LETTERS TO THE EDITOR

On the rational use of opiates in penitentiary centres. The balance between opiophobia and opiophilia

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Letter to the Editor,

After reading with great interest your communication Opiates in prison: Can we reduce its use?[1], we would like to take into account some facts that we believe most relevant. The WHO considers that the prescription of opiates is an appropriate indicator of how pain is managed in different countries[2]. In Spain, these figures have greatly improved in the last decades partly due to an enhanced awareness among physicians regarding the treatment of pain[3]. We could state that most of the reluctance regarding the use of opiates due to the development of dependence has been overcome and thus lifted the burden of opiophobia. However, the development of new opiates and the increasing advertising by the pharmaceutical industry has entailed a considerable increase of their prescription – which has been called opiophilia, by contrast[4]. In the United States this prescription has reached levels that call for concern, with the corresponding social alarm in a country where the mortality due to opiate overdose has suffered a four-fold increase between 1999 and 2010. Yet, we believe that in Spain these troubling levels will not be reached.

Pain is a disturbing symptom that aggravates any disease's prognosis and deteriorates the quality of life of those suffering it. Impaired access to opiates in chronic pain patients who could benefit from them since they have the right to appropriate treatment, goes against the most basic ethical principles. Thus, in a context of prevailing opiophobia up until not so long ago, we believe that any measure aimed at limiting their use should be cautious and extremely well argued.

In the imprisoned population, were 42% report having used heroin at some point and 24% reported having used this substance in the 30 days prior to entering prison[5], it goes without saying that measures aimed at preventing drug use are of paramount importance. It is not unusual that patients seek consultation in outpatient addiction centres after serving their sentences to continuo their opiate agonist therapies. Sometimes these patients lack an appropriate medical record with the drugs and doses prescribed during their conviction: this must be requested, and it takes very long to get it. This situation needs a quick and efficient intervention: the medical record should be standardized (at least regarding treatments and doses) upon the release of inmates. Supervised treatment in prisons makes somewhat unlikely that these treatments were used for illicit purposes and modified release formulation would further enable this.

Yes, we agree that, as you suggested, along with clinical guidelines we would need a thorough re-evaluation of the effectiveness of certain therapies, by means of specific tools for the assessment of addiction risk (such as Opioid Risk Tool[6]) prior to the initiation of treatment. We should remember that there are no absolute contraindications for the use of opioids. However, they should be avoided in patients with primary headache or migraine, functional visceral pain, fibromyalgia, chronic pain due to mental disorders (depression, generalized anxiety disorder (GAD) or PTSD), inflammatory bowel disease (IBD) or chronic pancreatitis, comorbidity with severe mood disorders and/or suicidal behaviours, inappropriate use of

other drugs, pregnant women or women who plan to become pregnant[7].

Conflict of interests: none to declare.

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RESPONSE TO THE LETTER TO THE DIRECTOR
Reply

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Mr. Editor of the *Revista Española de Sanidad Penitenciaria* (Spanish Journal of Prison Health):

We would like to thank the interest of Muquebil Ali Al Shaban-Rodriguez and colleagues on our publication (Opioids in prison: Can we reduce their use?[1]) We agree on the importance of a comprehensive approach of chronic pain in the correctional setting, therefore using whatever necessary measures, with all dedicated resources or treatments, as medical deontology obliges and the legislation in force in our country establishes. However, it is different when we are dealing with an opioid use disorder, where the only measures that have proven effective are pharmacological treatment and psychosocial interventions (and dual therapies including both modalities[2]). Among pharmacological therapies, opioid agonists (methadone, buprenorphine) and antagonists (naltrexone) have proven effective. Precisely in our previous letter we referred to complications derived from the use of other agonists (tramadol and codeine), which are not indicated for opioid use disorder, and are frequently associated with dependence disorders. Last and as a consequence of all this we can not but reiterate what we already established in our last communication: we believe that we should consider the need to be more restrictive in the use of opioids for the use of chronic pain in the correctional setting.

The authors of this letter hereby confirm the absence of any conflict of interest.

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