We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Opioid Therapy and Chronic Low Back Pain

To the Editor: I find JABFP's decision to publish the article by Brown et al "Chronic Opioid Analgesic Therapy for Chronic Low Back Pain"[1] puzzling. The studies cited to support their contentions regarding the use of COAT were not controlled. Abuse was documented in at least three of the studies. The protocols needed for implementation of COAT in an average family practice setting are formidable.

The studies aside, the paper downplays the extensive data that COAT is a risk factor for developing drug and alcohol problems.[2] How many physicians in everyday practice are trying to get patients off narcotics that have been inappropriately prescribed for chronic pain? Numerous studies have indicated that physicians are able to diagnose only a small percentage of patients who are dependent on alcohol and drugs.[3] Dr. Murphy's editorial politely points out that COAT is fraught with problems even in a tertiary care pain center.[4] Dr. Murphy's final sentence to first do no harm is wise indeed; if I read between the lines of the editorial, COAT has no place in a primary care practice.

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References

1. Brown RL, Fleming MF, Patterson JJ. Chronic opioid analgesic therapy for chronic low back pain. J Am Board Fam Pract 1996;9:191-204.
2. Portenoy RK, Foley KM. Chronic use of opioid analgesics in non-malignant pain: report of 38 cases. Pain 1986;25:171-86.
3. Meikle TH. In: Training about alcohol and substance abuse for all primary care physicians. New York: Josiah Macy, Jr. Foundation, 1995.
4. Murphy TM. Chronic opioids for chronic low back pain—solution or problem? J Am Board Fam Pract 1996;9:225-8.

To the Editor: The article on chronic opiate use in low back pain by Brown, Fleming, and Patterson[1] and the accompanying response by Murphy[2] were welcome reflections in a sea of confusion about what to do for chronic low back pain patients. Actually we are also confused as to whether we should or should not prescribe short-term opiates for acute low back pain patients, because we never know which patients are going to be problems for the long term.

Back pain remains an enigma despite billions spent on its care and study, and the issue is further muddled by very real psychosocial and economic factors. After spending the past 9 years in the coal-mining area of far western Virginia and encountering almost nothing but low back injuries, I began in earnest to try to understand what is going on. On the one side, we find patients who radiate enthusiasm for their chiropractors who prescribe no pain medicines at all. On the other hand are legions of patients who seem to benefit greatly from opiates and even manage to work with them. I have had older miners tell me that if they could just keep their Percocets (or Lorcets or whatever) refilled, they could work indefinitely or at least a few more years until they could retire. Failing this, many ended up filing workers' compensation claims and appeared bitterly let down by the system. In economically depressed areas where only one major employer or industry is present (as in coal mining in the Appalachian region) low back complaints seemed to soar with any hint of a mine closing.

I attended Back Pain 93 in Boston only to find orthopedists, neurologists, neurosurgeons, and therapists as baffled as I was. After I took the first of several McKenzie seminars on back pain, I realized that most of my mining patients did, in fact, work bent over all day and were greatly aggravating their problem. I have heard Norman Hadler expound on the three populations of back pain—people, patients, and claimants—and reflected on how logical his descriptions are, but nothing has really made much difference so far in how I have been able to manage back pain in individual patients. I have found little help from my referral sources, all of whom prescribe widely disparate, sometimes opposite, therapies about which they mostly are not very enthusiastic except for the rare case when some operative approach is clearly called for. All of us have seen firsthand how too early use of expensive diagnostics creates iatrogenic disability, and in the final analysis, I am back to believing that thorough history and physical examinations offer not only the best initial information, but also the best assurance to the injured worker that someone is taking his or her complaints seriously.

Yes, we obviously need some controlled studies. The issues are confusing and bewildering. But in the meantime, I am thankful that thoughtful articles such as these are available so I can at least quote them to my colleagues who are similarly concerned. I have often (and to myself) used the simple observation of a pack of cigarettes in a worker's pocket as a reason to decline prescribing any narcotics based on the (possibly very flawed) personal theory that any evidence of