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Chronic pain: A new disease?



Nearly one-third of the American population experiences chronic pain at some point in life. This figure, disturbing on its own, becomes more problematic in light of recent studies which demonstrate that chronic pain is a destructive disease process that creates pathologic changes in the central and peripheral nervous systems. This means a paradigm shift for physicians who must begin to understand chronic pain not as a simple disorder, but as a serious medical disease that demands early and aggressive treatment.

Chronic pain is being understood more clearly today as far more — and far more pernicious — than a protracted version of acute pain. The repeatedly generated neural signals characteristic of chronic pain can become embedded in the spinal cord like a memory, creating physiochemical changes in the neural pathways and creating hypersensitivity to those same pain signals. Patients who have suffered from uncontrolled pain for months or years often develop pain in areas well beyond the organ or dermatome originally affected.

Physicians unfamiliar with this concept of neural plasticity may deem their patient's chronic pain psychogenic because it fails to conform to their pre-conceived map of the nervous system. Instead, physicians need to realize that failure to treat chronic pain can result in physical, psychological, and behavioral consequences. The changes wrought by chronic pain on neural pathways may also require new treatment approaches. Author Daniel Brookoff, M.D., says the clinical implications of such neural phenomena are “clear but underappreciated — inadequately treated pain is a much more important cause of opioid tolerance than the use of opioids themselves.”

Brookoff concludes by suggesting that opioid analgesics can be the mainstay of safe, effective treatment for chronic pain disease, and so, prevent the damage of untreated

chronic pain. (Brookoff D. *Hosp Pract.* 2000;35(7):45-52,59.)

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Physicians' attitudes toward pain and the use of opioid analgesics: Results of a survey from the Texas Cancer Pain Initiative

"Serious mismanagement and undermedication in treating acute and chronic pain" continue to plague both patients and the physicians who treat them. The clinical scenario seems to endure despite significant advances in knowledge of human pain mechanisms. Clinicians lack knowledge of opioid pharmacology and use; have difficulty making equianalgesic conversions among opioids; have a negative view of patients with chronic pain, and remain reluctant to prescribe opioids (some are inhibited by multicopy prescription programs and fear of regulatory reprisal). Using a 59-item survey, researchers studied the practices, beliefs, and attitudes about pain among 386 physicians in Texas. The intent of the survey was to identify barriers to adequate pain management and to assess the impact community size and medical discipline might have on those barriers.

Many physicians were, in critical clinical instances, reluctant to use opioids, i.e., often reserving them until patients' pain is severe and intractable. Ten percent would "withhold opioids from a patient with severe pain until prognosis is < 1 year, or terminal." (See Table.) Fear of iatrogenic addiction was widespread. Prescribing habits were greatly affected by fear of government scrutiny. The majority thought there should be limits on the number of opioid tablets prescribed and 25% believed adherence to this practice would minimize potential for regulatory scrutiny. One-third believed that tolerance, rather than unrelieved pain, underlies an increase in requests for opioids. Physicians also displayed inadequate knowledge of the prevalence of pain in cancer, and the value of opioids in cancer pain. Half of physicians surveyed said they did not enjoy treating patients with intractable conditions.

Physicians in large communities feared creating addiction; physicians in small communities also feared creating addiction, knew less about pain management, and were less accepting toward treating chronic pain with opioids. Psychiatrists had the least negative attitudes toward pain and its treatment, were less reluctant to prescribe opioids, and less fearful of addiction risk than physicians in other disciplines including internal medicine and surgery/anesthesia. (Weinstein SM, Laux LF, Thornby JI, et al. *South Med J.* 2000;93:479-487.)

Selected responses to survey of 386 Texas physicians

Agreement shows misconception about pain management

Survey Question	Agree (%)	Disagree (%)
Narcotics should be restricted to treatment of severe intractable pain	30.5	64.4
Using narcotics to relieve the pain of benign conditions is ill-advised	31.5	57.5
There are limits to the number of narcotics tablets a patient should be prescribed	67.1	21.7
I give patients a limited supply of pain medications to avoid being investigated	23.8	53.6
Increasing requests for analgesics indicate tolerance to the analgesic	62.4	24.7

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A drug use evaluation of selected opioid and nonopioid analgesics in the nursing facility setting

Results of this multicenter, 3-month retrospective drug use evaluation among nursing facility (NF) residents found that analgesic prescribing for most residents was inconsistent with recommended pain therapy for older persons (e.g., high use of propoxyphene, low use of long-acting opioids, and frequent prn prescribing). The authors state that the current approach to pain management in NF settings is substandard and conclude that education is urgently needed for NF practitioners. (Cramer GW, Galer BS, Mendelson MA, Thompson GD. *J Am Geriatr Soc.* 2000;48:398-404.)

The 2065 NF residents, of whom 76.8% reported chronic pain, received at least one selected analgesic for pain. The following data on this group was also reported:

40.6% of residents received no pain assessment during the 3-month study period

- 41.8% of patients were assessed for pain by observation only
- 16.6% of patients were assessed by objective measures (i.e., numeric pain scales)

69.4% of patients received no nonpharmacologic therapy for pain

55.8% of all opioid prescriptions were for drugs containing propoxyphene

35.6% of all analgesic prescriptions were for propoxyphene with acetaminophen

- Propoxyphene is specifically not recommended for older patients due to lack of proven superiority to acetaminophen, renal toxicity, long half life, and toxic metabolite accumulation.

63.2% of analgesics prescribed were short-acting drugs prescribed prn, rather than the long-acting agents recommended for the elderly population

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Opioids and pain management: What do nurses know?

Since 1998, researchers McCaffery and Ferrell have surveyed 8000 nurses to assess their knowledge of pain management. In comparing results of two earlier surveys (1988-1990, 1995), it was clear that nurses have become more informed about pain assessment and relief during the elapsed time. However, they also discovered that too many nurses still lack "basic knowledge necessary to manage pain properly."

Between 1990 and 1995, nurses became more adept at assessing pain on the basis of patient self report (the accepted method) rather than on the basis of behavior (i.e., if the patient's verbal report was of severe pain, but the individual, for whatever reason, was also smiling or laughing, the nurse was less likely to record and take steps to relieve the pain). This suggested that the most difficult concept for nurses to accept is that they must act on *reports of severe pain, regardless of patient's behavior*. They also improved in their willingness to increase a safe but ineffective dose of morphine by 50% to relieve pain. Nevertheless, in 1995, more than half (53.2%) still failed to grasp basic principles of pain assessment and titration of safe but ineffective opioid doses. Overall, patient's behavior was still the factor most likely to lead nurses to undertreat pain. Many nurses also harbor the fear of creating addiction among pain patients. A significant educational effort is required to help nurses fully understand — and differentiate among — the concepts of addiction, tolerance, and physical dependence. (McCaffery M, Ferrell BR. *Nursing*. March, 1999:48-52.)

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Pain and pain treatment in AIDS patients: A longitudinal study

Among AIDS patients, there is a high incidence of disturbing pain, which is often inadequately treated. In 95 AIDS patients enrolled in a 2-year study, incidence of pain was 88%. In 69% of patients, pain was constant and interfered with daily living to a degree described as moderate or severe.

Pain conditions were related to infections, malignancy, or neuropathy, and pain localizations increased as death approached. Survival rate for patients without pain at study entry was higher than for those with pain. At the start of the study, 77% of patients had inadequate pain control, as indicated by negative scores on the Pain Management Index (PMI) a measure of patient-reported pain relief from analgesic therapy.

Patients received a variety of pain treatments during the study. Adequate analgesic treatment, as assessed using World Health Organization guidelines, increased during the study from 23% to 64%, as did PMI.

Although the great majority of patients said they were satisfied with their analgesic treatment, many felt that pain was not taken seriously by physicians and were often reluctant to take analgesics (See below). (Frich LM, Borgbjerg FM. *J Pain Symptom Manage*. 2000;19:339-347.)

Commonly expressed attitudes and beliefs among AIDS patients

Issue	Attitude/belief
Pain treatment	<ul style="list-style-type: none"> • Belief that physician is authority and responsible for pain treatment • Belief that pain not taken seriously by physicians • Preference for contact with the same physician or nurse during treatment • Belief that treatment received is optimal, so that they must accept living with pain
Reluctance to take analgesics	<ul style="list-style-type: none"> • Patient "taught not to take it"

- Patient "wants to save it for later"
- Patient fears "using up the possibility if pain gets unbearable"
- Patient "afraid of addiction"
- Patient fears side effects of sedation, dizziness, constipation, nausea, if doses are increased

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Cancer pain management by radiotherapists: A survey of radiation therapy oncology group physicians

According to a recent survey, most radiotherapists may believe that cancer pain is inadequately controlled. Results of this survey, conducted among 92 physicians at a 1997 meeting of Radiation Therapy Oncology Group (RTOG), revealed that 83% felt pain in most cancer patients is undermedicated.

Forty percent rated pain control as fair or poor in their own practices, which may be explained in part by prescribing habits. Almost half (47%) would only prescribe a "weak" opioid (e.g., codeine) rather than a "strong" opioid (e.g., morphine) for severe bone-cancer pain of long duration.

In addition, 23% would wait to prescribe maximal analgesia until a patient's prognosis was less than 6 months; 25% would not choose the oral route. In contrast, physicians who would treat pain earlier were also more likely to use oral medications. A full 95% of the physicians surveyed did not prescribe laxatives or antiemetics to manage opioid side effects. Radiotherapy physicians cited many familiar barriers to effective pain management (see below).

Forty-four percent rated their medical school training in pain management as poor — a finding similar to that obtained in a 1993 survey conducted among oncologists by the Eastern Cooperative Oncology Group (ECOG). In that survey, radiotherapists and surgeons were less likely to treat pain aggressively with medications than were medical oncologists. Authors of the current survey suggest that "Radiation oncologists are more liable to see radiation

as a way to treat pain, and may be more concerned with opioid side effects than medical oncologists." (Cleeland CS, Janjan NA, Scott CB, et al. *Int J Radiation Oncol Biol Phys.* 2000;47:203-208.)

Most frequently cited barriers to cancer pain management: 1997 RTOG* survey

Barrier	% physicians citing
Inadequate pain assessment	77
Patient reluctance to report pain	60
Patient reluctance to take opioids	72
Staff reluctance to prescribe opioids	41
Inadequate staff knowledge of pain management	40
Patient inability to pay	23
Excessive state regulation of analgesics	22
Staff reluctance to administer opioids	20
Lack of specialists	17

*Radiation Therapy Oncology Group

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Pain is an epidemic, undertreated disease, experts say

With chronic pain affecting over 40 million Americans, experts are now recommending that it be "considered a disease state of the nervous system, not merely a prolonged acute symptom." Left untreated or undertreated chronic pain can consume a patient's life, making even the most basic activities difficult to perform. Compounding the problem is physicians' reluctance to prescribe opioids for fear they will lose their license or face criminal action. Fortunately, state and federal legislation, as well as professional society guidelines, are in the works and/or being adopted which will make it easier for physicians to prescribe pain medication to those who need it most.

But conquering this new epidemic will take more than legislation. Effective treatment of chronic pain is going to require widespread education to dispel providers' misconceptions and to teach proper diagnosis. Chronic

pain can manifest as headache, myofascial pain, fibromyalgia, neuropathic pain, phantom limb pain — syndromes best diagnosed on the basis of *clinical* criteria. Unfortunately, physicians too often rely on results of MRIs or CT scans; and these imaging tests won't pick up nerve damage or other problems that can contribute to pain. As a result, physicians end up describing the patient's problem rather than providing a diagnosis — or they may dismiss the pain as psychogenic. The author suggests that physicians can learn to treat chronic pain more effectively if they begin to trust their own clinical judgment rather than rely solely on routine tests or "mechanical" evaluations. Pain medicine specialists interviewed for the article conclude that, while diagnostic tools and treatment options continue to be refined, most pain today can be managed using the tools we have available. (Sipkoff M. *The Quality Indicator*. May, 2000;1-8)

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Ethnicity and analgesic practice

A study of admissions to an Atlanta, Georgia emergency department found that black patients were less likely to receive analgesia than white patients with similar injuries. Records were reviewed for a 40-month period and included 217 patients (127 black, 90 white) who were managed by 37 different physicians. All patients included in the study were admitted to the emergency room with new, isolated long-bone fractures.

The presence of pain was noted in similar proportion for both black and white patients. However, only 57% of black patients received analgesics compared to 74% of white patients. The authors state that this finding suggests "...patient ethnicity affects decision-making, independent of objective clinical criteria."

The authors found that physicians were not failing to properly assess pain, rather they failed to administer appropriate analgesia in a consistent way. The authors go on to suggest that since the only factor affecting the disparity in prescribing analgesics was the physician's decision to administer medication, those prescribing decisions may be affected by patient ethnicity. To correct this problem, the authors suggest that pain management guidelines be refined so that existing, standardized pain assessment scales are paired with clear analgesic guidelines. (Todd KH, Deaton C, D'Adamo AP, Goe L. *Ann Emerg Med*. 2000;35[1]:11-16.)

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Analysis of pain content in nursing textbooks

Nurses are essential professionals in pain management, yet their textbooks have only limited content on pain.

According to a new study by Ferrell and colleagues, pain content accounted for only 0.5% of the total text content in 50 textbooks used in nursing education; end-of-life (EOL) care accounted for only 2% of the content. An analysis of texts also showed that most had no information about many key topics, such as the principles of addiction, tolerance, and dependence, as well as barriers to pain management. These results are shown in the table below. The authors concluded that there are significant deficits in nursing texts when it comes to pain management. They urged publishers and editors to fill the "void" and enhance pain content in books used by nurses. (Ferrell B, Virani R, Grant M, et al. *J Pain Symptom Manage*. 2000;19:216-228.)

Ratings of Pain Content by Category for Nursing Texts (N=46)

Pain Content Category	Absent/No mention	Present	Content helpful, commendable
Definition	52%	15%	33%
Assessment - Physical	43%	20%	37%
Assessment - Scales	57%	13%	30%
Pharmacologic management of pain at EOL	57%	17%	26%
Use of invasive techniques	65%	2%	33%
Principles of addiction, tolerance, dependence	60%	20%	20%
Nonpharmacologic management of pain at EOL	48%	9%	43%
Physical pain vs. suffering	83%	11%	6%
Side effects of opioids	68%	15%	17%
Barriers to pain management	76%	11%	13%
Fear of opioids hastening death/opioids near death	76%	15%	9%
Equianalgesic	72%	17%	11%
Recognition of nurses' own burden in pain management	80%	13%	7%
Summary score of pain content	64.4%	13.7%	21.9%

Adapted from Ferrell B, Virani R, 2000.

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Should Pain Management Services Be Denied If There Are No Objective Signs of Injury?

Measurable physiologic changes are associated with chronic pain but may be undetectable on imaging studies. Why? In patient terminology, it's because pain is essentially a "software" problem, whereas imaging studies show only the "hardware," telling us nothing about changes in receptor fields, neurotransmitters, metabolism of neuron pools or altered thresholds of pain signal propagation - the software.

Patients with chronic neuropathic pain may appear perfectly normal on the outside - and on imaging studies as well - yet may truly be suffering severe and often debilitating pain. Likewise, a patient with a small injury can be debilitated by pain that is organic and very real, yet be denied services by an insurance carrier because the extent of the pain cannot be explained by an identified anatomic change. Such patients can be abandoned by their insurance carriers and left as malingerers.

Science teaches that the size of injury does not correlate with the extent of pain. Yet physicians often ignore this fact in their actual clinical practices. Since pain is largely a software problem, analysis during a clinical situation is basically only a cursory look at the hardware.

The author suggests that physicians be persistent in teaching and advocating for their patients, that they support and perform research, and that they take an active role in medical societies and political lobbies that strive to improve patient care and health care delivery. In his opinion, passive behavior will not help the field of pain medicine. (Saberski LR. *The Pain Clinic*. 2000;Feb:10,12.)

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"We Don't Carry That" - Failure of Pharmacies in Predominantly Nonwhite Neighborhoods to Stock Opioid Analgesics

Fewer than 50% of New York City pharmacies have, in stock, an adequate supply of first-line opioid medications to treat a person suffering from severe pain. Pharmacies in predominantly nonwhite neighborhoods are significantly less likely to stock opioids than are pharmacies in predominantly white neighborhoods. Two thirds of the pharmacies that carried **no** opioids were in predominantly nonwhite neighborhoods.

Pharmacists give three chief reasons for having inadequate supplies of opioids: (1) regulations with regard to disposal, illicit use, and fraud; (2) low demand (which is consistent with other reports that nonwhite patients are

significantly less likely than white patients to receive prescriptions for opioid and other analgesics); and (3) fear of theft.

These findings suggest that members of racial and ethnic minority groups are at even greater risk for undertreatment of pain than reported in the clinical literature. (Morrison RS, Wallenstein S, Natale DK, et al. *N Engl J Med*. 2000;342:1023-1026.)

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Four Perspectives on the Concept of 50% Pain Relief from Pain Forum

The Fallacy of 50% Pain Relief as Standard for Satisfactory Treatment Outcome

“The 50% pain threshold has too little real meaning for so many people that it should be eliminated as the most important of measures. How different would our literature appear if we chose pain relief at the 90% level and required that outcomes correlated the meaning of that pain reduction with the other factors that better describe our patients? The threshold for satisfactory relief we have accepted is so low that it makes our work acceptable, at least to us, without really describing what happens to our patients.” *J. L. Seres*

How did medicine get here? The concept of the 50% relief threshold originated in publications by the Johns Hopkins pain group in 1991. The effort to report outcomes in a standardized fashion was a major contribution and the 50% standard offered an objective goal with some statistical meaning. It is still true that outcome measures in the treatment of chronic pain are difficult to standardize. Pain levels and improvement in pain often don't correlate with functional ability, need for medication or suffering behaviors. The 50% threshold became the standard for minimally adequate pain relief despite the fact that very little literature supports this outcome as valid. It is easy to use and so has in effect become the “gold standard” of outcome, a term author Seres challenges as confusing, misleading and one that should be discontinued. The review looks at composite outcome measures that potentially have greater meaning.

Richard B. North, M.D., is professor of neurosurgery, anesthesiology and critical care medicine at Johns Hopkins University School of Medicine, i.e., part of the Hopkins Pain Group. In his responsive commentary, “The Glass is Half Full,” Dr. North points out that the “modern” criterion of 50% pain relief was preceded by numerous publications, spanning two decades, on spinal cord stimulation and failed back surgery syndrome that used this criterion explicitly. North does agree with Seres that other outcome measures should be reported as well. He also states that the Johns Hopkins pain group routinely includes standard

pain rating methods, but considers the following as additional measures of outcome: patient satisfaction, need for additional treatment, medication requirements, activities of daily living and return to work. Patients and physicians should not place undue reliance on any single outcome criterion. Nor should there be excessive reliance on outcome measures that only indirectly reflect relief of pain.
R. B. North, MD

Also in response to Dr. Seres, John D. Loeser, MD, writes, in "Seres' Fallacies," that decent outcome measures are needed, outcomes that reflect the use of valid and relevant instruments to assess the many aspects of pain, suffering and pain behaviors. Statistical issues and appropriate measures to determine outcomes for patients with chronic pain are two components of poor outcome reports that Seres did not identify, says Loeser. He also believes that work is important in an adult's life and the treatment of pain must use return to work or, in the elderly, return to retirement activities as a primary outcome measure.

Loeser comments that although measures of treatment efficacy are important, he believes the approach is an inadequate measure of medicine. Physicians, and particularly surgeons, should not think of themselves as only providing technology; they play many additional roles and should also be providing guidance, information, reassurance, prognosis, comfort, and support. To the degree the physician perceives his/her work as unidimensional, concepts such as patient report of pain level as a primary measure of efficacy take hold. The "good" physician who embodies both technical skill and compassion looks beyond the single-measure report for other indicators — both subtle and apparent — of success. *J. D. Loeser, MD*

Kenneth A. Follett, MD, in the third response to Dr. Seres, "The Fallacy of Using a Solitary Outcome Measure as the Standard for Satisfactory Pain Treatment Outcome" says that "percent of pain relief" is a solitary measure that, used alone, minimizes the multidimensional nature of pain, pain management and outcomes. If it is agreed that pain intensity ratings are a measure of therapeutic outcome, who should provide the rating? Patients may not accurately describe their responses to treatment. Patients, significant others and physicians all rate treatment outcomes differently, with significant others typically reporting the lowest. Ratings of pain intensity are subjective giving rise to the need for more objective measurements of pain and outcomes of treatment. In different capacities, family members, healthcare providers, employers, payors, and society all share the burden of pain. Since each of these parties has a different goal for treatment of the individual's pain disorder, their measures of success will be different.

The Uniform Outcome Measures project of the American Academy of Pain Medicine is developing an outcome measure that incorporates standardized assessment tools

and functional testing. The purpose is to reduce the subjectivity and inconsistency in the assessment of responses to pain therapy. Success or failure of therapy will depend on whether the goals established for each patient have been met, although the determination of success will remain as varied as the individuals seeking relief. *K. A. Follett, MD*

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Dispelling the Myths & Misconceptions of Pain Management

Patients in the long-term-care setting may believe that chronic pain is an inevitable sign of aging, that nothing can be done, that it is a punishment for past actions, or a sign of serious illness or impending death. They may hesitate to acknowledge pain, fearing that this would be a sign of personal weakness, lead to painful tests, or result in a loss of independence. Caregivers may perceive elderly patients (particularly the cognitively impaired) as having a higher tolerance for pain, using pain as an attention-seeking behavior, or being prone to opioid addiction.

These myths and misconceptions, many of which are imbedded firmly in sociocultural beliefs, pose significant barriers to pain relief for the elderly. These are best corrected through education of patient and family, and through ongoing in-service programs for healthcare staff.

The International Narcotics Control Board and the World Health Organization are urging governments to identify – and work to remove – “barriers to opioid access.” The medical use of opioids for pain relief restores patients' comfort and dignity and improves quality of remaining life; results which far outweigh the sociocultural fears that have grown up around them. (Kaldy J. *Caring for the Ages*. 2000; 1(1):27.)

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Palliative Care and Hospice Programs

Palliative care and hospice programs are points on a continuum of comprehensive patient care, with hospice care being the final chapter. Although palliative medicine has become a subspecialty within American medicine, all physicians must become more skilled at meeting the palliative-care needs of their patients.

The American Medical Association has developed a new training module that provides physicians with fundamental skills in communications, ethical decision making, and palliative care. The American Society of Clinical Oncology recently adopted recommendations about end-of-life care. The World Health Organization has reiterated its “ladder approach” to pharmacologic pain management, which

progresses from nonopioids (e.g., nonsteroidal anti-inflammatory drugs) to “weak” opioids (e.g., codeine, oxycodone) to “strong” opioids (i.e., morphine and morphine-like drugs) and advocates the formulation of a pain regimen tailored to the needs of each patient.

Many physicians fear creating opioid addiction and abuse because they do not understand the mechanisms and principles of pain management or the need for high doses of analgesics to relieve severe pain. (Kaur JS. *Mayo Clin Proc.* 2000;75:181-184.)

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Barriers to Effective Cancer Pain Management: A Review of the Literature

It is estimated that up to 90% of cancer pain can be treated through available means. Yet many patients continue to suffer needlessly: pain is experienced by as many as 45% of patients with early-stage cancer and 75% of patients with advanced-stage cancer.

According to clinical practice guidelines developed by the World Health Organization (WHO) and the U.S. Agency for Health Care Policy and Research (AHCPR), opioids are the drugs of choice for the management of moderate to severe pain. Despite the wide availability of these guidelines, however, both healthcare providers and patients continue to hold misconceptions about opioids and other drugs used to treat cancer pain. Other barriers to effective relief include poor communication between patients and healthcare providers and the lack of formal assessment procedures.

The majority of physicians and nurses agree that most cancer patients who experience pain are undermedicated, yet they believe that patients' requests for increased analgesic doses are the result of drug tolerance rather than disease progression or increased pain. Many of these professionals do not accept the fact that cancer pain is not inevitable. They fear that opioid use will result in addiction, drug tolerance, and uncontrollable side effects, especially respiratory depression. They fail to differentiate between addiction and physical dependence and to recognize that a) the risk for addiction is low in patients with no history of substance abuse and b) that there is little or no tolerance to the analgesic effects of opioids. They often base opioid doses on the severity of disease or their own fear of drug tolerance rather than on the intensity and level of the patient's pain. Many do not acknowledge the efficacy of opioids administered orally or antidepressants prescribed as adjuvants.

Physicians acknowledge that insufficient knowledge and inadequate education contribute to the problem of undertreated pain. Cancer specialists, family practitioners, and other providers have different levels of knowledge regarding the management of cancer pain. Not all

physicians are familiar with the WHO principles of pain management, and even those who are may not necessarily use this knowledge in clinical practice. A European study of 306 physicians who treat cancer patients found that only 25% of physicians were familiar with the WHO principles. And, while 86% were willing to prescribe "strong" opioids for cancer pain, 44% undermedicated. The majority (97%) of physicians in this study expressed concerns related to cancer pain management including difficulty in managing side effects to inadequate pain relief. They also responded that their education in cancer pain management was inadequate.

Physicians seldom use standardized assessment procedures to measure pain intensity, despite the fact that the patient is the best source of information for the treatment of pain. Moreover, they do not separately evaluate different types of pain, even though these could reflect different etiologies.

Patients and caregivers present additional barriers to effective pain management. These barriers include the belief that cancer pain is inevitable and cannot be alleviated; concern that pain is indicative of disease progression; reluctance to report pain which would "bother the doctor," or distract the physician from dealing with the cancer itself; and fear that the medication will be addictive, be "bad" for their bodies, or produce unpleasant side effects.

Interventions have been designed to educate healthcare providers, patients, and family members regarding the treatment of cancer pain and to overcome the frequent lack of communication between providers and patients regarding pain. Yet much remains to be done to address this problem. (Pargeon KL, Hailey BJ. *J Pain Symptom Manage*. 1999;18:358-368.)

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Controlling Cancer Pain: Missed Opportunities

Healthcare professionals miss opportunities every day to help relieve the pain and distress experienced by cancer patients and those with other serious illness.

During an office visit, a time, theoretically, devoted to physician-patient communication, a physician will frequently fail to treat, or even discuss a patient's pain. The reasons are many. Communication often requires that the patient speak up voluntarily, to "complain" about pain. Emotional barriers to this proactive behavior include 1) wanting to be a good (noncomplaining) patient; 2) concern about having to take "strong pain killers;" and 3) worry that talking about pain will take time from dealing with the disease. "Assessment can overcome this reluctance,

especially if it is part of the visit routine." Patients with aggressive disease must be asked about pain severity at every visit (minimum) and told to call the office between visits if pain becomes a problem.

On the physician side, the barriers that impede inquiry about pain are rooted deeply in the medical education process. Studies show that poor physician training, particularly in pain assessment but also in pain management significantly impedes adequate pain treatment. Little or no time is devoted to teaching pain assessment and management to medical students and postgraduate training is not much better. This is true even among cancer specialists, who, in two studies, delayed giving morphine to a dying patient until the prognosis narrowed to < 6 months. This pain management "strategy" was practiced despite the physicians' knowledge that morphine is required to treat severe cancer pain. Concern over analgesic adverse effects was the barrier in these cases to earlier use of morphine. In both studies, inadequate assessment was named the major barrier to effective pain control.

Patients need to expect that contact with their physician will result in good pain management; in pain reduced to a level where function is enhanced. When patients can expect this, they can be trained to report pain, take appropriate medication and, most importantly, to collaborate in assessment and management of their pain. Communication means fewer missed opportunities. (Cleeland CS. [Report]. *MSJAMA*. January 5, 2000)

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Dismantling the Barriers: Providing Palliative and Pain Care

In 1997, the Institute of Medicine (IOM) called for the need to improve care of patients at the end of life in its report "Approaching Death." Noting that the United States suffers from severe deficiencies in the delivery of palliative care, the IOM requested that healthcare professionals commit themselves to use existing knowledge to reduce pain and manage symptoms in patients nearing death. Perhaps most important, the IOM recommended that medical training programs educate practitioners in the care of dying patients.

Many barriers prevent healthcare professionals from delivering - and patients from receiving - humane and compassionate treatment at the end of life. These barriers include clinicians' fears of inducing physical or psychological addiction to pain medications, their misconceptions about pain tolerance, and assessment biases. Fear of regulatory scrutiny affects physicians' willingness to even prescribe pain medication. Medical and nursing textbooks devote only a few pages to current pain

and symptom control guidelines. This professional ignorance of proper use of opioids has been most glaring in the care of dying patients who have spent their final days or hours in needless suffering.

Increased attention to pain and palliative care education at all medical schools is essential. Education, clinical experience, and role modeling, all elements of medical training, can help reduce undertreatment of pain, at the end of life, and across the continuum of care. (Foley K. *MSJAMA*. 2000;283:115.)

While pain is one of the most common nonspecific complaints of patients seeking medical attention, the fear of pain is especially heightened when thoughts turn to the end of life. The following statistics - on human fear and on the prevalence of pain - support the concept that pain has become a serious public health problem.

- 72% of people in the general population fear dying in pain
- 57% of cancer patients agreed with the statement that a painful death can be expected with cancer
- 69% of the same cancer patients said they would consider suicide if their pain could not be managed
- 56% of 1308 oncology patients reported moderate to severe pain while 72% of physicians (same study) expressed lack of knowledge concerning pain management
- 50% of seriously ill patients (noncancer diagnoses) who were conscious during the last 3 days of life reported moderate to severe pain
- 4.5 million patients from developing and industrialized countries die in pain each year

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Opioids for Managing Patients with Chronic Pain: Community Pharmacists' Perspectives and Concerns

A survey of retail pharmacists in New Jersey was conducted in order to assess knowledge and attitudes regarding the use of opioids in chronic cancer and noncancer patients. Since previous studies have shown that pharmacists often have concerns about stocking and dispensing opioids as a result of a fear of robbery and federal investigation, this study also attempted to quantify these fears.

The most enlightening discovery of this study was the many misconceptions that pharmacists have about tolerance, physical dependence and addiction. Physicians often carry the same misconceptions and often underprescribe necessary pain medications. The Drug Enforcement Agency has emphasized that physicians should prescribe controlled substances when appropriate without fear of investigation. In the same vein, pharmacists should not fear dispensing for legitimate medical purposes. The authors suggest that communication between the prescriber and the dispenser can enhance legitimate medical practice. (Greenwald BD, Narcessian EJ. *Journal of Pain and Symptom Management*. 1999;17[5]:369-375)

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The Art and Science of Relieving Pain

The goal of ideal pain management is to relieve both acute and chronic pain with appropriate medications while minimizing side effects of those medications. This type of treatment often does not happen for many different reasons. One of the primary reasons that patients frequently do not receive adequate pain relief is that pain levels are not properly assessed. One way to reduce this problem is by allowing the patient to communicate his pain through the use of pain assessment tools. Once pain has been assessed, there are several measures that health care professionals can take to minimize other factors that contribute to a patient's suffering. The author suggests premedicating a patient before procedures that are likely to induce increased pain as a method of avoiding needless suffering. Additionally, increasing early evening doses should assist the patient in achieving a restful sleep as sleep deprivation can increase suffering. (O'Brien ME. *Home Health Care Consultant*. 1999;6[10]:26-33)

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Correlates and Management of Nonmalignant Pain in the Nursing Home

Nonmalignant pain is common among nursing home residents. Approximately 26% of the 50,000 residents studied experience pain on a daily basis. As a result of this pain, many residents experience severe impairment of daily activities, impaired sleep, depression and anxiety. The investigators found evidence that one-quarter of residents reporting pain receive no analgesics. Furthermore, men, racial minorities, and cognitively impaired residents were less likely to receive analgesics than residents who were cognitively intact.

The authors conclude that it is likely that many more nursing home residents may experience daily pain but do not report it. In fact, 56% of day-to-day health symptoms are not reported to health professionals. Older patients often feel that their symptoms cannot be treated or they

believe that pain is a natural part of aging. In order to prevent nursing home residents from having to live with daily pain, the authors suggest that adopting a multidisciplinary approach including research and education for professionals and patients will lead to optimal pain management. (Won A, Lapane K, Gambassi G, Bernabei R, Mor V, Lipsitz L. *J Am Geriatr Soc*. 1999;47:936-942)

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Lower Body Osteoarticular Pain and Dose of Analgesic Medications in Older Disabled Women: The Women's Health and Aging Study

Older women are frequently afflicted with osteoarticular pain that affects the lower back, hips, knees or feet and often produces physical disability, depression and disturbed sleep. An article, which appeared in the *American Journal of Public Health*, reveals the findings of a study designed to determine the doses of analgesic medications in relation to the severity of osteoarticular pain.

The study revealed that almost 50% of participants experienced severe pain most frequently in the knees or hips. Based on data collected on dose, the authors concluded that many women experiencing severe pain use either extremely high or extremely low analgesic doses that may not be effective in relieving pain. The cost of the drugs and lack of contact with a physician may be reasons why participants used very low doses of medication. One of the reasons participants may have used exceedingly high doses is a result of a lack of drug efficacy at recommended dosage. The authors conclude that severe osteoarticular pain may lead to the worsening of disability. As a result, older women must be treated with more effective and safer pain controlling agents. (Pahor M, et al. *Am J Public Health*. 1999;89:930-934)

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Chronic pain-associated behaviors in the nursing home: resident versus caregiver perceptions

Pain assessment in nursing home residents has been poor. These older adults are often hesitant to complain and seek treatment and often view the pain that they are experiencing as a result of the aging process. Additionally, nursing home staff frequently overlook chronic pain when residents do not manifest physical symptoms of pain when residents do report it. Furthermore, there is a wide range of reactions that residents with varied levels of cognitive function have to the pain that they experience which makes it difficult to find an appropriate method of assessment. The

authors suggest that nursing home staff use more objective measures such as caloric intake and sleep efficiency to aid in the diagnosis of chronic pain. (Weiner D, Peterson B, Keefe F. *Pain*. 1999;80:577-588)

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In the system: the lived experience of chronic back pain from the perspectives of those seeking help from pain clinics

Twenty back pain patients in the UK describe their lived experiences in dealing with "the system." For these patients in pain, the systems which caused them grief were the medical, social security and legal systems -- systems that are designed to treat and support them. Participants in the study described the irrevocable changes that their pain had made to all aspects of their lives.

The authors concluded that suppressed anger is a common experience of chronic pain sufferers. They suggest that this study will offer clinicians a better understanding of negative attitudes of back pain patients. It is hoped that gaining awareness of this problem will prompt further research in the development of more effective and humane approaches to the management of people who have acute and chronic pain. (Walker J, Holloway I, Sofaer B. *Pain*. 1999;80:621-628)

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Organizational factors hinder more effective use of opioids to relieve pain

Although effective relief for most forms of pain are obtainable through medical prescription, too many cancer patients still suffer with unrelieved pain.

The numerous stumbling blocks to managing pain effectively that exist within the medical profession, as well as governmental regulations that inhibit use of some important pain medications in many countries throughout the world are discussed in an article from *Support Care in Cancer*. Lack of sufficient knowledge of modern pain medications among doctors and nurses have been manifested in poor decision-making in treating patients' pain as well as the spread of unfounded beliefs against the use of opioids.

The article also mentions the lack of continuity that exists when a patient moves from the hospital into community care, and how a single patient can often have several physicians addressing his or her case at the same time, with no single clinician overseeing the patient's pain.

Ways in which these and similar barriers can be surmounted are discussed at the article's conclusion.

(Redmond K. *Support Care Cancer*. 1997;5:451-456)

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Physicians surveyed on managing cancer pain

Physicians in Canada were recently surveyed on their knowledge and practices in managing cancer pain. Of the 2,686 who responded, 39% were medical or radiation oncologists and 18% were classified as family physicians. The extent of professional education received in the area of palliative care and management of cancer pain was rated as "fair" or "poor" by two-thirds of the responding physicians.

The authors concluded that Canadian medical training programs need to place greater emphasis on pain management. The authors further suggested that surveys of this type, when given periodically, can act as a check on physicians' adherence to official pain management guidelines. (MacDonald N, Findlay HP, Bruera E, Dudgeon D, Kramer J. *J Pain Symptom Manage*. 1997;14:332-342)

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Minority patients' cancer pain inadequately treated

Pain can be a prominent symptom in any person with cancer. Sadly, it has been found that cancer patients who are members of ethnic minorities often receive less adequate treatment for their pain than their nonminority counterparts.

In a recent study of 281 minority patients with cancer, 77% suffered from pain related to their cancer or took pain medication. Forty-one percent of the patients who suffered from pain reported severe pain. Only 35% of minority patients with cancer pain received prescription medications at guideline-recommended dosage strengths, compared with 50% of Caucasian patients. Less adequate pain relief was reported by Hispanic cancer patients in particular.

It is hoped that gaining awareness of this problem will prompt health professionals to improve their attention to controlling pain in minority patients. (Cleeland CS, Gonin R, Baez L, Loehrer P, Pandya KJ. *Ann Intern Med*. 1997;127:813-816)

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Elderly burn victims are shortchanged on pain medication

In a recent study, patients with burns covering an average of 17.2% of their body were divided into three age

categories: age 55-65, age 66-75, and age 76-92.

Investigation showed a difference between the amount of opioid prescribed and the amount actually administered. Patients in the youngest group were given significantly more opioid medication during treatment procedures than the minimum prescribed, and patients in the oldest group were given significantly less opioid medication on an as-needed basis than the minimum prescribed. (Honari S, Patterson DR, Gibbons J, Martin-Herz SP, Mann R, Gibran NS, Heimbach DM. *J Burn Care Rehabil.* 1997;18:500-504)

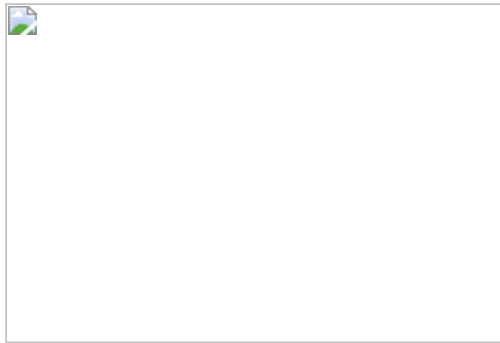
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One of Five Adults in Chronic Pain

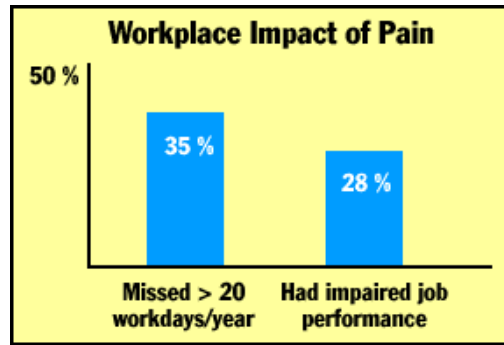
A recent pain survey confirms what health professionals know: lots of Americans are missing work and missing out on life because of pain.

The "Michigan Pain Study" polled a sample of 1,500 adults in Michigan about the severity of their pain, its treatment, and its impact on their lives. The poll was conducted by the public opinion firm EPIC/MRA and sponsored by the Pain Education Fund of Chelsea (Michigan) Community Hospital.

By generalizing from the sample, the poll estimated that 1.2 million residents of Michigan suffer from chronic pain--about one in five adults.



Of this group, 42% reported that their pain has affected personal and work relationships. Thirty-five percent missed more than 20 days of work and 21% went to the emergency room for pain in the past year. A full 70% said they are still experiencing pain despite treatment.



These results show that chronic pain has far-reaching effects on family and economic life. Says EPIC/MCA pollster Ed Sarpolus:

"Pain is a major health problem, not only for those who directly suffer from it, but for everyone in Michigan. The costs to society are real, in the form of lost productivity, repeat hospital visits, and ineffective treatment. In addition, the situation is denying people and their families basic quality of life."

Michigan Pain Study Results At-A-Glance

Design Polled sample of 1500 adults, generalized statewide

Extent of Chronic Pain

- 1.2 million adults in Michigan (one out of five) suffer some form of chronic pain

Nature of Chronic Pain

- 40% of people with chronic pain reported that pain is constant and has a major impact on their lives

Workplace Impact

- 35% of people with chronic pain missed more than 20 days of work during the past year
- 28% reported pain severe enough to impair job performance for more than 20 days during the past year

Personal Impact

- 42% of people with chronic pain reported that pain affects relationships with family, spouse, co-workers
- 48% said they "get depressed" about their pain
- 0% said they have thought about committing suicide

Treatment

- 21% of people with chronic pain visited a hospital emergency room an average of four times during the past year

- 70% said they still experience pain despite treatment
- 22% reported that treatment makes pain worse
- 13% reported being denied pain medications, medical devices and/or referrals to other professionals/pain centers
- 22% feel uncomfortable discussing pain with their physicians

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Pain at End of Life Inadequately Treated

Washington, DC--A special panel of the Institute of Medicine has concluded that too many Americans are dying without skillful palliative care and pain control.

According to panel chair Christine Cassel, MD, head of geriatrics at Mt. Sinai-New York, the result is that Americans have come to fear that they will die alone, and that they will die in distress and pain. (Source: *The New York Times*, 6/4/97)

- American emphasis on high-tech cures has caused us to neglect pain management and palliative care for the dying. In trying so hard to save lives, we have become less skilled at helping people as they approach death.
- More medical training in palliative care is necessary
- Changes are needed in laws regulating prescription narcotics and in our attitudes toward narcotic use for pain control. One attitude that especially needs changing is our unreasonable fear about addiction at life's end. As noted by panelist Robert Burt, a professor at Yale Law School, "There is a tension between the need to control illegal drugs and the need for palliative care to control pain...Controls are more rigid than they need to be." (Source: *The New York Times*, 6/4/97)

The panel's report, *Approaching Death: Improving Care at the End of Life*, is available from National Academy Press, 1-800-624-6242.

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