

Pain through the Ages

"Pain relief can be obtained by following the eight-fold path of life."

Indian Buddhist tradition

"When anyone suffers from toothache, let him lay a finger upon the sore spot and recite the 99th verse of the sixth sutra."

Mohammed

"Pain results from a violent disruption of the basic elements (earth, air, fire, water) causing a disturbance of the sensitive 'soul atoms' that communicate via the nerves to form a tripartite soul."

Plato

"The blessed delight which comes from the contemplation of divine things suffices to reduce bodily pain."

St. Thomas Aquinas

"Pain is a more terrible lord of mankind than even death itself."

Albert Schweitzer

"Your pain is the breaking of the shell that encloses your understanding."

Kahlil Gibran

"I am suffering. They ask. 'Do you have a lot of pain?' I am angry. I feel abandoned. I feel betrayed. And I feel hurt and angry and betrayed for one reason: I am being left to suffer. I am being put off because of my doctor's lack of knowledge. I know it is not for lack of caring. But for whatever reason, they are letting me suffer."

*Anonymous diary of a young woman
dying of cancer, California, 1975*

Common Myths about Pain

Myth: “Dying is always painful.”

Many people die without experiencing pain. If pain does occur, it can be relieved safely and rapidly.

Myth: “There are some kinds of pain that can’t be relieved.”

There are some types of pain that require "multi-modality" (combined approaches) pain relief. Recent advances in analgesia assure that all pain can be relieved by using commonly available medications and/or a combination of approaches that may include chemotherapy, radiation therapy, nerve block, physical therapies and whatever else is appropriate.

Myth: “Pain medications always cause heavy sedation.”

Most people with severe, chronic pain have been unable to sleep because of their pain. The opioid analgesics (morphine, codeine, et. al.) produce initial sedation (usually about 24 hours) that allows patients to catch up on their sleep. With continuing doses of medication they are able to carry on normal mental activities. Sedation often occurs because of other drugs, such as anti-anxiety agents and tranquilizers that have been prescribed for other reasons.

Myth: “It is best to save the stronger pain relievers until the very end.”

If pain is not relieved by the lesser strength analgesics (aspirin, NSAIDs, codeine, hydrocodone, etc.) it is best to change to a stronger analgesic to bring the pain under continuous (24 hour) control. Pain that is only partially or occasionally controlled tends to increase in severity. This leads to two mistaken assumptions: The *patient* mistakenly fears that the pain is so severe that it can never be controlled; the *doctor* mistakenly believes that the patient is becoming addicted or is developing tolerance to the analgesic medication. In most cases, an adequate dose of a stronger analgesic (e.g., morphine) prescribed on a regular basis usually brings the pain under control.

Myth: “Patients often develop tolerance to pain medications like morphine.”

When morphine and other opioid analgesics are prescribed for the management of pain, the dose is sometimes raised to be sure that pain is well controlled 24 hours a day, seven days a week. Opioids given to relieve pain generally do not lead to the development of tolerance. As a disease like cancer progresses, more opioids may be needed to control the pain on a continuing basis.

Myth: “Once you start pain medicines, you always have to increase the dose.”

In fact, the converse is true. Once pain is under control and the dose of opioid held at a steady level for several days, the dose of opioid analgesic can be lowered without the pain recurring. Levels of opioid can be raised safely as needed to control increasing pain. Also, the dose can be lowered gradually if pain has been controlled on the same dose for several days. This change in dose to meet patient needs is known as "titration." The fact that the dose of opioid can be lowered once pain is controlled is one of the paradoxes of treating severe, chronic pain.

Myth: “To get good pain relief, you have to take injections.”

Until the mid-1970s it was believed that morphine was not an effective analgesic when administered by mouth, so was universally administered by injection. We now know that morphine is effective when given by mouth or even by suppository. Patients generally do not like injections, as they are painful in themselves. There are several excellent long-acting opioid analgesic preparations. Morphine and related opioids are available that control pain for 12 hours when used on a regular basis twice daily. Other long acting opioid preparations available for trans-dermal (through the skin) delivery are available with a 72-hour (3-day) period of action.

Myth: “Pain medications always lead to addiction.”

When prescribed on a regular basis in a dose sufficient to relieve pain, there is no empirically based evidence that opioids lead to addiction.

Myth: “Withdrawal is always a problem with pain medications.”

When prescribed for managing severe, chronic pain there is no problem discontinuing the dose once pain is controlled. Withdrawal from the opioid analgesics is not a life-threatening condition as is withdrawal from a number of other commonly prescribed medications, such as barbiturates. The symptoms of withdrawal from opioids are generally mild and fairly easy to manage with commonly available medications. Many patients who receive opioids for severe pain have had their dose adjusted down without experiencing any withdrawal symptoms.

Myth: “Enduring pain and suffering can enhance one’s character.”

This myth developed in the years before we learned to provide excellent pain management, but is not appropriate today. Suffering does not enhance character or earn people a higher place in the life hereafter; it merely brings about a miserable life, a horrible death and needless anguish in all who see helpless dying people suffer.

Myth: “Once you start taking morphine, the end is always near.”

Morphine does not initiate the final phase of life or lead directly to death. Morphine provides not only relief of severe, chronic pain; it also provides a sense of comfort. It makes breathing easier. It lets the patient relax and sleep. It does not cloud consciousness or lead to death. Morphine does not kill.

Myth: “Pain is a solitary phenomenon.”

Severe chronic pain never occurs alone, but is usually accompanied by a number of other symptoms including (but not limited to) anxiety, depression, fearfulness, insomnia, anorexia (loss of appetite), withdrawal and thoughts of suicide. All of these symptoms are compounded with memories of pain already experienced, currently perceived pain, and anticipation of more pain yet to come. Unmanaged (or inadequately managed) severe, chronic pain is a complex problem that needlessly aggravates the symptoms of the underlying disease.

Myth: “Heroin is needed to provide excellent pain control.”

Heroin is a derivative of morphine that is more soluble in water than morphine and therefore passes from the blood to the brain more rapidly, thus affording the ‘rush’ or ‘high’ desired by intravenous drug abusers. Morphine has a longer period of action. It can be safely taken by mouth. New preparations for sustained release make it possible to obtain excellent relief when taken by mouth only twice daily.

Myth: “People have to be in a hospital to receive effective pain management.”

It is easier to provide safe, effective relief of severe chronic pain at home than it is in the average hospital. There are fewer medication errors when there is only one patient to receive medications and no other patient emergencies to interrupt the care. Accurate messages regarding pain management can be shared on a regular basis by means of a ‘Comfort Control Chart’ on which the patient indicates the level of pain relief by using numbers (0 to 10) to let the doctor know the adequacy of pain management.

About the Author: William Lamers, MD, is one of the first physicians to develop a hospice program in the United States; he also helped establish the first program to train people to develop hospices. He served as the Chair of the Standards and Accreditation Committee of the National Hospice Organization. He developed the curriculum for Peer Educators and conducted the “Train the Trainer” sessions for HFA’s recent Hospice Medicaid Education Project. Dr. Lamers serves as Medical Consultant to Hospice Foundation of America.