Response to: "Some patients with chronic pain need low-dose opioid therapy for survival and quality of life"

[This letter responds to a response by Dr. Lal Fernando[1] to Dr. David Juurlink's commentary published in the Oct. 2, 2017, issue of *CMAJ*.][2] One thing that makes sure that chronic pain will persist is that it is much easier to prescribe painkillers, including narcotics and marijuana, than to take the time to examine the patient to find a cause for their pain. In my office, every day, I see between one and three patients with severe low-back pain, who have had radiography, computed tomographic scans and magnetic resonance imaging of their lumbar spine, which show a variety of pathologies, most of which are not a cause of the pain. Unfortunately, no one appears to have examined their sacroiliac joints, where I have found that most severe low-back pain originates.

Physicians may become so reliant on medical imaging that they no longer use their hands to make a diagnosis, and it is very difficult to diagnose a sprained sacroiliac joint using medical imaging. I just completed reviewing the charts of 180 patients in my practice with low-back pain, and only 16 presented with pain coming from their lumbar spine. In all the others, the main pain generators were the sacroiliac joints. In this case series (ethics approval obtained from the research ethics board at the University of British Columbia), correcting the alignment of sprained sacroiliac joints resulted in immediate complete pain relief in 50% of those treated, and partial pain relief in a further 30%. [The findings of this study will be presented as a poster at the Canadian Pain Society meeting in May 2018 (https://www.youtube.com/watch?v=NXNS6PNKRPo).]

Neuropathic pain can also be diagnosed through palpation along the course of the affected nerves, because these nerves are larger than normal and more sensitive to pressure.[3,4] Ultrasonography can also be used to make this diagnosis.[5,6] For patients with neuropathic pain, there are nonnarcotic options for treating their pain. For example, mannitol can downregulate the capsaicin (TRPV1) receptor.[7] I am currently studying how this can be used in a topical cream formulation to reduce pain.

In my clinical experience, chronic pain in many patients can be relieved using prolotherapy, nerve blocks, corrective exercises and manipulation. I do not use narcotics stronger than acetaminophen/codeine or tramadol/codeine; I do not need to.

Most chronic pain is not in patients' heads and does not need to be treated with narcotics.

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Competing interests: None declared.