How do prescription pain pills (opioids) affect HIV?

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Are prescription opioids a concern?

Yes. Prescription pain pills (opioids) such as oxycodone, hydrocodone and methadone have helped millions of people effectively manage chronic pain. But for some, opioids have become a complex, tangled web of misuse and abuse that has led to dramatic increases in addiction, overdose, hepatitis B and C infection, and potentially, HIV infection in the US.[1]

Prescription opioids sold in the US more than doubled from 2001 to 2015, yet there has not been a decrease in the amount of pain reported. The amount of oxycodone and hydrocodone alone tripled from 2000 to 2015. Healthcare providers wrote 259 million prescriptions for opioid painkillers in 2012—enough for every adult in the US.[2]

The CDC recommends that prescription opioids should not be considered first-line or routine therapy for chronic pain.[3]

Why are prescription opioids a concern?

People often don't know the risk involved in taking prescribed opioids. Opioids make people feel good, the side effects often are not bothersome, and patients tend to think that doctors would not prescribe something that is dangerous. Patients may not understand they can become physically dependent on them, and providers may not understand or adequately explain this. People being prescribed opioids should ask their providers if opioids are really the safest way to manage their pain.

Overdose. From 2000 to 2014, nearly half a million people died from drug overdoses, and more than 60% of drug overdose deaths involve an opioid. Every day, 46 people in the US die from prescription opioid overdose.[2]

Opioids are highly addictive. As many as 25% of people using opioids long-term struggle with opioid dependence.[4] And people become dependent on them extremely quickly. The chances of chronic use begin to increase as early as after the third day taken, and rise rapidly with each day after.[5]

What is their effect on HIV?

Potential negative effects on PLWH. For people living with HIV (PLWH), long-term opioid use may lead to depression, can trigger relapse, and actually can increase chronic pain.[6]

Increased risk behavior. Like alcohol and other drugs, prescription opioids can interfere with judgment and decision-making, and can result in users doing things they wouldn't do when not in an altered state. People using opioids may have lowered inhibitions and be less likely to use condoms and more likely to share syringes, behaviors that increase the risk of transmitting and acquiring HIV as well as hepatitis C (HCV) and hepatitis B.[7]

Transition to injecting and heroin. The epidemic of prescription opioid misuse has resulted in a large population of people who are new to injecting. Almost 80% of new heroin users report using prescription opioids prior to heroin.[8]

What are concerns for PLWH?

Long-term opioid use. Chronic pain occurs in as many as 85% of PLWH and many use prescription opioids to manage their pain. Side effects from long-term and regular use of opioids include: decreased libido and testosterone, depression, neurological and heart rhythm problems. Repeated use of opiate pain medicines can, in fact, heighten—instead of alleviate—chronic pain in PLWH.[6]

Opioid misuse. Problematic prescription opioid use may be common among PLWH especially persons with a history of substance use, mental health issues, and poor adherence to ART. One study of PLWH prescribed opioids found that 62% had problematic use.[9]

Relapse and overdose. For PLWH with a history of alcohol and drug abuse, opioids may cause relapse. Accidental overdose is common, especially when opioids are combined with alcohol or benzodiazepines (such as Valium and Xanax), or with anti-depression and seizure medications.[3]

HIV healthcare. For many HIV providers, the unique factors in HIV care can influence whether they adopt federal guidelines for prescribing opioids. For example, goals such as retaining patients in HIV care or being an ally with patients, may be seen as more important than conservative opioid prescribing guidelines. Specialized training on opioid prescribing may be warranted for HIV providers.[10]

What are concerns for persons at risk for HIV?

Lack of safer injecting knowledge and programs. The opioid epidemic has led to an increase in people who inject drugs (PWID). These new injectors tend to be mostly White, live in rural and suburban areas, have little knowledge of safe injecting practices or HCV and HIV risks, and have little or no access to education or services for injectors, such as syringe

access programs.[11] This creates the potential for rapid spread of HIV once introduced into communities.

Hepatitis C. Currently, HCV infection is a major concern for injectors, especially among young adults and those living in small towns and rural areas in the US who inject opioids. In 2013, 30,000 new cases of HCV occurred, and 28 states reported increases in HCV infections. This was an increase of more than 150% from 2010 to 2013.[11]

Potential rapid spread of HIV. In 2015, the first HIV outbreak associated with injecting prescription opioids occurred in rural Indiana. HIV infection spread quickly in this small community, with 135 people testing positive, and 80% of those reporting dissolving and injecting tablets of oxymorphone.[12]

What needs to be done?

While opioid prescriptions, use, addiction and overdose have skyrocketed in the past few years, federal, state and local agencies have responded with guidelines, regulations and programs to promote safety. In 2016, the CDC issued guidelines intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, to improve the safety and effectiveness of pain treatment, and to reduce the risks associated with long-term opioid therapy, including addiction, overdose, and death.[3]

Healthcare providers

Non-opioid pain management. Providers working with PLWH should consider age, gender, socioeconomic status, current mental health, and substance use, as addressing pain without looking at these may have limited success. As the CDC recommends that opioids should not be a first-line therapy for chronic pain, providers should consider non-opioid means of managing pain. PLWH may get relief from pain with cognitive behavioral therapy, physical therapy, hypnosis or medical marijuana.[13]

Overdose prevention. If providers and patients wish to use opioids, providers should discuss and provide written materials on the risks of dependence and overdose, and consider co-prescribing naloxone to reverse potentially fatal overdose.

People living with HIV

PLWH who are prescribed opioids by their doctor should discuss any concerns and ask about non-opioid pain relief methods. If prescribed an opioid, they should use it for shortest period of time possible and be aware that dependence can happen right away, within 3 days of use.[5] PLWH who have been taking opioids for a long time should talk to their doctor about weaning off, or reducing their use.

Policymakers

We know how to prevent HIV, and we have multiple effective HIV prevention interventions. The HIV outbreak among rural PWID in Indiana has shown what can happen when states and local communities do not invest in prevention. We need to make a serious commitment to expanding education; harm reduction services such as syringe access programs; overdose prevention including access to naloxone; and drug treatment.[14]

Despite years of scientific evidence of their need, cost-effectiveness and effectiveness, there exist political and legislative barriers to implementing programs for PWID. We need to support, protect and expand existing laws and programs for the health and wellbeing of people who use and misuse prescription opioids, including PWID and their partners.

Says who?

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