Breakthrough cancer-related pain: The truth hurts

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Healthcare professionals must do more to address an issue that impacts a patient’s daily life.

Cancer patients contending with breakthrough pain face an array of confusing questions: If they complain to their healthcare providers about their pain, will it impede their cancer care? What if they become addicted to their pain-relieving medication? What if health insurance won't cover the cost of that medication? Finally, what if their healthcare provider doesn't ask about their pain issues on a routine basis—are they still allowed to bring it up?

Addressing breakthrough pain related to cancer "fits into a larger construct about the problem with pain in general," said Pamela Bennett, BSN. "Pain is a major public health problem. It affects at least 53 million Americans; that is more than the number of people with diabetes, cancer, and coronary heart disease combined. Pain that is not treated can slow recovery from disease or injury and can weaken the immune system." Oncology News International spoke with a trio of experts on some of the prevailing attitudes about managing breakthrough cancer pain. In the end, they all agreed that pain can't be treated as an afterthought either by healthcare professionals or patients. The panelists were:

• Ms. Bennett, executive director of healthcare alliance development at Purdue Pharma in Stamford, Conn.
• David S. Craig, PharmD, BCPS, a clinical pharmacist specialist and residency director in the psychosocial, palliative care, and integrative medicine department at H. Lee Moffitt Cancer Center and Research Institute in Tampa, Fla.
• Robert Kronenberg, PharmD, director of pharmacy at HealthSouth/Valley of the Sun Rehabilitation Hospital in Glendale, Az., and president of the Arizona Pain Initiative board of directors.

ONI: What do you think is the most common misconception among healthcare professionals about breakthrough cancer pain?
Dr. Craig: I think [healthcare] professionals underestimate the extent of impact that breakthrough pain episodes can have on patients. A recent American Pain Foundation (APF) survey noted that effectively treating breakthrough pain episodes was often more important to cancer patients than treating their cancer diagnosis (see Related Reading). Furthermore, many oncology professionals still don't know what breakthrough cancer pain is or how to effectively screen, assess, and treat it (see Table 1).
Dr. Kronenberg: Sudden breakthrough pain is extremely debilitating and it's difficult to deal with because it comes on without notice and it lasts a short period of time, maybe five or 10 minutes. We know that oral [pain] medications take about 20 minutes to work. Why don't we manage pain better?
We have communication problems. During a fairly short scheduled visit, the patient and physician may assume that, of course there is going to be pain. Types of breakthrough pain

- Incident pain occurs with or following physical activity.
- End-of-dose failure occurs in the time between doses of medication.
- Spontaneous breakthrough pain occurs without predictable cause or frequency.
- Apparent pain occurs because of the tumor (injury) but the pain subsides with healing.
- Chronic pain occurs when the pain remains even though the injury has healed.

Ms. Bennett: Patients don't necessarily understand that they have a right to an appropriate assessment and treatment for pain. And they don't always have healthcare providers who are trained to adequately assess pain. Unfortunately, this is particularly true in oncology. The American Cancer Society did a call center survey to better understand the impact of pain on patient's lives. Sixty-five percent of the callers said they were experiencing cancer-related pain at that time with 76% rating it as moderate to severe. But only 58% said they were asked about their pain at their clinical visit (CA: Cancer J Clin 59:285-289, 2009).

ONI: In the cancer care continuum, whose responsibility is it to address breakthrough pain: the oncologist, oncology nurse, the primary care physician, a palliative care specialist?

Dr. Craig: I think everyone has some responsibility in screening, assessing, and treating all types of pain, including noncancer pain in cancer patients. I think it is important to have at least nonspecialists (primary care physicians, etc) thinking about the concept and asking patients about it.

Ms. Bennett: Ideally, every clinician who comes in touch with the patient should address pain and pain treatment. The reality is that healthcare professionals are already overburdened, so patients have become more sophisticated in advocating for themselves.

The survey was conducted in 2009 (October 2 to October 29) with 545 adults responding.

ONI: Do you think there is concern that asking cancer patients to serve as their own pain advocates will add to an already stressful situation?

Ms. Bennett: So often people with pain feel disempowered; they feel like no one is listening to them. Or they have a caregiver who wants to be more involved in the patient's treatment process but they don't know what to do. Using a pain diary with a pain scale gets the patients and caregivers more engaged in the process.

For example, the pain diary may show the patient that her breakthrough pain is related to a specific activity. Or does it come at the end of the medication dose? The clinician can then adjust the treatment plan.

Dr. Craig: Empowering patients to take part in their medical care can be very useful. However, many providers don't have the time or focus to use patient-collected data unless [the patient is] specifically being evaluated/treated for chronic pain. Primary MDs won't do this and, in my experience, pain management specialists and palliative care physicians rarely do it. But it can be useful, like a diabetic patient tracking his morning blood sugars to assist in the management of his diabetes mellitus.

ONI: There are plenty of pain assessment tools available today. What are some of the pros and cons of pain scales?

Dr. Kronenberg: Most pain scales ask patients to rate their pain from zero to 10. But if you ask a patient in pain to rate his experience, he isn't going to say 'Today, my pain is a 3.481.' We are not born with this concept that we can put a number on pain. People who work in the area of pain management think it's easy to rate pain, but that's not always the case for the patient. I prefer pain scales that offer some descriptive language along with the number. The physician or nurse needs to share what the numbers mean and it's important for patients to understand that they have to stay within this language.
Ms. Bennett: One major issue is that physicians are not actually using pain scales as often as they should. The Alliance of State Pain Initiatives surveyed doctors in Georgia and Washington. Less than half of the responding doctors said they used any kind of scale or standardized tool to assess their patients' pain as part of the conversation.

The pain scale and diary are empowerment tools and they open the pain dialogue between patients and practitioners. If patients understand that the clinician is going to use this pain tracking tool to deliver better care, they will do it.

ONI: What about patients’ fear of addiction to pain medication? What is the best way for a healthcare professional to address that?

Dr. Craig: The addiction issue is always a concern for all of our patients; unfortunately, even the ones who are actively dying from cancer. Our society has a way of punishing "the weak," those who take opioids (narcotics) and holding up the "strong" who resist opioids. The short answer is yes, patients, providers, caretakers, spouses, employers, physicians, nurses, pharmacists, etc, are all concerned about addiction. I have never heard anyone say to me "I don't care about addiction to pain medication."

Dr. Kronenberg: Why are we so afraid of addiction? It's our misunderstanding of what addiction is. An addict wants that drug all the time. When you picture an addict, you picture someone who is maybe homeless, or who has done a lot of illegal things in order to get drugs; we think of people whose lives are down the tubes. But with cancer patients, you are talking about a population of people whose lives are being ruined by pain. Most people will talk about the side effects of pain medication. Yes, the medication gives some pain relief, but they are not happy about the adverse effects. Can they be addicts? You've got to love the drug to be an addict. What we typically see is confusion between addiction and dependence. Dependence is a physical need; if you stop a substance abruptly, there will be withdrawal symptoms.

ONI: In the current healthcare climate, there is an emphasis on cost-effectiveness and cost cutting. How do you think pain and pain management will fare under healthcare reform?

Dr. Craig: I don't think cost-cutting efforts are initially the reason breakthrough pain gets overlooked; it may happen later if a particular drug (see Table 2) is not covered by a medical insurance plan. We encounter this problem because of the cost associated with [pain management] products on a regular basis with our cancer patients with breakthrough pain episodes. I think physicians want to do what is best for the patient and worry about possible cost considerations later.

Dr. Kronenberg: The FDA has been looking at short-acting pain medications as something that can be very dangerous to society. They are trying to develop risk evaluation mitigation strategies (REMS) that require education of the prescriber and the patients. It limits access to a lot of potential pain therapies that may start to work very quickly.

Ms. Bennett: My hope is that healthcare reform actually does change the landscape. If we are managing pain well and palliative care is provided to patients, it will cost less and they will do better (see Table 3). I also hope that looking at comparative effectiveness and cost-effectiveness will change the way we educate our healthcare professionals. Until that occurs, there is a danger that care decisions will be...
made solely on the basis of cost, rather than on what is most effective in terms of an individualized treatment regimen.

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