Pain control—a basic kindness

Annie Cavanagh, Wellcome Images

Morphine crystals

For **information on nurse and pharmacist prescription of analgesics** see http://www.dh.gov.uk/health/2012/04/prescribing-change/

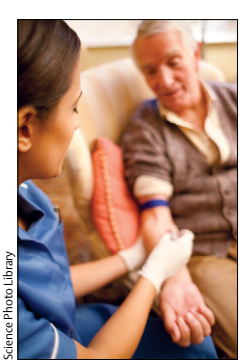
For more on **NICE guidelines on opioid prescription in palliative care** see http://www.nice.org.uk/CG140

When pain is reduced, so too is at least some of the distress associated with serious illness. The correct amount of analgesia given at the right time has a considerable positive effect on the quality of life of a patient in palliative care. Thus the introduction of independent prescribing of opioid analgesia by appropriately qualified nurses and pharmacists in the UK in April, 2012, was a welcome move, as was the publication on May 23 of new guidance on palliative pain management from the UK's National Institute for Health and Clinical Excellence (NICE). *Opioids in Palliative Care* is particularly commendable for its emphasis on the need to communicate the risks and benefits of opioid drugs to patients and their relatives, and for its call for further research into patients' concerns and the best ways of delivering information.

Prescribers, too, need information and reassurance. In launching the guidelines, NICE highlighted evidence suggesting "that pain caused by advanced disease remains under-treated", as well as the "reservations" that some health-care professionals have about giving strong opioids. The reasons why health-care workers are reluctant to prescribe opioids to patients who need them are unclear. It has been suggested that the lethal use of opioids by Harold Shipman might be a factor, as well as the well-publicised role of opioid over-prescription in medical negligence cases. In other words, opioid drugs are suffering from guilt by association. But there is nothing intrinsically wrong with giving opioid drugs: it is all a question of appropriate use.

Health-care workers may also be worried that, even if they prescribe responsibly, opioid painkillers lend themselves to misuse. This is a legitimate concern: but physicians must read the evidence, and apply it humanely for the individual patient's benefit. Prescription drug misuse should be prevented, but the comfort of seriously ill patients cannot be sacrificed for fear of it. Though some patients may be beyond hope of cure, they are not beyond care. Opioid prescription in such cases is not just medical treatment: it is basic human kindness. ■ *The Lancet*

To screen or not to screen for prostate cancer?



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For **USPSTF recommendations** see http://www.annals.org/content/early/2012/05/21/0003-4819-157-2-201207170-00459?aimhp

For **AUA statement** see http://www.auanet.org/content/media/USPSTF_AUA_Response.pdf

For the **Johns Hopkins Community Physicians survey** see http://archinte.jamanetwork.com/article.aspx?doi=10.1001/archinternmed.2012.135

Does earlier diagnosis lead to better clinical outcomes? Many physicians and patients will probably answer yes. Thus screening tests are commonly done with good intentions of enabling earlier intervention and management to reduce mortality and suffering. However, inappropriate screening can harm healthy people as a result of overdiagnosis, overtreatment, and negative psychological effects. Prostate-specific antigen (PSA)-based prostate cancer screening is a case in point.

Prostate cancer often has an indolent natural history, and patients are more likely to die with than to die from the disease. There is reliable evidence that PSA testing results in considerable overdiagnosis and overtreatment of men with prostate cancer, while associated potential harms include pain, fever, bleeding, infection, and transient urinary difficulties resulting from prostate biopsy, as well as erectile dysfunction, urinary incontinence, and bowel dysfunction.

On May 22, after reviewing the evidence on both benefits and harms of PSA testing, the US Preventive Services Task Force (USPSTF) concluded that the reduction in prostate cancer mortality after PSA testing was very small and that the benefits did not outweigh the harms. Their recommendations are against PSA-based screening for the general US population of men at any age. Not surprisingly, the USPSTF recommendations have ruffled the feathers of some physicians. The American Urological Association (AUA) was outraged and released a statement disputing the recommendations. Furthermore, a survey of 125 primary care physicians and nurse practitioners from Johns Hopkins Community Physicians found that fewer than 2% of participants planned to follow the recommendations and completely stop ordering routine PSA-based screening.

Although substantial changes to clinical practice may be unlikely in the USA, the recommendations create an opportunity to raise public awareness about the PSA test. Men concerned about prostate cancer should be informed of benefits and harms of the PSA screening prior to the test, so they can be empowered to make better shared decisions about their care and treatment with their physicians. ■ *The Lancet*