Management of cancer pain is still a significant problem in healthcare today despite the fact that such discomfort can be controlled in approximately 90% of patients. Emotional, psychosocial, and spiritual suffering associated with this 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 an interdisciplinary care team, as well as a need to provide spiritual support to both patient and family, are included in this discussion. A case vignette describes management of cancer pain in a typical patient admitted to hospice.

“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 for both patient and family. Personal and professional experiences have led the author to champion the cause of ensuring every patient has access to palliative care, and every healthcare professional understands those factors contributing to overall suffering. Current technical expertise enables treating patients for 90% of all pain in terminal illness. Physicians have ethical, moral, and legal obligations to manage pain or to assure that the patient referred to another physician who is competent and willing to do so. It is encouraging to observe that most of the healthcare community now views successful treatment of patients with cancer pain as a mandatory aspect of care.

Standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)3 call for healthcare providers to:

- Recognize the right of patients to have appropriate assessment and management of pain;
- Assess the existence and, if present, the nature and intensity of pain in all patients;
- Record results of an evaluation in a way that facilitates regular reassessment and follow-up;
- Determine and ensure staff competency in pain assessment and management, and address these important responsibilities in orientations of all new staff;
- Establish priorities and procedures that support appropriate prescription or ordering of effective pain medications;
- Educate patients and their families about successful 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 issues such as fear, worries, concerns about loved ones, or knowledge of impending death can also influence how pain affects an individual. 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, and those who are cognitively impaired, known or suspected substance abusers, and/or non—English-speaking.

When developing a pain treatment plan, physicians should be aware of unique needs and circumstances of patients from various ethnic, religious, and cultural backgrounds. Knowledge of costs and side effects of proposed therapies are also important considerations. Elderly patients should be considered at high risk for undertreatment because many healthcare providers believe that pain is “just a part of growing old.”

Religious influences may perpetuate a belief that suffering is a penance for past sins. All healthcare professionals must recognize uncontrolled pain as a contributing factor to feelings of hopelessness, suicidal ideation, and, at the extreme, requests for physician-assisted suicide or euthanasia.

Culture has a vital influence on illness beliefs and behaviors, healthcare practices, and receptivity to healthcare interventions. Several societal worlds interact when assessing and managing pain, including cultural backgrounds of

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both patient and clinician, and professional mores associated with Western healthcare. Awareness of and sensitivity to cultural issues is key to providing effective pain management to people with cancer.

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 communication. Patients fear becoming addicted to pain medication and/or their complaints may be perceived as a weakness. 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 Health Care Policy and Research) issued the following guidelines:

- Provide patients with information about pain management options and what to expect using them.
- Use standard pain-intensity scales to measure pain.
- Believe the patient and family in their reports of pain and how best to relieve it.
- Educate patients about the need to communicate unrelied pain, and assist with ways to report pain, such as selecting an appropriate pain-intensity scale.
- Make wise use of an array of pain management techniques ranging from medications to nonpharmacologic techniques such as massage and acupuncture to provide relief.
- Encourage patients to use medications and other therapies to prevent pain from occurring whenever possible, an approach preferable to attempting to banish pain once it is well established.
- Keep checking with patients to ensure that pain reduction efforts are working well and providing adequate relief.
- Empower patients and their families to seek the best pain relief possible.

**Informing Patients About Disease Course and Symptom Management**

Important topics to discuss from the time patients are told they have a cancer diagnosis is the expected course of the disease and available interventions. Elisabeth Kübler-Ross, MD,² 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 their loved one’s 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 competence to manage symptoms that may arise as the disease progresses.

Knowing that treatment for their pain will be a priority and their pain will be 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. Unrelied pain can slow healing; isolate patients from enjoying family, friends, and social events; and interfere with thinking and concentration. Pain, if not relieved, is exhausting, contributing to fatigue and depression, and it can affect the overall quality of a patient’s life.

Oncology staff has 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.³ Sharing this information with patients and families can provide much needed reassurance and help to alleviate fears.

**Measuring Pain Intensity**

An “A B C D E” 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.

It is important to educate patients about the need to communicate unrelied 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 0-to-10 numeric scale for rating pain intensity and the Wong-Baker FACES Scale (http://www.jaoa.org/cgi/content/full/105/suppl_5/S4/FIG2).⁶

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, will medication be available to me if the pain gets worse?”
- “My face feels like a 6, but I’m constipated!”

Patients may point to a face indicating they are in emotional distress rather than in physical pain. Healthcare providers need to remain aware that suffering may be emotional or spiritual. Patients may downplay the severity of their pain in the presence of family members as not to upset them. In a clinic setting, patients may see a different healthcare professional at each visit with each physician interpreting the patients’ response differently. Adhering to the previously cited “A B C D E” 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 unrelied pain in a manner consistent with their style will build the trust so critical in the physician-patient relationship.

Pain assessment in the disoriented, confused, or 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,
nondrug therapies.
vide relief, ranging from medications to pro-

It is essential to make wise use of an array
Pain-Relieving Techniques
Treatment modalities should be used in
obstipation) may also cause pain.1 Most
induced plexopathy, opioid-induced
be aware that management of adverse
effect (eg, chemotherapy-induced
tumor effect, physicians also need to
accurate assessment
Pain is a complex phenomenon that needs to be
evaluated thoroughly. It is essential to
ardent intention is to provide comfort
through techniques that promote deep
relaxation and relief from pain.

groaning, or grimacing, especially with

In addition to disease progression
and tumor effect, physicians also need to
be aware that management of 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 reevaluation of all causes
of pain are cornerstones of effective treat-
ment of patients with cancer.

Pain-Relieving Techniques
It is essential to make wise use of an array
of pain management techniques to pro-
vide relief, ranging from medications to
nondrug therapies.

In most patients, nonpharmacologic
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 patients what usually helps control
their pain and encourage them to con-
tinue using that modality 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 methods have been
handed down through generations.

Many open-minded physi-
cians and nurse practitioners are now
incorporating reflexology, massage, reiki,
shiatsu, and acupuncture into care plans.

A simple mind/body technique
called “Mindfulness” or “Insight Med-
itation” uses the breath as a point of focus
for the mind and can help acknowledge
in a nonjudgmental way the full range of
feelings that can arise. When a person has
negative feelings—physical or emo-
tional—there is a tendency to attach blame
to it, thereby doubling the suffering.
Mindfulness simply recognizes and
observes the feeling, letting it happen
without being pulled into it. Through
Mindfulness, one can embrace that
staying positive in the face of cancer
includes recognizing and validating all
the feelings that are experienced as nec-
essary toward personal healing.7

Use of herbal products in the United
States has risen during the past decade,
whereas discussion of their use with med-
ical professionals remains suboptimal.8
A discussion of such use should be part of
the initial assessment. Although products
such as shark cartilage or sea cucumber
have not been proven to be effective in
fighting cancer or preventing pain,
patients might be taking them. To pre-
vent harmful drug interactions, patients
should be encouraged to report all herbal
remedies or supplements that they are
taking. Questioning about use of alcohol
and marijuana should be included in an
interview in a nonjudgmental manner.

Before suggesting a new pain man-
gerthods, and physical therapy are widely
used and accepted for pain management,
complementary and alternative methods
(CAM) are now recognized and accepted.
The growing field of psychoneuroim-
munology (PNI) shows that the mind and
body are constantly communicating with
each other. Many open-minded physi-

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Bitros • Advocating for Management of Cancer Pain


A

B

C

D

E

Ask about pain regularly.
Assess pain systematically.
Believe the patient and family in their reports of pain and what relieves it.
Choose pain control options appropriate for the patient, family, and setting.
Deliver interventions in a timely, logical, and coordinated fashion.
Empower patients and their families.
Enable them to control their course to the greatest extent possible.
Opioid-Related Constipation

**DAY 1**
- **Administer orally:**
  - 100 mg of docusate twice a day
  - 1 senna tablet twice a day

**DAY 2**
- **Administer orally:**
  - 100 mg of docusate twice a day
  - 2 senna tablets twice a day
- **Insert:**
  - 1 to 2 bisacodyl rectal suppositories after breakfast

**DAY 3**
- **Administer orally:**
  - 100 mg of docusate twice a day
  - 3 senna tablets twice a day
- **Insert:**
  - 3 to 4 bisacodyl rectal suppositories after breakfast

**DAY 4**
- **Administer orally:**
  - 100 mg of docusate twice a day
  - 4 senna tablets twice a day
  - 15 mL of lactulose or sorbitol twice a day
- **Insert:**
  - 3 to 4 bisacodyl rectal suppositories after breakfast

**DAY 5**
- **Administer:**
  - Sodium phosphate enema
  - Oil retention enema
  - High-colonic tap water enema

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**Figure 2.** Suggested bowel regimen for opioid-related constipation. (Source: Family Practice Notebook.com. Bowel regimen in chronic opioid use. Available at: http://www.fpnotebook.com/GI181.htm. Accessed December 3, 2007.)

Often, fear and anxiety accompany physical and emotional pain, illness and distress. Fear itself is often a cause of secondary pain or tension. This pain can lead to more fear and anxiety, which in turn, leads to more pain. Comfort Touch Massage helps to break this cycle, helping the patient and family members feel more in control of their own physical and emotional reality.¹⁰

It is imperative that healthcare professionals explore the use of CAM with their patients with cancer, educate them about potentially beneficial modes of therapy, and work toward providing an integrated model of healthcare.

**Preventing Pain**

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. It is easier to prevent pain than it is to treat patients for established pain. Patients should be instructed to take prescribed medication when the pain is mild or anticipated rather than waiting until it is 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.¹¹

**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.¹²

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. Reassurances give the patient “permission” to take those medications necessary to treat them for pain and symptoms.

Patients with cancer often have intense psychological and spiritual reactions to the diagnosis and then 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.

**Caring for the Patient’s Body, Mind, and Spirit**

An often overlooked aspect of treatment of patients with cancer is care of the human spirit. If nurtured, it is strong enough to sustain individuals when their body, mind, and emotional strength are...
made communication difficult with physicians and other staff. Her attending physician requested Gertrude’s referral to hospice to facilitate a multidisciplinary approach to her plan of care.

An extensive interview with Gertrude and her family revealed that they think her pain is exacerbated by fatigue and anxiety. In the nursing home, Gertrude’s fatigue and anxiety were managed with massage; while still living at home, Gertrude was calmed by drinking herbal tea, and watching television before bedtime. When speaking with the chaplain, Gertrude expressed a recent fear of death but viewed her suffering as penance. She admitted to feelings of loneliness and abandonment.

Gertrude was concerned about her boxels and felt anxious about her increasing pain and dependency. She was reluctant to ask for pain medication because she did not want to “bother the staff.” Gertrude was worried about her family and expressed regret that her great-grandchildren were too young to remember her.

To address the challenging physical and psychosocial issues affecting Gertrude’s quality of life, the hospice team recommended:

- oxycodone hydrochloride-controlled-release tablets, 10 mg every 12 hours, with a highly concentrated solution of morphine sulfate (20 mg/mL) for breakthrough pain
- lorazepam, 1 mg taken by mouth every 6 hours as needed
- bowel regimen such as that provided in Figure 2
- Comfort Touch massage administered during morning care and prior to bedtime (instruct family on technique)
- chamomile tea after dinner
- contact local priest to offer Sacrament of the sick

In addition, a hospice volunteer would visit Gertrude regularly for socialization and support. The family was asked to bring in pictures and write stories about Gertrude to be used in a legacy book that would be passed down to her great-grandchildren to ensure that she will be remembered and to give her comfort in that knowledge.

Case Presentation
Gertrude, an 80-year-old German, Catholic woman with end-stage breast cancer, had been living in a nursing home. Although she has had a long history of chemotherapy and radiation, her pain has been well controlled with 5 mg of oxycodone given every 6 hours as needed for pain. She has become increasingly debilitated and requires added assistance with activities of daily living. After arriving at the nursing home, Gertrude began to suffer from constipation, anxiety, and insomnia. Although she was cognitively aware, her German accent...