The authors arrived at a more positive conclusion regarding the beneficial effects of aspirin for cancer prevention than a thorough and well-reported systematic review published in 2013.[4] This 2013 review was not discussed in the current review.

The authors of the 2013 systematic review concluded that the uncertainty around their cancer estimates remained high.[4] The long-term all-cause mortality data did not provide compelling evidence for the use of aspirin for protection against cancer and cardiovascular mortality.[4] It was reported that the absolute benefits and harms of aspirin for the primary prevention of cancer and cardiovascular disease were low, with only 34 – 36 colorectal cancer deaths and 60 – 84 major cardiovascular events averted per 10 000 people over ten years.[4]

Conclusions and implications for clinical practice

Although the 2014 review reported promising results for aspirin as prophylaxis for certain types of cancer it is unclear how reliable the results are. More high-quality research is needed, including long-term randomised trials, before any definite conclusions can be drawn regarding the benefits and harms of aspirin for the primary prevention of cancer. It is important that clinicians weigh up the benefits and adverse events associated with aspirin before prescribing it, especially in older patients, as gastrointestinal bleeding and peptic ulcer are common in this group.

References

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3. Antithrombotic Trialists' (ATT) Collaboration, Baigent C, Blackwell L, et al. Aspirin in the primary and secondary prevention of vascular disease: collaborative meta-analysis of individual participant data from randomised trials. Lancet 2009;373:1849–60.
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CORRESPONDENCE

We have received many letters in regards to our recent and ongoing series on the use of oxycodone in New Zealand. We have dedicated the correspondence section in this edition to these letters. To respond to any of these letters and express your views, you can add to the discussion online at: **www.bpac.org.nz/BPJ/2014/September/correspondence.aspx**

What are the real reasons behind the use of oxycodone?

Dear Editor,
Re: Oxycodone – How did we get here and how do we fix it?

I read with interest the prescribing rates for oxycodone in your latest update sent to all GPs. I would like to make a few points.

The first is that the article is unlikely to be convincing to those doctors who prescribe oxycodone, and is more likely to be a pleasant message to those who do not. If this is true the article is pointless as nothing will change!

Thinking on that a little deeper the question is "why do we (GPs and hospital doctors) prescribe oxycodone?

I think the answer is the widely held belief that this is a medication with some reduction in side effects. I think perhaps that needs to be directly and thoroughly addressed, quoting serious research, if there is to be a sea change in prescribing habits. Having said that there are countless times that GPs have claimed certain drugs are better or worse despite so called evidence and in the end we have often been found to be correct. So the research has to be very, very good, i.e. double blind crossover, etc.

The suspicion is that the main reason for publishing articles on various opioids is that funding for bpac and other organisations like yours, e.g. Pegasus, comes with strings attached asking you to help save money – perhaps this should be stated? To me the money is irrelevant as my clients would be incensed to think it is relevant.

The third point is if you add up all opioid scripts apart from codeine, then the overall trend for the total is going up strongly. Is this true? The drivers for this could be widespread abuse of non-cancer pain but it also reflects a growing trend for total failure of the health system to keep up with demands for orthopaedic procedures. This should be highlighted.

***Dr Hammond Williamson**, General Practitioner*
Christchurch

We thank our correspondent for his candid comments which add to the debate on the challenges of prescribing opioids for use in the community.

In the article "Oxycodone – How did we get here and how do we fix it?" (BPJ 62, Jul, 2014), we discussed the available evidence on the efficacy and adverse effects of oxycodone. The problem is that there are very few high quality, head-to-head trials comparing oxycodone with other strong opioids. Perhaps it is better to view the evidence in terms of what is not proven, which would lead to the conclusion that we cannot say for certain that oxycodone is superior to morphine in terms of adverse effects. There is some evidence that oxycodone may be less associated with nausea and vomiting than morphine, but there is also some evidence that it is more associated with constipation. If in balance, these two medicines are considered similar in efficacy and adverse effect profile, it then comes down to a decision based on other risks and benefits. The emerging misuse and addiction problems with oxycodone in New Zealand, coupled with the lessons learnt from other countries that have been dealing with these problems, swings the balance in favour of morphine, if a strong opioid is required at all. This is actually the bigger message in the "oxycodone story" – with the exception for use in malignant pain, why are we prescribing strong opioids in the community at all?

Although the prompt to explore and write about medicines is often directed at those medicines with significant cost to the health system, in order to reap the health benefit of this expenditure the medicines need to be used in accordance with best available evidence and practical application of this evidence, which is the thrust of many of our articles. This is true of medicines that are relatively inexpensive and used frequently in medicine (often general practice), as it is true of more expensive treatments that are used in a very few patients. Cost is relevant to many patients, who make cost-benefit decisions daily in all aspects of their lives. Patients are sometimes flabbergasted when they find out the actual cost of their medicine, as opposed to the $5 prescription fee they pay at the pharmacy.

In the case of oxycodone, we have collaborated with both PHARMAC and Medsafe to highlight the general safety issues with this medicine, and cost has not been a significant factor in these discussions.

As for the final point - the amount of strong opioids being used in New Zealand is increasing, as evidenced by national pharmaceutical dispensing data. It is difficult to say with certainty what is driving this increased use, but it is likely to be a combination of many factors, including widespread use of strong opioids for both malignant and non-malignant pain, misuse and misappropriation of prescriptions and pressures on the health care system to meet demands for definitive treatment of painful conditions.

We hope that the article in this edition, "Helping patients cope with chronic non-malignant pain: it's not about the opioids" may at least give clinicians some tools to help stem the tide of opioids.

Were problems with morphine formulations a factor in the uptake of oxycodone?

Dear Editor,
Re: Oxycodone – How did we get here and how do we fix it?
I have read the above article in your July edition of Best Practice. I have taken on board a number of the relevant points that you have made.

I would like to remind you and your readers that the introduction of Oxycontin to the New Zealand market was prompted by a group of concerned providers in the palliative care sector. This

followed PHARMACs decision to stop funding MST branded slow release morphine in favour of M Eslon. M Eslon appeared to have only an eight hour duration of action rather than the 12 hours previously experienced by MST. This led to widespread concern amongst palliative care patients. PHARMAC as usual totally ignored their concerns and it was a great relief when a new product that worked well did become available.

Oxycontin and Oxynorm have been my first-line choice where an opiate is medically indicated because of this previous experience.

***Dr Ross Ogle,** General Practitioner*
Tauranga

It is pleasing that points made in the article "Oxycodone – How did we get here and how do we fix it?" (BPJ 62, July, 2014) have been found to be relevant to our correspondent and useful in his clinical practice.

It is also interesting to review some of the history of the introduction of m-Eslon and oxycodone in New Zealand. When prescribing a new product, be it a new medicine (in the case of oxycodone) or a new product formulation (in the case of m-Eslon) there will be a period of gaining experience with prescribing it, understanding its effect and effectiveness for patients, and learning where it fits into your own, and wider, clinical practice.

As substantiated by our correspondent, when m-Eslon became funded on the Pharmaceutical Schedule there were anecdotal reports that its analgesic effect did not always last the expected 12-hour duration; this may have been more prevalent at lower daily doses of m-Eslon. However, there have also been reports of the MS Contin formulation not controlling cancer pain using a 12-hourly dosing regimen: in an review of early studies of patients with moderate to severe cancer-related pain who were transferred from a 4-hourly, immediate-release morphine dosing regimen to 12-hourly, sustained release MS Contin, 93% of patients were successfully treated with 12-hourly MS Contin, but 7% required 8-hourly MS Contin dosing.*

Similarly, we have learned more about oxycodone and its formulations as experience has been gained. So is it the medicine, the new formulation, the patient or the change?

* Kaiko R, Grandy R, Oshlack B, et al. The United States experience with oral controlled-release morphine (MS Contin tablets). Cancer 1989;63:2348-54.

Managing patients expectations when prescribing oxycodone

Dear Editor,
Re: A Disaster in the making
I enjoyed reading Dr McMinn's impassioned discussion in your June 2014 edition [BPJ 61] warning of an opioid tsunami heading towards New Zealand. As a New Zealand GP on a locum adventure to a single doctor outback town in NSW a few years ago, I remember my bewilderment on discovering a staggering 15% of consultations related to the renewal of prescriptions of Australia's favourite opioid, oxycodone. Patients seemed evenly divided between those purportedly suffering from chronic back pain and those professing to be hopelessly addicted to strong analgesics. All pleaded their case that an increase in dose was surely required and hoped that I had a better understanding of their suffering than their regular doctor. It was hard to know what to believe and even harder to know what approach to take. Should I adopt the path of least resistance and risk escalation of the community drug problem or put my foot down, refuse to play ball and risk a riot and the hard-working GP returning and wishing he had not left me in charge? I chose the middle ground; refusing to escalate analgesia and documenting a sufficient degree of concern in the medical records hoping the returning GP might be able to use this as leverage.

I would be most interested in Dr McMinn's comments on the use of combined preparations of oxycodone and naloxone available in Australia and other countries. Evwwidence seems to suggest that constipation is lessened without reducing analgesic effect. It is promoted as having less potential for abuse but I am uncertain if there is evidence of this. Is this a product we should be making available in New Zealand?

***Dr Kerr Wright,** General Practitioner*
Bay of Plenty (currently working overseas)

Response from Dr Jeremy McMinn:
Dr Wright's experiences are common – "inheriting" patients in whatever capacity, e.g. as a locum, present compelling opportunities to re-consider diagnosis and the consequences of earlier treatment. The patients on long-term opioids seeking escalating doses demonstrate the need to review the original treatment contract in the light of incomplete recovery or, worse, emerging iatrogenic deficits.

How to address this depends on which prescriber(s) will be able to see a revised treatment approach through. The duration of the cover will determine how much can be tackled – often setting the scene for change (but not actually making changes) is a powerful tool to hand over to the returning doctor, who may be grateful for the opportunity to use a colleague's second opinion to good effect. But if you are taking over the prescribing for the longer haul, this needs to fit with your prescribing integrity – after six months, every treatment contract with the patient is yours, not the earlier doctor's!

The combination of oxycodone and naloxone has much false promise, in my view. The key concern is that this maintains a perspective that chronic opioids are a normal, valid, readily used intervention – we should be questioning this with wise and grave doubt.

As for the alleged effects on constipation and abuse potential, it is important to distinguish between evidence and marketing. There is little good evidence for oxycodone, but one can extrapolate from other combination attempts. Naloxone, when combined with buprenorphine (in the form of Suboxone), has no clinically useful effect on constipation. Research by Larance et al*[*] *demonstrated that even buprenorphine with naloxone in a buccal film preparation was still subject to significant rates of abuse. That having been noted, buprenorphine alone may have a greater abuse potential: the same may be true for oxycodone alone.*

The analogy of low tar cigarettes springs to mind – the gains are so little, but the product has a seductive sense of being safer.

* Larance B, Lintzeris N, Ali R, et al. The diversion and injection of a buprenorphine-naloxone soluble film formulation. Drug Alcohol Depend 2014;136:21-7.

ACKNOWLEDGEMENT: Thank you to **Dr Jeremy McMinn**, Consultant Psychiatrist and Addiction Specialist, Wellington for providing this response.

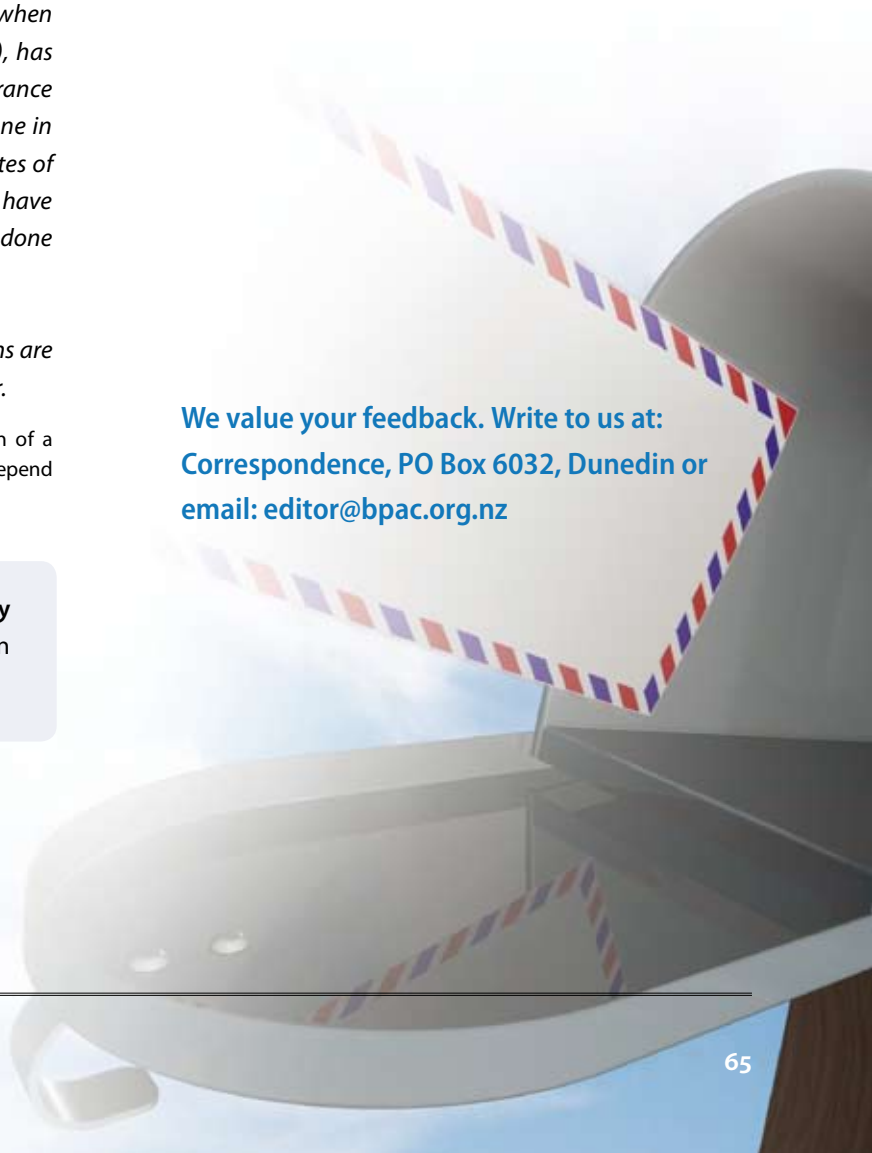
Incorrect graphic in oxycodone article

Dear Editor,

Page 24 of Issue 62 (July, 2014) of Best Practice Journal carries a graphic of a tablet bottle with an oxycodone hydrochloride label on it. I wonder if it was intentional that the label also had "Pharmacy Only Medicine" displayed? I'm sure you're aware that oxycodone is classified as a Controlled Drug and not a Pharmacy-Only Medicine and as such, it is inappropriate, and illegal for a real tablet bottle for oxycodone to bear the words "Pharmacy Only Medicine". I understand that this is just a graphic, but a reasonable level of accuracy in your publication is expected.

***Andrew Orange**, Pharmacy Advisor*
MidCentral DHB, Palmerston North

We apologise for this oversight. You are correct, this was just a graphic and is not a real dispensing container. We have corrected this graphic in our online version of this article.



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