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Cancer pain in Yugoslavia-still lot to be done

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In this issue of Archive of Oncology, a comprehensive review on fentanyl patches, might be a good reason for the initiation of several steps toward better treatment of cancer pain in our country.

Cancer mortality is expected to rise, especially in developing countries such as Yugoslavia, mainly because of aging population and increases in tobacco consumption. Recently, WHO Cancer Control Program set up three priorities for the developing countries: establishment of the national cancer control programs, cervical cancer and palliative care. Every government should include pain control and palliative care in its health care system as it is an effective strategy to relieve pain and other symptoms and to provide a better quality of life to cancer patients with advanced disease (1).

Pain is a major symptom in cancer. It has been estimated that about 30% of patients undergoing active treatment and 70% of patients with advanced untreatable disease suffer pain due to tumor progression (2-5). Estimates are that approximately 30,000 patients in Yugoslavia suffer undertreated cancer pain. Recent surveys found that cancer pain is less than optimally controlled because pain medications and other therapies are not used appropriately (5,6). Physicians' knowledge and attitudes in pain management are likely to contribute to under-treatment (6,7). Some health professionals as well as patients and families are concerned about opioid (narcotic) analgesic side effects and addiction. Undertreated cancer pain destroys the quality of life. Unrelieved pain may lead to feelings of anxiety, depression, anger, isolation and even to thoughts of suicide.

Clinicians taking care of cancer patient, especially oncologist and family physicians, should be aware of the following basic facts about cancer pain management (8,9,10):

* Most cancer-related pain can be relieved by existing therapies.

* The first-line treatments of cancer pain are those directed at the cancer itself such as surgery, radiation and chemo/hormonal therapy.

* Analgesics are the mainstay of cancer pain therapy. The right drug in the right dose at the right time relieves 80 to 90 percent of cancer pain.

* Addiction, or psychological dependence, is extremely rare when opioids are used to treat cancer pain.

* A team effort is essential for effective management of cancer pain. The doctor, nurse, pharmacist, patient, and family must work together to develop the optimal pain management strategy. Since the pharmacotherapy (analgesics and a limited number of other drugs) alone usually gives adequate relief from pain caused by cancer, these are general principles of analgesic use (11,12):

* Base the initial choice of drug on the patient's report of pain: mild, moderate or severe.

* Increase the dose of drug until pain is relieved or until side effects are unacceptable to the patient.

* Administer drugs orally whenever possible; avoid painful injections.

* For continuous pain, administer drugs at regularly scheduled times "by the clock" rather than "as needed".

* Anticipate and treat side effects aggressively.

* Do not use placebos.

* Assess pain frequently and adjust treatment as necessary.

It is well recognized what are the main barriers for the improvement of cancer pain treatment (13):

* Insufficient quota of opioids for the country;

* Official prescription pads are difficult to obtain;

* Myths about morphine and addiction;

* Confusion about the meaning of terms physical dependence, psychological dependence, addiction, tolerance and abuse;

* Uploads limited to large urban centers; lack of access in rural areas;

* National laws impose limits on the number of days allowed for prescription;

* Limits on the number of doses allowed per day;

* Physicians fear legal sanction when they prescribe morphine;

* Cost of some opioids is too high for lower income patients;

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* Government has not examined national drug policies that affect medical use of opioids;

* No official method to estimate medical needs for opioids;

* No system to collect data about medical needs for opioids;

* The government does not provide an estimate of needs for opioids to the International Narcotics Control Board (INCB).

What are the major action steps, to be taken in a country, in the process of translating barriers into action?

* Create a task force to open dialogue between hospital directors and the Health Ministry;

* Improve communication between clinicians and the regulatory authorities to share information about medical needs for opioids;

* Organize workshops to educate the regulatory authorities;

* Encourage the government to add the necessary policies and administrative procedures to comply with the international treaties;

* Import low cost morphine powder and obtain machine to manufacture tablets to meet the needs of lower income patients;

* Review and evaluate laws that regulate the use of analgesics;

* Identify specific barriers in the legislation that impede access of patients to opioid analgesics.

If above steps are taking in a proper way they should bring the following outcomes:

* A wider range of opioid analgesics will be available.

* New presentations (syrup, patch) will be available.

* Dosage limits will be eliminated.

* Prescription pads will be easy to obtain.

* A simplified bar code method will be adopted for prescription monitoring.

* The number of physicians allowed to prescribe will increase.

* More effective distribution systems will make opioids available even in rural areas.

* The government will have the necessary funds to procure opioids.

* The WHO Analgesic Ladder will be adopted formally in the major health institutions.

* Adequate amounts of opioids will be imported or manufactured to meet the needs of cancer pain patients.

* Advanced cancer will be recognized as a significant public health problem.

* The consumption of potent analgesics such as morphine will increase every year.

Clinicians and regulators should meet yearly to monitor progress and ensure balance. Our national narcotic control laws should recognize that opioids are essential for the relief of pain and suffering. The WHO guidelines, recognizing that physicians should have the flexibility to decide the dose and duration of opioid treatment based on individual patient need, recommend that a coun-

try's narcotic legislation not restrict the amount of opioids prescribed at one time. Data from the INCB show that the worldwide consumption of morphine is increasing. But although cancer incidence is increasing in developing countries, data indicate that 93 percent of the total morphine consumption occurred in developed countries. Ten countries with the highest consumption used 87 per cent and the remaining 13 per cent was consumed in approximately 100 countries, where the majority of the population lives (14).

Several efforts were done by some enthusiastic doctors in the aim of improvement of cancer pain treatment in Yugoslavia:

* Morphine syrup has been made locally by our pharmacy at the National Cancer Research Center since 1996. Unfortunately, according to our regulations all drugs made locally in the pharmacies are not covered by health insurance and patients need to pay such drugs. Morphine raw material is not easy to obtain.

* The policy that doctor could prescribe only 200 mg of morphine per day has been changed. Now the policy is: whatever the dose patient needs for two weeks.

* WHO book: Cancer pain control, with a guide to opioid availability (12) has been translated to Serbian.

* A booklet on the cancer pain treatment recommendations is published.

* WHO book: Symptom relief in terminal illness, 1998 is also translated in Serbian. Note: All translated books could be obtained free on request to the following address: sinisar@ncrc.ac.yu.

* Several talks on the subject of cancer pain relief were given throughout the country.

* Several clinical studies using modern trial methodology were done. Some clinicians are members of Pain Subcommittee in Multinational Association of Supportive Care in Cancer (MASCC).

* Our health authorities were successfully forced to give prompt market authorization for slow-release morphine tablets.

* Methadone is recognized as a useful and low price drug in severe cancer pain (15).

* At the Institute for Oncology and Radiology of Serbia a multidisciplinary team has been built with twice a week outpatient ambulance work.

* Postgraduate students of oncology and general medicine were given two hours about the treatment of cancer pain (unfortunately not any longer!).

These important steps for the improvement of cancer pain treatment in our country, but additional efforts are mandatory.

There is a simple checklist for our government or other interested groups, including all of us, health care professionals, we may use to guide analysis of national drug control policies. I will leave to the readers of our journal to try to answer the following questions and judge by themselves what we did and what we still need to do:

1. Has the government conducted an examination to determine if there are overly restrictive provisions in national drug control policies that impede prescribing, dispensing or needed medical treatment of patients with narcotic drugs, or their availability and distribution for such purposes, and made the necessary adjustments?
2. Is there a provision in national drug control policies that recognizes that narcotic drugs are absolutely necessary for the relief of pain and suffering?
3. Is there a provision in national drug control policies that establishes that it is the government's obligation to make adequate provision to ensure the availability of narcotic drugs for medical and scientific purposes, including for the relief of pain and suffering?
- 4a. Has the government established administrative authority for implementing the obligation to ensure adequate availability of narcotic drugs for medical and scientific purposes, including licensing, estimates and statistics?
- 4b. Are adequate personnel available for the implementation of this responsibility?
- 5a. Does the government have a method to estimate realistically the medical and scientific needs for narcotic drugs, including for the opioid analgesics which are needed for pain relief and palliative care?
- 5b. Has the government critically examined its method for assessing medical needs for narcotic drugs, as requested by the INCB?
- 5c. Has the government established a satisfactory system to collect information about medical need for opioid analgesics from relevant facilities?
6. Does the government furnish annual estimates to the INCB of need for narcotic drugs for the next year in a timely way?
7. If it appears that the medical need for opioid analgesics will exceed the estimated amount which has been approved and confirmed by the INCB, is it government policy furnish a request for a supplementary estimate?
8. Does the government submit to the INCB in a timely way the required annual statistical reports respecting production, manufacture, trade, use and stocks of narcotic drugs?
- 9a. Has the government informed health professionals about the legal requirements for the use of narcotic drugs, and provided an opportunity to discuss mutual concerns?
- 9b. Has the government identified and addressed concerns of health care professionals about being investigated for prescribing opioids?
10. Is there cooperation between the government and health care professionals to ensure the availability of opioid analgesics for medical and scientific purposes?
11. Has the government taken steps, in cooperation with

licensees, to ensure that there are no shortages of supply of opioid medications caused by inadequate procurement, manufacture and distribution systems?

12. Do national drug control policies provide for the licensing of an adequate number of individuals and entities to support a distribution system that will maximize physical access of patients to pain relief medications?
- 13a. Has the government established a national cancer control program to which it allocates health care resources?
- 13b. Has the government taken steps to ensure the practice of the WHO Analgesic Method for cancer pain relief by continuing education programmes and by its inclusion in medical, pharmacy and nursing curriculum?
14. Is there terminology in national drug control policy that has the potential to confuse the medical use of opioids for pain with drug dependence?
15. Are there provisions in national drug control policy that restrict the amount of drug prescribed or the duration of treatment?
16. Are there prescription requirements in national drug control policy that may unduly restrict physician and patient access to pain relief?

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