Myths and Facts on Use of Opioids and Misconceptions that Hamper Pain Assessment

Managing the pain of cancer can be a challenge for most family physicians and clinicians.

Myth:
You can tell if a patient has pain by their facial expression.

Fact:
Probably the most humbling and challenging aspect of caring for the patient with pain is to accept that the sensation of pain is completely subjective. Pain is 'whatever the experiencing person says it is, existing whenever he says it does'.

'The single most reliable indicator of the existence and intensity of pain - and any resultant distress - is the patient's self report. (McCaffery, 2001)

Myth:
The patient in pain will fit the acute pain model. If a patient has pain there will be visible signs of discomfort, physiological and/or behavioral.

Fact:
The pain may remain severe but physiological and behavioral adaptation occurs, leading to periods of minimal or no signs of pain. Lack of pain expression does not necessarily mean lack of pain. The lack of objective signs may prompt the inexperienced clinician to say that the patient does not 'look' like he or she is in pain. Neither sleep nor sedation can be equated with pain relief. Many drugs sedate without relieving pain. Never hold a scheduled pain medication just because the patient is sleeping.

Myth:
Opioid use can lead to addiction.

Fact:
This is a very common fear that patients and family members have about the use opioids. Opioids do not cause the psychological dependence involved in addiction. After taking an opioid on a daily regular basis for one month or longer, most patients will develop tolerance and physical dependence but not addiction. Taking opioids for pain relief does not equate with addiction, no matter how high the dose or for how long.

Addiction is a complex phenomenon. Its hallmark is psychological dependence on drugs and a behavior syndrome characterized by compulsive drug use and continued use despite harm. It is important to distinguish between true addiction, pseudo addiction caused by under-treatment of pain, behavioral/family/psychological dysfunction, and drug diversion with criminal intent.

Physical dependence 'is a state of adaptation that often includes tolerance and is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist' Abrupt opioid withdrawal may result in an abstinence syndrome characterized by tachycardia, hypertension, diaphoresis, nausea and vomiting, diarrhea, body aches, abdominal pain, psychosis and /or hallucinations.

Myth:
If a patient presents with moderate to severe pain related to their disease, you should initially start with a long acting opioid.

Fact:
Most opioids used in the treatment of pain work best when titrated; dose to effect. This means starting at a low dose of immediate release (IR) and increasing the dose at scheduled intervals until there is an analgesic benefit or the patient experiences unacceptable side effects that do not improve with time and vigorous side effect management. Titration can be done on a daily basis.

When pain has stabilized, switch to a sustained-release (SR) preparation, at an 8-12 hourly interval for best control. The breakthrough medication should always be of the same immediate release opioid. Prescribing long intervals between breakthrough doses only prolongs a patient's pain unnecessarily. A guideline for breakthrough doses is Q1H prn if administered orally, and Q30 minute's prn if administered subcutaneous.

Myth:
Pain is an inevitable part of certain illnesses.

Fact:
There are many good scientific, ethical, institutional and medico-legal reasons to treat pain of all types more effectively.

The WHO has developed a 3-step model to guide analgesic choice depending on the severity of the patient's pain. The non-opioid analgesics that characterize

step 1(mild pain) of the WHO ladder (acetaminophen, NSAIDs) all have a ceiling effect to their analgesia. Start with moderate to maximal doses to achieve optimal efficacy quickly. The Step 1 analgesics have the greatest risk of severe adverse effects. Anticipate and monitor for them carefully.

Step 2 and 3 (Moderate to Severe Pain) opioid analgesics (e.g. codeine, hydromorphone, morphine, oxycodone) follow first order kinetics. They reach their peak plasma concentration approximately 60-90 minutes after oral or rectal administration, 30 minutes after subcutaneous injection, and 6 minutes after intravenous injection. They are eliminated from the body in a direct and predictable way, irrespective of the dose. The liver first conjugates them. Then the kidney excretes 90% to 95% of the metabolites.

Myth:
Opioids have a ceiling dose.

Fact:
Many patients express a desire 'to save the strong drugs' "until I really need them", and are fearful of not having the effect of pain control at that time. There is no dose ceiling for pure agonist opioids (morphine, hydromorphone, codeine, oxycodone, methadone, and fentanyl). If the patient is not experiencing any analgesia and has no side effects, then continue to titrate. However, as the dose increases, so does the potential for adverse effects. It should be the outcome of treatment for the patient, rather than the dose of opioid prescribed, that is most important.

Myth:
Most elderly persons don't feel pain as intensely as younger patients do.

Fact:
Although they can be slower to perceive and respond to pain, elderly persons do feel it as intensely. However, they are less likely than younger people to report it. Assessment of pain in the elderly cognitively impaired patients may be difficult but not impossible. There is a need for multiple assessment tools and approaches including verbal or visual analog scales, the faces scales, the pain thermometer and observation for increasing agitation, moaning, or pain on movement (incident pain).

Myth:
Elderly persons should receive lower opioid doses than younger patients.

Fact:
Regardless of age, no two people have the same opioid threshold. The opioid dose for any person should be based on his/her needs, response to the drug, and tolerance. However, the elderly person needs to be monitored more closely, and their pain assessed more frequently, because their rates of metabolism and drug excretion have slowed and they may be at greater risk for drug toxicity and/or respiratory depression. The rule of thumb in this population is "start low and go slow" with respect to opioid therapy.

Myth:
If an elderly person becomes confused, you'll know that he's been overmedicated with an opioid.

Fact:
This is not necessarily true as confusion can also signal uncontrolled pain. Other possible contributing causes include infection, hypoxia, fluid and electrolyte imbalances. A complete physical assessment and check of lab values as well as an assessment of medications may help to determine the reason for the confusion.

Myth:
It is appropriate to reduce the dose of opioid when a patient is unconscious and dying.

Fact:
When patients are no longer able to verbally communicate whether they are in pain or not, the best approach is to assume that their cancer (disease) is still painful and to continue with their regular medications. Continued opioids simply assure that death will be as peaceful and painless as possible.

References:

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2. Ian Anderson Program in End of Life Care (2000), Module 2, Pain Management, University of Toronto. (www.cme.utoronto.ca/endoflife/modules.htm)

3. Jovey, R., Boulanger, A., Gallagher, R., Gillen, M., Goldman, B., Peloso, P., and Thompson, E., (2002), Managing Pain. Healthcare & Financial Publishing, Rogers Media.