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To the Honorable Assemblyman, Assemblywomen, and Senators
of the Legislative Committee on Health Care for the Great State of Nevada.

Mr. James Oscarson, Chair, Mr. Joseph Hardy, Vice Chair,
Mr. Ben Kieckhefer, Ms. Pat Spearman, Ms. Teresa Benitez-Thompson,
and Mr. David Gardner.

I come forth with greetings and salutations,

I am Richard L. Martin. I was a hospital pharmacist for 25 years. The last four years I was involved with the cancer ward helping oncologists to recommend pain medications, adjust pain medications, and switch from one to another. Even though it's been some 15 years since I worked hospital, I still have at least a rudimentary knowledge of prescription opioid pain management.

I've come to represent the non-cancer chronic pain patients who are being thrown under the bus. To be a voice of reason, compassion, empathy, and common sense. This anti-opioid McCarthyism sweeping our country has to slow down. I myself am a chronic non-cancer chronic pain patient. The opioid-phobic media, politicians, insurance companies, addiction treatment centers are in my opinion misrepresenting, misinterpreting, and in some cases out right lying about the opioid epidemic.

I'd like to give some examples of what is being misrepresented and what is not reported.

Dr. Sanjay Gupta on CNN says opioid deaths are the #1 preventable deaths in the US. Not even close. Tobacco and alcohol are the most preventable at 480,000 deaths per year. Opioids 28,000 to 29,000.

Long term use of opioids for the treatment of chronic pain is not effective. Wrong! The CDC says "the long term use of opioids for chronic pain has not been established". We don't really know.

However, there is at least one article written that shows patients on long term chronic opioid dosing do quite well on stable doses for many years. This study evaluated around 100 patients, some on opioids for 10 years. http://www.practicalpainmanagement.com/treatments/pharmacological/opioids/opioid-treatment-10-year-longevity-survey-final-report

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Opioids make your pain worse. It's called hyperalgesia. This gets lots of media chatter. However, there are articles that report this is fairly rare. And it is relatively easy to differentiate hyperalgesia from tolerance.

Tolerance. Your body adjusts to the opioids and they become less effective requiring higher doses. If you are a cancer patient and this develops, the doctors increase the dose. But why not in chronic pain patients? The answers given by some doctors are lame.

Dr. Ballantyne, who is for lack of a better phrase, is a known opioid-phobic. She states, "Chronic use of opioids can lead to increasing doses because of hyperalgesia, tolerance, and disease progression. SAY WHAT? Yes, if your disease gets worse, your pain gets worse and therefore requires higher doses. NOBODY reports on this. Why? Because it justifies using a higher dose and the opioid-phobics don't want anyone to know this.

Another factoid never reported. AND THIS IS ON PAGE 2. of the CDC's very own guidelines. "a recent study of patients aged 15-64 years receiving opioids for chronic non-cancer pain and followed for up to 13 years revealed that 1 in 550 patients died from opioid-related overdose at a median of 2.6 years from their first opioid prescription". That is less that 1%. To be exact, 0.2%. "And 1 in 32 patients who escalated to opioid dosages greater than 200 morphine mg equivalents died from opioid-related overdose". That is 3.1%. Most patients on long term chronic opioid doses do well but now are being thrown under the bus.

Another article not reported is the p450 enzyme genetic defect. Some reports indicate up to 30% of the patient population have this defect. It is a defect in opioid metabolism that requires higher, often much higher, doses of opioids. Do we ignore these patients? Throw them under the bus with the CDC guidelines.? http://www.practicalpainmanagement.com/treatments/pharmacological/opioids/genetic-screening-defects-opioid-metabolism-historical

Fentanyl gets a lot of bad press lately. However it is a very effective opioid for treating chronic pain. Due to absorption variations in patients, some require a 50% higher dose when using the adhesive patch formulation. Never mentioned.

Hydrocodone 10mg/325mg acetaminophen is a maximum pill formulation known familiarly as Vicodin or Lortab. Taken as one pill every 3 hours + 1 rescue dose is 9 tablets per day or 270 tablets per month. Should this raise an eyebrow? Well, it shouldn't. This amount is 90 MME per day which is the CDC's maximum daily dose. Will the patient get hassled at the pharmacy? Maybe. Will the prescribing doctor get hassled by a government agency? Maybe.

The CDC recommends NSAIDS as an alternate pain management medicine. But in the chronic pain patients long term, these meds can have serious adverse reactions. Ulcers, GI bleed, heart attack, stroke and kidney failure. One NEJM article reported 15 years ago that up to 16,500 arthritis patients die each year from NSAIDS. AND THE CDC wants us to use this instead ?
This article from the Harvard Medical School:
http://www.health.harvard.edu/blog/fda-strengthens-warning-that-nsaids-increase-heart-attack-and-stroke-risk-201507138138

Another article in the prestigious NEJM just published July 7,2016 reported 81 new state laws were enacted from 2006 to 2012 in response to rising opioid abuse or overdose. After reviewing, they concluded "adoption of controlled-substance laws was not associated with reductions in potentially hazardous use of opioids or overdose among disabled Medicare beneficiaries, a population particularly at risk.
http://www.nejm.org/doi/full/10.1056/NEJMsa1514387

I have tried to make a case that the media, politicians, insurance companies are cherry picking what they want to report. Almost certainly misrepresenting the CDC or other articles.
There is a recent article just published July 13, 2016, in the Journal of Pain and Palliative Care Pharmacotherapy. "it suggests that the opioid epidemic has at times been misrepresented by politicians and the media".
https://www.sciencedaily.com/releases/2016/07/160713102505.htm
The article "advocates balanced and comprehensive drug control policies".
In other words, common sense and not myopic hysteria.

Here is another article published in 2015 in the journal Pain Medicine:
Oct2015, Vol. 16 Issue 10, P1851 6p
"The Proliferation of Dosage Thresholds in Opioid Prescribing Policies and Their Potential to Increase Pain and Opioid-Related Mortality"
It is a long article criticizing how state policy-makers are under pressure to do something about the opioid overdose rates. "One such intervention involves the adoption of daily opioid thresholds in state prescribing policies that, once reached, will trigger specific actions or recommendations".
In part they conclude, "that sometimes politics has been known to trump science. The reliance on dosage in these models as THE factor instead of being A FACTOR in preventing overdose is not supported by the evidence". In my opinion, based on this and other evidence, dosage thresholds or triggers, should not be a sole determination.

The State of Nevada is preparing to institute legislation to limit opioid prescribing either by law or by rules and regulations of the various medical boards.
Governor Sandoval wants to institute a "Best Practices agenda".

However, I quote Governor Sandoval during his June 22, 2016 teleconference, "I do not want to interfere with the Doctor/patient relationship" I believe this type of meddling will do exactly that.

I have had several articles and Letters to the Editor published in the last 2 months. They represent many many of the similar comments I read about daily.

http://www.painnewsnetwork.org/stories/2016/7/19/cdc-opioid-guidelines-not-rule-regulation-or-law

http://pharmacytoday.org/article/S1042-0991(16)30677-6/pdf

http://thepainfultruthbook.com/2016/08/the-other-side-of-the-pain-story/

Before passing any legislation restricting the use of opioids for patients in non-cancer chronic pain, please read BOTH sides of opioid prescription use.

Respectfully submitted,

Richard L. Martin, BSPharm (retired due to pain)