Commentary

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# Cancer pain for the 21st century: stepping off the ladder, stepping up to new challenges

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This issue of *British Journal of Pain* contains four stimulating papers on aspects of cancer pain mechanisms and management.[1–4] It comes 4 years after the landmark British Pain Society (BPS) publication 'Cancer Pain Management', led by Jon Raphael and which boasted a total of 17 co-authors, giving an indication of its breadth of coverage.[5] In view of its impact and sheer size, the BPS document was subsequently split and published in two papers in *Pain Medicine*;[6,7] it is still available in full on the BPS website.[5]

The editors of this issue's collection – Paul Farquhar-Smith and Mike Bennett – were also co-authors of the 2010 BPS document, and they have done an admirable job of bringing back to our attention four of the most important themes identified then: molecular mechanisms and biological factors affecting pain treatment, pain in cancer survivors and issues regarding collaboration – or conversely, separation – between pain medicine and palliative medicine. Farquhar-Smith's and Bennett's[8] editorial gives further information about these highly readable and informative papers.

I would like to reflect, in this Commentary, on some of the broader aspects of cancer pain and where we have reached in 2014. It is now 28 years since the World Health Organization (WHO) first launched its two-pronged attack on cancer pain and cancer palliative care. Looking back on this quarter century, it is salutary to think about what we have gained and what has yet to be learned. First, it is no longer necessary to hedge our comments about the lack of evidence base for the WHO three-step ladder and other components of the cancer pain programme. Even in 2010, Raphael et al.[6] had to say cautiously, 'It is recognized that the World Health Organization (WHO) analgesic ladder, while providing relief of cancer pain toward the end of life for many sufferers worldwide, may have limitations in the context of longer survival and increasing disease complexity'. What they could have said was that it was becoming an embarrassment and even an impediment to the advancement of good pain management, that national and international guidelines were still – in the 21st century – citing the 1986 programme for analgesics and end-of-life care as the model for all stages of cancer. Cancer survivorship is not a new concept, but in the WHO paradigm, one would hardly be aware that some patients were indeed surviving cancer and living with it as a chronic disease. The healthcare model proposed in the BPS document was of supportive care which can be customised to all stages of cancer illness, not just brought in at the end of life.[9]

Other key tenets of the WHO approach have also been roundly criticised by experts worldwide, such as its emphasis on oral morphine, which continues to be recommended because of its 'familiarity' and cheaper cost, rather than any evidence of its superiority.[10,11] The 2013 update of the Cochrane review on morphine for cancer pain concluded only that 'There is qualitative evidence that oral morphine has much the same efficacy as other available opioids'.[12] The European Association for Palliative Care (EAPC),[13] in the latest update of its own cancer pain recommendations, declared that

> The data show no important differences between morphine, oxycodone, and hydromorphone given by the oral route and permit a weak recommendation that any one of these three drugs can be used as the first choice step III opioid for moderate to severe cancer pain.

The papers in this issue of *British Journal of Pain* show how we have to think, not only beyond morphine as the

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ideal opioid but also beyond opioids as the drugs of choice for cancer pain. Even patients who have advanced cancer and are approaching the end of life, when rigorously surveyed, make it clear that they are intolerant and wary of classical opioid adverse effects.[14,15] There is general agreement that overuse of opioids in chronic non-cancer can lead to serious harms.[16] We have recently shown that not only are multiple myeloma 'survivors' (i.e. those who are at least 2 years into remission after intensive treatment) suffering chronic pain but also that the side effects of conventional analgesics, predominantly opioids, significantly reduce their quality of life.[17,18]

So much then, for the problems of adhering to a 20th-century medical model; what are the solutions? The papers in this issue offer some enlightenment and guidance for researchers and clinicians. We have to think of the molecular mechanisms triggering and maintaining cancer-related pain (which, we are increasingly aware, includes pain from cancer surgery and treatment toxicities) and of the genetic factors that determine which patients may respond to conventional drugs and which may not. We have to stop thinking of cancer pain as an 'end-of-life' issue, but one which affects patients – and often, their families – from the first biopsy and surgery to remission, into advanced disease or long-term survivorship. And we need to break down the barriers set up by a generation of pain medicine and palliative care divergence in order to offer cancer patients a 'joined-up' approach that embraces not only pharmacological interventions (including sophisticated drug delivery or neurolytic blockade as appropriate) but also a more holistic environment that includes psychological, social and existential support to rebuild their lives.

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