Dear Editor,
Thank you for your feedback report on oxycodone vs. morphine prescribing. I am in complete agreement, however, it is probably not General Practitioners you need to convince but hospital prescribers.

I have never (and I'm sure about this) initiated oxycodone. This has always been done by hospital doctors and then one feels somewhat obliged to continue with this, especially if the patient appears to be benefiting.

Dr Andrew Smillie, General Practitioner
Dunedin

Dear Editor,
I have just received your personalised Report of "my" oxycodone prescribing. In this area, we are constantly receiving patients discharged from Hospital on oxycodone. Since this medication has been prescribed by the "specialists" we have little option but to continue it.

I think there IS a place for this medicine in my practice, which is when terminal care patients, still on oral medication, turn out to be intolerant of morphine (my first choice always). I do not think there is any evidence to support that oxycodone has fewer side effects or is better tolerated; but, occasionally it will be tolerated when morphine is not.

The reps are promoting oxycodone as having fewer side effects, which as we know is not supported by evidence. It is important to critically analyse what is presented to you and some clinicians may be temporarily forgetting this.

Dr Sergio Battistessa, General Practitioner
Waiuku

Dear Editor,
Re. The latest personalised feedback regarding oxycodone prescribing.

I have never initiated an oxycodone prescription, but have on occasions renewed prescriptions for patients (largely surgical) who have been prescribed the drug whilst in hospital. I suspect a good number of my General Practitioner colleagues will be in the same boat.

This follows a familiar theme seen in the past with Fortral [pentazocine – discontinued], tramadol and other new drugs, that have been enthusiastically adopted by our less discriminate hospital colleagues, usually surgeons, only to fall by the wayside at a later date when issues such as lack of efficacy, side effects or expense have surfaced.

I would feel much happier getting your feedback reports if I knew that the hospital doctors were getting similar feedback, and being vigorously encouraged to prescribe responsibly.

John Hudson, General Practitioner
Christchurch

We thank all of the correspondents for their feedback on this important issue. Two main themes emerge from the discussion:

1. Oxycodone is largely being initiated in secondary care
2. Primary care prescribers feel that they have no choice but to continue these prescriptions

Therefore the outstanding questions are: why are secondary care prescribers using oxycodone in preference to morphine or other analgesics? Has the marketing of this medicine caused the medical profession to forget that it is a potent narcotic? How can primary care prescribers feel

"empowered" to not continue these prescriptions? How can we influence secondary care to not use this medicine, or at least ensure that it is used in the right patients for the right length of time?

Oxycodone is essentially an equivalent medicine to morphine – there is no evidence that it has a better adverse effect profile, or a better analgesic effect. Like morphine, it would not be the first choice strong opioid for people with renal dysfunction (fentanyl or methadone are "renally safer").

Given that oxycodone is considerably more expensive than morphine, and oxycodone misuse is an emerging trend in New Zealand (and an even greater problem overseas), there seems no reason to prescribe oxycodone in preference to morphine, except when morphine is not tolerated. Other strong opioids such as fentanyl or methadone may be appropriate for some patients.

Although not all prescribers will agree with these points, it appears that the ground swell of opinion among General Practitioners is that they do not wish to initiate oxycodone. This is obviously simple to achieve by not writing prescriptions, but two problems remain – how can this message be adopted by secondary care prescribers and how can General Practitioners avoid continuing oxycodone once a patient has begun taking it?

A suggested strategy for managing a patient discharged from secondary care on oxycodone is as follows:

- When the patient presents in general practice after discharge or for a renewal of their prescription, assess their level of pain and consider whether an opioid is still required
- If a strong opioid is not required, step down to a weaker opioid such as codeine or to paracetamol
- If a strong opioid is still required, explain that morphine is equally effective, with a similar adverse effect profile and is the preferred choice of strong analgesia in general practice
- Remember to prescribe an antiemetic, a laxative and a breakthrough pain dose as required
- Prescribe a short course of morphine and regularly assess pain levels and step down analgesia when appropriate

Changing prescribing behaviour in secondary care is more challenging. This will involve a collaborative effort from organisations such as ours to ensure that responsible prescribing messages are being disseminated across the health sector as a whole. We require the cooperation of our secondary care colleagues to prevent oxycodone being prescribed inappropriately, both in hospitals and in the community.

We value your feedback. Write to us at: Correspondence, PO Box 6032, Dunedin or email: editor@bpac.org.nz