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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

1. Wooltorton E. Patient self-care: helping patients make therapeutic choices [Book review]. *CMAJ* 2003;169(8):810.