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Agreeing a gold standard in the management of cancer pain: the role of opioids

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Introduction

Most pain in cancer responds to pharmacological treatment using orally administered analgesics and adjuvants. Current management is based on the World Health Organization (WHO)'s concept of an 'analgesic ladder', which involves a simple stepwise approach to the use of analgesic drugs and is essentially a framework of principles rather than a rigid protocol (Table 6.1). This allows considerable flexibility in the choice of specific drugs, and should be regarded as but one part of a comprehensive strategy for managing cancer pain. Symptomatic drug treatment is used in an integrated way with disease modifying therapy and non-drug measures.

Criticism from a systematic review (Jadad & Browman 1995) of the strength of the evidence to support the use of the WHO method is misplaced. Criticism of the WHO validation studies centres on the lack of randomised controlled trials (RCTs), the retrospective nature of some of the studies, short follow-up, high withdrawal rates and poorly defined outcome measures. A more pragmatic view would take into account the large number of patients involved (almost 4,000), the remarkably consistent results in different countries and environments (Table 6.2), the weight of supporting anecdotal clinical experience over the last three decades and the impossibility of conducting RCTs now that the WHO method is a world standard.

The most important part of the WHO method, and the reason for its success, is the use of oral opioids for moderate-to-severe pain. Until now morphine has been the benchmark 'step 3' opioid because it is effective and familiar to prescribing

Table 6.1 The WHO method for cancer pain relief: the principles

Simplicity – in choice of analgesics

Simplicity – in choice of route (oral)

Individualisation of dose, particularly of strong opioids

Continuous pain requires continuous medication

Use of adjuvant analgesics

Treatment of adverse effects to allow adequate dose titration

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Box 8.1

- Portenoy & Hagen (1990) assessed 90 inpatients referred to their pain service over a three-month period. Sixty-three of the patients met their requirements of stable opioid dosage for the previous 48 hours and base line pain of moderate or less intensity. In this selected group, 63 per cent described one or more episodes in the previous 24 hours of severe or excruciating pain (breakthrough pain). Twenty-eight per cent had more than one distinct type of breakthrough pain.
- Portenoy *et al.* (1999a) recently repeated this initial study in an inpatient population of cancer patients within an oncology treatment centre and found 51 per cent had experienced breakthrough pain in the previous 24 hours.
- Banning *et al.* (1991) analysed pain in 200 consecutive cancer referrals to a pain clinic. The median survival of the group was ten weeks. Although not focusing specifically on episodic pain, this results show that 86 per cent of the patients had pain on motion. Those with bone pain on movement formed a particularly difficult group to treat.
- Zech *et al.* (1995) studied 613 cancer patients referred to their pain clinic. They defined breakthrough pain as any pain that is 'characterised by transience and intensity over baseline'. Using this definition, 40 per cent had breakthrough pain.
- Fine & Busch (1998) studied 22 terminally ill patients with pain at home. Eighty-six per cent had breakthrough pain using Portenoy's definition.
- Grond *et al.* (1996) assessed 2,266 new referrals with cancer pain to their pain service and classified their pain using the IASP classification of chronic pain (International Association for the Study of Pain 1986). Axis III of the classification divides the temporal characteristic of any pain into nine categories. They found 23 per cent of the main pain syndromes were classified as 'recurring regularly or irregularly', 'paroxysmal' or 'sustained with paroxysms'. A further 36 per cent were classified as 'continuous, fluctuating'.
- Zeppetella, O'Doherty & Collins (personal communication) prospectively surveyed pain patterns in 414 consecutive hospice admissions using a schedule adapted from Portenoy & Hagen (1990). Of those with pain, 89 per cent described one or more breakthrough pains.
- Swanwick, Haworth & Lennard (personal communication) studied 132 hospice admissions who had experienced 228 separate pains in the previous 24 hours. Only 7 per cent of these were steady continuous pains. The remaining 93 per cent varied with time, 36 per cent having a background element (corresponding approximately to Portenoy's 'breakthrough pains') and 57 per cent occurring in the absence of any background pain (recurrent, acute pains).