www.cmaj.ca/cgi/data/168/13/1671/DC1/1 (accessed 2003 Aug 28).
2. US Centers for Disease Control and Prevention. Updated US Public Health Service guidelines for the management of occupational exposures to HBV, HCV and HIV and rationale for post-exposure prophylaxis. *MMWR Morbid Mortal Wkly Rep* 2001;50(RR-11):1-42.
3. Public Health Service Task Force. *Recommendations for use of antiretroviral drugs in pregnant HIV-1-infected women for maternal health and interventions to reduce perinatal HIV-1 transmission in the United States*. Bethesda (MD): US Department of Health and Human Services; 2003 Jun 16. Available: aidsinfo.nih.gov/guidelines/perinatal/archive/PER_061603.pdf (accessed 2003 Oct 2).
4. Cooper ER, Charurat M, Mofenson L, Hanson IC, Pitt J, Diaz C, et al. Combination antiretroviral strategies for the treatment of pregnant HIV-1-infected women and prevention of perinatal HIV-1 transmission. *J Acquir Immune Defic Syndr* 2002;29(5):484-94.

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.

Jason W. Busse
Department of Clinical Epidemiology and Biostatistics
McMaster University
Hamilton, Ont.

References

1. Gardner-Nix J. Principles of opioid use in chronic noncancer pain. *CMAJ* 2003;169(1):38-43.
2. Kouyanou K, Pither CE, Wessely S. Iatrogenic factors and chronic pain. *Psychosom Med* 1997;59:597-604.
3. Kouyanou K, Pither CE, Rabe-Hesketh S, Wessely S. A comparative study of iatrogenesis, medication abuse, and psychiatric morbidity in chronic pain patients with and without medically explained symptoms. *Pain* 1998;76:417-26.
4. Chronic Pain Initiative. *Report of the Chronic Pain Expert Advisory Panel*. [Toronto]: Ontario Workplace Safety and Insurance Board; 2000.
5. *Evidence-based recommendations for medical management of chronic non-malignant pain: reference guide for physicians*. Toronto: College of Physicians and Surgeons of Ontario; 2000.
6. Moulin DE, Iezzi A, Amireh R, Sharpe WK, Boyd D, Merskey H. Randomized trial of oral morphine for chronic non-cancer pain. *Lancet* 1996;347:143-7.

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.

Anthony S. Russell
Stephen L. Aaron
Department of Medicine
Division of Rheumatology/Clinical Immunology
University of Alberta
Edmonton, Alta.

References

1. Gardner-Nix J. Principles of opioid use in chronic noncancer pain. *CMAJ* 2003;169(1):38-43.