COMMENTARY

Malignant pain or malignant patients?

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There is a difference in approach to patients with pain between professionals who specialize in palliative care and those who treat chronic nonmalignant pain (CNMP). This reflects not only the differences in the presentation of patients with malignant versus nonmalignant pain but also the differences in orientation of physicians who provide palliative care compared to those who treat CNMP. The use of opioid analgesics differs when the approach is palliation versus management of CNMP. This article contrasts the differing approaches to patients receiving palliative care versus those with CNMP with regard to the use of opioid analgesics.

Palliative care is the coordinated service offered to a patient with a progressive disease and his or her family when the illness is no longer curable, with the aims of maximizing quality of life and alleviating distressing symptoms.[1] Malignant pain is usually associated with terminal diagnoses; most often it is a result of cancer and/or complications of the treatment, but it may occur with other conditions such as AIDS and neurologic diseases. Management of malignant pain with opioid analgesics has gained wide acceptance within the field of palliative care.[2]

Practitioners who provide palliative care include infectious disease specialists and geriatricians, but frequently they are oncologists. Most palliative care research is performed in the context of cancer treatment. Therefore, the approach to the management of malignant pain is relatively consistent, as is the promulgation of medical education on the topic, by virtue of the relative homogeneity of palliative care practitioners. In contrast, CNMP encompasses a diverse group of diagnoses and syndromes (neuropathic pain, fibromyalgia, failed back surgery syndrome, chronic abdominal or pelvic pain, migraines, etc.). Practitioners who manage CNMP are a diverse group of generalists and specialists in disparate fields (primary care, rheumatology, neurology, neurosurgery, orthopedics, gynecology, psychiatry, anesthesia, etc.). This diversity poses significant challenges to the development of unified goals in research and medical education regarding CNMP management.

Some of the early research in pain management involved cancer pain, so there are studies from which to derive best-practice guidelines. Evidence-based guidelines for management of malignant pain have been accepted and updated over the past two decades. In the absence of other evidence, CNMP management was initially guided by research involving patients with malignant pain. Due to the heterogeneity of CNMP diagnoses, though, unified guidelines are challenging, and a one-size-fits-all approach is impractical. Even narrowing the scope of possible guidelines to the issue of opioid analgesic use reveals significant controversy. Research on abuse liability in opioid therapy for pain treatment shows little consistency in patient populations or definitions of terms such as "abuse" and "addiction."[3] Much of the guidance in medical literature for practitioners treating CNMP is based more on expert opinion than empirical research.

Treatment of malignant pain is supported by a diagnosis of malignancy. With cancer, this is obtained through tissue diagnosis, and with AIDS it is done through specific serology and a well-defined constellation of infections and cancers. Patients with CNMP most often have pain as the only unifying factor. Many diagnoses are syndromes based on a set of criteria or clinical judgments and pattern recognition, e.g., Complex Regional Pain Syndrome. Definitive diagnosis is elusive without the benefit of tissue pathology or clear-cut biomarkers. Cancer may be rapidly progressive, and symptom escalation leads to aggressive evaluation, with tissue identification allowing confirmation of a diagnosis/prognosis. Malignant pain often worsens in direct response to tissue damage from tumor growth or treatment (radiation, chemotherapy). Because of this practitioners generally (and rightly) view pain reported by cancer patients as being primarily somatogenic, but they frequently regard pain reported by patients with CNMP, who lack adequate objective physical pathology, as psychogenic.[4] Complaints of pain from patients with CNMP are often considered out of proportion to findings from examinations or objective testing. Patients with CNMP may suffer for years before their pain is adequately managed. Maladaptive behaviors for dealing with chronic pain may develop over time while patients with CNMP try to convince practitioners of the

severity of their pain. Demands for opioids made by patients with CNMP may lead to frustration on the part of the practitioner and feelings that the patient is "malignant," even if the condition is not.

Another difference between the approaches to pain management taken with palliative care and CNMP is the time course of the treatment. Palliative care does not attempt to be curative, so pain management is undertaken with the understanding that therapy will be limited by the remaining life span of the patient, often less than 12 months. The concept is to keep the patient comfortable. The terminal nature of malignancy allows for increased acceptance of aggressive treatment. Management of CNMP may also be for the remaining life span of the patient, but this may be several decades. Initiation of long-term therapy is not undertaken lightly, and aggressiveness is often checked because negative outcomes may result in consequences the patient will have to endure for many years. The use of opioids for CNMP is regarded with caution, and the issue is debated by practitioners because of concern—whether justified or not—about the potential for misuse/abuse over years of treatment. However, only a small minority of patients with pain appears to be at high risk for developing addiction.[3]

Adequate treatment of chronic pain remains challenging, and even cancer pain is undertreated.[5] Aggressive management of pain with opioids is more accepted in palliative care, as the terminal nature of the diseases involved and the assumption of a relatively short treatment time minimizes concern about addiction. Definitive tissue diagnoses mitigate fears of malingering for secondary gain. Unfortunately, patients with CNMP are more likely to be viewed with suspicion by practitioners. Concerns about secondary gain include malingering to avoid employment, investment in the "sick" role to fulfill unmet dependency needs, and access to opioids that may lead to abuse or diversion. Some patients deriving secondary gains from their CNMP condition or its treatment do intentionally deceive practitioners so they can continue to benefit, and practitioners treating CNMP should be vigilant for possible secondary-gain seeking in patients, but definitive determination of patient motives can be a challenge. Approaching patients with suspicion for secondary gain is not a natural extension of the healing arts or helping attitude of many practitioners and usually causes discomfort and concern. Maladaptive behaviors, comorbid psychiatric conditions, and pseudoaddiction all contribute to drug-seeking behavior, but they are not the same as intentional malingering. This complexity and uncertainty about patient motives play large roles in feeding the frustration experienced by practitioners who are dealing with patients with CNMP.

Suspicion regarding secondary gain may lead to an adversarial relationship with patients suffering from CNMP, instead of a patient-physician relationship based on healing or helping. Adversarial feelings may be intensified by medication contracts that stipulate conditions for refills and require urine samples for drug testing. These are appropriate, and often necessary, tools for monitoring, but they may add to feelings of mistrust, doubting of patient motives, or patients' feeling their clinicians are trying to "catch them in the act." This adversarial relationship often revolves around opioids. Escalating demands for opioids, along with maladaptive behaviors, complex comorbid psychiatric conditions, and the lack of a clear etiology for the pain, may lead some practitioners to view patients with CNMP as being "malignant" themselves. The adversarial nature of the relationship between practitioner and patient with CNMP is not usually seen in the context of palliative care. Practitioners of palliative care will partner with the patient to fight against the cancer and the pain it causes. The cancer, not the patient's behavior, is malignant. This provides solidarity in the patient-physician relationship and reaffirms the helpful nature of the practitioner. This solidarity is often not present when CNMP is the focus of treatment.

It is important to recognize these different approaches to the management of pain, especially regarding the use of opioid analgesics, between palliative care and treatment of CNMP. This can help prevent the frustration felt by both practitioners and patients that arises from attempting to use a one-size-fits-all approach in different populations. Incorporating a clear understanding of this difference into medical education about pain management will assist trainees in diverse disciplines as they attempt to reconcile disparate approaches when working with different patient populations. Practitioners who focus on either palliative care or CNMP management can learn from both approaches to opioid use, since malignancy survivors may develop CNMP from complications of the malignancy or its treatment, and patients with CNMP may develop cancer or other conditions that should not be overlooked (i.e., attributed to CNMP until too late). Pain management research may benefit from more formal differentiation that utilizes more homogeneous populations and clear delineations when assessing outcomes of interventions, especially involving opioids.

In summary, the use of opioids in palliative care is often more liberal due to definitive diagnoses and the terminal nature of malignant pain. Practitioners who manage CNMP are from diverse subspecialties with varied educational backgrounds regarding chronic pain management. They are managing patients who often have maladaptive behaviors and complex comorbid psychiatric conditions stemming from years of poorly controlled pain without a clear etiology. In addition, long-term concerns about medication abuse and fewer

evidence-based management guidelines contribute to a more adversarial relationship with patients regarding opioid analgesics. Acknowledging and learning from differences in approach can lead to improvements in research and better pain management. With such changes, only the diagnosis will be considered malignant and not the patient, due to a better understanding of the behavior of patients with CNMP that now so often results in practitioner frustration.

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