Feasibility Study of Rapid Opioid Rotation and Titration: Is it Truly Feasible or Paradoxical?

To the Editor:

It is with great interest that I read the article by Korkmazsky et al, "Feasibility study of rapid opioid rotation and titration" published in the 2011 January/February issue of Pain Physician. The feasibility study was done to investigate the feasibility of rapid opioid rotation and titration. Based on their protocol, the patients were admitted to the hospital for 24 hours, during which, IV PCA oxymorphone was used in conjunction with oral extended release oxymorphone (ER). Upon discharge, based on the total oxymorphone usage during the previous day (oxymorphone ER plus IV-PCA oxymorphone), patients were placed on oxymorphone ER and oxymorphone immediate release (IR) as needed. From their pilot study, the authors concluded that rapid opioid rotation and titration could be performed safely and effectively by incorporating IV-PCA during the first 24 hours, followed by 2 weeks of further opioid titration as outpatient. The authors feel that this novel approach would help primary care physicians (PCP) practice opioid rotations when needed, as they are usually not comfortable with doing this.

Although this approach seems novel and feasible, I wonder if it has any true practical value.

It is obvious that pain specialists may find this approach unnecessary, as decisions of opioid rotations are made during routine patient visits without much difficulty. For PCPs, I am highly doubtful that they will embrace this new idea or find it easy to follow. It would not even surprise me if told by many PCPs that they have no idea what oxymorphone is. I wonder how many of them will be comfortable admitting their chronic pain patients to the medical floors, starting them on IV-PCA with oxymorphone as well as oral oxymorphone (ER), just for the sake of opioid rotations. Also, will the insurance carriers be willing to pay for the admission expense for opioid rotations? Can opioid rotation itself serve as a sufficient criterion for admission? Will they cover the expense for using an IV-PCA device for non-acute painful conditions such as opioid rotation? Or will they ever question whether the utilization of IV-PCA oxymorphone in this chronic pain setting is medically indicated and necessary, as I believe that IV-PCA opioid given as inpatient is quite costly?

As a fellowship-trained pain specialist, I have never used the IV form of oxymorphone during my 8 years of private pain management practice or during my fellowship training. As a matter of fact, I have hospital privileges from 3 local hospitals (one of them is a university teaching hospital) and none of them has IV oxymorphone on their formularies. Considering all of the above, I am quite skeptical about the true utility of this approach. I wonder if the authors could give me their feedback in response to my questions/comments.

Xiulu Ruan, MD
Director of Clinical Research
Physicians' Pain Specialists of Alabama,
2001 Springhill Ave
Mobile , AL 36607
Email:xiuluruan@yahoo.com