

Michael Saulino, MD, PhD, Rebutts

Dr Schreiber eloquently describes the historical and current status of opioid use in the United States. His narrative of the societal pressures involved with COT is well grounded. All practitioners, including psychiatrists, must consider the larger community context of their treatment decisions. On this basis, there is no disagreement about the need for caution in approaching COT.

My colleague then poignantly outlines the potential disadvantages of using COT in the proposed patient. He comments about the potential requirement for lifetime treatment and the concomitant financial burden. Although this account is not incorrect, is it all that different from other treatments for chronic pain specifically and for all chronic diseases in general? As with nearly every other medication therapy, a nongeneric, more costly formulation is the initial foray of a particular product, which is nearly uniformly followed by a less-expensive generic formulation. Although longacting oxycodone products have been the subject of considerable legal debate over the branded status of OxyContin, it is reasonable to anticipate that, at some point, a less-expensive alternative will be available [1]. Consideration of the financial implications of any medical decision is appropriate, but to eliminate an entire class of medications exclusively on the basis of cost is unduly restrictive. It also would be an entirely reasonable approach to consider less-expensive, long-acting opiates in this hypothetical patient.

Dr Schreiber then describes potential adverse effects of COT. He specifically mentions “cognitive difficulties, apathy, depression, and fatigue.” The proposed patient scenario does not specifically detail these signs and symptoms. Thus, it is challenging to deny access to COT based on this argument. In addition, the presence of this constellation of findings should not be uniformly attributed to adverse effects related to COT. It is well recognized that many patients with chronic pain may demonstrate these exact observations [2].

My counterpart ably depicts a multimodality approach to the patient with chronic axial low back pain. His portrayal of various aspects of treatment is appropriately delineated. It also is quite similar to my own proposals outlined in the opening narrative. In no way was support being put toward an approach that COT would be the totality of the patient’s interventions, Rather, COT would be a reasonable component of a more comprehensive approach.

Also, Dr Schreiber reports that this treatment approach will require “a commitment from the physician to the patient and from the patient to the physician” and “he will need to see his physician regularly.” What a stunningly radical concept that the patient and physician should be engaged in collaborative decision making on a consistent basis. Is it not entirely reasonable to expect a patient with a chronic and complex disease to have regular follow-up with a medical provider? Is it not similarly reasonable for that provider to continually assess the ongoing need for pharmacotherapy, including recurrent consideration of risks, benefits, advantages, disadvantages, and alternatives? Don’t practitioners in other specialties use a similar approach in management of chronic disease states such as hypertension, diabetes, and asthma? Don’t these same physicians titrate, wean, modify, and rotate pharmacotherapy based on therapeutic responses, adverse effects, payer coverage, and out-of-pocket costs? To uniformly eliminate COT from consideration in the management of chronic pain is excessively restrictive. Although there are unique concerns in COT, which both Dr Schreiber and I describe in parallel, these issues are insufficient to exclude this treatment approach to the proposed patient.

REFERENCES

1. Young D. FDA approves generic OxyContin. *Am J Health Syst Pharm* 2004;61:882-886.
2. Fine PG. Long-term consequences of chronic pain: Mounting evidence for pain as a neurological disease and parallels with other chronic disease states. *Pain Med* 2011;12:996-1004.

Adam Schreiber, DO, Rebutts

With all due respect to Dr Saulino, his approach is naïve and oversimplified. He assumes where history is lacking in the described patient, the best is in him. This is the instinctual to a physician; being a patient sympathizer and advocate. With chronic pain, we cannot default to this natural instinct which has fed the opioid epidemic, which was caused by physicians and pharmaceutical companies in the 1990s and still endures. As physicians, we assume that our training and

experience are a reliable foundation to allow us to sense which patients are taking medications appropriately, but Turk et al revealed that clinician intuition and observation are unreliable.¹ This is further evidenced by a prospective survey of prescription drug abusers entering a treatment facility that found the most commonly abused drugs were hydrocodone- (78%) and oxycodone-(69%) containing formulations. 84% of these victims of the epidemic received prescribed opioids for pain at some point.²

Dr. Saulino mentions tools such as Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R), Opioid Risk Tool (ORT), and DIRE (Diagnosis, Intractability, Risk and Efficacy). He concludes their “validity, reliability, sensitivity and predicative value of these tools is considered fair to good.” Alas, these small studies are not validated by large studies and are predominately academic tools that are not the standard of care.

The opioid epidemic is far more complex, therefore the DEA and individual states are scrambling to better control this problem that has spread into our society to a greater degree than other countries. Dr Saulino and others who share his views must open their eyes to what our government already knows, despite published guidelines from the American Pain Society and American Academy of Pain Medicine, that opioid use is out of control, spilling out into US streets, emergency departments, and morgues.

This scenario leaves the clinician in a conundrum, usage of neither empiric evidence nor published guidelines are effective or there would be no epidemic. We must help this patient and help prevent others from becoming victims. Limiting opioid use must be initiated by physicians, as the pharmaceutical industry continues to produce new opioids or delivery systems. This industry growth is attributable to the continued large market available to consume these new medications despite them being abused at a rate that calls for national attention.

Despite Dr Saulino’s articulate argument, the continued oxycodone prescription without further intervention is irresponsible to this patient and our society.

¹ Turk DC, Swanson KS, Gatchel RJ. Predicting opioid misuse by chronic pain patients: a systematic review and literature synthesis. *Clin J Pain* 2008;24:497-508.

² Passik SD, Hays L, Eisner N, et al: Psychiatric and pain characteristics of prescription drug abusers entering drug rehabilitation. *J Pain Palliat Care Pharmacother* 2006;20:5–13.