Pain as the Fifth Vital Sign: Challenges in Managing Cancer-Related Pain

BETH FAIMAN, PhD, MSN, APRN-BC, AOCN®, BMTCN, FAAN, FAPO

Pain is one of the most distressing symptoms for patients diagnosed with cancer. Few would argue with the fact that undertreated pain has negative consequences, including physiological, psychological, functional, social, and socioeconomic, which ultimately affect quality of life.

For these reasons, the idea that pain should be measured in all patients as the "fifth vital sign" was heavily promoted by the American Pain Society in the mid-1990s to assess the presence of all types of pain and elevate awareness of pain treatment among health-care professionals (Max et al., 1995). In 2000, the Joint Commission acknowledged the effects of unrelieved pain on patients, mandating that pain be regularly assessed and treated to avoid the development of chronic pain (Phillips, 2000). The Joint Commission recommended that providers accept and respect patient self-reporting of pain. This strong recommendation by the Joint Commission, coupled with marketing by pharmaceutical manufacturers to encourage the expanded use of opioids for pain control, along with other factors, contributed to opioid overprescribing and thus the opioid crisis in the US.

PAIN IN CANCER

Cancer pain is challenging to manage, as the perception of pain and pain thresholds result from complex interactions among and between physical, sensory, emotional, and behavioral factors. Types of cancer pain include nociceptive, neuropathic, somatic, or visceral.

Advanced practitioners (APs) face a conundrum when a patient complains of pain. They must determine the type and underlying source of pain, and assess and manage whether it is an acute or worsening pain, all while balancing the risks of continued opioid use and addiction with the benefits of pain control.

Adding to the complexities of assessing and intervening in cancer pain, there have been numerous policy changes and programs aimed at decreasing opioid misuse at both local and national levels within the past 10 years. These include educational modules for safe prescribing, mandated naloxone coprescribing, written pain agreements, and routine urine toxicity screening before prescribing, as required by the Drug Enforcement Administration.

PAIN MANAGEMENT

What are the current recommendations for managing cancer-related pain? The World Health

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Organization (WHO), the International Association for the Study of Pain, and others have proposed systematic approaches to diagnosing, monitoring, and treating cancer pain. Similarities include the use of analgesia with or without adjuvant medications as a first approach. The WHO has one of the most recognized stepwise approaches to pain management (World Health Organization, 2019).

While I believe pain is critical to assess in all patients and at each encounter, my approach to pain management has changed over time. First, health-care quality metrics, including patient satisfaction, experience, and patient perception of an encounter, are collected through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The individual's pain and its management (whether good or bad) undoubtedly influence responses to the HCAHPS questionnaire; thus, pain assessment and management are quality metrics that will remain important to address, regardless of concerns about prescribing. Secondly, it is well known that APs should address the physiological and psychological concerns associated with poorly managed pain to improve quality of life. For this reason, I conduct a brief pain and psychosocial assessment on every patient I see at every visit in my clinic. If pain medication is required, I perform a thorough assessment of the underlying cause, then proceed using a stepwise approach and a limited supply of opioid pain medications when required.

As the management of pain remains highly complex and multifactorial, I recognize that managing pain is a collaborative effort. Taking an empathetic approach to acknowledge patients' pain and enacting a team-based approach through referral to a palliative or pain management specialist are essential components of a patient encounter.

IN THIS ISSUE

Within this issue, read about a strategy to improve safe opioid prescribing by implementing an electronic health record alert to prescribe naloxone for cancer patients receiving high-dose opioids or concomitant high-risk medications. Shor and colleagues approach the issue by establishing screening for substance use disorders in order to identify patients at risk and facilitate referrals.

Also in this issue, a study explores drivers of satisfaction in our modern era where care teams have fragmented work locations and diverse communication methods. Hwa and colleagues consider the role of bridging therapy for patients receiving CAR T-cell therapy. The impact of body image on quality of life is a growing area of inquiry, and the article by Thomas and Brady extends this discussion to patients with advanced breast cancer. While NP and PA programs are growing nationwide, the demand for clinical rotations places stress on institutions and preceptors. APP CROSS is a system that promotes objective student selection, enhancing recruitment and retention. A candid article by Brown, who navigated the anxiety of awaiting pathology results during her diagnosis, provides practical insights to both providers and patients. Finally, read about the exciting area of tumor treating fields for glioblastoma and other solid tumors.

References

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