Undertreatment of Cancer Pain in Elderly Patients
[Editorials]

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Outline

- REFERENCES

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Undertreatment of pain is a persistent clinical problem. A leading indicator of inadequate pain management is the poor control of cancer pain, a condition for which every effort should be made to assure patient comfort. Cancer pain is feared by patients, their families, and the general public and this fear has helped to fuel the debate concerning assisted suicide.

In this issue of THE JOURNAL, the study by Bernabei and colleagues [1] takes advantage of a large database to examine the treatment of pain in elderly patients with cancer who are cared for in nursing homes. Using the Resident Assessment Instrument and the Minimum Data Set, part of the Health Care Financing Administration's Demonstration Project, the investigators found that 38% of nursing home residents with cancer in a 5-state area complained of, or showed evidence of, daily pain. The study found that 26% of these patients with daily pain received no analgesics. Patients older than 85 years were more likely to receive no analgesia, as were patients in minority groups. Using as a standard the World Health Organization's guidelines for analgesic use in cancer pain (later endorsed by the Agency for Health Care Policy and Research clinical practice guideline on the management of cancer pain [2]) about half of the patients in pain and very few patients older than 85 years were receiving opioid analgesics.

The findings of Bernabei [1] et al are consistent with other studies [3-5] that have reported that cancer pain is poorly managed in most settings, and that patient characteristics are predictors of the level of poor pain management. Patients in minority groups and elderly patients have been shown to be at increased risk of inadequate analgesia. Women are also less likely to receive adequate analgesia. Patients who have cancer pain that is underestimated by their physicians or who are judged by their physicians to be less ill also are at risk for receiving less than adequate...
analgesia. [3,4] Patient characteristics also are associated with less than adequate pain management for other types of pain, including postoperative pain (minorities, women) [6,7] and pain management following trauma (minorities). [8] But all patients with cancer are at particularly high risk. Among outpatients with metastatic disease, 1 in 3 will have pain that interferes with the way they live. [3]

Pain control during the last weeks of life can be a challenging patient management problem. However, in the months before death or for those who eventually will be cured, patients often experience pain for protracted periods, pain that can be managed with analgesics that are straightforward to use. Despite periodic entreaties in medical journals to improve pain control, inadequate pain management persists. In contrast to the simplicity of providing pain control, the cost of not providing it is high, both in terms of impaired function and quality of life. Patients with pain also are less able to commit to fighting their disease.

Although it is unclear why health care professionals fail to use the best available pain management techniques for their patients with cancer, several factors contribute to the problem. Clinical training in pain management, other than for pain specialists, is almost nonexistent. Few health care professionals feel that they have received adequate training in pain management in medical school or during residency. Even those who have had specialty training in oncology report that their preparation for managing pain has been inadequate. [11] Most clinicians have catch-up learning to do. Careful reading of the Agency for Health Care Policy and Research clinical practice guideline on management of cancer pain, [2] although now somewhat outdated, is a good place to start.

But even with improved training, achieving adequate pain management will be difficult. The best pain management requires an informed patient who is willing to report pain and to voice complaints if pain is not controlled. Patients are reluctant to report pain for a variety of reasons, including fear that reporting pain will take physician time away from the treatment of their cancer. [12] Language and status differences compound this reluctance. Unfortunately, it is the rule rather than the exception that patients must volunteer that they are in pain before health professionals take notice. Unrecognized pain is untreated pain. Routine assessment of pain, using pain severity scales that both patient and clinician understand, is seldom done. Pain is a "vital sign" for most patients, and often is more relevant to their care than pulse or blood pressure. Some centers are beginning to record the presence or absence of pain routinely, and if pain is present, to document its severity. Patients who expect pain relief and know how to request it, such as those seen in clinics that routinely assess and treat pain in a systematic way, are more likely to have better pain control. A recent randomized trial from the Netherlands found that educating outpatients with cancer about pain, and teaching them how to report their pain and how to contact health care practitioners, improved pain control for those in the intervention group. [13] Another study included pain assessment information in the charts of randomized patients. Physicians treating these patients were more likely to increase the patients' analgesics, and the patients were more likely to report a decrease in number of days with pain. [14]

Treatment of pain should be a top priority in cancer care. However, excellence in pain control and symptom management has not been adopted as a "mission" of cancer practitioners, probably for several reasons. First, patients do not die of pain, although some evidence suggests that untreated pain begets worse pain. [15] Second, pain treatment must be guided by the subjective report of the patient, although using pain scales helps to objectify this report. Third, adequate pain management takes time, as it must include careful patient assessment and reassessment, analgesic titration to the desired end point, and monitoring and management of adverse effects, all of which can add to cost. Fourth, clinicians may be concerned that stronger analgesics will
cause confusion, constipation, or balance problems, which are legitimate concerns, but not ones that justify untreated or undertreated pain. Fifth, the optimal management of pain and adverse effects of analgesics requires aggressive use of controlled substances, potentially raising fears of regulatory scrutiny or the disapproval of professional colleagues. Finally, until recently, patients, families, and the public have expected cancer to be painful and have not pressed clinicians for better pain management.

Changing medical practice is difficult, and improving pain management may be especially difficult. Two recent articles [16,17] provide examples of methods that should be explored to improve the quality of pain control for patients with cancer. First, local oncology opinion leaders might be identified who are willing to champion good pain relief, learn about it, and teach it to those who respect them. This approach for improving cancer pain control has already been suggested. [18] Second, information about patients with cancer who have pain of moderate or greater severity could be used as a negative "quality indicator" in a hospital or other practice setting, and feedback and dissemination of this information to physicians might encourage concerted efforts to improve pain management.

Ample evidence indicates that patients, their families, and the public are becoming less tolerant of poor pain management. That intolerance may prove to be the ultimate driving force behind improving care of patients with pain.

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