PALACE HOTEL
San Francisco

8/3/01

Dear Ms. Tozzer,

Please forgive the handwritten note, as I am at a conference in San Francisco. In any event, my name is Dr. Juliane W. Childs, and I am a hematologist oncologist in private practice in Southern, New Jersey. I have recently been placed on a council for the State of New Jersey with regard to Pain Management based on my experience as a community physician dealing with chronic pain.

I wish to submit this letter as an official statement for the FDA Anesthetics and Life Support Drugs Advisory Committee meeting (Sept 13-14, 2001). Specifically, I would like to address my concerns over the lack of adequate pain management in general with regard to patients suffering with chronic pain. I believe that this is an education phenomena, or the lack of education, rather. Unfortunately, a major issue in addressing chronic pain is knowledge in the use of long-

p2 acting analgesics. At this juncture, as a practicing physician who cares for patients with chronic cancer pain, I have only three forms of long acting analgesia. These would include the fentanyl patch, long acting morphine and long acting oxycodone. Some patients are not good candidates for the patch for example, if they are very thin secondary to cancer cachexia they tend to lack ability to absorb the medication transdermally. Also, some develop a rash where the patch is placed, and some experience other more common narcotic side effects such as nausea, vomiting, and pruritus which are intolerable. Long acting morphine and oxycodone also exhibit the latter side effects such as nausea vomiting, pruritis as well as constipation which can be quite severe. In any event, (in all 3) in my practice, I do not rely more heavily on one method than another. I tend to utilize <u>what the patient tolerates</u>. If they cannot swallow I'll use the fentanyl patch, if they've developed an ileus with the patch, I'll try long acting oxycodone. If they develop nausea & vomiting not controlled with antinauseants with oxycodone by history, I'll try long acting morphine. It has been a true blessing to many patients intolerant to long acting morphine (the oldest form of long acting analgesia) to have ability to switch to the other options.

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I must say, given the recent news attention to people abusing long acting oxycodone is not only frustrating, but also concerning. While the abuse potential for Fentanyl patches should be lower than the long-acting oral meds, I would suspect the abuse potential for long acting morphine & long acting oxycodone would be similar ie. any foolish individual could crush either medication and attempt to get "high" with them! My point here is that I hope both long acting oral forms will remain available for use, despite the ill advised acts of unfortunate addicted individuals. I would like to have access, for my patients, ALL three of these crucial pain managing modalities. If restrictions on prescribing these medications are needed, so be it, such as limiting the use to cancer physicians, pain specialists, and others dealing with patients with chronic pain. Most importantly, education is the key, to helping patients utilize their medicines correctly and educating would-be abusers of possible severe side effects and death.

I hope my comments have been somewhat helpful

Sincerely,

Dr Julianne W Chitwood