

Chronic Neuropathic Pain in Women Following Breast Cancer Surgery

By Fozia Bokhari, Vic R&E Research and Evaluation Associate

Among Canadian women, breast cancer is still the most prevalent cancer; one in 9 women will develop this disease in her lifetime and one in 28 will die from it. Breast cancer treatment usually begins with surgery. Chronic neuropathic pain is a complication that may affect between 20% and 50% of women who have had surgery and other treatments for breast cancer.

Chronic neuropathic pain in this population may persist and go unrecognized and untreated for years. Therefore this can be an issue for long-term survivors of cancer, as well as those currently receiving cancer therapies. Educating both patients and health care professionals can increase the awareness of this often debilitating condition and optimize patient outcomes.

Below are some sample questions nurses and other healthcare professionals can ask [based on the four domains of the Human Response to Illness (HRTI) Model]:

Physiologic response

(i.e., the normal biologic functions of a healthy person)

- Have you had any pain or discomfort in the area where you had surgery or radiation therapy?
- How long have you had this pain or discomfort?
- What makes this pain better or worse?

Pathophysiologic response

(i.e., the disordered, abnormal, or undesired biologic function)

- Have you had or are you experiencing increased pain with movement?
- Has this caused arm restriction on your surgical side?
- How long have you had this pain or restriction?

Behavioural response

(i.e., directly measurable and observable signs and symptoms)

- What does the pain feel like?
- How severe is this pain on a scale of 0-10?
- What measures are you taking to relieve this pain?

Experiential response

(i.e., the experience of living with the response to illness)

- What does this pain mean to you?
- Describe your experience of living with this pain.
- How is this pain affecting your life?

Trial of Behavioural Pain Assessment Tools in the Cognitively Impaired

By Chinyere Asagwara, Vic R&E Research and Evaluation Associate

Introduction

This study on pain conducted at Victoria General Hospital (VGH) revealed matters addressed by staff in assessing and managing pain in cognitively impaired patients. Behavioural pain assessment tools help determine if pain is present and assess efforts made to relieve it. The purpose of this study was to determine whether selected behavioural pain assessment tools (BPAT), the Checklist of Nonverbal Pain Indicators (CNPI) and the Non-Communicative Patient's Pain Assessment Instrument (NOPPAIN) are useful for nurses (RNs) and healthcare aids (HCAs).

Results

- A total of 42 patients were assessed over a 3-week period from 5 VGH units
- The average age was 81.5 years, (range 28 to 100), majority (76.2%) were female
- The most frequent activity was transferring the patient (eg. bed to chair)
- Facial grimacing (pain faces) was the most common pain behavior
- Comparing RNs to HCAs for each tool, CNPI verses NOPPAIN kappa values* above 60 occurred at a ratio of 3:2.
- For CNPI kappa values ranged from .385 to .725 during movement compared with .077 to .323 at rest. As well upon rest, non-verbal complaints, bracing, and verbal complaints were all non-significant
- For NOPPAIN kappa values ranged from .160 to .862, with 'the patient sat up', 'you dressed the patient' and 'you helped the patient walk' being non-significant
- Majority of observers (53.8%) said both tools took 1 to 5 minutes to complete
- Improved assessment was found for CNPI by 12 (92.3%) respondents; and for NOPPAIN by 10 respondents (83.3%) [1 no response (N/R)]
- 61.5% found CNPI to be useful; 69.2% found NOPPAIN to be useful
- 46.2% found CNPI easier; 23.1% found NOPPAIN easier. Remaining % are N/R)

Conclusion

Though NOPPAIN appears to be a useful and well received tool, the data shows it was a demanding tool to correctly fill out. However CNPI also had its problems with some areas having poor inter-rater reliability. Having a tool for assessing pain in this population of patients would be beneficial in assisting RNs and HCAs, but at this time both tools need further analysis and refinement before implementation.

*Kappa Values:

Poor Agreement; Less than 0.20 Fair Agreement; 0.20 to 0.40 Moderate Agreement 0.41 to 0.60 Good Agreement; 0.61 to 0.80 Very Good Agreement; 0.81 to 1.00

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Please join us in welcoming our new Research and Evaluation Associates, Fozia Bokhari and Chinyere Asagwara!

With our recent expansion and our newly developed partnerships, they will be a great asset to our unit.

Welcome to our team
Fozia and Chichi!

From rest of us at Vic R&E

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~S.S.

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