How should pain be controlled in clinical trials for pancreatic cancer?

To the Editor: T. Okusaka et al. (Jpn. J. Clin. Oncol., 215–220, 1996) recently reported the clinical response to chemotherapy in patients with advanced pancreatic cancer. To assess the clinical efficacy of the treatment, they used pain assessment by the patients themselves (employing a pain assessment card) and the amount of morphine consumed. This type of assessment is already used in the USA and will be widely applied in Japan in the future. However, there are several pitfalls with this evaluation.

Even in clinical trials, patients have the right to be given optimal pain control. If medical oncologists themselves control pain, the amount of morphine and the method of pain control may be affected by the course of chemotherapy and the doctors' expectations. It is also possible that patients would have to tolerate uncontrolled pain for longer periods than those not enrolled in clinical trials.

Moreover, self-assessment of pain by patients may be affected by the expectations of doctors if the patients know that self-assessment is of major interest to medical oncologists. Thus the evaluation reported by Okusaka et al. might have been less than objective. For these reasons, in clinical trials, it is mandatory to give the task of pain control to an independent doctor, hopefully an anesthesiologist or specialist in pain control, to make the evaluation objective and to achieve rapid and optimal pain control. In clinical trials of medical treatment for advanced pancreatic cancer, pain control and chemotherapy should be carried out separately by two independent groups of doctors. Assurance of optimal pain control by such a system should be explained in the context of informed consent.

Considering the low response rate and quite limited survival benefit of chemotherapy for pancreatic cancer, it should be regarded as merely a palliative measure. Therefore the effect of treatment evaluated by QOL would seem to be more important than that based on tumor response, until such a time when a reasonably effective drug appears. For this reason, correct assessment of QOL in clinical trials for advanced pancreatic cancer is of paramount importance. Pain control system for clinical trials by specialists should be urgently established in Japan.

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Authors' reply: We thank Dr. M. Sasako for his interest and comments on our article. He suggested that pain control and chemotherapy should be carried out separately by two independent groups of doctors during treatment of pancreatic cancer. We agree with his opinion that a patient's pain has to be managed by specialists in order to achieve optimal control. We intend to follow his advice in future studies, if possible.

Dr. M. Sasako was concerned that patients might have uncontrolled pain for a longer time when pain was evaluated as one of the primary endpoints in clinical trials. He claimed that patients ought to receive the optimal pain control even in clinical trials. In our reported study, however, we took care to administer sufficient analgesics to control the patients' pain both before and during chemotherapy (FP therapy).

Although this study was, in a sense, preliminary, we think that it was significant in that the clinical response, as well as the tumor response, was demonstrated to be one of the endpoints of chemotherapy for pancreatic cancer. We will pursue more precise assessment of the clinical response to establish a more effective chemotherapy for pancreatic cancer.

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