abuse as measured by the DAWN system. Although there are year-to-year variations, the abuse levels have remained low and relatively stable for the past 7 years despite substantial increases in the medical use of opioids. Although abuse of most opioids decreased during the study period, several caveats are needed to place these results in context.

First, these data also indicate that there is some abuse of opioid analgesics. However, compared with the abuse of other drugs, illicit drugs in particular, the abuse of opioid analgesics appears to be relatively low, accounting for 3.8% of total DAWN mentions in 1996. Moreover, even though there were increases in the total number of mentions of abuse for opioid analgesics during the study period, the proportion of mentions for opioid abuse relative to total reports of drug abuse decreased by 25% (from 3.1% to 3.8%).
Second, the DAWN system may underestimate the extent of the drug abuse problem. The DAWN system measures only those episodes of drug abuse that result in an admission to an ED, and thus underreports the true extent of all drug abuse, such as drug-related overdoses and deaths occurring out of the hospital. We believe that this limitation, which is common to all drug abuse monitoring systems, should not affect the proportional representation of drug categories because it should affect all drug categories equally. Furthermore, our study primarily addresses changes in abuse trends rather than abuse levels at a single point in time. As such, it is important to evaluate these data longitudinally to examine the stability of the incidence frequency, and to detect relative changes in abuse levels. However, the apparent stability of abuse levels over the study period suggests that actual abuse of opioid analgesics, regardless of total prevalence, is also relatively stable.

Third, although the DAWN system collects some information about the severity of adverse events resulting from drug ingestion, such as mortality rates and hospital admissions, we were unable to use the data to detect any trends in the severity of adverse events related to the abuse of opioid analgesics. The mortality data in the DAWN ED system are sparse because most deaths do not occur in the ED. Instead, these deaths appear in the DAWN medical examiner data. However, the DAWN medical examiner reports were not used because drug-related mortality data do not differentiate among deaths related to morphine, heroin, and codeine. Moreover, data on hospital admissions related to abuse of opioid analgesics are not available for most of the drugs examined in this study.

Fourth, we used data on abuse of opioids from the DAWN system. Two other sources of drug abuse information were considered but not used. The National Household Survey on Drug Abuse,28 a widely known survey measuring drug abuse prevalence, was not used because data are not available for specific opioid analgesics. Also, the Toxic Exposure Surveillance System,29 which tracks exposures to toxic substances from a large sample of regional poison control centers, was not used because it is not nationally representative and because the cost of acquiring the data was prohibitive.

**CONCLUSION**

Conventional wisdom suggests that the abuse potential of opioid analgesics is such that increases in medical use of these drugs will lead inevitably to increases in their abuse. The data from this study with respect to the opioids in the class of morphine provide no support for this hypothesis. The present trend of increasing medical use of opioid analgesics to treat pain does not appear to be contributing to increases in the health consequences of opioid analgesic abuse. To maintain this trend, manufacturers, pharmacies, clinicians, and patients should continue their efforts to improve pain management while exercising care so that the diversion of opioid medications for nonmedical use is minimized. If the abuse of opioid analgesics should increase, the sources of diversion should be addressed directly without interfering with medical availability of opioid analgesics, legitimate medical practices, or patient care.

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Cast aside your allegories
And empty hypotheses!
Give us straight answers
To the accursed questions.
—Heinrich Heine (1797-1856)