Prolonged postoperative pain

The editorial accompanying Clarke and colleagues’ paper offers only superficial analysis of the complexity of prolonged postoperative opioid use. Hospital systems are protocol-driven—early surgical discharge is encouraged to reduce costs. Unsurprisingly, patients are now often discharged on stronger analgesics, and systems to ensure timely review of analgesia are not robust. Society no longer tolerates prolonged suffering, and this may lead to demands for (surgical) solutions where they do not exist.

The maxim that “a good surgeon knows how to operate; a better surgeon knows when to operate” seems to have been lost in pursuit of efficiency. Recent work highlights that chronic postoperative pain is often a continuation of existing pain problems.

Opioids have a strong evidence base in the management of postoperative pain. It is simplistic to assume that pain in the prolonged postoperative phase is mainly neuropathic in nature. The cited example of chronic post-thoracic surgical pain has a neuropathic component in only two thirds of patients. The evidence for opioid induced hyperalgesia is mainly from basic science and has a limited clinical evidence base.

The proposed solution—use of adjuvant agents—lacks firm evidence in treating and preventing ongoing pain. The study of these drugs in acute pain has been associated with hidden data, publication bias, and even fraudulent research. It is now recognised that, like opioids, the prolonged use of some adjuvant agents may result in dependence and addiction.

Prolonged postoperative pain, as with chronic pain, is a complex biopsychosocial problem. Like surgery, analysis of problematic prolonged postoperative opioid use should be incisive and aim to restrict unwanted collateral damage.

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Competing interests: MB and CR have received honorariums for presenting at meetings sponsored by drug companies that promote gabapentinoids and opiates in pain.

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1 Dualé C. Prolonged use of opioids after surgery. BMJ 2014;348:g1280. (11 February)

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LETTERS

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Fourthly, because fibromyalgia overlaps with many other disorders with medically unexplained symptoms, patients are best treated within the same specialised service in the general hospital. Experience in Europe suggests that such specialised units can be established with multidisciplinary teams.

Poly symptomatic distress has been recognised as a somatoform disorder—specifically, a somatic symptom disorder in DSM-5. About 40% of people with fibromyalgia in the population satisfy criteria for this disorder, which suggests that fibromyalgia is primarily a somatic symptom disorder. People with these diverse complaints present to doctors in all branches of medicine, particularly in primary care. A greater awareness of the psychosocial determinants of musculoskeletal complaints would benefit all doctors and prevent the medicalisation and potential for iatrogenic harm that accompanies a diagnosis of fibromyalgia.

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DAVID OWEN: RESEARCHER INTO HUBRIS

A case of innate hubris?

As a medical student at St Thomas’ Hospital in the 1950s, David Owen was already showing strong prodromal signs of “hubris.” His subsequent foray into the exercise of power as a political leader would appear to be an example of innate hubris, not “acquired personality change” as the Daedalus Trust might express it. 1

Is this not a case of the pot calling the kettle black?

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RESPONSE

J Barbosa and colleagues reply to Diana NJ Lockwood and colleagues

We wish to clarify some of the points raised by Diana NJ Lockwood and colleagues. 1

We disagree with the view that the leprosy elimination target is harmful, given the robust evidence available and the active commitment of affected countries and the global community.

Leprosy reached its current low prevalence and low number of new cases as a result of two major developments. These were the introduction of World Health Organization multidrug therapy in 1981 and the commitment of leprosy endemic countries in 1991 (World Health Assembly resolution 44.9) to eliminating leprosy as a public health problem (reducing prevalence to <1 case/10 000 population globally by 2000). 2 During the past 20 years there has been a global decrease in disease prevalence and new case detection of 94% and 65%, respectively.

Although some countries did not meet the target, this is not uncommon in public health practice—target dates for eradication of smallpox, poliomyelitis, and dracunculiasis have been moved more than once. Leprosy can definitely be eliminated because transmission has been interrupted in several communities and countries.

The statement that endemic countries can achieve elimination only by sleight of hand and manipulating data lacks scientific evidence. This railing accusation against the ministries of health of Brazil, India, and others serves only to support the fallacious argument of the authors, who try, without evidence, to show that it is impossible to reduce the burden of a disease like leprosy.

Brazil was neither under pressure nor reported to have achieved elimination in 2005; these statements are inaccurate and not supported by published sources.

During recent years, the slowing down and stagnation of new case detection and consequent smaller leprosy burden compared with other diseases has reduced countries’ political commitment.

To analyse the relevant issues, WHO organised an international leprosy summit in Bangkok in 2013 to bring together ministers of health of the top 17 endemic countries in collaboration with the Nippon Foundation, with the participation of the International Federation of Leprosy Associations, technical experts, and other stakeholders.

At this summit, through the Bangkok Declaration, 3 ministers reaffirmed their political commitment to using vigorous and innovative approaches to reduce the leprosy burden further. They also committed to achieving the WHO target of reducing the number of new leprosy cases with grade 2 disability to fewer than one case per million population by 2020. 4 5

Efforts to control, eliminate, or eradicate neglected tropical diseases have gathered momentum in recent years. In early 2012, WHO defined several targets and milestones for the control, elimination, and eradication of such diseases by 2015 and 2020. 6 The WHO roadmap details specific targets; defines terminology for control, elimination, and eradication; and specifies epidemiological criteria to facilitate measurement of progress towards achievement of targets.

The elimination of leprosy requires targeted, focused, and intensive implementation of antileprosy activities. Several countries have achieved elimination at subnational levels within a reasonable time period. It is for other countries to learn from such experiences.

The enormous progress made resulted from a unique partnership between endemic countries, international organisations, and civil society, and it must continue to free future generations from this disabling and stigmatising infectious disease.

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1. Lockwood DNI, Shetty V, Penna GO. Hazards of setting targets to eliminate disease: lessons from the leprosy elimination campaign. BMJ 2014;348:g1136. (7 February.)
6. WHO. Accelerating work to overcome the global impact of neglected tropical diseases, 2012.

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