In addition to describing the steps doctors should take when assessing pain and determining whether opioids are appropriate, the new document gives doctors some advice on spotting a person who is likely to abuse or divert drugs. It also clarifies the differences between true drug addiction, and drug tolerance or physical dependence.

The distinction is important, said Joranson, because fear of addiction keeps so many people from getting proper pain relief. People who use opioids may well become physically dependent over time—if they quit the drugs abruptly, they will experience withdrawal symptoms. Or they may develop a tolerance to the drug, requiring higher doses to achieve pain relief. But those conditions aren’t the same as addiction.

“Addiction is a much more complex disease that occurs in vulnerable people due to genetics, biology, environment,” he said. “It involves maladaptive behaviors and a compulsive need to continue using these drugs for nonmedical purposes.”

The World Health Organization and major national and international scientific organizations have recognized the difference between addiction and physical dependence, Joranson said. Yet misperceptions persist.

“Every clinical panel has always said the risk of addiction is so low in patients with cancer that it really shouldn’t be a consideration, yet people continue to be concerned and the reason for that is they don’t understand addiction,” he said.

Simmonds agreed. “People think if they become tolerant they will eventually become addicted, or that there won’t be a sufficient dose to relieve their pain,” she said, “and that’s not true.

“All these myths are in everybody’s mind and they’re fearful of taking medication. But for moderate to severe pain, a nonopioid is not going to be potent enough and there’s no need to suffer.”

Cancer pain is complex, Simmonds said. It can involve multiple types of pain in the same person for different reasons, and may even be combined with pain from other conditions. A patient may need to try different dosages or different medications, or combine medications to achieve relief.

The document encourages patients to talk openly with their physician about their level of pain, and to seek out a doctor who takes these concerns seriously. Patients should tell the doctor if the medication isn’t working or if it causes problematic side effects.

People seeking pain relief must also understand that doctors have certain procedures they need to follow in order to stay within the law.

“Doctors act in ways that patients may see as capricious or idiosyncratic,” Portenoy said, “when really it’s that the doctor needs to be sure he’s acting with the right documentation and within the parameters of the law.”

MRI FINDS BREAST CANCER IN HIGH-RISK WOMEN

Magnetic resonance imaging (MRI) can detect breast cancers mammograms miss in women at increased risk, according to Dutch researchers. Their finding, published in the New England Journal of Medicine (2004;351:427–437), lends support to the notion that screening with both methods may be a better option for high-risk women than using either one alone.

“These new investigations expand our knowledge in a very important area, which is how to screen for breast cancer in very high-risk groups,” said Robert Smith, PhD, Director of Cancer Screening for the American Cancer Society. “At this point in time, the amount of information we have is quite thin with respect to age to begin screening and the best way to screen in women who are at higher risk.”

Annual screening with mammography is already recommended by the American Cancer Society and other organizations for women
aged 40 and older at average risk of getting breast cancer. But for women at high risk—those with a strong family history of the disease or with a genetic mutation that predisposes them to breast cancer—that schedule may not be enough.

These women are at greater risk of developing breast cancer before age 40, when regular screening would ordinarily begin; or they may have cancers that grow very fast, developing in between mammograms. Moreover, mammograms are less effective in younger women because their breast tissue is denser, making the images harder to read. And in some cases, the types of tumors high-risk women develop are less identifiable by mammography.

ACS guidelines advise high-risk women to discuss with their doctor other screening methods—like MRI or ultrasound—that can be used to supplement regular mammography. Beginning screening at a younger age or screening more frequently are also options.

Mieke Kriege, MSc, of the Rotterdam Family Cancer Clinic at Erasmus Medical Center, and colleagues from a number of Dutch centers, recruited 1,909 women at increased risk for breast cancer because of a family history of the disease and/or a genetic mutation. The women were given a physical breast exam by a doctor every six months, and a mammogram and MRI scan every year.

Fifty breast carcinomas were found within a median follow-up period of 2.9 years. For 45 of these, sufficient data were available for comparison of mammography and MRI. MRI found 32 tumors, of which 22 were not visible on the corresponding mammogram. Overall, mammography detected 18 tumors, of which eight were not visible with MRI. Mammograms were better able to find cases of ductal carcinoma in situ (DCIS); five of six DCIS lesions were identified by mammogram. MRI found only one of six DCIS cases, but it was the one missed by mammography.

The tumors found in women who participated in this study were significantly smaller and less likely to have spread to axillary lymph nodes than those found in two age-matched control groups of women with breast cancer.

“Our study shows that the screening program we used, especially MRI screening, can detect breast cancer at an early stage in women at risk for breast cancer,” wrote Kriege and colleagues.

They do not suggest, however, that MRI is an appropriate screening tool for women at average risk of developing cancer.

For one thing, the cost of MRI is about $1,000 to $1,500, compared to $100 to $150 for a mammogram. And MRI has a higher rate of false-positive results than mammography, leading to costs, discomfort, and anxiety associated with unnecessary follow-up procedures.

“In our study, screening by MRI led to twice as many unneeded additional examinations as mammography (420 versus 207) and three times as many unneeded biopsies (24 versus 7),” the researchers wrote.

Those drawbacks make MRI impractical for use on women who aren’t especially likely to develop breast cancer. For women at high risk, though, the trade off is more balanced.

“The fact that the rate of false-positives is higher [with MRI] is of very little consequence to women at high risk,” said Smith. “Everyone would like to avoid a false positive, but the greater priority is to detect breast cancer early.”

Although the findings are not definitive enough to make explicit recommendations that high-risk women begin screening at a particular age and with a particular method or combination of methods, Smith said, the study lends support to the ACS guideline for high-risk women to consider supplementing regular mammography with MRI.

“The current thinking is that mammography plus MRI offers greater advantages to younger, very high-risk women than either...
modality alone,” he said. “The more we learn about which tumors MRI detects and which it does not detect, and how we account for failures in both modalities to detect breast cancer early, the greater the potential for establishing tailored [screening] regimens for high-risk groups that will be more effective.”

Improving screening in this group of women could have important long-term implications, Smith noted. Many women who know they are at very high risk of developing breast cancer choose bilateral prophylactic mastectomy and/or oophorectomy to reduce the chances they will get cancer. Better screening could allow some women to choose more intensive surveillance, or postpone the decision about prophylactic surgery to a later time.

“The more we learn about early detection [in this group of women], the more we may gain confidence that more intensive, regular screening is a viable and perhaps even competing option to other, more difficult and nonreversible decisions such as prophylactic surgery,” he said.

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