Pain and disability: are we ignoring parts of the picture?

Anna Towers

Clinical experience shows us that many of the patients that we see in our clinics present with comorbidities: pain, numbness, a range of motion limitations, reduced joint movement, functional problems, etc. I am part of a group that is conducting a multisite Canadian study, aiming to chart the incidence and course of three types of arm morbidity — pain, range of motion (ROM) restrictions and lymphoedema — in 750 women during the first five years following breast cancer surgery. Members of our group had already raised the question of arm morbidity and its importance (Hack et al, 1999; Kwan et al, 2002). As with any research, we answer a few questions and our eyes are opened to many more.

What is striking is the degree of pain and functional problems that these women present (Thomas-MacLean et al, 2008). Preliminary data show that these problems are not transient. The first year data (gathered 6–12 months post-surgery) on 347 patients with breast cancer shows that 39.4% have pain, 12% experienced swelling, and ROM restrictions were observed in over half the sample. Pain and ROM restrictions were significantly correlated with disability. Women reported difficulties in completing everyday tasks, including heavy household chores, gardening/yard work, making a bed, carrying a shopping bag or briefcase, carrying an object over 10 pounds in weight and putting on a pullover or sweater. Pain was also correlated with problems with work and recreational activities involving arm motion. Despite the impact of pain upon their lives, most women reported that they did not discuss arm morbidity with healthcare professionals.

These findings have implications for those of us working in lymphoedema clinics. Are our lymphoedema services comprehensive enough? For years I told women in my clinic that the pain they were experiencing was not related to the lymphoedema — and I dismissed them. I unconsciously abandoned these patients, as various physicians before me had done. As a lymphoedema clinic physician, I was trained in lymphoedema management but received no specific training in chronic pain management, in the assessment of functional problems, or in the follow-up of women who cannot work because of their mixed-source disabilities. Yet, patients in my clinic seem to have no other healthcare professional to whom they can turn to support them in their quest for compensation, disability insurance or work re-integration.

For years I told women in my clinic that the pain they were experiencing was not related to the lymphoedema — and I dismissed them. I unconsciously abandoned these patients, as various physicians before me had done.

The International Society of Lymphology (ISL) Consensus Document on the diagnosis and treatment of lymphoedema does not cover co-morbidities, pain or disability. The recently published Best Practice document (Lymphoedema Framework, 2006) does cover the assessment of movement and function as part of the process of determining severity of lymphoedema. There is an outline of pain assessment, with an acknowledgement that pain is a significant problem in these patients. This document merits careful study.

Clearly there is a need for additional, longitudinal research into the trajectory of all types of arm morbidity, along with their inter-relationships, in order to demonstrate the need for comprehensive rehabilitation.

How many of our programmes integrate physiotherapists, kinesiologists, pain experts and social workers to cover adequately all the issues that our patients face, and early on in the trajectory? What types of interdisciplinary programmes exist to address the needs of these patients with multiple comorbidities and complex sources of disability, physical and psychosocial? I, for one, would like to hear about such successful programmes in the pages of this journal. JL

Anna Towers is a palliative care physician who co-ordinates a lymphoedema clinic at the McGill University Health Centre, Montreal, Canada

References

Hack TF, Cohen L, Katz J, Robson LS, Goss P (1999) Physical and psychological morbidity after axillary lymph node dissection for breast cancer. *J Clin Oncol* **17(1)**: 143–9

International Society of Lymphology (2003) Consensus Document: The diagnosis and treatment of peripheral lymphedema. *Lymphology* **36**: 84–91

Kwan W, Jackson J, Weir LM, Dingee C, McGregor G, Olivotto IA (2002) Chronic arm morbidity after curative breast cancer treatment: prevalence and impact on quality of life. *J Clin Oncol* **20(20)**: 4242–8

Thomas-MacLean R, Hack T, Kwan W, Towers A, Miedema B, Tilley A (2008) Arm morbidity and disability after breast cancer: new directions for care. *Oncol Nurs Forum* **35(1)**: 65–71

Lymphoedema Framework. *Best Practice for the Management of Lymphoedema*. International Consensus. London: MEP Ltd, 2006