

To: Anesthetic and Life Support Drugs
Advisory Committee 8-1-01

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Anesthetic and Life Support Drugs
Advisory Committee
from - Dennis Grundy, Fort Worth, Texas

Enclosed: Hand-written 2-page 1st-person
account of personal experience

Typed 8-page persuasive essay

One Doonesbury cartoon strip
(photocopied)

I have lived with Chronic pain - due to Peripheral Neuropathy - for about eight years. And I have taken Methadone for pain relief during most of this time. If it were not for this safe, legal, and effective opiate medication, I would not be accurate in using the word live - Exist would be a more suitable verb. I have tried to manage my "Monotonous Monster" (my name for this constant, intractable, unrelenting pain) with more "conservative" or "acceptable" drugs which are listed in the anti convulsant or antidepressant categories, drugs which were not designed to be prescribed as analgesics for chronic pain, but which are preferred by many narrow-minded doctors because some of their patients say that Elavil, for example, "takes the edge off" their pain. However, I have never experienced any success with these. I am under the treatment and care of a Chronic Pain Management Specialist, who prescribes for me 50 mg of Methadone per day. I take this opioid medication because he knows and I know that this type of drug is the only one which makes it possible for me to maintain a relatively normal, stable life. (A Diagnostic Drug Infusion procedure confirmed that only opiates provide any noticeable pain relief.)

Just as a diabetic needs insulin day after day in order to sustain his life,

I indeed need Methadone (or perhaps some other opiate drug some day) to quiet and control this Monotomous Monster, which, if I were denied access to opiate painkillers, would instantly begin to increase the burning pain in my damaged nerves and kill what helps me the most to cope with chronic pain and to hope I will never reach the end of my rope.

In conclusion, I will briefly mention the so-called and often misunderstood issue of "addiction" or dependence. I do not worry or concern myself about the possibility of addiction to Methadone because I trust my physician in this matter. I take my meds as prescribed, and if some situation were to develop because of some sort of anti-opioid hysteria which would drastically limit the use of opiates to, say, only acute malignant health problems, I believe my chronic pain doctor (who is on the staff of one of the biggest and best hospitals in Texas) would provide what I would need. However, I do not believe that such a hypothetical situation will unfold unless many in the medical community continue to inculcate, through erroneous rhetoric and demagoguery, the mythological beliefs about prescription drugs and addiction.

Dennis Grundy Ft. Worth, TX

In America's "War on Drugs" there are millions of innocent civilians who are being caught in the crossfire and are being harmed by "friendly fire."

The victims are the 80 million Americans who suffer from intractable, non-malignant chronic pain which is caused by disease or injury or both.

Many of these people are able to function quite well and manage to maintain a somewhat comfortable life by simply taking over-the-counter pain pills such as ibuprofen and acetaminophen.

Others require stronger, more effective painkillers, and their physicians prescribe Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) to manage the more stubborn type of chronic pain.

And still others receive prescriptions from their physicians for various other medications -- antidepressants and anticonvulsants, drugs developed for purposes other than pain relief, but which, some patients have found, "take the edge off of pain."

However, that still leaves millions who find themselves lost -- lost in a frustrating maze of bureaucratic power-plays and doctors who are afraid to use more aggressive measures in the treatment of more aggressive chronic pain. Even though millions of people are suffering from excruciating, unrelenting pain caused by more critical conditions than, say, moderate osteoarthritis, hundreds of physicians can't or won't allow these patients access to medication that goes beyond what the consensus of opinion considers conventional methods.

Many in chronic pain are desperately seeking anything which will rein in and control the relentless, runaway pain which won't go away.

When their doctors -- rheumatologists, neurologists, general practitioners -- sigh and shrug and inform their patients that the best they can offer them are NSAIDs or antidepressants and send them on their way, long-suffering pain victims sometimes put what are becoming seemingly hopeless cases in the hands of clinics which specialize in chronic pain management. Along with prescribing conventional pain drugs (e.g.

antidepressants and anticonvulsants), these clinics provide alternative -- often experimental -- therapy and treatments such as electrical stimulation, acupuncture, and biofeedback.

However, there's no guarantee that these measures and methods -- some which can be quite costly -- will work. In the chronic pain gamble, it is all too often a crapshoot. Each effort for some relief -- be it a tablet or surgery -- can be only a roll of the dice.

With all the advances in medical research in the past 50 years, one would think that such a monumental problem as chronic physical pain would receive more attention and would have more solutions to present to those silently suffering; that think tanks and medical consortiums would be working constantly to find a way to help people in constant pain get help; that resources would be readily available in a "whatever means necessary" method.

One would think.

Yes, chronic pain is a monumental problem when one simply considers the sheer numbers whose lives are controlled by the tyranny of this "monotonous monster" (my name for chronic pain). However, is chronic pain, the condition itself, beyond the pale of scientific knowledge? Is it a mystery for which our culture should build a monument and gaze at with glazed eyes while we scratch our heads in prostrate resignation?

No.

As any pre-med student knows, all pain is in the brain. When a part of the human body is damaged, neurotransmitters relay this information to the receptors in the brain. The brain readily responds to this signal, and the result is the sensation called pain.

This warning system could not be improved by any human effort, and scientists still marvel at its brilliance and have tried in vain to duplicate it.

However, when a part of the body -- e.g. connective tissue or an organ -- is permanently damaged, the signals continue unabated to the brain. And though the body

has the capacity to "slow down" these pain signals by creating a natural chemical called endorphins, pain persists relentlessly. The gate has been opened; the gatekeeper does not have the authority to close it, thus stopping the pain signals from reaching the brain's pain receptors. The result is chronic pain.

A class of high school students would probably be able to brainstorm their way to a solution for this stationary storm in the brain. Because the pain receptors in the brain are unable to restrain the pain signals, they would no doubt theorize that if the pain receptors can be desensitized somehow, be altered to deflect the transmission of pain signals to the always-vigilant receptors, then the person in chronic pain could possibly receive some relief.

If the source of the pain cannot be "fixed" and if the "data" cannot be diverted from making its natural course through the nervous system and to the brain, perhaps pain can be "regulated" after it reaches its destination. Perhaps, the pain can be silenced or muted even though cacophony is the normal condition when pain wreaks havoc in a chronic pain patient.

The irony, the frustration, the quandary, the crying shame in our society is that we have a medication at our disposal which has proven to be a reasonable, safe, and effective treatment in chronic pain management. Millions of Americans are suffering needlessly because they simply are not provided access to these prescription drugs.

These drugs are opioids -- narcotic pain pills which bring about relief by bringing out the painkilling nature of opiates.

However, those who control this type of controlled substance are overzealously prohibiting far too many people in chronic pain from experiencing the benefits of opioid medications, which happen to be legal, safe, and highly effective.

The powers that be in federal regulatory agencies are usurping the right of some physicians to write prescriptions for their patients who need powerful medication in their daily struggle with the monotonous monster. Also, even without the concern of scrutiny

and intimidation by government agencies, many doctors choose not to prescribe opiates. Why? Because they are misinformed or they are minimizing their patients' pain.

These physicians are quite reluctant, for whatever reason, to give their patients a chance to regain some control over their lives, some of which has been stolen by the monotonous monster. Reluctant? Dead-set against the use of narcotics is a more accurate description. Case closed.

Opponents of the use of opioids in the treatment and management of chronic pain express -- and carry out -- their opposition by using rhetoric based on myths and misconceptions about this medication and by using faulty inductive logic.

They point to the possible drawbacks of opiating those in chronic pain while missing the obvious point that the use of opiates is a reasonable treatment. Because these narcotic drugs are safe, legal, and effective, there should be, under routine circumstances, no reason that a physician -- and especially one whose specialty is chronic pain management -- should withhold them from his or her patients whose pain does not respond to what the status quo has determined to be the "best option."

However, the propaganda of the "narcotics-for-acute-pain-only establishment" attempts to present as fact that any possible side effect completely outweighs the benefits which opiate painkillers provide.

Those who desire to limit the availability of opioids wave red flags of warning as they wage war against the law-abiding citizens who ask only that doctors realize, on one hand, just how debilitating chronic pain can be and, on the other hand, the vast contrast between the way in which permanently damaged nerves respond to 50 mg of a tricyclic antidepressant and 5 mg of an opioid drug such as Methadone.

What we have now, instead of a society willing to pull out all the stops in order to make safe and legal pain medication available to its suffering citizens, is a self-appointed confederation of government and medical regulatory agencies bent on stopping doctors from prescribing opiates to their chronic pain patients.

Those seeking to severely limit the availability of prescription narcotics rely on rhetoric which is formulated through capricious and arbitrary theoretical speculation.

Instead of a spirit of cooperation, there is a power struggle among those who make the decisions about who should have the right to take opiate drugs and the right to write prescriptions for opiates. There is a tug-of-war, a needless conflict -- one perhaps which involves conflicts of interest rather than having the best interests of each patient at heart.

In this "uncivil war," one with chronic pain cannot help but view as the enemy those who deprive him or her of access to drugs which can drastically reduce the ever-present pain. Those whose plight is chronic pain should not be denied the constitutional right to "life, liberty, and the pursuit of happiness," even though a small, yet forceful, brigade of elitists has made it their mission -- for whatever reason -- to deny a certain segment of the population access to legal prescription drugs which will, can, and do make it possible for them to experience the constitutional rights of every American.

With the stigma firmly in place -- based only on prima facie evidence -- that narcotic drugs, including opiates used in the management of chronic pain, are simply "bad," the medical establishment is able to maintain the status quo by waving rhetorical red flags. Through demagoguery -- which often includes misinformation -- opponents of opiate pain medication rely on negativistic rhetoric while the public perception, viewed through uneducated eyes, remains on the side of the outspoken opposition.

"If you begin taking opiates to alleviate your pain, you will soon become addicted and shortly thereafter cease receiving any benefits in terms of pain relief," the demagogues in the drug regulatory bureaucracies say with authority. "You will be up the proverbial creek."

The public, with its limited knowledge, simply nods in agreement.

And if the public asks for "evidence," the authorities are likely to only add to the confusion by offering: "Well, take a look at Methadone (a common opioid in the

management of non-malignant, intractable pain). We all know that most people on Methadone are heroin addicts."

Concomitant with the rhetorical contortion of information concerning the issue of opiate drug use by those in chronic pain is building a case through inductive logic based, however, on faulty and nebulous premises.

There are typically four premises employed by those who take exception to those who take opiates for pain management:

1. Addiction. If a drug causes addiction, then it should be used -- if at all -- in only unusual or extreme cases.

2. Tolerance. One quickly develops a tolerance for these medications -- that is, they soon lose their potency within an individual's nervous system.

3. Side Effects. Opioids make a patient so drowsy that he can barely function. We will soon become a society of stoned zombies if chronic pain patients are allowed to take opioids.

4. Overall Long-Term Effect. Other than addiction these drugs create other health problems and the one who takes these drugs is faced daily with the stigma of being "on narcotics."

Allow me to counter all four illogical points with the facts.

1. Yes, there is the POTENTIAL for addiction. However, very rare is the person who becomes "hopelessly" addicted and craves more and more opiates just for the sake of taking them. One cannot obtain a "high" through normal opioid use.

Those who oppose opiates conveniently fail to point out the vast difference between people who live to take drugs (addicts) and people who take drugs to live (patients). Surely the bureaucrats in the medical profession are able to distinguish between the two.

Ironically, there seems to be no such zealous resolve when the possibility of addiction exists if the prescribed drug is a tranquilizer or sleeping aid.

2. Tolerance toward a medication is impossible to predict. For some it develops after about two years. At that point, the doctor may decide to increase the dosage slightly. However, is it by no means a given that a chronic pain patient will lose the painkilling benefits derived by taking opiates.

3. Side effects are also unpredictable. The most stubborn one in my experience -- I've taken Methadone daily for about five years -- is constipation. It's unpleasant, of course, but manageable.

Another side effect of opiate pain medication is short-term memory loss. But would it not be better to be able to go someplace yet forget some of the specifics of that place than not to be able to go anywhere at all?

4. Long-term use of opioids is not as dangerous to organs such as the liver and kidneys as long-term use of over-the-counter analgesics.

And as far as the stigma of opiate drugs is concerned, that's more of a problem for the biased, the misinformed, and the uneducated than for those who benefit from the drugs.

Thus, the answer to the equation cannot be correct if the variables (i.e. the premises in the process of logic) are unfounded or fallacious. Reasoning with questionable or unproven reason proves to be unreasonable.

In some surveys half the chronic pain patients have expressed suicidal tendencies. If a physician who realizes the benefits of treating chronic pain with opiate drugs and does not have to worry about interference -- and even intimidation -- from the powers that be and who refuse to release their stronghold of power over who prescribes these pain pills and how they are utilized, then the potential suicide statistic becomes a case-study in the importance of prescription narcotics and someone who has something to help him greatly to cope with the pain rather than sliding to the end of his hope rope.

Doctors and administrators would do well to consider that chronic pain can be not only a symptom but also a disease unto itself.

Sure, drug regulators need to draw a line in order to regulate prescription narcotics. But should they be allowed to force all physicians to adopt their subjective, capricious, and arbitrary mindset? Which is more criminal -- revoking the license of a doctor who, in the opinion of a regulatory agency, is providing access to opioids for patients who are in so much relentless pain that they want to die or permitting the doctor to practice the healing arts as he sees fit, which could include prescribing safe, legal, and effective analgesics?

No, 80 million Americans should not be taking opiates for their chronic pain. Opiate medication should be used circumspectly. But there are millions who would find life worth living again if there weren't so much opposition from authorities who apparently do not suffer from chronic pain and who just might benefit if doctors who treat those who suffer from chronic pain were controlled and forced -- even in a somewhat subtle way -- to limit their treatment to, say, acupuncture (or something more complicated or costly than oral opioids).

The latest miracle cure this year is the use of magnets. What will it be next year?

If a veterinarian determines that your household pet is suffering severely, the doctor will more than likely arrange for the animal to be put to death mercifully. What are the best options for the chronic pain patient? Some who are suffering might choose euthanasia.

Either that or magnets -- given the present circumstances.

A handwritten signature in black ink that reads "Dennis Grundy". The signature is written in a cursive, flowing style with a long horizontal line extending from the start of the name.

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