Journal of Palliative Care & Medicine
ISSN: 2165-7386

Rozzi et al., J Palliat Care Med 2014, 4:2
DOI: 10.4172/2165-7386.1000e129

Editorial Open Access

Treatment of Cancer Pain: New Drugs and Same Old Questions?

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Although, recently, many advances in treatment of cancer pain occurred due to the introduction into clinical practice of new opioids, pain continues to be a significant problem and the unsatisfactory management of pain in oncology still represents a prevalent issue.

According to the definition of International Association for the Study of Pain (IASP), pain is an unpleasant sensory and emotional experience associated with actual and potential tissue damage [1]. Cancer pain has several components (physical, psychological, social, emotional and spiritual) and all these aspects must be evaluated within the concept of total pain as originally stated by Cicely Saunders [2].

Even today the majority of the world's population is undertreated for moderate to severe pain and, as emerged in a systematic review, pain is a commonly reported symptom: its prevalence ranges from 25% in newly diagnosed patients to 64% in patients with advanced cancer [3,4].

Recently, a review of Deandrea et al. reported discouraging results: under treatment of cancer pain was observed in about 50% of cases [5].

Negative findings also emerged in the pan-European survey of Breivik et al. in this survey more than 5000 cancer patients experiencing pain were screened and a high proportion (56%) of them reported from moderate to severe pain during the last month of care [6].

Many barriers hinder a satisfactory control of cancer pain: insufficient assessment, patient's refusal to take opioids and patient's difficulty in referring pain [7].

The limited attention that physicians dedicate to the management of pain is an important factor: in a recent survey involving about 2000 oncologists, frequent referrals to pain or palliative care specialists were reported in a small minority of cases [8]. A comprehensive pain assessment represents another crucial step in the treatment of cancer pain: physicians should use one of the most used tools for self-reporting assessment of pain intensity (VAS, NRS or VRS)) and, moreover, evaluate the quality of pain, its onset, duration and possible modifications linked to specific actions [9].

In addition to inadequate assessment, physicians are still showing improper opinions that negatively influence their prescription of analgesics (mainly opioids). For example, lack of education has brought to misplaced beliefs over addiction and tolerance to analgesics as well as problems with critical concepts such as the management of adverse events and the utilisation of specific routes of administration [10].

Certainly, pharmacotherapy represents the cornerstone of cancer-related pain and the most used drugs are opioids, non-opioids and adjuvant analgesics.

In 1986 WHO designed the 3-step analgesic ladder that still guides the treatment of cancer pain: despite the new drugs currently available (fentanyl, oxycodone hydromorphone and methadone) morphine still represents the reference drug for cancer patients with severe pain [11-13].

Important advances have been achieved in the treatment of breakthrough pain (BTP): several drugs are now available in this therapeutic setting and include oral immediate-release morphine sulfate (IRMS) and fentanyl (oral, buccal, transmucosal, or intranasal). Nowadays, no definitive recommendations exist about the best therapeutic option in this setting but it is evident that BTP should be carefully assessed and should be promptly treated with immediate-release oral opioids or with oral (or intranasal) fentanyl [14].

Several side effects (constipation, nausea, vomiting, pruritus, delirium, sedation, respiratory depression and cognitive impairment) are related to administration of opioids. Each adverse effect needs a careful assessment and treatment: management of side effects from opioids should be consensual to their administration.

Major opioid-related adverse events, including respiratory depression, are really feared both by physicians and patients but their incidence is fortunately rare. These events must be taken into account but their overestimation can lead clinicians to underprescribe opioids: this attitude should be avoided.

As previously reported, despite the recent advances in medical management of cancer pain, under-treament probably still represents the most relevant issue: data emerging from review of Deandrea are absolutely discouraging and, in the absence of more recent data, we can only hope that this situation is evolving towards a positive progress due to a better medical education and attention.

According to the previously reported data, despite the pain management became an area of real interest and the significative improvement in our therapeutic armamentarium observed in the recent years, unsatisfactory pain management in cancer patients still represents a major issue.

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Received February 14, 2014; **Accepted** February 16, 2014; **Published** February 25, 2014

Citation: Rozzi A, Lanzetta G, Salerno M (2014) Treatment of Cancer Pain: New Drugs and Same Old Questions? J Palliat Care Med 4: e129. doi:10.4172/2165-7386.1000e129

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