CANCER PAIN MANAGEMENT IN AN EAST MALAYSIAN HOSPITAL; AN ELECTIVE REPORT

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INTRODUCTION
Pain is one of the most common and burdensome symptoms of cancer. It is estimated that more than 50% of cancer patients will experience pain. In a Malaysian palliative care unit, 89% of patients experienced cancer-related pain with 43% reporting moderate to severe pain (pain score >4). Despite this, only 24% of those with moderate to severe pain receive adequate opioid analgesia and morphine consumption in Malaysia is significantly lower than global use. To try and combat insufficiencies in cancer patient care, Clinical Practice Guidelines were implemented in 2010 with the aim to assist healthcare providers to improve the management of pain in cancer patients. The guideline provides algorithms for the management of cancer pain based on pain score and the WHO step-wise approach.

METHODS
An audit was conducted in Sarawak General Hospital (SGH), East Malaysia, to assess if cancer pain is being managed in accordance with the current Clinical Practice Guidelines. Consecutive inpatients were recruited from the adult oncology wards over a three week period in April 2012. Clinical notes were reviewed to determine demographics, cancer type and stage, evidence of pain scoring during admission, currently prescribed analgesics and co-prescription of laxatives.

RESULTS
20 patients were recruited (12 males and 8 females) with a mean age was 54.8 years (SD 13.98). The majority of patients had advanced disease. A mean of 2.4 analgesics were prescribed during their admission. Morphine was the most frequently prescribed analgesic, however 63% of prescriptions were parenteral and 50% were 'as required' (prn) doses, hence the basic principles of 'by the mouth, by the clock and by the ladder' were not achieved. Breakthrough doses and drug titration were also inadequate. Furthermore, only 41.6% of patients on opioid analgesia were co-prescribed laxatives to prevent constipation, which is the most common side effect. Although a pain chart was available at the bedside of all patients, there was no evidence of a pain scoring tool and there was discrepancy between doctors and nurses pain scores, with nurses reporting lower pain scores.

DISCUSSION
Opioid prescription frequency may have improved since guideline publication; however there are still inadequacies in pain assessment and prescription practice. Previous research has demonstrated that healthcare professionals tend to significantly underestimate patients level of pain, with discrepancy between estimations increasing with pain severity. Therefore, pain assessment tools should be accessible at the bedside of each patient to improve the accuracy of pain scoring. The three basic principles 'by the mouth, by the clock and by the ladder' should be reinforced, with the WHO analgesic ladder being used in relation to adequate pain scoring.

Interventions are therefore required to improve the implementation of the current Clinical Practice Guidelines. A previous review of barriers to physician adherence to clinical practice guidelines found that knowledge (lack of awareness or familiarity), attitudes (lack of agreement,
self-efficacy and motivation) and external factors (resource availability and time limitations) can influence guideline implementation. The availability of resources can be a more of a problem for developing countries. A study conducted in Timor-Leste, looked at the application of clinical guidelines and found that the development of guidelines needs to reflect local needs and reality in order to be put into practice where resources are limited. Another study in South Africa developed and successfully implemented locally applicable guidelines, adapted to suit local resources and priorities.

Malaysia is considered a developing economy with East Malaysia being less developed than Peninsular Malaysia. On conduction of the current study, not all of the medications recommended in the Clinical Practice Guidelines were available for use, which may therefore impede guideline implementation. Perhaps local guidelines or algorithms should be developed to suit resources and needs. A review of the methods used to implement guidelines found that dissemination of educational materials, audit, feedback, reminders (manual or computerised) and educational outreach are effective interventions. These approaches could be taken in SGH to improve the management of pain in cancer patients. Future research could also address health care professionals and patients' attitudes and beliefs to explore potential barriers to pain management.

REFERENCES

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