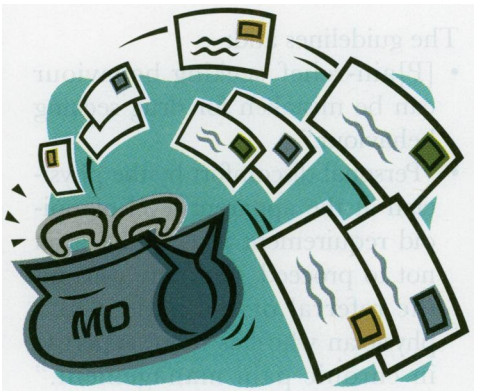
LETTERS

Potential for abuse

Like every doctor in general practice, I despair at the poor armamentarium available to treat pain. However, the encouragement of the five doctors in ivory towers advocating opioid use[1,2] scarcely helps the situation, especially in persuading busy and junior doctors to more freely prescribe morphine. I believe opioids should rarely be used for non-malignant conditions and then only short term as a final resource.

The eminent doctors seem *not* to know of the poorly comprehensive records in practice; they appear to have never prescribed for patients taking ever-increasing doses of Tylenol 3, tranquilizers, and hypnotics. The vast consumption of pethidine HCl for migraine headaches (unpublished data) is symptomatic of the medical profession's loss of responsibility – giving patients what they desire, and soon learn to demand. Conscientious doctors know there is little they can do to deny the drug demanders except to be on salary and spend hours in counseling, often to find that the patient can easily find the drug elsewhere.

The abuse of pethidine should alert us to reserve morphine very carefully. Morphine is a last-ditch defense we all need, but it has great potential for abuse, addiction, and drug peddling, and is associated with crime and diminished responsibility. Not to stress these dangers is also neglect of professional responsibility.



I believe doctors should continue their responsible stance on opioids. Plaintive patients often do not know what is best for them.

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References

1. Melzack R. Model of scientific reasoning. Landmark article on the management of chronic non-malignant pain. *Can Fam Physician* 1995;41:9-12 (Eng), 17-9 (Fr).
2. Hagen N, Flynne P, Hays H, MacDonald N. Guidelines for managing chronic non-malignant pain. Opioids and other agents. *Can Fam Physician* 1995;41:49-53.

Guideline interpretation varies

It was encouraging to read the articles in your January edition on chronic pain management,[1,2] although I think your use of the word landmark[2] is premature. In February 1994, The College of Physicians and Surgeons of British Columbia released an earlier version of Alberta's *Guidelines for Management of Chronic Non-malignant Pain.*[3] I, too, thought this humane and liberal document was a breakthrough and that practitioners would now be allowed to try to control severe pain with opioids.

Unfortunately, the College in Vancouver does not take kindly to the top 10% of prescribers of opioids and threatens to discipline such wayward doctors. The guidelines state that "no greater than 12 tablets [of Percocet®] may be taken per day because of the risk of acetaminophen toxicity," and that doses "above 300 mg [of morphine] daily are unusual but not contraindicated in chronic non-malignant pain."[3] I find it very difficult to reconcile the views of the College administration with the recommendations in their guidelines. As I cannot believe they are unfamiliar with this publication, I must assume that they interpret the guidelines differently, for there are a number of inconsistencies and flaws in this document.

Both of these provincial colleges maintain that the problem of chronic non-malignant pain is ubiquitous but later add that opioids are occasionally helpful. A drug that is only occasionally helpful is usually held by the medical profession to be useless. Opioids are always useful for any kind of pain.

I am at a loss to understand the logic of the following statements:

- "A large group of patients have chronic non-malignant pain that is best described as idiopathic, ie, pain perceived by the clinician to be excessive for the degree of organic disorder evident."
- "The underlying medical condition causing the pain should be established, and the pain should