Correspondence

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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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

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.

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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.

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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.)