# The news on the street: prescription drugs on the black market

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*Editorial*

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Prescription drug seekers are people who exploit the trust inherent in the physician–patient relationship to obtain licit pharmaceuticals for their own use and for sale on the street. That much has been known for some time. However, the world of prescription drug diversion is a murky one for most physicians. Because it is a criminal activity, the trafficking of pharmaceuticals does not ordinarily lend itself to scientific study.

Dr. Amin Sajan and colleagues deserve praise for their fascinating examination of the street value of prescription drugs in Vancouver's east end (page 139). As with previous reports on the street value of prescription drugs,[1,2] the findings are anecdotal. There were few attempts in those earlier studies to confirm the authenticity of the findings, but Sajan and colleagues took steps to verify their data. Before approaching potential participants, the authors conducted a pilot study at local methadone and walk-in clinics to determine the approximate street value of prescription drugs, so that they would not be misled by study participants.

The final report confirms the widely held view that the desirability of licit opioid analgesics such as morphine and oxycodone varies inversely with the availability of illicit drugs such as heroin. This relation was indirectly indicated by the fluctuating street prices for the prescription drugs reported by Sajan and colleagues. Their findings also confirm the anecdotal observation that licit pharmaceuticals may be sold on the street to obtain money to purchase illicit drugs, they may be used as a substitute for illicit drugs when the latter aren't available, or they may be sought as drugs of choice.

This paper also advances the current state of knowledge about the diversion of opioid analgesics in several important ways. First, Sajan and colleagues appear to be among the first to publish evidence on the street value of controlled-release opioid preparations (so-called "peelers"). It has been argued previously that controlled-release preparations might be less desirable as drugs of abuse than immediate-release pharmaceuticals.[3–5] The relatively high street price of controlled-release opioid analgesics reported in this study clearly indicates that these drugs are coveted. This should ring alarm bells. The manufacturer of one brand of morphine sulfate tablets (MS Contin) has warned that injection of the drug obtained by crude street methods could result in local tissue necrosis and pulmonary granuloma.[4] These issues need to be resolved. Now that controlled-release oxycodone has been licensed in Canada, we can expect that it and other controlled-release opioid analgesics will also find their way onto the black market.

A second fascinating finding about the illicit market for prescription opioid analgesics was the relatively low street price compared with prices quoted in previous anecdotal reports. Immediate-release hydromorphone has reportedly fetched a street price of upwards of US$75 per 4-mg tablet;[6] in the Vancouver study, the median price per tablet was a "modest" Can$25.

The study had some obvious limitations. The sample was extremely small, and the information was obtained at a single location in Vancouver. Although they may accurately reflect the local phenomenon of drug diversion in east Vancouver, the findings may not be relevant to other cities, since street prices and individual drugs of choice reportedly vary from city to city. Moreover, they vary with the prescribing practices of local physicians and the availability of illicit drugs.

What, then, are the broader implications of this study? It is always disturbing to learn that licit pharmaceuticals, prescribed in good faith by physicians and dis-

pensed by pharmacists, can end up as commodities on the black market. Health care providers must practise with an awareness of this fact.

The publication of these findings will undoubtedly lead some to call for more action to stop the diversion of licit controlled substances. But it's important not to overreact. Although Sajan and colleagues have given us a fascinating window on the world of prescription drug diversion, their study provides no perspective on the scale of diversion, without which we risk overreacting to what may be an extremely limited phenomenon.

According to the 1990 National Household Survey on Drug Abuse in the US, only 1.4% of the general population over the age of 12 was using licit psychoactive drugs that had not been prescribed.[7] In fact, a growing number of authors argue that the problem of undertreated pain in our society is far greater than that of prescription drug diversion,[8,9] and there is a substantial risk that any increase in controlling and monitoring opioid analgesics and sedatives will result in reduced availability of such drugs to patients. Strategies intended to decrease diversion should not exacerbate the problem of undertreated pain.

Yet increasing the regulations and restrictions on the prescribing and dispensing of controlled substances has been shown to exert a chilling effect on these activities, beyond what is needed to control illegal distribution. Given that BC has a triplicate prescription program, it is relevant to note that when New York State added benzodiazepines to the drugs in its triplicate prescription program, the prescribing of these drugs decreased significantly.[10] Furthermore, with fewer physicians willing to prescribe fewer benzodiazepines, the prescribing of less safe alternatives increased. Anderson and associates[11] studied BC physicians for whom the total number of prescriptions for opioid analgesics exceeded 2 standard deviations above the mean. They found that after the College of Physicians and Surgeons of British Columbia simply notified them of their prescribing status, the physicians reduced the number of prescriptions by 25%.[11]

In 1992 Cooper and colleagues[1] pointed out that existing methods to severely restrict the prescribing of drugs such as heroin and amphetamines have had little impact on the availability of such drugs for purposes of abuse. They called for studies to determine the precise dimensions of the problem of drug diversion, concluding that, in the absence of hard data, reliance is often placed on anecdotal and impressionistic information to justify or oppose policies to control diversion.

Little has changed since that landmark article, except for developments in technology. Across the US, multiple-copy prescription programs are being phased out as electronic data monitoring systems are phased in. Despite the amassing of potentially useful data on drug-seeking behaviour, prescribers and dispensers continue to be kept in the dark. In the absence of hard data, education of health care providers is justified; increased regulation and punitive measures are not.

A final observation from the study by Sajan and colleagues merits a study of its own. If anecdotal reports from the interviewees are reliable, then the diversion of nonregulated prescription drugs may be far more important than we have previously thought. Given the retail price of antiretroviral compounds, it would not be surprising to discover that a vibrant black market for such drugs exists. As new products from the innovative pharmaceutical industry become more expensive, this trend may one day render the scale of diversion of regulated drugs trivial by comparison.

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