Palliative Care for the Cancer Patient

Barbara Reville, MS, APRN, ACHPN[a,*], David Axelrod, MD, JD, FACP[b],
Rebecca Maury, MD[b]

KEYWORDS

- Palliative care • Pain • Cancer-related fatigue • Constipation
- Dyspnea • Anorexia • Nausea • Vomiting

The current model of palliative care focuses on prevention and relief of suffering to optimize quality of life (QOL) for patients with serious illness. The World Health Organization (WHO) defines palliative care as "total care."[1–5] In addition to its fundamental core of symptom control, palliative care addresses psychosocial and spiritual issues, clarifies patient preferences, facilitates decision-making, and coordinates care between different settings.

Traditionally, palliative care was synonymous with hospice, which provides comfort care for patients with a life expectancy of 6 months or less. However, that model has expanded. Patients can receive palliative care from the time of diagnosis of cancer at any disease stage, concurrent with treatments designed to prolong life (**Fig. 1**). When the patient's goals, or a lack of curative treatment options, favor a shift to hospice, palliative care becomes the main focus of care. The National Comprehensive Cancer Network (NCCN) recommends that patients be introduced to palliative care's integral role in overall cancer care at the time of initial diagnosis.[6]

The palliative care philosophy runs counter to the "cure at all costs" culture of the acute care environment. However, recent evidence suggests that more aggressive care, including prolonged hospitalization, intensive care unit (ICU) admissions, and procedures for patients with incurable, chronic illnesses, does not improve QOL or duration of life.[7]

Interdisciplinary palliative care programs are offered in 31% of hospitals in the United States.[8,9] Using a team model, physicians, nurses, chaplains, and mental health professionals collaborate to meet the complex needs of the palliative care population. Emerging evidence shows palliative care improves satisfaction with care, symptom relief, and QOL, at lower costs.[9]

---

[a] Palliative Care Service, Department of Family and Community Medicine, Thomas Jefferson University, 1015 Walnut Street, Suite 401, Philadelphia, PA 19107, USA
[b] Palliative Care Service, Department of Internal Medicine, Thomas Jefferson University, 833 Chestnut Street, Suite 701, Philadelphia, PA 19107, USA
[*] Corresponding author.
E-mail address: barbara.reville@jefferson.edu (B. Reville).

Prim Care Clin Office Pract 36 (2009) 781–810
doi:10.1016/j.pop.2009.07.010 **primarycare.theclinics.com**

Fig.1. Model for palliative care throughout cancer illness. (*Reproduced with permission from* the National Quality Forum. Copyright © 2006.)

The authors' intent is to review assessment and management of pain and common symptoms in the patient with cancer. Symptom management at the end of life, or in the dying patient, is outside the scope of this article.

PAIN MANAGEMENT

Background

Pain is a common finding and a major cause of suffering for patients with cancer, particularly for those at the end of life suffering from advanced cancer. Pain, an unpleasant perceptual experience, occurs with actual or potential tissue damage.[10] With few reliable objective criteria to quantify it, one must listen to the patient to effectively assess pain and to evaluate response to therapy. For many patients near the end of life, assessing pain can be challenging, especially when patients are nonverbal or delirious, and side effects of pain medications may exacerbate drowsiness.

The assessment and treatment of pain are increasingly recognized as high priorities. The Joint Commission and the American Pain Society advocate using pain as "the fifth vital sign."[11] Studies confirm that high levels of symptom distress are associated with a diminished QOL and decreased satisfaction with inpatient care.[12–14] Unrelieved suffering is associated with a poor QOL and denies a dying patient the opportunity for satisfaction and growth at the end of life.[15]

Studies suggest that in the hospital setting, 52% to 74% of patients on medical wards or medical surgical units experience pain.[12,16] Cancer, in particular, is associated with a prevalence of pain that has been estimated to be as high as 50% to 90% for patients at some time during the course of their illness, with one study demonstrating that 42% of patients with pain continue to have poorly controlled pain despite treatment.[17–19]

Assessment

Although pain is a subjective experience, some physical signs, such as facial grimacing, tachycardia, and hypertension, may be suggestive of pain. Although it is important to assess for signs of pain, because of their poor sensitivity and specificity, such signs are not required for diagnosis. One should attempt to rate pain using 1 or more of the conventional pain measurement scales. Conducting a pain assessment at each visit helps to diagnose pain and to determine response to treatment.

The reporting of pain by patients using simple scales of intensity with a numeric rating provides vital information to evaluate response to analgesic therapy.[20] The visual analogue scale (VAS), the current standard by which pain intensity is measured, has been found to be reliable and valid.[21–23] The VAS rating should be charted along with vital signs. Another commonly used tool is the Wong-Baker FACES Pain Rating Scale.[24] Using this scale, patients can point to a face that best describes their level of pain. The FACES Scale can also be correlated to the VAS Rating Scale. For more in-depth evaluation, a variety of measurement scales are available.