Definition(s)

- **Pain:** an unpleasant physical or emotional experience related to potential or actual tissue damage; subjective and may be experienced acutely or chronically. Pain is what the patient says it is.
- **Total pain:** recognition that pain can be experienced from more than solely physical causes, including psychological, social and spiritual causes.

Physical Pain Classifications:

- **Neuropathic pain:** pain associated with peripheral nerve damage or dysfunction; often described as tingling, burning, cold, pins and needles and/or electric shock-like. Pain is experienced in the areas of the body covered by the sensory function of the affected nerve(s). See "Peripheral Neuropathy SMG" for more information.
- **Nociceptive pain:** pain arising from the stimulation of pain receptors within inflamed or damaged body tissue.
  - **Somatic pain:** pain in the skin, muscle, or bone. May be described as throbbing, stabbing, aching or pressure-like (e.g. bone fracture). Pain is generally experienced in the location of tissue damage.
  - **Visceral pain**: pain originating in the body's organs. May be described as aching, cramping, or sharp (e.g. liver capsular pain). The pain may be referred to undamaged areas in non-dermatomal patterns.
- **Incident pain:** pain immediately following a movement or action such as weight bearing, defecation, breathing or coughing; may be predictable or unpredictable depending on cause.
- **Breakthrough pain:** transient exacerbation of regularly-controlled pain that "breaks through", or is not alleviated by, an individual's regularly-scheduled (and normally effective) pain medications.

Opioid-Related Terminology:

- **Opioid:** a class of analgesic medications which act on neuronal opioid receptors to relieve pain.
- **Long-acting opioid:** opioids which have a long-lasting duration from 12 hours to one week. Available in oral or transdermal patch formulations. May be labelled sustained release (SR), controlled release (CR), or extended release (ER). Should never be used for pro re nata (PRN) doses (i.e. breakthrough doses).
- **Short acting opioid:** opioids which have a short-lasting duration of up to 4-6 hours. Immediate release (IR).
- **Opioid naïve:** describes an individual who has never taken opioids or has not taken opioids within the last month.
- **Opioid toxicity:** a syndrome causing a spectrum of symptoms including sedation, nausea, confusion, hallucinations (often visual or tactile), cognitive impairment and myoclonus. Individuals with renal impairment or on high doses of opioids for long periods of time are considered at higher risk for opioid toxicity. Delirium should also be considered as a cause of symptoms.
- **Tolerance:** desensitization of the receptors which an analgesic medication generally acts on, leading to the requirement of increasing doses of analgesic medication to accomplish same level of pain relief.
- **Physical dependence:** a chemical phenomenon created by receptors in the brain whereby persons who no longer need an opioid after long-term use need to reduce their dose slowly over a prolonged time period to prevent withdrawal symptoms.
- **Opioid use disorder:** symptoms include craving for opioid medications related to effects other than those for which they were prescribed along with the inability to control such cravings; accompanied by negative consequences.

Other Terminology:

- **Breakthrough dose:** an unscheduled (extra) dose of analgesic medication taken to control breakthrough pain.
- **Adjuvant analgesic:** non-opioid medications normally indicated for use to treat symptoms/conditions other than pain, which have been found useful for pain control. May be used on their own or in conjunction with opioids.
- **Complementary/alternative therapy**: Non-pharmacological strategies utilized for pain management (e.g.superficial heat/ cold, massage, relaxation, imagery)

Focused Health Assessment

PHYSICAL ASSESSMENT

Vital Signs
- As clinically indicated.

Weight
- Take current weight and compare to pre-treatment or last recorded weight as indicated.

Observe General Appearance:
- Observe painful areas for signs of infection, trauma, skin breakdown and changes in bony structure.
- Observe facial features, note any grimacing.
- Observe posture, gait, affect, and note any guarding.

NOTE: Cognitive impairment and age-related factors may impair the client's ability to express pain. These factors do not decrease the ability to feel pain. Objective cues of pain and observation is critical.

Functional Status
- Activity level/ECOG or PPS

SYMPTOM ASSESSMENT

***Consider contributing factors**

Normal
- Do you have any pre-existing pain?

Onset
- When did it begin? Is this a different pain (new location)
- How often does it occur? How long does it last?
- Distinguish between acute and chronic pain

Provoking / Palliating
- What brings it on? What makes it worse? better?

Quality
- What is your pain like at rest? Does it hurt if you cough or move?
- How would you describe it? (i.e. persistent, burning, stabbing, shooting, numbing)

Region / Radiation
- Where is it? Does it spread anywhere? Ask the patient to point to where the pain is or draw it on a body map.

Severity / Other Symptoms
- How would you rate your pain level on a scale of 0 – 10, with 0 being not at all to 10 being the worst imaginable). What is it on average? At worst/ best?
- How bothered are you by this symptom? (on a scale of 0 – 10, with 0 being not at all to 10 being the worst imaginable)
- Does the pain keep you awake at night? Does the pain prevent you from performing ADLs?
- Are you experiencing any other symptoms? (i.e. loss of bowel or bladder functioning, motor weakness)

Treatment
- What medications or treatments are you using right now? (Include over the counter, complementary and alternative treatments, cannabis). How much? How often? Has this been effective? Any side effects?
- What medications have you tried in the past?
- Have you received treatment in the area? (i.e. radiation, surgery)

Understanding / Impact on You
- Assess patient's understanding of what the pain means to them
- Assess patient's understanding of the importance of reporting any new pain to the nurse or oncologist
- Assess patient's understanding of taking the medication regularly as prescribed
- Assess patient's level of distress related to the pain and physical and psychological impact

Value
- What are your beliefs surrounding pain and pain management?
- Goals for pain management?

- NOTE: Cognitive impairment and age-related factors may impair the client's ability to express pain. This does not decrease the ability to feel pain. Objective cues of pain and observation are critical. For patients with advanced dementia, an observational pain rating scale, such as the Pain Assessment in Advanced Dementia Scale

	(PAINAD), is recommended.

PAIN GRADING SCALE NCI Common Terminology Criteria for Adverse Events (CTCAE) (Version 5.0)				
GRADE 1 (Mild)	**GRADE 2 (Moderate)**	**GRADE 3 (Severe)**	**GRADE 4 (Life - threatening)**	**Grade 5**
Mild pain	Moderate pain, limiting instrumental ADL	Severe pain, limiting self-care ADL	–	–

***Step-Up Approach to Symptom Management: Interventions should be based on current grade level and include lower level grade interventions as appropriate**

GRADE 1 (MILD PAIN): Support, teaching, & follow-up as clinically indicated	
Patient Assessment and Care	● Collaborate with physician to rule out other causes or identify concomitant causes of pain (e.g. oncologic emergency such as spinal cord compression, pathologic fracture) and to determine if further investigation warranted. ● If neuropathic pain, see *Peripheral Neuropathy SMG.* ● Assess for opioid toxicity (see page 1). ● Reassure patient and family that pain can be relieved and effectively managed.
Pharmacological Management	Medications as prescribed by physician: ● Acetaminophen, or NSAIDS PRN or regularly if not contraindicated (refer to WHO pain relief ladder - page 3). ● Topical local anesthetics may be prescribed for prevention of procedure-related pain ● Medicinal cannabis is found to be helpful by some patients. ● Refer to protocol-specific algorithm if patient is on immunotherapy.
Non- Pharmacological Management	● Rest, distraction, relaxation, meditation, yoga, deep breathing, cognitive behavioural therapy (CBT) and adaptation of activity.
Patient Education and Follow - Up	**How & when to access resources:** ● Review contact numbers ● Reinforce when to seek immediate medical attention: – T ≥ 38° C – Pain onset is sudden and/or severe and/or acute – Pain is associated with loss of function, such as weakness of the legs or incontinence **Follow-up:** ● Instruct patient/family to call back or see family physician if pain does not improve, increases in severity, or if new pain develops. ● Arrange for follow-up in ambulatory care setting if indicated
Possible Referrals	● Telephone Care for follow-up ● Patient and Family Counselling Community resources such as: ● Massage therapist ● Acupuncturist ● Physiotherapist ● Occupational Therapist ● Psychologist

GRADE 2 (MODERATE PAIN): Requires medical attention within 24 hours	
Pharmacological Management	Medications as prescribed by physician: ● Opioids analgesics (e.g. morphine, oxycodone, hydromorphone). Use short-acting formulations on a PRN basis for intermittent pain, or on a regular basis for continuous pain, with breakthrough doses as prescribed, until dose is stabilized and pain is adequately managed. Then, transition to long-acting. For some patients with continuous pain it works better to start with a small dose of a long-acting opioid and titrate up slowly according to effect. ● If the patient is already receiving an opioid analgesic, consider switching to another opioid in collaboration with physician and pharmacist. ● Adjuvant medications: – Bisphosphonates (e.g. pamidronate IV, zoledronic acid IV) or denosumab may be helpful for some patients with myeloma, breast & prostate cancer. Topical analgesics may be helpful.
Other Treatments	• If pharmacological management with oral opioids is not providing adequate relief, consider an interventional analgesic procedure such as peripheral nerve block or cementoplasty depending on the cause of the pain.
Patient Education	● Ask patient to express any concerns re: starting an opioid. Provide support re: "Pain Management Myths and Misconceptions" ● Discuss the importance of: – Taking analgesics regularly around the clock and as prescribed – Taking breakthrough medications as necessary – Anticipating possible painful events and taking analgesics 30 minutes prior – Not running out of their opioid prescription ● Keeping a pain diary and recording pain levels and breakthrough doses and times. ● If necessary, write the analgesic schedule out for patient ● Discuss common side effects of opioids (Appendix B: Opioid Side Effects) Advise patient that long acting medications should not be crushed or chewed; though those provided in capsules may be opened and granules spread on pudding, apple sauce etc.
Follow - Up	● Instruct patient/family to call back or see family physician if pain not improved, increases, if new pain develops, or if adverse effects related to analgesics occur ● Arrange for nurse initiated telephone follow – up in 24-48 hours ● Arrange for physician follow – up in ambulatory care setting if indicated

GRADE 3 (SEVERE PAIN): Requires IMMEDIATE medical attention	
Patient Care and Assessment	● Patients generally require hospital admission – notify physician, facilitate transfer as necessary ● If patient is on Immunotherapy, remind them to present their Immunotherapy alert card. ● Assess: – if pain onset is sudden and acute (possible bone fracture) or if acutely exacerbated from previous level – for any associated motor weakness, tingling and numbness of extremities and loss of bladder and bowel function (possible spinal cord compression ,bowel obstruction)
Pharmacological Management	● Medications that may be prescribed or dose titration: PO or SC route ● Adjuvant medications: ➢ Corticosteroids (e.g. dexamethasone) for bone and neuropathic pain, pain from spinal cord compression and bowel obstruction, lymphedema pain, liver capsule pain, and headache caused by increased intracranial pressure.
Other Treatments	● Radiotherapy – useful in the management of bone pain or spinal cord compression ● Surgery (e.g. surgical pinning for an impending fracture, or consider cementoplasty) ● Interventional treatments (e.g. epidural or intrathecal infusion, celiac plexus or other regional nerve block)

RESOURCES & REFERRALS	
Possible Referrals	● Telephone Care for follow-up ● Pain and Symptom Management/Palliative Care (PSMPC) ● Home Health Nursing ● Home Hospice Palliative Care Service (http://vch.eduhealth.ca/PDFs/GV/GV.110.V36.pdf) • Patient and Family Counseling
Patient Education Resources	● Coping with Cancer Pain: http://www.bccancer.bc.ca/health-info/coping-with-cancer/managing-symptoms-side-effects/pain-from-cancer ● Resources about managing deep breathing, progressive muscle relaxation etc. In Patient Handout Section http://www.bccancer.bc.ca/health-info/coping-with-cancer/emotional-support/managing-stress ● BC Cancer Agency: "Pain Management and You" video http://mediasite.phsa.ca/mediasite/Play/8c70a524ad11402e987bcb851510b7001d
Immunotherapy	● Immunotherapy Alert Card ● Algorithms:.http://www.bccancer.bc.ca/health-professionals/clinical-resources/nursing/immunotherapy-checkpoint-inhibitors
Opioid Management	● Principles of Opioid Management: https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Professionals/Professionals-Resources/Hospice-palliative-care/Sections-PDFs-for-FH-Aug31/9524-25-FH---Sym_Guide-PrinciplesOfOpioidMgmt.pdf
BC Inter-professional palliative symptom management guideline	• https://bc-cpc.ca/wp-content/uploads/2018/08/01.-SMG-Clinical-Best-Practices-print-col-intro-1.pdf
Bibliography List	• http://www.bccancer.bc.ca/nursing-site/Documents/Bibliograpy%20-%20Master%20List.pdf

Contributing Factors	
Cancer related	• Tumor obstructing passageways (e.g. bowel, lymph nodes) or compressing/infiltrating nerves • Pathologic fractures, nerve compression, and/or sclerosis related to bone metastases • Headaches related to central nervous system tumors • Spinal cord compression • Distension of the hepatic or renal capsule • Increased susceptibility to pain-inducing infections (e.g. herpes zoster: post-herpetic neuralgia) • **Note: the incidence and intensity of cancer-related pain generally increases with disease progression; continuous assessment and planning is therefore crucial.*
Side Effects of Medication	• Hormonal therapy: tumour flare reaction; osteoporosis; arthralgia; myalgia • Granulocyte colony stimulating factor: transient bone pain • Bisphosphonates: bone pain, osteonecrosis of the jaw • Intrathecal chemotherapy administration: headache • Ondansetron: migraine-type headache • Immune checkpoint inhibitors: immune-mediated side effects (e.g. abdominal/chest pain) • Vinca alkaloids and taxanes: peripheral neuropathy; headache • 5-Flurouracil: mucositis; photophobia; skin reactions • Aromatase inhibitors: arthralgia, myalgia
Radiation Therapy	• Bone pain flare, mucositis, neuropathy, osteoradionecrosis, dermatitis, esophagitis, cystitis, lymphedema
Surgery and other Procedures	• Postoperative pain (e.g. mastectomy, axillary lymph node dissection, phantom limb pain). • Procedural pain: Catheter insertion (e.g. pleural, peritoneal, intrathecal)
Consequences	

- Decreased quality of life: physiological & psychological distress, compromised role function, decreased functional status, exacerbation of other symptoms
- Physiological response (e.g. deconditioning, excess catecholamine production, or immune suppression)

Appendix A. WHO's Pain Relief Ladder

Figure 1. Modified "analgesic ladder" for cancer pain, including interventional management. *Adapted from* World Health Organization. World Health Organ Tech Rep Ser. 1990;804:1-73; Miguel R. Cancer Control. 2000;7:149-156 *and* Krames E. Med Clin North Am. 1999;83:787-808.

Appendix B. Opioid Side-Effects

Constipation	● Common side effect; Initiate BCCA bowel protocol (after ruling out obstruction and/or impaction)
Nausea and Vomiting	● Common side effect; usually mild and temporary when first starting opioid ● May need an antiemetic (e.g. metoclopramide) during first week of opioid initiation ● If lasts longer than a week, assess for other causes and consider opioid rotation
Sedation	● Common side effect; usually temporary (2-4 days) when first starting or increasing opioid doses ● Inform patient that it could be a matter of catching up on lost sleep due to pain ● If continues, assess for other causes and consider lower dose or opioid rotation
Respiratory Depression	● Very uncommon as pain serves as a stimulus, so keeps patient awake ● If unable to rouse: call 911.
Myoclonus	● May occur with any dose and any route of opioid (usually high doses of opioids) ● Possible opioid-induced neurotoxicity (especially in elderly), assess electrolytes & renal function ● May precede hallucinations, agitation, delirium, and possible seizures ● Patient needs assessment by GP with possible opioid rotation or dose reduction
Pruritus	● Rare; consider opioid rotation or reduction ● May need an antihistamine or dose reduction
Urinary Retention	● Usually temporary and passes within a week. Ensure constipation is not a contributing factor ● More common in men with prostatic hypertrophy, or those with pelvic tumors
Reduced libido	● Long-term opioid therapy may suppress testosterone levels
Delirium	● Consider opioid rotation

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