Some Particularities About the Use of Opioids in Cancer-Related Pain

Algumas Particularidades Sobre o Uso de Opioides na Dor Oncológica

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Dear Editor-in-Chief

I read with interest the article by Vieira *et al*.[1]

Although opioids are the pillar of treatment of moderate to severe cancer pain (CP),[2] there is undertreatment of CP in Portugal.[3] There are some particularities in the use of opioids, as Vieira *et al* pointed out.[1] I want to add a comment regarding this topic.

While, in Table 1, several opioids were described for breakthrough cancer pain (BTCP), the authors argued (page 393) that oral formulations of morphine (and tramadol, I say) are intended for incident pain whereas formulations of fentanyl (transmucosal, sublingual and buccal film) are recommended for BTCP. This should be included in the "Summary of Product Characteristics" of different opioids, but for commercial reasons, I think, there is a willingness to maintain several opioids associated with BTCP. Recently, a brand-new fentanyl in nasal spray appeared on the market.

Sublingual buprenorphine is intended for patients with a history of drug addiction who are followed up at specialized centers. It is not recommended to use it outside this setting unless patients are followed up at pain clinics.

There is concern that buprenorphine may prolong the QT interval, but this concern has not been observed with tramadol.

The morphine dose for incident pain should range from 1/10 to 1/6 of the morphine equivalent daily dose (in milligrams) and may be administered at repeated intervals up to 4/4 hours (upper limit of its duration).

Whenever a sustained-release opioid is corrupted (crushed, shredded, split in half, etc.) it becomes an immediate-release opioid. The pain may decrease but unbearable side effects may arise.

Opioids whose boxes have < 20 tablets are not intended to control baseline CP. I am talking about tramadol (with paracetamol or dexketoprofen), morphine and all fentanyl placed in the oral cavity. In CP, all these should be used exclusively to: a) titrate the required dose of opioids at the beginning of treatment; b) rescue an outbreak of incident pain or BTCP, always as needed.

Morphine is still the first choice for moderate to severe CP, the authors concluded.[1] In Portugal, however, morphine is poorly prescribed: 15 times less than fentanyl and 1.5 times less than hydromorphone.[4] I hope the state of the art will change soon. Perhaps, then, medical students and young interns do not find that the risks of opioids outweigh the clinical benefit.[5]

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