Dear Readers,

Breakthrough pain (BtP) in cancer is since several years a hot topic. On one side it is good that this problem is discussed on multiple symposia and conferences and doctors are aware of this problem. On the other side we all need to look at this phenomenon with a certain criticism as most of the clinical data available is coming from the industrial trials and the independent data are coming up only slowly. Interest in BtP is mainly because of the huge market for multiple "quick" fentanyl preparations used to treat BtP. This billion market is booming in the USA, but develops much slower in Europe. Two articles in this issue of Advances in Palliative Medicine are directly and indirectly involved with BtP. First of them (Janecki) is a typical epidemiological questionnaire study trying to establish the magnitude of the problem and awareness of doctors. Doctors asked about BtP answer in a very similar way as doctors in the US or UK: BtP is a common problem, but the treatment, according to Janecki's respondents is usually adequate with morphine, NSAIDs or even Paracetamol and Tramadol. Indeed, most of the BtP, worldwide is being treated with these drugs and in only very few cases a rapid absorption of fentanyl is of great significance. For those few, it is worse to spend money these preparations cost. However, the possibility of using fentanyl preparations should not replace careful diagnosis and differentiation of pain, which will lead in most cases to effective treatment.

Surprisingly, among the pains that were diagnosed in a workup of the BtP most were related not to the background pain, but compression of peripheral nerves. Some of these patients were described in a papers published in Advances [1–3]. Many of these patients, suffering of nerve compression against bony prominences could be successfully treated with local injections with depo-steroids and local anaesthetics. Multiple compression syndromes, in literature known as mono-neuropathies, were identified [4] and wait for further exploration. The technique of injection is very simple and is in our hospice a bedside procedure. Complications are rare. Sometimes patients experience first more pain after infiltration. Sometimes there is a haematoma after injection. Important complication would be inhibition of the adrenals by the injected corticosteroids. Currently available preparations of triamcinolone di-acetonide and methylprednisolone remain in place of injection for a long time, but it does not mean that they could not have systemic toxicity. Especially in patients with reduced adrenal activity, these drugs may disturb the balance. Review of this systemic toxicity is presented in the article by the undersigned. (Zylicz) Less important is transient increase of blood glucose in diabetics, which lasts usually not more than couple of days.

Taking all together it could be said that there is a lot of interest in BtP around. However, most of the interest is directed to a generic phenomenon of BtP which when analysed, can be treated with simple and inexpensive drugs and measures. Rapid absorption of fentanyl and quick response may be of a great value for few patients. New in whole this discussion is that many patients, due to peripheral sensitisation but also cachexia, may suffer of nerve compression syndromes which could be treated in a very effective way. This treatment, local infiltration with local anaesthetics and corticosteroids is effective, but is not without toxicity in some of the patients. I wonder why we still do not have controlled trials in this area. Clinicians should do careful weighing of the pros and cons, as usually. Despite disadvantages morphine remains standard in the treatment of BtP [5].

Other articles in these issue are also worth reading. One is a very illustrative case of primary hyperthyroidism falsely diagnosed as metastasised breast cancer (Teodorczyk). Doctors working in Palliative Care should be all time "awake" and challenge the diagnosis made by the clinical colleagues. Once a year or two (may be) we may be able to correct diagnosis and when this is not too late, it may be of great significance to the patient. I myself once admitted a patient with a cachexia with a diagnosis of a lesion in the lung. Because the patient

refused further diagnosis and therapy, the patient was admitted to our unit. I compared the available X rays and asked question whether this may be something else. It appeared to be a tuberculosis! The patient was re-directed to the hospital and eventually survived treatment. Keeping him longer in hospice would probably end up in his death.

How do we cope with stress, apparently is dependent on our Attachment styles.(Franczak) Secure attachment styles are significant predictors of an ability to cope under difficult circumstances. On the other hand, distorted attachment styles create an unfavorable dynamic for dealing with stressful situations, consisting of destructive and ineffective behaviors. So, may be in the future, selecting patients who want to work in palliative care we may look at their Attachment Styles? This may be of incredible value.

A tool for Phasiotherapist had been developed and tested by Tylinska-Tekielska. This tool should help the Physiotherapis to ask the question what does the patient expect from me? Can I fulfil his/her expectations? Are we thinking about the same? Answer to this question may be important in development of the relationship between the patient and his physiotherapist.

And finally a very interesting article by Binnebesel. Death at school. How often this surprises and paralyses everybody in school. How often the teachers are not able to say a word to their students and they let them fully down. The article discusses problems of grief at school and gives some practical indications how to deal with this problem.

I hope you will enjoy reading these articles. If you have any remarks, share them with us.

Zbigniew Zylicz
Vice Editor

1. Zylicz Z., Haijman J. Suprascapular nerve entrapment: a neglected cause of shoulder pain in cachectic patients? J. Pain Symptom Manage 2000; 20: 315–317.
2. Wolfs W., Zylicz Z. Myofascial and nerve compression pain as an important factor of uncontrolled pain in advanced disease. Adv. Pall. Med. 2009; 8: 13–22.
3. Zylicz Z. Obturator nerve block as a clue to the diagnosis of focal spinal metastases of gastric cancer — a case report. Adv. Pall. Med. 2009; 8: 121–124.
4. Zylicz Z. Entrapment neuropathies. Adv. Pall. Med. 2010; 9: 105–109.
5. Ruiz-Garcia V., Lopez-Briz E. Morphine remains gold standard in breakthrough cancer pain. BMJ 2008; 337: a3104.