

Jeevodaya Hospice

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Editorial

I am happy to inform our well wishers that Jeevodaya has gained the services of a full time doctor in the person of Dr. P. K. Ganga. This has enabled us open a community clinic to address general health concerns especially those of women and children. Our screening Centre at MMM is progressing well and two more screening centres, one in Santhome and the other in Royapuram, are on the anvil.

A new programme that Jeevodaya has recently undertaken is the training of girls to look after sick patients at home. This will hopefully alleviate the hardships faced by families, due to the lack of trained help. A batch of five girls have just finished their training and a new batch of six is commencing in June.

Ask anyone who is battling cancer or someone who had to stand by and watch a loved one die of cancer, they will tell you that cancer is accompanied in its later stages by severe and unbearable pain. We hope that the exhaustive article on oral morphine will be of help to those trying to deal with this pain.

Sr. Lalitha Teresa FCC
Editor

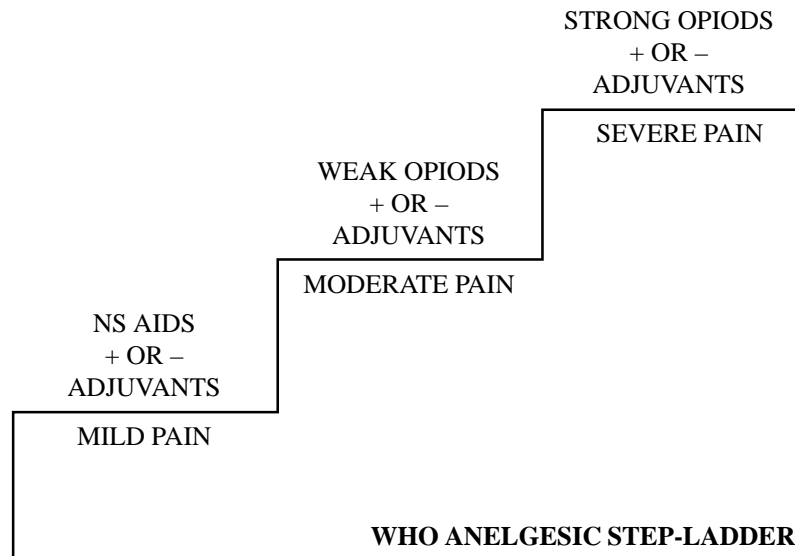
Oral Morphine

– A boon to Cancer patients

Pain is one of the most common and most feared symptoms of Cancer; feared more, sometimes, than death itself. Paradoxically most cancers are painless to start with; however, 70 – 75% of patients with cancer experience moderate to severe pain in the course of their disease. The severity of pain is more likely to increase with the progression of the disease or during therapy.

In the past two decades, there has been considerable advancement in the understanding of cancer pain and its management. Consensus has been reached, that cancer pain is indeed manageable with simple drug regimens – the mainstay of treatment revolving around the use of oral morphine, which is considered to be the gold standard in cancer pain management.

The WHO recommends the analgesic “step-ladder” as a general guideline for cancer pain control.



The first step is the use of non-steroidal analgesics for mild pain, the second, weak opioids for moderate pain and the third step the use of strong opioids (morphine) for severe pain. The second and third step may need additional co-analgesics or other adjuvants.

It is now well established that 90 – 95% of Cancer pain responds to pharmacological management, which include the use of oral morphine. Less than 5% of patients need other procedures like radiotherapy and nerve blocks for pain relief. Of course, symptomatic drug management, drug modifying therapy and non-drug measures go a long way in giving over all benefit to the patient.

In spite of the well-established principles of cancer pain management, the number of cancer patient receiving effective pain relief is dismally low. A western commentator put it at 1 in 4 but in India it could be anywhere between 1 in 400, 1 in 4000, perhaps even more. The main reason for this huge gap between knowledge and implementation is due mainly to

- a) The lack of knowledge among the medical professionals with respect to cancer pain management.
- b) The myth and misconceptions surrounding the use of morphine.
- c) The stringent Governmental law that acts as deterrent to the use of morphine and also is a cause of
- d) Non – availability of the drug.

The first and foremost myth or misconception that has to be shattered in that oral morphine (taken in the form of tablets or liquid) has no addictive properties. It does not give a kick (psychotropic effect) nor does its use cause ‘craving’ which is so typical of an addict. The side effect it produces precludes it from being used by a person for any reason other than pain relief.

The patient, public and the physician alike have to be re-educated on the use of oral morphine for therapeutic use of morphine and also to get some of the facts straight.

I. Fear of Addiction :

As already explained oral morphine does not cause addiction. Addiction has to be distinguished from physical dependence, which means that patients may have to continue taking morphine for long periods to keep themselves pain free. However, it is possible for the dose to be reduced and even discontinued, without any difficulty as the patient’s pain decreases.

II. Fear of side effects :

a) Fear of Excessive sedation :

The initial drowsiness that occurs with the initiation of treatment with oral morphine usually disappears in a few days and subsequently the patient experiences pain relief without sedation. This enables many a patient to resume his normal activities and many patients have been known to continue with their jobs while on morphine.

b) Nausea and Vomiting :

This side effect too disappears after a few days of initiation of therapy during which time it can be effectively treated with anti-emetics and discontinued once the symptoms subside.

c) Constipation :

This is a problem that lasts as long as the patient is on morphine. Hence the patient has necessarily to take laxatives along with morphine.

d) Confusion :

Confusion is a rare side effect that occurs in the very elderly and frail patients, which can be countered by lowering the dose.

III. Barriers to the use of morphine can arise :

- 1) From the patient himself or the family in the mistaken belief that the use of oral morphine means impending death or that morphine itself may hasten death. It must be explained to them, that the use of morphine on the contrary, by providing good pain relief will improve the quality of life which is turn can actually prolong life without suffering.
- 2) Barriers may well come from the treating physician too
 - a) Wanting to reserve the “trumpcard” morphine to the last when all else has failed.
 - b) If morphine fails, what next? This is a worry that most physicians have. This makes them postpone the use of morphine to the very

last as they juggle with all sorts of analgesics during which time the patient suffers from inadequate pain relief.

The doctor must realize that morphine can be used for long periods of time – months or even years, without any ill effect. Unlike other drugs, morphine doses not have a ceiling effect and hence the drug can be stepped upto very high doses – 2000 to 3000 mg per day have been prescribed but it is seldom that a patient requires more than 200 – 300 mg per day. The failure of morphine to relieve pain is more often due to failure to accurately evaluate and assess different pains of a patient and use appropriate drug and non-drug regimens. Morphine alone can not be considered to be a “panacea” for all pains in cancer.

- c) Many doctors are unfamiliar with the use of morphine in cancer pain.
- d) Fear of respiratory depression: Morphine in the doses used for pain relief seldom causes respiratory depression, in fact, morphine is the drug of choice in cancer dyspnoea.
- e) Doctors are not willing undertake the responsibilities and paper work involved in using morphine as required by legislation.
- f) Last but not least especially in our country is the non-availability of the drug due to stringent legislation regarding the use of narcotic drugs.

Only when their misconceptions are dispelled and barriers removed does the cancer patient have any realistic hopes of getting his pain relieved.

Guidelines for the use of Oral Morphine :

Once it is established that the patient is not getting adequate pain relief with a short term trial of first and second step of the WHO ladder, there should be no hesitation in moving up to the third step and initiating the use of strong opioids. There is no benefit or rationale in moving along the same step horizontally trying out the various drugs available for the efficiency of the group as a whole will remain the same.

Oral morphine is generally used

- by the mouth
- by the clock
- by the ladder
- tailored to the needs of the individual patient.

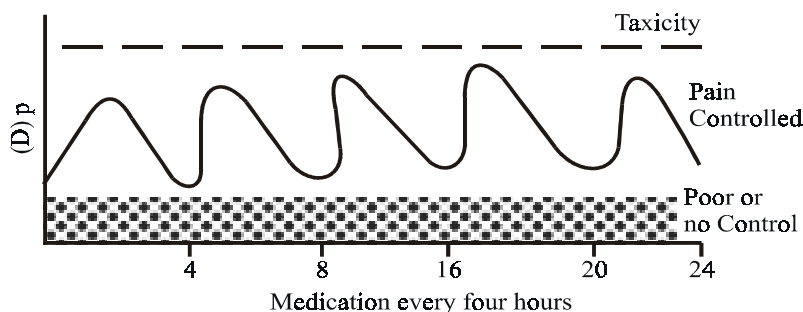
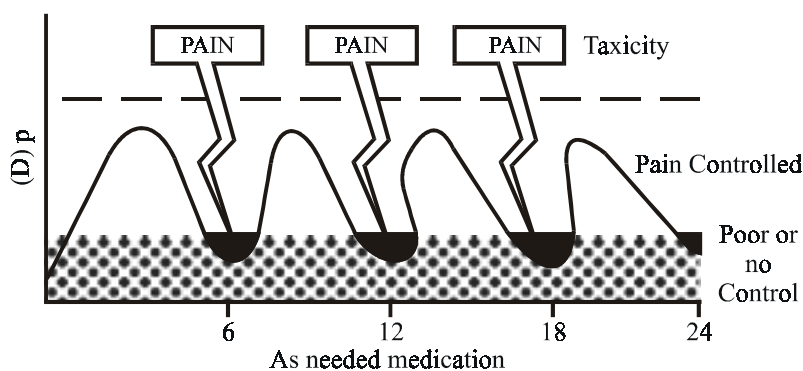
By the mouth :

The easiest way to administer opioid is orally in the form of tablets or liquid. Unless for some reason the patient cannot take orally (morphine can be given through Ryle's tube or enterostomy tubes)

By the Clock :

The half-life of immediate release morphine is 2.30 hours. It has been established by practice that immediate release morphine requires to be given every four hours by the clock irrespective of whether the patient has pain or not to keep the patient pain free round the clock.

One must not wait for the pain to appear before the next dose is given.



By the ladder :

Not only doses one move up the WHO ladder, but even while using morphine once starts with a small dose and quickly steps it up till adequate pain relief is achieved.

Tailored to the patients needs :

There is no prescribed dose for morphine. The starting dose depends on what medicines the patient has been taking previously for pain relief. Usually the patient is started on a small dose – 5 mg X 4th hourly and is increased in multiples of 5 till satisfactory pain control is reached. This dose can be arrived at in 48 – 72 hours. Another method is to start on a regular 5 or 10 mg X 4th hourly dose and if the patient experiences pain in between doses (breakthrough pain) to give additional doses without altering the routine. Then the additional doses given can be added on to the regular dose to determine the total dose required in 24 hours and to divide it accordingly. This is especially useful when determining the dose of sustained release morphine tablets (when available) which has to be given twice a day.

Once the patient is stabilized on a particular dose, the same can be continued. Periodic review is necessary, since the pain can increase either due to progression of disease or new pains can develop in which case the dose has to be increased.

If a patient remains pain free on a particular dose for a long period, it may be possible after proper assessment to reduce the dose or even discontinue it totally. However, morphine must never be stopped abruptly, for it may cause unpleasant withdrawal symptoms. It must be tapered and stopped.

It is good practice to always prescribe anti-emetics and laxatives along with morphine. The anti-emetics can be stopped once the patient gets over the symptoms of nausea and vomiting but the laxative should be continued as long as the patient is on morphine.

It is advisable to explain to the patient and the family of the possible side effects especially the temporary nature of drowsiness, nausea and vomiting. This will go a long way in getting the compliance of both the patient and the family.

Alternate counter of administration of Morphine :

The recommended route for morphine is oral. If for some reason it can not be given orally. The other routes are,

- Rectally as suppositories.
- Parenterally as subcutaneous injection (Injection dramorphine is twice as potent as oral morphine) usually used in syringe drivers for continuous pain relief.
- Can be used intra venously to patients with indwelling CVP line (given IV the potency of IV morphine to oral morphine in 1:3)
- Can be used intra-theccally or as an epidural injection in special circumstances.
- The newer opioids (e.g. Fentanyl) has come in the form of transdermal patches, which can be applied, to the skin.
- The buccal, sublingual or nebulised routes of administration of morphine are not recommended because there is precisely no evidence of clinical advantage over conventional routes.

Opioid Availability :

It is ironic that though India is the largest producers of opium, the consumption of opium for medicinal use (morphine is a derivative of opium) is the lowest, most of it being exported to the developed countries. The reason for this is that there is strict legislation governing the use of narcotics. This was necessary to curb to abuse of the narcotic drug, but in a way has proved counter productive in that it makes it very difficult for the genuine user, namely the cancer patient.

The WHO is seized with the problem and in the last decade has relentlessly lobbied for the simplification of rules so that the cancer patient will not be denied this essential drug. The narcotic legislation is a state subject, hence the changes have to be made by each state separately.

In Tamil Nadu for a doctor or institution to procure store or dispense morphine complicated procedure existed involving not less than 3 departments, namely the revenue, excise and health department. However, thanks to the efforts of the WHO, Indian Association of Palliative Care, palliative care practitioners in Chennai, the state authoritative have amended the existing laws to simplify the procedures for those institutions that need morphine for therapeutic purposes. It is now possible through a single window namely the drug controller who is the sole authority for granting the status of RMI (Recognized Medical Institution) to the institution and to license them to procure, store and dispense morphine.

It is to be hoped that with increasing awareness among the public, the medical professional and the law makers, no cancer patient will suffer from unrelieved pain. Infact, every cancer patient should realize that he has a right to demand "Freedom from Cancer Pain."

P.S. : Any information regarding use of Morphine, RMI, procedures for procurements of morphine, or copy of amendment can be had from Jeevodaya Hospice, Chennai on request.

Dr. Manjula Krishnaswamy, M.S.
Medical Director, Jeevodaya Hospice

Take Life as it comes

Life is a challenge, meet it. It is very difficult, yet we have to take it as it comes. In each ones life, God has a plan. It is like a drama. Each one has his/her role to perform. It is not a joke or easy to act in this drama. We have to face so many problems. But it is upto each one, how we are going to take it.

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When miserable things happen in our lives, immediately we have a question, how could it happen? We had done nothing to deserve such suffering. But if we learn to take it as a test, a test of our faith, we will be able to face it with courage and stand as a witness for the world. This test is proposed in heaven but staged on earth. From Bible we have learned, how the good men faced calamities and accepted the challenge of Satan.

Like all grieving persons, I also had undergone the pain of separation. I had lost my only beloved son, Vincent Vibin Kumar Patnaik. My husband and myself stood numb, when we heard that he was having cancer and he was dying. The ears couldn't believe it. Our life suddenly seemed to stop. He was at his prime age, a young and energetic boy of 22 years old, full of dreams for a bright future, doing his MCA I year at Madras University and side by side

working as a residential Computer Engineer for a reputed firm. But for my son his dreams will always remain dreams.

Knowing that we had to part forever very soon, we parents stayed with him for six months, burning inside with our feelings and unbearable pain. We had to put up a brave front, a smiling face in front of others, for the sake of our beloved son.

We have to take life as it comes. The question over here was, how we were going to take it? After 22 years of life with our son, it was time to say goodbye. But with faith we said farewell to him. We have faith, that we will meet him again over there along with Jesus, our saviour. We have to accept the truth and come to reality. It is possible only by faith, love and care.

In Jeevodaya, the sisters are doing the same thing. The way they look after the cancer patients! There are no words to appreciate the work they are carrying on. They bestow love and care to the patients, they are able to help them to accept God's will in their lives and prepare them to meet death peacefully. Only when we grow in faith, will we be able to understand the meaning of our life. Death is not the end, it is the beginning of our eternal life. Sooner or later, we all come into a position, where we find nothing makes sense any more. God seems too distant and silent. At such moments of crisis, each one of us is put on trial where we have to stand with honesty and by faith as it comes.

"Naked I come from my mother's womb and naked I will depart. The Lord gave and the Lord has taken away. May the name of the Lord be praised."

A Grieving Mother,
Lueiza Balaram

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