In Response

We appreciate the comments by Atluri. Over the past decade, there has been a steady increase in the use of illicit drugs, such as marijuana and cocaine, and the non-medical use of prescription drugs (1-9).

Statistically significant increases between 2000 and 2001 in the non-medical use of pain relievers and tranquilizers has been identified. Mixing illicit drugs and licit drugs is not only dangerous to the public, but also is dangerous to the practitioners of interventional pain management under the scrutiny of numerous agencies, including the Federal and State Drug Enforcement Administrations, Board of Medical Licensures, and multiple other authorities. It is further indicated that interventional pain physicians should take all necessary precautions in providing medically necessary care, but at the same time, not encouraging diversion. In fact, a higher prevalence of illicit drug usage was shown in patients abusing controlled substances (10).

With regards to the suggestion of lower cutoff limits for cocaine, as well as amphetamines, while appears intriguing, it does not appear to be practical as the cutoff limits utilized in the study are the accepted limits.

It is interesting to note a recent publication by Rosenblum et al (11) in *JAMA* evaluating the prevalence and characteristics of chronic pain among chemically dependent patients in Methadone maintenance and residential treatment facilities. These authors showed that chronic severe pain is prevalent among patients in substance abuse treatment, especially methadone maintenance treatment program patients. Further, this study showed that pain is associated with functional impairment and multiple correlates varied with the population. They concluded that self-medication for pain with psychoactive drugs appeared especially problematic among substance users who enroll in drug-free treatment programs. Thus, they suggested that substance abuse treatment programs can develop comprehensive and structured pain management programs. Vice versa, interventional pain physicians must realize that illicit drug usage is prevalent among chronic pain patients and physicians have to develop comprehensive and structured drug evaluation programs.

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