The big picture

Roman D Jovey MD

Physicians are used to accepting most information provided by their patients at face value. Trust is essential for a good doctor-patient relationship. This is especially true in the area of pain management because the best way to assess the severity of pain is to ask the patient. We are advised that "pain is whatever the experiencing person says it is, existing wherever he says it does."

The commentary in the present issue of *Pain Research & Management* by Strang and Rashid (pages 188-189) regarding the street value of prescribed opioid analgesics is important reading for all physicians who prescribe opioids for pain. It reminds us to carefully assess and monitor each patient who receives a prescription for opioids – especially if provided on a long-term basis. Prescribed opioids have a significant value on the street and can do great harm when taken by the wrong person for the wrong reasons.

This requires all clinicians to use 'universal precautions', which includes screening for the risk of addiction/misuse when assessing all new patients with persisting pain (1,2). It also requires monitoring patients for any aberrant drug-related behaviours and structuring prescribing boundaries accordingly (2). Events such as lost or stolen medication, early refills, buying medications on the street, etc, often increase our suspicions about the true motives of our patients. Unfortunately, this may mean that we have to 'filter' and interpret what some of our patients report about their pain. Making a distinction between true opioid addiction and pseudoaddiction can be very challenging, but there is some guidance available (3).

There are other strategies to try to decrease the risk of prescription misuse. Such strategies could include part fills when starting long-term opioids, random pill counts, urine drug testing, witnessed doses of medication in the office, and communication with collateral sources of information, and others. It would also be very helpful if local law-enforcement personnel, such as one of the authors of the commentary, provided information on a regular basis to physicians about the street drug trade in the local community.

It should certainly come as no surprise to anyone that street drug misusers would prefer a pharmaceutical-grade opioid over street heroin. A clever and determined drug-seeking individual can temporarily fool even the best and most careful of physicians. It is only by serial observation and careful documentation

of repeated drug-misuse behaviours that such people's true purpose will eventually come to light.

Both regulators and law enforcement officers need to understand the challenges faced by physicians when managing pain:

"Despite appropriate medical practice, competent physicians may occasionally be misled by skillful patients who wish to obtain opioid medications for purposes other than pain treatment, such as diversion for profit, recreational abuse or maintenance of an addicted state. It must be recognized that physicians who are willing to provide compassionate, ongoing care to challenging psychosocially stressed patients may more often be faced with deception than physicians who decline to treat this difficult population." (4)

It would seem that being an astute pain clinician today requires some fundamental knowledge of addiction medicine.

There is another side to this story, however, that is often overlooked by the media. Ongoing published surveys continue to demonstrate that pain of all types is still severely undertreated in society. There is a severe shortage of interdisciplinary pain management programs in this country, with patient waits of up to three years for assessment. Opioids are physically the safest analgesics in our 'tool kit' and have never been demonstrated to cause organ damage when used therapeutically. The vast majority of patients in pain use opioids responsibly. Therefore, any attempt to restrict the use of opioids from those who would misuse them must not be done at the cost of treating patients in pain.

We need to keep the 'big picture' in mind.

REFERENCES

1. Savage SR. Assessment for addiction in pain-treatment settings. *Clin J Pain* 2002;18:S28-38.
2. Gourlay DL, Heit HA, Almahrezi A. Universal precautions in pain medicine: A rational approach to the treatment of chronic pain. *Pain Med* 2005;6:107-12.
3. Heit HA. The truth about pain management: The difference between a pain patient and an addicted patient. *Eur J Pain* 2001;5(Suppl A):27-9.
4. Canadian Society of Addiction Medicine. Use of opioids for the treatment of chronic pain. <www.csam.org/policy.htm> (Version current at October 24, 2005).

CPM Health Centres Inc, Mississauga, Ontario

Correspondence: Dr Roman D Jovey, CPM Health Centres Inc, 6711 Mississauga Road, Suite 404, Mississauga, Ontario L5N 2W3.

Telephone and fax 905-855-7304, e-mail drjovey@sympatico.ca