

Control of Pain and Dyspnea in Non-Pharmacological Interventions: Patients with Oncologic Disease in Acute Care

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Summary

To identify non-pharmacological strategies in the control of pain and dyspnea, in patient with oncological disease, in acute care. The gold standard to an adequate symptom control is a systematized assessment. Non-pharmacological measures: psycho-emotional support, hypnosis, counseling/ training/ instruction, therapeutic adherence, music therapy, massage, relaxation techniques, telephone support, functional and respiratory re-education increase health gains. The control of oncologic pain and dyspnea require a comprehensive and multimodal approach.

Keywords: Oncologic pain; Dyspnea; Nursing interventions; Acute care

Introduction

Globally, more than 14 million new cases of cancer will occur each year and the number of people with this disease expected to triple by 2030, because of survival (DGS) [1-3]. Survivors continue to experience significant limitations, compared to those without a history of cancer [4]. The presence of symptoms persists permanently, resulting from the direct adverse effects of cancer, treatment, exacerbation and/ or onset of new ones, associated with recurrence or second tumor [5,6].

Pain, dyspnea, fatigue, emotional distress arises simultaneously and is interdependent. In this way, the term *cluster symptoms* become known when two or more symptoms are interrelated, since they can share the same etiology and produce a cumulative effect on the person's functioning. Richards et al. [7] found that patients with a high prevalence of pain were more likely to be treated with high-dose pain relief than those who did not. The incidence of pain at the onset of the disease pathway is estimated at 50% and is increased to approximately 75% at advanced stages, which means that the survivor does not experience it only as an immediate treatment outcome [8-11]. In an advanced stage of the oncological disease, dyspnea is one of the symptoms that assumes relevance, often arises associated with pain (about 45%), represented a cluster symptoms inducer of greater anxiety and fatigue. That is responsible for the demand for health care, so it is fundamental a serious investment in their control [12]. The objective of this systematic review of the literature is to identify non-pharmacological strategies in the control of pain and dyspnea, of the patients with oncological disease, in acute care.

Discussion

The assessment of pain is considered the first step towards effective pain control, which includes self-assessment tools that enable a more measurable dimension, where the person's speech is the gold standard in data collection. The characteristics of pain are influenced by the psycho-emotional state, the activities of daily living, the existence of other comorbidities and/or additive behaviors. The performance of previous or current oncological treatments, analytical and imaging data was related to the etiology of pain. This aspect is considered fundamental in a comprehensive analysis of the person with cancer pain [13-15]. The non-pharmacological strategies are the person-centered care, which

emphasizes the individualization and inclusion of a significant person that increases health outcomes. Directed interventions for counseling, education for self-management, training/ instruction, telephone follow-up, health literacy and nurses as case manager, with interconnection with other health professionals and health services increase therapeutic adherence and satisfaction with care [16,17]. Therapeutic massage, hot and/ or cold application, positioning, hypnosis, transcutaneous electrical nerve stimulation and music therapy are considered measures that improve the effectivity of medication regimen [18,19].

In the evaluation of dyspnea, the literature suggests the use of the acronym O, P, Q, R, S, T, U and V to better evaluate its characteristics: (onset) frequency, provoking factors of relief and exacerbation, (Quality) description of the dyspnea sensation, (region/radiation) the existence of other symptoms simultaneously, (severity) intensity of dyspnea, (Treatment) medication used for its control, efficacy and adverse effects, (Understanding) dyspnea on human living, (Values) the level of acceptable / desirable dyspnea intensity for the person. The instruments to be included in its assessment are: the Edmonton System Assessment Scale, Clinical Anxiety and Depression Scale - HADS, Modified Dyspnea Index (MDI) and Numerical Rating Scale (NRS) for breathlessness, Modified Borg and Chronic Respiratory Questionnaire. The etiology of dyspnea should be carefully investigated to determine the need of other complementary techniques for its relief [20-22].

Non-pharmacological strategies aimed at functional and respiratory rehabilitation, cold application, adoption of healthy lifestyles, education for self-management/counseling, psycho-emotional support and relaxation/ visualization exercises in anxiety control and referral to others health professionals/ services allow better control of dyspnea (ONS, 2011) [23-27].

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Conclusion

The efficacy of the drug regimen and/ or adverse effects control can be enhanced by the use of non-pharmacological techniques simultaneously, which contribute to the reduction of basal pain intensity and control of exacerbations, increase comfort, well-being, reduce the level of anxiety, pain and dyspnea, which are results sensitive to nursing care [28]. The combination of two or more symptoms experienced at the same time, can lead to high levels of distress, which when undervalued or subtreated predispose to the appearance of burden symptoms. Concomitantly, the manifestation of a symptom rarely occurs in isolation, so both assessment and treatment requires a comprehensive and multi-modal approach.

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