

## Factors influencing the decision to take or reject opioids for cancer pain: are we on target?

Pain afflicts most cancer patients, mainly in the advanced phase of the disease [1]. Despite the existence of several guidelines for cancer pain management, undertreatment is frequent and it is usually attributed to an incorrect use of opioids for reasons conceptualized in terms of barriers related to health care provider, patient, family, institution and society [2]. In their interesting qualitative study, Reid [3] studied some of the patients' factors influencing the decision to accept or reject morphine. Results support the idea that for patients opioids represent more a comfort measure for dying than drugs to reduce pain and ameliorate quality of life. This attitude is not due to concerns about addiction or tolerance but because participants were not ready to die. They rejected opioids, despite the pain experienced, as they felt it is a signal that their physicians thought they were dying. As well summarized by Maltoni [4], this extreme fear of opioids may be the most relevant barrier for appropriate palliative care. Maltoni also suggests that given the presence of several barriers related to systems, professionals and patients, efforts to change the current poor attitude to treat pain should be based on an integrated approach including professional competence, correct communication, and appropriate relationship with patients based on trust, in the context of a model of simultaneous care.

While we agree with this call for a new alliance between oncologists, palliative care specialists and cancer patients when deciding to treat pain with opioids, we would like to underscore the fact that, at least in Italy, the very problem is not only related to the issue of pain management but it concerns the wider issue of cancer management. Data from an ongoing study on 1801 cancer patients carried out by the Cancer Pain Outcome Research Study Group, a network of 110 hospitals coordinated by the Mario Negri Institute, to describe the epidemiology, pattern of care and outcome of analgesic care [5], suggest that the situation is more complex. While up to 40% of cancer patients receives at the time of admission an analgesic drug that does not match the intensity of pain, half are still on chemotherapy and only 31%, according to what reported by physicians, are aware about their actual prognosis. After 28 days, about 20%–30% may be classified as nonresponders to the analgesic care.

It seems to us that the target is not only to reinforce the collaboration between stakeholders but also to change the attitude of health professionals with respect to the very objective of medicine that is centered to patients and not to symptoms or diseases. Again, in absence of a correct information about diagnosis and prognosis, it is difficult to imagine a communication based on trust when deciding the right analgesic care. A correct program of empowerment focused on patients with advanced disease cannot effectively be implemented without a correct approach of health professionals toward a complete and correct information to

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patients. If this does not happen, chemotherapy might become a surrogate of lack of communication.

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