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Editorial:
Chronic Noncancer Pain Management and Opioid Overdose: Time to Change Prescribing Practices
A. Thomas McLellan and Barbara J. Turner
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# RE: CHRONIC NONCANCER PAIN MANAGEMENT AND OPIOID OVERDOSE:TIME TO CHANGE PRESCRIBING PRACTICES

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Drs. McLellan and Turner were thoughtful to reply to my letter and to that of Dr. Gelfand. I had taken issue with the statement, made in their editorial that, "Prescribing opioids at high doses is both dangerous and questionable for indications other than methadone treatment of opioid dependence." Dr. Gelfand had expressed a number of concerns about the use of opioids, including their use in patients with mental health disorders.

Drs. McLellan and Turner characterized my remarks as supporting the use of high dose opioids. I want to clarify that what I support, in both my role as an addiction medicine physician and an ABMS certified pain medicine

specialist, is the inclusion of a range of doses of opioid medication as being appropriate over a wide spectrum, given the vast clinical variation present in chronic pain patients. Higher doses, prescribed long term, should generally be prescribed to a minority of the patients with chronic non-cancer pain.

Drs. McLellan and Turner suggest that I did not distinguish between cancer and non-cancer pain. Although they are correct, and indeed their editorial was aimed at non-cancer pain, it is also true that the broad statement in their editorial that I took issue with likewise did not distinguish between the two. Furthermore, concerns and issues around appropriate opioid treatment in cancer pain can often significantly overlap, if not become indistinguishable from, concerns and issues with respect to opioid management of chronic non-cancer pain.

A strategy for the management of pain that is infrequently discussed in the American pain literature and one that may confer excellent efficacy, as well as much greater safety than full opioid agonists, is the use of buprenorphine, a partial mu opioid agonist, in the management of chronic pain. Although buprenorphine is best known in the United States in recent years as a treatment for opioid addiction, it has a thirty-year history of use as an analgesic around the world. In the U.S. it has been available as a parenteral analgesic since 1981, and in Europe it has been available as a sublingual tablet over this same time period. For the past ten years, transdermal buprenorphine has enjoyed a growing application in Europe for chronic cancer and non-cancer pain and has been the subject of commensurate attention in published studies and reports (1-6). It appears to have significant utility in those chronic non-cancer pain syndromes that have raised the most concern including neuropathic pain, hyperalgesia, and those associated with aberrant or addictive behaviors. And to the issue studied by Dunn, et al, buprenorphine is much less prone to be associated with overdose death due to its much more limited

depression of the central respiratory drive. Understandings of the "ceiling effect" of buprenorphine are evolving towards greater appreciation of its efficacy in chronic human pain, approaching the effectiveness of full agonist opioids.

Perhaps this controversy over the statement made in the editorial by McLellan and Turner can stimulate us to explore the unrealized potential for buprenorphine and, in particular, motivate greater study and interest of this medication for pain in the United States.

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**Conflict of Interest:**

None declared

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## First Letter to the Editor:

Use of opioids in management of chronic noncancer pain.

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