

“Can the institutionalisation of cancer pain assessment as a 5th vital sign improve cancer pain control in the acute setting?”

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Rationale

- Numerous studies show very poor cancer pain control particularly in the acute setting (50%)
- Guidelines alone do not work
- American Pain Society – Pain is the 5th Vital Sign

- Package to achieve the
“Institutionalisation of Pain Assessment”
- Edinburgh Pain Assessment Tool
(EPAT[©])

EPAT ©

Developed by:

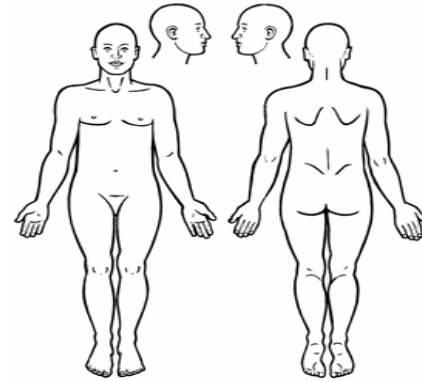
- Palliative Care
- Acute Pain Service
- Chronic Non-malignant Pain Service

Edinburgh Pain Assessment Tool © (EPAT) Step 2

Keystone to pain management is the WHO ladder (See EPAT© Algorithm)

Name: _____ DOB: _____ Ward: _____ Date/Time: _____

LOCATION



SEVERITY SCORE

	A Most severe	B	C
Worst Pain in Last 24 hrs (0 - 10)			
Least Pain in Last 24 hrs (0 - 10)			

0 = No pain 10 = Worst pain imaginable

On the diagram, mark the sites where you have felt worst pain (ABC)

Does your pain disturb your sleep?
Yes No

NERVE PAIN?

⚡ Is your pain..?

Shooting or Stabbing Tingling or Pricking Pins & Needles Hot or Burning

Do any areas of your skin feel numb or strange or unpleasant to touch?

Yes No Detail: _____

⚡ Consider neuropathic pain. Treat with adjuvants.

⚡ Use 'starting gabapentin/starting amitriptyline' EPAT algorithms.

MOVEMENT PAIN?

Does moving make your pain worse? Yes No

Does your pain come on suddenly at rest? Yes No

⚡ Is the patient experiencing movement-related or spontaneous pain? Consider bone pain.

⚡ Use WHO analgesic ladder - See EPAT algorithm. Give PRN analgesia before movement.

⚡ Consider NSAID's / Palliative Radiotherapy / Bisphosphonates

WIDER ISSUES?

What makes your pain better? _____

⚡ Remember: non-pharmacological interventions!

Consider: Position change / Relaxation / Physiotherapy / TENS / Acupuncture

REFERRAL:

☹ Is there anything worrying or concerning you about your pain? Discuss with patient.

⚡ Remember: ☹ anxiety/depression may co-exist with severe pain.

📞 Consider referral to Palliative Care Team (PCT) for patients who have persistent pain:

- > Patients with severe pain
- > Patients requiring a rapidly increasing opioid dose
- > Patients with opioid-induced drowsiness
- > Patients with movement-related pain
- > Pain unrelieved by initial management

Aim of tool

Simple, meaningful bedside tool – acute setting

Step 1 Warning flags

Step 2 Prompts

Associated management algorithms

Overall aim: **INSTITUTIONAL CHANGE!**

Pilot Study

Aim:

- To assess if the introduction of EPAT[©] in a Regional Cancer Centre leads to improved cancer pain control

Methods

Prospective controlled study of 3 pain assessment approaches

- EPAT©
- BPI
- Standard (no bedside tool)

Methods

- Wards randomised to :
 - EPAT ©
 - BPI
 - Standard Care
- Baseline worst pain ≥ 4
- Assessments:
 - In first 24 hours of admission
 - Day 4
 - Day 7

Primary outcome measure

- Worst pain reduced to $< 4/10$

Secondary outcome measures

- Worst pain reduced by 2 points on 0-10 VAS
- Patient satisfaction
- Staff satisfaction

Results

- BPI 75 patients
- EPAT[©] 75 patients
- Standard Care 75 Patients

Pain control defined as $< 4/10$ on Day 4

Day 4

Standard 55% pain control

BPI 65%

EPAT[©] 90%

Conclusion

The institutionalisation of cancer pain assessment as a 5th vital sign using EPAT© gave better pain control than both the BPI and standard care in a UK Regional Cancer Centre

Next Step

Cluster randomised controlled trial
(CR-UK, PBSC)

18 centres – UK

Development helped by NCRI Palliative
Care Clinical Studies Development Group

- Cluster randomisation of 18 cancer centres in UK
- Cannot randomise individual patients
- Cannot randomise wards
- Blinding is not possible

- Patients with cancer pain $\geq 4/10$
- Patients recruited within 24 hours of admission
- Follow-up day 3
(+ day 7)

Primary outcome measure:

- Magnitude of change in pain scores at the 2 evaluation points

(defined as % patients with worst pain reduced by at least 2 points [BPI])

Secondary outcome measures:

- Magnitude of change in BPI scores over the 2 evaluation points
- Patient satisfaction with attention to pain
- Regular use of the EPAT©
- Analgesic prescribing
- HADS
- Non-pharmacological methods of pain control
- Staff satisfaction with the EPAT©
- Drug toxicity

Proposed sample size

- Reduction of the results for each centre to a single number (Difference in % of patients achieving clinically significant reduction in pain between baseline and study period)
 - 50 pre-intervention
 - 50 study period
 - 18 Centres

EPAT © Development Group

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