Did You Know?
That many medications used orally can be prepared for direct topical application to the pain site?

Compounding for Pain Management and Palliative Care
An Interview with Alexander Peralta, Jr, MD

Alexander Peralta, Jr, MD, a specialist in pain and symptom management, is the director of Palliative Care Services for American Hospice of Texas in Fort Worth, Texas. Dr. Peralta received his undergraduate degree from the College of Pharmacy at the University of Texas at Austin, Texas, in 1968. In 1975, he was chosen as one of 50 national scholarship recipients by the president of Mexico to attend medical school; he subsequently completed his medical education at the Centro de Estudios Universitarios, Instituto de Estudios Biomedicos, Mexico, and New York Medical College in Valhalla, New York.

While practicing in internal medicine, Dr. Peralta developed a special interest in and compassion for patients in pain. He is a diplomate of the American Board of Hospice and Palliative Medicine and a member of the American Medical Association, the American Academy of Hospice and Palliative Medicine, the National Hospice and Palliative Care Organization, and the Texas and New Mexico Hospice Organization. In the following interview, Dr. Peralta describes the use of compounded medications in patients suffering from acute or chronic pain.

How did you become interested in pain management?
In addition to maintaining my office-based practice in internal medicine, I worked for 12 years as a hospitalist in the intensive care and critical care units in several local hospitals, where providing pain control was often an essential part of treatment. In my private practice, I identified three sets of patients who usually do not receive adequate pain management. First are those experiencing an acute

CASE REPORT
Ketoprofen 5% and Gabapentin 5% Gel for Neuropathy

Sam Pratt, RPh
Pharmacy Specialists
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A 72-year-old white woman presented with significant pain and numbness in her lower legs and feet. She had been given a diagnosis of diabetic neuropathy with associated nerve damage and essential tremors 8 years earlier. Her other medical problems included heart disease, chronic obstructive pulmonary disease, and rheumatoid arthritis. She had been treated for the last 4 years with oral gabapentin (Neurontin). However, the gabapentin did little to ease her pain and numbness, which she described as “like walking on broken glass.”

Treatment
Her physician, a neurologist, set up a pharmacy consultation and asked me to prepare a topical gel containing ketoprofen 5% and gabapentin 5%, to be applied 3 or 4 times daily. He was especially interested in trying a topical compound instead of an oral medication for this patient because she was already taking a number of oral medications.

Outcome
Before using the ketoprofen/gabapentin gel, the patient felt pain from the tops of her calves to the bottoms of her feet. After the first application, she noticed improvement. Within a month, her symptoms were more tolerable; her condition has continued to improve since that time. In view of these results, her physician discontinued the use of the oral gabapentin. She now relies solely on the ketoprofen/gabapentin gel to relieve the symptoms of neuropathy. Today, the pain and numbness have been significantly reduced and are limited to her ankles and feet.

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pain crisis caused by a myocardial infarction, a pulmonary embolus, sickle cell anemia, or a traumatic injury. The literature has shown that treating an acute pain crisis does not mask the origin of a patient’s pain.

The second set of patients whose pain is inadequately treated includes those with conditions such as rheumatoid arthritis, lupus erythematosus, progressive systemic sclerosis, or other connective tissue disorders. Many physicians are very reluctant to provide analgesic medications to relieve the severe pain caused by such disorders. I found that treatment with anti-inflammatory drugs, gold therapy, and methotrexate often did not relieve the pain caused by rheumatic diseases, which is debilitating and causes the eventual loss of functional capacity. Without effective pain relief, performing the activities of daily living becomes nearly impossible. I began to prescribe low-dose opiates (morphine 30 mg once or twice daily) for those patients, many of whom were elderly and, therefore, that they experienced fewer side-effects related to adverse effects. In fact, they could engage in more functional activities, such as water aerobics. Their quality of life improved measurably when they were not in pain.

The third set of patients with inadequately treated pain consists of residents of medical care facilities such as nursing homes. I provide medical care for many of my elderly patients who are admitted to the facility once or twice daily. I have found that their pain is often not sufficiently treated. Staff members often are afraid to administer prescribed opiates routinely, and because they understand the adverse effects of needed, true pain relief is never achieved.

As I began to understand the needs of those three sets of patients, I became more actively involved in providing pain management. One of my patients was a 42-year-old black woman who had been suffering acute pain crises caused by sickle cell anemia. The ischemic pain caused by that disease is excruciating. Before she became my patient, she had been hospitalized for treatment of a sickle-cell pain crisis approximately 12 times during a 3-month period. As her pain management consultant, I promised her that pain would no longer control her life. She did not believe me initially, but effective therapy made that possible. During the subsequent 2 years, she was hospitalized only twice for the treatment of pain caused by her sickle cell disease. She was able to visit family members who lived in distant areas of the country and could continue activities that were once prohibited by her disease-related pain. She even entertained the possibility of re-enrolling in college, providing that type of care is what pain management is all about.

How did you become interested in prescribing compounded medications for pain management?

I began to appreciate the benefits of compounding when I practiced pharmacy for 7 years before I pursued a medical career. I worked as the compounding pharmacist at a university teaching hospital that included 58 specialty programs such as the clinic at a remote site. We prepared cough syrups, ointments, creams, lotions, parenterals, and other medications very economically on a large scale. One of our British clinicians even asked us to make a Brompton’s cocktail (a mixture of morphine, cocaine, chlorpromazine, and Everclear [grain alcohol])! We also compounded preparations used in hyperalimentation, which for me is the epitome of compounding. I was quite content being a pharmacist, but the opportunity to study medicine presented itself at the right time.

Why do you prescribe compounded medications for pain management? About 10% to 15% of the medications that I now prescribe are compounded, and approximately 85% of my patients respond to those formulations. That is an excellent rate of success for the treatments. Compounded medications have a risk of adverse effects that is far less than with off-the-shelf commercial products. Compounded medications help to identify the cause of the disease, but experienced providers of pain management are not complex.

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