

Kathleen Foley talks about the definition and classification of cancer pain syndromes

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MARCIA MELDRUM: Now, this is very interesting to me, and I must admit when I read it in your brief biography, it said, “Common cancer-pain syndromes,” I said, “Oh?” [she laughs] People who have cancer should have pain; why do we have to define pain syndromes? So maybe you could talk a little about that and explain a little.

KATHLEEN FOLEY: Well, we put an enormous emphasis on the idea that you can’t treat pain unless you can assess it properly, and that’s become even more apparent. And by calling these common pain syndromes, it’s partially related to my role as a neurologist in that we were seeing patients with very characteristic symptoms, that had not been defined into a single complex, and therefore were not recognized as such. And we know that the way we teach medicine is by putting things into these common characteristic phenomena, that when people see them as a constellation, they know what the lesion is. Now, neurologists go from the lesion back to the syndrome, and we were attempting to do both of that.

So for example, we serve a large number of women who have significant pain in their arm, for example, that was secondary to tumor infiltration of the brachial plexus, the nerve that innervates the arm. Well, this is such a characteristic syndrome, and if it was not recognized and treated early, then these patients would have significant damage to the nerve. So it meant when the doctor saw a patient with breast cancer who came in and said, “I have terrible pain in my elbow and numbness and tingling in the fourth and fifth fingers of my hand,” forty bells should go off in their head and they should say, “She might have a tumor involving the brachial plexus. I need to have her radiated; I need to have her treated.”

We were then viewing the construct that we could prevent many of these significant neurologic pain syndromes by early diagnosis, particularly in treatable disorders. In the same way, we identified a series of novel pain syndromes. From simple mastectomy on up to radical mastectomy was the common approach to treating breast cancer in the 1970s, and we identified a population of women who developed a very significant chest-wall pain syndrome after their surgery. And it was very stereotyped, very characteristic, and the women were thought to be crazy by their doctors seeing them.

MELDRUM: A variation of phantom limb, sort of?

FOLEY: Well, it's a neuropathic pain syndrome that comes from interruption of the nerve in the chest wall. But we were seeing these women coming to us, and their surgeons were saying, "I've never seen this before; this never happens." They were telling that to the patients, who were then thought, "Not only do I have breast cancer, but now I'm crazy." And we defined it and defined it in great detail as a syndrome and gave it -- one, a name -- and [two,] took it out of the realm of this psychological phenomenon in women, to a very real pain syndrome that was well defined, well described, has characteristic appearances, has a variety of treatments, and has, now we know, an anatomical variation associated with the size of the nerve.

So that, you know, in trying to build the field and very sort of plodding a long way -- and I would be the first to say it was plodding -- it was trying to identify these neurological complications of cancer, which was what our department was doing, and to define them in a way that could then be readily recognized by neurologists, who could then readily treat [them]. So part of the pain in cancer, because we decided pain was a neurological complication of cancer, we put it into that domain. And we put it into the field of neuro-oncology. There was this enormous need to describe the field.

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