‘You Need to Have Pain,’ St. Joseph’s Doctor Says

By Kevin Madigan
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In a concerted effort to curtail addiction to opioids, an Atlanta pain specialist is taking a tough approach with patients who demand painkillers.

“They’ve swung now towards telling patients, ‘You need to have pain. Pain is a signal from your body that something is not right, and I can make you comfortable, but if I do, you’ll be comatose or dead,’” physician James L. Carlson said in an interview.

Carlson, who works in pain management and anesthesiology at Emory St. Joseph's Hospital, added: “I say it in a pleasant way, but that summarizes where I am and where I think medicine has gone wrong.”

Narcotic painkillers have a strong potential for abuse and addiction. The National Institute of Drug Abuse estimates that 81 percent of the global supply is consumed in the United States, with a large number of legal prescriptions being diverted to street users.

“It has gone from just doing procedures and injections to, in the early-to-mid-90s, drug companies promoting, with very little supporting evidence by the medical community, the unlimited use of oxycodone and OxyContin, with no ceiling required in terms of dosing,” Carlson said. It’s “the concept that no one should be expected to have pain. If you’ve paid any attention to society, the results of that have been horrific.”

The overprescription of opioid painkillers is directly related to the national epidemic of heroin addiction.

“Huge doses of narcotics are being given to patients,” the doctor said. “They get hooked on these meds and become dependent on them, and they need them to maintain the euphoria they get.”

Current studies show that little benefit is gained by prescribing opioids for pain, Carlson said. “It’s almost impossible to verify that anyone with moderate to large doses of opioids functions any better. In fact, they become depressed, have all sorts of negative side effects, their hormones get out of balance, they get constipated, and their insurance would expect me to fix their pain and make something happen, that I might have a magic wand or a potion for pain management.

“In fact, the only thing you can do is get active: Use the pool, live your life, stay away from doctors. You can get some temporary relief from a pain pill, but in a few weeks you become adapted to it. That becomes your new baseline.”

In trying to treat pain, James L. Carlson says, doctors have nearly destroyed lives. In trying to treat pain, James L. Carlson says, doctors have nearly destroyed lives.

Rampant drug use by adults has affected children, Carlson said.

“There’s always kids who’ll take them from their parents, and they’ll try them and give them to their friends. Middle school kids are getting high and dependent on the same drugs. In my family I’ve got three nieces and nephews who’ve become addicted to opioids.”

“Medicine is just coming to grips with treating pain that doesn’t involve opioids. Physicians are really struggling with how to deal with this issue right now. We know what we’ve been doing is wrong and hurtful more than helpful. We have to encourage patients to do what they need to do, lose weight, you know, exercise, do all the things we know are good for you vs. just taking a pill. That just masks the symptoms.”

In trying to treat pain, James L. Carlson says, doctors have nearly destroyed lives.

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Drug Treatment Success Begins With Genes

By Cady Schulman
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When it comes to treating drug addiction, genetics can play a major role. The genetic factor hasn’t been used in treatment plans, but that’s changing with pharmacogenetic testing that recently was approved by Medicaid and rolled out as a nationwide program.

The test is simple: just a swab from both of the patient’s cheeks. In three to five days, a drug treatment center receives a report listing what medications the patient can and cannot metabolize.

In other words, the genetic report reveals which medications would have no effect on that particular patient, no matter how large the dose.

In addition, the test can determine the likelihood of that person to turn to alcohol, nicotine or sugar as secondary addictions, as well as possible side effects, such as weight gain.

The test is easy to interpret. A green circle means the patient can metabolize the medication. A caution triangle means to proceed with caution because the patient may have an increased risk of side effects or has a poor response to the medication. A red circle means the patient cannot metabolize the medication.

Currently, doctors focus on either the physical or the physiological side of drug addiction.

But “it’s both,” said Mark Benveniste, the director of operations of Atlanta-based Readmissions Reduction Group, which created the pharmacogenetic testing.

The RRG approach “is way advanced. It’s amazing. We swab them upon admission, and within a couple days they can use this as a playbook to prescribe the exact medication.”

He said half the people who take medications do not metabolize them. “We tell them not predictively, but exactly which chemicals their body will respond to.”

That information will help doctors treat patients more accurately from the beginning and should reduce the incidence of relapse, which can occur when patients don’t absorb and respond to medicine. Benveniste said a study by the University of Massachusetts Medical School of 52,000 people being treated for drug addiction found that the use of proper medication for each person cut the relapse rate in half.

“Addiction is not an acute illness that is treated in a short time,” Benveniste said. “It’s a real disease.”

Although Benveniste’s organization has worked on creating the addiction panel test since December, it took until the summer to get approval for coverage by Medicaid. The test also is approved by many private insurance companies.

The protocol has been tested at Valley Vista, an inpatient alcohol and chemical dependency treatment center in Bradford, Vt., where Benveniste said the results were phenomenal. Officials at Valley Vista did not return a phone call seeking comment.

RRG “did a number of tests with them to make sure their medical director was happy with it, our medical director was happy, and state Medicaid realized it’s in their financial best interest,” Benveniste said.

The protocol also was one of 40 national semifinalists for ABL’s Innovations in Healthcare ABBY Awards but didn’t make the list of nine finalists announced Aug. 23.

Not only can the test be used to help treat drug addiction, but people also can be tested at their doctors’ offices to see which medications they take truly work for them. If necessary, the results include options for other medicines.

Doctors must be participants with Readmissions Reduction Group to perform the test. On the last page of the clinical report is a card that can be laminated and kept in the patient’s wallet to show future doctors and pharmacists.

You need the test only once in your lifetime because genes never change, Benveniste said.

Now that the testing is available nationwide, Readmissions Reduction Group anticipates being contacted by facilities across the country.

“I think the biggest influx we’re going to have is clinically from medical directors,” Benveniste said. “Their level of frustration in trying to figure out what to give somebody who comes in off the street is reaching an all-time high. At the root of it all is your genes. It’s a game-changer.”

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Electronic Records Help Grady Handle Pills

By Michael Jacobs
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When Hany Atallah, the chief of emergency medicine at Grady Memorial Hospital, started in the Grady emergency room 13 years ago, he typically saw one or two drug overdoses a month. Now he sees them all the time.

Prescription pill abuse has become an epidemic, and if people get hooked on the pills but can’t get them anymore, sometimes they turn to street drugs such as heroin, he said.

Grady is among the health systems re-evaluating their opioid prescription habits. Atallah said his department is working on a report about how many opioid prescriptions are coming out of the emergency room and how often regular ER visitors are leaving with prescriptions.

The use of electronic medical records helps respond to the problem of overprescription, he said. Doctors can include notes to draw other health care providers’ attention to opioid concerns and even recommend against additional prescriptions.

One important distinction is between chronic and acute pain. Opioids aren’t as effective as exercise and anti-inflammatories against chronic pain, Atallah said, and some doctors try to treat even acute pain with nonopioids.

“If you come in with a broken leg, opioids are appropriate. They’re not appropriate for two months,” Atallah said.

Some patients with a history of opioid addiction refuse any painkillers for fear of getting hooked again, which Atallah said he understands. But he also sees patients who have heard about the addiction epidemic and, despite no history, are wary of taking any opioids.

“We have to be careful about overdosing it,” Atallah said. While there probably are too many opioid prescriptions being written by primary care physicians and emergency rooms across the country, there’s also a danger of causing an epidemic of pain by overreacting. “We have to be careful the pendulum doesn’t swing too far.”

Electronic Records Help Grady Handle Pills