1. Addiction: In 1997, the American Society of Addiction Medicine (ASAM) defined addiction in the context of pain treatment with opioids as " a persistent pattern of dysfunctional opioid use that may involve any or all of the following: adverse consequences associated with the use of opioids; loss of control over the use of opioids; preoccupation with obtaining opioids, despite the presence of adequate analgesia."

It is important to understand the terminology here: addiction refers to psychological dependence: a condition characterised by a pattern of compulsive behaviour and overwhelming involvement in acquiring a drug for non-medical purposes e.g. for psychic effects as opposed to pain relief. In other words, addiction involves a pattern of behaviour that includes compulsive use of opiates and a preoccupation with obtaining them, despite evidence that continued use results in physical, emotional, social or economic damage.

Chronic pain patients may sometimes be labelled as addicts when they repeatedly seek opiates as a result of inadequately treated pain: they are in fact "pseudoaddicts" as their behaviour may be suggestive of addiction but is entirely motivated by a need for pain relief.

In reality, there is plenty of evidence that pain patients very rarely develop addiction. Physical dependence is a term meaning that if the drug is discontinued or the dose reduced, then withdrawal symptoms will be experienced (these are discussed later).

It is due to the body becoming accustomed to the drug. The Canadian Pain Society clearly state "physical dependence, in the absence of other indicators, is neither predictive nor diagnostic of addiction." Virtually all patients who take opioid analgesics will develop physical dependence to some degree and will experience withdrawal symptoms if the drug is suddenly discontinued.

2. Tolerance: this means the need for increasing doses to achieve the same effect: a common feature if opiates are being used for recreational purposes. In pain patients, tolerance to adverse effects such as sedation and nausea develops readily within a couple of weeks, but it appears that tolerance to the pain relief does not.

A need for escalating doses of opiate is therefore more likely to be related to the condition that is causing the pain.

The ASAM make it clear that tolerance

"does not, in and of itself, imply addiction."

Therefore, a patient should feel able to approach his doctor and request higher doses if the current dose is failing to provide adequate relief, without fear of being labelled an addict.

When tolerance does occur, the patient tends to notice that the duration of pain relief becomes shorter and they experience an increase in pain.

3. Diversion: authorities and health professionals are concerned that prescribed controlled drugs may be distributed on the "street" illegally. However, this is highly unlikely if they are necessary for achieving pain relief.

4. Respiratory depression and other side-effects: Respiratory depression is the most serious adverse effect of opioids as it can be immediately life-threatening.

However, it is now recognised that it only tends to be a short-lived problem in patients who have never had opioids before (are "opioid na?ve") and that pain itself antagonises it.(pain is a respiratory stimulant).

Side-effects such as sedation and nausea tend to subside within a couple of weeks. Constipation is the most common long-term side-effect but can often be managed fairly simply (see below.)

Long-term use does not carry risks such as those with Non-steroidal anti-inflammatory drugs (NSAIDs): these are known to cause liver, gut and kidney damage.

Opiates do not cause this kind of "end-organ damage". "There is no recorded risk in the medical literature of direct permanent organ damage associated with the long term clinical use of opioid therapy" (Canadian Pain Society Consensus, 1998)

5. Opioid responsiveness: neuropathic pain has been regarded as "opioid resistant" but it has now been found that it can respond provided that high enough doses are used.

Patients may be labelled as "unresponsive to opioids" unless there has been an adequate trial of opioids with properly titrated doses as well as adequate time for tolerance to adverse effects to develop.

As the Canadian Pain Society stated in their consensus "patients whose pain is found to be unresponsive to an adequate trial of opioid therapy should not be assumed to have psychogenic pain or to be malingering."

6. Chronic pain of unknown origin: clinicians have tended to label patients whose diagnosis is unclear as suffering from psychological problems. This can lead to patients who are experiencing understandable distress and possibly depression as a result of being in chronic pain, being reluctant to admit this to their doctor.

The Canadian Pain Society consensus suggested that the term "psychogenic" is imprecise and stigmatising. Pain specialists generally acknowledge that depressive symptoms accompanying chronic pain are likely to be a secondary effect of the pain itself rather than the reverse, and true primary psychological pain disorders are very rare.

Therefore concerns that there is a psychological basis for the request for opiates need not be of significant concern to clinicians prescribing for patients who have no clear organic diagnosis.