Correspondence

Therapy of chronic non-malignant pain with opioids

To the Editor:
We read with interest the paper by Mak *et al.*[1] concerning the use of methadone and tramadol for chronic pain in an actively employed police officer. It is well established that the use of potent opioid medications in chronic non-cancer pain is appropriate and comprises good clinical care. Several Canadian provincial Colleges of Physicians and Surgeons and the Canadian Pain Society have published guidelines for such use[2] as well as those noted in this report. What we think is unique and important in this report are that works reports were prepared regularly by this officer's employer for performance analysis. This individual was able to return to and function effectively in a demanding position.

To our knowledge this is the first report of this type of evaluation in an individual using opioids for chronic non- cancer pain. This finding lends support to what we frequently see in clinical practice; patients who are prescribed opioids for chronic non-cancer pain can and do return to productive life styles with control of their pain and with minimal impairment in psychomotor functioning. Zacny has reviewed the effects of opioids in opioid dependent users on psychomotor and cognitive functioning and shown little effect.[3] The same is true for the driving ability of individuals with cancer pain who are treated with opioids.[4] Within the patients followed at our pain management unit we have more than 20 who use the equivalent of 300 mg or more of morphine per day, who lead productive lives and are able to perform everyday activities safely, such as driving. Some also continue to hold fulltime positions effectively. The use of an opioid on a chronic basis can be safe and effective.

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References

1 *Mak PHK, Tsui SL, Ng KFJ.* Long-term therapy of chronic non-malignant pain with potent opioids in an active police officer. Can J Anesth 2002; 49: 575–8.
2 *Jovey RD, Ennis D, Cardner-Nix J, et al.* Use of opioid analgesics for the treatment of chronic noncancer pain. A consensus statement and guidelines from the Cancer Pain Society. Pain Res Manage 1998; 3: 197–222.
3 *Zacny JP.* A review of the effects of opiods on psychomotor and cognitive functioning in humans. Exp Clin Psychopharmacol 1995; 3: 432–66.
4 *Vainio A, Ollila J, Matikainen E, Rosenberg P, Kalso E.* Driving ability in cancer patients receiving long- term morphine analgesia. Lancet 1995; 346: 667–70.

Reply:

We thank Drs. Clark and Lynch for their constructive comment on our case report.[1] It is reassuring to learn that more pain physicians share our view, opinion and clinical practice pattern.

As well as regular work reports from the patients' employer, we also emphasize that continuous psychological support from professionals and family members are important contributing factors to a successful outcome for these very often 'difficult' cases.

Although opioid medications can provide pain relief pharmacologically, the patients' attitude towards recovery and acceptance of their chronic illness is also essential. Psychological help is invaluable. As stated in the report, we recommend regular follow-up by a professional pain psychologist.

Guidelines are also an important first step towards education. We are aware that many, similar guidelines are available in North America, Europe, Australia and New Zealand but they are lacking in parts of Asia. We continue to strive for more comprehensive and specific guidelines for physicians in Hong Kong.

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Reference

1 *Mak PHK, Tsui SL, Ng KFJ.* Long-term therapy of chronic non-malignant pain with potent opioids in an active police officer. Can J Anesth 2002; 49: 575–8.