YaleCares News & Notes on Supportive Care, Symptom Management, and Care at the End of Life

"The primary goal of palliative care is to prevent and relieve the many and various burdens imposed by diseases and their treatments."

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Fear of Morphine

There are several classes of medications available for the treatment of cancer-related pain. The patient's history and specific type of pain—musculoskeletal, visceral, bone, neuropathic—will lead to a pain diagnosis and the best combination of interventions to include in a treatment plan. For moderate to severe pain, the recommended interventions almost always include opioid analgesics. Opioids are the most effective single class of analgesics for the treatment of moderate to severe pain. Co-analgesics (non-opioid analgesics such as acetaminophen, ibuprofen, and lidocaine patches) and/or adjuvants (medications originally approved for a different indication but which also relieve certain types of pain) are frequently part of the pharmacologic intervention. In fact, hydrocodone and oxycodone, combined with acetaminophen, aspirin, or ibuprofen ("combination products"), are among the most widely prescribed analgesics.

Barriers

Unfortunately, there are many barriers to the appropriate use of opioid analgesics. These include institutional or systemic barriers, clinician barriers, and patient/family barriers. Each of these has been investigated and interventions to lower barriers have been initiated, but with slow and limited success.

As a society, we have failed to appreciate pain, even cancer-related pain, as an important health issue. Medical and nursing schools have belatedly begun adding coursework in pain management to their curricula. Efforts to combat substance abuse have had a major adverse impact on treatment of pain: prescribers are reluctant to put themselves at risk for regulatory or criminal investigation. They report being uncomfortable prescribing opioids and to feel unprepared to identify and manage substance abuse. Many physicians and nurses also have exaggerated fears about serious side effects such as respiratory depression, and unfounded fears about hastening death in patients with advanced disease.

Patients and families fear addiction and side effects. In addition, a recent study has found that patients with advanced cancer associate "strong opioids" such as morphine with disease progression or imminent death. They see morphine as a "last resort" medication that is likely to hasten death.

Addressing fears

Opioids are among the safest classes of medications when prescribed and used as directed. "Iatrogenic addiction," if it exists at all, is very rare. Clinically significant respiratory depression is rare, and is associated with inappropriate prescribing and administration (a future article in *YaleCares* will be devoted to opioid safety).

For many years it was assumed, based on little or no evidence, that there was a high risk of hastening death when opioids and sedatives were administered to patients with severe symptoms at the end of life. The ethical principle of "double effect" was invoked to justify these treatments. Double effect states that it is permissible to use a high risk treatment, even one that could result in death, if it is proportional and the intent is to relieve suffering, not to hasten dying. There is a growing body of evidence that it is unnecessary to invoke double effect as a justification, because

appropriately titrated opioid analgesics and sedatives do not appear to hasten death, even in very vulnerable populations. The well-established principle that opioids should be titrated to individual symptoms can be maintained even at the end of life.

Conclusion

There have been significant improvements in pain management in the past 30 years. Yet, despite years of research and clinical practice, inadequate treatment of pain, including cancer-related pain, remains prevalent. Confusion about the relationship between pain management and substance abuse is a significant barrier. Unfounded or exaggerated fears about opioid risks is a significant contributor; both clinicians and patients are vulnerable to these fears.

News

- There was an interesting article in the *Chicago Tribune* on Do Not Resuscitate orders in schools, Schools ponder role as child nears death. The article is only available for a fee, but the issue is discussed at Pallimed.org.
- Yale University has announced that it will provide open access via the Web to some of its most popular courses. Seven courses were posted on Dec. 11. Among them is the course titled "Death" in the Department of Philosophy.
- U.S. childhood cancer death rate declines sharply
- New safety warnings have been issued by the FDA regarding inappropriate prescribing and use of fentanyl patches (e.g., Duragesic) and the fentanyl buccal tablet (Fentora).
- The Drug Enforcement Administration (DEA) has issued liberalized rules regarding the issuance of multiple prescriptions for Schedule II Controlled Substances.

Journal Watch

- Thomas J. Optimizing Opioid Management in Palliative Care. *Journal of Palliative Medicine* Dec 2007;10(Supp 1):S1-S18.
- Visovsky C, et al. Evidence-Based Interventions for Chemotherapy-Induced Peripheral Neuropathy. *Clinical Journal of Oncology Nursing*. 2007 Dec;11(6):901-909.
- Fulcher CD, Gosselin-Acomb TK. Distress Assessment: Practice Change Through Guideline Implementation. *Clinical Journal of Oncology Nursing*. 2007 Dec;11(6):817-821.
- Mercadante S, Arcuri E. Pharmacological management of cancer pain in the elderly. *Drugs & Aging*. 2007;24(9):761-76.

Resources on the Web

- *The Assessment of Pain in Older People*. National Guideline for the United Kingdom.

Palliative Care Calendar & CE

Yale

- End-of-Life Issues Studies Group (Interdisciplinary Center for Bioethics) monthly meeting. Institution for Social & Policy Studies (ISPS), 77 Prospect Street. All meetings start at 5:30pm. Contact ashley.simmons@yale.edu.
  - Jan Chalmers Clark – *Medical Friendships in Assisted Dying: Broader Horizons*
  - Jan 22 – Pauline W. Chen, MD – *Being there*.
  - Feb 19 – Robert Burt, JD. – *Death in the Practice of Medicine*
  - Feb 26 – Kathy Foley, M.D. – *The Mockery of Public Health: The Oregon Public Health Division's Reports on Physician Assisted Suicide*

Connecticut

- Mar 28, 8:00am – 4:00pm. 5th Annual Conference of the Connecticut Coalition to Improve End-of-Life Care; Cromwell. **The Integration of End-of-Life Care in Acute Care Settings**. info@ctendoflifecare.org.

Elsewhere

- Program in Palliative Care Education and Practice—the premier multidisciplinary palliative care education program for educators & leaders. Apr 29 - May 6 & Nov 11-18, 2008 (must attend both sessions) **Application deadline: 15 Jan 08**.

Online

- Managing Toxicities in Breast Cancer Patients: Emesis, Pain and Depression [CME] (Quest MedEd)
- Persistent and Breakthrough Pain: Individualizing Therapy, Optimizing Function [CME] (Quest MedEd)
- Late Effects of Cancer Treatment and Survivorship: Strategies for Primary Care and Oncology Care Providers [CME] (Quest MedEd)

References: Fear of Morphine

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2. Castellano G. The Criminalization of Treating End of Life Patients with Risky Pain Medication and the Role of the Extreme Emergency Situation. *Fordham Law Review*. Oct 2007;76(1):203-234.
3. Good PD, Ravenscroft PJ, Cavenagh J. Effects of opioids and sedatives on survival in an Australian inpatient palliative care population. *Intern Med J*. 2005;35:512-517.
4. Intersection of Pain Management and Addictive Illness.
5. Maltoni M. Opioids, pain, and fear. *Annals of Oncology*. 2007 Dec 10 [Epub ahead of print]
6. Morita T, Chinone Y, Ikenaga M, et al. Efficacy and safety of palliative sedation therapy: A multicenter, prospective, observational study conducted on specialized palliative care units in Japan. *J Pain Symptom Manage*. 2005;30:320-328.
7. Portenoy RK, Sibirceva U, Smout R, et al. Opioid use and survival at the end of life: A survey of a hospice population. *Journal of Pain and Symptom Management*. 2006/12;32:532-540.
8. Reid CM, Gooberman-Hill R, Hanks GW. Opioid analgesics for cancer pain: symptom control for the living or comfort for the dying? A qualitative study to investigate the factors influencing the decision to accept morphine for pain caused by cancer. *Annals of Oncology*. 2007 Dec 10 [Epub ahead of print]
9. Sykes N, Thorns A. The use of opioids and sedatives at the end of life. *Lancet Oncol*. 2003;4:312-318.
10. Sykes N, Thorns A. Sedative use in the last week of life and the implications for end-of-life decision making. *Arch Intern Med*. 2003;163:341-344.
11. Sykes NP. Morphine kills the pain, not the patient. *Lancet*. 2007;369:1325-1326.
12. Thorns A, Sykes N. Opioid use in last week of life and implications for end-of-life decision-making. *Lancet*. 2000;356:398-399.