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CANCER PAIN IN PALLIATIVE CARE: ASSESSMENT, MONITORING, AND THE ROLE OF NURSING

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ABSTRACT

Cancer is one of the leading causes of death, following cardiovascular diseases. Despite significant advances in medicine, cancer incidence continues to rise, with the number of affected individuals having doubled over the past decades. Pain is the most common symptom experienced during the course of cancer. On average, approximately half of patients with cancer, at various stages of the disease, suffer from pain. According to the concept proposed by Cicely Saunders, founder of St Christopher's Hospice in London, cancer pain is a multidimensional and overwhelming experience referred to as "total pain" which includes physical, psychological, social, and spiritual components. The aim of this study is to present the issue of pain in the course of cancer, to define appropriate nursing management strategies for the assessment and monitoring of this symptom, and to provide a descriptive analysis of current knowledge on pain and its treatment. This paper is based on a review of the relevant literature, including textbooks, scientific articles, and current legal regulations. It consists of three chapters addressing palliative care, the characteristics of cancer pain, and principles of nursing management in its assessment and control.

KEYWORDS

Chronic Pain, Breakthrough Pain, Palliative Care, Pain Assessment, Cancer Pain

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Introduction and Background

Palliative care focuses on identifying and addressing the needs of patients in all domains of life, as well as alleviating symptoms associated with disease. Its primary goal is to improve the quality of life of patients with incurable illnesses and their families. Contemporary approaches are based on a patient-centered model, family support, and a holistic perspective encompassing biological, psychological, social, and spiritual dimensions [1,2]. According to the definition of the World Health Organization, updated in 2002, palliative care should be introduced as early as possible, alongside disease-modifying treatment, and should not be limited to oncology patients but extended to all individuals with advanced, life-limiting illnesses [1,2]. Its core objective is the prevention of suffering through effective pain and symptom management, as well as providing support to families, including during the bereavement period. Similar principles are emphasized by the European Association for Palliative Care, which highlights the importance of quality of life for both the patient and their social environment [3]. High-quality interdisciplinary palliative care requires adherence to key principles, including: providing holistic care addressing biological, psychological, social, and existential needs; striving to ensure optimal quality of life as perceived by the patient in the context of their condition and time; acceptance of death as a natural and inevitable process that should neither be hastened nor postponed; alleviation of suffering through appropriate symptom management, including treatment of both physical and psychological pain; effective collaboration within an interdisciplinary team to ensure comprehensive medical and non-medical care; maintaining appropriate communication with the patient's family and supporting them in coping with impending loss and during the grieving process; ensuring equal access to palliative care services regardless of racial, ethnic, socioeconomic, or social status. Through its comprehensive and holistic approach to both the patient and their family, palliative care constitutes a fundamental component of modern medicine, enabling patients to experience the final stage of life with dignity [1,4].

Cancer Pain

Palliative care focuses on identifying and addressing patients' needs in all domains of life, as well as alleviating symptoms associated with disease. Its primary goal is to improve the quality of life of patients with incurable illnesses and their families. Contemporary approaches are based on a patient-centered model, family support, and a holistic perspective encompassing biological, psychological, social, and spiritual aspects [1,4]. According to the World Health Organization, palliative care should be introduced as early as possible, alongside disease-modifying treatment, and should be provided not only to oncology patients but to all individuals with advanced disease [5]. Similar principles are emphasized by the European Association for Palliative Care, which highlights the importance of quality of life for both patients and their environment [3,6]. Pain is one of the most common and burdensome symptoms in chronic diseases, particularly cancer. According to the International Association for the Study of Pain, pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage [7,8]. When pain persists for more than three months despite treatment, it is classified as chronic pain and is associated with a significant deterioration in quality of life and psychological well-being. Cancer pain, which may be nociceptive or neuropathic in nature, is one of the most frequently reported problems among oncology patients and affects millions of individuals worldwide [9,10,11]. It may occur as continuous pain, typical of advanced stages of the disease, or as intermittent, episodic pain. During the course of the disease, acute pain episodes may also arise as a result of tumor progression, oncological treatment, or comorbid conditions. Particularly severe pain is observed in cancers of the pancreas, bones, brain, lungs, and head and neck [1,12,13]. Effective pain management is therefore a fundamental component of palliative care, significantly influencing patients' quality of life and their functioning during the final stage of the disease [14].

Types of Pain

Pain is always classified as an unpleasant experience that evokes negative sensations and is inherently subjective, depending on the individual experiencing it. The duration of pain plays a crucial role and significantly influences the clinical presentation of the patient. One of the basic classifications distinguishes acute pain, lasting up to three months, and chronic pain, persisting longer than three months [15]. This temporal threshold has been established by experts from the International Association for the Study of Pain and is widely used in clinical practice. However, classification based solely on duration is insufficient, as differences in pain function, physiological patterns, emotional responses, and perceptual mechanisms must also be considered [15,16]. Acute pain is typically associated with a clearly identifiable cause and is usually well localized. It most often results from tissue damage or disturbances in homeostasis and serves an important protective function by signaling potential harm. However, inadequate management or neglect of acute pain may lead to functional impairment and, in severe cases, permanent disability or even death [7,17]. Early identification of the underlying cause and prompt implementation of appropriate treatment are essential. Pain perception is subjective and influenced by individual factors such as life experiences, personality, temperament, and emotional state. Therefore, management should be multidisciplinary, combining causal and symptomatic treatment with psychological support to prevent the development of chronic pain. In oncology patients, acute pain may occur at any stage of the disease and can result from tumor progression (e.g., nerve compression, metastases), diagnostic procedures, or anticancer treatment [12,16]. In advanced stages, it is often associated with pathological fractures and gastrointestinal complications [12]. Chronic pain, defined as pain persisting for more than three months, is associated with long-term changes in the nervous system and may occur despite tissue healing or in the course of chronic diseases [15,16]. Unlike acute pain, it loses its protective function and becomes a disease in itself, significantly affecting the patient's quality of life and psychosocial functioning [16,17]. Persistent pain is frequently accompanied by negative emotions such as frustration, anger, and helplessness, and increases the risk of depression. Depressive disorders may further intensify pain perception by lowering the pain threshold and altering its processing, thereby complicating treatment. Studies have shown that symptoms of depression occur significantly more frequently in patients with chronic pain compared to the general population [17,18]. In cancer patients, chronic pain may result from the disease itself, its treatment, or paraneoplastic syndromes. Therefore, effective care requires not only somatic management but also psychological support, including psychiatric and psychotherapeutic interventions [12,19]. In addition to the classification into acute and chronic pain, other types of pain are of particular importance in palliative care, including breakthrough pain, end-of-dose pain, and total pain, as their recognition enables appropriate management. Breakthrough cancer pain is defined as a transient exacerbation of pain that occurs despite

adequately controlled baseline pain. It affects approximately 40-60% of oncology patients and is characterized by rapid onset (3-5 minutes), high intensity (typically >5 on the Numerical Rating Scale [NRS]), and short duration (usually 30-60 minutes). Two main types are distinguished: spontaneous (idiopathic) pain and incident pain, which is associated with a specific trigger. Incident pain may be involuntary (e.g., coughing, sneezing, visceral spasms) or voluntary (e.g., movement, walking, daily activities). It is important to differentiate breakthrough pain from end-of-dose failure, which occurs as the analgesic effect of medication diminishes and is usually related to inadequate baseline pain control or suboptimal dosing regimens [12,19]. Management involves optimization of baseline analgesia, including adjustment of dosing intervals (e.g., administration every 8 hours instead of every 12 hours) or increasing opioid doses. Breakthrough pain significantly impairs patients' quality of life, affecting sleep, activity levels, and emotional well-being. Treatment typically includes rapid-onset, short-acting opioids administered as rescue doses, usually equivalent to 10-20% of the total daily opioid dose or 1/12-1/16 of the daily dose. Commonly used formulations include fentanyl administered intranasally, buccally, or sublingually, as well as immediate-release morphine and oxycodone. In predictable incident pain, pre-emptive administration of analgesics before the triggering activity is recommended [20,21]. Accurate clinical assessment, including evaluation of both baseline and breakthrough pain, as well as its mechanism and intensity (e.g., using the NRS), is essential for effective management [20]. Pain affecting all dimensions of human functioning physical, psychological, social, and spiritual is referred to as total pain. This concept was introduced by Cicely Saunders, a British physician and founder of St Christopher's Hospice in London. The contribution of each dimension varies depending on the individual patient's situation. Lack of appropriate support and intervention may lead to increased suffering and the development of negative perceptions such as hopelessness, loss of control, and persistent distress [2,22]. Total pain encompasses somatic factors related to the disease and its treatment, as well as psychological and social components, including anxiety, anger, loss of dignity, and depression resulting from limitations in social and professional roles. Effective patient care requires a comprehensive assessment of individual needs, values, and relationships. A bio-psycho-social-spiritual approach enhances the therapeutic relationship and improves the effectiveness of treatment, including pharmacological therapy [17,23].

Pain Assessment

Pain is a multidimensional and subjective experience; therefore, its proper assessment should encompass all of its components: physical, psychological, social, and spiritual. According to the recommendations of the European Society for Medical Oncology, particular attention should be paid to the evaluation of psychological and spiritual distress, as well as the need for support in these domains during routine cancer pain assessment [19,24]. In advanced stages of cancer, pain often represents only one element of so-called symptom clusters, co-occurring with fatigue, insomnia, constipation, and in the case of lung cancer - dyspnea and cough. Patients at this stage frequently experience multiple concurrent health problems, which necessitates a comprehensive and multidisciplinary therapeutic approach [17,22]. According to the principles of the World Health Organization, proper pain assessment should include consideration of the patient's subjective report, evaluation of pain intensity and course, its impact on psychological, social, and spiritual functioning, as well as the selection of appropriate treatment methods and assessment of their effectiveness [16,24]. The first step in the proper assessment of cancer pain is a structured interview conducted with the patient and, when possible, their family. During this process, the clinician aims to build trust, demonstrating empathy, tact, and understanding. The interview should address the following aspects: location of the pain, presence of radiation, possible cause of the pain, duration of symptoms, pattern of pain (constant, recurrent, episodic), character of pain (e.g., dull, stabbing, burning, sharp, tender), intensity of pain, factors that exacerbate or trigger pain, factors that relieve pain, impact on sleep, impact on daily functioning, previous pain management strategies, occurrence of adverse effects related to prior treatment, presence of other accompanying symptoms, comorbid conditions and history of surgical procedures. In interviews with family members, it is also important to assess changes in the patient's mood and behavior during pain episodes, as well as the ways in which pain is expressed [19,25]. The second essential component of pain assessment is the use of standardized scales and questionnaires. These tools allow for the evaluation of pain intensity at admission, during treatment, and for monitoring therapeutic effectiveness, as well as facilitating the selection of the most appropriate treatment strategy. The most commonly used methods for assessing pain intensity, both acute and chronic, include: Numerical Rating Scale (NRS) - patients rate their pain on a scale from 0 (no pain) to 10 (worst imaginable pain). It is simple, sensitive, reliable, and widely used in both clinical practice and research. Its use may be

limited in young children; Visual Analogue Scale (VAS) - represented by a 10 cm line with endpoints corresponding to extreme pain intensities. The patient marks a point reflecting their pain level, enabling precise monitoring of changes over time; Verbal Rating Scale (VRS) - based on descriptive categories of pain intensity. Its limitation lies in the subjective interpretation of descriptors by patients; Wong-Baker Faces Pain Rating Scale - uses facial expressions and is particularly useful in children and patients with communication or cognitive impairments; Behavioral scales (e.g., Doloplus, Behavioral Rating Scale - BRS) - applied in patients with impaired verbal communication. These scales rely on observation of behavior across somatic, psychomotor, and psychosocial domains; McGill Pain Questionnaire (MPQ) - a multidimensional tool that assesses sensory, emotional, and cognitive aspects of pain, allowing both qualitative and quantitative evaluation [19,25]. The use of these tools enables a more objective assessment of pain and facilitates monitoring of analgesic treatment effectiveness. In the assessment of neuropathic pain, specialized questionnaires are used, such as NPQ (Neuropathic Pain Questionnaire), DN4 (Douleur Neuropathique en 4 questions), PainDETECT, and LANSS (Leeds Assessment of Neuropathic Symptoms and Signs). These instruments help to characterize pain and identify patients with a neuropathic component. Comparative studies have shown that the DN4 scale has the highest sensitivity (approximately 78.5%), whereas LANSS demonstrates lower sensitivity (approximately 48%) [26,27]. The most reliable diagnostic methods for neuropathic pain include skin biopsy and laser-evoked potentials; however, due to limited availability, they are not routinely used in clinical practice. Clinical examination remains of great importance, particularly in identifying sensory disturbances such as hypoesthesia, allodynia, hyperalgesia, or hyperpathia [28]. Supplementary to the medical interview and standardized assessment tools are the results of psychological evaluation, which include assessment of mood, anxiety, depression, and personality disorders. Proper diagnosis of depression is particularly important in patients with chronic pain, as these disorders may intensify pain perception and hinder therapeutic progress. Behavioral scales and activity assessment tools are also useful in objectifying patients' pain-related behaviors [18]. An important component of pain assessment is the physical examination, including neurological evaluation, which involves the assessment of muscle strength and tone, range of motion, superficial and deep sensation, tendon reflexes, and cranial nerve function [27]. The diagnostic process also includes the evaluation of physiological parameters associated with pain. In acute pain, increased heart rate, respiratory rate, and blood pressure are commonly observed, whereas in chronic pain, neurochemical changes may be assessed, such as the activity of pronociceptive neuropeptides (e.g., substance P) and antinociceptive substances (e.g., endorphins) [17].

Principles of Pain Management

The majority of patients with cancer experience cancer-related pain, defined as any type of pain occurring during the course of the disease or its treatment. Studies indicate that the use of simple and well-defined principles of analgesic therapy allows effective pain control in approximately 70-80% of patients [19,24,25]. A multidimensional assessment of pain, focused on its underlying mechanism (neuropathic, somatic, visceral), enables the implementation of individualized treatment, which increases therapeutic effectiveness while reducing the risk of adverse effects. Untreated pain may lead to numerous negative consequences, including sleep disturbances, development of depression, impairment of immune system function, and overall deterioration of the patient's condition. Therefore, patients should be provided with comprehensive pain management at every stage of the disease, in parallel with anticancer treatment [17,25]. The cornerstone of pharmacological treatment of cancer pain is the three-step analgesic ladder developed by the World Health Organization and further elaborated in the recommendations of the European Association for Palliative Care. Its main objective is to select analgesics appropriate to the intensity of pain, taking into account its underlying mechanism [19,24]. At the first step, non-opioid analgesics are used, including paracetamol, nonsteroidal anti-inflammatory drugs (NSAIDs), and metamizole. These agents act by inhibiting cyclooxygenase activity and reducing prostaglandin synthesis, which leads to decreased pain perception and inflammatory response. They are recommended for patients with mild pain (1-4 on the Numerical Rating Scale [NRS]), provided there are no contraindications to their use. In cases of insufficient efficacy, escalation to the next step of the analgesic ladder or modification of treatment is required [25,29, Figure 1].

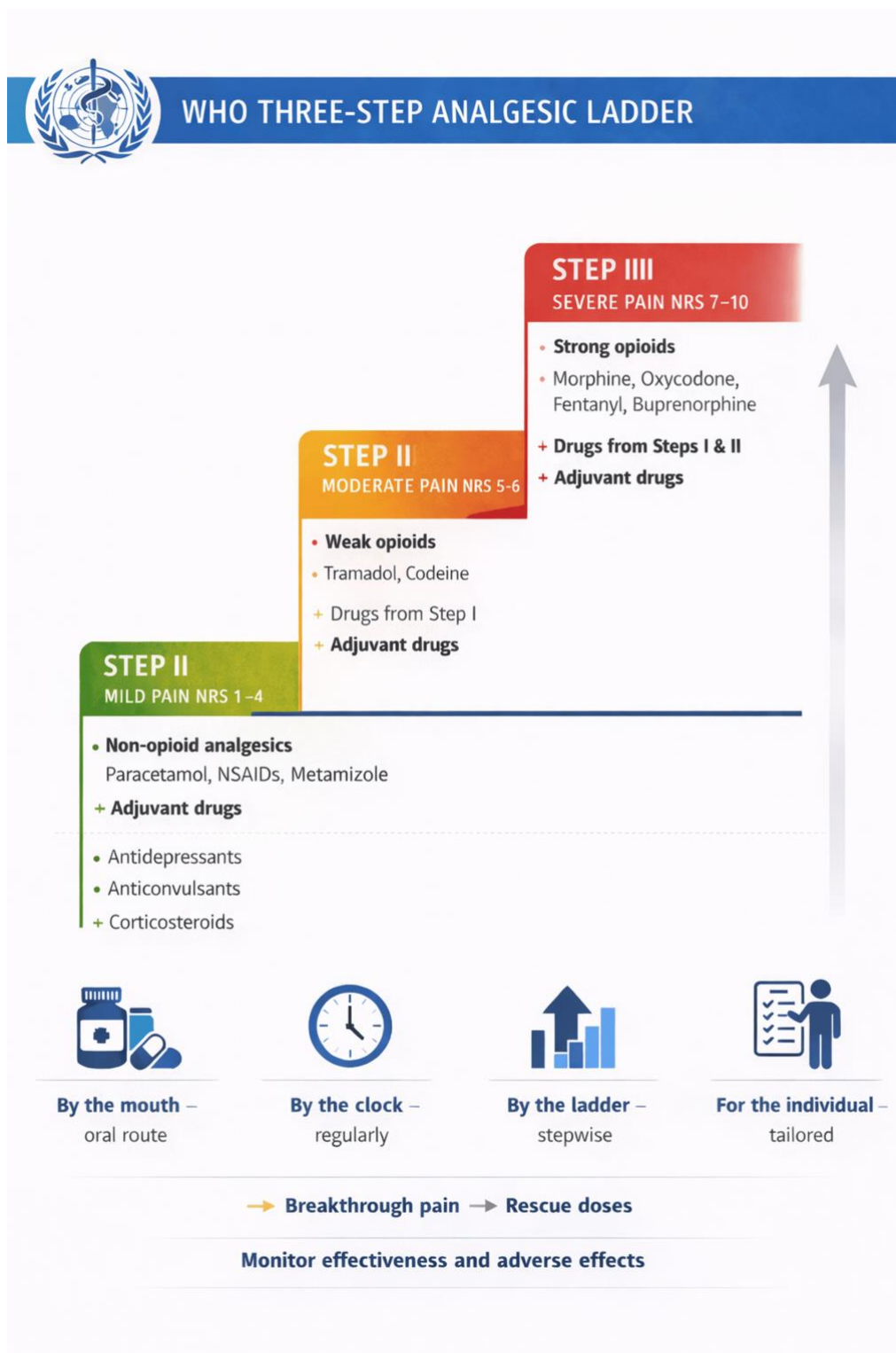


Fig. 1. WHO Three-Step Analgesic Ladder. Own elaboration based on World Health Organization guidelines [24].

The Role of the Nurse in the Assessment and Monitoring of Cancer Pain

Across various levels of healthcare, nurses maintain a unique therapeutic relationship with patients through continuous assessment, monitoring, and clinical interventions. Due to this role, nurses are able to ensure continuity of care that responds to the needs of patients with incurable diseases [30]. Nursing care plays a crucial role in both the assessment and monitoring of pain in the course of cancer. Through a combination of patience, openness, empathy, attention to detail, and teamwork, nurses establish and maintain relationships that enhance the quality of palliative care. However, like all healthcare disciplines, nursing has certain limitations in practice. Therefore, interdisciplinary collaboration is essential to ensure appropriate care for terminally ill patients and their families [31]. The responsibilities of nurses caring for patients experiencing pain include thorough pain assessment as well as monitoring of vital signs and the patient's psychosomatic condition. The role of the nurse involves a comprehensive evaluation of both baseline and breakthrough pain, as well as other accompanying symptoms such as changes in appetite, sleep disturbances, constipation, and nausea. Nurses actively observe patients during pharmacological treatment, paying particular attention to potential adverse effects of medications, such as opioid-induced constipation. They assess treatment effectiveness and respond promptly to the emergence of new symptoms. In addition to making nursing diagnoses, performing nursing procedures, and implementing medical orders, nurses are responsible for educating patients and their families about pain management therapy, possible side effects, and proper identification of different types of pain (e.g., breakthrough pain, baseline pain, end-of-dose pain). Increased patient awareness of their disease and pain significantly supports nurses in the accurate assessment and monitoring of cancer pain [2].

Pain Assessment by the Nurse

Pain assessment is as important as monitoring vital signs; therefore, according to the American Pain Society (APS), pain is referred to as the "fifth vital sign." A nurse intervening during pain performs its initial assessment, determining its location, quality, onset and duration, timing, intensity, aggravating and relieving factors, as well as its impact on daily functioning. This initial evaluation is crucial for identifying the underlying cause of pain and implementing effective treatment. Assessment of the patient's emotional state is also essential, including their attitude toward the illness and experienced symptoms. The outcome of this evaluation may involve providing psychological support, initiating appropriate therapy, or, if necessary, implementing pharmacological treatment. A nurse who actively listens to the patient's description of pain can better understand their perception of symptoms such as anxiety, fear related to unidentified pain, and concerns that may influence their willingness to report pain and their response to it. Accumulation of negative emotions may increase the risk of depression and may also suppress immune function, making the patient more susceptible to infections. In addition to communication with the patient, maintaining contact with family members is equally important. Family and caregivers should receive both informational and emotional support. High-quality care is based on building relationships founded on truth, respect for life, and human dignity. Assessment of the family situation also plays a significant role in further pain management. An essential component of pain assessment is the use of scales and questionnaires tailored individually to the patient. Some patients, particularly those with cognitive impairment, may have difficulty verbally expressing pain intensity; in such cases, behavioral scales (e.g., Doloplus) are recommended, as they assess patient behavior during pain episodes. However, pain expression is highly individual, and behavioral responses may vary between patients. Studies have shown that the effective use of pain assessment scales by nurses often depends on their personal beliefs regarding the usefulness of these tools. Pain assessment including evaluation of type, location, intensity, duration, associated symptoms, and the level of relief achieved should be routine and mandatory. Systematic and careful observation of pain has been identified as an important factor in improving treatment outcomes. Accordingly, nurses may encourage patients (when possible) to keep a pain diary, documenting pain duration, triggering factors, medications used, and the effects of analgesic treatment. A holistic approach and attentive observation enable nurses to recognize additional nonverbal indicators of pain, such as sighing, groaning, moaning, crying, counting, praying, complaining, or even swearing. This allows for early intervention, often before the patient verbally reports pain. Before performing nursing procedures that may cause discomfort (e.g., morning hygiene care), the nurse should consider administering analgesics prophylactically approximately 30 minutes in advance. It is important to prevent prolonged suffering. During opioid therapy, patients should remain under continuous supervision by medical staff, with regular monitoring of pain intensity, level of sedation, and respiratory status, as well as ongoing evaluation of treatment effectiveness. Accurate, routine, and thorough documentation of pain assessment by nurses significantly improves pain management outcomes, facilitating and expediting clinical decision-making regarding appropriate therapeutic interventions [31,32].

Attention to Detail in Nursing Care

Providing nursing care to patients suffering from cancer-related pain requires a broad range of knowledge, skills, and professional behaviors in order to ensure holistic support for both patients and their families. Particular attention to detail is essential, as it facilitates effective cooperation between the interdisciplinary team and the patient. Effective communication skills play a crucial role in establishing and maintaining therapeutic relationships with patients and their relatives. It is important that information regarding diagnosis, treatment options, and prognosis is communicated by nurses with appropriate expertise, in a manner that is both honest and sensitive to patients' concerns and questions. Patients left without adequate support during disease progression may experience significant difficulty in making decisions regarding their treatment and care. In addition to direct patient interaction, nurses have a responsibility to support and guide less experienced colleagues, advising them on how to respond to difficult questions and when to seek assistance. Although there are no simple answers to life's most challenging questions, several communication strategies may facilitate effective interaction in palliative care settings. These include: encouraging patients to express fears, doubts, and questions, using active listening and empathy to demonstrate understanding, not avoiding appropriate physical touch and reassurance, respecting silence and not feeling compelled to fill it, avoiding providing more information than the patient requests, responding directly to repeated questions, verifying whether the patient has understood the information provided, using language that is clear and appropriate for the patient [33]. Patients experiencing progressive cancer pain should receive clear information regarding the nature of their pain, its management, medication administration, potential side effects, and possible complications. Effective cooperation during analgesic therapy is essential. The simplest possible dosing regimen should be proposed in order to minimize the risk of errors. This includes both regularly administered medications and rescue doses. In the case of immediate-release opioid analgesics administered orally or subcutaneously, typically given every 4 or 6 hours, dosing schedules should be adjusted to avoid interrupting the patient's sleep. In such cases, the last evening dose is usually administered at 22:00 and may be increased by approximately 50% compared to previous doses to ensure adequate pain control overnight despite the dosing interval. Nurses caring for patients receiving analgesic therapy should also monitor accompanying symptoms. In patients treated with nonsteroidal anti-inflammatory drugs (NSAIDs), the use of proton pump inhibitors should be considered. In patients receiving opioids, antiemetics (especially at the beginning of therapy) and laxatives (on a regular basis) should be administered. In addition to pharmacological treatment, patients should be encouraged to use supportive methods for pain control, such as physiotherapy, group therapy, distraction techniques, massage, relaxation, music therapy, and the application of heat or cold. Patients should also be provided with clear written instructions regarding the use of regular and rescue medications to ensure full understanding of their treatment [22,32].

Patient Observation During Therapy and in the Course of Cancer Pain

Cancer pain is characterized by variable dynamics, with periods of severe exacerbations and relief. To ensure proper control, it must be accurately recognized, assessed, treated, and continuously monitored. The first step in providing appropriate care is the assessment of baseline pain, which includes determining its location, mode of perception (localized, radiating, generalized), duration (hours, days, weeks, months, years), temporal pattern (nighttime, daytime, or constant), and character (e.g., stabbing, dull, piercing, burning). Patients may report pain in multiple locations, each of which requires separate evaluation and monitoring. Standardized pain assessment tools (e.g., NRS, VAS, Likert scale, Doloplus) are used to evaluate pain intensity, selected according to the experience of healthcare professionals and the patient's cognitive abilities. Alongside diagnostic assessment, previously used pharmacological treatment of baseline pain should be carefully reviewed in order to adjust medication doses and ensure adequate pain control. The ability to modify dosing based on patient condition requires comprehensive knowledge of opioid pharmacodynamics and pharmacokinetics, including onset of action, duration, time to peak concentration, and potential adverse effects. Despite appropriately selected pharmacotherapy, patients may experience short-lasting but intense exacerbations of pain, which are highly distressing and complicate treatment. Breakthrough pain, which significantly exceeds baseline pain despite adequate treatment, may hinder effective pain management. Patients may lose confidence in therapy and attempt to modify medication doses independently in search of relief. To prevent such situations, all patients with chronic pain should undergo thorough assessment of pain exacerbations. This evaluation should include location, character, intensity, duration, dynamics, and triggering factors. Before diagnosing episodic (breakthrough) pain, the following conditions should be excluded: inadequately controlled baseline pain, pain occurring without baseline pain, end-of-dose pain associated with

diminishing analgesic effect, pain exacerbations in the absence of regular analgesic dosing and pain occurring during titration of baseline analgesic therapy. Two main types of breakthrough pain are distinguished: idiopathic pain, which is unpredictable, and incident pain, which may be either predictable or unpredictable. If the number of pain exacerbations exceeds three episodes per day, the dose of baseline analgesic medication should be increased and administered at regular intervals. If no improvement is observed, the introduction of adjuvant analgesics or switching to a different opioid should be considered. Patients receiving rescue doses require continuous monitoring, particularly for adverse effects associated with rapid dose escalation, such as dizziness, confusion, excessive sedation, nausea, and vomiting. Patients and their caregivers should be educated on the proper administration of rescue medications, potential side effects, and methods of managing them. Thorough and systematic observation of the patient including verbal and nonverbal behavior, as well as monitoring of vital signs using appropriate tools such as scales and questionnaires is essential for effective care and relief of suffering [19,25,29].

Conclusions

Cancer pain is a subjective and multidimensional experience, therefore its assessment should be based on the patient's self-report and addressed through a holistic approach. Effective pain management requires interdisciplinary collaboration, continuous evaluation of treatment, and appropriate communication within the therapeutic team and with the patient and their family. Nurses play a key role in this process through systematic pain assessment, monitoring of treatment effectiveness, identification of adverse effects, and patient and family education. Establishing a therapeutic relationship based on empathy and trust facilitates accurate problem identification and supports individualized care. Modern management of cancer pain is supported by the use of standardized assessment tools and guidelines developed by organizations such as the World Health Organization and the European Association for Palliative Care. However, the effectiveness of care ultimately depends on the competence, commitment, and communication of the interdisciplinary team, which are essential for improving patients' quality of life.

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