In Response

We appreciate the interest in our work and are excited to discuss the results. The protocol as it was utilized in the report was first articulated by and placed into practice by Dr. William O, Witt as director of the University of Kentucky Pain Center for almost a decade ago. As such this protocol and has become standard practice in our institution (over 200 pumps) and by many physicians in our region. The first and primary discussion point of the letter writer is the feasibility of the opioid taper and opioid-free interval in general practice. It is common for physicians in discussing the technique with us to raise this concern.

The intriguing part of our work anecdotally is that many patients initially are hesitant at the idea of coming off their oral opioids, however when it is pointed out to them that they are not currently receiving the efficacy they desire from oral opioids, the short term sacrifice for long term better results seems reasonable to them. In this opioid tolerant group, there is usually ready acknowledgement that the current course of therapy is not working well. It is common for us after the trial to question the patients only to have them admit that they could tell little difference in their pain control on the oral opioid and following the taper. In fact we have had patients after the opioid taper state that they felt better and wanted did not want to proceed with the intrathecal trial. Though this is rare, we feel this is likely evidence of opioid-induced hyperalgesia. In the study the fact that VAS scores were virtually unchanged (perhaps slightly improved) after the opioid taper attest to the lack of long term increase in pain off the oral opioid.

With regard to the question about dose range, we assume the writers are asking about oral opioid dose ranges prior to taper. Generally speaking most subjects were on 60-120 mg per day of oral morphine equiva-

lent with the highest opioid dose being 180 mg of SR oxycodone BID with hydrocodone 10 mg up to 4 times per day for breakthrough pain. In reference to another question, indeed our trials last 3-5 days. We have had little reason to extend the trial as; in our experience the analgesia is consistent once established in virtually all patients. We concede the point about peripheral edema as this has been an unexpected side effect not discovered by our current trialing system in at least two subjects.

Finally, we agree that a comparative study of oral opioids versus intrathecal opioids prospectively after the opoid taperl would be fascinating and we are working through the ethics of this idea currently with our departmental research coordinator before submitting to the institutional review board. In response to the interest of the study, we anticipate presentation of our 24 month data in these subjects and 12 month observational data soon. We thank the authors of the letter again for their enthusiastic comments.

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