Safe Use of Opioids to Manage Pain in Patients With Cirrhosis

To the Editor: The duty to relieve symptoms, safely, is a preeminent one of health care professionals. We appreciate the concerns of Chandok and Watt about the need for cautious use of opioids, particularly in patients with advanced liver disease. Indeed, we concur that caution should be exercised by all health care experts in use of therapeutics. However, we have concerns with the recommendations by Chandok and Watt regarding opioid use. Although the fear of precipitating encephalopathy or causing excessive sedation is real, an equally cogent concern is that this fear may result in less-experienced practitioners thinking that pain must be experienced regardless, or that opioids are not safe to be used in patients with cirrhosis. Medically appropriate pain management to improve function and quality of life is acceptable for patients before they undergo transplant. For those unsuitable for transplant (up to 85% of patients), palliative care and occasionally hospice are appropriate for many. Opioids can be used safely to relieve pain and dyspnea, even in those with advanced liver disease (as well as advanced renal, pulmonary, and cardiac disease), and are preferred to nonsteroidal anti-inflammatory agents or other drugs, especially for moderate to severe pain. In our diverse and varied practices, we routinely use low doses of opiates such as intravenous fentanyl (with its short half-life) or oral or parenteral hydromorphone (which has less hepatic clearance than morphine) and believe that this can be done safely. The clearance of these drugs is reduced in patients with liver failure; thus, the initial dose may need to be lower, the interval between the doses may need to be increased, and such patients will need to be assessed on a regular basis. The effect of opioids can always be reversed with naloxone, but the effect of undertreated or untreated pain on patients (or the patient’s family) cannot. Effective palliative care and pain management involve 3 key components: (1) open and honest communication about the illness, options, and medically appropriate goal setting; (2) careful attention to symptom assessment and management; and (3) appropriate care of the family, including medical, psychosocial, spiritual, and other concerns. These components are completely congruent with the best practices in hepatology.

We are concerned by the message conveyed by Chandok and Watt with blanket statements such as “opioids can have deleterious effects in patients with cirrhosis…and thus they should be avoided in patients with cirrhosis,” because these statements can be misleading, particularly to clinicians-in-training, and can precipitate excessive fears regarding opioid use. Long-acting opioids may be appropriate for chronic pain in patients with cirrhosis, once a safe and effective dose of short-acting opioids has been established. We disagree with the authors’ recommendations for starting transdermal, continuous-release fentanyl for intractable pain (suggested in Figure 2 of their article as an acceptable “first-line” option comparable to low-dose oral hydromorphone), because introduction of a fentanyl “patch” would not be prudent until opioid requirements have been determined for the individual patient by titrating short-acting opioids to symptom relief.

Furthermore, claims of “any sign of [sedation, constipation, or early encephalopathy] necessitates immediate discontinuation of the opiate” are misleading. Indeed, in a reference cited by Chandok and Watt, those authors note that “were alternative analgesia not available, [patients] should be prescribed lower doses of opioids, with extended dosing intervals.” Clinical context is required in all these settings, and we concur that it is likely that clinical prudence may suggest titrating opioid doses downward, increasing dosing interval, or rotating to an alternative agent as appropriate options, rather than abruptly discontinuing opioid therapy. This is particularly critical in an end-of-life situation or when opioids have been used for a longer period, because abrupt discontinuation may not only precipitate pain but also opioid withdrawal symptoms.

End-stage liver disease (cirrhosis) is incurable and irreversible, although patients can be kept “compensated” and have good quality of life. Quality of life can be maintained only if pain and non-pain symptoms are aggressively addressed and managed. Recommendations presented by Chandok and Watt can easily be taken out of context and can perpetuate fear and lack of understanding of opioids in the non-pain and palliative care community. This fear may lead to suboptimal treatment of pain and increased suffering in this fragile patient population.

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