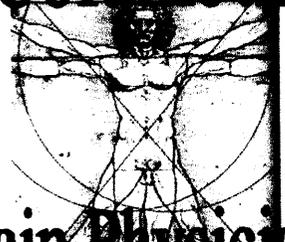


# Columbus



## Pain Physicians

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6/7/01

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Regarding Oxycontin and the upcoming meeting on the abuse of the drug:

I am a pain management physician utilizing multiple modalities of pain treatment, one of which is narcotics. It may be beneficial to see the problems associated with Oxycontin from a practicing pain physician standpoint. In November 2000, we began having several pain patients appear in the emergency department of our hospital in a community of 40,000 located 45 min from Indianapolis. Although we had experienced isolated cases of Oxycontin overdose and even one death previously associated with the drug, the rash of patients being seen stuporous, comatose, and in overt respiratory depression became alarming. These patients were overtly abusing the drug and were discharged from the pain practice immediately since they were taking far in excess of what was prescribed. Most were prescribed 80-240mg per day for chronic non-malignant pain. TID dosing is used in approximately half the patients since even by Purdue Fredericks data, the blood levels are reduced by ½ over the first 12 hours (log scale on the ordinate axis in the PDR). These patients were taking 3-5 times as much. Some were cutting the drug, some were pulverizing it, some were injecting it IV, but most were simply taking more than prescribed. It was discovered some were simultaneously being treated at other pain centers and since we have no centralized prescription tracking in our state, it was not possible to obtain this information. The abuses we were seeing were almost uniquely due to Oxycontin.

In early December, I performed a lit search on the drug and found it was being widely abused across the country. I spoke at a medical executive meeting at our hospital regarding this abuse, subsequently in early January 2001 gave a CME for all local physicians and pharmacists regarding the abuse potential of the drug. We continued to have overdoses and the drug began appearing on local school grounds. After soul searching, I put out a community wide alert on the drug, contacted the local newspapers, and withdrew approximately 95% of all patients taking Oxycontin from the drug converting them to methadone, MS Contin, and Duragesic patches. We had a rash of

patients then discharged from the practice for becoming hostile and we subsequently found out through the police these patients had been selling the drug. When they were discharged from the pain practice, threats were made against me, including death threats. Restraining orders were obtained. Local pharmacies became very cooperative and when patients were discovered obtaining narcotics from multiple providers, they too were discharged since we have very rigid rules regarding narcotic prescribing that the patient must acknowledge by signature on entering the pain practice that they have read and understand.

Since that time, the pain practice has become enormously different, with far less hassle from those abusing drugs (by the criteria adopted by the modification of the DSM-IV by the American Society of Addiction Medicine). I contacted Purdue Frederick with an official proposal to conduct a scientific study looking at healthy volunteers who would be given Oxycontin in its prescribed form (control group) and in a crushed form (study group) with measurement of blood levels, respiratory depression measures, etc. The company declined stating they have internal data on such already and do not wish to repeat the study. Of course this data is not available anywhere on the net or on medline, so it is being kept secretive for obvious reasons.

I have taken steps by writing to our state senate and house to strengthen drug laws making Oxycontin sale equivalent to that of heroin in penalties. They have declined thus far to address the issue. I have contacted the state pharmacy board to strengthen the narcotic tracking which is currently only done state wide on schedule III drugs by the state police who only do a cursory job of it, but were told I need to contact the state legislature, which I did.

After eradicating approximately 50 drug abusers from the practice (some of which were being simultaneously being treated in a methadone maintenance center in Indianapolis and by us for pain management), I began slowly re-introducing the drug back into the practice. Oxycontin is a very powerful and useful drug in chronic pain management, but I question as to whether our society has the common sense or self control necessary to use the drug appropriately. Since its reintroduction into the practice in a limited fashion, I have had another patient overdose and die. Perhaps the drug should have rigid controls on its use, but abusers will always find a way to use the drug inappropriately. Chronic pain is subjective. It is not measurable with objective findings. Physiologic variables do not correlate with pain perception which is shaded by experiences, psychologic state, sleep deprivation, and by receptor/metabolic variability.

I believe strengthening laws regarding its illegal sale, use of a mandatory statewide narcotic prescription computerized tracking system, adoption of laws making it a misdemeanor to be receiving narcotics from multiple providers without their knowledge of such, and more forthcoming data mandated from Purdue Frederick would help solve this problem.

Please feel free to contact me at the above number if you have inquiries about my practice or Oxycontin.

Sincerely



ML Whitworth, MD