# NEWS BRIEFS

## DR. WILLIAM HURWITZ SENTENCED TO 25 YEARS FOR PRESCRIPTION PRACTICES

Dr. William Hurwitz was sentenced to 25 years in federal prison in an Alexandria, Virginia courtroom on April 14, 2005. Dr. Hurwitz was previously convicted in December of running a drug conspiracy out of his office and trafficking narcotics, which resulted in the death of one patient and serious injury to two others. In addition to these charges, Dr. Hurwitz was accused of lying during his previous testimony and ignoring repeated warnings regarding his prescription practices.

The prosecutors accused Dr. Hurwitz of prescribing excessive amounts of dangerous drugs to addicts and others, even though he was aware of patients abusing the drugs and/or selling them for profit on the black market. In one instance, he issued a 1,600-pill-per-day prescription. The one death in this case came as the result of an overdose of morphine from a "massive prescription," according to the patient's daughter.

Arguments for Dr. Hurwitz's defense included testimony from patients whom had found relief through his prescriptions. Support for Dr. Hurwitz also came from patient advocacy groups, with the urging that a conviction would make other doctors afraid to issue adequate prescriptions for patients with legitimate pain concerns. The prosecutors maintained that although Dr. Hurwitz's practices were effective for some, the remaining facts showing his ignorance of prescription abuse and endangerment of his patients warranted punishment regardless.

Jurors convicted Dr. Hurwitz on 50 counts of a 62-count indictment, which included conspiracy to distribute controlled substances. He was acquitted on nine of these counts, and the jury deadlocked on the remaining three. This case is part of an ongoing investigation within a broader federal one by the Drug Enforcement Agency into doctors, pharmacists, and patients suspected of selling potent narcotics, fueling the epidemic in the Appalachia area. (Source: *The Washington Post*, April 15, 2005.)

## MORPHINE PLUS GABAPENTIN BETTER FOR NEUROPATHIC PAIN

According to a study in the March 31, 2005, issue of the *New England Journal of Medicine*, combined administration of morphine and gabapentin produces better analgesia for neuropathic pain, rather than the use of either drug alone. In a double-blind, four-period crossover trial, 57 patients were randomized to receive placebo (lorazepam), sustained-release morphine, gabapentin, or a combination of gabapentin and morphine. Doses were administered orally, and the trial lasted five weeks. Forty-one patients completed the study.

The primary outcome was mean daily pain intensity in patients receiving a maximal tolerated dose, which was rated on a scale of 1 to 10 (with the higher numbers indicating more severe pain). The secondary outcome measures were pain ratings on the Short Form McGill Pain Questionnaire, adverse effects, maximal tolerated doses, mood, and quality of life.

Study results show that mean daily pain at a maximal tolerated dose (on a scale of 1 to 10) was 5.72 at baseline, 4.49 with placebo, 4.15 with gabapentin alone, 3.70 with morphine alone, and 3.06 with gabapentin plus morphine ($p < 0.05$ for the combination versus placebo, gabapentin, and morphine). The most frequently noted side effects were constipation, sedation, and dry mouth.

Study limitations include partial blinding, in that approximately one-third of the participants guessed they were receiving an active drug while receiving the placebo. This may have decreased the difference between treatment with gabapentin or placebo, according to the authors. They also recommend further research on other analgesic combinations with their respective single agents. (Source: *Medscape News*, March 30, 2005.)

## OPIOID HIGHLIGHTS FROM THE 21ST ANNUAL MEETING OF THE AMERICAN ACADEMY OF PAIN MEDICINE

The 21st Annual Meeting of the American Academy of Pain Medicine (AAPM) was held February 23-37, 2005, in Palm Springs, California. Among the many topics discussed at the meeting, opioids continued to be a point of concern for those in attendance.

An important distinction in the definitions of abuse and addiction was made by Dr. Scott Fishman, who stated that addiction is a psychological disorder independent of the substance, whereas abuse is an aberrant use of a substance. Because addiction is usually associated with a strong family history, an assessment of addiction should include a thorough evaluation for obsessive use and use despite known harm (e.g., physical, economic, family/friends) to differentiate from signs of abuse, which are often more subtle. Dr. Fishman also touched on the legal issues of prescribing opioids and noted that the practitioner must treat each patient appropriately, through thorough assessment and constant reassessment, with documentation of quality of life, function, and benefits for each case.

Dr. Howard Heit focused on issues of misuse and diversion of opioids, and emphasized that a controlled substance agreement should be used to define the constructs for what a practitioner will and will not do in providing care. Patients should be motivated to reach treatment goals and have a stable behavioral profile. Although previous addiction does not give an absolute contraindication for opioid treatment, it does reinforce the need for a program that maintains previous addiction recovery, according to Dr. Heit. He provided the following list of guidelines for the prescription of opioids:

1. Ask the patient to sign an agreement setting clear rules and expectations.

2. Set the dose of medications at the appropriate level to treat the condition and titrate as necessary. Get feedback from the patient.

3. Give enough medication, plus rescue doses.

4. Ask the patient to bring any remaining drug doses to the next meeting in the original bottles. (This provides information on pharmacies used and other prescribing physicians.)

5. Monitor lost or stolen prescriptions.

6. Obtain random urine screens. Know what drugs laboratory screens can actually identify.

7. Use adjuvant analgesics as necessary.

8. Document all your thoughts in the chart.

9. See the patient as frequently as needed.

10. Work with significant others.

11. Know how to withdraw the patient from the medication(s).

12. Know the pharmacology of the drugs used.

13. Adequately treat acute pain to prevent the development of chronic pain.

(Source: *Medscape News*, April 5, 2005.)

## NO CLASS ACTION FOR OXYCONTIN CASE

A New York judge in late January said a personal injury lawsuit against the makers of OxyContin that alleges addiction and other harm from the pain medication cannot go forward as a class-action case.

Justice Stephen J. Maltese, in the Supreme Court of the State of New York for Richmond County, said the case does not meet the criteria of a class action because addiction is an individual injury, and not a common one.

"[This case presents] important individual issues, and to lump all of those issues together would be inappropriate for all of the parties involved," Maltese wrote.

This case marks the ninth written opinion in a state or federal court that has rejected a request for class-action status in the various lawsuits that patients and/or their families have filed against manufacturer Purdue Pharma, LP over the past four years. (Source: American Medical News, February 21, 2005.)