substance abuse should be a contraindication for any opiates at all.

Someday, all this will sort out. In the meantime we will have to continue to do the best we can.

John Ellis, MD, MPH
Richmond Memorial Hospital
Richmond, Va

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. Murphy TM. Chronic opioids for chronic low back pain—solution or problem? J Am Board Fam Pract 1996;9:225-8.

The above letters were referred to the author of the article in question, who offers the following reply.

To the Editor: I agree with Dr. Ellis that our knowledge about the treatment of chronic noncancer pain pales in comparison with our opinions and our confusion on this important topic. Unfortunately, I have found that Dr. Ryan's and Dr. Troncale's "extreme skepticism" about chronic opioid analgesic therapy (COAT) is not uncommon. I wonder whether they have confused the lack of convincing evidence for the effectiveness of a treatment with the presence of convincing evidence against its effectiveness. Their bias is apparently so strong that they could not appreciate Dr. Murphy's well considered, balanced editorial,[1] in which he agreed, despite appropriate reservations, that when COAT results in less pain and verified reports of improved function, such treatment is "probably fine."

I agree with Dr. Murphy and Dr. Ryan that function should be regarded as an important clinical outcome for patients with chronic noncancer pain who receive COAT. I am currently administering COAT to 20 patients with severe low back pain, neuropathy, or arthritis. My patients include a previous Social Security Disability recipient who is now employed full-time, a prematurely retired construction worker who enjoys swimming and mowing his lawn again, two wheelchair-bound patients who had been severely depressed but now enjoy regular volunteer work with youth, and a single mother who continues working 50 to 60 hours a week as a licensed practical nurse. Apparently Dr. Ellis knows of other individuals whose opioid use has allowed them to continue performing strenuous work.

I have no doubt that Dr. Murphy, a pain specialist, sees many patients who are indeed addicted to opioids and function better after detoxification. As Dr. Murphy indicates, this observation does not rule out the possibility that many patients with chronic pain who take opioids do not have substance use disorders.[1] I wonder whether Dr. Murphy and other pain specialists see a selected group of particularly dysfunctional patients. Whereas several uncontrolled studies show a substantial prevalence of substance use disorders among pain clinic patients, a controlled study suggests that primary care patients with chronic back pain are at no higher risk for substance use disorders than other primary care patients.[2]

Dr. Ryan doubts the utility of patient self-report in monitoring patients for addiction. Recent guides implore us to accept patients' reports of their pain,[3,4] and experts agree that patient interviews are the most accurate means of diagnosing substance use disorders.[5-7] Of course, there are particular approaches to conducting such interviews that are recommended for maximizing their accuracy.[8,9] Nevertheless, as stated in the original article, I agree that other methods of gathering information should supplement self-report in the monitoring of COAT recipients.

I infer from Dr. Troncale's mention of his membership in the American Society of Addiction Medicine that he has particular concern for preventing and treating substance use disorders. As an author[8,9] and frequent speaker on the recognition and treatment of substance abuse in primary care settings, and as president-elect of the Association for Medical Education and Research in Substance Abuse (AMERSA), I share his concern. Although the dictum "First do no harm" is popular among physicians, it is clearly outdated. We physicians regularly subject patients to risk from even the most widely accepted and commonly administered diagnostic tests and treatments. We do so appropriately when the potential benefits justify the risks. For many patients who suffer the misery of severe, chronic pain, the likelihood of substantial relief, improved function, and enhanced quality of life might justify the exposure to a low risk of addiction. Dr. Troncale cogently points out that many physicians are not well trained to recognize addiction. Indeed, physicians who do decide to offer COAT to their patients must be able to provide effective monitoring for substance use disorders and be willing to discontinue COAT when necessary despite patients' protests.

There seems to be agreement that a randomized controlled trial of COAT for chronic back pain is needed. My colleagues and I are hopeful that a randomized trial we have planned will soon be funded by the National Institute on Arthritis and Musculoskeletal and Skin Disease.

Richard L. Brown, MD, MPH
University of Wisconsin-Madison

References

1. Murphy TM. Chronic opioids for chronic low back pain—solution or problem? J Am Board Fam Pract 1996;9:225-8.
2. Brown RL, Patterson JJ, Rounds LA, Papasouliotis O. The prevalence of substance use and related disorders among primary care patients with chronic back pain. J Fam Pract, in press.
3. Principles of analgesic use in the treatment of acute pain and cancer pain. 3rd ed. Skokie, Ill: American Pain Society, 1992.
4. Management of cancer pain: adults quick reference guide. Rockville, Md: Agency for Health Care Policy and Research, 1994. (AHCPR publication no. 94-0593.)

5. Babor TF, Kranzler HR, Lauerman RJ. Early detection of harmful alcohol consumption: comparison of clinical, laboratory, and self-report screening procedures. Addict Behav 1989:14:139-57.
6. Pokorny AD. Comment: validity of self-report in alcoholism research (letter). Alcohol Clin Exp Res 1989:13:299-300.
7. Forman SG, Linney JA. Increasing the validity of self-report data in effectiveness trials. NIDA Res Monogr 1991:107:235-47.
8. Brown RL. Identification and initial management of alcohol and drug abuse. In Fleming MF, Barry K, editors. Addiction medicine: a practitioner's guide. St Louis: Mosby Year-Book, 1992:25-43.
9. Brown RL. Alcohol and drug abuse. In Schwiebert LP, Mengel MB editors. Ambulatory primary care handbook. 2nd ed. Stamford, Conn: Appleton & Lange Publishing, 1996:509-16.

To the Editor: The recent article "Chronic Opioid Analgesic Therapy for Chronic Low Back Pain" by Brown et al[1] and the accompanying editorial by Terence Murphy[2] offer interesting views regarding the debate about the use of opioids for the treatment of chronic back pain. Brown et al appear to base their conclusion that chronic opioids should be considered a legitimate treatment of chronic low back pain on the self-reported responses to surveys given to patients on chronic opioid therapy. Is proper measure to be used, however, to assess the effectiveness of chronic opioids? Alcoholics in the midst of addiction will report that a drink calms them down, improves their thinking, and makes them feel better. Patients when first attempting to stop smoking will frequently have considerable deleterious mental and physical symptoms. If the patient's sense of well-being is the criterion upon which physicians should base treatment decisions, then the argument can be made that physicians should not advise patients to discontinue alcohol or tobacco if using these substances make them feel better. Most physicians would recognize that an alcoholic's or smoker's view of how the drug is affecting his or her life is unreliable at best.

Dr. Murphy in his editorial touches upon what should be the true measure of the effects of opioids on chronic pain. His position discouraging the use of opioids is based upon his observations that patients who enter his chronic pain program are frequently impaired in their ability to participate in rehabilitation because of their medication use. Functional ability, not self-reported relief of symptoms, should be the benchmark by which opioid usage is measured. A more convincing argument supporting the use of opioids would have been made had Brown et al shown that the use of opioids decreased lost work days, improved rehabilitation potential, or returned previously disabled individuals to the work force. The data presented by Brown et al do not appear to address these issues.

It is important periodically to reexamine commonly held beliefs to see whether these beliefs continue to hold up under the scrutiny of our continually expanding body of knowledge. Brown et al make the case that opioids might need to be considered in the treatment of chronic low back pain, but the evidence to support its effectiveness is lacking. Until studies showing improved functional abilities of those treated with opioids are forthcoming, I will continue to approach the use of narcotics for chronic conditions with extreme caution and skepticism.

Jerry Ryan, MD
University of Wisconsin-Madison

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. 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 abstract and the concluding summary of the paper of Brown et al on the prescription of oral opioid analgesics for chronic backache patients suggest that the authors feel comfortable with recommending wider use of this treatment modality.[1] The intervening 10 pages of text, however, contain numerous important caveats about their use, along with warnings about patient subgroups for whom maintenance opioid therapy is clearly contraindicated. Additional reservations are presented in a related editorial in the same issue of the *Journal*.[2]

Risks and restrictions aside, Brown et al offer little evidence that opioids help backache or other chronic pain patients. They note a lack of adequate published studies on the subject, and they describe the outcome assessment in the principal relevant uncontrolled publication[3] as "vague."

A recently published double-blind crossover study using oral sustained-release morphine showed statistically significant benefits and would appear, at first glance, to support the position of Brown et al.[1] Careful inspection of the figure accompanying the paper of Moulin et al,[4] however, reveals a disturbing pattern: patients reported striking improvement during an initial 3-week titration period, but this benefit appeared to diminish gradually but inexorably during the subsequent 6-week evaluation period. It appears likely that the ratings would have approached placebo levels by 12 weeks after treatment onset had the study been continued for that length of time. This observation is consistent with the known tendency for the benefits of opioid treatment to diminish with time unless dosage is escalated.

Given the known salience of psychosocial factors in pain disorder,[5] the weakness of the evidence for sustained efficacy of opioid use in these patients, the increasing reluctance of third party payers to underwrite treatment of unproved value, and the time-tested proscription of interventions that might harm patients, more liberal use of opioids in this population seems unwise. Physicians who choose to try it might be wise