

May 18, 2001

David Haddox, M.D.  
Purdue Pharma L.P.  
1 Stamford  
Stamford, Connecticut 06901

**Re:** OxyContin 160 mg tablets.

Dear Dr. Haddox:

I am an attending physician in a multidisciplinary pain practice in Columbus, Ohio. We have patients from almost every state east of the Mississippi; and in terms of patient volume, we may be the largest practice in this area of the country. We have built and will soon move into a brand new free-standing pain center with state of the art technology, operative suite, full-service radiology suite, physical therapy, rehab, psychology, electrophysiologic testing, etc.

It is my understanding that Purdue is working with various law enforcement agencies in an attempt to reduce the abuse and diversion of OxyContin. This is, of course, admirable and we applaud the concept but not the vehicle.

I should also mention that I hold the commission as a Deputy Sheriff in the state of Ohio and have served 20 years on the road as a deputy in my spare time. I have also served as a squad leader on an interagency SWAT team and have, therefore, perhaps a better grasp of the problems in the abuse and diversion of OxyContin.

I have been informed that a proposed solution to reduce the abuse of OxyContin is to remove the 160 mg tablets from this region of the country. I am not, of course, privileged to all the conversations or decision making processes that have occurred, but I would like to state that I feel this defies logic. In the sense that some of our patients may be diverting medications to the street and yet at the same time have coexisting painful disease, if we limit the number of pills they have, they cannot share them. If I have them on a 160 mg twice a day they only get two pills a day to work with. They can choose, to either divert that or take it. If, however, I am forced to give them 80 mg tablets, this gives them four pills a day, they can take two and divert two and still have pain coverage.

May 18, 2001

Page 2

**Re:** OxyContin 160 mg tablets

I should state at this point also that we confirm the existence of painful disease before we prescribe to any patient. This validation comes in the form of two electrophysiologic studies, the somatosensory-evoked potential and the selective tissue conductance studies. If they turn up negative on both of these studies, we do not prescribe schedule II or III medications to them. The mere presence of a pathologic condition does not imply that it is necessarily a painful pathologic condition (NEJM 14 July, 1994). Therefore, any of our patients on narcotics have these confirmative diagnostic electrophysiologic studies validating their pain. This immediately eliminates the pure “gamers” or “drug seekers” from narcotics as they will have “normal” test results.

This means that even our patients who may be diverting drug have confirmed painful disorders. We believe that most our patients have legitimate painful pathology but recognize that there will be some who will divert part or all of their prescribed narcotics. If we humanely but unknowingly prescribe to such patients because we believe that they have pain and have done our best to confirm this and limit them to 160 mg tablets this therefore forces them to choose between their own pain relief and their street income. They will not have both if they are on 160 mg tablets (assuming that they fit it in that milligram dosing category).

Therefore, I must say that I object to this selective distribution policy as ill advised and misdirected while I support enforcement efforts, and in fact I am currently working with four separate law enforcement groups in three states to help quell the abuse of this invaluable pain medication, I must say that I do not support withholding 160 mg tablets from this region of the country.

I do propose an alternative for you. Our organization is very keen on giving patients adequate pain relief yet being responsible to the rest of society and doing what we can to prevent misdirection of this very potent narcotic analgesic. We have in place several methods to crosscheck the validity of patients’ complaints and their handling of the medications we prescribe. We have in place several security measures that crosscheck patients’ behavior and would be more than happy to share them with you if you are interested in this practitioner educational process. Patients who divert medications have certain behavioral patterns that can be frequently exposed with diligence toward “red flag” information. When such behavior occurs the patient can be transitioned off opioids in a kinder and gentler fashion than merely dropped off their opioids. We also improve patient compliance and decrease medication misuse and misunderstanding through our mandatory Treatment Adherence Training class for our patients.

It is by this physician practice vigilance that, I believe, we could better affect the supply rather than increase the quantity of the drug available for diversion i.e. the number of tablets (160 mg equals two 80 mg tablets). Better physician monitoring capabilities

May 18, 2001  
Page 3

**Re:** OxyContin 160 mg tablets

through simple cross reference techniques would go a lot further to secure legitimate use of the medication and help reduce diversion. We consider this a responsibility that is part and parcel of the prescribing practice.

If I can be of further assistance to you please contact me.

Sincerely,

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