

Pain Relief Connection

The Pain Information Newsletter

Provided by MGH Cares About Pain Relief



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Clinical Focus:

Q & A: How can different answers both be correct?

Q: “In the nursing orientation manual, there is information on prescribing breakthrough medication for a patient who is on around the clock pain medication. The ratio for the breakthrough is listed as 15-20% of the total daily pain medication, controlling for equianalgesia. Is this ratio correct? The scenario is a patient who receives 40mg TID OxyContin® (extended release oxycodone) who was then prescribed 15mg oxycodone PRN for breakthrough pain. Shouldn't the answer be 20mg oxycodone given that it comes in 5mg and 10 mg tabs? Or better yet, 18-24 mg using liquid oxycodone?”

A: It's a good question and one that commonly causes confusion, because we'd all rather have a cut and dried "right" answer. Many clinicians will default to the lowest dose that rounding (to available tablet sizes) will support, while others default to the higher. At 15 mg this patient would need to take 3 tablets of 5 mg each, vs. 2 of the 10mg tabs. The pill count can be a factor for some patients and the cost per tablet can also be taken into consideration. The patient's history and current anticipated pain pattern may guide a decision in either direction, but I suspect there was nothing in the scenario to provide that guidance. So you're both right. The 2-3 mg of precision that you gain by using a liquid probably is clinically unimportant at this dose. Liquids are great for people in whom it is difficult to titrate because they have a narrow range of efficacy vs. unacceptable side effects, but that usually only occurs at doses less than 10 mg of oxycodone.

By the way, equianalgesia is not a factor in this case since we are not switching drugs or routes.

Q: “During the Pain Relief Champions course in April one of the faculty said that you shouldn't combine opioids, while another said that sometimes you can. Who's right?”

A: The conventional wisdom, based on theory and lots of clinical experience, is that mixing opioids is either pointless or harmful, depending on the situation. You should certainly not combine opioid agonists with mixed agonist-antagonist opioids. The most common opioid agonists (morphine, oxycodone, hydromorphone, etc.) bind to the mu opioid receptor. The mixed agonist-antagonist pentazocine (Talwin®) binds at the kappa receptor and blocks the mu receptor. Giving Talwin to a patient who has been on morphine for several days could precipitate withdrawal and certainly pain.

It seems pointless to give 2 different mu receptor opioid agonists, because they both occupy the same kind of receptors. A typical reason heard for combining opioids is that the first one wasn't effective. Almost certainly the real issue is that the dose is too low. For simplicity then, you should stick to the same opioid and titrate to effect. Of course, if your patient is using a fentanyl patch, a different opioid is going to be necessary for breakthrough pain.

That's the conventional wisdom, and it works for the vast majority of patients. On the other hand, there is also theory and some anecdotal reports to support the concurrent use of 2 mu opioids in certain subsets of patients with chronic pain. The NMDA receptor has been implicated in the development and maintenance of chronic

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neuropathic pain. Propoxyphene (Darvon®) and especially methadone (both mu opioids) exhibit NMDA receptor antagonism. Small doses of either of these combined with a conventional mu opioid have been reported to have improved efficacy vs. the conventional opioid alone. There have also been anecdotal reports that two pure mu opioids, such as oxycodone and hydromorphone, have appeared to work better in combination than alone. Defining the subset of patients for whom this combination may be appropriate has not even begun. However, it is known that there is great heterogeneity among mu receptors, a possible explanation for the phenomenon.

Unless you're a specialist in pain management, stick with the conventional wisdom until there is stronger evidence to support combining opioids, especially pure mu opioids. But be open to the notion that incremental increases in knowledge could one day result in changing the conventional wisdom.

In the News

Education for Physicians on End-of-Life Care ([EPEC](#)) has recently launched a geriatrics adaptation of the EPEC training program entitled, "EPEC-G: Educating Provides in End of Life Care in Geriatrics." These modules are designed to supplement existing modules in the EPEC Curriculum. The original pain module (text and PowerPoint) is available in the EPEC web site. For more information, please send e-mail to info@epc.net.

JCAHO and the National Pharmaceutical Council have jointly produced 2 excellent new [monographs](#): *Pain: Current Understanding of Assessment, Management and Treatments*; and *Improving the Quality of Pain Management Through Measurement and Action*.

Medication Safety Notes

The [Institute for Safe Medication Practices](#) (ISMP) has for 25 years promoted safe practice by pharmacists, physicians, nurses and patients. ISMP recently launched a free (through 2003) monthly e-mail [newsletter](#) for nurses. Among the many analgesic topics covered in previous issues of the older [ISMP Medication Safety Alert](#) are discussions about PCA by proxy and clarity in ordering medications.

- "PCA by proxy" occurs when a person other than the patient pushes the button to deliver a dose—so it isn't actually patient-controlled analgesia. When clear policies and teaching are not in place, this practice has lead to unintentional overdose and even death.
- When orders are written only in terms of volume for drugs that have multiple available concentrations, errors will inevitably occur. Ditto when ordering tablets (e.g., Percocet) that come in multiple strengths.

Pain Education on the Web

["The Cost of Pain"](#) is a new approved continuing education offering for physicians, physician assistants, pharmacists, and nurses. Despite the implications of the title, it is not all about economics and gives a good overview of pain management.

Journal Watch

A review article on the diagnostic dilemma of "Acute Abdominal Pain in Children" appears in the most recent issue of [American Family Physician](#) (June 1, 2003;67(11):2321-2326). The [American Academy of Family Physicians](#) provides free full text access to *AFP*. Full text articles are also available free through [Magic](#) on MGH network computers.

URL notes: **Hold your cursor over the link for a second to see the URL.** If you are reading this in hard copy, this month's links are:
Past issues of *Pain Relief Connection*: http://www.massgeneral.org/painrelief/Newsletter/mghpain_connection.htm
Education for Physicians on End-of-Life Care (EPEC): <http://www.epc.net>
JCAHO Pain Monographs: <http://www.jcaho.org/news+room/health+care+issues/pm+monographs.htm>
Institute for Safe Medication Practices (ISMP): <http://www.ismp.org>
ISMP Nursing Newsletter: <http://www.ismp.org/NursingArticles/index.htm>
ISMP Medication Safety Alert: <http://www.ismp.org/MSAarticles/msa.html>
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