

Celebrity magazines all too often feature stories about overdose deaths and rehab admissions, and the Office of National Drug Control Policy is running an advertising campaign about the dangers of prescription drug abuse.

But when taken as prescribed, just how risky are drugs like [OxyContin](#) and [Vicodin](#)?

The truth might surprise you. Myths and misinformation about [opioid painkillers](#) are widespread. Here are the facts.

Myth No. 1: Toughing it out is always better than relying on painkillers.

Although Americans pride themselves on their toughness, those who refuse medications despite severe pain may be putting their health—and their jobs and relationships—at risk.

“Uncontrolled pain is associated with adverse consequences in terms of daily functioning, mood, sleep, overall quality of life, energy level, the ability to work and marital relationships,” says Russell Portenoy, chair of Pain Medicine and Palliative Care at Beth Israel Medical Center in New York City.

Adds Dr. Richard Payne, professor of medicine and divinity at Duke University: “Newer studies actually show that [persistent pain causes changes in the brain](#) and spinal cord that begets more pain.” Some animal studies suggest that controlling pain could help prevent these problems.

“It’s clearly obvious that people whose pain is controlled effectively following surgery go home earlier, have fewer complications, get out of the hospital faster and recover better,” says Dr. Gavril Pasternak, a neurologist at Memorial Sloan-Kettering Cancer Center in New York City. “On the other hand, do I think every time a child scrapes his knee he needs an opioid? No.”

Myth No. 2: People on opioids are always impaired—and cannot drive safely or work in demanding jobs.

[Studies of drivers](#) on steady doses of opioids do not find impairment. In fact, says Portenoy, “At least one study by Finnish researchers showed that impairment on standard driving measures was more correlated with poorly controlled pain than with taking medication for it.”

“What people are concerned most about is judgment and somnolence,” says Pasternak.

“Would I recommend that someone just starting opioids drive? Of course not. But I would give the same advice to someone starting a sleeping pill. Once someone has been on the same dose for a while, they can.”

Adds Payne: “For people on a stable dose, they acclimate or develop tolerance to sedative and mental clouding effects.”

Myth No. 3: When taken as directed, opioids are more likely to kill you than aspirin, ibuprofen or naproxen.

“False. When taken as directed, opioids are safe drugs,” says Pasternak.

The vast majority of opioid-related deaths occur amongst recreational users or deliberate suicides. Deaths amongst pain patients are rare—in fact, recent research finds that even for [people with advanced illnesses](#), use of high-dose opioids does not significantly increase risk of death.

Nearly three times as many people die from complications of correctly taking painkillers like aspirin and ibuprofen— known as non-steroidal anti-inflammatory drugs—than die from opioid overdose.

“More people die from gastro-intestinal bleeding from NSAIDs taken in correct doses than from inadvertent opioid overdose,” says Payne.

“It is true that the death rate has increased from accidental overdose related to opioids, but still the number of deaths related to accidental OD is dwarfed by the gastro-intestinal and [stroke and heart-related] complications of other analgesics,” Payne adds.

Myth No. 4: Accidental overdose is common amongst pain patients.

Most opioid overdoses do not result from medical use.

“As patients take opioids over weeks and months, they develop a tolerance to the respiratory depressive effect, which is the thing that can cause death,” says Payne.

This means that even if people forget they've taken their medication already and accidentally double their dose— unless they have dementia and do this rapidly and repeatedly— the risk of death is low.

Instead, the vast majority of opioid overdoses involve combinations of drugs that cause sedation— typically alcohol and sleeping pills or anti-anxiety medications like Valium or Xanax (benzodiazepines).

At least [80 percent of opioid overdoses are actually caused by such drug mixing](#)—and while some severe pain patients need both benzodiazepines and opioids, they are prescribed together with great caution.

In many overdose deaths, use is obviously non-medical because the victims injected or snorted drugs meant to be taken orally.

CONTINUED: [Addiction myths](#)

Myth No. 5: Most people who get addicted to painkillers are “accidental” addicts who sought pain treatment and had no prior history of drug problems.

When a Florida newspaper covered the “OxyContin epidemic” in 2003, it later had to [retract its series](#), in part because a man portrayed as an innocent victim of a pill-pushing doctor actually had a prior federal cocaine conviction.

Inadvertently, the paper had illustrated the real story of painkiller addiction: The vast majority of people who become addicted to prescription opioids have significant prior histories of drug problems.

Nearly 80 percent of OxyContin addicts have taken cocaine, for example, according to large [national survey research](#). This means either that pain patients prescribed OxyContin suddenly start using cocaine—or, more plausibly, that most people who misuse opioids have a past or current drug problem.

“We published [data](#) on this; we looked at people who had Oxycontin addiction who presented for treatment— essentially, nobody had gotten addicted to Oxycontin who hadn't previously been using opioids recreationally,” says Thomas McLellan, professor of psychiatry at the University of Pennsylvania.

More than three-fourths of the patients who had misused OxyContin in this national sample of addicts in treatment had never received a prescription for it.

Even having chronic medical problems—which includes chronic pain—did not increase risk for OxyContin addiction.

If you do not have a personal or family history of addiction—especially if you have never suffered psychiatric problems like depression, schizophrenia or bipolar disorder, and especially if you are middle-aged or older—your risk for developing addiction during pain treatment is “vanishingly low,” says Portenoy.

Myth No. 6: Addiction is inevitable if opioids are taken long-term or in high doses—and the risk of addiction is very high for short term use.

This myth stems from confusion about the nature of addiction. Many people believe that addiction is simply needing a substance to function—but if this were the case, everyone would have to be considered addicted to food, air and water. “To the average person, addiction is going cold turkey— they view addiction as physical dependence,” says Pasternak.

In fact, psychiatry defines addiction as compulsive use of a substance despite negative consequences—and it is this craving, impairment and loss of control that people fear. However, while most people who take opioids for long enough will develop physical dependence and suffer withdrawal if the drugs are stopped abruptly, addiction in pain patients is rare.

“The reality is that addiction appears to be distinctly uncommon in patients without a prior history of addiction or a family history of addiction,” Portenoy says. In his own [research on more than 200 patients treated with OxyContin](#) for chronic pain over three years, no new cases of addiction were reported.

“Over 30 years, I’ve seen a few thousand patients with cancer and sickle cell [disease] and other [conditions], and less than five that I’m aware of became addicted,” Payne says.

Myth No. 7: Opioid withdrawal is extremely debilitating and potentially deadly.

We’ve all seen the movies: the desperate addict shivering, shaking and vomiting from heroin withdrawal, pleading for relief. But while opioid withdrawal can be unpleasant, it doesn’t have to be.

“You can probably take 80 percent of people off opioids by decreasing the dose 50 percent every other day and they will be asymptomatic,” Pasternak says.

In fact, many patients go through withdrawal without even realizing that their “flu symptoms” are linked to the fact that they decided to stop their pain medication suddenly.

The severity of withdrawal also appears to have a genetic component—some people are susceptible to miserable symptoms, while others suffer few or even no effects. Portenoy describes a female patient on a very high dose of morphine whose prescription ran out before her appointment. Rather than asking for a renewal, “She waited to come and see me,” he says, “and she had no withdrawal.”

While withdrawal from alcohol or barbiturates is potentially fatal if not properly managed, even the worst opioid withdrawal is unlikely to be deadly. However, withdrawal can be risky if the patient is still in pain or on other drugs. “Managed incorrectly and in concert with other drugs, it can be very dangerous,” says McLellan.

Pasternak says the main reason people suffer withdrawal has “nothing to do with medicine, but rather to societal pressures that have led to laws that the Drug Enforcement Agency is required to enforce.”

For example, it is illegal for a doctor to prescribe opioids for addiction outside of certain settings, so some physicians are afraid to taper patients' doses for fear of being arrested for having “maintained” an addict. Similarly, doctors may drop patients suddenly if they suspect addiction, without tapering their medications.

Worst of all, many physicians won't prescribe opioids at all—even when they are clearly warranted—because they fear dealing with addiction and law enforcement issues. The unfortunate result: Patients in pain are left to suffer.