

Letter

To Editor

Miracles-Curses of pain management: A humble plea for conscientious use of opioids

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Pain has been recognized as global public health concern¹ and inadequate pain management has been called public health crisis² with over six million people annually suffering across the world due to inaccessibility to controlled medications³. However, aggressively overcoming inadequacies in non-acute pain management has its costs too⁴; and societies that are at infantile stages in regards to managing these pains (chronic and cancer pains) in their patient population should not compare themselves with the fore-runners in pain management only in terms of per capita consumption of medicinal morphine equivalents⁵ for pain relief. The societies that are still evolving in regards to pain management usually cater to cancer patient population and opioid dependence should not be ignored in this patient population as well because the misconception that opioid dependence is minimal if any in cancer patients has been seriously challenged by the societies that have recognized opioid dependence in cancer patients secondary to marked improvement in their cancer-free survivals⁶. Moreover, even though the poorer availability of opioids may be the major cause for under-served patient population's pains related suffering³, the best provisions for pain management with unlimited accessibility to opioids does not ensure efficacious pain relief. The key to improved efficacies in pain management is to understand origin of pains, freely and openly discuss with patients and then decide long term achievable goals in pain management, and always pursue for conscientious attempts to curtail the incidence of opioid dependence in all non-acute pain patients including the cancer survivors. Endorsing pain as the fifth vital sign⁷⁻⁸ has only helped in timely pain reports, but aggressively administering pain medications as a response to pain reporting may not justifiably counter patients' sufferings wherein simple words 'I am in severe pain' may mean anywhere from 'I am extremely

unhappy' to 'You are not paying attention to me at all'. With such extreme variance in implied as well as subconscious "pain" descriptions, the pain management may cause more suffering to patients (unrelieved "pain", opioid tolerance and opioid dependence) as well as physicians (transference and counter transference hurting physicians' objectivity across the patient encounters)⁹. Human body is not immune to opioid dependence genetically but regulations in the societies and general perceptions in the cultures about the appropriations in regards to opioid use may contribute to differential incidences and prevalence among the societies¹⁰⁻¹¹ in regards to physical dependence as well as psychological dependence on opioids. Additionally, this difficult task of checking opioid dependence in societies becomes a daunting task legally, financially and morally when despite enforcements of strict narcotics regulations across the world, the diversion of prescription drugs including opioids to the streets evolves as a definitive risk that pain medicine as a subspecialty has to continuously deal with¹². It is my humble opinion that the time may be ripe for the pharmaceutical laboratories to devise and install chemical barcodes¹³ in the prescribed opioid tablets to retrace back the seized street drugs to the diverting "pain" patients for ensuring accountability among pain patients and their personal care-givers who have access to patients' prescribed medications. It will also help busy pain clinics to recognize these diversions early. Moreover, it is my humble opinion that besides the opioid rehabilitation clinics that rely on the appropriate and effective use of oral methadone or oral buprenorphine maintenance therapy for managing opioid addiction, it may be time to additionally consider the possibility of interventional pain procedures that need clinical investigations and clinical trials like novel theoretical and investigational modality of implantable intra-ventricular opioid delivery

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pumps¹⁴⁻¹⁵ (that were rarely used in past for management of head and neck cancer pain) for simultaneous supra-spinal management of opioid dependence and spinal management of intractable pain in patients who are suffering with function-limiting physical dependence secondary to prescribed pain medications but have strong willpower against psychological dependence. In summary, the hide-and-seek with the responsible use of opioids will continue to mystify the pain medicine and even though societies in infantile stages of pain management have a long way to go to achieve pain-free populations, they should be aware and should imbibe from the experiences of the leaders in regards to non-acute pain management and its related aftermaths¹⁶. Sometimes it is prudent to 'Take It Easy'¹⁷ in our management of non-acute pains because pain medicine as a subspecialty is always likely to be stuck between rock (inadequate analgesia) and hard place (tolerance and dependence) irrespective of the culture or the society where pain medicine is practiced.

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