

The Challenges of Cancer Pain Assessment and Management

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Accepted 12 October 2011

Approximately one quarter of the world's population will develop cancer at some point in their lifetime. A high proportion will experience associated pain.^{1,2} Despite the World Health Organisation (WHO)'s assertion that over 80% of cancer pain is responsive to inexpensive oral medication,³ research suggests it remains undertreated in both the developed and the developing world.¹ To understand why, it is necessary to identify the ongoing challenges in the assessment and management of cancer pain, and recognise the complex nature of all pain and of cancer pain specifically.

Pain is often defined as 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage'.⁴ One of the challenges in addressing pain is negotiating this triad of sensory, emotional and physical (or quasi-physical) dimensions. On an even more fundamental level, the essentially experiential nature of pain makes it profoundly challenging to define and to assess. By its very nature we cannot know someone else's pain, nor as doctors can we capture it with imaging techniques, biochemical tests or other medical means. In this sense the more colloquial definition of pain as 'what the patient says it is' may be more pragmatic.

Attempting to define cancer pain as a specific subset of pain more generally is problematic. There really is no homogenous entity of 'cancer pain'; pain in cancer can encompass the full range of physiological subtypes (nociceptive, neuropathic, visceral, somatic), and be inflected by a multitude of emotional, psychological and spiritual factors. If there is anything unique about cancer pain, it may be the heightened role which these non-physiological dimensions play; pain in cancer is often tied up with concomitant psychosocial upheaval and existential anxiety. To many cancer sufferers, their pain has a 'sinister meaning' over and above its inherent unpleasantness as a sensory experience.¹

The first key issue in assessing cancer pain is communication, and patients identify this as a major concern.⁵ Quantitative and qualitative assessment of cancer pain relies primarily on patient description.⁵ Methods for assessing pain severity focus on self-reported rating scales (e.g. visual analogue scales, McGill Pain Questionnaire) and/or on functional aspects such as interference with sleep or impairment of daily activities.^{2,5} Similarly, information about the physiological origin of a particular pain comes from a good history. (For example neuropathic pain might be described as 'burning' or 'shooting', as distinct from the 'ache' or 'throb' of somatic nociceptive pain). Being able to differentiate pain in this way is key in identifying and treating any reversible underlying causes, and in selecting appropriate analgesic agents and adjuvants.

The most obvious challenges to communication arise when the patient is cognitively impaired, or unable or too ill to express him/herself.⁵ But there are also more subtle challenges to effective communication, arising from the relationship between the clinician and the patient on an interpersonal level. In the context of cancer, there may be particular challenges involved in establishing good therapeutic relationships. There are often heightened emotions and fears, doctors are often the bearers of bad news, and there may be ambivalence surrounding the fact that some of the pain and distress experienced may be due to medical interventions such as surgery, chemotherapy or radiotherapy.² Openness, honesty and empathy are essential to establish the trust necessary for effective communication.

Where it is achieved, good communication promotes concordance with medication⁵ and can help overcome negative misconceptions about analgesics, which sometimes limit their uptake (for example fears about opioid addiction or side-effects⁶). It may also combat under-reporting of pain arising from the desire to be a 'good' (ie uncomplaining) patient, or from fear and denial due to the belief that increasing pain implies disease progression.^{5,6}

In practice, because cancer care increasingly takes place in the community, the role of family and other lay carers in the assessment and management of cancer pain is often substantial, whether or not there is a specific impairment of the patient's ability to communicate.⁶ Caregiver's attitudes to cancer pain and its management have been shown to have a significant influence on the patient's experience of their disease.⁶ The challenge for the clinician, therefore, is to foster understanding and build up a relationship not just with the patient but also with his/her family or carers.⁵

When it comes to the pharmacological management of cancer pain, the standard approach follows the WHO's 1986 cancer pain relief programme, including the three step analgesic ladder.^{5,7} As simple as this may seem, in practice there are a range of difficulties for the clinician. Firstly, as discussed, cancer sufferers experience many different physiological types of pain. Furthermore, many cancer patients have multiple pains; research suggests one third have a single pain, one third have two separate pains, and one third have at least three different pains.¹¹ The clinician needs to be able to differentiate

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these and select appropriate adjuncts and combinations of analgesics. Dosing can also be complicated, particularly for opioids, as there is no standard dose and no set upper limit.^{3,7} A regimen to control both background and breakthrough pain is often necessary, and this must be tailored to the individual and adjusted over time if pain levels change.⁵ The clinician must also be able to adapt medications for different routes of administration if oral intake is not possible.

Sadly, in many resource poor countries, the primary challenge to implementing the WHO's recommendations is access to the drugs, in particular opioids.^{1,8} This is in part a by-product of international narcotics control measures, and local policymakers' fears about diversion and addiction.⁸ In some countries the prevailing medical culture is uncomfortable or unfamiliar with opioid use, and there is often a deficiency of clinicians with the necessary knowledge of pain management.^{1,8}

As well as pharmacological means, the clinician may also need to consider interventions such as surgery, radiotherapy or chemotherapy in order to control pain.⁵ This can raise complex dilemmas about a patient's fitness, overall treatment intent, and the relative merits of the different approaches.

With any intervention, pharmacological or non-pharmacological, there is the question of balancing benefits and side-effects. (Radiotherapy may relieve pain from bone metastases, but might also cause a painful skin reaction.) It is also important not to equate pain relief alone with improved quality of life. For example, large doses of opioids may be needed to eliminate pain in some patients, but this can induce considerable levels of sedation. For some this may be an undesirable trade-off. As the poet Byron put it, 'the great object of life is sensation, to feel that we exist, even in pain'.⁹ For many patients maximising analgesia might still be preferable; balancing the wishes of the individual is key.

Perhaps the greatest challenges for the clinician dealing with a cancer patient in pain lie beyond traditionally medical problems. WHO guidelines state that 'relief of psychological, social and spiritual problems is paramount' and furthermore 'attempting to relieve pain without addressing the patient's non-physical concerns is likely to lead to frustration and failure'.⁷ What is required is holistic care. Part of such an approach is an empathetic therapeutic relationship, as discussed above, which by necessity incorporates an appreciation of the psychosocial dimensions of the experience of cancer.⁵ There may also be a role for interventions such as antidepressant medication, or referral for cognitive therapy.⁵ It is essential to co-ordinate care with a multidisciplinary team that may include physiotherapists, occupational and speech and language therapists, social workers etc.⁵ Clinicians should be aware of and sensitive to a patient's spiritual or religious beliefs, and where appropriate facilitate input from chaplains or others who can provide spiritual support.⁵

Indeed one of the challenges for clinicians in these situations may be recognising that ultimately there are some aspects of cancer pain management that do not fall within the remit of the medical profession. As critics like Ivan Illich have argued, while modern medicine is often very good at the physiological relief of pain, it is very limited in its ability to elucidate meaning in human suffering.¹⁰ Research has reinforced the

idea that people need 'a sense of meaning to life' to be able to cope with their cancer and sometimes its treatments.⁵ This is especially true in palliative care. In response, it is important to avoid over-medicalisation, in order to allow room for other kinds of coping and meaning-making. Good pain relief should facilitate the patient in his/her own ways of dealing with the experience of cancer.

In conclusion, the challenges to the assessment and management of cancer pain are multifarious. They include establishing good communication and a positive therapeutic relationship with patients and their carers, and overcoming ambivalences about medical intervention and popular misconceptions about analgesics. Shortage of opioids is a serious problem, the solutions to which may be as much political as medical. Even where all options are available, a sophisticated approach to choosing treatments is required, and to be effective, cancer pain management must be holistic, involving a multidisciplinary team and taking cognisance of the psychosocial and spiritual dimensions of the patient's experience. Finally, it is essential, if not always easy, to recognise that medical management of pain should not be an end in itself, but should be conducive to improving the overall quality of life of the patient.

The author has no conflict of interest.

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