

CHAPTER 13

OPIOID THERAPY IN ADVANCED MEDICAL ILLNESS

Pain is a common manifestation of many advanced illnesses. Among these clinical settings, pain in cancer has been the most studied and best characterized. However, limited surveys in other diseases, including AIDS, advanced congestive heart failure, and advanced lung disease, suggest that the prevalence and impact of pain are significant in all advanced disease.

Although death is inevitable, a painful death is not. When attention is focused on relief of pain, and care is rendered by clinicians with even basic skills in opioid pharmacotherapy, the promise of a comfortable death can be realized in most cases. Opioids usually are considered the mainstay therapy for moderate to severe pain. With knowledge of opioid pharmacology and the principles of prescribing, the outcomes of treatment can be optimized, and a major barrier in pain control—clinician fear of inflicting harm or hastening death—can be eliminated.

Relevant constructs and palliative care

In the context of a progressive, incurable illness, pain must be considered from the perspective of a set of broad constructs, including suffering, quality of life, and goals of care. An understanding of these constructs continually informs decision making and supports the treatment of pain within a therapeutic model known as palliative care.

Suffering and quality of life

Suffering has been described as a perceived threat to the integrity of the person, as a type of total pain, or as overall impairment in quality of life. Suffering may be related to physical symptoms or losses, to psychiatric disorders or psychological processes, to social or family disruptions, to spiritual concerns, or to other factors, such as financial loss. Quality of life is related to the construct of suffering but has been more formally characterized for research. Most of the instruments created to measure quality of life codify the inherent subjectivity and multidimensionality of this construct by using self-report to ascertain well-being in these physical, psychosocial, and spiritual domains.

Comprehensive pain assessment in the setting of advanced illness must address issues related to suffering by evaluating the

physical, psychologic, social, and spiritual issues important to the patient. A therapeutic approach that is focused only on pain may not meaningfully benefit a patient whose suffering is caused by other disturbances.

Goals of care

From the medical perspective, the therapeutic approach to a patient with far-advanced disease usually is guided by several goals.

- Slow the progression of disease, if possible, with the least burdensome means possible
- Optimize function
- Provide comfort and relieve symptoms
- Provide treatments and resources to reduce suffering and improve quality of life

These goals are dynamic and evolve over time. They are strongly influenced by the attitudes and expectations of the patient and family, the vagaries of the disease, the availability of disease-modifying treatments, and expertise in palliative care. Immediate and longer-term goals must be continually reassessed.

The goals of care may influence every therapeutic decision. For example, some patients with advanced illness express the desire to limit diagnostic procedures. Without tests, the etiology of the pain may remain obscure and opportunities for primary therapy directed against the etiology will not be realized. Although the clinician may relate concerns about a decision to forego evaluation, the patient's desires must be respected and should not preclude aggressive symptomatic therapy.

Palliative care

In populations with advanced illnesses, pain management is best understood as a component of a larger therapeutic model known as palliative care. Palliative care aims to enhance the quality of life of the patient and family throughout the course of the disease by addressing problems in the physical, psychologic, social, and spiritual domains. It views the family as the unit of care and attempts to ensure that (1) the patient's values and decisions are respected, (2) comfort is a priority, (3) psychosocial and spiritual issues are addressed, (4) practical support (eg, homemaking services, assistive devices for self-care) in the home is available, and (5) opportunities for closure—and even growth—are available at the end of life. The need for palliative care usually intensifies at the end of life, at which time the goals include preparation for the dying process and bereavement support for the family. Patients and families with a high need for pal-

liative care interventions should have access to specialized programs, which include hospital-based palliative care services (now offered in about 30% of US hospitals) and several thousand hospice programs.

Despite the development of these specialized programs, there is considerable evidence that expertise in palliative care is not routinely available for patients with advanced illness and, consequently, symptoms like pain continue to be undertreated. Although hospice programs could help with pain control by providing much-needed support for patients and families in their homes, most patients with advanced disease are not referred into these programs, and those who are referred typically access the care very late in the course of the disease—oftentimes only days before death. Services funded by the Medicare Hospice Benefit, as well as most commercial insurance plans and Medicaid, include durable medical equipment, supplies, and drugs. However, the majority of eligible patients (and their families) who could benefit from these services do not obtain this help.

Managing pain in dying patients

In patients for whom death is imminent, expertise in pain management should be part of a therapeutic approach that attempts to address the full range of concerns and challenges that may occur at this critical time. Ideally, all dying patients and their families should receive specialist-level help through expert hospice care.

In the best case, patients have prepared for a time when decision making is impaired and have openly expressed their preferences and priorities (in a living will, for example) and appointed a surrogate decision maker. The laws that govern these procedures vary from state to state, and clinicians should understand and support the use of these advance directives.

When opioids are used to manage pain in advanced illness, the routine principles of prescribing apply (see chapter 5). These principles should be framed within considerations that are particularly relevant to this population.

- The opioid should be delivered using an approach that is the least invasive, most readily available, and most acceptable to the patient and caregiver. This is usually the oral or transdermal route. If the oral route is used, it is prudent to plan for an alternative should the patient lose the ability to swallow or absorb drugs. Planning in advance can avert pain crises. If there is some question that oral and transdermal delivery may not suffice, parenteral access should be established and a trial of intravenous or subcutaneous administration offered.

- Caregivers must be educated about the chosen approach to pain management. In the setting of advanced illness, it may be the caregiver who is most able to assure continued administration of an analgesic.
- Pain should be distinguished from delirium (terminal agitation) or anxiety, if possible. In the noncommunicative patient, this may require a trial of opioid therapy. Terminal restlessness or agitation unresponsive to rapid titration of opioids may respond to a neuroleptic or sedative-hypnotic agent.
- Pain crises that respond poorly to basic analgesic approaches merit consultation with a pain management consultant as soon as possible. More aggressive therapeutic methods may be warranted. Interventional techniques, such as epidural or intrathecal catheterization, certain types of nerve blocks or neurolytic procedures, or use of drugs such as ketamine, may be appropriate in selected patients.

Ethical imperatives and safeguards

The obligation to relieve suffering is an ethical imperative of the medical profession and is especially important in the care of patients who are dying. Among the greatest harms to dying patients, and their loved ones, is to abandon them in their need for comfort, of which relief from pain is paramount. Patients and family members expect that physicians will honor this need by effectively treating pain.

When providing opioid therapy to patients who are near death, the ethical principle of double effect must be understood and clearly communicated. This principle is particularly important in addressing the fear that aggressive opioid therapy at the end of life could potentially hasten death. According to the principle of double effect, a foreseeable “bad” outcome of an action (such as a potentially hastened death) is ethically acceptable if the intention (relief of suffering) is beneficent, and the need to accomplish the good is more important than the need to avoid the bad. At the end of life, this principle guides the aggressive use of opioids and other interventions. Physicians must defend the ethical nature of aggressive pain control and clearly distinguish pain treatment from euthanasia.

Although clinicians should understand and invoke the principle of double effect when using opioids in dying patients, it is nonetheless reassuring to know that there is no convincing scientific evidence that demonstrates a significant risk of hastened death if the opioid dose is appropriately titrated at the end of life. Indeed, there is more anecdotal evidence to the contrary. Given these reassuring observations and the well-recognized

adverse physiologic and psychologic effects from unrelieved pain, aggressive titration of the opioid dose to maintain relief of pain is warranted until the very end of life.

Suggested readings

Fine PG. The ethical imperative to relieve pain at life's end. *J Pain Symptom Manage* 2002;23:273-7

Field MJ, Cassel CK, eds. *Approaching death: improving care at the end of life*. Committee on Care at the End of life, Institute of Medicine. Washington, DC: National Academies Press, 1997

Liebeskind JC. Pain can kill. (Editorial) *Pain* 1991;44:3-4

Scull T, Montamed C, Carli F. The stress response and pre-emptive analgesia. In: Ashburn MA, Rice LJ, eds. *The management of pain*. New York: Churchill Livingstone, 1998:557-76

Portenoy RK, Bruera E, eds. *Topics in palliative care*. Vol 1. New York: Oxford Univ Press, 1997

Resources

Web sites

Beth Israel Medical Center
Department Pain Medicine and Palliative Care
<http://www.stoppain.org>

University of Wisconsin Comprehensive Cancer Center
Pain and Policy Studies Group
<http://www.medsch.wisc.edu/painpolicy>

American Academy of Pain Medicine
<http://www.painmed.org>

National Initiative on Pain Control
<http://www.painedu.org>

National Pain Education Council
<http://www.npecweb.org>

Professional Societies

American Academy of Pain Medicine
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