

Considerations in selecting rapid-onset opioids for the management of breakthrough pain

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Dear editor

We read with great interest the recent publication by Smith.¹ This article provides a valuable perspective on the selection of an agent to manage breakthrough pain. Smith recognizes the importance of a fast onset-of-action and the identification by Farrar et al² of a 33% (often ≥ 2 point) change in the pain intensity difference as a measure of a ‘clinically important improvement’. For these reasons, Smith focuses on the various transmucosal fentanyl formulations that offer a rapid onset and he provides a nice summary of the key features of each of the available products.

Smith¹ also provides some ‘advantages and disadvantages’ of different routes of administration which can be used to select an appropriate formulation for an individual patient. We agree with much of the commentary presented, but feel that the grouping of dissimilar formulations based on route of administration is potentially too simple. For example, Smith¹ includes two different products in the intranasal route discussion, despite earlier recognition of key formulation differences, and in doing so allocates weaknesses of one formulation to the other. We would like to inform readers of three important points regarding one intranasal fentanyl formulation:

- First, fentanyl pectin nasal spray (Lazanda[®]/PecFent[®] Archimedes Development Ltd, Nottingham, UK) includes the unique PecSys[®] technology that forms a bioadhesive gel on the nasal mucosa, which significantly reduces run-off/drip compared with a simple solution.^{3,4} This means that the fentanyl is retained in the nasal cavity and that variable absorption associated with nasal drip or swallowing is not an issue for fentanyl pectin nasal spray. Other formulations (nasal and oral) explicitly acknowledge in their prescribing information, the potential for variable absorption.^{5,6}
- Secondly, the absorption of fentanyl from fentanyl pectin nasal spray has been specifically studied in patients with rhinitis;⁷ in that setting the absorption of fentanyl was not affected by nasal inflammation (area under the curve from time 0 to time of last quantifiable plasma concentration, area under the curve from time 0 to 1 hour after administration, maximum plasma concentration, and time to maximum plasma concentration) – which by implication suggests that patients with colds or illnesses that result in changes to the nasal mucosa are suitable candidates for fentanyl pectin nasal spray.
- Finally, data from fentanyl pectin nasal spray Phase III trials^{8–10} show that patients did not have difficulty using the spray device; in fact the vast majority reported a high degree of satisfaction.

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We agree with Smith's conclusions¹ that treatment selections should be based on patient needs, but we felt it important to offer an added perspective on the criteria being used to make such a selection.

Disclosure

MP and SL are currently employed by Archimedes Pharma. The authors report no further conflicts of interest in this work.

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