Article published online: 2022-03-28

COMMENTS

I am delighted to be asked to comment on “Recent Trends in Cancer Pain Management” by Mishra, Bhatnagar and Singhal and I must congratulate the authors on their achievement. Summarising the many developments in this field is truly a challenge. They have correctly identified pain as the symptom which is most feared by patients with cancer. The good news is that using the simple framework of the WHO analgesic ladder, more than 90% of those with advanced cancer can have their pain controlled. The tragedy is that many doctors are either unfamiliar with the principles of the WHO ladder or are unwilling to put those principles into practice. Consequently many patients live and die in pain.

As a generalist working in the field of palliative care I am pleased that Mishra et al have concentrated in the first part of their article on the general principles of pain control. If patients with cancer are to experience the enhanced quality of life that comes when the misery of chronic pain is overcome, it is vital that all health care professionals have a working understanding of the principles of the WHO analgesic ladder. As well as providing a simple, easily remembered framework, the ladder advocates the use of one of the cheapest analgesics available: morphine. Consequently, the control of cancer pain does not have to be limited to affluent individuals and societies. Sadly, as Mishra et al point out, lack of palliative care training and experience amongst doctors can lead to under use of morphine. It needs to be stated categorically that when titrated appropriately, morphine is a very safe drug and, in the context of palliative care, it does not lead to addiction. When regional or national legislation limits the availability of morphine, it is part of the professional responsibility of doctors to lobby the authorities to improve its availability.

Pain management in palliative care, with so many new developments, is an exciting field to be working in. Mishra et al helpfully list some

of the interventional techniques now used in the control of cancer pain. It is very important that these techniques are available for our patients. The wide range of pharmacological, antineoplastic and anaesthetic approaches to pain management demonstrates that palliative care is truly a medical speciality. However, it is vital that we remember that the bulk of pain management in palliative care is done by generalists who can provide excellent pain control for the majority of their patients if they adhere to the simple principles of the WHO analgesic ladder. I well remember an elderly woman with advanced cervical cancer in Delhi who, when I fist met her, was curled up on her bed, rocking with pain and unable to speak, despite the intermittent use of strong analgesics. Three days later, with the use of regular paracetamol, her pain was controlled. She was able to go to the market and to chat with me over a cup of tea.

As clinicians, we do well to remember that pain is what our patients tell us it is. Pain dominates their attention and can take over their lives. It is our responsibility to help patients control their pain so that they can go on living their lives. Mishra, Bhatnagar and Singhal have helpfully outlined the important principles and the newer developments which will allow the medical community to manage cancer pain more effectively.

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IJMPO would like to publish 'Profile of a Cancer Centre' or an Oncology department in a major teaching institute/hospital in India outlining its history, facilities available, and achievements in the field of research, teaching and patient care. Please send your write-up (up to 2000 words) with 2-3 photographs.