

Clinical practice guidelines for the care and treatment of breast cancer: the management of chronic pain in patients with breast cancer (summary of the 2001 update)

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This article provides a summary of changes made by Health Canada's Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer to the article "Clinical practice guidelines for the care and treatment of breast cancer: 10. The management of chronic pain in patients with breast cancer," originally published in 1998¹ (the 2001 update can be found online at www.cma.ca/cmaj/vol-165/issue-9/breastcpg/guideline10rev.htm). Although the updated guideline does not contain many changes, it highlights the importance of optimal pain management in these patients (Table 1).

Pain is a common problem in women with metastatic breast cancer. The principles of pain management, such as thorough assessment, judicious investigation, comprehensive management and frequent reassessment, remain the same. There is an emphasis on determining the type of pain — somatic, visceral or neuropathic — as a means of

determining the best treatment. The principle of the patient as the primary source of information about her pain, its severity and response to medication is emphasized.

Once again, a stepwise approach to the use of analgesics is recommended. Mild to moderate pain can be managed with the use of acetaminophen or an NSAID. Since the publication of the 1998 guideline, selective cyclooxygenase-2 (COX-2) inhibitor NSAIDs have become available. They have been evaluated in patients with osteoarthritis and rheumatoid arthritis.^{2,3} Compared with older NSAIDs, COX-2 inhibitors reduced the risk of gastrointestinal bleeding; however, no difference was detected in efficacy against arthritis. Currently, there are no data from randomized controlled trials of the use of selective COX-2 inhibitors in cancer patients. Based on available data from the arthritis trials, the guideline recommends that these medications be considered if dyspepsia develops.

Table 1: Updated recommendations for the management of chronic pain in patients with breast cancer

- There are many reasons why a patient with breast cancer may experience pain. Identifying the cause and understanding the pathophysiology can lead to more effective management.
- The nature and severity of pain should be carefully evaluated using the history and physical, psychosocial and emotional assessments. Adequacy of pain relief should be evaluated regularly.
- The patient's self-report of pain intensity is the primary source of assessment data in all initial and subsequent evaluations.
- The development of a comprehensive, effective pain-management plan includes the education and involvement of the patient and family, together with an interdisciplinary team approach.
- The first objective in the management of pain is to identify the cause and treat it whenever feasible.
- The first priority of treatment is to control pain rapidly and completely, as judged by the patient. The second priority is to prevent recurrence of pain.
- Analgesic medication should be administered on a regular schedule, around the clock, with additional doses for breakthrough pain when necessary.
- When drug therapy is necessary, the World Health Organization's 3-step approach to the use of analgesics is recommended. The severity of the individual's pain will determine at which step the treatment regimen is commenced.
- The oral route should be the first choice for opioid administration. If the oral route fails, transdermal or rectal administration should be considered. When parenteral administration is necessary, the subcutaneous route is the first choice. Intramuscular administration of opioids is not recommended.
- Accurate conversion with careful observation and titration are required when switching from one opioid to another.
- When switching from long-term oral use of morphine or hydromorphone to parenteral use, a ratio of 2:1 should usually be used.
- After initiating opioid therapy or making any change in dose or route of administration, the dosage should be evaluated after approximately 24 hours.
- Tolerance to opioids is not common and must not be confused with addiction. Physical dependence to opioids is common and is not a symptom of addiction.
- Adjuvant analgesics should be administered, when necessary, with an opioid or nonopioid analgesic.
- Nonpharmacological measures such as psychosocial interventions, physical modalities and complementary therapies may offer relief.
- Neuroinvasive procedures can be considered when all other interventions have failed.

When pain is not adequately controlled with acetaminophen or an NSAID, a weak opioid such as codeine or oxycodone should be added. When pain is severe or unresponsive to the previous approach, one should immediately switch to potent opioids with or without NSAIDs. The 1998 guideline recommended that, when switching from long-term oral use of an opioid to parenteral use, a ratio of 3:1 should be used. The determination of equivalent analgesic doses of oral versus subcutaneous administration of the same narcotic or of 2 different agents is derived from single-dose studies, which may not be generalizable to long-term use.⁴ The updated recommendation for switching doses using a ratio of 2:1 instead of 3:1 is based on consensus and clinical experience. Finally, there are additional data supporting the use of bisphosphonates in patients with metastatic cancer to bone.⁵

The patient version of these guidelines has also been updated and can be found online at www.cma.ca/cmaj/vol-165/issue-9/breastcpg/guideline10revpt.htm.

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