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Trends in Pediatric Opioid Prescribing and Use

Robert W. Steele

Children's Mercy Hospital

Michelle DePhillips

Children's Mercy Hospital

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Trends in Pediatric Opioid Prescribing and Use

In this episode, Dr. Michelle DePhillips leads a discussion focusing on the rising trend in opioid prescribing, and its effects on global health.



Featured Speaker:

Michelle DePhillips, emergency medicine physician

Michelle DePhillips is an emergency medicine physician.

Transcription:

Trends in Pediatric Opioid Prescribing and Use

Rob Steele, MD (Host): Welcome to Pediatrics in Practice, a CME podcast. I'm your host, Dr. Rob Steele, Executive Vice President and Chief Strategy and Innovation Officer at Children's Mercy Kansas City. Before we introduce our guest, I want to remind you that you can claim your CME credits after listening to today's episode, and you can do so by visiting [CMKC.link/CMEpodcast](#), and then click the claim CME button. Today, we are joined by Dr. Michelle DePhillips to discuss trends in pediatric opioid prescribing and use. Dr. DePhillips is an Emergency Medicine Physician, Pediatric Emergency Medicine Rotation Director, and the Medical Director of the Opioid Stewardship Program at Children's Mercy Kansas City.

She is also an Assistant Professor of Pediatrics at the University of Missouri Kansas City School of Medicine and a Clinical Assistant Professor of Pediatrics at the University of Kansas School of Medicine. Dr. DePhillips attended medical school at Creighton University School of Medicine before [00:01:00] completing a residency and fellowship at Children's Mercy.

And in addition to emergency medicine and teaching residents, her interests also include appropriate opioid prescribing and global health. Dr. DePhillips, thank you for joining us today.

Michelle DePhillips, MD (Guest): Absolutely. Thank you for having me.

Host: So, before we get started, I understand that you may be taking a trip down to Gulf shores in September.

Michelle DePhillips, MD (Guest): Yes. We've always been beach people and our spot used to be Sanibel, Sanibel Island off of Florida. And then as we all know, a few years ago, they had that big hurricane and devastated a lot of it. And so we thought what's our new spot going to be? And so this is going to be the, I guess the third time we've been down there. So

Host: I gotta ask you, having been to Gulf Shores a number of times, are you a go to Foley and do some shopping or find a seafood place on Orange Beach?

Michelle DePhillips, MD (Guest): We're more of the seafood type people. I mean, really it's swimming. I mean, we are at the beach and then when we're not at the beach, we're at the pool and we are really just, checked out, relaxing, not doing a lot of anything. But definitely more seafood eating type of people.

Host: Awesome. Well, I'm sure you'll have [00:02:00] a fun time. Well, why don't we just jump right on into it and maybe you could give our listeners sense of just the history of prescribing behaviors of opioids, specifically as it pertains to pediatrics.

Michelle DePhillips, MD (Guest): Sure, you know, that's a good question. So, really a lot of this dates back to the late 90s, early 2000s when Joint Commission, it was their understanding that we were not appropriately controlling pain. And so a lot of people have heard this, pain is the fifth vital sign and we need to do better at treating people's pain.

And so that's, I think, where a lot of this shift happened. And so you started seeing more opioids being prescribed with that, seeing a lot of the other downstream effects in terms of just intentional, unintentional ingestions, overdoses, increase in hospitalizations. And as we know in kids, we tend to trail along with what the adult data is doing in a lot of different areas of medicine, right?

And so we started to see these huge increases almost a doubling between early 2000s and kind of mid 2015 [00:03:00] ish with both prescriptions of opioids. And then following that, as we can imagine, hospitalizations for opioid overdoses, ED visits for opioid overdoses, both intentional and unintentional. So that's where it came, and then I think we started, right, this opioid epidemic started, and then we started taking a step back and saying, hey, we need to curb this in some way, take a step back, what do we need to do? So that's the history of where all this began was really late 90s, early 2000s.

Host: Yeah. So, course that made a lot of news, with abuse, particularly on the adult side, although I'm sure that also included adolescence. And so there's been a lot of both lay and medical, literature about that. I'll be interested in your take on sort of where the pendulum is at this point.

Maybe we'll catch that later in the, podcast. but, what are now the current trends that we see in prescribing opioids to children? If we're talking about 2024, where are we and what are the best practices that we could suggest to particularly our primary care physicians that [00:04:00] are out there that may or may not be prescribing controlled substances.

Michelle DePhillips, MD (Guest): Sure. So we've really seen I think a really good improvement. Again, we can get to this and where the pendulum has swung and hopefully we're not over swinging that pendulum to the point we're not treating pain again, but really overall, the literature has shown really nice improvement, both from emergency department prescribing, from post surgical care prescribing.

And we're really showing that people are prescribing opioids in less numbers. And then even just seeing that even a lot of patients who haven't been prescribed opioids at all for their either postoperative pain or injury related pain, whatever that may be, really they're not having decreases in their satisfaction overall with their pain control at home.

And so really seeing some pretty positive data out there. So doing a good job overall, I would say has been the trend in 2024.

Host: And can you make a comment as to perhaps the trends on the types of opioids? Because, you know, of course there are shorter, there are longer acting, there are ones that tend to have a much higher opioid effect as compared to others. Where do you see those trends in [00:05:00] pediatrics?

Michelle DePhillips, MD (Guest): So I would say in pediatrics in general, other than your patients with cancer related pain, your patients with sickle cell related pain, or chronic pain that we have a pain specialist involved in really, those are most of the kids that we're seeing who are on any type of long acting opioids.

Otherwise, by far and away, the majority are sticking to your short acting. So oxycodone, I think is by far and away the biggest one that's prescribed in the pediatric population. You see some hydrocodone, codeine is a little bit of a, I don't want to say no, no, because I think probably in the correct situation it's still okay, but just seeing a very wide array of metabolizers with codeine, so we just don't see a lot of codeine anymore.

So by far and away I think most people are appropriately choosing a short acting something, an oxycodone or a hydrocodone.

Host: Yeah. So, I can remember, boy, this is going to date me; but, the use of codeine, as an example as an antitussive. I am presuming at this point, that really has gone significantly by the wayside. So do you see the use of those opioids outside of [00:06:00] pain control, in the pediatric population, or has that pretty well been eliminated at this point?

Michelle DePhillips, MD (Guest): It's pretty well been eliminated. You know, I have our organizational data and we, oh my gosh, very, very rarely prescribe codeine. They used to use it in some of our sickle cell population would probably be the most common, but yeah, in terms of a antitussive agent or outside of pain control; you really don't see it much at all anymore.

Host: Well, so now you've brought up those patients with chronic pain control issues, whether we're talking about cancer, or we're talking about sickle cell. Of course we're in the pediatric population, kids get hurt, and sometimes they get hurt pretty significantly, and I presume the use of opioids is used in those. Can you give us a sense of what best practice is with regard to assessing injuries, the pain control for those injuries, maybe length of time in which if you're going to use opioids, that should be used? Can you give us a sense just on that sort of the acute injury side?

Michelle DePhillips, MD (Guest): And this is actually where a lot of my research and studies have come from. And there's great [00:07:00] research out there from both acute injuries and then post surgical pain too. So more of those acute causes of pain. So I think you talk about a little bit of two things. So you talk about that acute period when they come in with a broken arm, a broken leg, whatever their acute injury is in the emergency department.

And I always say kids kind of wear their hearts on their sleeves. You for the most part can believe what they say. And if they're in pain, they're going to let you know. And if they're cool, they're going to be sitting there watching their phones or their tablets. And so you get a lot of nonverbal cues from kids as to their pain.

and so we were talking a little bit about where the pendulum has swung and I will get back to your original question, so we use a lot of intranasal fentanyl. So kid comes in with an obviously deformed arm, leg, whatever it may be, a pretty significant injury. And we like intranasal fentanyl because it's fast. It's fairly short acting. It works really well to get those initial images, make them comfortable until we can situate them in a little bit better way. And the faces that parents get, I've learned that I have to have this conversation with them prior to giving it to patients because fentanyl gets an awful rap in the media.

We're all [00:08:00] hearing it, right? And it appropriately should. But parents, I think, have a hard time with this separation of, Oh, I'm in a medical setting. They know what they're doing. It's actually a very safe drug. It's actually a very good drug when it's given in the correct way, versus all of this illicit fentanyl on the street that's in way higher doses than should be normally used.

So that's always an initial hurdle you have to get over to almost say, hey, I really think your kid needs this in order for us to proceed with medical care. And then we can talk about it. So that acute injury, acute setting in the ER is always an interesting conversation I have found within the last year or two and appropriate so.

It's a great opportunity for education for these families. So I've actually learned to appreciate that conversation. And then, yeah, thinking of it after the fact. So really what a lot of studies have shown in fractures, burns, again, post surgical care, really kids for treatment of acute pain are needing medicine, and I'm not even talking opioids, this could be Tylenol, ibuprofen, whatever combination, really for the first two or three days. And after that, kids do really well.

I had done a study a few years back looking at exactly that, acute [00:09:00] injuries and acute pain, and most kids with fractures, use two doses on average of the opioid that they were prescribed and really no more than that. Lower extremity fractures tended to be more painful. So those kids needed more and they're really showing the same thing in post surgical. So your hernia repairs, your apnies, your circumcisions, similar things, they're really showing that maybe 5 up to 10 doses, so 2 or 3 days, is really all of these kids are needing and using, so that would be my recommendation, is start with 2 to 3 days max, so somewhere between 8 and 12 doses, and I think you'll find that most of the time your families are not going to be calling back saying, their kid is still in pain and if they are, they probably need to be re examined to make sure there's not something else going on.

Host: Yeah, so, everything you've said, resonates. I'll give a shout out to your colleagues at, Children's Mercy because, one of my teens had a bike accident a few years back. It was probably about two or three years back with an open radius and ulnar fracture. There was some pain involved in that for sure.

But the experience is exactly as you mentioned, you know, he [00:10:00] definitely needed something right off the bat, but boy transitioned over to ibuprofen pretty quickly. So, very impressive. So, that leads sort of to what advice do you give, one, to the providers that are prescribing opioids? So, length of time. So, you're trying to assess, and we'll stick with the acute injuries or post surgical pain. What's best practice on just how much do you prescribe and for how long? And then the second one is, is what other things can we arm our parents with as other alternatives for pain control?

Michelle DePhillips, MD (Guest): So the conversation I usually have with my families is if it's a fracture or whatever it is, right, use all of our other modalities. So ice, make sure your kid is in a position of comfort. Make sure that whatever that injured extremity is, is elevated. And this can apply to, it doesn't always have to be fractures.

And then I will always say get in a pretty good regimen of ibuprofen. And if they're doing okay with that, awesome.

And if they're having breakthrough pain on that regimen, that's going to be the time that you're going to want to appropriately give a dose of an oxycodone or whatever opioid you are prescribed. So that is generally what I will tell [00:11:00] families. Do all of these things consistently. If they need that for breakthrough pain, that's the time to give it, is how I would answer that question. And then in terms of duration, so yeah, again, so a lot of the literature and especially what we have found has been true. I'd say max three days. We've actually had this QI project going on right now with some of our fracture patients that we're looking at limiting it to eight doses.

So really two days if you consider Q every six hour dosing. And that's we were kind of interested to see if we'd get a lot of callbacks to our follow up nurses or the ortho clinics to say, hey, I only got eight doses and my kid's still in pain and I need more and it has not happened, which is very consistent with what a lot of these studies and the literature has shown us.

So I would say somewhere between two to three days, so eight to twelve doses of whatever opioid is your preference, oxycodone, hydrocodone, whatever that may be, is for the very vast majority of your patients, probably over 95 percent of your patients, is going to be enough for treating their acute pain.

Host: And do you have any other pearls of wisdom with regard to sort of distractibility? As [00:12:00] pediatricians, we talk about avoiding your phone and those types of things. But in these instances, what other distraction pearls of wisdom can you impart?

Michelle DePhillips, MD (Guest): Sure, distractibility is always great. And again, I will say, and we use it a lot, just in terms of painful procedures and doing procedures in general, and it is absolutely amazing. And I will say, you know, once kids are, going back to fractures, because that's the majority of what we see, but once they're supported, right?

So once that broken bone is either back where it wants to be, or it's supported, or they have these other comfort measures in place, kids are just amazing. They're rock stars, right? Which is why I love dealing with them, because if they hurt, they're going to tell you, and if they don't, they're not.

And kids are naturally going to try to find things to do and distract themselves and try to start walking or using their broken arm in two days and you're like, what are you doing? But kids are just pretty incredible. But yeah, any of those things, any of those things that that you find help with your child's pain, I think are great.

Host: And then maybe lastly is the anticipatory guidance for those parents in which their child has been prescribed opioids. Safe storage, what do you do with, if you've got [00:13:00] leftovers, what advice do you have specifically for parents with respect to how to handle the medications and what to do if there's leftovers?

Michelle DePhillips, MD (Guest): Absolutely, I know, this is always a hard one. It's not hard, because the easy answer is get rid of it. Just get rid of it. You know, I think we all think, well, I paid for this, and what if, what if something happens where they have something else that happens and they're having pain, and I think the way I think of it is if something happens to your kid in another six months, and they're having enough pain that you feel that you need to give them an opioid, your kid probably needs to be seen.

And if there's something wrong with your kid that warrants him having an opioid to treat his pain, probably needs to be addressed in some way, whether he's got a broken something, or an appendicitis, or whatever that may be. And so, I always strongly say, when you're done with it, dispose of it. So, super easy ways, pharmacies have drug take backs, our Children's Mercy's, we have drug take backs that you can drop them off.

The other easy thing is to mix it with something that is unappetizing. So mix it in a bunch of coffee grounds, mix it in kitty litter, something that someone is not going [00:14:00] to want to go to dig through and might dissolve and then just throw it in your trash and get rid of it in the trash. There's a great resources actually on our Children's Mercy website for other ways of disposing your medicines, but I would say definitely dispose of them.

If you're going to keep them, it is shown that of adolescents that misuse opioids, the majority of them are getting from their own medicine cabinets of mom's leftovers, their leftovers, or a friend. A friend is bringing them in from said mom, dad, own personal use. And so I know we like to trust our kids, which I've learned we can't always do, and our teenagers especially.

And so if you are going to keep them, lock them up. There are medication safe lock boxes. If you have a cabinet at home that you can physically lock with a master lock or some other type of lock, lock them up. Because that is where they are getting them, and you, I would not think, would want to be the one responsible for them being able to get that. So that's usually the advice I give families.

Host: Yeah, great. Well, Dr. DePhillips, really great, large amount of information in a short amount of time. We really appreciate you giving us your wisdom as well as just backing it up with the research that both [00:15:00] you and your colleagues are doing. So, really, appreciate everything that you've imparted.

I have to ask now. So, you head down to Gulf Shores, we've already established you're going to be having plenty of seafood. I wish you one, no jellyfish, because sometimes that can be a problem. And no, no shark fins. May you have a shark fin free, jellyfish free vacation down at Gulf Shores. Great place.

Michelle DePhillips, MD (Guest): Thank you, I appreciate that. I have a four year old, she's gonna be four this week, and we went last year and she did get stung by a jellyfish, I will have to say, so we did not have such good luck with that last year, but there's always this year, so fingers crossed.

Host: And I will say for jellyfish stings, you don't need opioids for that. So there you go. Just to tie it back. Very good. Well, Dr. DePhillips, thank you again for joining us today.

As a reminder, claim your CME credit for listening to our show today. Visit cmkc.link/CMEpodcast, and then click the claim CME button. This has been another episode of Pediatrics in Practice, a CME podcast. I'm Dr. Rob [00:16:00] Steele. See you next time.