# Pain & Symptom Control: Dispelling the Myths

Hospice strongly advocates good pain control for terminally ill patients, including using narcotic drugs (also called opiates) such as morphine when they are necessary. Some patients and their loved ones question the use of narcotics. *Is it safe? Will the patient become addicted?* Let's explore some of the myths about the use of narcotics for pain and symptom control.

**Myth #1:** ***Morphine is offered to patients only when death is imminent.***

It is not the stage of a terminal illness, but the degree of pain or shortness of breath that dictates which medicine to use. We start with the mildest medicine and if it works, stop there. If it doesn't, we move on to morphine when it's appropriate. Some people never need morphine, while others will require it for quite a while.

**Myth #2:** ***People who take morphine will become addicted.***

Drug addicts are people who are driven by their need for narcotics; they may commit crimes or harm others to get their needs met. Hospice patients usually don't have drug-seeking behavior. When their pain and shortness of breath are in good control, they don't desire more opiates. Sometimes we can even decrease the dosage. If a patient has never received morphine, the initial dose is low. It is gradually increased to relieve the patient's pain or shortness o breath. After a few days of regular doses, the body adjusts to the morphine.

**Myth #3:** ***People who take morphine will become so sedated (sleepy) that they can't function.***

When patients start to take drugs like morphine, there is often the side effect of feeling drowsy. But this side effect will go away after a few days. Most patients whose pain is well-controlled on morphine are not bothered by unusual sleepiness. Some people, however, notice a difference in their alertness and might choose somewhat less than perfect pain control as a trade-off.

**Myth #4:** ***People who take morphine die sooner because morphine causes them to stop breathing.***

There is no evidence that opiods such as morphine hasten the dying process when used

at the right dose to control the symptoms a patient is experiencing. Fortunately, patients quickly adjust to any effect that morphine may have on their breathing. We prescribe a small initial dose, gradually increasing it if needed. Research suggests that using opiods to treat pain or shortness of breath near the end of life may help a person live a bit longer. In fact, morphine is a drug of choice for breathing distress in people with end-stage heart or lung disease; it makes their breathing more comfortable.

**Myth #5:** ***I'm allergic to morphine: once I had a shot of morphine after an operation and I felt very strange.***

Of course you can be allergic to morphine just like any other medicine, but this is rare and usually involves hives or swelling. Feeling strange is usually not a sign of morphine allergy. There are other opiates available for those people who are truly allergic to morphine.

**Myth #6:** ***Morphine must be given by injection.***

We used to think that opiates were not effective unless administered by injection. But hospice has been a leader in demonstrating the effectiveness of morphine and other opiates taken orally. Even people who required injections of morphine in the hospital (the most common way of giving morphine there) will probably be able to be well controlled on oral morphine at home. There are also long-acting preparations of morphine which can be given every 12 hours, or opiate skin patches which can be applied every 72 hours, to simplify the routine of pain control.

**Myth #7:** ***People should wait until their pain is bad to take morphine so it will be effective when it's really needed.***

There is no upper dose limit to the use of morphine or other opiates. If pain increases we can increase the dose; this is true of very few other medications. Using it when it's needed early in the course of a terminal illness does not mean that it won't continue to work later in the disease.

Morphine, one of the oldest drugs in existence, has found a well-deserved place in the new field of palliative care: the relief of pain and other symptoms. We recommend opiates for pain control only if they are needed. When they are needed, they are often successful in controlling the pain and other symptoms of terminal illness.

This article was excerpted from "Pain Control: Dispelling the Myths" by Dr. Joel Potash, MD, http://hospicenet.org/html/pain_myths.html