

Editorial

Cancer Pain: Still a Relevant Issue

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Despite the recent advances in pain management, cancer pain still represents a major issue.

Pain is a common symptom in cancer patients: in the systematic review of Van der Beuken- van Everdingen and Coll. its prevalence ranged from 25% in newly diagnosed patients to 64% in patients with advanced cancer [1].

Despite its high prevalence, cancer pain is often undertreated: in the recent systematic review of Deandrea and Coll. undertreatment of cancer pain was observed in about 50% of cases [2].

In 2009, a pan-European survey showed negative findings: in this survey that screened more than 5000 cancer patients experiencing pain, a high proportion (56%) of patients reported from moderate to severe pain in the last month of care [3].

There are many barriers between pain and its satisfactory control: suboptimal assessment, patient's refusal to take opioids and patient's difficulty in referring pain [4].

Moreover, a correct evaluation of pain represents a significant issue for many clinicians: physicians must evaluate the quality of pain, onset, duration and they should understand how the pain is improved or exacerbated by specific actions or stimuli [5].

The attention that physicians demonstrate to pain management plays a crucial role: in a Dutch survey that involved about 2000 oncologists, only 15% of them made frequent referrals to pain or palliative care specialists [6].

Inadequate pain evaluation is the most important obstacle to effective pain management [7]. Pain should be identified early and its assessment should include a complete medical history, psychosocial evaluation and physical examination. The most relevant guidelines recommend the use of one of 3 validated assessment scales: VAS, NRS and VRS; moreover, baseline pain assessment, reassessment and analgesia efficacy must be documented within the patient's record [8]. In 2007 an interesting article reported on pre-intervention findings related to barriers to pain management: less of 10% of patients were screened for pain at each clinic visit and in only 2.6% of cases was precisely described the quality of pain [9].

Moreover, physicians are still showing incorrect opinions that negatively affect their prescription of opioids. For example, lack of knowledge created erroneous beliefs over addiction and tolerance to analgesics as well as issues with crucial concepts about the management of adverse events and the utilisation of specific routes of administration [10].

Patient's unwillingness to report his pain and his poor compliance with treatment is also an important cause of suboptimal pain management. Patients frequently believe pain as an inevitable consequence of cancer and assume that admitting pain is a sign of weakness [11]. Furthermore, some patients are reluctant to report their pain because they don't want to distract the doctor from treating cancer or may believe that pain is a sign of progressive disease [12].

The patient's age and ethnicity may have a specific relevance in determining poor pain assessment: cognitive decline in elderly patients often represents a communication barrier and in ethnic minorities under-treatment of cancer pain is frequently reported [13].

Despite the treatment of pain constitutes an area of growing medical interest and the significant advances in developing new drugs reached in the recent years, inadequate cancer pain assessment and management still represent a relevant issue.

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