with. **Dr Dubin** has also received advisory board and consultant fees from Boehringer Ingelheim, Purdue Pharma, Eli Lilly, and Pfizer. **Dr Jovey** has consulted for or been a member of speakers' bureaus for AstraZeneca, Bayer, Biovail, Boehringer Ingelheim, Eli Lilly, Janssen-Ortho, GlaxoSmithKline, King Pharmaceuticals, Merck Frosst, Mundipharma Australia, Nycomed, Pfizer, Paladin, Purdue Pharma, Sanofi-Aventis, Valeant, and Wyeth.

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You can't measure pain

I am fascinated by the range of sincere opinions when it comes to the question of treating chronic noncancer pain with opioids.[1] But in all the discussions one little fact was consistently overlooked, a fact that was stated most clearly by Eldon Tunks 30 years ago: you can't measure pain. It was true then, and it is equally true now. This might have something to do with the absence of any solid, objective evidence that the effectiveness of opioid treatment outweighs the known and easily quantifiable risk.

Because pain itself can't be measured, the temptation has been to set up surrogates, all of which suffer from the same logical flaw: to establish correlations with pain intensity and pain relief, you have to be able to measure pain. Of course, if we could measure pain none of these surrogates would be necessary. Numerical and analogue scales? We have all asked the "on a scale of 1 to 10" question and received the answer "12." People who rate their chronic pain anything higher than a 5 have obviously never passed a kidney stone, or had a dentist hit a nerve.

Even so, the only person who can judge the effectiveness of pain relief is the person who feels the pain—and in come the factors of personality, pain tolerance, primary and secondary gain, and the sheer impossibility of comparing present pain with past pain, or with hypothetical pain. If we can't measure pain, then we can't measure the effectiveness of pain treatment in terms of objective evidence; and basing opioid treatment on unquantifiable self-report, in the presence of considerable risk of abuse, addiction, and even death, might not be the smartest strategy either.

But what would criticism be without a constructive suggestion? So here's one: As the evidence of risk points predominantly to oxycodone, rather than to opioids as a class, can we find the will to outlaw what is quite possibly the most addictive substance that it has been our collective misfortune to encounter?

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Competing interests
None declared

Reference

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