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Accessibility
Long-term opioid treatment of chronic nonmalignant pain: unproven efficacy and neglected safety?

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Background: For the past 30 years, opioids have been used to treat chronic nonmalignant pain. This study tests the following hypotheses: (1) there is no strong evidence-based foundation for the conclusion that long-term opioid treatment of chronic nonmalignant pain is effective; and (2) the main problem associated with the safety of such treatment – assessment of the risk of addiction – has been neglected.

Methods: Scientometric analysis of the articles representing clinical research in this area was performed to assess (1) the quality of presented evidence (type of study); and (2) the duration of the treatment phase. The sufficiency of representation of addiction was assessed by counting the number of articles that represent (1) editorials; (2) articles in the top specialty journals; and (3) articles with titles clearly indicating that the addiction-related safety is involved (topic-in-title articles).

Results: Not a single randomized controlled trial with opioid treatment lasting >3 months was found. All studies with a duration of opioid treatment ≥6 months (n = 16) were conducted without a proper control group. Such studies cannot provide the consistent good-quality evidence necessary for a strong clinical recommendation. There were profound differences in the number of addiction articles related specifically to chronic nonmalignant pain patients and to opioid addiction in general. An inadequate number of chronic pain-related publications were observed with all three types of counted articles: editorials, articles in the top specialty journals, and topic-in-title articles.

Conclusion: There is no strong evidence-based foundation for the conclusion that long-term opioid treatment of chronic nonmalignant pain is effective. The above identified signs indicating neglect of addiction associated with the opioid treatment of chronic nonmalignant pain were present.

Keywords: addiction, chronic pain, neuropathic pain, opioids, overdose death, quality of evidence, treatment efficacy

Introduction
Only relatively recently in the history of medicine, was there a need to demonstrate quality of evidence and strength of recommendations to validate treatment effectiveness.1–3 Such support has been provided for various treatments of acute pain with opioids.4 Opiates have been used for treatment of acute and persistent pain for centuries, before the current standards of evidence quality became the norm. Compared to this, the treatment of chronic nonmalignant pain with opioids is a relatively new development. For the period 1983–2012, PubMed has more than 2,000 articles on the opioid treatment of chronic nonmalignant pain, but almost no articles on this topic.
before then. In regards to the Bonica pain clinic treatment practices from 1960–1980, Loeser wrote that

“it did not enter our minds that there could be a significant number of chronic pain patients who were successfully managed with opioids, because if there were any, we almost never saw them.”

This explains the almost complete absence of publications on the opioid treatment of chronic pain before 1983. The value of opioids in the treatment of chronic pain attributable to cancer was well recognized before the 1980s. As far as nonmalignant chronic pain is concerned, several initial publications were collected and summarized in the mid-1980s. The use of opioids for chronic pain management was introduced when the new standards of evidence-based medicine were already in the final stages of their establishment. Despite this, the opioid treatment of chronic pain came into practice without convincing proof of effectiveness. Since then, doubts about the effectiveness and safety of long-term treatment of chronic nonmalignant pain with opioids have been expressed in several reviews.

The goal of the present study was to test the following hypotheses: (1) there is no strong evidence-based foundation for the conclusion that long-term opioid treatment of chronic nonmalignant pain is effective; and (2) the risk of addiction – the main problem associated with the safety of such treatment – has been neglected. The available information pertinent to these hypotheses was analyzed using scientometric approaches.

Methods
The articles were collected mainly using the National Library of Medicine’s PubMed website (http://www.ncbi.nlm.nih.gov/PubMed). Articles published in English over the 30-year period of 1983–2012 were included. Keywords related to chronic pain (“chronic pain” OR “neuropathic pain”) were added to the terms related to opioids (“opioids” OR “narcotic analgesics” OR “morphine”). In addition, cancer pain and terminal illness were excluded from the search by placing in the search box the following: NOT (“cancer pain” OR “terminal illness”). Boolean operations were used, in which the following variables were selected: keywords, years of publications, and type of publications. In addition to the electronic search of articles, related publications were also searched manually in the reference lists of reports and reviews.

Efficacy hypothesis
Articles found in the searches were reviewed to make sure that they fit the definition of chronic pain. Articles with titles that lacked certain indication of pain duration, such as “persistent,” “persisting,” or “long-term” were checked and included in the database only if the duration of pain was ≥3 months. Criteria for excluding articles were: (1) inclusions of cases with malignant pain; (2) inclusions of treatments combining opioids with local anesthetics or antidepressants; (3) duration of treatment of 1 day (or <24 hours); and (4) having fewer than ten patients. To assess the quality of evidence for the efficacy for the treatment, the following factors were taken into consideration: the type of the study (randomized controlled trial [RCT] or not), the duration of opioid treatment (≥6 months or not), and the study conclusion on the treatment efficacy.

Addiction hypothesis
The following signs were used to determine whether attention to the addiction-related safety of long-term opioid treatment was insufficient: the number of journal editorials on this topic, the number of articles in the top specialty journals, and the number of journal articles with titles clearly stating that the addiction-related safety of the treatment is involved. The editorials (articles solicited by an editorial board to provide an editorial perspective on an article published in a journal) on several topics associated with the safety of long-term opioid treatment of chronic pain were selected in the following way: keywords related to chronic pain (“chronic pain” OR “neuropathic pain”) and opioids (“opioids” OR “narcotic analgesics” OR “morphine”) were combined with keywords associated with addiction (“addiction” OR “dependence” OR “abuse” OR “misuse”) or with overdose death (“death” OR “mortality” OR “fatality”). The article type was selected by using the PubMed filtering tool “Editorial.”

To quantitatively evaluate the presentation of the above topics in leading medical journals, the 20 top journals were selected with the approach used previously. The journal selection was based on two factors: (1) the rank of a journal sorted by the impact factor, as indicated by Journal Citation Report for 2011 (http://science.thomsonreuter.com) and (2) the journal specialty area. They included biomedical journals in general (ten journals), pharmacology (six journals), and psychiatry or neurology (four journals). The impact factor was used for the selection of journals in each specialty area category separately. The following journals were included: Addiction, The American Journal of Psychiatry, Annals of Internal Medicine, Annals of Neurology, Archives of General Psychiatry, BMJ, The Journal of Clinical Investigation, The Journal of Pharmacology and Experimental Therapeutics, JAMA: The Journal of the American Medical Association, Lancet,

To select articles with titles clearly indicating that they are devoted to specific topics (topic-in-title articles), the indicator “(Title)” was added to the selected terms placed into PubMed search boxes. All types of articles were used for this index also.

Results

Efficacy hypothesis

The electronic and manual search of the literature identified 2,356 articles. The results of this initial search were reviewed and reduced to 250 articles; see flowchart (Figure 1) and Supplementary material. Fifty-three articles were original clinical research articles on the opioid treatment of chronic nonmalignant pain (Table 1). Analysis of these publications revealed that 25 are reports of RCT studies, the rest are studies that lack a proper control group. Most of the RCT studies had a treatment duration of ≤1 month. Only one study is in the “≥3 months category” (90 days). The other randomized investigation with long treatment duration (16 weeks) was an open study. Table 2 presents 16 studies in which the duration of opioid treatment was ≥6 months, none of which is an RCT. Thus, there is not a single study that both fits the high quality of evidence category and has a long-term opioid treatment (duration of treatment ≥6 months). Systematic reviews on the opioid treatment of chronic nonmalignant pain have come to the same conclusion regarding long-term efficacy of the treatment, ie, there is insufficient evidence to make a definite conclusion (Table 3).

Addiction hypothesis

The results on the editorials related to addiction in chronic nonmalignant pain patients are presented in Table 4. There were no editorials on this topic in 1983–1992, one in

![Flow chart of screened, excluded, and included articles on chronic nonmalignant pain from 1983–2012.](image-url)

**Abbreviation:** RCT, randomized controlled trial.
1993–2002, and four in 2003–2012. For the same period, editorials on opioid addiction in general (the right side of Table 4) were numerous (171 from 2003–2012). As far as editorials on death associated with opioid treatment of chronic nonmalignant pain are concerned, only two were found – both recent – in 2010–2011.67,69

Representation of opioid addiction in the top 20 journals is shown in Table 5 (left side – opioid addiction in patients with chronic pain; right side – opioid addiction in general). Once again, the problem of opioid addiction in chronic pain patients was discussed in only six articles (five of which appeared in 2003–2012). The problem of death associated with opioid treatment of chronic pain was discussed only in three articles from the top journals.71,72,77

The topic-in-title articles (articles clearly announcing that they are devoted to opioid addiction, dependence, abuse, or misuse) are presented in Table 6. The right side of the table presents the articles on addiction-related problems in general, and the left side presents those specifically in chronic pain patients. It indicates that in 1983–1992 only two topic-in-title articles related to opioid addiction in chronic pain patients were published; in the next 10-year period, this number increased to 13; and was 51 for 2003–2012. It is of interest that in the 15 years following 1983, the word “addiction” in titles appeared only once; the word “abuse” was used in the rest of the article titles. On the other hand, topic-in-title articles on addiction-related problems in general (the right side of Table 6) were numerous (1,404 in 2003–2012). It is of interest that during 1983–2002 when opioids were introduced for the treatment of chronic nonmalignant pain, there was a clear decrease in the number of articles devoted to the problem of opioid addiction in general (from 893 in 1973–1982 to 536 and 628 in 1983–1992 and 1993–2002, respectively).

Topic-in-title articles on death associated with opioid addiction in chronic pain patients are presented in Table 7. This table indicates only four such articles, all in 2003–2012. Topic-in-title articles on death associated with opioid addiction in general (the right side of Table 7) were also very rare (two to four articles per decade).

### Discussion

#### Efficacy hypothesis

Simple scientometric assessment of articles on long-term opioid treatment of chronic nonmalignant pain indicates the absence of high-quality evidence on efficacy. There is not a single RCT study lasting >3 months (Table 1). The longest randomized investigation (16 weeks) was limited by being an open study.65 All studies with opioid treatment ≥6 months (Table 2) were conducted without a proper control group;64 therefore, they do not provide the consistent good-quality evidence to support a strong clinical recommendation.1–3 Systematic reviews on opioid treatment of chronic nonmalignant pain have concluded that there is insufficient evidence to make a definite conclusion on the efficacy of long-term treatment.6–9

#### Addiction hypothesis

The problem of safety of opioid treatment revealed itself most dramatically in rising numbers of opioid overdose deaths.

According to the 2008 National Survey on Drug Use and Health (NSDUH) sponsored by the Substance Abuse and Mental Health Service Administration (SAMHSA), there has been at least a ten-fold increase in the medical use of opioids from 1988–2007.149 In 2007, 11,499 deaths were caused by overdoses of opioids, roughly a four-fold increase compared with 1999. Remarkably, even an increase of that size somehow did not trigger a timely response by the medical journals. This phenomenon is especially noticeable if one looks at the number of editorials on death associated with opioid treatment of chronic pain patients. Only two editorials on this topic were found (both late, in 2010–2011), as if there had been no dramatic increase in opioid-related deaths in 1999–2007.

Opioid abuse, misuse, and addiction are the main reasons leading to the opioid overdose deaths. Somehow the

### Table 1 Duration of opioid treatment in studies on chronic nonmalignant pain

<table>
<thead>
<tr>
<th>Duration of treatment</th>
<th>Number of studies without a proper control group</th>
<th>Number of randomized controlled trials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\leq 1$ m</td>
<td>$1$ m–$3$ m</td>
</tr>
<tr>
<td>Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1983–1992</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>1993–2002</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>2003–2012</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>

**Note**: 6Studies without a proper control group (see Grimes and Schulz).64

**Abbreviations**: m, month; y, year.

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<table>
<thead>
<tr>
<th>Reference</th>
<th>Study design</th>
<th>Diagnosis</th>
<th>Opioid</th>
<th>Route of administration</th>
<th>Number of enrolled patients</th>
<th>Length of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>France et al&lt;sup&gt;11&lt;/sup&gt;</td>
<td>Case series (uncontrolled, retrospective, selected patients)</td>
<td>Back pain</td>
<td>Codeine, oxycodone, hydromorphone</td>
<td>Oral</td>
<td>16</td>
<td>6–22 months</td>
</tr>
<tr>
<td>Portenoy and Foley&lt;sup&gt;12&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, retrospective, patients selected from two separate studies)</td>
<td>Back pain, postherpetic neuralgia, neuropathic pain</td>
<td>Oxycodone, methadone, levorphanol, codeine</td>
<td>Oral</td>
<td>38</td>
<td>6 months to 10 years</td>
</tr>
<tr>
<td>Zenz et al&lt;sup&gt;13&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, prospective)</td>
<td>Back pain, neuropathic pain</td>
<td>Sustained-release dihydrocodeine, buprenorphine, sustained-release morphine</td>
<td>Oral</td>
<td>100</td>
<td>≥1 year (20 patients)</td>
</tr>
<tr>
<td>Kanoff&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, prospective)</td>
<td>Reflex sympathetic dystrophy, arachnoiditis</td>
<td>Morphine via implanted delivery system</td>
<td>Intrathecal</td>
<td>15</td>
<td>2–44 months</td>
</tr>
<tr>
<td>Hassenbusch et al&lt;sup&gt;16&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, prospective)</td>
<td>Neuropathic pain</td>
<td>Morphine, sufentanil via implanted delivery system</td>
<td>Intrathecal</td>
<td>22</td>
<td>12–56 months (18 patients)</td>
</tr>
<tr>
<td>Tutak and Doleys&lt;sup&gt;17&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, prospective)</td>
<td>Back pain</td>
<td>Morphine via implanted delivery system</td>
<td>Intrathecal</td>
<td>26</td>
<td>16–27 months</td>
</tr>
<tr>
<td>Angel et al&lt;sup&gt;19&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, prospective)</td>
<td>Back pain, neuropathic pain</td>
<td>Morphine via implanted delivery system</td>
<td>Intrathecal</td>
<td>15</td>
<td>3 years (11 patients)</td>
</tr>
<tr>
<td>Anderson and Burchiel&lt;sup&gt;20&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, prospective)</td>
<td>Neuropathic pain, nociceptive pain</td>
<td>Morphine via implanted delivery system</td>
<td>Intrathecal</td>
<td>40</td>
<td>24 months (20 patients)</td>
</tr>
<tr>
<td>Harati et al&lt;sup&gt;21&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, prospective)</td>
<td>Diabetic neuropathy</td>
<td>Tramadol</td>
<td>Oral</td>
<td>117</td>
<td>6 months (100 patients)</td>
</tr>
<tr>
<td>Milligan et al&lt;sup&gt;22&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, prospective)</td>
<td>Neuropathic pain, nociceptive pain</td>
<td>Fentanyl</td>
<td>Transdermal</td>
<td>532</td>
<td>12 months (301 patients)</td>
</tr>
<tr>
<td>Mironer and Tollison&lt;sup&gt;23&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, prospective)</td>
<td>Back pain, neuropathic pain</td>
<td>Methadone</td>
<td>Intrathecal</td>
<td>24</td>
<td>6 months (9 patients)</td>
</tr>
<tr>
<td>Anderson et al&lt;sup&gt;24&lt;/sup&gt;</td>
<td>Uncontrolled study (prospective, randomized to morphine intrathecal infusion or its epidural injection)</td>
<td>Chronic nonmalignant pain</td>
<td>Morphine via implanted delivery system</td>
<td>Intrathecal</td>
<td>40</td>
<td>6 months (27 patients)</td>
</tr>
<tr>
<td>Allan et al&lt;sup&gt;25&lt;/sup&gt;</td>
<td>Uncontrolled study (prospective, multicenter, randomized to oral morphine)</td>
<td>Back pain</td>
<td>Fentanyl</td>
<td>Transdermal</td>
<td>680</td>
<td>13 months</td>
</tr>
<tr>
<td>Chao&lt;sup&gt;26&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, retrospective)</td>
<td>Back pain, neuropathic pain</td>
<td>Sustained-release morphine</td>
<td>Oral</td>
<td>68</td>
<td>12 months</td>
</tr>
<tr>
<td>McIlwain and Adhieh&lt;sup&gt;27&lt;/sup&gt;</td>
<td>Descriptive study (uncontrolled, prospective, multicenter)</td>
<td>Osteoarthritis</td>
<td>Extended-release oxymorphone</td>
<td>Oral</td>
<td>153</td>
<td>12 months (61 patients)</td>
</tr>
<tr>
<td>Portenoy et al&lt;sup&gt;28&lt;/sup&gt;</td>
<td>Uncontrolled registry study</td>
<td>Osteoarthritis, diabetic neuropathy, back pain</td>
<td>Controlled-release oxycodone</td>
<td>Oral</td>
<td>219</td>
<td>1–3 years (14–39 patients)</td>
</tr>
</tbody>
</table>
### Table 3: Systematic reviews on opioid treatment of chronic pain

<table>
<thead>
<tr>
<th>Study</th>
<th>Type of pain</th>
<th>Opioid</th>
<th>Route of administration</th>
<th>Duration of treatment</th>
<th>Conclusion on the treatment efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kalso et al.</td>
<td>Osteoarthritis, diabetic neuropathy, peripheral neuropathic pain, phantom limb pain, postherpetic neuralgia, musculoskeletal pain</td>
<td>Morphine, oxycodone</td>
<td>Oral, transdermal, or intravenous</td>
<td>From 4 days to 8 weeks</td>
<td>The short-term efficacy of opioids was good in both neuropathic and musculoskeletal pain conditions. However, only a minority of patients went on to long-term management with opioids; therefore, open-label follow-up data were too weak to make a definite conclusion.</td>
</tr>
<tr>
<td>Martell et al.</td>
<td>Back pain</td>
<td>Morphine, oxycodone, sustained-release morphine, controlled-release oxycodone, other opioids</td>
<td>Oral or transdermal</td>
<td>From 7 days to 16 weeks</td>
<td>Opioids may be efficacious for short-term pain relief. Long-term efficacy was unclear.</td>
</tr>
<tr>
<td>Noble et al.</td>
<td>Neuropathic pain, osteoarthritis, back pain</td>
<td>Morphine, tramadol, methadone, controlled-release oxycodone, extended-release oxymorphone, fentanyl, sufentanil, dihydrocodeine, buprenorphine</td>
<td>Oral, transdermal, or intrathecal</td>
<td>From 6–48 months</td>
<td>Weak evidence suggests that oral and intrathecal opioids reduce pain long-term in the relatively small proportion of individuals who continue treatment. The small to moderate beneficial effects of opioids are outweighed by large increases in the risk of adverse events. Therefore, opioids should not be routinely used, even if osteoarthritic pain is severe.</td>
</tr>
<tr>
<td>Nuesch et al.</td>
<td>Osteoarthritis</td>
<td>Codeine, morphine, oxycodone, oxymorphone</td>
<td>Oral or transdermal</td>
<td>From 3 days to 3 months</td>
<td>Weak evidence suggests that oral and intrathecal opioids reduce pain long-term in the relatively small proportion of individuals who continue treatment. The small to moderate beneficial effects of opioids are outweighed by large increases in the risk of adverse events. Therefore, opioids should not be routinely used, even if osteoarthritic pain is severe.</td>
</tr>
</tbody>
</table>

### Table 4: Editorials on opioid addiction in chronic pain patients

<table>
<thead>
<tr>
<th>Years</th>
<th>Number of editorials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1973–1982</td>
<td>0</td>
</tr>
<tr>
<td>1983–1992</td>
<td>19</td>
</tr>
<tr>
<td>1993–2002</td>
<td>1</td>
</tr>
<tr>
<td>2003–2012</td>
<td>4</td>
</tr>
</tbody>
</table>

Notes: OR “dependence” OR “abuse” OR “misuse;” OR “neuropathic pain” NOT (“cancer pain” OR “terminal illness);” reference 66; references 67–70.

### Table 5: Articles on opioid addiction in chronic pain patients in the top 20 journals

<table>
<thead>
<tr>
<th>Years</th>
<th>Number of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1973–1982</td>
<td>5</td>
</tr>
<tr>
<td>1983–1992</td>
<td>12</td>
</tr>
<tr>
<td>1993–2002</td>
<td>0</td>
</tr>
<tr>
<td>2003–2012</td>
<td>40</td>
</tr>
</tbody>
</table>

Notes: OR “dependence” OR “abuse” OR “misuse;” OR “neuropathic pain” NOT (“cancer pain” OR “terminal illness);” reference 66; references 67–70.
to opioid addiction in chronic pain patients, at a time when there were 536 topic-in-title articles on opioid addiction in general (right side of Table 6). There were also profound differences in the numbers of addiction articles related specifically to chronic pain patients and to opioid addiction in general for the periods 1993–2002 and 2003–2012. Especially interesting was the decrease in the number of topic-in-title articles on opioid addiction in general during 1983–2002 (right side of Table 6) when opioid treatment for chronic nonmalignant pain was being introduced. Could the acceptance of this new indication for opioid treatment be responsible for such a change?

Estimates of the rate of addiction problems among chronic pain patients extremely varied. Hojsted and Sjogren reported that the rates of addiction associated with long-term opioid treatment were 0%–50% in noncancer patients and 0%–7.7% in cancer patients, depending on the subpopulation studied and the criteria used. This uncertainty is similar to that with the rate of iatrogenic addiction in patients treated with opioids for acute or subacute pain. A systematic review on this topic concluded, “It is not known whether the risk for iatrogenic addiction among patients treated with opioids for acute or subacute pain is relatively high (>10%) or low (0.1%).” The difficulty of estimating the risk of opioid addiction and abuse (see Jamison et al) calls into question the accuracy of reported rates of risk for opioid addiction.

One author of a study on the use of opioids in chronic nonmalignant pain has asked: “Is this treatment a lifetime sentence?” If not, another question should be: “Has the withdrawal syndrome after long-term opioid use been adequately studied?”; and not only acute withdrawal syndrome, but protracted withdrawal as well? The latter (also called protracted abstinence or chronic withdrawal syndrome) is characterized by generalized symptoms (eg, discomfort, fatigue, decreased blood pressure, pulse rate, and body temperature) lasting 3–9 months. Long-lasting (3–4 months) neurobiological alterations following withdrawal from opioids have been well confirmed in animal experiments. Lack of knowledge regarding the risk of addiction and even greater uncertainty regarding protracted withdrawal following cessation of long-term opioid treatment of chronic pain call for studies with high-quality evidence that supports reliable recommendations.

This study has a limitation related to the absence of exact definition of chronic nonmalignant pain. It is associated with the lack of definition for chronic pain in general. For example, the International Association for the Study of Pain Task Force on Taxonomy – in the classification of chronic pain – has chosen not to define chronic pain.

### Conclusion

There is no high-quality evidence on the efficacy of long-term opioid treatment of chronic nonmalignant pain. As a result, the strength of any recommendation regarding this treatment is weak. The safety of opioid treatment in terms of risk of addiction and overdose death has not properly been assessed due to the complexity of these outcomes. Until 2003, opioid addiction associated with the treatment of chronic nonmalignant pain was clearly a neglected topic of publication. However, this topic is now beginning to receive the attention it deserves.

### Disclosure

The author reports no conflicts of interest in this work.

### References


147. Substance Abuse and Mental Health Services Administration. Results From the 2008 National Survey on Drug Use and Health: National Findings, Rockville, MD: Substance Abuse and Mental Health Services Administration; 2009.


Supplementary material


Angel IF, Gould HJ Jr, Carey ME. Intrathecal morphine pump as a treat...
Clark MR, Stoller KB, Brooner RK. Assessment and management of chronic pain in individuals seeking treatment for opioid dependence disorder. 


Compton P, Athanasas P. Chronic pain, substance abuse and addiction. 


Dellmijn P. Are opioids effective in relieving neuropathic pain? 

Dellmijn PL. Opioids in non-cancer pain: a life-time sentence? 

Denisco RA, Chandler RK, Compton WM. Addressing the intersecting problems of opioid misuse and chronic pain treatment. 

DeSio JM, Bacon DR, Peer G, Lema MJ. Intravenous abuse of transdermal fentanyl therapy in a chronic pain patient. 

Dhallia IA, Mamdani MM, Sivilotti ML, Kopp A, Qureshi O, Juurlink DN. Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone. 

Dillie KS, Fleming MF, Mundt MP, French MT. Quality of life associated with daily opioid therapy in a primary care chronic pain sample. 

Dubner R. A call for more science, not more rhetoric, regarding opioids and neuropathic pain. 


Dunbar SA, Katz NP. Chronic opioid therapy for nonmalignant pain in patients with a history of substance abuse: report of 20 cases. 


*Drug Alcohol Depend*. 2010;112:90–98.


Edlund MJ, Sullivan M, Steffick D, Harris KM, Wells KB. Do users of regularly prescribed opioids have higher rates of substance use problems than nonusers? 


Evans PJD. Narcotic addiction in patients with chronic pain. 

*J Subst Abuse Treat*. 2006;31:151–156.

Finlayson RE, Maruta T, Morse RM, Martin MA. Substance dependence and chronic pain: experience with treatment and follow-up results. 

Finlayson RE, Maruta T, Morse RM, Swenson WM, Martin MA. Substance dependence and chronic pain: profile of 50 patients treated in an alcohol and drug dependence unit. 


Fishbain DA, Gallagher RM. Comments on “prescription drug dependence and evolving beliefs about chronic pain management”. 


Fishbain DA, Rosomoff HL, Rosomoff RS. Drug abuse, dependence, and addiction in chronic pain patients. 

Foley KM, Fins JJ, Intrurissi C. A true believer’s flawed analysis. 

Foley KM. Opioids and chronic neuropathic pain. 


Gagnon B, Bruera E. Differences in the ratios of morphine to methadone in patients with neuropathic pain versus non-neuropathic pain. 

Galer BS, Lee D, Nagle B, Schlagheck TG. MorphiDex (morphine sulfate/dextromethorphan hydrobromide combination) in the treatment of chronic pain: three multicenter, randomized double-blind, controlled clinical trials fail to demonstrate enhanced opioid analgesia or reduction in tolerance. 


Gilron I, Bailey JM, Tu D, Holden RR, Weaver DF, Houlden RL. Morphine, gabapentin, or their combination for neuropathic pain. 

Gimbel JS, Richards P, Portenoy RK. Controlled-release oxycodone for pain in diabetic neuropathy: a randomized controlled trial. 

Goldman B. Use and abuse of opioid analogies in chronic pain. 


