When Cancer Pain Won’t Go Away

Non-opioid treatments and complementary approaches can help, but don’t fear using opioids when they are needed.

December 16, 2019 By Robin Warshaw

Erika Peterson, of Rathdrum, Idaho, hated taking medicine. She was especially opposed to opioid pain medications because people can become addicted to them. That’s why she planned to use only high-dose ibuprofen after a bilateral mastectomy for Stage II breast cancer in 2015.

She changed her mind after surgery “because the pain was so horrible,” she says. She was given an opioid for about a week until the pain lessened.

A year later, the cancer spread to her hip and spine. Peterson used ibuprofen or acetaminophen for pain. Then the cancer metastasized further in her bones, and her pain increased. She now uses non-opioid medications most of the time but takes oxycodone, a prescribed opioid, when she needs more relief. “My pain is pretty heavy, and some days I can’t kick it,” she says.

Pain is a complex and common side effect of cancer and its treatment. It may last only a short time, until the tumor is removed and the patient heals, for example, but it can also become chronic. Chronic pain can arise from metastases (cancer spreading beyond its original site), surgical scars, nerve damage from chemotherapy, joint pain caused by medications, radiation burns and even constipation.

About one third of cancer survivors in the United States—about 5 million people—have chronic pain on most days or every day, a 2019 study in JAMA Oncology found. For about half of these individuals, the pain is “high-impact,” which limits personal or work activities.

One reason for the rising numbers is, ironically, treatment success—many people with cancer now live much longer than they would have 10 or 20 years ago. “It’s great to get extra time in your life, but it means you have to manage your pain for longer,” says Marcin Chwistek, MD, director of the pain and palliative care program at Fox Chase Cancer Center in Philadelphia. “Pain becomes part of the whole experience of having cancer.”

Pain is often undertreated. More than a quarter of cancer patients receive substandard care for their pain, research shows, often because of a lack of insurance. Complicating the picture, our national battle against opioid addiction has unduly restricted access to opioid painkillers for some people with cancer.

If you are experiencing cancer pain, especially if it's chronic, it's important to know that treatments and supportive approaches can bring relief and promote a better quality of life.

When Opioids Are Needed

Opioid pain relievers, such as morphine and oxycodone, have long been a cornerstone of treatment for moderate to severe cancer pain. "Doctors prescribed them without a great deal of worry," says Diane M. Novy, PhD, a psychologist in the department of pain medicine at the University of Texas MD Anderson Cancer Center in Houston. There once was a mistaken belief that patients taking opioids for cancer pain couldn't become addicted.

They can. But addiction is chiefly a risk for people with cancer who already have had a substance use disorder or those who take them for non-pain reasons, such as anxiety.

Experts also stress that there is a key distinction between physical dependence and addiction. Physical dependence on opioids starts after a week or two of use; to stop taking them, you'll need to be weaned off or you'll experience withdrawal symptoms. "That happens to everyone, and it's not addiction," explains Chwistek. Addiction is a more complex disease, he says, "when you really lose control over the medicines."

Some people with chronic cancer pain need to use opioids for long periods of time, and this can be done safely. Just ask Heather Von St. James, of Roseville, Minnesota. She underwent extensive surgery for malignant mesothelioma in 2006 that removed her left lung, the lining of her right lung and heart, half of her diaphragm and a rib. While in the intensive care unit, she was on morphine and then was given oxycodone for the rest of her hospitalization and recovery.

About a month later, she tried to go off the opioid but had severe pain that non-opioid medications couldn't relieve; acetaminophen combined with an opioid helped.

Radiation followed. She was left with intense pain, "like a big steel band around my chest." That pain persists today. Oxycodone relieves it and allows her to be active and do advocacy work for mesothelioma. Opioid medicine "doesn't make me ditzy or loopy," she says, noting that she's been on the same dose for 13 years. "I have good quality of life because of it."

Unfortunately, national efforts to overcome opioid addiction have created barriers for some people with cancer. A survey conducted for the Cancer Action Network, the advocacy arm of the American Cancer Society, reported that cancer survivors had more trouble getting opioids from pharmacies in 2018 compared with 2016. They faced extra questions, were told the medicine was not in stock, were given only partial supplies or were denied outright.

Prescribers get warning messages from insurers when opioid prescriptions exceed recommended limits, even if appropriate. "I can almost always get the medication approved for a person with cancer. It's just jumping through the hoops that creates a delay," says Judith A. Paice, PhD, RN, director of the cancer pain program at Northwestern University's Feinberg School of Medicine.

The outcry over these barriers has led the Centers for Disease Control and Prevention to clarify its guidelines. The updated version emphasizes that patients with acute or chronic pain from cancer (or sickle cell disease) should have access to “clinically appropriate opioid therapy.”

Managing Pain with Fewer Opioids

Opioids do come with serious side effects, even for patients at low risk for addiction. “They dampen mood, the immune system, bowel motility and cognitive ability,” Novy says. Before prescribing an opioid, clinicians these days may first advise taking non-opioid painkillers: acetaminophen; nonsteroidal anti-inflammatory drugs (NSAIDs), such as aspirin and ibuprofen; antidepressants; and steroids. Gabapentin, an anticonvulsant, can help with neuropathic and surgical pain. For some people with chronic cancer pain, according to a 2019 review study in the Journal of Clinical Oncology, non-opioid medications can be as effective as opioids.

But NSAIDs, and even acetaminophen, aren’t right for people with cancer who have some conditions or are receiving certain treatments. “We have to carefully examine the risks and benefits of every pharmacological agent when we’re developing a plan of care,” says Paice.

Medical marijuana (cannabis) may also help. There is evidence that it may relieve mild to moderate cancer pain, especially neuropathy, although scientific randomized clinical trials are lacking. “We don’t go to it as a first-line therapy because there is not enough evidence,” Chwistek says. While cannabis is unlikely to stop severe pain, it might lessen it so people could take less opioid medication. It’s generally wise to start with a small dose, see the effects and then, if needed, slowly increase.

Interventional procedures can also be effective. Nerve blocks stop pain messages from getting to the brain. Vertebral techniques strengthen spine bones fractured by cancer. Embolization stops blood flow to reduce painful tumors. Ablation therapies using radiation remove tissues causing pain and can often result in complete pain remission (See “Riding With Reindeer”).

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Create a Pain Management Plan

The first step is to overcome any reluctance to talk with your health care providers about pain, so you can get the right medications or therapies and remove barriers to care.

Doing so will not only improve your quality of life but may also help you stick with your cancer treatment plan. Work with your oncologist as well as pain medicine or palliative care teams to develop an integrated pain management plan that works for you. Revise it as needed.

If you have pain, don’t ignore it. Speak up—at every visit. Keep track of daily pain in a log. Record when the pain happens, where it’s located, what causes it and what it feels like—throbbing, tingling, burning, pressing, shooting or something else. Tell your doctor or nurse if pain is interfering with your quality of life, including the ability to work, enjoy personal life and take care of yourself.

Check your health insurance to see whether it covers supportive therapies. “It’s difficult to get more than a few sessions of physical therapy, occupational therapy, psychological counseling or integrative measures like acupuncture or massage paid for,” Paice says. She would like to see that change. “In the best of all possible worlds, we would incorporate all of that into the treatment plan.”

Complementary Therapies for Cancer Pain

In clinical studies, these nondrug, noninvasive approaches have been shown to help with cancer pain:

- This approach, which trains people

  to regulate brain waves, can reduce pain from peripheral neuropathy.
- Scrambler therapy uses electrical stimulation to reorganize pain signals. Small studies show

  positive results; more research is under way.
- Acupuncture, massage, meditation, mindfulness-based stress reduction and yoga have all been

  shown to help with cancer-related pain.
- Staying active. When Heather Von St. James exercises and is active, she doesn’t need pain

  medicine as often during the day. “I think my mind is more preoccupied,” she says. She still

  needs medication before bed and when she wakes up.
- Cognitive behavioral therapy and other psychological therapies help people learn to pace

  activities, relax and challenge fearful thinking about pain, which can make it worse.

Pain psychologist Diane Novy, PhD, also encourages those with cancer pain to eat nutritious foods, follow good sleep habits and pursue activities they enjoy and find meaningful. “Having zero pain may not be realistic at all,” she says, “but there are many things you can do for yourself to make pain less severe so it won’t take up as much space in your head.”
