

7 Myths Regarding Opioid Use in Pain Management

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The National Center for Health Statistics estimates that chronic pain affects 76.5 million Americans, which is more than the combined total of diabetes, heart disease and cancer (National Center for Health Statistics, pp 68-71). The economic impact of untreated pain in the United States is difficult to measure, but is estimated at \$100 billion annually (National Institutes of Health, pp 98-102). While opioids remain the gold standard in managing pain today, there are many barriers and myths regarding their use and overall pain management that can result in negative patient outcomes. Although some myths are a part of the subculture of different medical disciplines, the following misconceptions are universal throughout the healthcare system.

Myth #1—Healthcare providers do an adequate job of providing adequate pain control. Statistics say otherwise. When physicians prescribe a dose range for analgesia, most nurses tend to give lower doses. The under treatment of acute pain (oligoanalgesia) can have many negative effects on patient recovery and satisfaction. Continued under treatment of acute pain has been suggested to cause chronic pain because of subsequent alterations within the central nervous system. These changes may result in an overall decreased pain threshold, which could eventually lead to a patient's overuse of analgesia. Oligoanalgesia has been observed in emergency departments, intensive care units, medical-surgical units, and throughout the healthcare system (Dachs, 2001). Nurses and physicians should be aware of their own beliefs regarding pain management in order to provide adequate relief for their patients. When the patient states pain, the patient must always be believed with prompt implementation of adequate pain modalities.

Myth #2—Pain medications always lead to addiction. When prescribed appropriately in a dose sufficient to relieve pain, there is no indication that opioids lead to addiction (Hospice Foundation of America, 2007). Recent studies have indicated that the incidence of addiction is less than 1% for those patients using opioids for short-term acute pain management (Joranson, Ryan, Gilson, Dahl, 2000). When clinicians believe that appropriate use of narcotics leads to addiction, their reluctance to prescribe these medications may result in chronic pain, which may lead to a long-term reliance on analgesics. Early use of narcotics, with tapering of the doses as pain is relieved, should be encouraged in managing acute pain. (Dachs, 2001).

Myth #3—Pain medications always cause heavy sedation. Because chronic pain can cause sleep deprivation, most opioids will cause initial sedation. However, once the patient catches up on lost sleep, continuing treatment with adequate narcotic doses will allow them to resume normal mental alertness and orientation. Sedation is often caused by other drugs, such as anti-anxiety agents and/or tranquilizers, which are prescribed for other reasons (Vilensky, 2002).

Myth #4—Some kinds of pain cannot be relieved. Because all pain is not the same, all pain medications do not have the same effect. Some pain may require a multi-modality approach, such as combining opioids with nonsteroidal anti-inflammatory agents. A thorough pain assessment and history can help a provider prescribe a medication regimen that will allow the patient to keep pain at a manageable level (Vilensky, 2002).

Myth #5—Pain and suffering are character-building. Although some cultural and religious communities view stoicism with pain as a sign of strength, the impact of pain on quality of life is monumental. With acute or chronic pain, the patient is affected holistically.

- Pain causes stress on the cardiovascular system through increased blood pressure and heart rate, and increased risk for thrombosis and pulmonary emboli.
- Pain results in delayed rehabilitation, immobility and possible resulting skin breakdown.
- Pain may result in a disruption of normal sleep patterns.
- Pain can cause a lack of interest in dietary intake and dehydration.
- Patients in pain have reluctance to take deep breaths and cough postoperatively, which can lead to atelectasis and pneumonia.
- Pain causes increased release of stress hormones, which negatively affect normal urinary and renal function.
- Pain can cause confusion, delirium, and increased risk of falls.
- Pain is known to cause delayed gastric emptying and constipation.
- Pain results in increased length of stay in acute care facilities, leading to increased risk for nosocomial infections and increased health care costs.
- Unrelieved pain causes dissatisfaction with the health care system. The patient whose pain is relieved will express more satisfaction with their care. In addition, family members of dying patients will express satisfaction with care if death of a loved one is perceived as painless (Ead, 2005).

Myth #6—Effective pain management can be achieved on an “as needed” basis.

Medications provided “around the clock” have a much better impact on pain management with fewer side effects (Ead, 2005).

Myth #7—Narcotic analgesics in older patients should be avoided. Pain has no age limit. Difficulty in completing a thorough pain assessment for a patient with dementia adds to the misconception that these patients have decreased sensitivity to pain. Because the elderly patient may be more susceptible to the negative effects of opioid analgesics, these patients may be prescribed doses of narcotics that are ineffective. Clinicians frequently express concern regarding the possibility of confusion or delirium as a result of these medications. Continuing patient and staff education and acceptance can have a positive impact on treating pain in the geriatric population. (Davis, M., Srivastava, M., 2003).

These are seven of the most often cited myths in the literature regarding pain management. Other myths include

- Morphine hastens death in a terminally ill patient.
- Injectable morphine works better than morphine by other routes.
- Heavy-duty analgesics should be withheld until death is imminent.
- A patient who is sleeping is not in pain.
- A patient who is watching television or laughing with visitors is not in pain.
- Infants and children don’t experience pain as adults experience pain.
- Once you start pain medications you always have to increase the dose.
- Alterations in vital signs are reliable indicators of pain in a patient.

“Pain is whatever the experiencing person says it is, existing whenever he says it does” (McCaffery, 1979). Clinicians are obligated to determine the most effective means of relieving pain in their patients. Understanding the clinician’s own biases regarding pain management is the first step in creating a pain-free environment for their clients. Adequately and consistently addressing pain within the health care system will ultimately lead to an increase in patient trust, shorter lengths of stay, and better patient outcomes.

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