FEEDBACK

Dear Sirs:

In perusing your Summer, 2001 issue of the Life Line Newsletter, I read with interest the article on Base Line and Breakthrough Pain - Recognizing the Difference" by Forrest Tennant, M.D., Ph. While I basically agree with the majority of the text of the article and think it is very informative to the average lay person, I have several comments.

The first has to do with the control of break through pain. This seems to be one of the most difficult subjects for both physicians and the pain patient to understand. Being a pain referral center, I have seen many odd combinations of pain medications. One of the major mistakes I see in break through pain management is the patient who is on a daily base line medication such as a Duragesic patch and then using a short acting opioid four times a day for breakthrough. In this particular case, the dose of the baseline medication should be increased to make the daily four time breakthrough pain unnecessary. Breakthrough pain is something that I envision as happening perhaps once a day or several times a month. I don't envision breakthrough pain as something that happens multiple times per day. I think if you are having breakthrough pain multiple times per day then I think that you are dealing with a problem of inadequate baseline medication.

I am someone who absolutely does not believe in double or triple opioid therapy. Most opioid medications work in the same manner in the central nervous system by attaching to the Mu receptor in the brain. Using two or three different opioid receptors that all attach and stimulate the Mu receptor serves no useful purpose other than to complicate the situation, increase side effects, and add cost. It makes much more sense to use an increased dose of one medication rather than to use two or three different ones. If a breakthrough medication is to be used, then there should be a limited amount of the breakthrough medication and this should be used in a limited fashion throughout the month. Breaking through on a daily basis almost by definition means that your baseline medication is not doing its job. The purpose of baseline medication is to keep the pain controlled through the day so that one does not need to use multiple medications through the day. If you are using a breakthrough medication three or four times during the day, then the baseline medication is inadequate or insufficient. I think the problem is that some physicians are simply afraid to increase the dose and think that they can compensate or feel safer by adding a second medication instead of simply doubling the dose of the first medication. I think patients sometimes feel a psychological satisfaction by being on two or three pain medications than by being on an increased dose of one as in the adage that "more is better".

An example of this would be a patient who is taking Oxycontin 40mg twice a day. When this inadequately controls the pain, the patient then takes a Lortab four times a day in between time. Instead of simply increasing the Oxycontin, the doctor decides to add a Duragesic patch. When adding a Duragesic patch inadequately controls the pain, the doctor decides to add a Fentanyl Lollipop. (I am not kidding, I have actually seen this hodgepodge of medications used). A more intelligent solution to the problem would be to simply increase the Oxycontin from a 20mg twice a day to 40mg twice a day or 80mg twice a day until you obtain the dose of Oxycontin that controlled the patient's pain where he didn't need all the other medication and was using the breakthrough medication only several times per month.

The other major problem I would have with the article was in the last paragraph when it was suggested that Kadian or Oxycontin may have to be administered three of four times a day to maintain an adequate blood level. I would like to see the literature evidence on this. While Kadian has a peak effect at eight hours, it does very well at maintaining a significant dose across a twenty-four time span. Oxycontin is also a twelve-hour medication. I have patients that come in my practice taking their Oxycontin four to five times per day and I see absolutely no scientific evidence to back this up. I think there are two processes that take place when a patient takes a sustained action medication more often than it is needed. One is that the patient may be looking for a psychological improvement in their pain by taking more medications or by taking more "pills" instead of simply increasing the dose of one

pill. (After all four pills a day are better than two pills a day, right?) The other problem is that some people are simply looking for that peak effect which even sustained action medications have and looking for that peak effect simply leads to more of an addictive problem than maintaining a sustained blood level. Therefore, I think it is very important that medications that are twelve-hour sustained medications be given at twelve-hour levels in order to keep the blood level down, avoid the peak, reduce the level of addiction and tolerance, and avoid the psychological aspects of simply feeling the need to take more total pills.

My final comment would be simply to emphasize that when we use opioids we should look for a MAXIMAL EFFECTIVE DOSE. I think that searching for the maximal effective dose of an opioid is much more important than supplying an unlimited amount of breakthrough medication or allowing their patient to take their long acting opioid multiple times per day (therefore using it as a short acting opioid, in which case they should simply be using a short acting opioid) and avoid the need for multiple medications. The analogy that Dr. Tennant used of a patient with hypertension requiring multiple medications is true only after you have reached the maximum dose of one medication. For instance, you wouldn't put someone on half a dose of hypertensive medication and quit and then go to a second medication. It would make much more sense to go to the maximum dose of one medication before you stopped and started a new medication.

Opioids are very important medication for the control of chronic pain. However, it is important that we use intelligence and common sense when we search for the maximal effective dose of whatever long acting opioid we are going to use along with searching for the dose that will allow the patient to require the least amount of breakthrough medication. After all, that is the purpose of placing someone on a baseline medication. If someone is on a baseline medication that does not control breakthrough pain on a daily basis or has to be taken multiple times per day, it really defeats the purpose of using a long acting opioid as a baseline medication. The index of whether a baseline medication is working is that the patient does not feel much of a need for frequent use of breakthrough medication.

Finally, I do think that Lifeline newsletter does provide a service to chronic pain patients. The more education pain patients have the more they are able to deal with their pain and the easier they will be able to work with the medical society through which they must obtain their medication.

Sincerely,

Randall L. Oliver, M.D.P.C

Dr. Oliver has been a member of NCPOA since 1992 and runs the Oliver Headache and Pain Clinic in Evansville, IN.

HELPING PEOPLE COPE WHEN PAIN WON'T GO AWAY SPRING 2002

Lifeline

THE NEWSLETTER OF THE NATIONAL CHRONIC PAIN OUTREACH ASSOCIATION, INC.

OXYCONTIN®: THE "OXYCONTROVERSY"

By David Lamborne, Board Member: NCPOA