

Guest Editorial

Editorial Special Issue: Pain Management

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Pain is one of the most common symptoms in patients with cancer. In a recent systematic review of 122 studies, pain prevalence rates were 39% after curative treatment; 55% during anticancer treatment; and 66% in advanced, metastatic, or terminal disease. Moderate-to-severe pain was reported by 38% of all patients.^[1] Although many clinical guidelines for cancer pain management have been established and pharmacologic pain treatment has been improved in the past 20 years, Greco *et al.* estimated that approximately one-third of patients still do not receive pain medication proportional to their pain intensity.^[2] Therefore, even though many clinicians and researchers have been making efforts to achieve freedom from cancer pain since 1990 when the WHO published the epoch-making report “Cancer pain relief and palliative care,” pain management has remained a challenging area in palliative care and oncology nursing.

Although pharmacological intervention plays a central role in pain treatment, nursing care also plays an important role in pain management, for example, in pain assessment, plan of care, nonpharmacologic interventions, management of adverse effects of pharmacologic treatment, communication with physicians, and patient education.^[3] Moreover, the advances in anticancer treatment and development of new anticancer agents have increased the number of cancer survivors in the current aging

population worldwide. This has led to opioid abuse and other behavioral changes in patients with cancer, which affect the patients’ families and clinicians and present new clinical challenges to oncology nurses.

The aging population is a worldwide phenomenon that also affects patients in Asia. In this issue, Dr. Brant has thoughtfully reviewed the emerging problem of assessment and management of cancer pain in older adults. She suggested three challenges to pain management in older adults such as “most older adults and health care practitioners perceived that pain is a normal part of aging and that might interfere with pain assessment and management,” “there exists a myth that older adults perceive less pain,” and “communication problem from cognitive impairment.” She proposed a five-step approach to pain assessment for older adults including “self-report,” “pathology,” “behaviors,” “caregiver input,” and “analgesic trial.” Of them, taking into account the physiological changes and multimorbidity associated with aging, the choice of treatment should consider the side effects of analgesics. From this perspective, opioid availability is a major challenge in most Asian countries.^[4] Pain and palliative care are issues not only for patients with cancer but also for those with other life-threatening conditions. The WHO adopted the first-ever global resolution on palliative care in 2014, which requires all governments to

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incorporate palliative care into their national health care system and improve access to palliative care.^[5] In another journal, Guerard and Cleary presented a similar view on the complex and challenging management of cancer pain in older patients with cancer. Although their conclusion was similar, that article would be helpful to readers interested in this subject.^[6]

Another major challenge is in the advancement of anticancer therapies. Yi and Hwang have argued about this challenge in the current issue. They analyzed pain and menopause symptoms in patients with breast cancer undergoing adjuvant hormonal therapy in Korea. They found that 88% of the participants experienced pain and 40% reported to have moderate or severe pain in the study, with more pain being reported by patients receiving aromatase inhibitor treatment than by those receiving tamoxifen. As we know, the causes of cancer pain are mainly classified into three categories: pain associated with tumor, pain associated with treatment, and pain unrelated to either.^[7] Although the treatment of pain associated with tumor has been improved by the advances in pharmacological treatment, a new pain associated with treatment, especially from chemotherapy, has emerged. Aromatase inhibitors have been used for treating hormone-sensitive breast cancer in postmenopausal women, and one of its common side effects is joint disorder. The authors revealed that joint and muscle complaints were higher in the aromatase inhibitor group than in the tamoxifen group. Moreover, in that study, older patients reported more pain than did younger patients. This might support the evidence of the “myth” mentioned by Brant. They explained that the result might be because the older patients had osteoporosis or basic musculoskeletal problems. In reality, the pain was found throughout the body. This shows the necessity of comprehensive assessment of the complex and multimorbid nature of older patients with cancer. In addition, the low-income group reported higher pain in that study. Social factors would have to be assessed in such cases because patients with a low income might have lower accessibility to and availability of medical systems. Furthermore, one of the most important findings in their study was that although adherence to adjuvant hormone therapy is important for patients undergoing such treatment, nonadherence was correlated with the rate of feeling increased pain. This might indicate that patient education and enhancement of self-assessment and self-care for their pain might contribute to treatment success.

Patient education is an area nurses have contributed to in pain management. Several recent systematic reviews strongly support the evidence of the effectiveness of patient education.^[8-11] In these reports included in reviews, although interventions were conducted by multiple professionals,

some of them were conducted by nurses. Zhou *et al.* conducted systematic reviews of six nurse-led educational interventions on cancer pain for oncology nurses and showed positive results regarding patients’ knowledge and attitudes toward analgesics and cancer pain management as well as decreased pain intensity.^[12] Moreover, Koller *et al.* evaluated the content, structure, and efficacy of interventions to improve patients’ self-management of cancer pain and reported the effectiveness of the educational intervention. However, they concluded that they could not identify the most efficacious intervention components or combination of components because of a variety of limitations.^[13]

One of the most indispensable components of these educational interventions is self-management or self-care. Yamanaka has reported the concept analysis of cancer pain self-management in this issue. She concluded that self-management of cancer pain was defined as “the process in which patients with cancer pain make the decision to manage their pain, enhance their self-efficacy by solving problems caused by pain, and incorporate pain-relieving strategies into daily life, through interactions with health-care professionals.” Moreover, she classified the attributes of self-management of cancer pain into five categories. This elaborate work would contribute to further research on conducting, evaluating, and summarizing self-management of cancer pain and educational interventions not only for nurses but also for multiple professionals engaged in pain treatment.

Pain is not a symptom only for patients with cancer but for all patients needing palliative care. The papers in this issue would contribute to the treatment of all patients and people experiencing pain. I believe that nurses would play an important role in alleviating the pain of such people. We must continue to make more efforts to improve assessment, treatment, care, education, and policymaking for patients until we achieve the goal of freedom from cancer pain.

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