Commentary

Commentary on Alsirafy *et al.* The use of opioids at the end-of-life and the survival of Egyptian palliative care patients with advanced cancer

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Alsirafy and colleagues (1) present an insightful article on the use of opioids at the end-of-life for Egyptian palliative care oncology patients and their length of survival. Myths of opioids are commonplace around the world, especially in areas where there are negative historical contexts related to opioids or where opioids are not available (and thus the benefits are not obvious). In Egypt, opioids are available, but myths persist. The authors address one of the main myths in their culture, that the use of opioids will hasten death.

Using a unique dataset of 123 patients the authors are able to study the effect of opioid use on cancer patients at the end of life. These patients received care were all diagnosed with terminal cancer and they received care in a palliative care unit in an Egyptian cancer center. Three groups of patients were identified: those with no or low-opioid use, intermediate use, and high-dose use. Findings from the study suggest that the myth that opioid use hastens death is unfounded. Opioid use was commonplace for the 123 patients. The estimated median survival was roughly three times higher for the high-dose group than the group with no or low doses.

This study has important practice and policy impacts. First, this study adds to the literature on opioid use overall, but makes a significant contribution since the evidence from lower income countries is generally not as well established as compared to higher income countries. Lack of evidence is also compounded by the fact that oftentimes when advocacy groups or international professional organizations address opioids, they tend to focus lower income or developing countries that have no access to opioids. While this is a serious issue that can lead to unneeded suffering, it is also the case that even in countries where opioids are available they may not be used in an appropriate manner. This is also critical to address. What good is it to have access to these medications if health care providers, or even patients, are hesitant to use them? Evidence on the association between opioids and increased survival should be presented to clinical champions and action plans should be developed to debunk the myth. Second, policy makers should be aware that having access to opioids is only half the battle. Policy makers should also use policy levers to ensure that opioids are being used appropriately and in a timely manner. These policy levers might include formularies, reimbursement, utilization review, etc.

As the authors suggest, further research is needed and included in that research should be a thorough review of the policies and protocols of opioid use at the national, local, and institutional levels.

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References

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