WRITTEN TESTIMONY
Committee on Health, Education, Labor and Pensions
"Oxycontin: Balancing Risks and Benefits"

Russell K. Portenoy M.D.

Chairman
Department of Pain Medicine
and Palliative Care
Beth Israel Medical Center
New York, N.Y.

I am grateful for this opportunity to contribute these comments to the Committee. I have extensive background in the area of pain management and opioid pharmacology. I am Chairman of the Department of Pain Medicine and Palliative Care at the Beth Israel Medical Center in New York City and Professor of Neurology at the Albert Einstein College of Medicine. I am a Past President of the American Pain Society, current Secretary of the International Association for the Study of Pain, a Director of the American Pain Foundation and the National Hospice Foundation, and Vice-Chairman of the American Board of Hospice and Palliative Medicine. For almost two decades, I have specialized in the treatment of patients with chronic pain and have been an educator and clinical investigator in the areas of pain and opioid pharmacology. I have had a particular interest in exploring the relationship between pain management and chemical dependency, and have helped organize four international conferences devoted to this topic.

My testimony is focused on the medical use and abuse of Oxycontin and is based on my experience as a clinician and my knowledge of pain medicine and opioid therapy. As disclosure, I will state that I have accepted honoraria for participating in educational symposia sponsored by several corporations that manufacture opioid drugs, including Purdue Pharma, and that my department has received grants from these companies for projects involving professional education and research.

Before September 11, media attention on Oxycontin abuse was intensifying. Frightening statistics concerning abuse, and the poignant stories of people whose lives have been damaged by addiction to Oxycontin, have justifiably raised concerns about the dangers associated with this drug. Some are now questioning the wisdom of continuing business as usual in providing access to Oxycontin, and perhaps to other potentially abusable drugs with legitimate medical purposes.

At the same time, however, the stories of abuse and addiction, and the potential for increased regulation of opioid drugs, have raised intense worries among pain specialists and patient advocates, who fear that over-regulation, ill-conceived enforcement policies, and worsening social stigma will lead to more undertreatment of pain, and hence more suffering for the millions of people with painful disorders.

The latter fear—that the unintended effects of regulation could hurt patients--was forcefully illustrated to me by two recent personal experiences. First I learned that a family member who requires long-term opioid therapy for a serious pain problem was told by her pharmacist that he would not dispense her medication any longer because he did not want to have patients who received such drugs on a regular basis. Soon thereafter, three of five patients I was seeing during one treatment session spontaneously expressed great fear that the government would "take away" their Oxycontin, causing them to return to states of unrelieved pain and severe disability. The government's response to Oxycontin abuse affects patients, and their interests must be considered.

Status of Opioid Therapy in the United States

To frame this issue, it is informative to review the history of opioid therapy during the past two decades. Since the 1980's, there has been a worldwide clinical consensus that opioid drugs should be the first-line treatment approach for severe acute pain and moderate to severe chronic cancer pain. Despite this consensus, numerous studies of cancer pain have demonstrated that opioid use often does not conform to published guidelines. The problem of undertreatment is complex, but it is certainly due, at least in part, to physician limitations, including inadequate knowledge of prescribing principles, an unrealistic fear of addiction and side effects, and concerns about regulatory scrutiny.

This last issue—fear of the government's reaction to the medical use of opioids—is very real and should be emphasized in this context. A 1998 survey of more than 1300 New York State physicians, for example, revealed that more than half were moderately to very concerned about regulatory oversight and that one-quarter to one-half admitted to changing their prescribing practices solely because of such concerns.

Despite persistent undertreatment, cancer patients did begin to benefit from pain treatment advances and clinician education in the 1980's. The release on the U.S. market of long-acting opioid drugs, the first of which was a morphine formulation developed by Purdue Pharma called MS Contin, was a significant advance in treatment. Purdue Pharma followed the launch of this drug with an extensive educational program, which was focused on the problem of cancer pain and sought to improve acceptance of opioid therapy by providing information and dispelling deeply held myths and misconceptions about these drugs. The later release on the market of other long-acting opioids was accompanied by similar marketing and educational strategies.

As opioid use for cancer pain was being encouraged, pain specialists began a major shift in thinking about the role of these drugs for noncancer pain. After more than a decade of debate, a 1997 consensus statement jointly issued by the American Pain Society and the American Academy of Pain Medicine rejected the traditional negative view of this therapy and acknowledged that long-term opioid administration was clearly beneficial for selected patients with chronic pain. A similar consensus statement followed from the American Society of Addiction Medicine. In response to this changing perspective, and the ongoing problem of undertreatment, the regulatory community and many state

legislatures have tried to reassure clinicians that the legitimate use of opioids will not place them at risk of investigation or sanction.

Most pain specialists now recognize that opioids are no panacea for chronic noncancer pain, but are nonetheless probably greatly underused in the management of painful disease. Given the extraordinary prevalence of chronic pain, which is estimated to affect at least 50 million people in the U.S. alone, pain specialists generally also believe that primary care physicians must become skilled in the administration of opioids, and comfortable with the approach, if there is to be any hope that the benefits associated with these drugs can be brought to those who are appropriate to receive them.

Pain specialists and other physicians also recognize that the opioids are potentially abusable drugs. They may be diverted to illicit use, and patients who are predisposed to addiction may get into trouble when administered one of these drugs for a legitimate medical purpose. In this context, it is important to recognize that the word "addiction" refers to a disease characterized by loss of control over the drug, compulsive use, and use despite harm. This disease, which has a strong genetic predisposition, can be activated by many types of medicine, including opioids. When prescribing any potentially abusable drug, the physicians has an obligation to select patients carefully, monitor drug-related behaviors, and control the therapy. This is particularly important in patients with a history of chemical dependency, and in those who may be predisposed to develop addiction.

Perspectives on Oxycontin Abuse and Addiction

The active ingredient in Oxycontin, the opioid oxycodone, has been commercially available for decades. Oxycontin provides a convenient long-acting delivery system for a drug that is commonly administered in many short-acting proprietary and generic formulations. There is no scientific evidence that oxycodone causes abuse or true addiction at any greater rate than any other opioid in its class. From the medical perspective, however, there is good evidence that individual patients vary greatly in their responses to different opioids, and that some patients have a much better outcome when given oxycodone than other opioid drugs. Experience with Oxycontin among pain specialists has confirmed that it is a convenient formulation that provides extraordinary benefit for some patients, and is less preferred by others.

When Purdue Pharma was developing Oxycontin, it opted to study the drug in populations with chronic noncancer pain, including those with arthritis pain and low back pain. The studies were positive. After the drug's launch, the company chose to market it to nonspecialists, and were permitted to do so based on the data from these studies. Their marketing, and the educational program they pursued in the primary care community, was very similar in style to the strategy that they and other companies pursued in trying to improve the management of cancer pain. It focused on benefits of pain control and the problem of undertreatment, taught the principles of opioid therapy, and tried to dispel the myths and misconceptions that stigmatize opioids and are barriers to appropriate opioid

prescribing. This educational program did not strongly address the potential liabilities of abuse and addiction.

Presumably, the combination of marketing and education in the primary care community, combined with an enormous unmet need among patients, led to a rapid increase in Oxycontin prescribing. As sales increased, pockets of serious abuse began to occur, particularly in populations with known histories of abuse or addiction.

The reports indicate that most abuse and addiction occurred among those with known histories of chemical dependency. Undoubtedly, however, some abuse and addiction occurred among those who had not experimented much with opioid drugs before, but were predisposed to develop problems and were given Oxycontin for pain by a well-intentioned physician. For these individuals, Oxycontin was a "gateway" drug to serious abuse.

There is no evidence that the amount of abuse by known abusers, or the amount of "gateway" use, has been more than would be expected with any opioid that had a similarly rapid increase in medical use over a short time. It is also impossible to know whether the media attention on the drug is partly responsible for spread of abuse.

Having said this, however, it also is a reasonable presumption that the Oxycontin problem is greater than would have occurred if the marketing to clinicians had focused more on the potential liabilities of therapy, including the potential for abuse and addiction. The problem is presumably greater than would have occurred if the makers of Oxycontin, the makers of other opioids, and professional medical societies had been providing educational programs for physicians that had included more about the management of addictive disease.

A Balanced Approach to Solutions

The approach to opioid drugs with legitimate medical purposes must derive from three perspectives. First, we should all recognize that access to opioid therapy is essential for millions of patients with acute and chronic pain. In this regard, we should all acknowledge that the epidemic of undertreated pain is a huge public health problem, that opioid drugs can be safe and effective but are medically underused, and that the underuse of opioid drugs is partly determined by stigma associated with addiction and by physician fear of regulatory oversight.

Second, we should all agree that decisions concerning the regulation of opioid drugs should be based on the available scientific information and be informed by accumulated clinical experience. Policy should not be driven by anecdote or fear.

Third, we should all acknowledge that the potential for abuse and addiction is a liability associated with these drugs and that both clinicians and those in government have a common interest in minimizing these negative outcomes while ensuring appropriate medical use. In this regard, the problem of Oxycontin abuse has been something of a "wake-up call" for those of us who believe that opioid therapy should be expanded and

that the primary care community must take on this therapy to meet the needs of patients. It is now clear that physicians who wish to help patients by providing long-term opioid therapy must have the knowledge and skills to both optimize benefit and minimize risk.

These perspectives must be considered in discussing the government's response to the problem of Oxycontin abuse. What would a reasonable response be? We must first avoid extreme reactions that could have unintended negative consequences. Of course, actions that would limit access to Oxycontin also would probably lessen its abuse. The great concern, however, is that regulatory or law enforcement initiatives intended to reduce diversion and abuse may have the unintended effect of reducing the availability for patients who are truly in need. The clinical community already undertreats, in part, because of fear of the regulators. Any extreme response to Oxycontin abuse, such as eliminating prescribing by nonspecialists or removing the drug from retail pharmacies, would do more than directly damage the large number of patients now benefiting from Oxycontin. It would have a "chilling effect" on prescribing overall and increase the fear of these drugs among prospective patients and the public. The overall result would be more undertreatment.

The government must not interpret less prescribing as equal to less abuse. For example, eliminating Oxycontin from state medical programs for the indigent might lessen prescribing, but where is the evidence that this directly addresses the problem of abuse or addiction? This type of action is not justified without such evidence.

At the same time, we do need to be circumspect about the marketing of opioid drugs to the primary care community. Marketing must be done in tandem with education and support. We are not yet ready for direct marketing of opioids to the public.

We need to encourage an ongoing dialogue between clinicians and those in the regulatory and law enforcement communities. To their credit, the DEA and the FDA are already reaching out to the clinical community. The DEA should be particularly commended for joining with a large number of professional medical societies, including the American Medical Association and the American Pain Society, in signing on to a consensus statement supporting the concept of a balanced approach to opioid drugs. This type of collaboration should be duplicated by law enforcement and regulators in every state, particularly those affected by a high level of Oxycontin abuse. It will help ensure that no action is taken without a careful review of the potential impact on the problem of undertreated pain.

We need the government to encourage improved education for prescribers and pharmacists. Education should be pursued through partnerships among professional societies, industry, and government agencies.

We also need the government to support research related to many aspects of pain and chemical dependency. This is the Decade of Pain Control and Research, but research in pain is still woefully underfunded. We need studies to define the risk of abuse and addiction, determine the relative impact of many factors that could be contributing to

these outcomes, and investigate various interventions to reduce abuse without adverse effects on pain management. If new laws or regulations are pursued, they should be accompanied by ongoing study of their effects on pain patients.

Finally, the treatment available for patients with addictive disease is inadequate. The current drug abuse treatment community needs support to develop models and novel therapies that can address the problem of opioid abuse in patients with acute and chronic pain.