

Correspondance

Narcotics for chronic nonmalignant pain

In an article in *CMAJ*'s rheumatology series, Simon Huang states that "narcotic analgesics should be avoided in patients with chronic musculoskeletal pain."¹ Nothing could be further from the truth.

The general consensus as stated in guidelines on the use of narcotics² as well as among physicians dealing with chronic pain disorders is that narcotics are almost certainly underutilized in the treatment of chronic musculoskeletal pain. Several studies have confirmed the relatively low risk of the development of drug dependence among these patients, provided they are adequately screened for addiction risk.^{3,4} The use of narcotics has improved the level of function and quality of life for many patients with chronic musculoskeletal pain, and elderly patients with arthritis are among the most satisfied clients.

Statements such as this are all too common and result in undertreatment of many chronic pain disorders by primary care physicians. We are now in the same position with respect to chronic nonmalignant pain as were our colleagues 15 years ago when patients with malignancies were often undertreated because of fears of creating drug addicts. Thankfully that situation has changed, and I am confident that in time so will the use of narcotics in the management of chronic musculoskeletal pain.

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Thwarting sore throats

A diagnostic tool for sore throats that can be used during the physician-patient interaction has been a long time coming and has clinical value.¹ However, the real utility of the tool may not be in its diagnostic accuracy. The patient may feel that his or her illness experience is receiving immediate validation when he or she witnesses the rigour the physician applies to assessing the sore throat with a multi-item test; this may result in a decreased desire for an antibiotic. The siren call of empathic prescribing for perceived patient demand will eventually be thwarted by adjustments to interpersonal relations rather than enhanced diagnostic testing.

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Reference

- McIsaac WJ, Goel V, To T, Low DE. The validity of a sore throat score in family practice. *CMAJ* 2000;163(7):811-5.

The report by Warren McIsaac and colleagues that there is no difference in the sensitivity and specificity of a clinical sore throat score for patients seen in community-based family practices and those seen in an academic family medicine unit¹ is helpful for promoting the use of the sore throat score in the community at large. Nevertheless, one has to question the feasibility of implementing this tool on a broad scale, not because there are superior alternative approaches, but rather be-

cause of the limitations of the tool that front-line prescribers might perceive.

The medical literature suggests that antibiotics are used excessively to treat upper respiratory tract infections because physicians want to minimize the risk of failing to treat patients who would benefit from antibiotic therapy. Thus, the critical issue for the sore throat score is whether a sensitivity of 85% (or a false negative rate of 15%) will make practitioners sufficiently confident in the tool that they will abide by its recommendations.

It would be helpful if McIsaac and colleagues provided data on the percentage of patients who required an antibiotic prescription but did not get one on the basis of physician judgement. If physician judgement had a false negative rate of less than 15% this would imply that the physician threshold for committing an error of undertreatment is too high for physicians to follow the recommendations of the sore throat score.

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Reference

- McIsaac WJ, Goel V, To T, Low DE. The validity of a sore throat score in family practice. *CMAJ* 2000;163(7):811-5.

[Three of the authors respond:]

Jarold Cosby's suggestion that the score approach may have other benefits is interesting. Anecdotally, some physicians have commented that they use it as a teaching aid to help explain their treatment recommendations. This may be helpful to patients with upper respiratory infection, as they report that sometimes they visit physicians for reassurance that they do not have a serious illness and not necessarily for an antibiotic prescription.¹

Mitchell Levine wonders how often physicians in the study missed cases of group A *Streptococcus* infection that would have been caught had the score approach been used. These data were omitted from the final version of the article to meet the word limit requested by *CMAJ*'s editors. We did, however, note that the physicians missed substantially more cases of streptococcal infection in children (20%) than if they had used the score approach (6%, $p = 0.006$).²

In the study, physicians identified 85 of 102 cases of streptococcal infection (83.1%).² The false-negative rate of 16.9% for physician judgement is not less than the 15% rate for the score. In addition, this estimate for physician sensitivity is somewhat higher than the 50-75% estimate generally reported in other studies.³⁻⁵ However, all family physicians in the present study were provided with an article about the sore throat score and a laminated pocket version of the score for quick reference; this may have affected their performance.

In the original study, in which no information about the score was provided, the sensitivity of usual physician care was 69.4% compared with 83.1% for the score ($p = 0.06$).⁶ This result is more in keeping with published reports and suggests that physicians miss 25%–50% of cases of group A *Streptococcus* when they rely on their clinical judgement. As a result, front-line practitioners can be reassured that they are likely to miss fewer cases of group A *Streptococcus* when they use the score approach than when they rely on their clinical judgement.

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Remote versus urban medical training

It is reassuring and not surprising to see that residents trained in remote or rural settings achieve Medical Council of Canada Qualifying Examination scores comparable to those of residents trained in urban settings.¹ Of greater interest would be information on the skill set and scope of practice maintained by candidates trained in remote and rural settings once they establish their practice and information on where they choose to set up practice.

Candidates trained outside of urban areas are more likely to include inpatient care, emergency medicine, obstetrics, basic office procedures and a variety of other skills in their practice. It is also evident to me that residents who are exposed to rural and remote settings are more likely to establish their practice in an underserved area.

There are many nonurban regions in this country desperate for capable, well-trained physicians willing to practice without the urban subspecialty safety net. Programs based outside of urban areas produce physicians with the skills and comfort level required to work in these areas. It seems logical that the College of Family Physicians of Canada, universities and other interested parties should shift their training focus to meet the needs of our health care system. If these groups fail to meet these needs, it is only a matter of time before another type of health care prac-

itioner assumes the role of primary care provider to Canadians living outside of urban areas.

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As a 24-year veteran of a family medicine training program based in a rural setting, I find it unfortunate that Robert McKendry and colleagues did not offer a description of the rural training programs in their article,¹ for example, the number of months of speciality training conducted in towns with less than 30 000 people. I would have found a table describing the site rotations, with information on the number of trainers per site, helpful in deciding if the the results of this study are applicable to our situation in Newfoundland.

One of the strong points of rural clinical teaching rotations is that the resident is often trained in a one-to-one situation with a clinical teacher. A good teacher makes a great rotation but the same site with a poor teacher makes no rotation at all. The process of recruiting rural clinical teachers and saying goodbye to departing ones is both delicate and constant. More information is needed concerning the differences between rural and urban rotations before we can determine the value of the results of McKendry and colleagues. In addition, if there was a difference in examination results between the residents trained in rural and remote settings and those trained in urban settings, perhaps, as the authors note, we should examine the examination.

On another note, I spend a bit of time in a canoe and I was appalled at the picture on the cover of the Sept. 19, 2000, issue of *CMAJ*. The canoeists