Ophthalmologists Say They Show 'Discretion in Opioid Prescribing.' Who Said They Didn't?

By Chuck Dinerstein — October 10, 2017

The opioid epidemic impacts so much of our lives and now this tsunami has washed upon the shores of academic reporting and studies. While I have championed several articles that discuss the real life (observational) data on the prescribing habits of surgeons, physicians that deal with a great deal of pain, I have noticed a new effort by some physician specialties to report their prescribing practices in a 'we are not to blame' manner. Really? The latest of these can be found in JAMA Ophthalmology entitled Association Between Opioid Prescribing Patterns and Abuse in Ophthalmology [1].

The authors reviewed the Medicare Part D database of prescriptions for Medicare beneficiaries and found and concluded that ophthalmologists

- Consistently, most ophthalmologists (88%-89%) wrote ten opioid prescriptions or fewer annually.

- On average, ophthalmologists wrote seven opioid prescriptions per year … with a mean supply of 5 days. The six states with the highest volume of opioid prescriptions written annually per ophthalmologist were located in the southern United States.

- In general, ophthalmologists show discretion in their opioid prescribing patterns.

If the rest of us could only emulate our more, shall we say, medically responsible colleagues? But wait, here is something else the authors point out.

Pain after cataract surgery is typically minimal, … Nonopioid pain relievers, such as
acetaminophen and nonsteroidal anti-inflammatory drugs, frequently control postoperative discomfort. Although specific ophthalmic procedures may require stronger medications in the immediate postoperative period, this is certainly not the norm. … opioid prescribing makes up a minimal amount of overall prescriptions in ophthalmology…

Our more virtuous colleagues prescribe so few opioids because the diseases that they care for involve little pain that is easily managed with non-opioid drugs. In discussing their prescribing habits aren’t we comparing physicians who treat ‘painless’ conditions with those that treat significant musculoskeletal and visceral (that is pain coming from within the abdomen) pain?

While opioids are far down the list of medications prescribed by ophthalmologists, medication treating age-related macular degeneration (AMD) is commonly prescribed – as an analogy let us say that these medicines are their ‘opioids.’ AMD results in a partial or complete loss of vision in the central part of the eye, one form of AMD can be managed by specific medications. The issue of which treatment is most efficacious in treating AMD remains controversial; and the debate is confounded by a significant difference in cost between therapies (and some argue payments to physicians, another confounder). A trial comparing the two drugs was released with a five-year follow-up that can be found here [2]. The study has its flaws, especially in the follow up since the study was meant to last only two years. But let me pull this quote from the report,

> Although few patients remained on their initially assigned drug and dosing regimen beyond the 2-year period of the clinical trial, our study does allow assessment as to whether or not the drugs and dosing regimens used during the first 2 years led to any detectable outcome differences at 5 years. At the end of 2 years of treatment in the clinical trial, …there was no statistically significant difference in mean visual acuity between eyes originally assigned to ranibizumab and eyes originally assigned to bevacizumab. … There were no obvious differences in visual acuity outcomes at 5 years between patients who were treated monthly for 2 years versus those treated PRN for 2 years.

Translating - both drugs do equally well at two years, and it seems that they worked equally well at five years. Giving the medication monthly (on a schedule) was no better than prn – when necessary. [1] Physicians who prescribe opioids are re-evaluating their prescribing habits. Ophthalmologists might better serve their peers and our profession by addressing their prescribing practices for AMD in light of new evidence rather than point out their lack of opioid use. Why is it that the phrase, “Let he who is without sin, cast the first stone” keeps coming to mind?

[1] Statements about 5-year follow up are made more difficult because of patients lost to follow up and because patients frequently were switched to other drug regimens (unspecified) after the 2-year study. PRN injections are given as necessary and generally less frequent than scheduled
doses.