Basic principles of managing persistent cancer pain

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Oncologists and palliative medicine practitioners usually consider widely accepted management principles in developing a treatment plan for persistent pain.[1] "Communicating an intent to control pain and stress early on and emphasizing the concern reassures both the patient and family. This includes active, concerned inquiry about pain, sleep, mental status, energy, and functional capability. Discussion should include family members as well as the patient."[2]

The intent to pre-empt or minimize pain includes knowledge of risk factors for increased pain. For instance, these are risk factors for developing chronic or persistent pain after breast cancer surgery:[3]

- More invasive surgery
- Radiation therapy after surgery
- Significant acute pain after surgery
- Young age (18 to 39 years)
- Dissection of axillary lymph nodes
- Pain in other parts of the body linked to increased risk of pain in the surgical area
- Imbalances of hormones such as cortisol, DHEA, thyroxine and sex hormones

Referral to a physical therapist and/or a lymphedema specialist before lymph node removal is an example of a preemptive intervention.

Persistent cancer pain can be managed, often with relatively simple treatments such as oral analgesics and adjuvant analgesics. The plan should seek to bring the pain under control and keep it under control around the clock. Note that good pain control doesn't necessarily mean the pain will go away. The goal is to bring it to a level the patient considers manageable. If the pain is frequent or constant, consider using treatments that are long-acting and are taken/administered no more than two or three times a day.

Treat unrelieved pain as an urgent problem. Pain assessment, especially your patient's description of pain and its impact on their life, is the place to start. Listen to the story of people's pain and suffering, knowing that telling the story sometimes profoundly shifts the experience of that pain.

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[1] Paice JA, Portenoy R et al. Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline. Journal of Clinical Oncology. 2016 Sep 20;34(27):3325-45; WHO Guidelines for the pharmacological and radiotherapeutic management of cancer pain in adults and adolescents. World Health Organization. January 2019. Viewed January 27, 2023.

[2] Chapman CR, Gavrin J. Suffering and its relationship to pain. Journal of Palliative Care. 1993;9(2):5-13.

[3] Gärtner R, Jensen MB et al. Prevalence of and factors associated with persistent pain following breast cancer surgery. JAMA. 2009 Nov 11;302(18):1985-92.

A multi-modal approach, combining nondrug and drug treatments usually works best.

- Base the treatment on the pain's location, type, intensity, duration, pattern, and other individual factors.
- Start with pain management strategies that are effective for the intensity of pain reported. If the pain is mild, consider non-drug approaches and/or non-opioid drugs such as acetaminophen or NSAIDs. If pain is moderate to severe, an opioid (such as morphine, oxycodone, etc.) is also usually needed. Other drugs such as anticonvulsants like gabapentin, or antidepressants like duloxetine, may be useful for neuropathic (nerve damage) pain. Other conventional techniques such as physical therapy or treatments such as surgery or radiotherapy may be needed.
- If pain is persistent and occuring frequently throughout the day or constantly, put long-acting pain management interventions (including opioids) on a round the clock schedule. A classic 1999 study emphasizes the importance of finding the correct dose and frequency of around-the-clock pain medications.[4]
- Healthcare professionals need to frequently check for breakthrough pain and adjust analgesic dosage and frequency accordingly.
- Give the patient a back-up plan for quick-acting treatments and medications in case of incident pain in which an incident increases or causes pain, such as entering/exiting a car or a painful procedure.
- Include treatments to prevent or manage side effects of pain treatment, such as constipation, as well as other symptoms that are related to the pain, such as sleep difficulties or anxiety.
- Consider integrating evidence-based complementary therapies and self-care practices that improve comfort. See What approaches can help me manage pain? for evidence for these therapies)
- Consider the influence of CNS neurohormones in protecting and generating nerves and promoting neuroplasticity. Early studies indicated that they may have considerable benefit for treating pain.[5] Additionally, monitor hormone levels among people treated with opioids. "Due to the high incidence and prevalence of hormone suppression in opioid-maintained pain patients, some practitioners recommend that these patients be periodically screened for hormone deficiencies."[6]

Check in regularly. Don't give up. Many more good options are available to manage pain. Refer to an oncology, palliative care, hospice, or other specialist for more complex pain management challenges. "The control of suffering represents a formidable challenge. We advocate a proactive, long-range perspective aimed at (a) preventing brief stress-eliciting events such as pain associated with procedures, (b) treating potentially chronic pain and symptoms aggressively, and (c) promoting the psychosocial well-being of patients at every opportunity."[7]

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[4] Portenoy RK, Payne D, Jacobsen P. Breakthrough pain: characteristics and impact in patients with cancer pain. Pain. 1999 May;81(1-2):129-34.

[5] Tennant F. Hormone testing and treatment enters pain care. Hospital Practice. (1995). 2014 Dec;42(5):7-13.

[6] Tennant F. Hormone testing and replacement in pain patients made simple. Practical Pain Management. 2012;12(6); Tennant F. The physiologic effects of pain on the endocrine system. Pain and Therapy. 2013 Dec;2(2):75-86.

[7] Chapman CR, Gavrin J. Suffering and its relationship to pain. Journal of Palliative Care. 1993;9(2):5-13.