PAINMEDICINENEWS

print this article

Primary Care

ISSUE: NOVEMBER 2013 | VOLUME: 11

Will Opioid Scrutiny Spur NSAID Overuse?

In the wake of FDA changes to labels for extended-release/long-acting opioid pain relievers, clinicians and patients may be looking elsewhere for ways to manage moderate pain. Non-steroidal anti-inflammatory drugs (NSAIDs) offer a potential alternative, but some clinicians are urging that a possible increase in NSAID consumption should be met with caution.

"We hope the impact will not be great," said Daniel Brzusek, DO, vice chair of the Alliance for Rational Use of NSAIDs. "But we think that not only physicians, but the lay public will rely on NSAIDs."

According to Michael Carome, MD, director of Public Citizen's Health Research Group, it's "hard to say" if the new FDA labeling will influence NSAID use. He cited the variety of pain relief options that could be used in lieu of opioids or NSAIDs. "Non-NSAIDs, like Tylenol, may be reasonable for some patients," said Dr. Carome. "And frequently, these are underutilized."

Both Dr. Carome and Dr. Brzusek mentioned there are ways to relieve pain that do not rely on pharmaceuticals, such as exercise and behavioral therapy. Dr. Brzusek also cited acupuncture as "a safer, zero-risk alternative" to NSAIDs.

In the United States, an estimated 23 million people use NSAIDs for daily pain relief. Although considered safe when used properly, these drugs may result in adverse effects, such as cardiovascular events and gastrointestinal (GI) bleeding. A recent meta-analysis of the adverse effects of NSAIDs found that, compared with placebo, for every 1,000 patients per year receiving a coxib or diclofenac, there would be three additional vascular events, of which one would be fatal. The meta-analysis also reported an increase in upper GI complications compared with placebo—most frequently, bleeding—at rate ratios of 1.81 for coxibs (P=0.0070), 1.89 for diclofenac (P=0.0106), 3.97 for ibuprofen (P<0.0001) and 4.22 for naproxen (P<0.0001) (*Lancet* 2013;382:769-779).

Patients who use NSAIDs should take the "least dose possible for the shortest period of time," Dr. Brzusek said. "That's a maximum of 10 days." Dr. Brzusek begins with a minimal dose—for example, 200 mg ibuprofen three times daily, 75 mg diclofenac daily or 250 mg naproxen twice daily—and titrates up the dosage every three days until there is no additional positive

response.

How big a problem NSAIDs pose is a matter of debate. In September, Lynn Webster, MD, president of the American Academy of Pain Medicine, told *Pain Medicine News* that "deaths from GI bleeding linked to NSAIDs rival deaths from opioids, according to some estimates." This statement provoked a strong response from Andrew Kolodny, MD, president of Physicians for Responsible Opioid Prescribing, who wrote on Twitter that Webster's remark was "false" and should be corrected.

Estimates of deaths from GI bleeding range from a high of 16,500 (*J Rheumatol Suppl* 1999;56:18-24) to a more conservative 2008 report from the Centers for Disease Control and Prevention, which cited 3,400 deaths. In contrast, the agency recorded 14,800 deaths from opioids in 2008.

When asked about the number of deaths from NSAIDs compared with the number of opioid-related deaths, Dr. Brzusek said he doesn't believe deaths from NSAIDs are quite so high. "There are definitely a lot of deaths from bleeding," he said, "but hospitalizations are more common." According to the Alliance for the Rational Use of NSAIDs, NSAIDs contribute to at least 100,000 hospitalizations per year.

Dr. Carome emphasized that he is not opposed to the reasonable administration of NSAIDs. "All drugs have problems," he said. "Patients need to be made aware of that."

—Ben Guarino