ISSUES IN OPIOID THERAPY FOR THE TREATMENT OF CANCER PAIN

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Evaluation and treatment of pain in the patient with cancer has now evolved to encompass a series of clinical guidelines which define a comprehensive approach to the management of this difficult medical problem. Current knowledge in cancer pain includes the description of the common cancer pain syndromes in this population, as well as their postulated neurophysiologic mechanisms; a classification of the types of patients with pain, the different types of pain (acute, chronic, breakthrough) and the psychological factors that contribute to and alter the pain complaint; the development and implementation of well-validated pain measurement methodologies to assess pain intensity, degree of relief, and mood (psychological distress); the modeling of pharmacokinetic pharmacodynamic relationships to correlate opioid drug distribution with pain relief and side-effects; and refined use of anesthetic and neurosurgical approaches and the broader integration of cognitive-behavioral approaches (1-16).

These advances have focused attention on the cancer patient as the clinical model of pain, and have led to improved pain management in patients with medical illness. Moreover, this patient population has offered the unique opportunity as a natural experiment to study the chronic administration of analgesic drugs, specifically the opioids, to non-addict populations, providing insight, as well as controversy, in their appropriate use for different types of pain and the phenomenon of clinical tolerance, and physical and psychological dependence.

Based on several national and international surveys, one-third of patients in active therapy and two-thirds of patients with advanced disease report pain. Tumor infiltration of bone, nerve, soft tissue or viscera are the most common causes of pain accounting for 65-75% of patients. Pain
as a result of cancer therapy from surgery, chemotherapy, or radiation accounts for 15-25% of pain, with 5-10% of patients reporting pain independent of their cancer or cancer therapy. Various factors influence the prevalence of pain including the primary tumor type; stage and site of disease; and patient variables, especially psychological variables (17-22).

**A GLOBAL CANCER PAIN RELIEF PROGRAM**

Data from the World Health Organization Cancer and Palliative Care Unit reports that 4.3 million cancer patients die each year with inadequate control of cancer pain (1-2). To remedy this situation, the WHO has created a Cancer Pain Relief Programme and through a series of expert panels has developed guidelines for the treatment of cancer pain. The Program has achieved a broad international consensus based on the concept that analgesic drug therapy is the mainstay of treatment for the majority of patients with cancer pain. Field testing of the WHO Guidelines in conjunction with clinical experience has shown that 80-90% of cancer patients' pain can be controlled using a simple, inexpensive method described as a Three Step Analgesic Ladder (23). This approach is based on the use of a combination of non-opioid, opioid, and adjuvant drugs, titrated to the individual needs of the patient, according to the severity of pain and its pathophysiology. Implementation of the analgesic guidelines; assurance of drug availability—specifically, opioids; the education of health care professionals; and designating cancer pain a priority for all national cancer control programs are the major goals of the WHO effort. Dr. Jan Stjernsward, Head of the WHO Cancer and Palliative Care Unit has repeatedly emphasized that nothing would have a greater impact on the treatment of cancer pain for patients in developing and developed countries than implementation of existing knowledge (24).

**BARRIERS TO EFFECTIVE CANCER PAIN TREATMENT**

These health care policy programs and scientific advances notwithstanding, the undertreatment of cancer pain remains a serious medical problem. Numerous barriers have been documented that prevent patients from receiving effective treatment and health care