This issue of CA—A Cancer Journal for Clinicians includes two excellent papers on palliative cancer care that highlight some of the achievements and challenges of this complex field.

The first article by Cherny,¹ which is also the first CME activity to be featured in CA, provides an excellent review of the state of the art in the management of cancer pain and includes concepts that should be part of the regular education of oncologists.

Cherny introduces some of the major challenges clinicians and researchers are currently focused on, such as the appearance of severe opioid side effects after prolonged use or high-dose administration. The traditional challenge—that of general undertreatment of cancer pain—has been replaced in recent years by the observation that many patients receive inappropriate treatment, particularly in developed countries.

The traditional challenge—that of general undertreatment of cancer pain—has been replaced in recent years by the observation that many patients receive inappropriate treatment, particularly in developed countries. This means that while some patients do not receive appropriate opioid dosages, in other cases, opioid-related toxicities are not diagnosed and therefore not corrected by dose modification or change of agent.

Cherny also discusses the great variation and differing incidence rates of intractable pain syndromes described by different authors, which probably reflects differing patterns of practice and different criteria for the diagnosis of intractable pain. Future research should focus on better understanding the reasons for these differences and on defining new analgesic interventions for these particularly difficult cases.

Dr. Bruera is Professor of Medicine, F.T. McGraw Chair in the Treatment of Cancer, Department of Symptom Control & Palliative Care at the University of Texas MD Anderson Cancer Center, Houston, TX.

This article is also available online at http://www.ca-journal.org.
Improved management of cancer pain will be greatly assisted by a “back to basics” approach. Although the basic mechanisms of pain transmission at the level of the peripheral and central nervous systems are well known, the mechanisms by which nociception occurs at the tumor level are almost completely unknown. By understanding why some cancers hurt and some don’t, it may be possible to act on pain at the level of tumor cells and stroma, as well as to develop drugs and/or procedures to affect release of immune cytokines or endothelial mediators.

Palliative Care and Hospice

Byock\(^2\) summarizes the fundamental principles of palliative care and the role of hospice in achieving some of these goals. He also discusses the limitations of the hospice model in the US, which are mostly due to funding arrangements (the Medicare Hospice benefits), and the separate administrative and clinical structures delivering cancer and hospice care, respectively.

Palliative care faces two major challenges at the administrative level. The first is to ensure increased patient access, as well as access at an earlier stage of the disease trajectory. This will require new and innovative administrative arrangements to secure seamless access by patients to palliative interventions, eliminating geographical and financial obstacles to care.

The second objective is the development of an evidence-based body of knowledge that will ensure that patients receive highest quality care. This can only be achieved by the establishment of strong academic components in most universities and cancer centers, and by securing research funding resources that are currently not generally available.

Another Level of Prevention

MacDonald\(^3\) has described a useful framework for finally incorporating academic palliative care standards into the practice of oncology. In addition to primary cancer prevention (i.e., smoking cessation), secondary prevention (i.e., early diagnosis with mammography or Pap smear), and tertiary prevention (i.e., preventing early death by administering antineoplastic therapies such as surgery, radiation, and/or chemotherapy), palliative care would be considered the quaternary level of prevention—preventing unnecessary suffering among patients and their families.

This issue of CA provides important recommendations for practicing clinicians, administrators, and clinical researchers in areas where future contributions could have significant impact on the health care system and the well being of patients.

References

1. Cherny NI: The management of cancer pain. CA Cancer J Clin 2000;50:70-116.
2. Byock IR: Completing the continuum of cancer care: Integrating life-prolongation and palliation. CA Cancer J Clin 2000;50:123-132.
3. MacDonald N: Palliative care: The fourth phase of cancer prevention. Cancer Detect Prev 1991; 15:253-255.