There is abundant evidence that cancer pain is undertreated despite the availability of therapies that could benefit most patients.\(^1\) Undertreatment has many causes, among the most important of which is inadequate assessment.\(^2,3\) Assessment is a dynamic process that includes evaluation of presenting problems, elucidation of pain syndromes and pathophysiology, and formulation of a comprehensive plan for continuing care.\(^4-8\) In this process, the management of pain must be incorporated within a broader therapeutic agenda that addresses the need for antineoplastic treatment, symptom palliation, and functional rehabilitation.\(^8,9\)

General Principles of Pain Assessment: Inferred Pathophysiology

Pain assessment in the cancer population begins with an appreciation of the relationships among nociceptive and neuropathic processes, pain, and suffering (Fig. 5.1). These constructs form the basis of a broad classification of pain based on inferred pathophysiology.

Nociception can be defined as the activity produced in the nervous system by potentially tissue-damaging stimuli. Although the neurophysiological changes associated with nociception cannot be directly measured in the clinical setting, these changes are imputed to occur whenever a potentially tissue-damaging stimulus impinges on a pain-sensitive structure.

Pain can be conceptualized as the perception of nociception. Like other perceptions, pain is determined by an interaction between pathophysiological changes, including nociceptive activity in sensorineural pathways, and other factors. These other factors presumably comprise two broad categories of mechanisms: neuropathic processes and psychological disturbances. In the cancer population, a comprehensive assessment usually reveals nociceptive and neuropathic factors sufficient to explain the pain.\(^10\) Psychological disturbances strongly influence the expression and impact of pain,\(^11,12\) but rarely predominate in its pathogenesis.

Suffering can be defined as the global perception of distress engendered by adverse factors that together undermine quality of life. Numerous factors other than pain may contribute to the suffering of the cancer patient (Fig. 5.1).\(^13,14\) The need to treat suffering effectively is a clinical imperative, and consequently, pain therapy should never be considered the sole objective in the care of the patient.

Thus, a useful pathophysiologic model posits three broad categories of mechanisms: ongoing nociception, neuropathic processes, and psychological influences.\(^15\) These putative mechanisms are used to label pain according to the predominant pathophysiologies that are inferred to exist from the information acquired through the assessment process. The clinical lexicon now commonly refers
Figure 5.1. Factors contributing to pain and the relationship between pain and suffering (from Portenoy).