## AFFIRMATION OF STATES' AUTHORITY

The Supreme Court of the United States has ensured that states, through their legislatures, professional licensing boards, and citizens' initiatives, will continue to decide what uses of medications are for a legitimate medical purpose.

In Gonzales v. Oregon, the US Department on Justice (DOJ) was seeking authority through the Drug Enforcement Administration (DEA) to make decisions about the legality of prescriptions in all situations, not just end-of-life care. DOJ could, for example, have ruled that under all circumstances the prescribing of Schedule II barbiturates for insomnia is not a legitimate medical purpose, or that prescribing Schedule II opioids for longer than 60 days is not a legitimate medical purpose. This is not to say DOJ would have done this, but it could if the Attorney General had won the case.

The Supreme Court ruling agreed with two lower federal courts that the states have the authority to determine what prescriptions have been issued for a "legitimate medical purpose." For more information on Gonzales v. Oregon ruling go to *www.webmd.com*. (Source: Medscape from WebMD news release, March 8, 2006.)

## KNOWING HOW TO PLAY THE GAME; ABUSERS' PAIN RELIEF

The Model of "Knowing How to Play the Game" was developed on the basis of participants' descriptions of their experiences and consisted of two core action categories "Feeling Respected/Not Respected" and " Strategizing to Get Pain Relief." The study examined 18 hospitalized substance abusers', 14 men and four women, strategies for obtaining pain relief. They had many suggestions about nursing actions that were helpful or not helpful in assisting them to obtain pain relief. Nursing practice, education, research, and policy implications were discussed.

The Purpose of this study was to identify and explore the experiences of people who have substance abuse problems who sought pain relief during hospitalization for a medical problem. The research questions were: 1) how do participants with substance abuse problems manage painful medical conditions during hospitalization? 2) what difficulties do they encounter in getting adequate help with pain while hospitalized? and 3) how do participants with substance abuse problems understand their interactions with nurses around issues of pain?

In summary, research examining the issue of pain management in people with substance abuse problems has only been examined over the last decade. Research from the perspective of patients with pain and substance abuse problems is needed to identify problems, strategies to manage the pain, and difficulties that arise in the interactions between patients with these problems and the healthcare professionals who care for them. All participants had a painful medical/surgical problem for which they were hospitalized. Their age ranged from 32 to 60 years. (Source: *Pain Management Nursing*, March 2006; 7(1):31-41.)

## ACUTE PAIN AND NARCOTIC USE DOES NOT IMPAIR THE ABILITY TO PROVIDE INFORMED CONSENT

From the Department of General Surgery, Naval Medical Center, Portsmouth, Virginia: Patients evaluated in acute pain will often have narcotics withheld until after the patient has been evaluated by a surgeon and has given informed consent. Concern that the patient would have impaired judgment due to narcotic effects often prevent the administration of timely pain relief. The Hopkins Competency Assessment Tool (HCAT) is a validated instrument for both psychiatric and medical patients; it has not been validated to evaluate drug effects on judgment. Thirty consecutive patients agreed to participate in the trial over a 12-month period. The HCAT was administered prior to the planned major elective procedure and repeated on each postoperative day up to and including postoperative day five. Narcotic use (as morphine equivalents), HCAT scores, demographic data, and surgical procedures were recorded. The average of our patients was 53 years. Twenty-seven patients passed the initial HCAT, and one patient failed subsequent exams. No correlation was seen between HCAT score and narcotic dose. Narcotic administration sufficient for pain control does not impair the ability to provide informed consent. The only patient who failed the HCAT after an initial passing score was somnolent on the narcotic dose. (Source: *American Surgery*, February 2006; 72(2): 154-7.)

## MASSIVE AMOUNTS OF PAIN MEDICATION

It is common practice in pain management to use a long-acting analgesic titrated to an appropriate level to control baseline chronic pain and to add a second, short-acting agent on an as-needed basis to treat occasional

breakthrough pain. It is recommended to determine whether therapy improves patient functionality prior to embarking on a course of long-term opiate therapy. If clear pain relief and improved functionality are not demonstrated, then other medication classes should be considered, as should nonpharmacologic alternatives to achieve patient-specific pain goals.

The rationale for prescribing two long-acting opioids (e.g., methadone and MS Contin) is questionable and appears to be a duplication of therapy. The duration of this particular prescribing regimen is not known; thus, it cannot be determined whether there is intent to wean the patient from extended-release morphine sulfate (MS Contin) and convert to methadone as a single long-acting agent, or otherwise switch to a different long-acting agent. The need for simultaneous prescribing of more than one long-acting opiate and the lack of a short-acting agent for breakthrough pain relief should be questioned.

The pharmacokinetics of methadone are reviewed briefly as follows: methadone acts at μ-receptors, inhibits NMDA receptors, and inhibits monoamine reuptake. The duration of analgesia is approximately three to six hours at the start of therapy and extends to eight to 12 hours with repeated dosing. Plasma levels of methadone generally stabilize within five to seven days due to its long half-life; dosing more frequently than every eight hours is not recommended. There are protocols available to rapidly discontinue the previously prescribed long-acting opiate and replace it with methadone or taper off the previously prescribed opiate with a concomitant upward titration of methadone. Additional information about converting to methadone dosing can be found in the package insert or in the references cited in this summary.

Patients may be at increased risk for respiratory depression with initial therapy, particularly if they are opiate naive, or if comorbid conditions exist (e.g., sleep apnea, heart failure, obesity, severe asthma, or respiratory conditions). Patients who concurrently take other sedative drugs may also be at risk. Caution should be exercised during upward titration because toxicity may not be apparent for up to five days following dosage change. (Source: Medscape Pharmacists, March 2, 2006.)