

The myths and realities of pain control with opioids

June L. Dahl, PhD

Numerous studies have shown that dying patients and those with advanced disease experience significant pain that is often inadequately treated. This occurs in spite of the existence of drugs and other therapies that can relieve almost all pain. Opioid analgesics are particularly important for pain control at the end of life. Unfortunately, they are often underutilized. Decisions about the use of opioids continue to be influenced by a lack of knowledge of their basic pharmacology and a variety of myths about these drugs. As a result, there is often apprehension surrounding their routine use—a fear that has been referred to as “opiophobia.” Disabusing yourself, your patients, and their families of these myths is critical to providing optimal care.

Myth: Opioid use will make my patient an addict.

Fact: Addiction rarely occurs. Addiction is a neurobiologic disease characterized by one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. It is important not to confuse

addiction with physical dependence. Patients regularly treated with morphine or other opioids will become physically dependent and will experience symptoms of withdrawal if drug therapy is stopped abruptly. That does not mean they are addicted. Physical dependence is an anticipated response to continued opioid therapy. If a patient no longer needs opioids, be certain to taper the dose to prevent symptoms of withdrawal.

Myth: My patient will need ever-increasing doses of opioids because tolerance develops rapidly to these drugs.

Fact: Tolerance is not an inevitable consequence of chronic opioid therapy. Persons with cancer may get pain control at essentially the same dose for weeks or even months. Only when the pain worsens because of disease progression will dose requirements escalate. If tolerance does develop, you can increase the dose because there is no ceiling to the analgesic effect of these drugs. You also can switch the patient to another opioid because there is incomplete cross-tolerance among these drugs.

Myth: Aggressive use of opioids will shorten life.

Fact: This is highly unlikely. Nevertheless, many believe that the

use of opioids for pain control increases the risk of death. This might be described as the “myth of double effect.” You may recall the principle of double effect—aggressive pain control is deemed ethically appropriate because a good effect (pain relief) is intended and that outweighs the potential bad effect (causing death by respiratory depression). Significant tolerance develops to the respiratory depressant effects of opioids. Those involved in hospice can attest to the fact that effective pain management may prolong life rather than shortening it.

Myth: I will get into trouble with the Medical Board or the Drug Enforcement Administration if I am not extremely cautious about using opioids for pain control.

Fact: This concern is far more related to perception than reality. Although there is no surefire way for those who prescribe opioids to protect themselves against unwarranted scrutiny, the chance of being investigated is very small, especially if one keeps accurate and complete medical records that document the why and what of prescribing practices. Review the response to treatment at regular intervals, monitor patient adherence to the medication regimen and adjust the treatment plan as needed to meet the goals of therapy: reduced pain, improved physical and psychosocial function.

Dr Dahl is a Professor of Pharmacology at the University of Wisconsin Medical School and the Director of the American Alliance of Cancer Pain Initiatives. This article has been reprinted with permission from HospiceCare Inc.



The mission of the *Wisconsin Medical Journal* is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

The *WMJ* (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of *WMJ*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the Society take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

For reprints of this article contact the *WMJ* Managing Editor at 866.442.3800 or e-mail wmj@wismed.org.

© 2003 Wisconsin Medical Society