

The James Logan Essay Prize

April 2011

James Alexander Logan, a second-year medical student at the Barts and The London School of Medicine and Dentistry, died in February 2001 after a distressing illness of three months duration. His family, friends and interested professionals subsequently set up the James Logan Trust¹ to encourage doctors and others to have the confidence to recognise and treat cancer pain. The trustees were not oblivious of the need for the proper recognition and treatment of pain arising in other conditions but they wished specifically to improve the general management of cancer pain and they felt that confidence and skill acquired in this could be applied in other cases.

Until pain is recognised it cannot be assessed or treated, and the recognition of pain, like the recognition of so many other conditions, depends almost entirely on listening to the patient and accepting what is being said. Once it is acknowledged that pain is present then treatment should follow. The Trust recognises that specialist palliative care teams provide an essential service especially when pain is severe and un-

relieved by standard medication but their existence does not absolve other doctors, no matter how junior or senior, from doing their best to treat pain promptly and effectively. The Trust would encourage every doctor to have the confidence to start a patient on simple pain-relieving medication and to know how and when to increase it according to well established guidelines.²

The James Logan Trust has provided funds for an annual prize for the best essay on "The challenges of cancer pain assessment and management" to be submitted by a Queen's University of Belfast undergraduate medical student after the completion of their fourth-year palliative medicine teaching. The University and its Palliative Medicine Undergraduate Curriculum Committee were instrumental in setting up the James Logan Essay Prize and the essays are to be judged by at least two members of the latter committee. The Trust is indebted to the University and to the Committee for their assistance.

The first essays were submitted in the summer of 2010 and the winning entry, written by Mrs Victoria Campbell, is published in this issue. The Trust congratulates Mrs Campbell on her effort and wishes her and the other essayists well in the future.

References:

- 1 Charity Commission Number 1102923.
- 2 WHO Pain Ladder: <<http://www.who.int/cancer/palliative/painladder/en/>>. Accessed 22

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The challenges of cancer pain assessment and management

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Accepted 13 January 2011

Both acute and chronic pain has been well documented as one of the most frequent and distressing symptoms in cancer, and has been shown to adversely affect quality of life.¹⁻⁵ While it is difficult to be precise, it has been estimated that pain is present in 36-61% of patients depending on cancer type, stage of disease, and patient setting e.g. in-patient or out-patient.¹ Of those patients with advanced cancer, at least 64% have been shown to experience pain.⁶ The magnitude of the problem has been acknowledged by the World Health Organization who first published the analgesic ladder in 1986 in an attempt to establish guidelines for cancer pain management.⁷ Yet despite advances in policy, diagnosis and treatment since then, research suggests that cancer pain relief is still inadequate.^{3,8-9} This contradicts alternative research which has proposed that effective treatment of pain should be feasible for 70-90% of oncology patients.^{8,10} The purpose of this essay will be to review those factors that may be contributing to the cancer

pain problem, and also to consider any solutions which have been proposed in the literature.

It is widely accepted that assessment is the first step in the management of pain, indeed a comprehensive understanding of pharmacological and non-pharmacological pain management is of little value if the assessment of pain is inaccurate.¹¹⁻¹² The current standard approach to the initial assessment of cancer pain includes a detailed history and physical examination, assessment of psychosocial circumstances, and a diagnostic work-up. It is important to consider what may be causing the pain, as well as to ask about pain intensity.¹¹ The specific challenge of cancer pain

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assessment lies in its subjective and evolving nature. Cancer pain is multifaceted, and clinically may be described as acute, chronic, nociceptive (somatic), visceral, or neuropathic.⁵ Indeed a combination of all these subtypes may be present in any given patient at any one time. Furthermore, pain characteristics evolve over time due to changes in underlying pathophysiology.¹² Together these factors make the challenges to cancer pain assessment obvious, and it has been suggested that no individual assessment tool exists that adequately and accurately captures the multidimensional phenomenon of cancer pain.^{5,12} This was well demonstrated by de Wit and colleagues who showed, using different assessment methods in the same patient population, that the percentage of uncontrolled cancer pain ranged from 16-96% depending on the method used to quantify it.¹³ The absence of a standardised approach to cancer pain assessment not only means that pain is being inadequately treated, but also exposes the limitations of comparing research results in cancer pain management.¹¹

In the literature, one of the main pitfalls of cancer pain assessment is failure to properly listen to the patient's complaint of pain, and to establish an accurate measure of pain intensity.^{11,14-16} The development of a pain classification system is complicated by the factors mentioned above, however in the same way that the TNM Classification System has been a common language between oncology specialists for some decades, it has been recommended that a useful approach to cancer pain assessment is to use either a standardised visual analogue scale or a numerical scale.¹¹⁻¹² The problem with these scales is that they are a one-dimensional assessment of pain intensity. In an attempt to develop a multidimensional assessment of pain Bruera and colleagues¹⁷ developed the Edmonton Staging System (ESS) to assess and classify pain on the basis of seven characteristics, including mechanisms of pain, presence of incidental pain, daily opiate use, cognitive function, psychological distress, tolerance, and past history of alcohol or drug addiction. Patients were defined as having a good, intermittent, or poor prognosis for pain control based on a combination of these features.¹¹ Like other cancer pain classification tools, clinical use of the ESS was limited by problems with definitions of some of the constructs. An evaluation of the ESS in 276 patients found it to be highly sensitive but with poor specificity.¹⁸ In response to its limitations, the ESS was later evaluated by a panel of experts and renamed as the Edmonton Classification System for Cancer Pain (ECS-CP).¹⁹ Despite this, some researchers maintain that there is still no internationally accepted tool for cancer pain assessment.¹¹

The literature suggests that inadequate pain management is a function of a number of factors, including misconceptions about the use of drugs commonly used to treat cancer pain, and a lack of communication between patients and clinicians, in addition to the absence of formal assessment procedures as outlined above.³ With regards pain management following initial assessment, numerous barriers have been documented that prevent patients from receiving effective pain treatment, and challenge clinicians when providing adequate pain relief. These barriers have been divided into patient-related as well as professional-related barriers, and together they contribute significantly to the challenges of cancer pain management.^{1,3-5}

Several studies have reported professional-related barriers that hinder cancer pain management. A recent systematic review of these studies found that nurses and doctors reported the following barriers most frequently: a) inadequate assessment of pain and pain management, b) patients' reluctance to report pain or to give a pain score, and c) professionals' inadequate knowledge of pain management.¹ Specifically, misconceptions expressed by health professionals have centred around the use of morphine in the treatment of cancer pain. A study by Elliott and Elliott surveyed 243 physicians and found approximately half to have misconceptions about drug tolerance, believing that an increased need for morphine was indicative of tolerance as opposed to increasing pain intensity. Over 20% had misconceptions about opiate addiction, though fewer oncologists expressed this misconception. Other misconceptions centred around opiate side effects and administration, with many physicians indicating that parenteral administration is the only route available when treating severe cancer pain. Perhaps the most concerning finding was that almost 20% of physicians believed that pain associated with cancer is inevitable and cannot be fully alleviated through treatment.^{3,20} Other studies since then have yielded comparable findings.³ The overestimation of addiction and an over-inflated fear of respiratory depression and other opiate side effects, has regrettably led to widespread under-treatment of pain in cancer patients.^{5,21} Physicians themselves have acknowledged education in the area of cancer pain management to be inadequate.²²

Like some health-professionals, patients and their families can add to the challenge of cancer pain management due to their misconceptions about analgesics and their side effects.^{1,3-5} This in turn can lead to non-adherence to treatment regimens and poor communication of concerns about pain to medical staff.³ Patients may not report pain for a variety of reasons, ranging from a desire not to 'bother' the doctor, to concerns that they are not being a 'good' patient, or a fear that their pain is indicative of disease progression and avoidance of this possibility. They may be reluctant to take their pain medication due to fears of becoming addicted or tolerant. They may also have concerns about side effects, or fear that the medications are 'bad' for their bodies.³ In 1993 Ward and colleagues²³ surveyed 270 cancer patients to assess their concerns regarding the use of analgesics and the reporting of their pain to medical staff. The patients were given a 27-item questionnaire called the Barriers Questionnaire (BQ) and also the Brief Pain Inventory (BPI) to measure pain intensity. Ward found that many of the patients surveyed expressed some concern over issues relating to pain management, with concerns about addiction receiving the highest mean score. Patients who were older, had lower incomes, and less education had more concerns about pain management.^{3,23} Further patient-related barriers were highlighted by a recent systematic review which analysed fourteen studies looking at adherence to analgesics by cancer patients.¹ One of these studies, by Lai and colleagues²⁴, showed that the stronger patients believed they could control their pain themselves, the less likely they were to adhere to treatment. In addition, the stronger they believed that medication was necessary for their pain, the more they adhered to treatment.¹

In response to the challenges to pain management raised in the literature, better education has been proposed as a solution.¹

In addition to health professionals who must be made better equipped to assess and therefore manage pain, patients and their families must be educated on the proper use of pain medications, and concerns regarding their side effects and addiction must be addressed. Only through facilitating open communication between professionals who are confident in their ability to deal with the complex nature of cancer pain and patients who understand and are less intimidated by their pain, may the doctor-patient relationship become one in which pain is best controlled.

The author has no conflict of interest.

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