



February 5, 2018

Susan R.B. Weiss, PhD
Director, Division of Extramural Research,
Office of the Director, National Institute on Drug Abuse
6001 Executive Boulevard, NSC, Room 5274
Rockville, MD 20892

RE: 128th Meeting of the National Advisory Council on Drug Abuse

Dear Dr. Weiss,

The Infectious Diseases Society of America (IDSA) and the HIV Medicine Association (HIVMA) applaud the attention that the National Institute on Drug Abuse (NIDA) is focusing on the opioid crisis. We look forward to learning more about NIDA strategic planning efforts, research initiatives, and collaborations with other National Institutes of Health (NIH) Institutes and Centers regarding this important topic. To successfully combat this rapidly evolving national emergency, our Societies urge NIDA and the National Advisory Council on Drug Abuse (NACDA) to include the effects of opioid use disorder on infectious diseases (ID) in its opioid research priorities. Below, please find additional information and recommendations about the infectious disease impacts of the opioid epidemic for your consideration.

Impacts of the Opioid Crisis on Infectious Diseases

We have witnessed new outbreaks of infectious diseases attributed to injection drug use in recent years, such as the 2015 HIV and hepatitis C (HCV) epidemic in Scott County, Indiana. Massachusetts reported a doubling in new HIV infections among injection drug users during 2017¹, sparking concerns about the potential for an epidemic to emerge. Northern Kentucky and Hamilton County, Ohio, have also seen significant increases in new HIV cases linked to injection drug use². The Centers for Disease Control and Prevention (CDC) identified 220 counties in 26 states that are vulnerable to similar outbreaks among injection drug users.³ Beyond the well-known consequences of HIV and hepatitis C (HCV), additional common complications of opioid drug use include infective endocarditis, septic arthritis, osteomyelitis and skin infections, all of which have severe health impacts at regional and community levels. **Based on what ID and HIV clinicians see on the opioid epidemic frontlines, much more needs to be done to**

¹ Freyer F. "Uptick in HIV among injecting drug users raises fears of a resurgent epidemic. The Boston Globe. 17 Dec 2017. Available at: <https://www.bostonglobe.com/metro/2017/12/16/uptick-hiv-among-injecting-drug-users-raises-fears-resurgent-epidemic/Mrzu1glhYosSGR3mVEEiLP/story.html>

² May, L. "Nearly half of Northern Kentucky HIV infections in 2017 came from injection drug use." WCPO9 Cincinnati. 9 Jan 2018. Available at: <https://www.wcpo.com/conquering-addiction/nearly-half-of-northern-kentucky-hiv-infections-in-2017-came-from-injection-drug-use>

³ Van Hendel, MM et al. County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States. J Acquir Immune Defic Syndr. 2016 Nov 1; 73(3): 323–331.

combat this concurrent rise of devastating infectious diseases. Focus should be directed toward addressing outstanding research gaps to inform and refine service delivery, prevention, and treatment interventions.

We are increasingly concerned about this escalating crisis. Some IDSA members report up to 25% of their consultations concern patients with injection drug use complications. Barriers to effective treatment of persons with infective endocarditis and other injection-related infectious diseases include lack of coordinated care between ID or HIV experts and addiction treatment. While patients are treated for their infection, there is a high likelihood that such problems will recur without simultaneous drug rehabilitation. As injection-related infections increase, more research is needed on the potential to improve outcomes by co-locating care across a disparate system (e.g. provider training for buprenorphine, introducing methadone into different clinical settings, increasing access to medication-assisted treatment in Ryan White clinics). The integration of ID, HIV, and addiction medicine is essential to successfully addressing the opioid epidemic. Consequently, patient care facilities and federal agencies such as NIDA should consider ways to integrate their resources and spur new innovative partnerships.

Investing in Opioid-Related Treatment and Prevention Strategies for Infectious Diseases

Historically, HIV and HCV have been the primary infectious drivers of morbidity and mortality among injection drug users. Shifts in the epidemic mean that more attention should be paid to other preventable infections associated with injection drug use. Currently, there is little funding for interventions to prevent bacterial infections. Additional research funding aimed at understanding how to help patients protect themselves against bacterial injection-related infections is needed. As federal agencies increase their attention to opioid use disorders, there is a strong corresponding need to fund implementation research aimed at linking patients to evidence-based interventions such as preexposure prophylaxis (PrEP) to prevent HIV, opioid use disorder treatment, and syringe services programs to prevent viral and bacterial infectious diseases. More information is needed on how to create models that reach across medical settings to expand these interventions and integrate patient care, particularly in resource-limited areas.

We lack longitudinal data on morbidity and mortality from serious bacterial infections such as infective endocarditis. This is, in part, because there is no tracking system in place for these infections. Aside from anecdotal experiences and scattered reports documenting the increasing death tolls from these serious bacterial infections, the scope of the problem remains unknown. Along with improved disease monitoring, vital research is needed to understand best practices for this population. This is particularly relevant around transitions following hospitalization to prevent relapse while supporting treatment adherence.

As research efforts in this area progress it is critical to include affected underrepresented groups such as incarcerated individuals and rural populations. Patients in rural areas are often ineligible for funding afforded to vulnerable populations as defined under the HHS Common Rule (45 CFR part 46) due to ethnic demographics. Additionally, despite clear health disparities experienced by persons within the criminal justice system, there is a dearth of research on this population. Understanding epidemiology and current standards of care for inmates with infections is essential, especially as incarcerated populations can represent a reservoir for continued infectious spread as documented for MRSA in some communities. More attention is needed to the

processes of transitioning people with HIV and HCV from incarceration to ongoing outpatient medical care, and to ensuring access to curative treatment for HCV. We recommend that NIDA fund HIV- and HCV-focused quality improvement and/or implementation science research on concurrent opioid use disorders in these and other vulnerable populations.

IDSA and HIVMA appreciate the opportunity to provide recommendations to NIDA on the research and policy impacts of infectious diseases concomitant with opioid abuse. We welcome the opportunity to discuss our recommendations further with NIDA staff. We recognize that addressing this national emergency will require a collaborative effort by stakeholders, patients, and other federal agencies, and we stand ready to aid NIDA as it focuses efforts on this topic.

Sincerely,

A handwritten signature in black ink, appearing to read "Paul Auwaerter". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Paul G. Auwaerter, MD, MBA, FIDSA
President, IDSA

A handwritten signature in black ink, appearing to read "Melanie Thompson". The signature is cursive and elegant, with a long horizontal stroke at the end.

Melanie Thompson, MD
Chair, HIVMA Board of Directors