

MEDIA COVERAGE OF OXYCONTIN IS ONE-SIDED

A statement from the Canadian Pain Society

For Immediate release

Toronto, Ontario - August 19, 2004 -- The president and the president-elect of the Canadian Pain Society have released a statement on behalf of the Society expressing their concern about the recent media coverage on the abuse of prescription opioid analgesics (pain medications). Doctors Gary Rollman and Roman Jovey were specifically referring to the recent media depiction of the misuse of one type of controlled-release opioid medication called Oxycontin.

"We believe that some of the reporting has been frankly inaccurate - such as confusing "oxycodone" with Oxycontin - and rather one-sided. The stories have focused mainly on the harm resulting when a relatively small group of people in our society choose to take big risks by using prescribed painkillers to get a high. Some unfortunate people across the country have died as a result of this choice.

Most of these stories have failed to mention that the vast majority of people, who use these medications properly, greatly benefit from reduced pain. As a result of this recent media coverage, all Canadians who take opioid analgesics to treat chronic pain have been stigmatized and made to feel like they might be doing something wrong. Many have been worried that the bad publicity might scare their doctors into stopping their pain-relieving medications.

Opioid analgesics, when prescribed appropriately and taken correctly provide valuable relief of pain. Provincial, national and international guidelines for managing chronic pain support the use of long-term opioid therapy as a legitimate medical treatment in appropriately selected patients. Patients with moderate to severe pain from injuries, cancer or other medical conditions should not be denied medications that can provide needed relief, nor should they feel afraid or ashamed to take the medication they need because these legitimate products have become stigmatized as "drugs of abuse."

The Canadian Pain Society does not in any way sanction the inappropriate prescribing or misuse of opioid analgesics. Physicians who prescribe opioids for pain need to carefully assess and monitor patients to minimize, as much as possible, the risk of misuse. Currently, the best method available for assessing both addiction risk and pain severity is still the patient's self-report. Therefore physicians should not be blamed for the willful attempt on the part of patients to obtain opioids for illicit purposes. Regulatory measures that attempt to control the diversion and misuse of prescribed opioids should not do so at the cost of inadequate treatment of pain."

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A Summary and Explanation of Key Points from the Canadian Pain Society Guidelines:

To provide the media and the public with a more balanced and in depth view of the issues involved, the Canadian Pain Society would like to provide the following reference to its published statement: **"Use of opioid analgesics for the treatment of chronic non-cancer pain - A consensus statement and guidelines from the Canadian Pain Society, 2002"**. The full version of this document is available online at: <http://www.canadianpainsociety.ca/formulaires/opioid.pdf>

In 1998 and again in 2002, a number of Canadian pain experts worked together to create a set of guidelines for doctors who wished to treat their patients with chronic pain safely using opioid analgesics. The following 10 points summarize the key issues discussed in the guidelines:

1. Pain of all types is undertreated in our society - from the newborn baby circumcised without using any analgesic; to the middle-aged man, disabled by severe ongoing back pain; to the elderly woman with a broken hip, moaning in pain while she waits in the Emergency Department for her turn in the operating room. Doctors and nurses are reluctant to treat pain adequately with opioids because of fears that they will create iatrogenic (medically-caused) opioid addiction, or contribute to the diversion and misuse of prescription opioids on the street. Many physicians are fearful of being labeled as "bad doctors," or worse, losing their license to practice their livelihood.
2. Chronic non-cancer pain (CNCP) is generally defined as pain which has been present for at least six months - or lasting longer than expected for the damaged or diseased tissues to heal. CNCP is not just a symptom of some other disease. It is a physical and chemical "rewiring" of the body's pain detection system.
3. Patients with chronic pain may have physical, psychological, social and/or behavioural contributors to their suffering. (Suffering refers to the impact of pain on a patient's quality of life.) Therefore, patients with chronic pain require a thorough assessment before deciding on treatment.
4. Many different treatments exist for CNCP, including physical, psychological, medicinal and surgical. Whenever possible, curing the underlying reason for the pain is always the first choice. For example, taking out an infected appendix is preferred to treating the pain with medication. When cure is not possible and the patient's pain has not responded to usual treatments, then it is quite appropriate to try long term opioid treatment.
5. Most patients who take opioids regularly for pain will develop physical dependence. If they stop their medication suddenly, they will experience a number of unpleasant symptoms called "withdrawal." These symptoms are similar to a severe influenza type illness and usually diminish within 1-2 weeks. Some patients taking opioids for pain develop analgesic tolerance - a need to increase the dose of medication to maintain the pain-relieving effect. A patient can have both physical dependence and tolerance and still not be addicted to opioids. Addiction is a biopsychosocial disorder defined by the repeated use of a substance and preoccupation with

obtaining it, despite evidence that its continued use results in physical, emotional, social or economic harm. A patient with a past history of addiction who has a legitimate source of severe pain should not be denied the use of opioid therapy; however assessment and monitoring of such a patient needs to be done very carefully.

6. Opioid analgesics are physically very safe medications when prescribed with appropriate monitoring. Unlike other pain medications, such as acetaminophen or anti-inflammatory drugs (NSAIDs), opioids used properly, do not cause stomach, kidney or liver damage nor increase blood pressure.

7. In all types of pain, opioids work best when dosed to effect, or to the point of persistent and unacceptable side effects. Each person has a unique dosage requirement. In persons suffering with pain around the clock, opioids should be dosed around-the-clock on a regularly scheduled basis, rather than be taken intermittently as required. With appropriate dosage adjustment (called titration) and regularly scheduled dosing, people usually adjust to most of the side effects of opioid therapy, including drowsiness. The use of a controlled release oral opioid analgesic, which lasts for 8-12 hours or an opioid skin patch which lasts for 48-72 hours can allow for better patient compliance, more stable blood levels of opioid and more stable control of pain.

8. The goal of long term opioid therapy for people in pain is improved quality of life. This improvement should include a significant decrease in pain severity, and ideally, an improvement in the person's physical, psychological, social and occupational functioning. People on long-term opioids need to be reassessed regularly to ensure treatment is doing more good than harm. People who demonstrate repeated episodes of drug misuse behaviours or whose function declines as a result of opioid therapy need careful reassessment of their treatment plan. In some cases it may be appropriate to taper completely off of opioid therapy and reassess the baseline pain.

9. Opioid therapy in CNCP generally works best when combined with other treatments such as non-opioid pain medications, physical rehabilitation and/or psychological treatments.

10. Adequate medical records are essential to assess the quality of care provided by a doctor to a patient. In a patient on opioids for pain, it is necessary to document the benefits as well as the lack of serious harm from long-term opioid therapy. In addition, documentation is required to demonstrate compliance with federal controlled substance legislation.

*Another source of information regarding the misuse of pain medication, is the recently available American document: "**Prescription Pain Medications – Frequently asked questions and answers for health care professional and law enforcement personnel**," published by the Drug Enforcement Agency of the U.S. Department of Justice, available online at: http://www.deadiversion.usdoj.gov/faq/pain_meds_faqs.pdf*