

Understanding and Managing Cancer Pain

Mankind has a long history of dealing with pain. Plato linked pain to the brain by emotions, undoubtedly due to the intense emotional component that often accompanies pain. The intent to alleviate pain is depicted in cave drawings along the Nile, where the application of electric eels (early TENS units?) over bumps and tumors has been identified. During Hippocrates' time, "treatments" for various maladies were often worse than the disease it intended to treat. Headaches were treated by induced unconsciousness, either by concussion, anoxia, or hemlock. These led Hippocrates to declare, "*Primum non nocere.*" First, do no harm. Obviously, we never intentionally harm our patients. All we do is done to improve their state. We constantly look for new ways to treat their problems, because their problems become ours. It is this constant search to relieve pain that has caused a literal explosion in analgesic neuropharmacology and the development of new pain relieving procedures and equipment in recent years.

Pain is the most common complaint in medicine. In oncology practice, it often heralds the presence of a malignancy. Any new complaint of pain in a known cancer patient should be considered a recurrence until ruled out. Cancer patients frequently associate wors-

ening of pain as a sign of a deteriorating condition, while its lessening may indicate a resolving or improving condition. Large sums of money are earmarked for research to develop innovations in cancer therapy, yet precious little time and resources are devoted to the study and treatment of this singular, most common complaint. At present, less than 1% of National Cancer Institute grants are used to fund pain-related research. Despite this, some advances have been made in identifying pain mechanisms involved in cancer pain.

In this issue, Joan M. Regan, MD, and Philip Peng, MBBS, FRCPC, present a review of the neurophysiologic processes involved in somatic, visceral, and neuropathic pain in cancer patients.

While obviously influenced by the underlying cancer responsible for the discomfort, pain per se is associated with significant personality changes, and it dramatically affects quality of life. Patients routinely require combinations of pharmacologic agents to achieve relief from cancer pain. Opioids, the mainstay of cancer pain therapy, provide excellent analgesia and are often useful as sole agents for relief. Two articles — by James F. Cleary, MD, and by Rom A. Stevens, MD, and Salim M. Ghazi, MD — delineate the various options avail-

able for analgesia and discuss the clinical pharmacokinetics of the various routes of opioid delivery that need to be understood so that an effective analgesic plan may be implemented. A proposal is made that for cancer pain, a two-step ladder be considered. However, opioid analgesia may carry unwanted side effects, and alternative analgesic methods need to be identified when opioid treatment is of limited effectiveness.

Chemical neurolysis has a long history of use in the cancer patient. As long as patients are selected appropriately and the risks and possible postprocedural sequelae are understood, it is an attractive option for analgesia. In his article addressing the role of chemical sympathectomy, Oscar A. de Leon-Casasola, MD, describes the importance of the sympathetic nervous system and the effectiveness of its ablation in relieving pain. New techniques and medications have been developed in this regard (eg, superior hypogastric plexus neurolysis for pelvic pain) to treat pain more effectively with fewer side effects.

In this vein, I present what should be considered the "4th step" in the World Health Organization's analgesic ladder, the interventional approach to cancer pain therapy. Despite these advances,

other side effects (or associated symptoms) continue to present problems in cancer patients. Insomnia, anxiety, and depression are frequent findings and need to be specifically addressed.

Elizabeth M. Thomas, PsyD, PhD, and Sharlene M. Weiss, RN, PhD, describe the impact of cancer pain on patients' psyche and address several nonpharmacologic methods to relieve that suffering. To utilize these advances more effectively, patients with chronic and cancer pain need to be evaluated by pain specialists in a multidisciplinary environment.

Barriers exist that prevent effective pain relief. Some of these originate at the treating physician level, where the knowledge base may not be sufficient to adequately treat complex pain problems. Other barriers exist at the patient or caregiver level; they may be reluctant to use opioid medications for fear of addiction or loss of faculties. Another great impediment to effective, widespread pain relief is real or perceived regulatory scrutiny. Examples of these are recent actions by the Drug Enforcement Administration supporting regulations, such as requiring triPLICATE prescriptions. One copy of each controlled substance prescription goes to the physician, one is kept by the pharmacist, and the third is forwarded to the respective State Department of Health. One highly touted "success" occurred in Texas, which implemented this system in 1992. In the first year, a 60% reduction in class II drugs was documented, with a concomitant 300%

increase in the use of nonsteroidal anti-inflammatory (NSAID) drugs. How many kidneys failed and pains went suboptimally controlled due to physicians' reluctance to undergo greater government surveillance or just plain inconvenience? There has been no comprehensive evaluation of these programs for efficacy, yet millions of dollars are spent each year to operate them. We, the prescribing physicians, should take the lead role in combating obstacles towards adequate pain relief by early pain diagnosis, appropriate referrals, and strident opposition to questionable regulatory scrutiny. It appears that legislators nationwide are finally realizing the importance of pain relief, especially in cancer patients.

Cancer appears to be flourishing in our society. It is diagnosed earlier and more consistently, making curative intervention — or at the very least a longer life — more commonplace. Cancer and its therapeutic strategies, such as surgery and radiation, may induce pain syndromes. In the final stages of life, most cancer patients have come to terms with their mortality. Their main concern may not be unrealistic expectations of survival, but rather a very clear request that their remaining days not be spent in pain. It is a request that demands our full and undivided attention.

"We must all die. But that I can save him from days of torture, that is what I feel is my great and ever new privilege.

Pain is a more terrible lord to mankind than death itself."

Albert Schweitzer, MD

Rafael Miguel, MD

Associate Professor and Chief

Anesthesiology Service

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