Assessment of Cancer-Related Pain

Reinhold Schwarz

Psychosoziale Beratungsstelle für Tumorkranken und Angehörige, Abteilung Sozialmedizin,
Medizinische Fakultät der Universität Leipzig, Germany

Among the many disturbances that appear in the course of a cancer illness, pain takes a special position. Apart from the massive impairment of quality of life, patients feel constantly reminded of the existence of a malignant illness and a potential progress of the disease. Finally, persistent pain may lead to a declining confidence in the attending physicians.

The high incidence and prevalence of tumor-associated pain represents a well known and continual problem in the supportive care of cancer patients. Over 70% of patients with cancer have moderate to severe pain that requires treatment with opiates [1]. In a recent study, pain took the lead amongst the most distressing symptoms in the palliative care situation [2]. Undertreatment of pain is described again and again and branded as a serious hindrance in symptom control, which considerably contributes to the negative stereotype of cancer and anti-cancer treatment. This circumstance is all the more regrettable as satisfactory pain control would be possible in 85–90% of the patients affected [3]. But according to a number of researchers [4], a therapy following the WHO guidelines is carried out only at an inadequate percentage. Hence, the majority of patients with moderate to severe cancer pain are not prescribed analgesics appropriate to their level of pain. These circumstances make pain a major health care problem, especially for patients with advanced cancer. The most likely reason for this is inaccurate pain assessment by health care professionals. Additionally, patients themselves may contribute to poor pain control because of difficulties in communicating the nature and extent of their pain or irregularities in adherence to pain management.

In response to this problem, clinicians and scientists have identified factors that contribute to poor treatment outcome and have designed corrective programs. In this context, it is important to note that the use of analgesic drugs alone does not always lead to the expected pain relief, since psychological factors play an important role in the perceived intensity of the

pain. Pain, and especially pain in cancer is not a purely physical experience, but involves complex aspects of human functioning including physical, psychological and social dimensions and their interferences [5]. To elucidate the potential relationship between pain and psychosocial variables, several domains have been identified [5, 6]: physical well-being and activities of daily life; psychological well-being consisting of affective, cognitive, spiritual factors, quality of communication, coping style, individual meaning of pain and meaning of cancer itself; and finally psychological co-morbidity and interpersonal well-being such as social support or role functioning. Cancer pain is best understood as the convergence of multiple activated systems with feedback mechanisms contributing to a pain syndrome as a complex, multidimensional interaction model [7].

However, on the other hand, all too frequently, psychological variables are proposed to explain continued pain or lack of response to therapy, while etiologic medical factors have not been adequately evaluated. Psychological disturbance may well be the consequence of uncontrolled pain [8], and unrelieved pain has a devastating effect on patients and their families [9]. Continuous assessment, i.e. of pain intensity and characteristics, pain-related functional interference with patients' lives, monitoring of intervention effects, pain relief etc., is crucial for effective treatment of cancer pain, which regularly involves a combination of several methods.

Based on the assumed symptom etiology, adequate medication, specific non-drug measures and interdisciplinary treatment have to be organized. This kind of assessment implies a physical and psychological examination, careful history taking, a thorough clinical interview, etc., which all together is sometimes felt to be very time-consuming. Meanwhile, a variety of standardized assessment tools has been developed ('clinical and psychosocial algometry' [7]) for screening or in order to abbreviate or complete the diagnostic process. Other

purposes include quality assurance and pain measurement in clinical studies. According to the rule that patients are the best judges of their pain [7], these instruments are primarily meant for self-assessment. Although patient ratings of symptoms are generally considered as the 'gold standard', in some situations proxy assessments may be helpful, and third-party assessments were conducted [10].

In the case of valid proxy measurement, the degree of concordance between patient and third-party rating can act as an indicator for the quality of an overall pain assessment in pain diagnosis and treatment. Following this line, the assessment of the various aspects and concomitants of pain fails to a certain extent as was shown by a number of investigations regarding the extent to which these symptoms were covered by the medical records. Additionally, many symptoms or problems were reported more often by the patients than by their doctors or nurses [11, 12]. According to the scientific literature, the concordance between patient self-assessment and proxy ratings of various medical and personal attendants is far from perfect and differs most of all in psychosocial aspects [13].

This discrepancy between proxy and self-assessment forms the starting point of the work of Budischewski et al. [14] who present in this issue the results of their cross-sectional study on the burden of pain of inpatients undergoing radiotherapy. Incidence and severity of cancer-related pain was assessed together with the primary and secondary burden of symptoms examining the quite heterogeneous clientele of a radiological clinic. In their study, the authors compared patient self-assessment with proxy ratings by nurses and physicians. Starting point was the assumption that each member of the different groups will make an original contribution to pain diagnosis and that this in turn may have an important influence on an integrated symptom management. As a first result, they report a considerable pain incidence. Because a self-made questionnaire was applied that apparently is nationally and internationally unknown, possibilities are limited to compare the results with those from similar studies of other working groups. Regrettably, the self and proxy rating instruments are not identical, which makes interpretation of the results somewhat difficult. Nevertheless, the results of Budischewski et al. resemble those of many other cross-sectional studies. Comparing the various pain estimates, proxy assessment by professional caregivers, particular physicians, differs from patient assessment. Furthermore, physician ratings were on average generally lower than patient ratings, and the difference widens as pain intensity rises. In contrast to the results of other working groups, this does not apply to the psychosocial complaints primary and secondary to the pain. In this study, the relatives of the patients have not been questioned, but it is interesting to mention that according to the literature relatives tend to overrate the patients as far as pain intensity is

concerned. In the discussion of their study, the authors pay special attention to the explanations of the discrepancy between self- and proxy assessment of pain and concomitants. These observations refer to gaps in the communication within the oncological ward. The methodological problems of the study, however, are discussed only briefly. It remains unclear why the authors have not made use of common and internationally approved instruments. Moreover, the study would have benefited considerably by using a longitudinal design with repeated measurements. Then it would have been possible to find out whether a longer and perhaps better doctor-patient relationship had led to a greater agreement in pain assessment and therapy.

The results of the study underline once again the subjective nature of the pain experience and pain perception of the patients (and of the medical attendants as well) and the close connection to fear. Fear or anxiety is next to depression the most disturbing emotion in the experience of a cancer disease. The authors therefore are completely right in pointing out the importance of communicating with the patients and the members of the staff in general. But information about pain and pain management can only be the first step. Of equal importance is the communication about the underlying cancer disease, the options of cancer treatment and finally coping with the disease and its consequences. Clinical experience in Psychosocial Oncology has shown that in the presence of pain other problems are hardly talked about. The conversation about cancer itself seems to be avoided by the patient as well as by physicians, nurses and relatives. In the process of psychic adaptation to the disease, pain often functions as some sort of body-language allowing the patient to allude to his hardship without directly referring to cancer but putting more emphasis on the pain instead. To decipher this metaphoric representation and to respond adequately to the hidden hints is one of the most difficult tasks in the care of cancer patients especially in the palliative situation.

Several studies have shown that the discordance between self and proxy ratings diminishes in the same degree as the quality of communication and the specific skills of the healthcare team improves [10]. Additionally, differences in pain assessment became smaller after the physicians had training in comprehensive pain assessment [15]. Diminishing these discrepancies in the ratings may be an important aim in the assessment of pain. However, accepting and acknowledging inevitable differences in the observations of pain by different persons can open an additional diagnostic perspective. This implies that an interdisciplinary team approach in clinical pain assessment and therapy will lead to a better understanding of the situation of cancer patients and their families, since each reference group may focus on another important aspect of a complex pain experience.

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