COLLEGE ON PROBLEMS OF DRUG DEPENDENCE, INC.

Executive Officer:
Martin W. Adler, PhD
Department of Pharmacology
Temple University School of Medicine
3420 North Broad Street
Philadelphia, PA 19140-5104
(215) 707-3242
Fax: (215) 707-1904
E-mail: baldeagl@vm.temple.edu
Website: http://www.cpdd.org

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August 13, 2001

Kimberly Topper
Center for Drug Evaluation and Research (HFD-21)
Food and Drug Administration
5600 Fishers Lane
Rockville, MD 20857
Email:topperk@cder.fda.gov

RE: September 13-14 Meeting of the Anesthetic and Life Support Advisory Committee

Dear Ms. Topper:

As President of the College of Problems on Drug Dependence and on behalf of this organization, I would like to enter this letter into the docket so that it will be considered by the Anesthetic and Life Support Drugs Advisory Committee, which will convene in Rockville, Maryland on September 13th and 14th. The College on Problems of Drug Dependence (CPDD) is a professional organization of scientists whose research is directed toward a better understanding of drug abuse and addiction. The mission statement of our organization is as follows:

We take it for granted that it is in the public interest to prevent or minimize the adverse consequences caused by drugs of abuse to individuals and society. As an organization of scientists, we are in a position to provide information on which sound drug policy can be based. We want to help policy-makers and the public to understand what is known about drug abuse and what is not known, so that those responsible for national drug policy can shape their efforts according to the best available scientific data.

With that in mind, the College would like to specifically address one aspect of the Committee's agenda on which it feels qualified to speak: "the committee will address concerns regarding the abuse potential, diversion and increasing incidence of addiction to opiate analgesics, especially to the modified release opiate analgesics."

The College would like to state its opinion as to what we know and do not know about this agenda point.

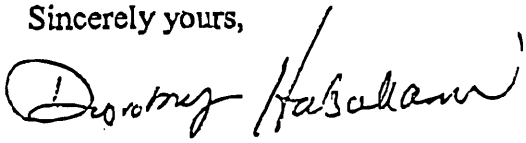
We do know quite a bit about the abuse potential of opiate analgesics, as many basic and clinical scientists in the College have, and are currently, studying abuse liability of opiates. We know that most of the oral opioids prescribed for pain have abuse potential. It is important to point out that these studies were conducted with opioid abusing volunteers. Less is known about the abuse potential of these opioids in patients in pain, because systematic abuse liability testing studies have not been done in this population. The available data, however, would suggest that in most pain patients, the liability for abusing these drugs is low. The first study examining the rate of opioid abuse in hospital inpatients was conducted in 1980 by Porter and Jick (Porter J, Jick H [1980] Addiction is rare in patients treated with narcotics. New England Journal of Medicine, 302:123). These investigators found a low rate of abuse, a finding that since has been replicated a number of times in different pain populations, including patients with chronic pain. The College, however, recognizes that a number of these patients may be physically dependent on opioids. However, physical dependence is no longer considered by scientific and medical communities as a defining characteristic of addiction. One can be physically dependent on antihypertensive medications, but nobody would consider that to be addiction. Addiction involves highly uncontrolled or compulsive use of a drug despite harmful effects. The overwhelming ***majority*** of chronic non-malignant and malignant pain patients, if their pain is treated properly, are not opioid addicts.

The College recognizes that there is increased abuse of prescription oral opioids. However, there are no data to support the notion that patients in pain and who are prescribed these opioids are responsible for the increase. The College also recognizes there is increased abuse of modified release opiate analgesics. One of those modified release opiate analgesics that has received a great deal of attention in the media over the last several months is controlled-release oxycodone. The College again asserts there is no data that it is aware of to support the notion that patients in pain who are prescribed controlled-release oxycodone are responsible for the increase in its abuse. There is significant concern voiced by pain organizations, physicians who treat chronic pain, and chronic pain patients themselves that actions will be taken by the government to either place further restrictions on the drug (e.g., by decreasing the amount that can be manufactured, by allowing only physicians who work in pain clinics to dispense the drug) or remove the drug altogether from the United States pharmacopoeia. Controlled-release oxycodone has been proven according to FDA standards to be both a safe and effective drug for the treatment of moderate-to-severe pain that lasts for more than several days. There are not a large number of FDA-approved oral opioids that have the high efficacy of controlled-release oxycodone that makes this medication crucial for many patients who are suffering excruciating pain. The controlled-release formula provides steady-state plasma levels so that pain control is achieved continuously throughout the day. Immediate-release opioids result in cyclic levels of pain intensity and "clock-watching." If controlled-release oxycodone were to be removed from the market, this would have a deleterious impact on patients in chronic pain, simply because physicians would have one

less effective controlled-release opioid in their armamentarium for treating moderate-to-severe pain of a prolonged nature.

The College hopes that the Committee will take a careful and balanced approach to the problem of oral opioid medication abuse, including controlled-release medication abuse. We concur with the World Health Organization's policy viewpoint that opioid abuse needs to be placed in the context of the large majority of people who do not abuse opioids but use them responsibly under the care of a physician for control of pain. The College recognizes there is oral opioid abuse, and the abusers need to be treated. Preventative strategies need to be implemented in the rural, isolated and impoverished areas in the United States where the abuse is primarily taking place. Law enforcement agencies need to have adequate resources and training to address and reduce the illegal diversion of controlled-release oxycodone and other opiate analgesics. At the same time, the College urges taking a balanced approach to this problem so that risk management strategies developed to prevent and reduce diversion of oral opioids do not deter physician's from prescribing high-efficacy opioids when those drugs are indicated. In closing, the College takes the position that although there is anecdotal information, there are no scientific data indicating that high-efficacy opioids, including controlled-release oxycodone, are abused by patients being appropriately treated for chronic pain. It is our opinion therefore that restrictions or removal of these drugs from the market is not warranted from a scientific standpoint. We thank the Committee for considering our position.

Sincerely yours,



Dorothy Hatsukami, Ph.D.
President, College on Problems of Drug Dependence (CPDD)

Cc: James Zacny, Ph.D., Chair of the Taskforce on Prescription Opioids
Warren Bickel, Ph.D., CPDD Policy Officer
Charles Schuster, Ph.D., CPDD Past President
Louis Harris, Ph.D., CPDD President-Elect
Martin Adler, Ph.D., CPDD Executive Secretary