Further defining and conceptualizing opioid misuse in chronic pain

Letter To Editor:

The recent review by Vowles et al.⁵ on the rates of opioid misuse, abuse, and addiction in chronic pain is a sorely needed step in the right direction toward better defining and understanding the prevalence of opioid misuse, abuse, and addiction among individuals with chronic pain. The authors are to be applauded for both synthesizing and advocating for literature using explicit definitions of opioid misuse (ie, not taken exactly as prescribed), abuse (ie, intentional use for nonmedical purposes such as euphoria), and addiction (ie, continued use despite harm or with impaired control, compulsion, or craving). Unfortunately, these distinct terms have too often been conflated in past research and surveillance, which may result in inaccurate data collection, interpretation, and counterproductive treatment approaches.⁴

Although the authors provide a compelling synthesis of the literature using these terms, still a more precise definition of opioid "misuse" is needed. In their review of 38 studies, the authors found misuse to be the most common form of problematic opioid use (at a weighted average rate of 21%-29%). However, as noted in the discussion, the actions constituting misuse in the studies were extremely broad, many of which may not be appropriately classified as problematic opioid misuse. For instance, "underuse," "overuse," and "erratic or disorganized use" of opioids all fell under the definition of problematic misuse, whereas we would argue that these classifications should remain distinct from one another. Furthermore, "use of opioids in conjunction with alcohol or illegal substances (eg, marijuana)" was classified as opioid misuse, presumably even if an individual continued to take their opioid medication exactly as prescribed. Such a classification is problematic in that it: (1) seems to suggest that any opioid-prescribed individual who uses alcohol or other substances is automatically considered to be misusing opioids, when in reality the misuse may be more related to the other substance being used rather than the opioid; (2) does not coincide with the growing body of research exploring adjunct analgesic treatments to opioid therapy for chronic pain, such as the potentially beneficial effect of cannabinoids alongside opioid therapy¹⁻³; and (3) perpetuates the dangerous notion that remains prevalent in the literature and in clinical care, which assumes that substance use and pain are mutually exclusive conditions and that individuals who use illicit substances in addition to opioid therapy may be immediately suspected to be "drug seekers" or "misusers" of opioid treatment.

Another important area of consideration is the adequacy of pain treatment among individuals in these studies. Many studies of opioid misuse in pain patients tend to focus on the behaviour of the patient as a primary concern, while neglecting to assess the adequacy of pain treatment provided by prescribers or clinicians. For instance, if an individual's pain is severely undertreated, and they consequently decide to take an additional dose of their opioid medication, should this behaviour still be given the

stigmatized label of problematic misuse? Thus, we propose that measures of treatment efficacy also be reported in future studies and reviews of problematic opioid use in chronic pain.

The potential for misclassified opioid misuse in this review may be heightened by the authors' use of definitions meant for rigorous patient assessment in clinical trials rather than opioid misuse in real-world clinical or observational settings, which constituted the setting for the majority of the studies on which the review was based. Nevertheless, the authors are to be commended for highlighting low-intensity interventions through which clinicians can attempt to ameliorate potential opioid misuse and for suggesting that alternative treatment options be explored for high-risk patients rather than completely denying care for these vulnerable individuals.

Overall, the authors have provided intriguing insights into the rates of opioid misuse, abuse, and addiction in chronic pain according to more tightly defined classifications and have provided important insights and recommendations for future research in this area.

Conflict of interest statement

The author has no conflicts of interest to declare.

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<http://dx.doi.org/10.1097/j.pain.0000000000000246>

Reply

Letter To Editor:

We wish to thank Voon for her comments regarding our review of opioid misuse and addiction in chronic pain.² We note agreement with the major points that she raises in her letter,¹ particularly with regard to the need for improved precision in the definition of opioid misuse.

Conflict of interest statement

The authors have no conflicts of interest to declare.

This research was supported by a grant from the Center for Health Policy at the Robert Wood Johnson Foundation to K. E. Vowles and D. N. van der Goes.