LETTER TO THE EDITOR

A PARADOXICAL, NOVEL APPROACH: COMBINING MINUTE NALOXONE WITH MORPHINE INTRATHECAL INFUSION

Dear Editor:

It was with great interest that I read the article by Drs Hamann, Sloan, and Witt, published in the July/August issue of *Journal of Opioid Management*.

I was very much fascinated and enlightened by the interesting approach employed by the authors in combining minute dose of naloxone with intrathecal morphine to achieve long-lasting, satisfactory analgesia in one of the most difficult subpolulation of patients who continued to experience intractable pain during conventional intrathecal analgesic infusion. It was quite a laudable and rewarding effort, to say at least, that had provided the patient with significant long-term pain relief and with better quality of living. This is especially precious in a world where defensive medicine is widely practiced.

As a tertitary interventional pain clinic located in Mobile, Alabama, we receive numerous referrals from physicians in nearby states (FL, MS, LA) for intraspinal drug delivery therapy (IDD). Our clinic currently manages more than 500 patients with permanent intrathecal infusion pumps.

We routinely implant Codman 3000 constant flow rate, nonprogrammable intrathecal pumps. The main advantage of using Codman nonprogrammable pump is that it does not have a battery within it, and therefore patients can avoid repeated surgery for battery replacement every 5-7 years. We closely follow the "Polyanalgesic Algorithm for Intrathecal Therapies," updated every few years (most recent version published in Ref. 1).

In our practice, we frequently encountered the aforementioned problems, ie, intractable pain, despite intrathecal analgesic rotations, dosage adjustment (up or down), adding other analgesics or adjuvant (following the Polyanalgesic Algorithm). Failure to achieve any significant analgesia undoubtedly creates disappointment and frustration in patients, their family members, and among physicians. Some of the patients became very depressed and hopeless.

From time to time, we feel that there is a dire need for finding some novel agent that can be used in this subpopulation of patients when conventional intrathecal infusion fails. This case report undoubtedly shines some light, although preliminary, in finding a possible solution to help the most difficult subpopulation of patients.

Lastly, I do have a few questions for the authors regarding the methodology of intrathecal morphine/naloxone trial. According to the trial protocol, the patient was "briefly withdrawn further pain therapy (oral and IT drugs) in prelude for the trial." What time frame did the authors refer to? What was the case patient's opioid status? Opioid dependent or opioid naïve? Or did the authors care about the opioid status at all? Had the patient been opioid naïve, would 2 mg intrathecal morphine bolus (in conjunction with 20 ng naloxone) have been too much? Did the case patient experience any withdrawal symptoms when coming off oral or IT opioids? Was intrathecal ziconotide ever tried?

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REFERENCE

1. Polyanalgesic algorithm for intrathecal therapies. *Neuromodulation*. 2007; 10(4).