We've Come a Long Way: A Review of Cancer Pain Management

In reviewing articles related to pharmacologic and nonpharmacologic cancer pain management in the archives of the Oncology Nursing Forum *and its predecessor, the* Oncology Nursing Society Newsletter, *seeing the vast improvement in cancer pain knowledge, attitudes, and management was enlightening. However, comprehending the limited status of cancer pain management in 1973 was sobering.*

Some readers will be transported back to when they were new oncology nurses and practice standards now considered outdated were cutting edge. Others will be amazed that our current understanding is vastly different than what was then known. Current knowledge and research trajectories exist because of the dedication and hard work of colleagues who pioneered the specialty of oncology nursing 40 years ago.

In the mid-1970s, cancer pain management was in its infancy. Many patients, nurses, and physicians believed narcotics might contribute to an early death, the drugs would alter thought processes too much, and patients—even those dying from cancer—would become addicted. The most commonly used cancer pain medication in the hospice setting at that time was Brompton's cocktail, a combination of morphine or heroin, cocaine, alcohol, and a phenothiazine (Hospice World, n.d.). This review of the *Oncology Nursing Forum* (*ONF*) archive highlights how pharmacologic and nonpharmacologic management of cancer pain have changed over the years.

Pharmacologic Management of Cancer Pain

In a presentation at the Oncology Nursing Society Second Annual Convention, Valentine (1977) reported on a double-blind randomized, controlled trial comparing methadone alone to methadone with cocaine or dextroamphetamine. The primary research questions were, "First, can an oral medication provide pain relief, second, and most important, does the addition of a [central nervous system] stimulant actually potentiate the action of a narcotic?" (Valentine, 1977, p. 1). All patients had received radiation, surgery, or narcotic analgesics other than methadone without relief. The investigators also noted that the medication was given on a regular basis, rather than PRN, on the notion that knowing when the medication would be given is reassuring to the patient and so a stable blood level was maintained. Initial response was similar for all three arms within the first two days. Extending past the first few days, the findings supported the benefits of methadone and cocaine over the other combinations.

Twelve years later, Ferrell, Wisdom, Wenzl, and Brown (1989) conducted a study designed to determine the effects of controlled-release morphine. The investigators assessed whether quality-of-life (QOL) outcomes, pain, and functional status were better in patients receiving short-acting versus controlled-release analgesia. Data were obtained at two-week intervals over six weeks. A key finding was patients who received the controlled-release morphine had lower pain intensity scores than those who received the short-acting analgesia. Significant differences in QOL outcomes were found in 8 of 28 QOL items. Participants who had received controlled-release analgesia reported better adjustment to the disease, less distress from pain, improved relationships, greater strength, improved overall QOL, and decreased pain. In addition, participants receiving short-acting analgesia reported significantly less bowel problems and nausea. Implications from this study were patients should not sacrifice greater pain management because of treatable side effects such as constipation and nausea, and nurses were encouraged to be strong patient advocates in addressing pain management and side-effect prevention.

By the late 1990s, adequate medications for chronic cancer pain and clear treatment protocols were available to oncology nurses and physicians. Although great strides had been made, the issue of breakthrough pain, a sudden intense pain, began to receive more attention. Long-acting analgesics generally were used to treat pain symptoms, yet many patients reported breakthrough pain that could last for a few minutes to a few hours. An understanding of the intensity and frequency of breakthrough pain, treatment regimens, and patient use of breakthrough medications in the home setting was not clear. Ferrell, Juarez, and Borneman (1999) interviewed 369 patients and collected survey data to document breakthrough medication practices in home care. Seventy-six percent of patients received scheduled medications, 55% took the prescribed amount, 38% took less than was prescribed, and 7% took more than prescribed. For breakthrough pain, most patients (88%–92%) had orders for breakthrough medications, yet only 3% took the prescribed amount and 96% took less than what was prescribed (Ferrell et al., 1999). No rationale for taking less than prescribed was presented in that study. The authors concluded that better patient