Analgesics in cancer pain: Results of a questionnaire

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Summary

A questionnaire was sent to seventy-five doctors in a London cancer hospital enquiring about their use of analgesics in cancer pain.

In the 37 replies which were returned a wide range of analgesics was prescribed.

In the most painful and distressing conditions, opiates were always used with a strong bias towards diamorphine. However, it was claimed that mild non-narcotic analgesics given regularly often gave better and longer lasting reliefs than narcotics which were prescribed on a pro re nata basis.

Introduction

The Royal Marsden Hospital is a postgraduate hospital devoted to the diagnosis and treatment of cancer. Since 1963 hundreds of in-patients and out-patients have been referred to the Pain Clinic for advice and treatment and many in-patients have voluntarily taken part in clinical trials of new and established analgesics. In the hospital, lectures, seminars and tutorials to nurses and doctors on the symptomatic relief of pain have encouraged informed interest on this subject. Moreover, in recent years, there has been considerable concern about the terminal cancer patient and his problems, not least of which may be pain. This has been coupled with the social and medical problems related to the abuse of addictive analgesics, especially diamorphine. At the same time there have been many postgraduate meetings throughout the United Kingdom on the problems of pain.

It was felt that the medical staff at the Royal Marsden Hospital might have helpful views on the pain problem in cancer that would be worthy of collection and analysis. Therefore a questionnaire about analgesics was sent to all medical staff at the Hospital who were prescribing drugs to patients. There was a covering letter from the Consultant in charge of the Pain Clinic requesting their co-operation.

The questionnaire

Seventy-five questionnaire forms were issued and 37 (49%) were returned for analysis. Two of the

FIG. 1. Percentage of replies from different groups of doctors. Figures in brackets give total number in each group.

forms were not fully completed. The breakdown by status is shown in Fig. 1.

Question 1:

What analgesics would you prescribe by mouth for MILD pain in cancer that is considered CURABLE, starting with the weakest analgesic and ending with the strongest analgesic?

Weakest Strongest

Answer:

In the weakest group all prescribed drugs contained aspirin, paracetamol or codeine and two doctors used combinations with dextropropoxyphene. In the strongest group fourteen doctors would use drugs scheduled under the Dangerous Drugs Act (DDA) or mixtures containing nepenthe. Fifteen doctors mentioned dihydrocodeine as a drug for use in this group.

Question 2:

What analgesics would you prescribe by mouth for SEVERE pain in cancer that is considered CURABLE starting with the weakest analgesic and ending with the strongest analgesic?

Weakest Strongest

Answer:

The weakest group had a scatter with most recommendations for dihydrocodeine (eight) and nine doctors using DDA drugs or opiate mixtures. The strongest group had twenty-five doctors prepared to use DDA drugs or opiate mixtures.

Question 3:

What analgesics would you prescribe by mouth for MILD pain in cancer that is considered INCURABLE starting with the weakest analgesic and ending with the strongest analgesic?

Weakest Strongest

Answer:

In the weakest group aspirin, paracetamol and codeine were the commonest choice, with an equal choice of aspirin or paracetamol. Two doctors would use nepenthe mixtures. In the strongest group nineteen doctors used DDA drugs or mixtures with opiates, nine recommended dihydrocodeine and five pentazocine.

Question 4:

What analgesic would you prescribe by mouth for SEVERE pain in cancer that is considered INCURABLE starting with the weakest analgesic and ending with the strongest analgesic?

Weakest Strongest

Answer:

Fifteen doctors would use DDA drugs or opiate mixtures in the weakest group; and in the strongest group this number increased to thirty-four out of the thirty-five, more preferring diamorphine to morphine.

Question 5:

If analgesics have to be given by injection because of vomiting or the severity of the pain, which drug would you prescribe in cancer that is considered INCURABLE starting with the weakest analgesic and ending with the strongest analgesic?

Weakest Strongest

Answer:

In the weakest group twelve doctors prescribed drugs which were DDAs, nine of them pethidine. Thirteen mentioned dihydrocodeine and eight pentazocine. In the strongest group all doctors prescribed DDAs and all but three would use diamorphine as their ultimate drug.

Question 6:

Is your choice of analgesic strongly influenced by efficacy and/or side effects of the drugs? Have you

any specially strong feelings regarding analgesics you use or do not use?

Answer:

To the first part of the question the replies were essentially as follows. Efficacy: yes—33; no—4. Side effects: yes—28; no—9.

Regarding 'Have you any specially strong feelings regarding analgesics you use or do not use?'

No comment—10; no strong feelings—7; anxiety about addiction—4; gastro-intestinal upsets—5.

There were specific comments regarding known side effects on the gastro-intestinal system of salicylates, dihydrocodeine, opiates, codeine and pethidine. Five doctors found pentazocine disappointing in use, to one who found it useful. One said he found dextromoramide useless.

Question 7:

(a) Do you systematically enquire from the patient his past experience with analgesics before prescribing?

Answer:

Yes—24; no—9; sometimes—4.

(b) How are you influenced by his comments?

Answer:

Greatly—9; moderately—3; slightly—7.

From the nineteen replies to the second part of this question comments were made that:

(1) Patients were usually not aware of past drugs;
(2) it was stressed that many weak analgesics had been abandoned as ineffective because they had not been given regularly, and regular giving of these should be re-tried. It was observed that regular mild analgesics often gave better and longer relief than narcotics *pro re nata*;

(3) drugs that had been prescribed in inadequate dosage should also be re-assessed, especially if they are mild drugs;

(4) the side effects suffered previously by patients should be avoided by not prescribing the offending drug;

(5) the nursing staff's opinion was better than direct questioning of the patient.

Question 8:

Are you influenced by the cost of analgesics when prescribing?

Answer:

Yes—13; no—18; not very much—4.

Five doctors commented specifically on trying to

avoid proprietary drugs, preferring to use the approved or generic name; one commenting that 'most tried and proved drugs are not particularly expensive'.

Question 9:

Are you influenced by 'ethical' medical articles on the use of analgesics in journals or books?

Answer:

Yes—10; no—17; slightly—7.

It is possible that the use of the word 'ethical', in inverted commas, misled some doctors into thinking that the word had a rather shady meaning which was not the intention of the authors.

Question 10:

Do you find yourself influenced by advertising matter regarding analgesics?

Answer:

Yes—5; no—18; partially—11; not seen—1.

Three doctors commented specifically about the advertising of pentazocine, one stated that the claims were exaggerated; another that he had first heard of pentazocine via an advertisement; and one wrote 'I suspect agents which are advertised a lot—hence I have never tried pentazocine'.

Question 11:

Do you find yourself influenced by visits by drug representatives regarding analgesics?

Answer:

Yes—3; no—24; sometimes—5; never see reps.—5.

One doctor commented that representatives do not approach junior staff.

Question 12:

What other drugs do you consider useful in the treatment of cancer pain?

Answer:

Tranquillizers and tricyclic antidepressants—18; phenothiazines—13; barbiturates—5; others (14 different drugs)—16.

Question 13:

Does the problem of addiction in the patient affect your prescribing?

Answer:

Yes—25; no—8; doubtful—4.

One doctor commented 'no, I regard it (addiction) as a side effect—possibly more easily treated than some other side effects'.

Question 14:

Does the problem of drug abuse in the community affect your prescribing?

Answer:

Yes—13; no—16; very little—8.

Six doctors commented upon the desirability of limiting the quantity of addictive drugs prescribed at any one time.

Question 15:

Are you aware of sex differences related to the frequency of request for pain relieving drugs?

Answer:

Yes—11 (more in females, 4; more in males, 3); no—26.

Two doctors commented that personality differences were much more important than sex differences. Patients who knew their diagnosis sometimes had special difficulty in coping with pain.

Question 16:

Do patients ever complain of increased pain following treatment by drugs?

Answer:

Yes—11; no—22; sometimes—4.

We did not specify analgesics in Questions 16 and 17 so the assessment of answers may be imprecise. However, since the questionnaire was about analgesics it is reasonable to assume that the answers refer to analgesics.

Question 17:

Do you find patients who refuse treatment for pain?

Answer:

Yes—12; no—14; rarely—11.

One doctor commented 'Yes. Some patients regard pain killers as an admission of failure and prefer to soldier on, sometimes mistakenly believing that they will become addicted'.

Question 18:

Are there any other comments you would like to make?

Answer: (Observations of interest groups as far as possible):

(1) 'Nurses should be better informed about the principles of analgesia'; 'I am sure many nurses could give illuminating answers to some of these questions'; 'probably the junior medical staff are better witnesses than I am' (from a consultant);

(2) 'most physicians are in fact not overly good in knowing how to deal with pain'; 'most doctors know very little about treatment of pain and also only know a few drugs';

(3) 'many contribute to addiction and drug-abuse because of their lack of knowledge of how to deal with pain' (overseas research fellow from Canada);

(4) 'no doubt, advisedly, this questionnaire excludes social, occupational and other mental influences on pain; but they are paramount. Generally speaking, a mild pain is one which is not much thought about, and a severe one, one that is much thought about';

(5) 'reassurance about the significance of a pain can be as important as the drug prescribed';

(6) 'in carcinoma pain I tend to be liberal with analgesics unless they are addictive in a curable patient. If the patient is incurable, it is the quality not quantity of his remaining life that matters. Freedom from pain is of primary importance' (a very sensible assessment by a Senior House Officer in Surgery);

(7) 'in order to establish whether drugs help, one must see a patient personally often and over the length of her treatment. This is unfortunately often difficult'; 'pain control is time consuming and therefore liable to be dealt with too superficially in a busy clinic';

(8) 'I am surprised how often patients complain of severe pain but stop their analgesics because they have been made constipated. To me this means that many patients overstate their degree of pain' (this brings the question of assessment by the doctor or the nurse into consideration and highlights the great distress patients feel about constipation);

(9) 'confidence in prescribing is not always communicated to the patient, and response to treatment of pain is sometimes not properly assessed or changed promptly if ineffective' (the question of confident prescribing is difficult and very personal);

(10) 'surprisingly, perhaps, in the sort of "medical malignancy" with which I mostly deal, pain is rarely a major problem';

(11) 'pain may be due to a combination of circumstances, e.g. patients with carcinoma of ovary have pain from intestinal obstruction, and measures for relief are not necessarily only analgesics'; 'following palliative irradiation, analgesic requirement is usually considerably reduced, especially with secondaries in bone'.

Discussion

The information given in this questionnaire on the treatment of cancer pain is of interest in its own right on this topical and everyday problem. Well established drugs are used most often, new drugs are tried occasionally and diamorphine is used quite freely

when indicated, especially in the terminal, more painful and distressing situations. Sometimes the prescribers use terms such as 'Haustus E' without being accurately aware of the doses in the mixture, and, indeed, whether morphine and/or diamorphine is being given. In this hospital, aspirin, phenacetin, and caffeine mixtures with nepenthe are used with success but prescribers may be vague about the exact dosage of nepenthe. Furthermore, because these mixtures are used freely the doctor may not be aware that a narcotic is included in the mixture. Muddled thinking can also arise because euphoriant preparations with morphine and cocaine are classified as 'mixtures', e.g. Brompton mixture, whereas most euphoriant preparations containing diamorphine are classified as DDAs. These administrative difficulties tend to dissuade doctors from prescribing effective diamorphine mixtures. There seems to be little appreciation that pentazocine is a weak narcotic antagonist and should not be prescribed concurrently with opiates (Rigas, 1970).

Some years ago Lasagna and his group (1967) polled all the house staff of a large university hospital to get information on their prescribing habits in regard to analgesic drugs. After analysing all the replies they concluded that the data obtained was of little value in establishing a scientific basis for ranking analgesics. Nevertheless some interesting information came to light. They were impressed by the great variability in drug preferences. The choice of an analgesic was based on a mixture of rationale, empiricism, ignorance and bias. Most of the doctors could be classified into two prescribing groups; those who chose a drug because therapeutically it was the most effective of available drugs and those who preferred a drug which was less effective but had a lower incidence of side effects. The replies also revealed that many of the house staff physicians had little concern for the cost of drugs. It was evident too that the addiction liability was not an important determinant in choosing powerful analgesics.

Lasagna comments 'it was depressing to see how poorly acquainted these doctors seemed to be with the available literature, clinical and non-clinical, on the drugs in question'.

The general impression on reading the answers to our questionnaire was that many of the thirty-seven doctors who replied held sound views on the treatment of pain. Fifteen doctors noted an increase in pain following treatment with analgesics. This is of special interest in view of a recent report on drug induced aches and pains (Davis, 1971). Surprisingly this report referred to pain production attributed to the taking of diuretics, corticosteroids, tranquillizers, sedatives and laxatives, all of which may be prescribed for the cancer patient. There was more concern for the problem of drug addiction in our

group, but this may be merely a reflection of the present day world-wide interest in this problem. Although the cost of analgesics influenced the prescribing habits of thirteen of our doctors, four of them stated that cost was of secondary importance. Macaraeg, Lasagna and Bianchine (1971) at the Johns Hopkins University School of Medicine have recently pointed out that the price of drugs as a determinant in prescribing patterns poses a dilemma for doctors since their training tends to emphasize optimal medical care as the deciding factor. There is a tendency to ignore the cost of drugs particularly in the hospitals situation if it means sacrifice in therapeutic potential. It is noteworthy that a significant number of house staff officers at Johns Hopkins University now expressed some concern for the economics of drug prescribing. This again may be part of a world wide interest in rising costs. Whether or not concern for drug costs really affects prescribing habits has not been shown. Although the answers to our questionnaire reflect a good knowledge of pain treatment among a significant number of doctors, our Pain Clinic group impression tends to support Lasagna's experience. From a study of patients in the wards we have noted frequently that

pain has been treated inadequately. Factors responsible for inadequate treatment of pain in hospital may be pressure of work on doctors, lack of interest of hospital doctors whose drives are therapeutic and not palliative; perhaps even plain cussedness due to differences in personality.

Other factors to be taken into account are the too frequent changing of personnel, the use of agency nurses and the ever present problem of inadequate communication between patient, nursing staff and doctors. It may be that these latter poor impressions emanate from the 51% who did not answer the questionnaire.

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