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Competing interests: David Burdge, Deborah Money, John Forbes and Sharon Walmsley have all received speaker fees and/or educational grants from various pharmaceutical companies manufacturing drugs mentioned in the original article. Burdge, Forbes and Walmsley have received travel assistance from various pharmaceutical companies to attend meetings within the past 2 years. No competing interests were declared for Lindy Samson.

Opioids and chronic pain

Jacqueline Gardner-Nix[1] advocates the use of opioids for chronic noncancer pain, but this issue is more controversial than her article indicates.[2,3] Both the Ontario Workplace Safety and Insurance Board (WSIB)[4] and the College of Physicians and Surgeons of Ontario (CPSO)[5] have prepared evidence-based guidelines for the management of chronic noncancer pain. The WSIB[4] found only 2 studies of sufficient quality for use in making recommendations for opioids, and the WSIB noted that these drugs were of limited use for up to 6 months. The CPSO[5] concluded that there was some evidence of benefit of short-term (up to 9 weeks) opioid use but noted that "long term opioid therapy may or may not improve functional status and there is some evidence that a treatment program that focuses on analgesics can reinforce pain-related behaviour at the expense of functional restoration."

The single randomized trial[6] that both the WSIB[4] and the CPSO[5] felt was of highest quality reported only modestly lower pain intensity with morphine relative to placebo; in addition, vomiting (39% in the morphine group), dizziness (37%), constipation (41%), poor appetite or nausea (39%) and abdominal pain (22%) were significantly more frequent with morphine use. The study had a 25% drop-out rate (15 of 61) and did not demonstrate any significant improvement in psychological or functional outcome, nor did it find a significant overall patient preference for morphine over placebo.

The role of opioid analgesics in the management of chronic noncancer pain has not been well established. Further research is needed to determine if the benefits exceed the costs.

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Jacqueline Gardner-Nix[1] claims that "It is now acknowledged that opioids may be appropriate in a subset of the population with a variety of conditions that cause chronic pain, including those that are impossible to diagnose exactly." Chronic nonmalignant pain occurs in a wide range of situations. As rheumatologists, we agree that narcotics are appropriate in some cases, for example, an older patient with serious, painful osteoarthritis of the hip who also has contraindications to surgery. Similarly, where palliative care is the goal, then surely it's appropriate to make the patient's terminal years as comfortable as possible. And for short-term problems, such as post-herpetic neuralgia, narcotics may well allow a patient to enjoy life with adequate function.

Conversely, we see a large number of patients — constituting perhaps the largest single diagnostic group in our practice — who have chronic musculoskeletal pain with no clear-cut structural basis. These medically unexplained symptoms include myofascial pain, fibromyalgia and sometimes chronic low back pain. The introduction of narcotics may provide transient pain relief, but no convincing evidence has been published to indicate that they will restore function, get patients back to work or indeed have any long-term benefit whatsoever.[2,3] The patients themselves typically describe opioids as merely "taking the edge off the pain."

In treating such patients, the physician must cope not only with underlying pain-avoidance behaviours and fear of a serious structural diagnosis, but also the potential for increasing use of narcotics. In addition, there is the unspoken belief that if narcotics are being used, then the problem must be "really bad," which may further aggravate the patient's illness behaviour.

Therefore, to Box 1 in Gardner-Nix's article,[1] which lists barriers to prescribing opioids, we would add the lack of evidence of any long-term beneficial impact, in particular improvement of function or restoration of a more normal lifestyle. In the absence of such evidence, we think a sharp distinction should be drawn between situations where it is appropriate to use narcotics for palliation and situations in which these drugs would not be used under any but extraordinary circumstances.

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[The author responds:]

The WSIB[1] and CPSO[2] guidelines cited by Jason Busse surveyed data up to 1998; these data involved studies that were conducted over just a few weeks and that did not always assess physical function or report return to work. Lack of evidence, if the studies have not been done, does not mean lack of efficacy. More recent studies have examined quality-of-life issues and have followed subjects for a year or more, and these have demonstrated benefit of opioid medication.[3-5] Level 2 evidence (strong evidence from at least one properly designed randomized controlled trial of appropriate size) now exists for use of opioids in the treatment of low back and musculoskeletal pain. "Benefit" may be an increased ability to interact with family and friends, better ability to function in the household or improvement in sleep.

In clinical practice, a trial of opioid therapy, with switching of opioids to find one with acceptable efficacy and side effects, may avoid repeat visits from patients with a generally poor response to opioids — such patients can at last be "heard." Once their pain has been addressed, they can move on to other strategies. Anthony Russell and Stephen Aaron cite 2 papers on fibromyalgia, but generally I have found opioids of limited benefit in this condition.

Clinical trials have so far not incorporated opioid rotations[6] or opioid blending, strategies that I have used to maintain opioid responsiveness in some of my patients. Of 209 of my current patients with severe noncancer pain who have been offered opioids and followed for 2 to 15 years, 80 (38%) report good pain control and enhanced physical function compared with before their opioid treatment (26/80 [32%] working, 11/80 [14%] retired) and 74 (35%) report minimal improvement in pain control but enhanced physical function (11/74 [15%] working, 15/74 [20%] retired). A further 44 (21%) report minimal improvement in pain control and physical function (none working, 10/44 [23%] retired), but for these patients slow opioid tapering has resulted in greater use of the health care system, as well as greater patient and family distress. The remaining 11 (5%) tapered off opioids because they experienced no benefit.

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Children and second-hand smoke

As noted in a recent *CMAJ* news brief,[1] there appears to be a general belief that the number of smokers is declining. Nonetheless, working in an area where tobacco production is a big industry and often a family business, I am astounded by the large number of my patients who smoke. For many of these people, I see a direct conflict between health issues and their need to make a living.

As a head and neck surgeon, I see many patients with cancer of the head and neck, and, not surprisingly, almost all of them are smokers. As part of my history-taking for all pediatric patients, I ask the parents whether there is any smoking in the house and, if the answer is yes, I require the parents to state exactly how many cigarettes the child is exposed to daily. This number is recorded in the patient's chart. I want these parents to acknowledge that when they smoke, their children are also smoking.

Parents must be made to realize the effect of their smoking on the short-term and long-term health of their children — they gave their children life and now are taking it away.

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Reference

1. Quebec butts out. *CMAJ* 2003;169(5):464.

Correction

The book *Patient self-care: helping patients make therapeutic choices*, which was reviewed in the October 14 issue of *CMAJ*,[1] is not available through the CMA bookstore.

Reference

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