Opioid patient controlled analgesia use during the initial experience with the IMPROVE PCA trial: A phase III analgesic trial for hospitalized sickle cell patients with painful episodes

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nals were scored as a split signal (chromosomal break), if two signals of different color were separated by a distance more than two times the diameter of one signal.

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References
eters were similar across treatment arms for both child and adult subjects. A reduction in pain intensity during PCA treatment was observed in both treatment arms (mean difference from baseline ± SEM: 2.6 ± 3 cm HDLI vs. 3.4 ± 4 cm LDHI). Time to target improvement (2.5 cm) did not differ (2.7 ± 0.3 days HDLI vs. 2.6 ± 0.5 days LDHI). The Patient Global Impression of Change Scale (PGIC) was rated as moderately better or higher by 79% of study participants and did not differ by treatment arm (P = 0.32, Cochran-Armitage trend test). The duration of hospitalization for adults in the HDLI group was 7.1 ± 1.3 days, and for the LDHI group was 3.9 ± 0.3 days. Hospital durations were similar for children in both PCA groups (HDLI 4.0 ± 0.7 days, LDHI 4.6 ± 1.2 days).

The frequency of morphine and hydromorphone use were similar in both treatment arms (HDLI 47% morphine, LDHI 53% morphine), but hydromorphone usage was much more prevalent in adult subjects (82%) compared to children (18%) reflecting local site investigator clinical practices and PCA pump capabilities. The mean total cumulative opioid utilization for the duration of PCA usage in morphine equivalents in adults for the HDLI treatment arm was 11.6 ± 2.6 mg/kg, and for the LDHI treatment arm was 4.7 ± 0.9 mg/kg, and in children was HDLI 3.7 ± 1.0 mg/kg and LDHI 5.8 ± 2.2 mg/kg. When converted to morphine equivalents there was little difference in opioid use between the hydromorphone and morphine treatment arms for both adults and children (Supporting Information Table 2).

For children, cumulative total morphine utilization in both PCA strategies was virtually identical for the first 2 days of hospitalization, but began to increase thereafter in the LDHI treatment arm compared to the HDLI arm (Fig. 1, bottom panels, Supporting Information Table 2A). Total morphine utilization in adults was different from that in children with the cumulative morphine utilization in the HDLI arm exceeding the LDHI arm on all days of hospitalization (Fig. 1, bottom left panel, and Table 2B Supporting Information). The observed opioid constant infusion dose usage was higher in the LDHI arm than in the HDLI arm as designed, and infusion dose usage within treatment arms was similar in both adults and children, the cumulative infused dose usage on discharge day for HDLI 1.5 ± 0.3 mg/kg (adults) and 1.1 ± 0.2 mg/kg (children), for LDHI 2.8 ± 0.4 mg/kg (adults), and LDHI 3.9 ± 1.4 mg/kg (children; Fig. 1, middle panels). However, the demand dose utilization was strikingly different in children compared to adults, with little difference in cumulative demand dose usage between the HDLI and the LDHI treatment arms in children (HDLI 2.0 ± 0.5 mg/kg, LDHI 1.6 ± 0.7 mg/kg), but with a much larger usage difference in adults (HDLI 9.3 ± 2.1 mg/kg, and LDHI, 1.7 ± 0.5 mg/kg; Fig. 1, top panels). This difference in demand dose utilization largely explained the differences in total opioid utilization between children and adults. Daily opioid usage in both adults and children was lower on those days with lower pain intensity scores and higher on those days with higher pain intensities (Fig. 2). This relationship was less prominent in adults randomized to the HDLI treatment arm, particularly on days with high (>7/10) pain intensities. More detailed analyses of dose-response relationships were not possible given the small sample size.

Each of 12 opioid related symptoms was rated by intensity, duration, and bothersomeness (0–4 Likert scales) [11]. Drowsiness, lack of energy, and itching were the most prevalent opioid-related symptoms in both children and adults. Reported opioid-related symptoms were generally mild to moderate and similar in children and adults (Supporting Information Table 3). The mean daily opioid symptom scores over the duration of PCA treatment were similar for each of the three components of the symptom score, with intensity scores for children 0.8 ± 0.2, adults 0.9 ± 0.1 (P = 0.67); mean daily duration score in children 0.9 ± 0.2, adults 1.0 ± 0.1 (P = 0.47); and mean daily bothersomeness score in children 1.0 ± 0.2, adults 1.0 ± 0.2 (P = 0.96). Opioid-related symptoms were similar in both PCA arms with a mean daily opioid symptom intensity score: HDLI 0.9 ± 0.1, LDHI 0.9 ± 0.2; mean daily duration score HDLI 1.0 ± 0.1, LDHI 0.9 ± 0.2; mean daily bothersomeness score: HDLI 1.0 ± 0.2, LDHI 0.9 ± 0.2. Mean symptom scores were relatively similar or showed a small decrease across the 3 or 5 day periods, except for increases in constipation symptoms in children and nausea and headaches in adults (Supporting Information Table 3). Antipruritics were prescribed somewhat more often to children (67%) than adults with diphenylhydramine being the predominant medication. Anti-nausea medications were prescribed somewhat more often to adults (55%) compared to children (42%), with promethazine more frequently prescribed in adults and ondansetron in children. Most adults and children were prescribed multiple laxatives reflecting the difficulty treating constipation symptoms. While not required by the protocol, low dose naloxone infusions were used during PCA treatment as standard of care by 58% of children and 9% of adults.

Symptoms consistent with an opioid withdrawal syndrome were elicited with a telephoned administered symptom scale at 3 and 14 days after discharge. Reported symptoms were somewhat more prevalent at the 3 day compared to the 14 day assessment, and were somewhat more prevalent in adults compared to children (Supporting Information Table 4). Symptom intensity was very mild with a mean total 10 symptom score of 0.1 ± 0.1 for children and 0.3 ± 0.1 for adults, reflecting the frequent usage of long-acting oral opioids after discharge.

A number of small cohort or randomized studies [5,7] have examined opioid PCA dosing strategies in children or adults with sickle cell disease, but several methodological issues limit the usefulness of these preliminary studies. While there were some differences in dosing strategies across studies, efficacy findings were not consistent across studies. To improve on these previous studies, we developed a comprehensive study protocol with extensive blinded assessments of opioid efficacy and safety endpoints, recognizing that balancing the degree of pain relief with the frequency of adverse effects is frequently the goal of opioid therapy for both healthcare providers and patients [12]. Detailed PCA dosing guidelines were developed to provide clinically relevant dose ranges to maximized protocol adherence. The study design did not blind the clinical team to treatment assignment to maximize subject safety. This initial subject cohort documented the feasibility of the study protocol and the PCA dosing guidelines, but demonstrated the continued challenges of recruiting SCD subjects to an in-patient interventional clinical trial. As seen in previous opioid PCA studies, the use of substantial PCA demand doses with modest continuous infusions (HDLI) in
adult subjects in this study resulted in larger total cumulative opioid utiliza-
tions than a strategy relying predominantly on continuous higher opioid infu-
sions with small demand doses (LDHI) [8]. However, similar paradigms in
children showed little difference reflecting a smaller use of available demand
doses [13]. As expected, both adults and children varied their opioid usage
in response to pain intensity. The somewhat blunt opioid usage at high
pain intensities, particularly for adults using the HDLI treatment arm, reflects
the clinical difficulties in obtaining pain relief in this situation and reinforces
the need to define optimum analgesic dosing strategies as these partici-
pants may have not been able to utilize a sufficient number or frequency of
demand doses. Opioid-related symptoms were well managed using detailed
symptom management guidelines in this cohort, and symptoms consistent
with withdrawal symptoms after hospital discharge were infrequent and rela-
tively minor in intensity.

Conclusions from the current PCA study are limited by the small sample
size. However, the results of this study demonstrate the feasibility of the
study design, and provide preliminary data that will allow further optimization
of study endpoints, sample size considerations, opioid dosing guidelines,
and pain and symptom assessments for the design of future analgesic
clinical trials in SCD. Determinations of opioid usage in future studies would
be facilitated by the use of consistent policies for PCA administration and
monitoring, and the use of PCA pumps that digitally record opioid dose
administration. Differences in degree of utilization of opioid PCA demand
dose in adults compared to children suggest the need for future studies that
are adequately powered to detect and explain analgesic utilization response
differences between these two age groups. Further larger studies to explore
the relationships between patterns of opioid utilization, pain relief, and hospi-
talization duration in patients with sickle cell disease are needed to optimize
clinical care for this patient population.

Methods

Protocol development. The Sickle Cell Disease Clinical Research Net-
work (SCDCRN) was established in 2006 to develop and conduct phase III
intervention trials within 31 clinical sites. The IMPROVE PCA trial (Improving
Pain Management and Outcomes with Various Strategies of Patient-
Controlled Analgesia) was developed as a randomized controlled trial of two
different PCA treatments, and was approved by the NHLBI Protocol Review
Committee in July 2009 and by the NHLBI Data Safety Monitoring Board in
August 2009. Local institutional review board (IRB) approval was obtained at
all participating clinical sites and study enrollment was initiated on December
31, 2009. The study was terminated in June 2010 due to slow enrollment
and insufficient time to complete the study prior to Network closure in March
2011.

Study design. The primary study endpoint was the time to first occur-
rence of a clinically relevant improvement in pain intensity, defined as a
2.5 cm decrease from baseline in daily average pain intensity measured on
a 10 cm VAS. This value was selected based on previous studies of SCD
subjects reflecting moderately significant pain intensity improvement [14].
Secondary effectiveness endpoints included the total daily cumulative opioid
dose delivered, the rate of change in daily average pain intensity scores,
and the magnitude of global patient satisfaction/evaluation scores obtained
at Day 3 for pediatric subjects and Day 5 for adult subjects or at day of dis-
charge, whichever occurs first. A number of exploratory pain assessment,
pain relief, and activity measures were also conducted and are reported in a
separate manuscript. Secondary safety endpoints included the daily intensity
opiod-related symptoms scores, including sedation, nausea, and pruritus
scores, and the magnitude of patient reported opioid-related withdrawal
symptoms as assessed by scripted telephone interview at 3 and 14 days
post hospital discharge.

Sample size calculation. Based on single institution pilot data, it is
assumed that half of all subjects randomized to the Low Demand PCA arm
would meet the primary endpoint criterion by 5.0 days. A total of 278 subjects
(139 per arm) is needed to detect a 30% reduction attributable to the High
Demand PCA strategy (i.e., half of all subjects will meet the primary endpoint
in 3.5 days rather than 5.0 days) with 80% power. This calculation assumes
incorporation of two inflation factors: (1) a 5% dropout rate shortly after ran-
domization (N0.95); and (2) a 2% inflation rate to account for interim looks at
the data during trial monitoring (N1.02). The dropout rate is assumed to be
very low because if dropout occurs during the hospital stay, there is still sta-
tistical information to be derived from the days of observation on treatment prior
to withdrawal from the trial, and thus such subjects are not truly full dropouts.
The choice of a 30% reduction and 80% power (N = 278) was based on the
importance of showing a definitive reduction to guide clinical management
and the available resources to complete the trial.

Study inclusion and exclusion criteria. Individuals with all genotypes of
sickle cell disease, >age 10 years with vaso-occlusive crisis, <12 hr of
parenteral opioid therapy from time of presentation to the Emergency
Department, and a 10 cm visual analogue scale (VAS) pain score >4.5,
were eligible for the study. This value was chosen as it was the minimum
value that encompassed the typical clinical practice of the study investiga-
tors. To reduce potential dosing issues related to opioid tolerance, subjects
were excluded if they were receiving chronic moderate to high dose oral
opioids such as methadone >40 mg/day, sustained release morphine >120
mg/day, or oxycodone >80 mg/day. Subjects with hyposia (pulse oximetry
oxygen saturations <92%) or acute chest syndrome were excluded to avoid
confounding with opioid induced respiratory depression. Because of potential
alterations in opioid metabolism related to significant renal/hepatic dysfunc-
tion, subjects were excluded for ALT >5 times institutional upper limit of nor-
mal, direct bilirubin >0.8 mg/dl, or creatinine >1.2 mg/dl for ages >18 years,
or ages 10–18 years creatinine >1.0 mg/dl.

PCA strategies. Ratios of opioid demand dose to infusion dose were
chosen at 3:1 or 1:3 (depending upon treatment assignment) to provide a
reasonable difference in opioid delivery. A lockout interval of 8 min was used on
all PCA pumps, but hourly or 4 hourly maximums were at the discretion of
the treating physicians for safety considerations of individual subjects.
Investigators used study provided opioid dosing tables for each morphine
or hydromorphone dose range to reduce the risk of medication errors or proto-
col non-compliance (see Supporting Information). Dosing was weight based
for patients who weighed <50 kg. The dosage range for adults (≥18 years)
spanned a two-fold range in 7 steps while a 4-fold dosing range was used in
pediatric subjects (10–17 years) to provide additional lower dosing ranges.

PCA treatment protocol. Patients (or their parent/legal guardian) were
approached about study participation after a clinical decision had been
made to admit for further vaso-occlusive pain management. Alternatively,
some IRBs allowed study pre-consent in the clinic setting followed by confir-
mation of consent at the time of admission. Following informed consent,
subjects were randomized to either a high demand dose, low infusion
(HDLI) opioid PCA dosing strategy or a low demand, high infusion (LDHI)
opioid PCA strategy. Either morphine or hydromorphone were used, based
on physician and/or subject preference. Treatment assignment was stratified
within site by opioid choice and by age group (adult versus pediatric). All
subjects started study PCA treatment at doses indicated in dosing guideline
tables (see Supporting Information). Long-acting opioids were discontinued
at the end of opioid analgesics, such as non-steroidal anti-inflammatory drugs,
were allowed and were administered as per stand-
ard practice at the respective clinical sites. If, in the judgment of the clinical
investigator and inpatient clinical care team, a subject required higher opioid
doses for adequate analgesia than those initially selected, options included
providing a limited number of additional parenteral rescue opioid doses or
increasing the opioid PCA dose to a higher level in the dosing guidelines.
The protocol provided guidelines for subsequently reducing opioid PCA dos-
ing for adequate analgesia, and for temporary opioid cessation and subse-
quent dose reduction for respiratory depression. The assigned PCA strategy
was continued until patients were transitioned to oral analgesics, the timing
of which was at the discretion of the clinical care team in collaboration with
the study investigator.

Each clinical site followed their own routine nursing policies and proce-
dures for administration of PCA, and used clinically available PCA pumps.
Sites that did not have PCA pumps that could deliver two-decimal accuracy
for infusion rates were not allowed to randomize individuals weighing less
than 50 kg to hydromorphone, as the hydromorphone dosing tables required
such accuracy. Opioid usage was calculated from clinical PCA flow sheets
submitted to the study data coordinating center.

Assessments. Assessments were collected by a member of the research
team blinded to treatment details. Analgesic response to PCA treatment was
assessed by self report of pain using a 10 cm VAS, three times daily at 4 hr
intervals between 7 am and 7 pm. This time interval was felt by investigators
to be the most clinically relevant to assess pain improvement, recognizing
that pain improvement during nighttime hours will be poorly recognized. At
the time of the last VAS measurement of the day in the late afternoon or early evening, subjects completed an opioid-related symptom scale modified from the Memorial Symptom Assessment Scale [11]. A Global Impression of Change (7 point Likert scale from very dissatisfied to very satisfied) was obtained on day 5 for adults, day 3 for pediatric patients, or on the day of discharge, whichever occurred first. Subjects were contacted by telephone interview 3 and 14 days after discharge to ascertain the presence or absence of symptoms of opioid abstinence syndrome using the short opioid withdrawal scale [15]. The median 24-hr period (infusion, demand dose, and other bolus doses as delivered by the PCA pump, in addition to any oral, intramuscular, and transdermal opioid medications taken). The cumulative total opioid use was the sum of all opioid analgesic medications received during the hospitalization. The scores on the opioid-related symptom scale and the short opioid withdrawal symptom scale were computed as specified by the developers, and are presented as average daily means ± standard error. Statistical analysis was performed using the R language for statistical computing, version 2.12.1 [16] with the lme4 package [17–19]. Raw averages of the cumulative opioid trends are depicted in Fig. 1. The trends in Fig. 2 are computed using generalized additive mixed models with 95% bias-adjusted empirical Bayes confidence intervals that account for correlation of trends within subject.

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Prevalence of pulmonary hypertension in hereditary spherocytosis

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Vascular complications, including pulmonary hypertension (PH), have been reported to occur following splenectomy for various disorders, including hereditary spherocytosis (HS). We performed a prospective cross-sectional study of 36 adults with HS (78% with prior splenectomy) utilizing echocardiography to estimate tricuspid regurgitant jet velocity (TRV) as well as measurement of N-terminal pro-B-type natriuretic peptide (NT-proBNP) to screen for PH. No participant with HS had a significantly elevated TRV or NT-proBNP level, despite a median 26-year interval since splenectomy (95% confidence interval for point prevalence 0.0, 0.097). Although our study was limited by a small sample size, it appears that persons with HS, following splenectomy, appear unlikely to be at significantly increased risk of developing PH to the degree reported for thalassemia and sickle cell disease.

Splenectomy is often performed in hereditary spherocytosis (HS), autoimmune hemolytic anemia, immune thrombocytopenia (ITP), and thalassemia intermedia and major. Overwhelming bacterial sepsis has long been known as a complication in persons with asplenia, but is now infrequent because of pneumococcal vaccinations, prophylactic penicillin, and prompt medical attention at the first sign of fever.

During the past decade evidence has emerged that an increased risk of thrombosis, both venous and arterial, may result from splenectomy [1]. This complication has been described in diverse asplenic states including HS, thalassemia, other hematologic anemias, and trauma [1–4]. In thalassemia and sickle cell disease, another vascular complication, pulmonary hypertension (PH), has also been described following splenectomy, with some studies reporting PH prevalence as high as 75% [5–7]. Asplenia has also been

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