

MISCONCEPTION	CORRECTION
1. Taking opioids for pain relief leads to addiction.	Addiction occurring as a result of taking opioids for pain relief is rare (<1%).
2. How much analgesia opioids can produce is limited.	The dose and the analgesic effect of mu agonist opioids have no ceiling.
3. Not all pain responds to opioids.	All pain responds to opioids, but some types of pain are more responsive than others. Opioids are particularly effective in relieving visceral and somatic pain and less effective in relieving neuropathic pain. Although a number of factors can affect opioid responsiveness, no evidence exists that any characteristic of the pain or the patient causes uniform opioid resistance.
4. Opioid treatment should be withheld in the early stages of disease to prevent the development of tolerance and lack of analgesia in the later stages.	Tolerance should be expected after several days of opioid treatment, but thereafter the dose usually stabilizes if pain is stable. In addition, tolerance is treatable, usually by increasing the opioid dose; no ceiling to the analgesia of opioids exists, and residents develop tolerance to respiratory depression. Clinicians should not withhold opioid treatment from residents with long life expectancies or delay initiating opioid therapy for fear of encountering unmanageable tolerance.
5. The more potent opioids are the more therapeutically superior opioids.	Potency does not determine efficacy. Potency can be viewed as the ratio of the dose of two analgesics required to produce the same analgesic effect. All mu agonist opioids are capable of producing the same degree of analgesia when given at equianalgesic doses. Increased potency alone does not provide any advantage because the more potent drugs also exhibit a parallel increase in their ability to produce undesirable effects.
6. When pain is no longer relieved by a given opioid dose, the opioid should be discontinued to allow the receptors to “reset” and become more sensitive to opioids.	Continued stimulation of opioid receptors does not result in desensitization. Stopping the opioid will not make the receptors more sensitive to opioids. When a given dose is safe but ineffective, the dose should be increased by appropriate percentages, keeping in mind that no ceiling to the analgesia of mu agonist opioids exists.
7. Opioids frequently cause clinically significant respiratory depression.	Opioid-induced respiratory depression is rare if opioid doses are titrated slowly and decreased when increased sedation is detected. Clinically significant opioid-induced respiratory depression can be avoided in opioid-naïve residents by careful nurse monitoring of sedation levels. Tolerance to the respiratory depressant effect of opioids develops within 72 hours of administration. Therefore in residents who have been taking opioids on a long-term basis a wider margin of safety exists. The fear of causing death from respiratory depression by administering opioids to the terminally ill also is exaggerated. Large doses of opioids given to relieve pain during the withholding and withdrawal of life support in terminally ill residents does not hasten death.
8. Agonist– antagonist opioid analgesics are safer than other opioids because they do not produce respiratory depression and will prevent addiction and discourage drug-seeking behavior.	At equianalgesic doses all opioids cause equal respiratory depression. The agonist-antagonist opioid drugs have a ceiling for the amount of analgesia and respiratory depression they cause (i.e., beyond a certain dose no further respiratory depression or analgesia is produced), but this is usually above recommended doses. Furthermore, respiratory depression is not readily reversed by naloxone in buprenorphine. Agonist-antagonist opioids can produce significant sedation and extremely unpleasant dysphoria. Addiction is no less likely with agonist-antagonist drugs than with other opioids. Finally, the practice of administering agonist-antagonist opioid analgesics to known drug abusers to discourage drug-seeking behavior is not appropriate because it may precipitate withdrawal. Because agonist-antagonist drugs antagonize at the mu opioid receptor site, they should be avoided in residents who are physically dependent on opioid drugs.
9. Endorphins and enkephalins are effective analgesics.	Endorphins and enkephalins bind to opioid receptor sites and prevent the release of the neurotransmitters, thereby inhibiting the transmission of pain impulses. Unfortunately, endogenous opioids degrade too quickly to be considered useful analgesics. Although administering morphine and other opioids probably temporarily decreases production of endogenous opioids, belief that use of opioids, such as morphine, should be avoided for this reason is unfounded.