Brief Report

Disparities Between Clinician and Patient Perception of Breakthrough Pain Control

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Abstract

Context. There are disparities in the level of symptom severity as perceived by patients and health professionals. There is limited information about patients' and clinicians' global assessment of breakthrough pain control, the need to change analgesics, and change in breakthrough pain over time.

Objectives. To establish whether patients and clinicians independently agree on adequacy of breakthrough pain control, management strategy, and impression of change over time.

Methods. One hundred patients with breakthrough cancer pain were assessed and followed up one week later by a palliative medicine specialist. The patient and clinician independently answered the same questions about the adequacy of the patient's breakthrough pain control and breakthrough pain management. The results were compared with items on the Breakthrough Pain Assessment Tool (BAT).

Results. At initial consultation, 35% of patients rated their breakthrough cancer pain as inadequately controlled compared with 72% of clinicians. Breakthrough pain analgesics were changed in 68% of cases. At one-week follow-up consultation, 62% of patients considered their breakthrough cancer pain to be better, and in 57% of cases, the clinicians also categorized the pain this way.

Conclusion. There are significant differences in global impressions of breakthrough pain between patients and pain clinicians that become less disparate as a therapeutic relationship evolves. Therapeutic decisions were based on clinical rather than patient perceptions. J Pain Symptom Manage 2016;51:933–937

Key Words
Cancer pain, breakthrough pain, pain assessment, quality of life, outcome measurement

Introduction

Patient-centered care is associated with improved satisfaction with treatment and medication compliance, as well as better staff morale and fewer admissions to hospital.[1,2] For this to be achieved, patients need to be informed, listened to, and involved in decision-making about their treatment plans. However, studies evaluating consultations between cancer patients and physicians reveal disparate versions of symptom severity and information exchanged.[3,4] This leads to different expectations and a lack of patient involvement in the decision-making process.

Consultations assessing pain severity and establishing management plans in cancer patients are complex, and there are often changes, or initiation, of strong analgesics. Appropriate clinical assessment of pain and patient perception and expectations regarding analgesics are essential. Breakthrough pain is a type of cancer pain defined as "a transient exacerbation of pain that occurs either spontaneously, or in relation to a specific predictable or unpredictable trigger, despite relatively stable and adequately controlled background pain."[5] There are poorer reported outcomes for patients with breakthrough

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pain, making assessment and shared decision-making even more important.[6]

There are documented disparities in quantitative pain and symptom assessment between patients and their clinicians, with clinicians often underrating the severity and distress experienced.[3,7] In addition, there is also a disconnect between patient and clinician prioritization of the relative importance of different pain domains and quality-of-life indicators.[8,9] However, there are limited data about the concordance of patient and clinician opinion regarding the general perception of breakthrough pain control. There is also limited information about clinician and patient impression of change in breakthrough pain experienced over time and whether further analgesic alterations are necessary.

The primary aim of this study was to establish whether patients and clinicians independently agree on adequacy of breakthrough pain control. The objectives of the study were to 1) evaluate whether patients and clinicians independently agree on breakthrough pain management strategy; 2) assess what aspects of breakthrough cancer pain (e.g., intensity, frequency, impact) influence patient and clinician evaluation of their breakthrough pain management; and 3) assess if patient-perceived changes in breakthrough pain over time correlate with clinician-perceived changes.

Methods

This study was a prospective observational study of patients with breakthrough cancer pain. The data were collected as part of a study to validate a newly developed Breakthrough Pain Assessment Tool (BAT).[10] Participants were recruited from three U.K. sites: the Royal Marsden Hospital, Sutton (tertiary cancer center), St. Luke's Cancer Centre, Guildford (District General Hospital), and St. Clare's Hospice, Hastingwood. The subjects were recruited from the inpatient and outpatient departments at the three centers. Inclusion criteria were 1) cancer-related pain; 2) expert-determined breakthrough cancer pain; 3) regular analgesia; 4) age >18 years; and 5) ability to complete the study protocol.

The subjects were given an information sheet about the study and asked to sign a consent form before entering. The study was sponsored by Imperial College, London, and ethical approval was obtained from the Royal Marsden Hospital Research Ethics Committee.

Assessment 1

The subjects were initially seen by a researcher and completed the BAT. The researcher then gave the patient a form with the following questions to complete: 1) Do you think your breakthrough pain is adequately controlled? Yes/no; and 2) Do you think changes need to be made to your breakthrough pain management? Yes/no.

The patient was then reviewed by a clinician with an interest in breakthrough cancer pain. Two consultants in palliative medicine participated in the study. They both had a special interest in breakthrough pain and participated in the Association of Palliative Medicine Task Group of Great Britain and Ireland on breakthrough pain. They have jointly published multiple articles in this area and have agreed standards on definition, assessment, management, and reassessment of breakthrough pain.

The clinician conducted a clinical assessment. The clinician did not look at the BAT or the questions that the patient had answered. The clinician was then handed a form with the following questions: 1) Do you think your patient's breakthrough pain is adequately controlled? Yes/no; and 2) Are you going to make changes to your patient's breakthrough pain management? Yes/no.

Assessment 2

Assessment 2 was conducted one week after Assessment 1. This occurred with the same clinician who was able to evaluate responses to previous interventions and initiate any further changes if necessary. The patient was asked exactly the same questions as Assessment 1 in the same order with this additional question at the end: How do you think your breakthrough pain is since you last filled in this questionnaire? Better/same/worse.

The clinician performed the same clinical assessment and was asked the same questions as previously with this additional question (he was blinded to the patient's self-assessment): How would you rate this patient's breakthrough pain compared to the last time you assessed them for this study? Better/same/worse.

Researchers collected data regarding age, gender, diagnosis, performance status, and current cancer treatment. Also, at each consultation, detailed information was collected about the breakthrough pain (etiology, pathophysiology, subtype), as well as the background and breakthrough medications administered. All changes to breakthrough pain management made by the clinician were noted.

Breakthrough Pain Assessment Tool

The BAT comprises 14 questions (Appendix, available at jpsmjournal.com)[10]: nine of the questions relate to the pain per se, and five questions relate to pain treatment. Numerical rating scales are used in six questions, categorical verbal rating scales in three questions, free text in four questions, and the remaining question necessitates the patient to mark the site of the pain on a body-shaped outline. The scoring of responses is detailed in our previous publication.