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CANCER PAIN RELIEF AND ORAL MORPHINE

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Cancer is an increasing health problem. Each year, nine million people develop cancer, and by the year 2030, this figure is expected to have risen to 15 million. Two thirds of these cases of cancer will be in the developing countries, which have only 5% of the global cancer control resources. Cancer pain relief was recognized as major public health problem in the mid 1980s. Pain is reported at diagnosis in 20-50% of cancer patients, and is experienced by at least 75% of those with advanced cancers. Worldwide at least 4 million people suffer from cancer pain every day. Pain relief remains inadequate in about 90% of patients despite efficiency of WHO's method for cancer pain relief. The International consensus on the management of cancer pain, held in Oxford, 1996, stated the following reasons mainly responsible for inadequate cancer pain relief :

1. Non availability of opioids as a result of regulatory restrictions.
2. Lack of knowledge and training of doctors and nurses in use of analgesics and other drugs to relieve pain and their indifference to pain as a treatable symptom of cancer.
3. Fear of addiction to opioids among policy makers, regulators, doctors, nurses, families and patients
4. Lack of public awareness that cancer pain can be relieved, and a resultant failure to report it to doctors considering it as inevitable and intractable.

Last two decades have seen increasing interactions of WHO and INCB (International Narcotics Control Board, Vienna.) with individuals, institutions, professional organizations and government to increase the availability of opioids for medical use, Morphine in particular. Morphine consumption per head population has been used as an indicator of implementation of cancer pain relief strategies. While it's use has risen dramatically in some countries, it is not so in many others, India in particular.

In 1996, WHO updated the three step ladder approach to cancer pain management in it's second edition of cancer pain relief. This is reflective of "broad spectrum" or "balanced" analgesia through inclusion of adjuvant analgesics as well as non-opioids and opioids. An increasing countries eg. Philippines, bypass step 2. Nevertheless, in most countries, step 2 remains indispensable because the use or availability of strong opioids remains restricted. It is surprising, therefore, that when we know how to relieve the pain of almost all cancer patients, why we are not doing so? On an optimistic note it too has been recognized that much suffering will be alleviated if health care professionals implement existing knowledge. Through Saitama (Japan) experience, it is well established that cancer pain can be optimally relieved in 87% patients with oral analgesics administered - "right drugs in right doses at right time" as per the guidelines of WHO analgesic ladder; in another 7% it can be relieved satisfactorily; only in remaining 6% alternative methods of pain relief have to be administered like neurolytic blocks etc.

While the use of conventional analgesics like nonopioids (eg. paracetamol, 0.5-1gm. six hourly, ibuprofen, 400-600 mg. eight hourly) and weak opioids (eg. codeine sulfate/ phosphate, 30 mg. four to six hourly, dextropropoxyphene, 65 mg. eight hourly) needs no emphasis, the use of strong opioids, morphine in particular, needs further elaboration.

In cancer pain relief, morphine is a versatile drug. Orally, it has a plasma half life of 2-2.5 hours and but for patients with renal failure, there is no danger of drug accumulation. By mouth no other strong opioid shows a clear advantage over morphine. In practice, the choice lies between a solution or tablet of morphine sulfate/ hydrochloride and slow release tablets or suspension; the former at every 4 hour intervals and later at every 12 hours. For most patients, 10 mg. at every 4 hours or slow release morphine tablets 30 mg. every 12 hours is the correct starting dose, the median maximum dose is 15-20 mg; few patients ever need more than 200 mg per day. Monitoring of the relief in pain is mandatory, usually after 24 hours. The dose is increased progressively until the patient's pain is relieved (dose titration). Generally a 50% increase is recommended. If the pain is not much relieved after one or two increments, it is possible that the patient has a morphine resistance pain such as pain arising as a result of bone metastasis, nerve compression, raised intracranial tension, movement induced pain etc. In these circumstances, an alternative strategy is necessary eg. Radiation therapy, adjuvant analgesics such as tricyclic antidepressants, anticonvulsants or corticosteroids, neurolytic blocks. But it will be equally important to exclude:

1. Underdosing- dose too small/ dose too infrequent/ dose given as needed
2. Poor absorption from the alimentary tract (rare), or
3. Ignoring emotional, social or spiritual factors.

With use of morphine (and other strong opioids), it's common adverse effects, constipation and nausea/ vomiting need use of a stool liquifier and/or a colonic stimulant and an antiemetic respectively. These are myths that morphine causes respiratory depression and/or addiction, the answer to their occurrence is an emphatic "no".

Despite significant role oral morphine has in cancer pain, it's availability is restricted due to it's strict regulation-licencing, procurement, storage, dispensation etc. through the drug controlling and excise departments. Fortunately, with efforts of Government of India, New Delhi, and in collaboration with WHO CC Wisconsin, USA and Indian Association of Palliative Care (IAPC), some states like Kerala, Madhya Pradesh and Sikkim adopted new simplified rules for oral morphine availability, while some more states eg. Orissa, West Bengal, Karnataka, Maharashtra, Gujrat have conducted state workshops on morphine availability to proceed with modification in existing rules. A strong political and administrative commitment along with involvement of health professionals and public can and does make a lot of difference. This is amply evident through the establishment and functioning of Pain and Palliative Care Society (PPCS), Calicut, Kerala in last five years to come up as WHO Demonstration Project for South-East Asia. Rajasthan is yet to move in this direction. Asking for optimal cancer pain relief can be considered a very genuine demand from the health administrators, professionals public and cancer patient and their families in particular.

FURTHER READING

1. Twyeross R and Sylvia Lack (1993): Oral morphine in advanced cancer. Revised second edition, Beaconsfield Publishers Ltd. Beaconsfield, Bucks, England.
2. Report of a WHO expert committee: Cancer pain relief and palliative care (1990). Technical report series 804, World Health Organization, Geneva, Switzerland.
3. International consensus on the management of cancer pain (1997): Looking toward to cancer pain relief for all. WHO collaborating centre for palliative cancer care, Oxford, U.K.
4. Face sheet, World Health Organization Collaborating Center (WHO CC) for policy and communication in cancer care (2000) : Morphine for cancer pain in India. University of Wisconsin, Comprehensive cancer center, Madison, Wisconsin, Massachusetts, USA.