Management of cancer pain is still a significant problem in healthcare today despite the fact that cancer pain can be controlled in approximately 90% of patients. Emotional, psychosocial, and spiritual suffering associated with the disease complicates the problem. Guidelines issued by the Agency for Healthcare Research and Quality address management of cancer pain. Pain intensity scales, complementary and alternative methods, and the role of the interdisciplinary care team, as well as the need to provide spiritual support to the patient and family, are included in the discussion.

"Freedom from pain should be seen as the right of every cancer patient and access to pain therapy as a measure of respect for this right."
—World Health Organization

Cancer” and “pain” have become almost synonymous as pain is one of the most feared side effects of cancer, both for the patient and the family. Personal and professional experiences have led the author to champion the cause of ensuring that every patient has access to palliative care and every healthcare professional understands those factors contributing to overall suffering. It is encouraging to see that now most of the healthcare community is viewing the successful treatment of patients with cancer pain as a mandatory aspect of care.

The standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) call for healthcare providers to:
- Recognize the right of patients to have appropriate assessment and management of pain;
- Assess the existence and, if so, the nature and intensity of pain in all patients;
- Record results of the assessment in a way that facilitates regular reassessment and follow-up;
- Determine and assure staff competency in pain assessment and management, and address pain assessment and management in the orientation of all new staff;
- Establish priorities and procedures that support appropriate prescription or ordering of effective pain medications;
- Educate patients and their families about effective pain management; and
- Address patient needs for symptom management in the discharge planning process.

Pain affects each person differently. Factors such as age, personality, perception, pain threshold, and past experiences with pain should be considered in the assessment. Psychological factors such as fear, worries, concerns about their loved ones, or knowledge of impending death can also influence pain. Insomnia, fatigue, and anxiety may lower the pain threshold, whereas rest, sleep, pastoral counseling, and diversion can raise it.

Physicians should give special attention to certain patient populations, including the very young and the very old, those cognitively impaired, known or suspected substance abusers, and non–English-speaking persons.

When developing a pain treatment plan, physicians should be aware of unique needs and circumstances of patients from various ethnic, religious, and cultural backgrounds. Elderly patients should be considered at risk for undertreatment of pain. Many elderly people think their pain is “just a part of growing old.” Religious influences may perpetuate a belief that suffering is a penance for sins of the past. All healthcare professionals must recognize that uncontrolled pain is a contributing factor to feelings of hopelessness, suicidal ideation, and at the extreme, requests for physician-assisted suicide or euthanasia.

As comprehensive as pain assessment tools may be, patients often hesitate to mention that they are in pain. Many psychosocial reasons account for this failure in communicating. Patients may think that they will be perceived as weak, or they may fear “addiction” to pain medication. Many think that pain is to be expected and nothing can be done about it. Frequently, patients say “the doctor should know I have pain,” or if “the doctor thought I needed something, the doctor would have ordered it.”

In an effort to address these issues, The Agency for Healthcare Research and Quality (formerly the Agency for Healthcare Policy and Research) issued the following guidelines:

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Elizabeth Kubler-Ross, MD, noted fear of pain as being universal when a patient is facing impending death. I have seen that fear in most patients whom I have admitted to hospice. Many have endured long bouts of chemotherapy and radiation and suffered not only from effects of the disease, but also from treatment modalities that have failed them. Family members, already exhausted as caregivers, fear they will be forced to witness a painful decline. It is my practice not to wait for the question patients and families are afraid to ask, but rather to let them know early in the discussion that though we do not have the ability to cure all disease, we do have the ability to manage symptoms that may arise as the disease progresses.

Knowing that pain will be treated as a priority and controlled—no matter what its cause or how severe it might become—comforts patients and their families. It should be reinforced, as often as necessary, that appropriate use of pain medications is not drug abuse but a legal, therapeutic, and important part of treatment. Unrelieved pain can slow healing, isolate patients from enjoying family, friends, and social events, and interfere with thinking and concentration. Pain, if not treated, is exhausting, contributing to fatigue and depression, and it can affect the overall quality of a patient’s life.

Oncology staff have contact with patients throughout the continuum of cancer care and are in an ideal position to advocate for pain relief. Studies by the World Health Organization (WHO) show that as much as 90% of all cancer pain can be relieved. Sharing this information with patients and families can provide much needed reassurance and help alleviate fears.

**Using Standard Pain Intensity Scales to Measure Pain**

An ABCDE acronym written for cancer pain provides a guideline for assessing pain (Figure 1). This guideline should be communicated to all members of the healthcare team, patient, and family. It is a contract between the physician and the patient and establishes a sense of trust and commitment extremely important for successful management of cancer pain and symptoms.

Educate patients about the need to communicate unrelieved pain, and assist with ways to report pain, such as the selection of a pain-intensity scale that can be used for this purpose.

By now, most members of the healthcare team are familiar with the numeric scale for rating pain intensity (Figure 2, top) and the Wong-Baker FACES Scale (Figure 2, bottom). Although these tools are widely used and accepted, there are some drawbacks related to interpretation. Patients often ask:

- “Do I rate my pain before or after I’ve taken pain medication?”
- “The worst possible pain I’ve ever had was related to an accident (or surgery) and not to my cancer. Does that count?”
- “If I rate my pain at 8, will medication be available to me if the pain gets worse?”

**Providing Patients With Information**

Important topics to discuss from the time patients are told they have a cancer diagnosis is the expected course of the disease and interventions that are available.
“My face feels like a 6, but I’m constipated!”

Patients may relate to a frown or tears when they are depressed or anxious about seeing the doctor. Physicians need to maintain an awareness that suffering may be emotional or spiritual. Patients may downplay the severity of their pain in the presence of family members so as not to upset them. In a clinic setting, patients may see a different healthcare professional at each visit with each physician interpreting the patient’s response differently. Adhering to the previously cited ABCDE acronym will help ensure continuity of appropriate pain management techniques while considering the differences and unique perspective of individual patients. Educating both patient and family about the need to communicate unrelieved pain in a manner consistent with their style will build the trust so critical in the physician-patient relationship.

Pain assessment in the disoriented or confused patient is challenging but necessary. Ask these patients “Yes” or “No” questions that do not require a descriptive response. If the patient is incapable of rating pain on a scale of 0 to 10, an alternative is to ask if the pain is mild, moderate, or severe. Patients who are demented or aphasic might relate more to the happy-to-sad faces scale. Healthcare providers should watch for nonverbal cues such as restlessness, agitation, excessive perspiration, pupil dilation, and anorexia.

Pain assessment in the comatose patient can be particularly difficult to determine because symptoms may be related to pain or possibly some other type of physical condition. Clues to watch for are agitation, a change in vital signs, diaphoresis, groaning, or grimacing, especially with movement.

In addition to disease progression and tumor effect, physicians also need to be aware that treatment adverse effects (eg, chemotherapy-induced mucositis or neuropathy; radiation-induced plexopathy; opioid-induced obstipation) may also cause pain.1 Most patients being assessed, especially the elderly, will report pain unrelated to the cancer, such as tension headaches, arthritis, and angina. Accurate assessment and frequent reassessment of all causes of pain are the cornerstones of effective treatment in the patient with cancer.

It is essential to make wise use of an array of pain management techniques to provide relief, ranging from medications to nondrug techniques.

In most patients, nondrug treatment modalities should be used in addition to analgesics with emphasis to the patient that they do not replace pain medication. Physicians should begin by asking the patients what usually helps with their pain and encourage them to continue using whatever that is if it is safe and not contraindicated. Patients often offer a wealth of information concerning pain-relieving techniques that work for them. Many of these techniques have been handed down through generations. Although they may have no basis in scientific fact, patients believe they work, and sometimes they do.

Although opioids, hot and cold appli-
Deep Breathing for Relaxation With the Option of Peaceful Imaging

1. Breathe in slowly and deeply.
2. As you breathe out slowly, feel yourself beginning to relax; feel the tension leaving your body.
3. Now breathe in and out slowly and regularly, at whatever rate is comfortable for you.
4. To help you focus on your breathing and breathe slowly and rhythmically:
   - Breathe in as you say silently to yourself, “in, two, three.”
   - Breathe out as you say silently to yourself, “out, two, three.”
   or
   - Each time you breathe out, say silently to yourself a word such as peace or relax.
5. You may imagine that you are doing this in a place you have found very calming and relaxing for you, such as lying in the sun at the beach.
6. Do steps 1 through 4 only once, or repeat steps 3 and 4 for up to 20 minutes.
7. End with a slow, deep breath. As you breathe out you say to yourself, “I feel alert and relaxed.”

**Additional points:**
- This technique for relaxation has the advantage of being very adaptable. You may use it for only a few seconds or for up to 20 minutes. For example, you may do this regularly for 10 minutes twice a day. You may also use it for one or two complete breaths any time you need it throughout the day or when you awaken in the middle of the night.
- If you use this technique for more than a few seconds, try to get in a comfortable position in a quiet environment.
- A very effective way to relax is to add peaceful images once you have performed steps 1 through 4 above. Following are some ideas about finding your own peaceful memories. Sometimes may have happened to you a while ago that can be of use to you now. Something may have brought you deep joy or peace. You may be able to draw on that past experience to bring you peace or comfort now.

**Think about these questions.**
- Can you remember any situation, even when you were a child, when you felt calm, peaceful, secure, hopeful, or comfortable?
- Do you get a dreamy feeling when you listen to music?
- Do you have any favorite poetry that you find uplifting or reassuring?
- Are you now or have you ever been religiously active?
- Do you have favorite readings, hymns, or prayers? Even if you haven’t heard or thought of them for many years, childhood religious experiences may still be very soothing. Very likely some of the things you think of in answer to these questions can be tape-recorded for you, such as your favorite music or a prayer read by your clergymen. Then you can listen to the tape whenever you wish. Or, if your memory is strong, you may simply close your eyes and recall the events or words.

**Figure 3.** Instructions for deep breathing and relaxation. (Adapted from Deep breathing for relaxation with the option of peaceful imaging. In: McCaffery M, Pasero C. Pain: Clinical Manual. 2nd ed. St Louis, Mo: Mosby, Inc; 1999:420. © 1999 Mosby, with permission from Elsevier.)

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much-needed sense of control and can assist in pain management through relaxation and deep breathing.

It is imperative that healthcare professionals explore the use of CAM with their cancer patients, educate them about potentially beneficial modes of therapy, though there is limited available evidence of effectiveness, and work toward an integrated model of healthcare provision.

Patients should be encouraged to use medications and other techniques to prevent pain from occurring whenever possible as an approach preferable to attempting to banish pain once it is well established. Pain is easier to prevent than to treat. Patients should be instructed to take prescribed medication when the pain is mild or anticipated rather than severe. According to principles of the WHO analgesic ladder, pain-relieving drugs should be administered by the clock rather than on an as-needed basis. The logic is to maintain reasonably constant blood levels. Provision should also be made to administer rescue doses for breakthrough pain. If possible, medication should be given by mouth, a route that is simple, convenient, cost-effective, and commensurate with patient independence and control.

Addiction is a concept still misunderstood by healthcare professionals and feared by patients. It is defined as “a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.”

Fears of creating addiction, especially in those with a terminal illness, should not be a concern in prescribing opioid doses sufficient to control pain. Patients and families need reassurance from the physician that their pain is being expertly managed. These reassurances give the patient “permission” to take those medications necessary to treat them for pain and symptoms.

Complementary modes of therapy such as guided imagery, music, aromatherapy, and meditation have been useful in helping patients prevent pain from occurring. Patients can be taught to simply close their eyes, take several deep breaths, and visualize their “happy place” when they feel anxious about pain (Figure 3).

Taking a bath, reading a favorite book, walking in nature, drinking chamomile tea, or spending time with friends can be comforting. Patients are experts about their own lives and their psychosocial-spiritual circumstances and, when allowed to express their personal preferences, beliefs, and values, will be able to identify the complementary modes of therapy that work for them.

Patients with cancer often have intense psychological and spiritual reactions to the diagnosis and ongoing fear of the disease. They suffer not only from pain related to the diagnosis, but also from symptoms such as headaches, nightmares, muscle tension, and emotional numbness. Emotional and spiritual pain can be just as debilitating as physical pain. Antidepressants, in addition to being a good adjuvant to treat patients in pain, will also treat patients for depressed mood, fatigue, concentration difficulties, insomnia, and other physical symptoms that accompany anxiety and depression.

An often-overlooked aspect of cancer treatment is care of the human spirit. If nurtured, it is strong enough to sustain individuals when their body, mind, and emotional strength are depleted. Many hospice patients express a crisis of faith when given a cancer diagnosis. According to Torosian and Biddle in *Spirit to Heal*,11 many patients feel a sense of abandonment by God. These feelings can foster intense hopelessness and despair. Spiritual hopelessness can contribute to the overall suffering felt by those in pain. This feeling is especially true when combined with the trauma of a cancer diagnosis.

When treatment is no longer effective or the patient desires to forego treatment, hospice care, with its broad focus on the suffering of those dying and their families, is the best option. It will increase the size and capabilities of a healthcare team. Despite the best efforts of physicians, they often have little ability to reverse the course of malignant disease. Accepting that fact allows physicians to pursue the meaningful work of helping patients come to terms with their illness, develop a deeper patient-physician collaboration, and become as aggressive as necessary to manage pain and related suffering.

**Comment**

A diagnosis of cancer is frightening for many reasons. With careful attention to the pain the disease might cause, physicians can work toward removing the fear of pain from the complex myriad emotions that will eventually arise. An interdisciplinary team approach including physicians, nurses, social workers, chaplains, and physical therapists will ensure the patients are exposed to the many medications, procedures, psychological, spiritual, and complementary modes of therapy available to them.

**References**