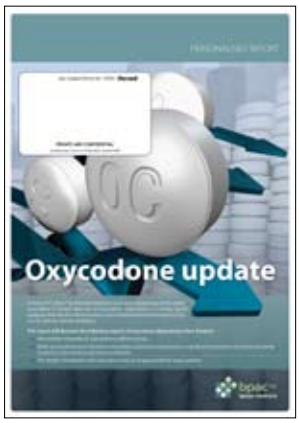

Oxycodone: are the right issues being addressed?

Dear Editor,

You wish to reduce the prescribing of oxycodone because it is expensive – fair enough, and you are putting the onus on General Practitioners to not prescribe this drug. But there are two problems that I doubt you can overcome:

1. *Patients are being discharged from hospital on this drug and with their pain satisfactorily controlled. Is your programme aimed at re-educating hospital doctors, junior and senior, about the costs of this drug?*
2. *Oxycodone comes in a 5 mg long-acting form. The lowest dose of morphine is a 10 mg long-acting form. If you are an old person needing 24 hour pain relief, which option would you prefer to start on? It's obvious isn't it - 5 mg is safer than 10 mg, so start safe.*

Your analysis of my prescribing and spending on this drug thus does not have any impact on me at all, expect to make me grumpy that the true issues are probably not being addressed.

General Practitioner, Whangarei

bpac^{nz} first addressed the issue of inappropriate oxycodone prescribing in November 2009 (BPJ 24). At the time, oxycodone dispensings had been rapidly increasing, driven by a prominent marketing campaign. We challenged General Practitioners to consider the appropriateness of their prescribing of this medicine. Based on the feedback we received, the feeling was that most oxycodone prescriptions were being initiated in secondary care.

In May 2012 we raised the issue of oxycodone prescribing again. This time we included data on the origin of prescriptions, and found that 70% of oxycodone was being initiated outside of general practice. We acknowledge that this is mostly a "secondary care problem", and we are currently looking at ways to deliver messages about appropriate oxycodone prescribing to secondary care, but the data also showed that 17% of prescriptions initiated in secondary care are continued in general practice and 30% of oxycodone is initiated in general practice. We encourage primary care clinicians to lead the way in the appropriate use of this medicine in the community.

Morphine can be prescribed as a safe first-line option for moderate to severe pain. Oxycodone is approximately twice as potent as morphine, therefore 5 mg controlled release oxycodone is equivalent to 10 mg long-acting morphine. Both medicines have similar safety profiles, although, there is some evidence that oxycodone has more addictive potential than morphine.

Editor

Drivers of increased oxycodone use

Dear Editor,

Thank you for your personalised report on oxycodone useage ("Oxycodone update", May 2012). I do recall your report of June 2011. I have not changed my prescribing habits in light of that report, or even your more recent update.

I feel there are two drivers to the increased use of oxycodone that you have not touched on in your report. One is the increased use of opiates for chronic non-malignant pain, particularly for those with chronic arthritis conditions. Many of these people are already taking, or intolerant of, anti-inflammatories and simple analgesics, and have been unable to access orthopaedic surgery in the public sector. These people get some measure of relief from opiate pain killers, with low risk of diversion or serious dependency.

The second feature which takes the prescription of oxycodone over morphine is PHARMAC's decision to choose a slow release morphine product which does not work. This left the field wide open for a medication that does work, and for the stated 12 hour duration. One can also argue that oxycodone has a fairly

linear titration curve without any side effects, such as found with tramadol.

I trust this sheds some light on why oxycodone may be being initiated in general practice against your best wishes.

General Practitioner, Tauranga

Increased use of strong opioids for chronic non-malignant pain would certainly explain the overall increase in opioids dispensed in New Zealand over recent years. As oxycodone prescriptions are the main contributor to this increase, it is safe to assume that people with chronic non-malignant pain are being prescribed oxycodone. However, depending on the patient, the condition being treated and individual psychosocial factors, prescribing a strong opioid may not always be appropriate, and oxycodone should be reserved for people who are unable to tolerate morphine.

There is limited evidence to support the use of strong opioids for chronic non-malignant pain, however, in practice sometimes they will be required, when "all else fails". The reason that morphine is chosen first-line is that it is equally effective as oxycodone, has a similar adverse effect profile, is less expensive, and there is evidence that oxycodone may have a greater addictive potential. The article "Oxycodone – what can primary care do about the problem?" in BPJ 44 (May, 2012) discussed the role of strong opioids for chronic non-malignant pain and included guidance developed by the Australian and New Zealand college of Anaesthetists

There are currently two fully subsidised forms of long-acting morphine – Arrow Morphine LA and m-Eslon. We are unaware of any published data that shows these medicines to be ineffective for a 12 hour duration. We are interested in any other anecdotal reports of this lack of effect. If this is a widespread consensus, then it would indeed go some way to explain why oxycodone may be prescribed in preference to morphine.

Editor

Download this clinical audit from our website:

www.bpac.org.nz

We value your feedback. Write to us at: Correspondence, PO Box 6032, Dunedin or email: editor@bpac.org.nz