EDITORIAL

Podiatry and the Opioid Epidemic

A Call to Action

More than 10 million Americans misused prescription opioids in 2019.[1] Prescription drug misuse is second only to marijuana use as the nation's most commonly used illicit drug.[2] From 1999 to 2019, almost half a million people have died from overdoses involving opioids[3]; of note, the mortality rate in 2019 was more than six times higher than in 1999.[3] Further, we know that almost half of opioid overdose deaths involve prescription opioids.[4] Almost all of us have either lost a loved one or knows someone who has due to opioid overdose. It has made a personal impact on my life; I lost my sister Britney after an opioid overdose.

Many of us likely understood that the United States opioid epidemic was a real problem before it was declared a national emergency in 2017.[5] Yet, year in and year out, the problem persists.[6] So, what can you do about it? Perhaps the better question is "*Can WE do something about it?*" Collectively, we can. Podiatry can have a positive impact on the opioid epidemic that has claimed the lives of almost 50,000 Americans in 2019.[3,6] Several studies have demonstrated that the excess opioid prescribing, which has fueled the United States opioid epidemic at its origin, continues to be a serious problem,[7-9] including within our own profession.[10-13]

My experiences with excess opioid prescribing and opioid misinformation began while on a clerkship in 2014. I was working with the chief resident at an "elite" podiatry residency program. This resident prescribed 42 tablets of percocet 10mg/325mg for a patient who had just undergone a chemical matrixectomy. I was shocked because I had never seen such prescribing practice before. So naturally, I asked why they opted to prescribe both percocet and 42 pills. Their response to me was "because I'm on call." The chief resident wasn't interested in having a dialogue about prescribing practice. While several states have prescribing limitations, such as only allowing a "7-day supply" for acute pain, would the resident's prescription violate such a law? Although I don't recall the dosage schedule that the resident wrote for, assuming it was every 4–6 hours, 42 tablets technically would not exceed a 7-day supply. Therefore, a 7-day limit or restriction by the state wouldn't stop this behavior. Further, do patients always take their medication as directed? No. So, 42 tablets very well could be a de facto 10–14 day supply. Excess opioid prescribing, which has contributed to the opioid epidemic, is something that we can crack down on as a profession.

Excess prescribing is not the only culprit. Misinformation regarding opioids and viable alternatives remains rampant. Some of the older and middle-aged podiatric physicians were sold a false bill of goods regarding the addiction potential of opioids. Many prescribers still consider tramadol to be a non-opioid analgesic. Last year, I had a conversation with my then-chief of surgery in the surgeon's lounge at a rural hospital in South Carolina near where I used to practice; this doctor is a nice guy and I consider him to be intelligent. During our conversation, he mentioned that he was getting pressured to prescribe less opioids, and he noted that our hospital doesn't have any good and safe non-opioids except for tramadol. I had to explain to him that tramadol is an atypical, synthetic opioid with some non-opioid analgesic mechanisms, but like other opioids, it still has a risk of addiction and overdose. The chief of surgery earned my respect because he was able to listen, participate in a discussion, and remained open to changing his prescribing practice. None of us are perfect. Sometimes we just need an open dialogue in order to improve.

We also need to approach the United States opioid epidemic on a united front with our allopathic and osteopathic physician colleagues. This means sharing both our successes and failures; participating in opioid stewardship programs; collaborating in research; volunteering on hospital committees; and staying active in local, state, and national organizations. If you are looking to work with MDs and DOs among a group of DPMs, then joining the American Public Health Association's

Foot and Ankle Health Section is a great place to start. Rather than criticize and shift blame among various specialties, we can be introspective and carefully examine our own opioid prescribing practices within our specialty. Given the historical shift in our profession's education and training towards surgery over the past 30 years, with the 2-year nonsurgical residencies being phased out in 2011 and replaced by the current 3–4-year surgical residency model, understanding our postoperative prescribing habits is paramount to determine what we can improve upon.

Admittedly, there are few national guidelines for the management of acute pain. So, how can we work to overcome this within our profession? One potential solution involves collaboration between grassroots podiatrists, leadership within our professional organizations, and our experts (i.e., the APMA's Clinical Practice Advisory Committee) in establishing our own national recommendations on typical ranges for postoperative opioids. Detractors to this notion may argue that it interferes with the *Physician-Patient Relationship*; however, the aforementioned changes could serve as true recommendations rather than hard guidelines. Although many states have rolled out prescription drug monitoring programs and stricter prescribing laws, there needs to be further national-level solutions given that the United States opioid epidemic is a national problem. Hopefully, we can all recognize that opioid prescribing needs to be both patient-centric and procedure-focused. National guidelines could be a steppingstone to better protect your patient and you.

As podiatrists, we are among the many stakeholders of the United States opioid epidemic. Governmental agencies and bureaucrats alone won't solve this problem; they have tried and failed already. We can step up as a profession and heed the call to action. The misuse and abuse of opioids can improve if we, as prescribers, strengthen our collaborative efforts with other stakeholders. There is no instant fix. At this stage, we know that the opioid epidemic will continue for years into the future and will likely result in more restrictive laws and regulations, but we can have an influence on these future changes. We should have a seat at the table, and we can earn one by leading efforts to adequately treat patients' acute pain while reducing the risk of opioid addiction and overdose. At minimum, please inform your prescribing practice by reading the published articles in the three *Opioid Editions* of JAPMA to learn more about how your peers treat postoperative pain as well as some helpful tips and tricks.[11-15] Your patients may never thank you for putting in the extra work, but I will. Thank you.

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