The Contribution of Patient Satisfaction to the Opiate Abuse Epidemic

To the Editor: In their editorial on opiate overdose, Berge and Burkle1 list the release of new opioid drugs, the aggressive marketing to physicians, the declaration of pain as “the fifth vital sign,” and the increased willingness of physicians to treat noncancer pain with opioids as the measures that led to the explosion of sales of prescription opioid pain relievers. It is imperative that 3 others be added to this list: the patient satisfaction survey industry, the Centers for Medicare and Medicaid Services (CMS), and hospital administrators.

Despite conflicting literature, the patient satisfaction survey industry was able to convince payers and hospitals that patient satisfaction and quality of care are directly correlated. The CMS, in their drive to pay for quality instead of quantity, had such faith in this flawed concept that they weighed patient satisfaction at 30% in their value-based purchasing program. As a result, hospitals bought patient satisfaction survey tools and consulting services from these companies and started providing physicians with “feedback” on their performance, asking those with poor scores to improve. To that end, physicians started working harder to please patients, giving them what they wanted (which was not always the same as what they needed) and erring on the side of overprescribing to avoid being scored poorly. Patients seeking opiate prescriptions then learned to tell physicians that an opiate prescription would make them “highly satisfied,” a not-so-veiled threat that anything less would result in a poor satisfaction score and the resultant increased scrutiny by hospital administration.

Until the CMS and hospital administrators realize that patient satisfaction is not an accurate measure of the quality of care, the role of prescribed opiates in the opiate abuse epidemic is unlikely to lessen.

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In reply—The Contribution of Patient Satisfaction to the Opiate Abuse Epidemic

We agree with Dr Hirsch in his contention that patient satisfaction surveys and ratings can create perverse incentives for physicians to overprescribe controlled substances. Physicians wish to maximize satisfaction ratings in order to preserve reimbursement levels and their online reputations as caring and compassionate practitioners. Doubtless, this creates, in many cases, a motivation to prescribe simply because the patient desires it and to not aggressively question the necessity or appropriateness. We concur that this laxity is contributing to the ongoing epidemic of prescription drug abuse and that broader recognition and correction of these perverse incentives is required to combat this complex and multifactorial problem.

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Synthetic Cannabinoid Leading to Cannabinoid Hyperemesis Syndrome

To the Editor: Cannabinoid hyperemesis (CH) has been increasingly recognized as a cause of cyclic nausea and vomiting since it was first reported in 2004 and was further described in a case series of 98 patients. Proposed diagnostic criteria include long-term cannabis use, cyclic nausea and vomiting, resolution with cessation of cannabis, relief of symptoms with hot showers, abdominal pain, and weekly use of marijuana. We report a variant of this syndrome in a patient who experienced similar symptoms after synthetic cannabinoid use.

A 29-year-old man presented with a 2-year history of recurrent episodes of severe nausea and vomiting with epigastric pain. Hot showers for up to an hour provided relief. He reported experiencing similar symptoms more than 5 years previously when he was regularly smoking marijuana, and these symptoms resolved with cessation of cannabis. For his more recent symptoms, he was evaluated multiple times in the primary care setting and emergency department. At each visit he denied use of any “illicit substances or drugs” since he quit using marijuana. Results of multiple investigations including laboratory testing, abdominal imaging, and esophagogastroduodenoscopies were unremarkable. Health care professionals considered CH, but repeated urine drug screens were negative for Δ9-tetrahydrocannabinol (THC). Later, the patient admitted to regularly smoking K2 and Kryptonite, which contain unidentified and uncertain synthetic cannabinoid agonists marketed as “legal” herbal incense. Considering his history of highly probable CH from habitually smoking marijuana 5 years previously, we believed that his current symptoms were due to development of CH from smoking these products. He was advised to discontinue the use of any cannabinoid products. After 6 months of abstinence, he noted complete resolution of symptoms.

Products containing synthetic cannabinoids are often referred to as herbal products that provide “legal” highs.
Manufacturers have been able to circumvent laws by changing the chemical structure of THC and marketing these substances as incense. These synthetic cannabinoids can be potent agonists of the cannabinoid CB1 receptors, which are the same receptors by which THC produces its effects. Therefore, users of synthetic cannabinoid agonists may experience the similar desired psychoactive effects of marijuana. Furthermore, both THC and synthetic cannabinoid agonists have been shown to down-regulate the CB1 receptor, which we believe may result in a dysregulation of the emetogenic centers in the area postrema and result in CH. Despite of these similarities in action, synthetic cannabinoid metabolites differ enough from cannabis metabolites that standard drug screens do not identify the synthetic cannabinoids.

To date, only 2 other cases of CH associated with synthetic cannabinoids have been reported. Cannabinoid hyperemesis has been well described in patients who use cannabis but may be unrecognized in patients using synthetic cannabinoids. A urine drug screen negative for THC may point physicians away from this syndrome, and patients may not report use if they believe they are using herbal products rather than illicit drugs. Therefore, regardless of negative urine drug screen results and patient denial of cannabis use, physicians should have a high index of suspicion for synthetic CH syndrome in patients who present with classic symptoms of cyclic emesis.

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CORRECTION

In the article “Vascularized Composite Allotransplant in the Realm of Regenerative Plastic Surgery,” published in the July 2014 issue of Mayo Clinic Proceedings (2014;89(7):1009-1020), the affiliation should read: From the Essam and Dalal Obaid Center for Reconstructive Transplant Surgery, Mayo Clinic, Rochester, MN.