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CLINICAL HARM REDUCTION FOR ADDICTION: A STRATEGY INTERNISTS CAN (AND DO) EMBRACE

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With the opioid epidemic raging, there are many calls from advocates and policymakers to expand access to addiction treatment as well as harm reduction services in cities around the United States. Clinicians of all stripes understand the concept of treating a disease. But fewer appreciate how medical practice aligns with the latter endeavor: reducing harm. I posit that practitioners of general internal medicine are already well-acquainted with the philosophical and pragmatic underpinnings of this parallel approach to care.

Harm reduction is a term that conjures images of syringe exchanges and—with growing public attention, supervised use sites—as examples of programs largely administered outside of the traditional medicine sphere. Yet what constitutes harm reduction is not limited to facilities or programs. According to the Harm Reduction Coalition, a national advocacy and capacity-building organization, harm reduction has no universal definition, but "…accepts, for better or worse, that [the disease/behavior] is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them," "establishes quality of…life and well-being…as the criteria for successful interventions," and "calls for the non-judgmental, non-coercive provision of services and resources," among many other guiding principles.[1] Internists share these values, and they already practice harm reduction in managing many chronic diseases.

Consider atrial fibrillation. How many teaching points occur daily during morning rounds on decisional aids for anticoagulation? Warfarin and apixaban do not directly address the mechanism of disease (i.e., a cardiac conduction abnormality). Rather, they prevent a serious complication prevalent in this population, especially when the underlying pathology is *not* well controlled. Potential harm is reduced in a non-judgmental fashion.

Or consider a more commonly referenced example: type II diabetes. Comprehensive diabetes care includes early screening for neuropathy, retinopathy, and nephropathy. These interventions do not, of course, affect blood sugar levels directly. But there is an acceptance that, despite our best efforts, not every patient in all circumstances will have adequate blood sugar control. It is still reasonable to detect and reduce the impact of these medical complications; I am not aware of any concerns about *enabling* poor glucose control by doing so.

The American Society of Addiction Medicine (ASAM) now describes addiction as "a primary, chronic disease of brain reward, motivation, memory, and related circuitry."[2] And as readers are aware, there are almost too many medical complications of substance use to count. But with this chronic, relapsing and remitting, biopsychosocial disease, what recommendations currently exist for harm reduction—perhaps better received among medical professionals as *tertiary prevention*—in clinical practice? The following are selected examples of clinical harm reduction that may be well-known but not fully recognized as part of substance use disorder (SUD) management.

- The United States Preventive Services Task Force (USPSTF) gives a grade B recommendation to screen men between age 65 and 75 who have ever smoked for abdominal aortic aneurysms.[3]
- The American Medical Association Opioid Task Force provides guidance on co-prescription of naloxone with opioids for patients at high risk of overdose, and for their family and friends.[4]
- The Advisory Committee on Immunization Practices (ACIP) recommends that people who inject drugs get vaccinated against Hepatitis A and Hepatitis B. Additionally, the Centers for Disease Control & Prevention (CDC) recommends testing anyone who has injected drugs for Hepatitis B and Hepatitis C infections.[5]
- The ACIP lists *alcoholism* and *cigarette smoking* as indications for pneumococcal polysaccharide vaccine (PPSV23) immunization.[6]

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These are established guidelines that do not directly address the pathophysiological mechanism of SUDs. Yet they can reduce harms that stem from these conditions. Internists should incorporate these recommendations into standard SUD care, and we also need more. What harm reducing strategies besides abstinence-based treatment exist for alcohol-related injuries? Cocaine-induced hypertensive crises? Cannabis-associated hyperemesis? I think many of us have seen and written the *Plan* section of a *SOAP* note that states, "Recommend cessation," without any other actionable ideas.

I ask the clinical research community to devote more time and resources to tackle not only treatment of addiction but also *prevention* of its medical complications, acknowledging that many will have paroxysmal relapses regardless of an airtight treatment plan. Harm reduction must become part of our lexicon; at least as recognizable as $CHADS_2VASC$ and *A1c*.

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