THE BRITISH PAIN SOCIETY

Letter to the Editor

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Dear Editor

I want to congratulate you for the improved new format of *British Journal of Pain* (*BJP*). Well done. The *BJP* editorial concluded with the statement:

The pain management community must set an example for other healthcare professionals.

This was followed by an opinion piece on opiate use in chronic pain by Dr Cathy Stannard, she stated that the current thinking with regard to opiate use is when *not* to prescribe them. The time is right to address the issue of the significant iatrogenic harm from opiate use for chronic non-malignant pain sufferers. The prevalence of deaths due to opiates is now second only to road traffic accidents in the USA. We should not be complacent and we must consider ways of preventing similar events in the UK. The pain management community should lead the way to prevent a public health disaster from prescribed opiates for chronic non-malignant pain.

To consider ways of preventing similar events, if we start at the beginning we know that the reason for opiate use in chronic non-malignant pain is humanistic. It was believed that pain must be controlled and it is our patient's right to expect clinicians to apply World Health Organization cancer pain guidelines. It was also postulated that patients would function better if their pain is controlled. These claims have not been substantiated. There was a time when pain specialists who did not prescribe were labelled as opiophobes. It is worthwhile asking ourselves whether opiates really do improve a patient's perceived ability to function better in both emotional and functional dimensions.

If the answer to this question is yes, then how can we objectively confirm it? Do we escalate the dose if there is no improvement in function, and, if so, by how much? How can we objectively monitor its effects? I believe these questions should be considered if long-term opiate use is to be recommended. We should maintain the duty of care to our patients and provide clear guidelines for prescription, dose escalation and discontinuation, and establish appropriate supportive arrangements.

We now have the advantage of the international consensus recommendations for the measurement of chronic pain (www.immpact.org) and objective measurement of outcomes can be incorporated into care. The question is; will prescribers confronted with a patient's SF 36 scores say low physical summary score (PCS = <30) and mental summary score (MCS = <35) prescribe opiates or consider escalating the dose? I do not think so. We may be able to avert the public health disaster and protect our population in the UK if we take up routine objective measurement of pain, at least on patients for whom opiates are prescribed. We need to change our practice to incorporate objective measurements if we really want to be sure to improve matters.

We can only be sure to improve what we can actually measure.

Lord Darzi

Quality Healthcare for the 21st Century (2008)

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