Narcotics for chronic nonmalignant pain

In an article in *CMAJ*'s rheumatology series, Simon Huang states that "narcotic analgesics should be avoided in patients with chronic musculoskeletal pain."[1] Nothing could be further from the truth.

The general consensus as stated in guidelines on the use of narcotics[2] as well as among physicians dealing with chronic pain disorders is that narcotics are almost certainly underutilized in the treatment of chronic musculoskeletal pain. Several studies have confirmed the relatively low risk of the development of drug dependence among these patients, provided they are adequately screened for addiction risk.[3,4] The use of narcotics has improved the level of function and quality of life for many patients with chronic musculoskeletal pain, and elderly patients with arthritis are among the most satisfied clients.

Statements such as this are all too common and result in undertreatment of many chronic pain disorders by primary care physicians. We are now in the same position with respect to chronic nonmalignant pain as were our colleagues 15 years ago when patients with malignancies were often undertreated because of fears of creating drug addicts. Thankfully that situation has changed, and I am confident that in time so will the use of narcotics in the management of chronic musculoskeletal pain.

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Thwarting sore throats

A diagnostic tool for sore throats that can be used during the physician–patient interaction has been a long time coming and has clinical value.[1] However, the real utility of the tool may not be in its diagnostic accuracy. The patient may feel that his or her illness experience is receiving immediate validation when he or she witnesses the rigour the physician applies to assessing the sore throat with a multi-item test; this may result in a decreased desire for an antibiotic. The siren call of empathic prescribing for perceived patient demand will eventually be thwarted by adjustments to interpersonal relations rather than enhanced diagnostic testing.

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1. McIsaac WJ, Goel V, To T, Low DE. The validity of a sore throat score in family practice. *CMAJ* 2000;163(7):811-5.

The report by Warren McIsaac and colleagues that there is no difference in the sensitivity and specificity of a clinical sore throat score for patients seen in community-based family practices and those seen in an academic family medicine unit[1] is helpful for promoting the use of the sore throat score in the community at large. Nevertheless, one has to question the feasibility of implementing this tool on a broad scale, not because there are superior alternative approaches, but rather because of the limitations of the tool that front-line prescribers might perceive.

The medical literature suggests that antibiotics are used excessively to treat upper respiratory tract infections because physicians want to minimize the risk of failing to treat patients who would benefit from antibiotic therapy. Thus, the critical issue for the sore throat score is whether a sensitivity of 85% (or a false negative rate of 15%) will make practitioners sufficiently confident in the tool that they will abide by its recommendations.

It would be helpful if McIsaac and colleagues provided data on the percentage of patients who required an antibiotic prescription but did not get one on the basis of physician judgement. If physician judgement had a false negative rate of less than 15% this would imply that the physician threshold for committing an error of undertreatment is too high for physicians to follow the recommendations of the sore throat score.

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1. McIsaac WJ, Goel V, To T, Low DE. The validity of a sore throat score in family practice. *CMAJ* 2000;163(7):811-5.

[Three of the authors respond:]

Jarold Cosby's suggestion that the score approach may have other benefits is interesting. Anecdotally, some physicians have commented that they use it as a teaching aid to help explain their treatment recommendations. This may be helpful to patients with upper respiratory infection, as they report that sometimes they visit physicians for reassurance that they do not have a serious illness and not necessarily for an antibiotic prescription.[1]