

Best Practice Statement ~ *April 2004*

# The Management of Pain in Patients with Cancer

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## **Introduction**

NHS Quality Improvement Scotland (NHS QIS) was established as a Special Health Board on 1 January 2003 bringing together the Clinical Resource and Audit Group (CRAG), Clinical Standards Board for Scotland (CSBS), Health Technology Board for Scotland (HTBS), Nursing and Midwifery Practice Development Unit (NMPDU) and the Scottish Health Advisory Service (SHAS).

The purpose of NHS QIS is to improve the quality of healthcare in Scotland by setting standards and monitoring performance and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

One of the key aims of the former NMPDU was to identify areas of nursing and midwifery practice amenable to the development of 'best practice statements'. A series of 'best practice statements' designed to offer guidance on good practice relating to specific areas of practice and to encourage a consistent and cohesive approach to care has been produced.

## **Background to Best Practice Statements**

While many examples of clinical guidelines exist there is a lack of reliable statements focusing specifically on nursing and midwifery practice. The development of best practice statements reflects the current emphasis on delivering care that is patient centred, cost-effective and fair, and will attempt to reduce existing variations in practice. The common practice that should follow their implementation will allow comparable standards of care for patients wherever they access services.

## **What is a Best Practice Statement?**

A best practice statement is a statement to describe best and achievable practice in a specific area of care. The term 'best practice' reflects commitment to sharing local excellence at national level. Best practice statements are underpinned by a number of key principles (page ii).

### **Key Principles of Best Practice Statements**

- Best practice statements are intended to guide practice and promote a consistent and cohesive approach to care.
- Best practice statements are primarily intended for use by registered nurses, midwives and the staff who support them, but they may contribute to multidisciplinary working and other members of the health care team may find them helpful.
- Statements are derived from the best available evidence at the time they are produced, recognising that levels and types of evidence vary; where a statement is developed in the absence of research evidence and is predominantly based on consensus this will be noted.
- Information is gathered from a broad range of sources in order to identify existing or previous initiatives at local and national level, incorporate work of a qualitative and quantitative nature and establish consensus.
- Statements are targeted at practitioners, using language that is accessible and meaningful.
- Consultation with relevant organisations and individuals is undertaken.
- Statements will be reviewed and updated every 3 years.
- Responsibility for implementation of statements will rest at local level.
- Key sources of evidence and available resources are provided.

### **How Can the Statement be Used?**

The recommended best practice statement is primarily intended to serve as a guide to good practice and promote a consistent and cohesive approach to care. The statement is intended to be realistic but challenging and can be used:

- as a basis for developing and improving care;
- to stimulate learning amongst nursing teams;
- to promote effective interdisciplinary team working;
- to determine whether a quality service is being provided; and
- to stimulate ideas and priorities for nursing research.



## Use of Evidence in Best Practice Statements

The need to embrace evidence in its broadest sense has been acknowledged by NHS QIS in the development of best practice statements. Best practice statements represent a unique synthesis of research evidence, evidence complemented by audit, patient surveys and evidence derived from expert opinion, professional consensus and patient/public experience.

The process for developing these statements adopts a rigorous, transparent and consistent 'bottom-up' approach to articulating best practice that involves professionals and patients, and is based on all types of available evidence.

The following stages describe the process of identifying and reviewing evidence for inclusion in statements:

1. Define question
2. Gather evidence from a range of sources including published literature, grey literature and other relevant sources, eg patient groups, manufacturers, professional groups
3. Evaluate evidence using recognised methods of evidence appraisal
4. Integrate evidence with patient-related factors, eg issues of access, equity and ethics
5. Develop recommendations
6. Evaluate process and impact of recommendations.

## Who was Involved in Developing the Statement?

### Project Leader

Roma Maguire	Oncology Sister, seconded from North Glasgow University Hospitals NHS Trust
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### Assessment Group

Janette Barrie	Pain Management Clinical Nurse Specialist, NHS Lanarkshire
Eleanor Clausen	Research Sister, Western General Hospital, Edinburgh
Marilyn Cringles	Cancer Pain ICP Co-ordinator, Southern General Hospital, Glasgow
Linda Kerr	Nurse Specialist/Training Officer in Palliative Care, Ayrshire & Arran Acute Hospitals NHS Trust
Karen Lockhart-Wood	Lecturer, Marie Curie Centre, Fairmile, Edinburgh
Elaine Peace	Lead Cancer Nurse, Borders
Susan Sutherland	Clinical Nurse Specialist in Palliative Care, Grampian University Hospitals
Jane Wason	Community Staff Nurse, NHS Dumfries & Galloway

### Pharmacological Management Group

Rhona Baillie	Community Palliative Care Team Co-ordinator, Lanarkshire Primary Care NHS Trust
Janette Barrie	Pain Management Clinical Nurse Specialist, NHS Lanarkshire
Susan Jackson	Lecturer in Palliative Care, University of Paisley
Janice Malecki	Clinical Nurse Specialist in Palliative Care, Fife Acute Hospitals NHS Trust
Janie Neilly	Nurse Advisor in Cancer Care, Ayrshire & Arran Primary Care NHS Trust
Claire O'Neill	Clinical Nurse Specialist in Palliative Care, Beatson Oncology Centre, Glasgow
Lorna Roe	Macmillan Lead Cancer Nurse, Forth Valley Acute Hospitals NHS Trust
Susan Sutherland	Clinical Nurse Specialist in Palliative Care, Grampian University Hospitals NHS Trust
Jane Wason	Community Staff Nurse, NHS Dumfries & Galloway

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## Non-Pharmacological Management Group

Nicola Lamb	Physiotherapist, Beatson Oncology Centre, Glasgow
Lorna McGoldrick	Clinical Nurse Specialist in Palliative Care, Western General Hospital, Edinburgh
Suzanne Nimmo	Staff Nurse, Palliative Care/Chronic Pain, Stirling Royal Infirmary
Elaine Peace	Lead Cancer Nurse, NHS Borders

## Multidisciplinary Reference Group

Lynn Adams	Lead Cancer Nurse, Grampian, Shetland and Orkney
Mr John Anderson	Consultant Colorectal Surgeon, Glasgow Royal Infirmary
Carole Archibald	Ward Sister, Southern General Hospital, Glasgow
Mairi Armstrong	Deputy Matron & Head of Community Team, Strathcarron Hospice
Lena Baird	Senior Occupational Therapist, The Ayrshire Hospice
Gillian Bonner	Practice Nurse, Greenock Health Centre, Inverclyde
Alice Cain	Castle Douglas Community Hospital, Dumfries & Galloway
Evelyn Paterson	Macmillan Palliative Care Nurse, Stirling Royal Infirmary
Keith Farrer	Macmillan Lead Cancer & Palliative Care Nurse, NHS Orkney
Maureen Fee	Centre Head, Maggie's Centre, Glasgow
Margaret Fitzpatrick	Clinical Support Nurse, Gartnavel Royal Hospital, Glasgow
Lynn Forrest	Staff Nurse/Research Nurse, Glasgow Royal Infirmary
Dr Hilary Glen	Senior Registrar in Medical Oncology, Beatson Oncology Centre
Dr David Linden	Macmillan GP Facilitator in Palliative Care, Ayrshire
Maria McGill	Centre Manager, Marie Curie, Glasgow
Rosemary McIntyre	Head of Studies, Marie Curie, Scotland

Elaine McLean	Palliative Care Professional Adviser, The Care Commission
Louise Shakespeare	Macmillan Nurse, Caithness General Hospital, Caithness
Charles Sinclair	Head of Practice Development, Fife Acute Hospitals NHS Trust
Professor John Welsh	Chair of Palliative Medicine, University of Glasgow
Helen Wright	Principal Pharmacist, Marie Curie, Edinburgh
Jackie Wright	CNS Oncology and Haematology, Hairmyres Hospital, Lanarkshire
Patients Representatives	From across Scotland

### **NHS Quality Improvement Support Team**

Penny Bond	Senior Nurse
Bette Baillie	Secretary

### **Further Information**

For further information about NHS QIS, or to obtain additional copies of this best practice statement, please contact:

NHS Quality Improvement Scotland  
Edinburgh Office  
Elliott House  
8-10 Hillside Crescent  
Edinburgh  
EH7 5EA

Tel: 0131 623 4300

Fax: 0131 623 4299

[comments@nhshealthquality.org](mailto:comments@nhshealthquality.org)  
[publications@nhshealthquality.org](mailto:publications@nhshealthquality.org)

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## **Best Practice Statement on The Management of Pain in Patients with Cancer**

Approximately 80% of patients with cancer in Scotland experience pain; 16% experience mild pain and 42% moderate to severe pain (Scottish Pain Audit, 2000). Following consultation, nurses throughout Scotland have recognised this problem and requested guidance in this area of practice to improve patient care.

NHS Quality Improvement Scotland (NHS QIS) has developed this best practice statement in collaboration with a network of nurses and allied health professionals involved in the management of pain in patients with cancer. A multidisciplinary reference group has advised the network.

The statement refers to the care of adult patients with cancer, in all care settings, who may experience pain. It therefore incorporates healthcare services in community, hospital and hospice settings.

The importance of recognising that pain is multidimensional in nature and unique to the individual is essential in ensuring best practice for these patients and is reflected throughout the statement. The management of pain in partnership with the patient and multi-professional team working are reinforced as being key elements in achieving adequate pain control.

The aim of the statement is to offer guidance to healthcare professionals on the best practice in this area, aiming to provide a consistent approach to practice to enable seamless provision of care to be delivered between the hospital and the community.

### **Format of Statement**

The statement is divided into four sections covering:

1. Pain Management Education;
2. Assessment of Pain;
3. Pharmacological Management of Pain; and
4. Non-Pharmacological Management of Pain.

Each section contains a table corresponding to the what, why and how of best practice, ie summarising the statement, the reason for the statement and how to achieve the statement or to demonstrate it is being achieved. Preceding each statement are key points that act as a summary of each statement, and following are key challenges, which are not core elements of effective pain control, but are important in achieving the desired aims of each statement. When information is relevant to a specific statement, supplementary figures are used.

**Please Note:**

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## Section 1: Pain Management Education

### Key Points ~

1. *Patients and their carers are provided with education and information regarding the management of pain.*
2. *All healthcare professionals, involved in the care of patients with cancer, attend education programmes on the principles of cancer pain management.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
Patients and carers are provided with information/education regarding the management of pain.	The provision of both verbal and written information has been demonstrated to improve the patient's knowledge of pain and lower their pain intensity (Ferrell et al, 1997; SIGN 44, 2000).	There is documented evidence that the patient and their carers have been educated and given appropriate information regarding the management of pain.
All healthcare professionals involved in the care of patients with cancer are provided with continuing education on the principles of holistic cancer pain management.	There is lack of pain management training amongst healthcare professionals (SIGN 44, 2000).  Education of healthcare professionals has been demonstrated to improve pain control in patients with cancer (SIGN 44, 2000).	Education programmes on cancer pain management are available to all healthcare professionals at both pre- and post-registration levels.  There is a record of healthcare professionals' attendance at education programmes related to the management of pain in patients with cancer.

### Key Challenges ~

1. *Ensuring adequate resources are available to provide staff, patients and carers with education and training*
2. *Identifying ways to deliver and evaluate education and training that recognise local needs.*
3. *Ensuring all patients with cancer have access to a healthcare professional who has specialist knowledge of pain management (SIGN 44, 2000).*



## Section 2: Pain Assessment

### Key Points ~

1. *Enquiry into the presence of pain is included in the nursing assessment of all patients with cancer.*
2. *The patient is the prime assessor of his/her own pain and is involved in the ongoing assessment wherever possible.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Assessment of all patients with cancer includes a question regarding the presence of pain.</p> <p>All patients with cancer, wherever possible, are encouraged to take an active role in the ongoing assessment and management of their pain (Scottish Executive, 2003).</p>	<p>Approximately 80% of patients with cancer report pain as a symptom (Scottish Pain Audit, 2000).</p> <p>Unrecognised and uncontrolled pain remains a significant issue for patient care (Larue et al, 1995).</p> <p>The patient's perceptions of pain may vary from that of their carers and healthcare professionals (Grossman et al, 1991; Field et al, 1996).</p>	<p>There is documented evidence in the patient records that the presence of pain has been addressed.</p> <p>There is documented evidence that, wherever possible, the patient is involved in his/her own pain assessment.</p>

Figure 1: Suggested Core Elements of a Pain Assessment Tool: Edinburgh Cancer Centre (2003)

Core Elements Essential (E) Preferable (P)	Building a Profile of Pain in Partnership with the Patient
Location of pain (E)	What hurts? Identifies specific sites of patient's pain. Use a body outline chart for precision: easy for patients to use.
Severity/Intensity of the Pain (E)	How much it hurts? Measures patient's individual experience of pain. A consistent pain scoring system allows for quantification of the patient's pain and assessment of interventions. (0-10, 0-4, mild/moderate/severe).
Duration of Pain (P)	How long it hurts? Pattern of pain. How long has the patient been suffering? How long does each episode of pain last?
Aggravating Factors (E)	What makes it hurt? Factors that make the pain worse. Movement / coughing / lying down.
Relieving Factors (E)	What stops it hurting? Factors that help to make the pain better. Position change / heat / analgesia.
Quality of Life Impact (P)	Does it affect? Sleep / appetite / mobility / intimacy / ability to participate in 'life'.
Psychological Impact (P)	Does it affect? Distress / anxiety / worry / mood / attitude.
Social Impact (P)	Does it affect? Employment / personal finances / social activities / relationships.
Spiritual Impact (P)	Does it affect? Meaning of illness and suffering / purpose of life / changing roles within society and family / fear of burdening loved ones / challenge to beliefs about life and death.
Description of Pain (E)	How it hurts? Helps to identify features suggestive of a specific pain type. Patient may choose words: shooting / burning / stabbing / tingling / aching etc. Describe each pain that the patient is experiencing.
Pain Expectations (E)	What is it about? Explore patients understanding and beliefs about pain and their hopes regarding management. Set shared management goals.
Medication (E)	What helped? Detailed drug history, reviewing for side-effects.
Opioid Toxicity (P)	Treatment complications? Screen for symptoms. Drowsiness / confusion / hallucinations / jerking.
Interventions (P)	What helped? Breakthrough analgesia / ↑ dose of regular analgesia / regular analgesia changed / use of adjuvant drug(s) / position change / heat / cold. Assess effectiveness.
Complementary Interventions (P)	What helped? Distraction techniques / massage / acupuncture / TENS. Assess effectiveness.
Management (E)	What needs to be done? Goal setting and planning to manage pain.
Outcome (E)	What next? Patient review to include re-assessment. Regular pain evaluation. What worked / what didn't / why / side-effects.

## Section 2: Pain Assessment

### Key Points ~

1. *A formalised pain assessment tool is used by healthcare professionals in partnership with the patient.*
2. *Pain is multidimensional comprising physical, psychological, social and spiritual elements.*
3. *Patients with cancer may experience pain in more than one site.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Pain in patients with cancer is assessed using a formalised, pain assessment tool which:</p> <ul style="list-style-type: none"> <li>• Reflects the multidimensional nature of pain.</li> <li>• Identifies each individual site of pain experienced by the patient.</li> </ul> <p>See Figure 1 above.</p>	<p>Comprehensive pain assessment is directly linked to improved pain management (Ferrell, 2003).</p> <p>Pain is multidimensional comprising physical, psychological, social and spiritual elements (Ferrell, 2003).</p> <p>80% of patients with cancer experience pain in more than one site (SIGN 44, 2000).</p>	<p>Healthcare professionals use a formalised pain assessment tool to assess pain in patients with cancer.</p> <p>Completed pain assessment tools are stored in patients' notes.</p>

### Key Challenges ~

1. *In the acute care setting initial pain assessment should be undertaken on admission. Re-assess frequently (eg daily) or more regularly depending on the severity of pain or level of distress.*
2. *In the community, pain should be assessed at each visit, the timing dependent on each individual patient's circumstances. Patient-held records incorporating an integrated care pathway may be useful in involving patients in the assessment and management of their pain (Cringles, 2002).*
3. *Following assessment, healthcare professionals are accountable for ensuring that actions to maximise patients' pain control are promptly taken.*
4. *NHS Boards, Independent and Voluntary Sectors should ensure that each area of practice has a formalised pain assessment tool appropriate for each care setting*

## Section 2: Pain Assessment

### Key Points ~

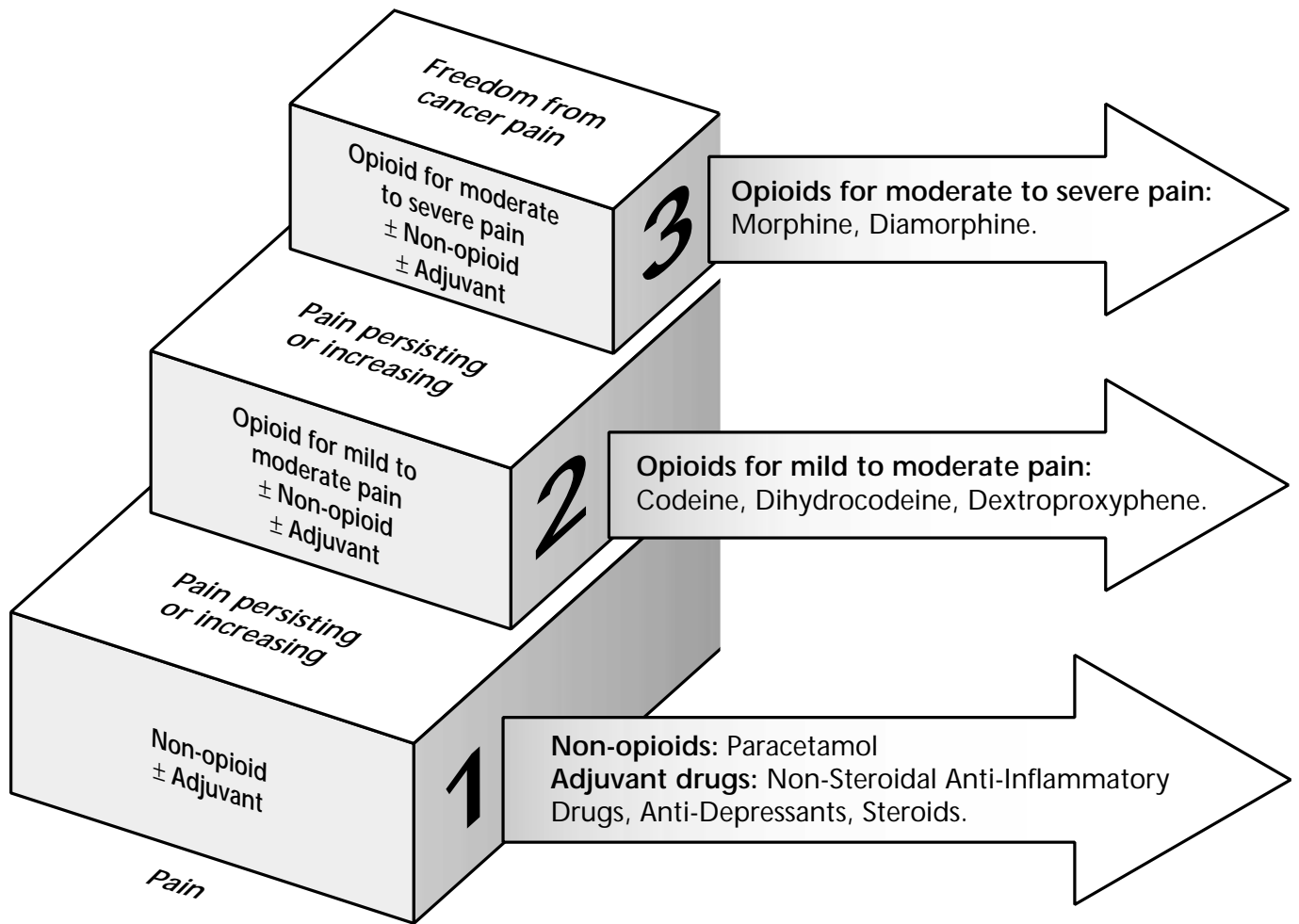
1. *Patients with complex and/or poorly controlled pain are referred to an appropriate specialist.*
2. *Sudden, severe pain in patients with cancer is a medical emergency and patients must be assessed as soon as possible.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
Patients with complex and/or poorly controlled pain are identified and referred to an appropriate specialist.	It is recommended that more complex treatment regimes receive specialist input (SIGN 44, 2000).	Referral to a specialist service is documented.
Sudden, severe pain in patients with cancer is treated as a medical emergency.	Sudden, severe pain in patients with cancer is a medical emergency and should be managed without delay (SIGN 44, 2000).	There is documented evidence that sudden, severe pain in patients with cancer has been recognised as a medical emergency and managed accordingly.

### Key Challenges ~

1. *Nurses should be aware of the provision and referral pathway to specialist pain services within their local area, eg palliative care team, hospices, chronic pain service.*

Figure 2: The WHO Analgesic Stepladder (1996)



**Figure 3: Principles of Using the WHO Analgesic Stepladder (WHO, 1996)**

- The general treatment strategy for cancer pain developed by the World Health Organisation (WHO) programme for cancer pain is illustrated in Figure 2.
- The principles of treatment outlined in the WHO cancer relief programme should be followed when treating people with cancer.
- The WHO Analgesic Stepladder should be used as a recommendation of principles rather than a rigid framework. The ladder was never intended to be used in isolation and may have to be combined with other treatment modalities.

To obtain the optimum outcome when using the principles of the ladder, a multi-professional approach is recommended. Healthcare professionals may include: allied healthcare professionals, anaesthetists, clinical psychologists, nurses, oncologists, palliative care specialists, pharmacists, and surgeons.

**How to Apply the WHO Analgesic Stepladder (WHO, 1996)**

**'By mouth':** If feasible, analgesics should be administered orally.

**'By the Clock':** Analgesics should be administered 'by the clock', ie at fixed time intervals (based on the pharmacokinetics of the drug being used) in order to suppress pain continuously.

**'By the ladder':** Start at:

- Step 1 if mild pain
- Step 2 if mild/moderate pain
- Step 3 if moderate/severe pain

**'For the individual':** There is no standard dose for opioid drugs. The correct dose of an opioid is one that relieves the patient's pain with few/acceptable side effects.

**'Attention to detail':** The need for regular administration of pain relief drugs should be emphasised. Good practice is to provide information on the patient's drug regime in full for the patient and family to work from.

- **If one drug on the step does not control pain, re-assess and move up a step.**

**Figure 4: Adjuvant Analgesics**

- "Adjuvant analgesics are a diverse group of drugs that have a primary indication other than pain, but are used to enhance analgesia in specific circumstances. Adjuvant analgesics may be used to improve pain relief in combination with primary analgesics at any stage of the WHO Analgesic Stepladder" (WHO, 2002).
- They are particularly effective for pains that are difficult to manage and/or are relatively unresponsive to morphine, eg nerve pain, bone pain.
- **Frequent pain assessment is considered essential for patients who are taking adjuvant analgesics.**

**Please Note:** Every effort has been made to ensure the accuracy of the text and that the best information available has been used. The information contained within this document does not replace the British National Formulary (BNF) and all prescribers should refer to the BNF for information on doses, side effects, drug interactions and more comprehensive information on a wider range of drugs. All medicines should be administered according to the NMC guidelines for the administration of medicines (NMC, 2002).

## Section 3: Pharmacological Management of Mild Pain

### Key Points ~

1. *Patients with cancer who have mild pain receive analgesia according to Step 1 of the WHO Analgesic Stepladder.*
2. *If pain persists or increases, move up to Step 2 of the WHO ladder; do not move across (ie to a different drug on the same step).*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>The patient with cancer experiencing mild pain receives pharmacological management according to Step 1 of the WHO Analgesic Stepladder:</p> <ul style="list-style-type: none"> <li>• Non-opioids.</li> <li>• +/- Adjuvant Drugs.</li> </ul> <p>See Figures 2, 3 &amp; 4 and Appendix 1.</p>	<p>The WHO recommends a 3-step approach to the pharmacological management of pain in patients with cancer (WHO, 1996).</p> <p>The WHO Analgesic Stepladder has been demonstrated to improve pain in approximately 85% of patients with cancer (Hanks &amp; Hawkins, 2000).</p>	<p>Documentation reflects the correct use of Step 1 of the WHO Analgesic Stepladder.</p> <p>It is documented that levels of pain relief and side-effects are acceptable to the patient, carers and healthcare professionals.</p>

### Key Challenges ~

1. *Healthcare professionals should ensure that the patient is the prime assessor of his/her own pain wherever possible.*
2. *Healthcare professionals should be aware that non-pharmacological interventions as described in Section 4 may be useful in the management of pain in patients with cancer.*
3. *Nurses involved in prescribing drugs used for the management of pain in patients with cancer should adhere to NMC guidelines for the administration of medicines (NMC, 2002), Extending Independent Nurse Prescribing within NHSScotland (Scottish Executive, 2002), Supplementary Prescribing by Nurses Within NHSScotland: A Guide for Implementation (Scottish Executive, 2003).*

**Figure 5: Management of the Possible Side-Effects of Opioids**

<ul style="list-style-type: none"> <li>• <b>Constipation</b> <ul style="list-style-type: none"> <li>- Almost all patients on opioids will get some degree of constipation.</li> <li>- This must be anticipated, treated <b>prophylactically and monitored</b> with appropriate laxatives: Peristaltic stimulant + Stool softener (or combination laxative).</li> <li>- If possible, the patient should be advised to increase activity as able, and drink plenty of fluids.</li> <li>- Other causes of constipation should be considered.</li> </ul> </li> <li>• <b>Nausea and Vomiting</b> <ul style="list-style-type: none"> <li>- Occurs in half to two thirds of patients taking oral morphine.</li> <li>- Usually only a transient side-effect; resolves in 5-10 days.</li> <li>- An anti-emetic should be prescribed for all patients on opioids, to be taken if required. Once nausea stops, this should be discontinued. If nausea severe, consider other routes for the administration of medication or change opioids.</li> <li>- Exclude aggravating factors such as constipation, hypercalcaemia.</li> </ul> </li> <li>• <b>Sedation</b> <ul style="list-style-type: none"> <li>- Commonly occurs at the start of treatment with opioids.</li> <li>- Usually decreases within 7-14 days once dose is stabilised.</li> <li>- In cases of prolonged drowsiness, all medication that may cause drowsiness should be reviewed and modified as appropriate.</li> <li>- Consider other causes.</li> <li>- Change opioids if sedation persists.</li> </ul> </li> <li>• <b>Dry Mouth</b> <ul style="list-style-type: none"> <li>- This is common with the use of opioids.</li> <li>- May also be due to concurrent medication.</li> <li>- Patients should be advised to take regular sips of cool water.</li> <li>- Good oral hygiene should be encouraged.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Pseudo-Hallucinations</b> <ul style="list-style-type: none"> <li>- May occur at any stage.</li> <li>- Ensure adequate hydration.</li> <li>- Investigate other causes.</li> <li>- If persists, reduce dose of opioid or consider changing opioid.</li> </ul> </li> <li>• <b>Respiratory Depression</b> <ul style="list-style-type: none"> <li>- Rare in patients with cancer taking opioids for pain relief.</li> <li>- Exercise caution in patients with renal failure and malignant/non-malignant lung disease.</li> <li>- Ensure that starting dose is tailored to each individual patient. Caution is advised in opioid-naive patients.</li> <li>- Reduction in dose or temporary withdrawal of opioid is all that is usually required, however, for opioid overdose, specialist advice should be sought.</li> </ul> </li> <li>• <b>Pruritus (itching)</b> <ul style="list-style-type: none"> <li>- Occurs only in a small number of patients.</li> <li>- Usually decreases with time.</li> <li>- Use a mild antihistamine if necessary.</li> <li>- If itching persists, consider changing opioids.</li> </ul> </li> <li>• <b>Myoclonus (muscle jerking)</b> <ul style="list-style-type: none"> <li>- Can occur if opioid dose is too high for the individual patient or with renal dysfunction. <b>Be aware of using drugs that induce renal toxicity.</b></li> <li>- Try lowering dose of opioids without affecting pain control.</li> <li>- If persists, change opioids.</li> </ul> </li> <li>• <b>Urinary Retention/Hesitancy</b> <ul style="list-style-type: none"> <li>- Has been known to occur:                             <ul style="list-style-type: none"> <li>After the administration of spinal opioids.</li> <li>When constipation is present.</li> </ul> </li> </ul> </li> </ul>
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### Section 3: Pharmacological Management of Mild to Moderate Pain

**Key Points ~**

1. *Patients with cancer who have mild to moderate pain receive analgesia according to Step 2 of the WHO Analgesic Stepladder.*
2. *If pain persists or increases move up to Step 3 of the WHO ladder; do not move across (ie to a different drug on the same step).*
3. *Healthcare professionals are aware of the side-effects of opioids and their management.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>The patient with cancer experiencing mild to moderate pain receives pharmacological management according to Step 2 of the WHO Analgesic Stepladder:</p> <ul style="list-style-type: none"> <li>• Opioids for Mild/Moderate Pain.</li> <li>• +/- Non-opioids.</li> <li>• +/- Adjuvant Drugs.</li> </ul> <p>Healthcare professionals are aware of the side-effects of opioids and their management.</p> <p>See Figure 5 above.</p>	<p>The WHO recommends a 3-step approach for the pharmacological management of pain in patients with cancer (WHO, 1996).</p> <p>The WHO Analgesic Stepladder has been demonstrated to improve pain in approximately 85% of patients with cancer (Hanks &amp; Hawkins, 2000).</p> <p>Inadequate management of the side-effects of opioids may limit titration of analgesia (SIGN 44, 2000).</p>	<p>Documentation reflects the correct use of Step 2 of the WHO Analgesic Stepladder.</p> <p>Levels of pain relief and side-effects are achieved that are acceptable to the patient, carer and healthcare professionals.</p> <p>Documentation reflects that the side-effects of opioids have been assessed and managed as appropriate.</p>

## Figure 6: Initiating and Establishing Opioids

- Oral morphine is the drug of choice.
- When moving from Step 2 to Step 3 of the WHO Analgesic Step ladder initiate normal release morphine (5-10mg) at 4-hourly intervals unless otherwise contraindicated (SIGN 44, 2000).
- Remember breakthrough analgesia, which should be a normal release preparation of morphine and should be one sixth of the total regular daily dose of oral morphine (see Section 3).
- When pain control is achieved with normal release morphine, conversion to controlled release morphine should be considered:

Calculate by adding up the total dose of normal release morphine taken in the past 24 hours. Divide this by 2 and prescribe as a twice daily, 12-hourly preparation of controlled release morphine (SIGN 44, 2000).

OR

Calculate by adding up the total dose of normal release morphine taken in the past 24 hours. Prescribe this as a once daily, 24-hourly preparation of controlled release morphine (SIGN 44, 2000).

- The first dose of controlled release morphine should be administered at the time the next normal release morphine dose is due. Continue to prescribe the appropriate dose of normal release morphine as breakthrough analgesia (SIGN 44, 2000).

**There are a variety of controlled release morphine preparations available.**

## Figure 7: Increasing the Dose of Controlled Release Morphine Preparations

- It is necessary to adjust opioid doses against a **person's pain, side-effects and clinical state.**
- When a patient is on controlled release morphine and taking breakthrough analgesia, the dose of opioids may be increased by calculating the:
  - Total dose of normal release morphine taken for breakthrough pain (in the past 24-hours) + total dose of controlled release morphine (taken in the past 24 hours) divided by 2 for twice daily, 12-hourly preparations of controlled release morphine.

OR

- Total dose of normal release morphine taken for breakthrough pain (in the past 24 hours) + total dose of controlled release morphine (taken in the past 24 hours) for once daily, 24-hourly preparations of controlled release morphine.

## Section 3: Pharmacological Management of Moderate to Severe Pain

### Key Points ~

1. *Patients with cancer who have moderate to severe pain receive analgesia according to Step 3 of the WHO Analgesic Stepladder.*
2. *Healthcare professionals understand the basic principles of initiating and establishing opioids for the management of moderate to severe pain in patients with cancer.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>The patient with cancer experiencing moderate to severe pain receives pharmacological management according to Step 3 of the WHO Analgesic Stepladder:</p> <ul style="list-style-type: none"> <li>• Opioids for moderate to severe pain.</li> <li>• +/- Non-Opioids.</li> <li>• +/- Adjuvant Drugs.</li> </ul> <p>Healthcare professionals are aware of and understand the underlying principles of:</p> <ul style="list-style-type: none"> <li>• Initiating and establishing opioids.</li> </ul> <p>See Figures 6 &amp; 7 above.</p>	<p>The WHO recommends a 3-step approach for the pharmacological management pain in patients with cancer (WHO, 1996).</p> <p>The WHO Analgesic Stepladder has been demonstrated to improve pain in approximately 85% of patients with cancer (Hanks &amp; Hawkins, 2000).</p>	<p>Levels of pain relief and side-effects are achieved that are acceptable to the patient, carers and healthcare professional.</p> <p>Documentation reflects the correct use of Step 3 of the WHO analgesic ladder in the management of moderate to severe pain in patients with cancer.</p>

### Key Challenges ~

1. *Healthcare professionals need to be aware of the difference between normal and controlled release morphine preparations for the management of moderate to severe pain in patients with cancer.*
2. *Nurses should be aware of the various opioid preparations that are available and be proficient in their administration.*

## Figure 8: The Management of Breakthrough Pain

- Breakthrough pain is defined as "episodic or transient pain" (Mercadante et al, 2002) that occurs in addition to otherwise stable pain.
- Breakthrough analgesia should be available for every patient with cancer requiring opioids for moderate to severe pain (SIGN 44, 2000). **Breakthrough analgesia is not a replacement for regular analgesia.**
- Breakthrough analgesia should be a normal release preparation and should be one sixth of the total regular daily dose of oral morphine (SIGN 44, 2000) or other opioid.
- Always assess the patient 30 minutes following administration of breakthrough analgesia to evaluate effectiveness. If pain continues, repeat breakthrough analgesia and re-assess patient in a further 30 minutes. If pain is not controlled at this stage, a full re-assessment of the patient is required (SIGN 44, 2000).
- If pain is poorly controlled with the use of breakthrough analgesia, referral should be made to the appropriate specialist.
- Patients and carers should be fully informed, as appropriate, on how and when to administer breakthrough analgesia.

## Figure 9: The Management of Incident Pain

- Incident pain is defined as "episodes of pain in relation to movement" (Douglas et al, 2000) in patients who are otherwise free from pain at rest.
- **Caution is advised for patients who have incident pain when titrating the dose of opioids.** If all the analgesia taken for pain on movement is incorporated in the new regular morphine dose, the patient may become opioid toxic. In patients with incident pain, optimum pain control is achieved by (SIGN 44, 2000):
  - Optimum background analgesia.
  - Anticipatory analgesia for movement related pain, where possible, 30 minutes prior to movement.
  - Optimum use of non-opioid and adjuvant analgesics.
  - Consideration of other types of treatment, eg radiotherapy, nerve blocks.

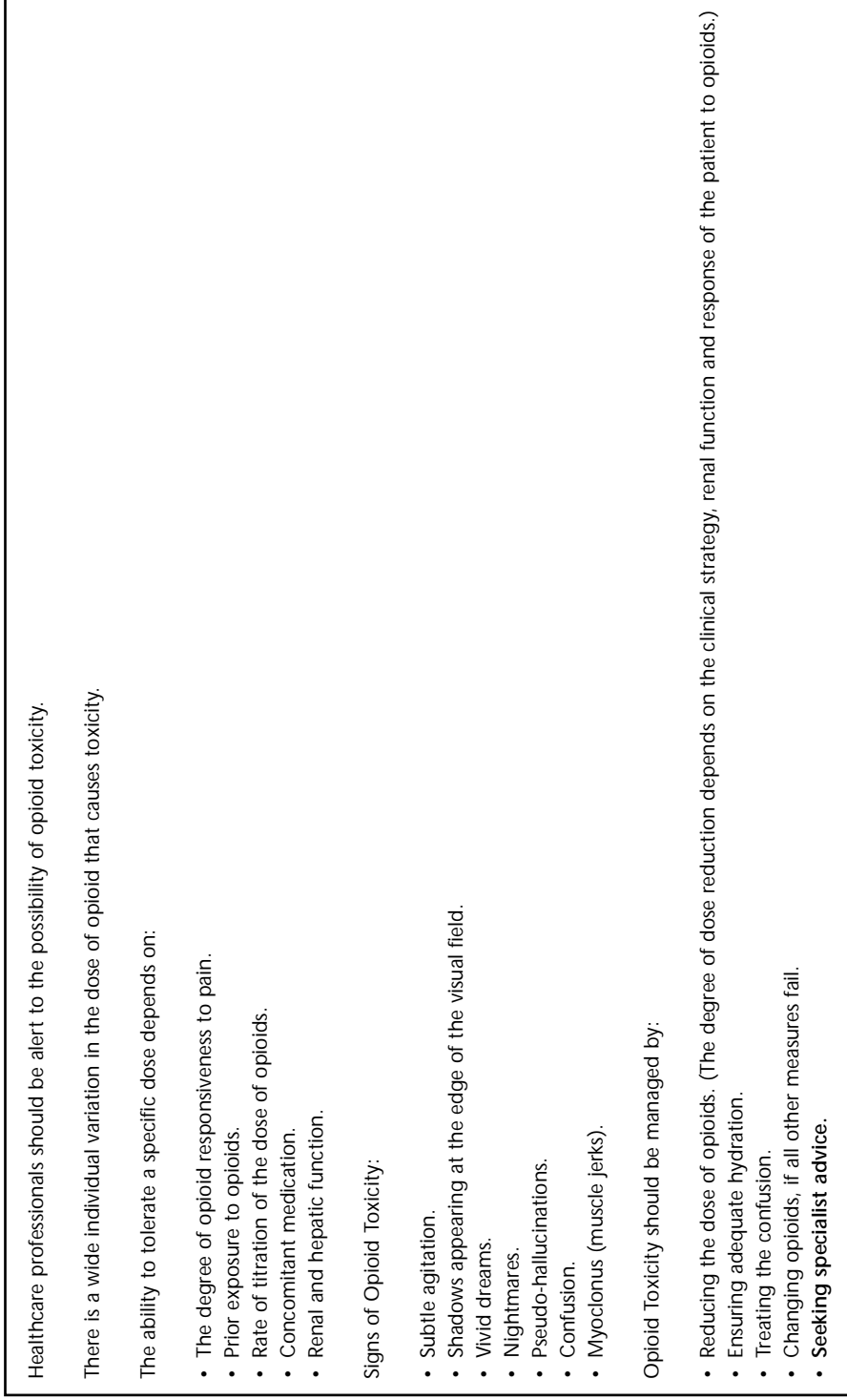
### Section 3: Pharmacological Management of Breakthrough and Incident Pain

#### Key Points ~

1. *Breakthrough analgesia is available for every patient requiring opioids. Breakthrough analgesia is not a replacement for regular analgesia.*
2. *Breakthrough analgesia should be an oral normal release morphine preparation and should be one sixth of the total regular daily dose of morphine.*
3. *Healthcare professionals are aware of the differences between breakthrough pain and incident pain and their management.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Healthcare professionals are aware of and understand the underlying principles of:</p> <ul style="list-style-type: none"> <li>• Management of breakthrough pain.</li> <li>• Management of incident pain.</li> </ul> <p>See Figures 8 &amp; 9 above.</p>	<p>Approximately 50% of patients with cancer may experience breakthrough pain (Portenoy et al, 1999).</p>	<p>Documentation reflects the correct use of analgesia for breakthrough/incident pain.</p> <p>Levels of pain relief and side-effects are achieved that are acceptable to the patient, carers and healthcare professional.</p>

**Figure 10: Opioid Toxicity**



## Section 3: Pharmacological Management of Opioid Toxicity

### Key Points ~

1. *Healthcare professionals understand the basic principles and management of opioid toxicity.*
2. *Patients with signs and/or symptoms of opioid toxicity are referred to an appropriate specialist.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Patients receiving opioids for moderate to severe pain are closely observed for signs and symptoms of opioid toxicity (SIGN 44, 2000).</p> <p>Patients with complex, uncontrolled pain are referred to an appropriate specialist.</p> <p>See Figure 10 above.</p>	<p>To minimise the risk of exposure to opioid toxicity (O'Neill &amp; Fallon, 1997).</p> <p>It is recommended that more complex treatment regimes require specialist input (SIGN 44, 2000).</p>	<p>Documentation reflects that signs/symptoms of opioid toxicity have been monitored and managed as appropriate.</p> <p>There is evidence of timeous referral to a specialist service.</p>

Figure 11: Opioids and Addiction

"Addiction is the compulsive use of drugs for non-medical reasons; it is characterised by a craving for mood altering drug effects, not pain relief" (WHO, 1998).

**Clinical Relevance:**

- This is rare in patients with cancer receiving opioids for pain relief.
- Factors that are closely related to addiction include biochemical, social and psychological factors.
- Opioids should never be withheld due to fears that a patient may become addicted.
- If a patient requests a strong analgesic, it is probable that their pain control is inadequate.

(WHO, 1998)

Figure 12: Opioids and Tolerance

"Increased resistance to the usual effects of a drug as a result of long-term continual use" (WHO, 1996).

**Clinical Relevance:**

- Higher doses of opioids are usually required in the presence of worsening pain/disease progression.
- If tolerance to analgesia does occur, re-assess the pain and increase the dose until pain control is achieved or side-effects are no longer tolerated.

(WHO, 1998)

Figure 13: Opioids and Physical Dependence

"Physical dependence is the physiological adaptation of the body to the presence of an opioid. It is defined by the development of withdrawal symptoms when opioids are discontinued, when the dose is reduced abruptly or when an antagonist or an agonist-antagonist is administered" (WHO, 1998).

**Clinical Relevance:**

- It is normal for physical dependence to occur with continuous opioid use.
- The occurrence of physical dependence varies among individual patients.
- Physical dependence (in the presence of withdrawal symptoms) does not indicate that the patient is addicted to opioids.
- Healthcare professionals should inform patients to take their analgesia as prescribed and that withdrawal symptoms may occur if they abruptly reduce or discontinue their medication.
- Symptoms of withdrawal are agitation, sleeplessness, diarrhoea, sweating, a rapid heartbeat and shivers.
- In cases where the source of pain is effectively removed, physical dependence may be managed by gradually decreasing the dose of opioid according to regulated local guidelines.
- Physical dependence should not limit opioid therapy.

(WHO, 1998)

### Section 3: Barriers to Effective Pain Control

#### Key Points ~

1. *The main barrier to effective pain control is poor pain assessment (Section 2).*
2. *Opioid analgesia is not delayed in patients with cancer experiencing moderate to severe pain due to fears and misconceptions about its use.*
3. *Education of patients, carers and healthcare professionals addresses issues such as addiction, tolerance and physical dependence.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Opioid analgesia is not delayed in patients with cancer experiencing pain due to fears and misconceptions about its use (SIGN 44, 2000).</p> <p>See Figures 11, 12 &amp; 13 above.</p>	<p>Patients, carers and healthcare professionals may be overly concerned regarding addiction, tolerance and physical dependence to opioid analgesia (WHO, 1998).</p> <p>Fear about addiction is a barrier to achieving pain relief with opioid analgesia (Paseo, 1998; Morrison, 2000).</p>	<p>Documentation reflects the correct use of the WHO Analgesic Ladder in the management of pain in patients with cancer.</p> <p>Education of patients, carers and healthcare professionals addresses topics such as addiction, tolerance and physical dependence.</p>

Figure 14: When to Use a Syringe Driver

When to Use a Syringe Driver	Review
<ul style="list-style-type: none"> <li>• The patient is unable to take medication by mouth.</li> <li>• Persistent nausea and vomiting.</li> <li>• Dysphagia.</li> <li>• Persistent fits.</li> <li>• Profound weakness.</li> <li>• Poor absorption.</li> <li>• Uncontrolled pain (rare indication).</li> <li>• When other routes of administration have been exhausted.</li> </ul>	<p>Check effectiveness by looking at indicators of good performance and documenting:</p> <ul style="list-style-type: none"> <li>• Satisfactory pain control with reducing/no breakthrough pain.</li> <li>• Satisfactory control of other symptoms.</li> <li>• Patient satisfaction.</li> <li>• Infusion running to set time.</li> <li>• No leaks.</li> <li>• No signs of skin irritation.</li> </ul>

### Section 3: The Use of Syringe Drivers in the Management of Pain in Patients with Cancer

#### Key Points ~

1. *Without formalised education and training, safe practice in the use of syringe drivers cannot be guaranteed.*
2. *Healthcare professionals without formalised education and training on syringe driver use, seek specialist advice when caring for patients with syringe drivers.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>All healthcare professionals involved in the use of syringe drivers receive formalised education and competency training (Scottish Home and Health Department, 1995).</p> <p>Patients and carers receive written information on syringe drivers and offered instruction and self-training on use.</p> <p>See Figure 14 above.</p>	<p>There is a high incidence of human error involved in the use of infusion systems (Medical Devices Agency, 2003).</p> <p>To facilitate safe, evidence-based practice.</p> <p>To encourage participation in care and ensure understanding of treatment.</p>	<p>There is documented evidence of a locally agreed training strategy.</p> <p>Records of attendance at training sessions are maintained.</p> <p>Ongoing audit and review of the education package.</p> <p>There is documented evidence that this information has been given to the patient/carer.</p>

#### Key Challenges ~

1. *All healthcare professionals involved in the use of syringe drivers should have access to the manufacturers' instructions and local guidelines.*
2. *Resources should be available to allow healthcare professionals to regularly update knowledge via education and training sessions.*

### Section 3: The Use of Syringe Drivers in the Management of Pain in Patients with Cancer

#### Key Point ~

1. *There are locally agreed guidelines on the use and management of syringe drivers*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>There are locally agreed guidelines on the use of syringe drivers in the management of pain in patients with cancer including:</p> <ul style="list-style-type: none"> <li>• Initial set up, preparation of infusion and reason for use.</li> <li>• Drug compatibility and stability.</li> <li>• A list of commonly used drugs.</li> <li>• Incident reporting.</li> <li>• Documentation and labelling for syringe driver use.</li> <li>• The provision of one single type of syringe driver.</li> <li>• 24-hour access.</li> <li>• Maintenance and repair of equipment.</li> </ul>	<p>To provide clinical guidance and ensure safe practice within the local area (Clinical Standards Board for Scotland, 2002).</p> <p>All operational aspects of infusion systems must be documented (Medical Devices Agency, 2003).</p>	<p>Review and audit guidelines annually.</p>

#### Key Challenges ~

1. *Healthcare professionals should be aware of how to access syringe drivers and relevant drugs at all times.*
2. *It is strongly recommended that guidelines on the use of syringe drivers be reviewed annually.*
3. *Each Trust/Health Board should aim to provide one type of syringe driver for use in the management of pain in patients with cancer, as confusion between different models of syringe drivers exists (Medical Devices Agency, 1994).*

### Section 3: The Role of Radiotherapy and Bisphosphonates in the Management of Pain in Patients with Cancer

Key Points ~

1. *Radiotherapy may be used in the management of bone pain in patients with cancer.*
2. *Bisphosphonates may be used in the management of bone pain in patients with metastatic breast cancer/multiple myeloma.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
Healthcare professionals are aware that: <ul style="list-style-type: none"> <li>• Radiotherapy</li> <li>• Bisphosphonates</li> </ul> may be useful in the management of bone pain in patients with cancer.	Radiotherapy has been demonstrated to be effective in relieving pain from bone metastases (SIGN 44, 2000).  Bisphosphonates have been demonstrated to be effective in the management of bone pain in patients with metastatic breast cancer and multiple myeloma (SIGN 44, 2000).	Healthcare professionals have knowledge of these treatment options in the management of pain in patients with cancer.

Key Challenge ~

1. *Healthcare professionals should be aware that other techniques may be used in the management of pain in patients with cancer (SIGN 44, 2000).*



## Section 4: The Non-Pharmacological Management of Pain

### Key Points ~

1. *Good communication is essential in achieving effective pain management.*
2. *Information is tailored to the individual needs of the patients and carers.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>All healthcare professionals are aware that effective pain management is dependant on good communication, which is tailored to the individual needs of the patients and carers (Gamble, 1998; Heaven &amp; Maguire, 1999; Davies &amp; Higginson, 2003).</p>	<p>Good communication returns control to the patient (Munroe, 2003). Information needs to be tailored to the individual (Gamble, 1998; Heaven &amp; Maguire, 1999; Davies &amp; Higginson, 2003).</p>	<p>Any new or relevant information is sensitively relayed to the patient by the appropriate healthcare professional and documented. Healthcare professionals attend courses on basic communication skills and such attendance is documented.</p>

### Key Challenges ~

1. *All healthcare professionals attend courses on basic communication skills.*
2. *Local areas should facilitate attendance at such courses.*

**Figure 15: Core Elements of Good Communication and Basic Counselling Skills**

(Adapted from *A Patient Centred Approach to Counselling* (1979; Heaven & Maguire 1999).

Objectives	How this Can Be Achieved
Providing a safe environment	<ul style="list-style-type: none"> <li>• Be aware of body language and non-verbal communication (personal and patients).</li> <li>• Aim to give a clear idea of how long you can spend with the patient so that you can give them your undivided attention.</li> <li>• Be sensitive to the obstacles that may be around, that may affect open disclosure, eg noisy environment, constant interruptions, giving the impression of being too busy, patient feeling guilty about talking especially if one partner does not want to etc.</li> <li>• Provide unconditional acceptance and respect for the person regardless of what is being shared. Be open and genuine, acknowledge time constraints, unavoidable obstacles etc.</li> </ul>
Sensitively ascertain if the patient wants to talk	<p>Examples of questions:</p> <ul style="list-style-type: none"> <li>• "I'm wondering if you feel up to talking / would like to talk?"</li> <li>• "How have things really been for you recently?"</li> </ul>
Actively listen	<ul style="list-style-type: none"> <li>• Give eye contact, periodic affirmation, and reflection, repeating some words and do not rush in to fill silences, avoid premature advice.</li> </ul>
Invite more expression if appropriate to help clarify the situation	<ul style="list-style-type: none"> <li>• Allow silences, appropriate touch, summarising, pick up on frequent 'cues' (repeated phrases that occur, can be indicative of something deeper or important).</li> <li>• Try to focus on emotions, feelings and thoughts.</li> <li>• Prioritise by asking what is the worst thing at this time.</li> </ul>
Dealing with difficult overwhelming emotions/ uncontrolled crying	<ul style="list-style-type: none"> <li>• Be comfortable with silences – do not rush in to fill them.</li> <li>• If emotions are overwhelming, ask sensitively if the patient is able to tell you what they are thinking - this is easier to put into context.</li> <li>• Do not offer false reassurances such as "everything will be okay", it is better to hear and acknowledge the situation.</li> </ul>
Closing	<ul style="list-style-type: none"> <li>• Only after the full impact, nature and extent of fears, concerns etc are determined, can information or advice be given that is appropriate or the discussion summarised and a plan made for follow-up.</li> </ul>

## Section 4: The Non-Pharmacological Management of Pain

Key point: ~

1. *Pain is influenced by mood, morale and the significance of the pain to the patient.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Patients have the opportunity to express their emotions, thoughts, fears and expectations regarding their pain.</p> <p>See Figure 15 above.</p>	<p>For many patients, pain is the most feared consequence of cancer (Breitbart, 1994).</p> <p>The perception of pain is subjective and modified by mood, morale and the meaning of pain to the patient (Twycross, 1998).</p>	<p>Discussions regarding the patient's emotions, thoughts, fears and expectations regarding their pain are documented and referred onward as appropriate.</p>

Key Challenges ~

1. *All healthcare professionals should have access to basic counselling skill courses.*
2. *Local areas should facilitate attendance at such courses.*



## Section 4: The Non-Pharmacological Management of Pain

### Key Point ~

1. *Nursing interventions have an essential role in the management of pain in patients with cancer.*

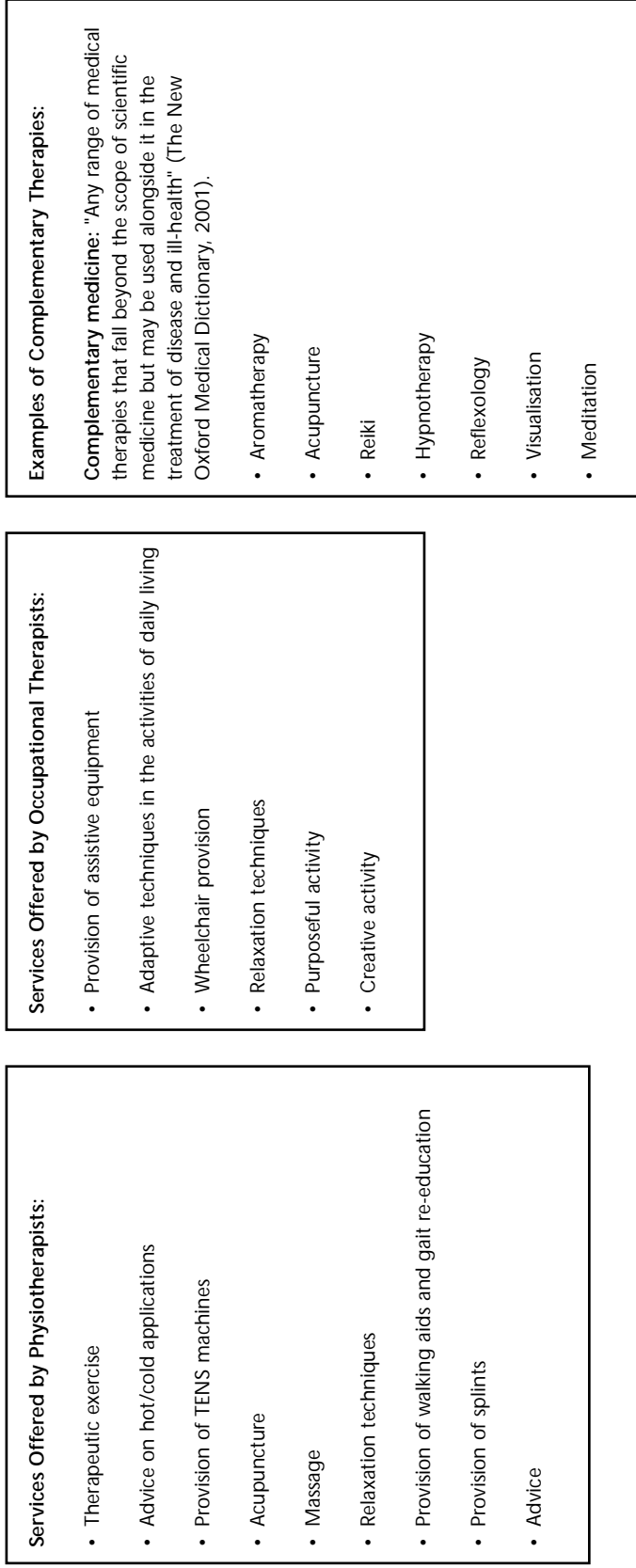
Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>All healthcare professionals are aware that nursing interventions have an essential role in the management of pain in patients with cancer.</p>	<p>Effective nursing care is therapeutic and may have a beneficial impact on physical, psychological, social and spiritual wellbeing (Corner, 1997).</p>	<p>Documentation includes details of nursing interventions such as:</p> <ul style="list-style-type: none"> <li>• Bowel and Bladder Management</li> <li>• Skin Care</li> <li>• Positioning</li> <li>• Oral Care</li> <li>• Environment</li> <li>• Nutritional Status</li> <li>• Communication</li> </ul> <p>The nursing care plan should demonstrate how these issues have been addressed in relation to pain management.</p>

### Key Challenge ~

1. *Healthcare professionals in all settings are aware of the key roles they play in managing pain in patients with cancer.*

**Figure 16: Services Involved in the Non-Pharmacological Management of Pain**

(It must be noted that service provision and access will vary in each local area.)



## Section 4: The Non-Pharmacological Management of Pain

### Key Point ~

1. *A multi-professional approach to pain management is essential.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>All healthcare professionals are aware of:</p> <ul style="list-style-type: none"> <li>• The contribution of other health disciplines in the management of pain in patients with cancer.</li> <li>• The local referral pathways to access members of the multi-professional team.</li> </ul> <p>See Figure 16 above.</p>	<p>The treatment of cancer pain should be holistic and a multi-professional approach to pain management is essential (Parris et al, 1996).</p>	<p>Evidence of multi-professional working is documented.</p>

### Key Challenge ~

1. *Healthcare professionals should be aware of the availability and access to local services involved in the management of pain.*



## Section 4: The Non-Pharmacological Management of Pain

### Key Point ~

1. *Complementary therapies may have a role to play in the individual management of pain in patients with cancer.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>All healthcare professionals are aware of that:</p> <ul style="list-style-type: none"> <li>• Complementary therapies may have a role to play in the individual management of pain in patients with cancer.</li> <li>• The local referral pathways to access complementary therapies.</li> </ul> <p>See Figure 16 above.</p>	<p>Complementary therapies may be of benefit in the management of pain in patients with cancer (Kohn, 1999).</p>	<p>Records demonstrate that complementary therapies have been considered as a management option, if appropriate and locally available.</p> <p>Healthcare professionals are aware of access to complementary therapies and refer as appropriate.</p>

### Key Challenges ~

1. *There is conflicting research on the use of complementary therapies in the management of pain in patients with cancer. They should be used only after further consultation and agreement with patients and key medical personnel.*
2. *Only professionals accredited in use of complementary therapies should be used.*
3. *Further research is required to evaluate the role of complementary therapies in the management of pain in patients with cancer.*

## Appendix 1: Adjuvant Drugs

Adjuvant Analgesics Definition: ‘Adjuvant analgesics are a diverse group of drugs that have a primary indication other than pain, but are used to enhance analgesia in specific circumstances’ (WHO, 2002).

- A trial of adjuvant analgesics should be considered if the patient describes difficult to manage pain.
- Neuropathic pain is pain associated with nerve injury or irritation.

Type of Adjuvant Drug	Example	Mode of Action
Tri-cyclic antidepressants should be considered for neuropathic pain.	Amitriptyline Imipramine Venlafaxine	May be effective in the treatment of neuropathic pain. <ul style="list-style-type: none"> <li>• Block central reuptake of monoamines to increase descending inhibitory input to dorsal horn (Attal, 2000; McQuay, 1996).</li> </ul>
Anticonvulsants should be considered for neuropathic pain.	Gabapentin  Carbamazepine	May be effective in the treatment of neuropathic pain. <ul style="list-style-type: none"> <li>• Frequency-dependent block of neuronal calcium channels (McQuay et al, 1995).</li> </ul>
Steroids should be considered for raised intracranial pressure, severe bone pain, nerve infiltration or spinal cord compression (SIGN 44, 2000).	Dexamethasone	May be effective in the treatment of severe bone pain, raised intracranial pressure, nerve infiltration or compression, pressure due to soft tissue swelling or infiltration, spinal cord compression and liver capsular pain (SIGN 44, 2000). <ul style="list-style-type: none"> <li>• Inhibits calcium currents (Stefani et al, 1998).</li> <li>• Increases GABA synthesis to enhance inhibitory modulation at the dorsal horn (Taylor et al, 1998).</li> <li>• Inhibits glutamate synthesis to reduce excitatory input to dorsal horn neurons (Taylor et al, 1998).</li> </ul>

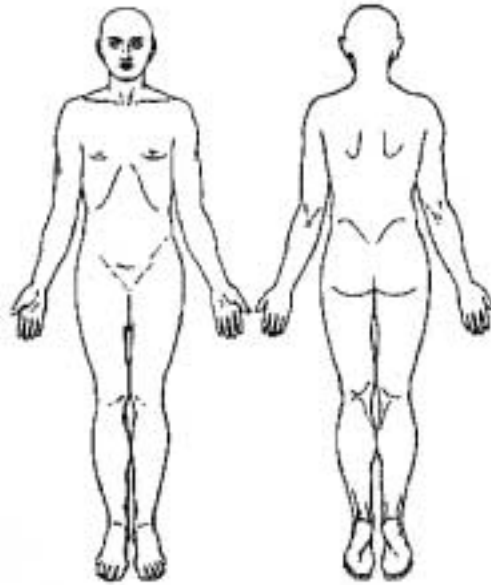
<p>Antispasmodics should be considered for pain related to muscle spasm.</p> <p>NMDA antagonists should be considered for complex and difficult to manage neuropathic pain.</p>	<p>Hyoscine butylbromide</p> <p>Baclofen</p> <p>**Ketamine</p>	<p>May be effective in the treatment of pain associated with smooth muscle (SPA, 2000).</p> <p>May be effective in the treatment of pain associated with spinal infiltration and skeletal muscle spasm.</p> <ul style="list-style-type: none"> <li>Stimulates GABA-B receptors to increase inhibitory input to dorsal horn neurones (Sindrup et al, 1999).</li> </ul> <p>May be effective in the treatment of difficult to manage neuropathic pain.</p> <ul style="list-style-type: none"> <li>Blocks NMDA receptors to inhibit depolarisation of dorsal horn neurones and reduce central sensitisation (Woolf &amp; Mannion, 1999).</li> </ul>
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\*\*Should only be used with supervision of a pain specialist.

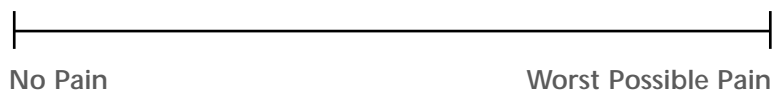
These are only some examples of adjuvant drugs and their actions. **Any medication which is prescribed and administered, should be according to British National Formulary (BNF)/NMC Guidelines for the Administration of Medicines (2002).**

## Appendix 2: Example of a Body Outline Chart and Visual Analogue Scale

Body Outline Chart



Visual Analogue Scale



A 10cm baseline is recommended for Visual Analogue Scales.

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## Glossary of Terms

pain	“An unpleasant sensory and emotional experience associated with actual or potential tissue damage” (The International Association for the Study of Pain, 1986).
acute pain	Related to injury and resolves during an appropriate healing period.
addiction	“Addiction is the compulsive use of drugs for non-medical reasons” (WHO, 1998).
adjuvant analgesic	“Adjuvant analgesics are a diverse group of drugs that have a primary indication other than pain, but are used to enhance analgesia in specific circumstances” (WHO, 2002).
analgesic	Substance or technique that reduces pain.
bisphosphonates	Bisphosphonates are a family of drugs that may be used to treat bone pain in patients with metastatic breast cancer and multiple myeloma. They slow down bone loss by reducing the rate of bone turnover.
breakthrough pain	“Episodic or transient pain” (Mercadante et al, 2002) that occurs in addition to otherwise stable pain.
chronic pain	Pain that persists for more than 3 months or that outlasts the healing process.
complementary therapy	Any range of medical treatments that fall beyond the scope of scientific medicine.
controlled release morphine	A prolonged released formulation of morphine designed to be taken 12-hourly or once every 24 hours.
incident pain	“Episodes of pain in relation to movement” (Douglas et al, 2000) in patients who are otherwise free from pain at rest.
mild pain	A score of 30mm on a visual analogue scale ranging from 0mm (no pain) to 100mm (worst possible pain) (SIGN 44, 2000).
moderate pain	A score of 31mm to 54mm on a visual analogue scale ranging from 0mm (no pain) to 100mm (worst possible pain) (SIGN 44, 2000).
neuropathic pain	Neural injury or irritation is the source of pain.
normal release morphine	A formulation of morphine usually administered 4-hourly. The time taken to reach maximum plasma concentration is approximately 1 hour.
noxious	Damaging to tissue.

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opioid	“A broad term that applies to any substance which produces its effects by binding opioid receptors and which is stereospecifically antagonised by naloxone” (Schug & Cardwell, 2003).
opioid naive	Patients who have never received opioids.
physical dependence	Physical dependence is the physiological adaptation of the body to the presence of an opioid.
pseudo-hallucinations	Vivid mental images, which differ from true hallucinations in that they lack the full qualities of true perception.
severe pain	A score of above 54mm on a visual analogue scale ranging from 0mm (no pain) to 100mm (worst possible pain) (SIGN 44, 2000).
specialist services	Acute Pain Service, Chronic Pain Service, Palliative Care Services and Oncology.
tolerance	“Increased resistance to the usual effects of a drug as a result of long-term continual use” (WHO, 1996).
WHO	World Health Organization.

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## Our Commitment

Our work will be undertaken in line with the following values:

- **patient and public focus**
  - ~ promoting a patient-focused NHS that is responsive to the views of the public
- **independence**
  - ~ reaching our own conclusions and communicating what we find
- **partnership**
  - ~ involving patients, carers and the public in all parts of our work
  - ~ working with and supporting NHS staff in improving quality
  - ~ collaborating with other organisations such as public bodies, voluntary organisations and manufacturers to avoid duplication of effort
- **evidence-based**
  - ~ basing conclusions and recommendations on the best evidence available
- **openness and transparency**
  - ~ promoting understanding of our work
  - ~ explaining the rationale for our recommendations and conclusions
  - ~ communicating in language and formats that are easily accessible
- **quality assurance**
  - ~ aiming to focus our work on areas where significant improvements can be made
  - ~ ensuring that our work is subject to internal and external quality assurance and evaluation
- **professionalism**
  - ~ promoting excellence individually and as teams and ensuring value for money in the use of public resources (human and financial)
- **sensitivity**
  - ~ recognising the needs, opinions and beliefs of individuals and organisations and respecting and encouraging diversity

This document can be viewed on the NHS Quality Improvement Scotland website. It is also available, on request, from NHS Quality Improvement Scotland in the following formats:

- Electronic
- Audio cassette
- Large print

## NHS Quality Improvement Scotland

*Edinburgh Office* ~ Elliott House 8-10 Hillside Crescent Edinburgh EH7 5EA Tel 0131 623 4300

*Glasgow Office* ~ Delta House 50 West Nile Street Glasgow G1 2NP Tel 0141 225 6999

[comments@nhshealthquality.org](mailto:comments@nhshealthquality.org) [www.nhshealthquality.org](http://www.nhshealthquality.org)

