

BLOOD AND URINE TESTING FOR OPIOIDS

Introduction

Lab testing of pain sufferers has become widespread because doctors have been forced into the role of drug diversion investigators. Surprisingly, when a doctor is prosecuted, the presence of a testing program is not taken as an indication that the doctor attempted to limit diversion; instead the details are nitpicked by ignoramuses, intent on demonstrating that the testing program was only “window dressing”, intended to disguise the doctor’s drug dealing behind a veneer of medical practice.

Interpretation of test results, while it would seem to be straightforward, is actually anything but, and failure to do so competently often results in disaster for the legitimate patients who get tossed out. If not executed perfectly, the presence of a drug-testing program assists prosecuting attorneys in convicting the doctor they have targeted.

Interpreting Laboratory Results

Every result returning from the laboratory should be reviewed with skepticism regarding its accuracy, and each value should be interpreted in the context of the patient’s entire clinical picture. Any lab value departing from the expected should receive scrutiny, with consideration of all of the possible pharmacological, metabolic, and laboratory variables that could have influenced the test.

Quantitative variation

Simply put, a lab value can be too low or too high. The key approach to sorting out this sort of thing is repetition of the test, with as much control over the circumstances as possible.

Due to human and machine error, laboratories will produce a range of values, when repeatedly running exactly the same test. If a value looks too low or too high, the test should be repeated. Because of individual variation in absorption and metabolism of opioids it is impossible to know what a patient’s blood level of a particular medication should be, without repeated testing. Levels are more meaningful when the patient is *observed* taking a dose of medication, usually about 1 hour prior to having his blood drawn.

False negative and false positives

In addition to being too high or too low, lab results can also be completely wrong. Urine testing for opiates is the situation in which this most commonly occurs in pain management. The test is fairly sensitive for opiates such as morphine, codeine, and heroin, but is not specifically designed to pick up the synthetic opioids, such as hydrocodone, oxycodone, and meperidine. The situation is further complicated by the fact that some of these substances are metabolized by some individuals into opiates that the urine screen does pick up. Other patients using synthetic opioids will consistently test negative for urine opiates.

Many legitimate pain patients have been unfairly excluded from pain treatment because of a false negative on a urine drug screen for opiates. This situation also carries the risk of being used as evidence in a courtroom, that the doctor who continued to prescribe opioids to a patient after a negative urine opioid screen result returned, was knowingly contributing to drug diversion, by supplying a patient who wasn’t taking his medication. This is not speculation; it is actually happening in courtrooms around the country.

The only way to defuse the above accusation is by ordering blood opioid levels every time a urine drug screen is ordered.

Prodrugs

Certain opioids are not active in the form they are taken, and must be converted within the body to substances that effectively treat pain. Codeine and hydrocodone are the most notable examples. Codeine is converted primarily to morphine, and hydrocodone is converted to hydromorphone. Not every patient has the enzymes required to perform these metabolic conversions, and this has implications for what substances will be discovered upon testing.

Metabolic Conversion

A patient taking codeine can be expected to have both morphine and hydrocodone in his urine and blood, as a result of these conversions. As a consequence if an unexpected substance appears on testing, it is necessary to consider the metabolic pathways that may have produced it, prior to accusing the patient of stepping outside of the therapeutic relationship, and imposing sanctions against him.

The body converts carisoprodol (Soma) to meprobamate. This is important to know, because carisoprodol is a common and effective neuromodulator, used in the treatment of chronic pain.

The presence of any substance, other than what the doctor prescribed, or the absence of any substance he did prescribe, must be fully explained in the medical chart. Otherwise, this apparent failure will be offered in the courtroom as proof of drug diversion, which the treating physician criminally ignored. This sort of thing bolsters the prosecutor's contention that the doctor was nothing but a "drug dealer in a white coat".

Urine Opioid Levels

Urine opioid levels are almost worthless, because opioids tend to be concentrated in the urine. High urine opioid levels say more about the duration of treatment and concentration of the urine than they do about the dose of medication taken. They can produce confusing results, and in most cases, should not be ordered.

Recommended Strategy

In the current climate of regulatory oppression, the sane response is not to prescribe controlled substances, but if one must, here are some suggestions.

1. Assume that prosecutors and their hired "experts" are malicious idiots, but don't underestimate them. They are good at what they do, and your conviction is their work product. It is also consistent with their drug war ideology, and a source income and power.

2. Order blood levels for every drug prescribed, at the same time urine drug screens are obtained.
3. Initiate a drug-testing program by ambush.
4. Test regularly and often.
5. Obtain blood levels every time a medication is titrated.
6. Thoroughly document the analysis, decision-making process, and plan, regarding every result received, no matter how ordinary or expected it seems.

Ambush

Prosecuting attorneys have argued that positive blood and urine tests are worthless to detect diversion, because the patient was diverting all along, and only took their medication to pass the lab test. For this reason, it is necessary to initiate a testing program by ambush. Preferably the blood and urine are obtained in the office. A second option is to require the patient to go directly to the lab following their appointment.

Results obtained in this fashion can be crosschecked by having the patient bring in their medications, so that they can be observed taking their prescribed dose. This is followed shortly by testing for blood levels.

Regularity/Completeness

Blood and urine testing for opioids should be obtained for every patient, on a regular schedule. This should include urine testing for common drugs of abuse, and blood testing for every medication the doctor is prescribing, and the metabolites of each medication prescribed.

Decision Making/Follow-up

All decision making, and the resulting plan of action must be clearly documented in the medical record. Otherwise, it will be second-guessed by prosecuting attorneys, and the "experts" they hire to nitpick through every element of care. One must assume that the "expert" who will be reviewing the charts is completely ignorant about the meaning of lab test results, but that he will think he knows everything. These guys are dangerous