Journal Club 29

JAN

Informing Practice and Policy Worldwide through Research and Scholarship

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前言

- 疼痛是癌症病人最常見且最困擾的症狀之一，嚴重影響其生活品質。
- 新診斷的癌症病人中30-40%有疼痛問題。
- 末期病人更有70-90% 會經歷中至重度疼痛。
- 有25-30% 的疼痛是難以忍受的。

Pain

= 5th vital sign

相信病人的疼痛!
痛就是痛...

癌症疼痛控制的障礙

病　人

- 猶豫告知疼痛
- 顧慮會因而使醫師不能專心於疾病
- 恐懼疼痛可能是癌病惡化的徵象
- 怕未能表現為一“好”病患
- 害怕成癮
- 擔心藥越用越無效

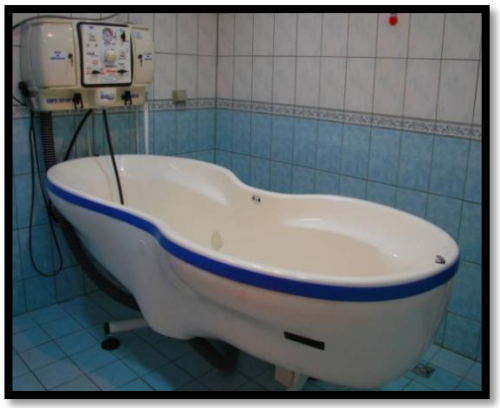
癌症疼痛控制的障礙

醫護人員

- 疼痛處置的知識不足
- 疼痛評估不適當
- 對藥品管制法令的過分顧慮
- 害怕導致患者成癮
- 過分顧慮止痛藥物的副作用
- 顧慮患者會對藥物產生耐受性

臨床問題(案例)

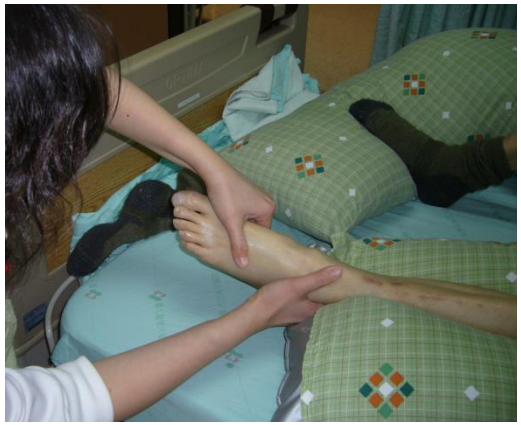
- 陳先生 ，80歲，膽道癌，腹部悶痛約5-6分，每3日使用Fentanyl 25 mcg/hr 貼片
- 芳香師使用精油按摩、志工、關懷師陪伴聊天並關心
- 看到泡澡機，痛就減輕一半了.....
- 某日護理師協助使用按摩浴缸為病人泡澡約30分鐘，病人感覺舒服，未抱怨疼痛，即入睡



臨床常使用之非藥物方式減輕疼痛方法

- 精油按摩
- 冷熱敷
- 針灸
- 足療
- 泡澡
- 物理治療
- 能量轉換

- 社工師/關懷師/宗教師精神關懷，或支援團體協助
- 催眠/冥想/音樂治療/放鬆訓練
- 經皮神經刺激術
- 超音波刺激
- 神經阻斷手術治療
- 放射線治療



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Informing Practice and Policy Worldwide through Research and Scholarship

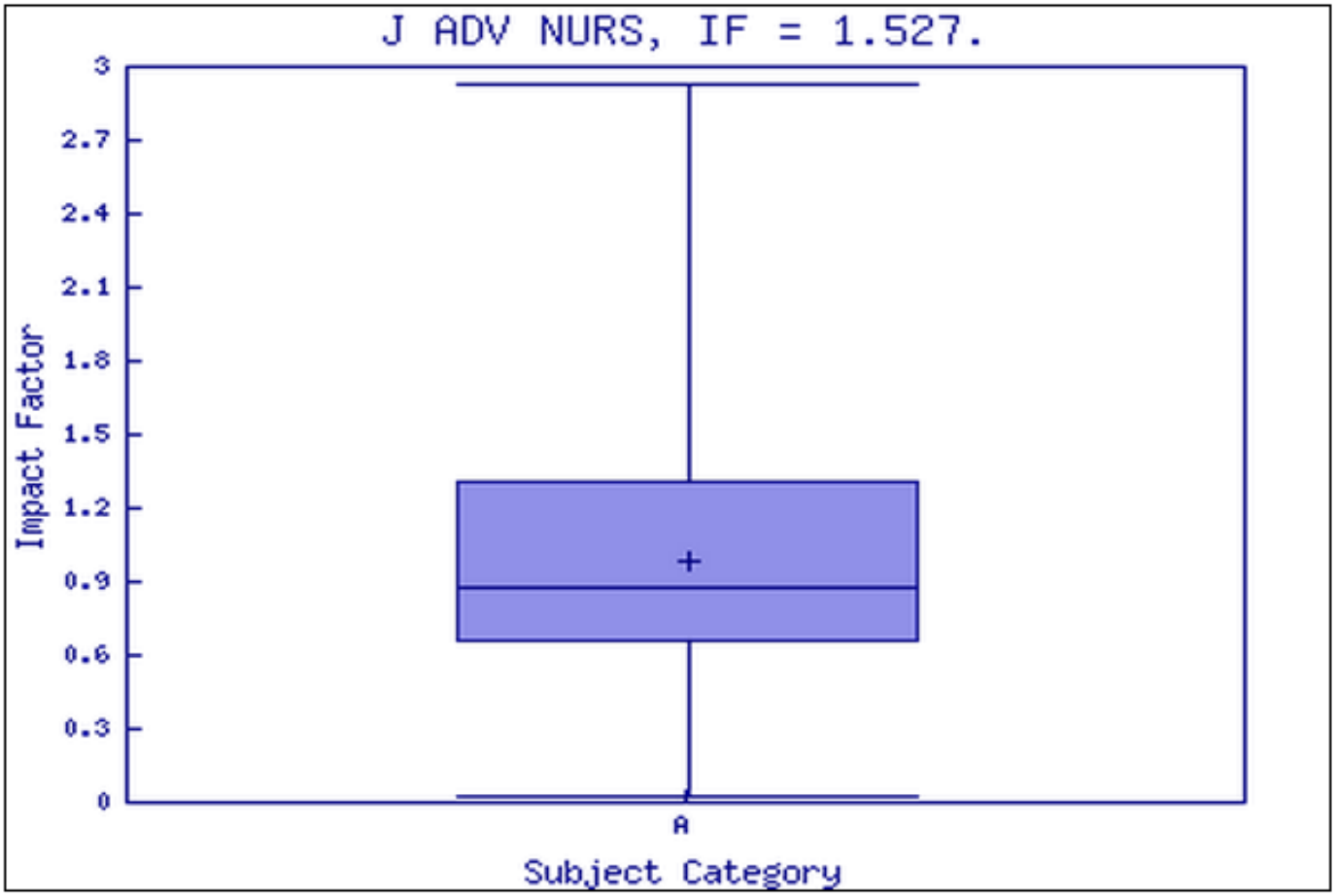
REVIEW PAPER

A systematic review: non-pharmacological interventions in treating pain in patients with advanced cancer

Minna Hökkä, Pirjo Kaakinen & Tarja Pölkki

JOURNAL OF ADVANCED NURSING

Category Name	Total Journals in Category	Journal Rank in Category	Quartile in Category
NURSING	106	16	Q1



步驟1:系統性文獻回顧探討的問題為何?

- 研究族群/問題 (population/problem)
  - adult patients with advanced cancer
  - Cancer pain
- 介入措施(Intervention)
  - non-pharmacological intervention
- 比較(Comparison)
  - Usual care
- 結果(Outcomes)
  - Perceived pain control and experience, pain intensity and pain interference

Abstract

Aims. To assess and synthesize the evidence of the effects and safety of non-pharmacological interventions in treating pain in patients with advanced cancer.

Background. Pain is a common symptom experienced by patients with advanced cancer; the treatment of such pain is often suboptimal. To manage it, non-pharmacological interventions are recommended after pharmacological treatments have been re-evaluated and modified. However, there remains a lack of knowledge about the effects and safety of such interventions.

Design. A systematic review was conducted based on the procedure of the Centre of Reviews and Dissemination.

Data Sources. Research papers published between 2000–2013 were identified from the following databases: CINAHL, MEDIC, MEDLINE (Ovid) and PsycINFO. The references in the selected studies were searched manually.

Review Methods. The studies selected were reviewed for quality, using Cochrane Effective Practice and Organisation of Care Review Group risk of bias assessment criteria.

Results. There was limited evidence that some of the non-pharmacological interventions were promising with respect to reducing cancer pain. Relatively, few adverse events were reported as a result of using such interventions.

Conclusion. It was not possible to draw conclusions about the effects and safety of the non-pharmacological interventions in reducing cancer pain. Some interventions showed promising short-term effects, but there is a need for more rigorous trials. Qualitative studies are required to collect information about patients' perceptions. There are several research gaps: we found no studies about music, spiritual care, hypnosis, active coping training, cold or ultrasonic stimulation.

步驟2:系統性文獻回顧的品質如何?(FAITH)

F-研究是否找到所有的相關證據?

搜尋4個資料庫

文獻搜尋包含英語、芬蘭語、瑞典語，並使用MESH Terms 及一般檢索詞彙

Search methods

With the help of an information specialist, a search strategy was devised to identify studies that met our inclusion criteria (Table 2) (Whittemore 2005). To identify the best relevant terms for the final searches, preliminary trials were undertaken.

Four databases were systematically searched to identify relevant studies: CINAHL, MEDIC (the Finnish database of Medicine and Health Sciences), MEDLINE (Ovid) and PsycINFO. The search years were limited to the period from 2000–30 January 2013 to ensure that the studies included were up-to-date. The following key terms were used: 'palliative care or hospice care or terminally ill' and 'complementary therapies/methods or non-pharmacological' and 'neoplasms or cancer' and 'pain or pain management'. The key MESH terms were exploded if possible in the databas-

Table 2 Inclusion and exclusion criteria.

Inclusion	Exclusion
Written in English, Finnish or Swedish	Written in other languages
Paper's main focus on non-pharmacological interventions in treating cancer pain	Focusing on interventions other than non-pharmacological ones
Palliative, hospice or end-of-life care patients with advanced cancer.	Not focusing on palliative care or advanced patients with cancer or patients' stage of cancer not described.
Papers focusing on adults (over 18 years)	Papers focusing on children or adolescents under 18 years
Date limit 2000–early 2013	Not a peer-reviewed empirical research article
Peer-reviewed empirical research articles	Full-text not available
Full-text available	

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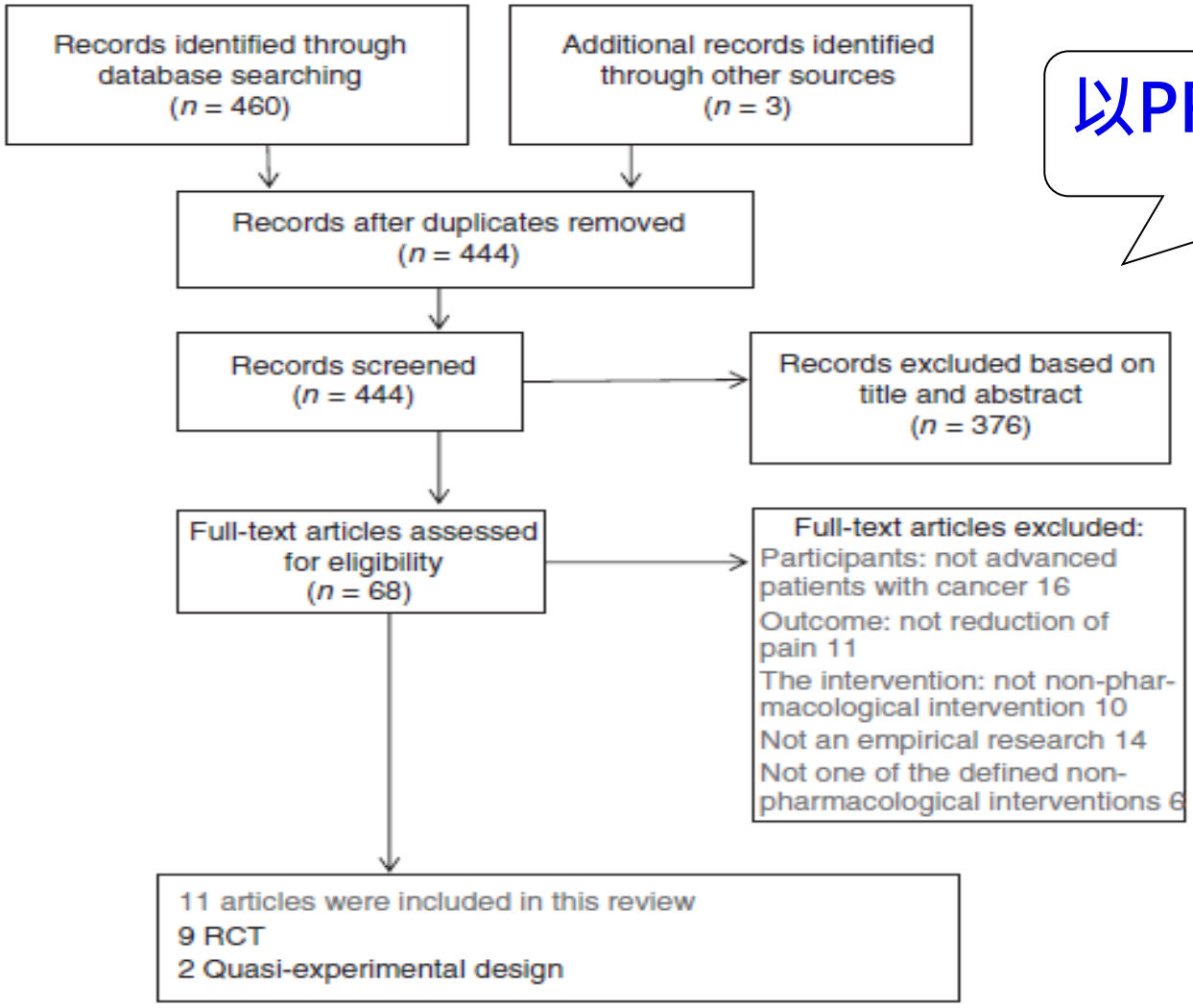
步驟2:系統性文獻回顧的品質如何?(FAITH)

F-研究是否找到所有的相關證據?



以PRISMA流程圖呈現

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步驟2:系統性文獻回顧的品質如何?(FAITH)

A- 文獻是否經過嚴格評讀(Appraisal)

使用Cochrane risk of bias
進行文獻評讀

Quality appraisal

To assess the quality of the studies selected, we used the risk of bias assessment tool recommended by the Cochrane Collaboration to address the following six domains: sequence generation, allocation concealment, blinding, incomplete outcome data, selective outcome reporting and other sources of bias (Higgins & Green 2009).

Before the assessment, the authors (MH and PK) discussed and read through the documentation describing the tool to ensure that they both had a similar understanding of the assessed domains. The quality of the different studies was independently evaluated by the authors, after which the authors compared their evaluations.

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The Cochrane Collaboration's tool for assessing risk of bias

Domain	Description	Review authors' judgement
Sequence generation	Describe the method used to generate the allocation sequence in sufficient detail to allow an assessment of whether it should produce comparable groups.	Was the allocation sequence adequately generated?
Allocation concealment	Describe the method used to conceal the allocation sequence in sufficient detail to determine whether intervention allocations could have been foreseen in advance of, or during, enrolment.	Was allocation adequately concealed?
Blinding of participants, personnel and outcome assessors *Assessments should be made for each main outcome (or class of outcomes)*	Describe all measures used, if any, to blind study participants and personnel from knowledge of which intervention a participant received. Provide any information relating to whether the intended blinding was effective.	Was knowledge of the allocated intervention adequately prevented during the study?
Incomplete outcome data *Assessments should be made for each main outcome (or class of outcomes)*	Describe the completeness of outcome data for each main outcome, including attrition and exclusions from the analysis. State whether attrition and exclusions were reported, the numbers in each intervention group (compared with total randomized participants), reasons for attrition/exclusions where reported, and any re-inclusions in analyses performed by the review authors.	Were incomplete outcome data adequately addressed?
Selective outcome reporting	State how the possibility of selective outcome reporting was examined by the review authors, and what was found.	Are reports of the study free of suggestion of selective outcome reporting?
Other sources of bias	State any important concerns about bias not addressed in the other domains in the tool. If particular questions/entries were pre-specified in the review's protocol, responses should be provided for each question/entry.	Was the study apparently free of other problems that could put it at a high risk of bias?

Possible approach for *summary assessments* outcome (across domains) within and across studies

Risk of bias	Interpretation	Within a study	Across studies
Low risk of bias	Plausible bias unlikely to seriously alter the results.	Low risk of bias for all key domains.	Most information is from studies at low risk of bias.
Unclear risk of bias	Plausible bias that raises some doubt about the results	Unclear risk of bias for one or more key domains.	Most information is from studies at low or unclear risk of bias.
High risk of bias	Plausible bias that seriously weakens confidence in the results.	High risk of bias for one or more key domains.	The proportion of information from studies at high risk of bias is sufficient to affect the interpretation of the results.

步驟2:系統性文獻回顧的品質如何?(FAITH)

I- 是否只納入(included)具有良好效度的文章?

Quality appraisal

To assess the quality of the studies selected, we used the risk of bias assessment tool recommended by the Cochrane Collaboration to address the following six domains: sequence generation, allocation concealment, blinding, incomplete outcome data, selective outcome reporting and other sources of bias (Higgins & Green 2009).

Before the assessment, the authors (MH and PK) discussed and read through the documentation describing the tool to ensure that they both had a similar understanding of the assessed domains. The quality of the different studies was independently evaluated by the authors, after which the authors compared their evaluations.

1. 文獻有先進行 Quality Appraisal，針對有無隨機分配、Blind、結果完整描述等進行評估，以確定是否具有良好效度。
2. 納入RCT及Quasi-experimental study

11 articles were included in this review
9 RCT
2 Quasi-experimental design

步驟2:系統性文獻回顧的品質如何?(FAITH)

I- 是否只納入(included)具有良好效度的文章?

Domain	YES	NO	Unclear
Sequence generation	6	-	3
Allocation concealment	5	-	4
Blinding of participants, personnel And outcome assessors	1	4	4
Incomplete outcome data	2(描述完整) 1(原因未知) 5(影響結果?)	1(high)	
Selective outcome reporting	6	-	3

N= study number

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步驟2:系統性文獻回顧的品質如何?(FAITH)

T- 作者是否以圖表及表格總結試驗結果?

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Table 3 Data extraction.

Author	Study aim	Method/Design and sample	Pain measurement tools	Non-pharmacological intervention	Findings: Effects on pain	Findings: Adverse events
Bennett *et al.* (2010) UK	To investigate the feasibility of running a large-scale phase III trial to investigate the efficacy of active TENS in the control of cancer pain.	Randomized crossover trial of TENS or placebo. Baseline assessment was undertaken. Pain was assessed during TENS sessions (lasting 30 and 60 minutes). *n* analysed 19	Numerical Rating Scale (NRS) Short-form McGill Pain Questionnaire (SF-MPQ)	One-termed transcutaneous electrical nerve simulation (TENS) session and one placebo TENS session. Median interval between applications 3 days.	TENS has the potential to decrease pain during movement (difference between groups 14·2, 95% CI = −3·34, 31·76) more than pain during rest (difference between groups −1·32, 95% CI = −3·42 to 0·79).	9 patients experienced adverse events. Distribution of adverse events was similar following active or placebo TENS application. 3 of the events were possibly related to the TENS. 1 event was related to placebo TENS.
Jane *et al.* (2009) Taiwan	To describe the feasibility of full-body massage and to examine the effects of massage on present pain intensity and other symptoms	Quasi-experimental one-group, pre-test-posttest design with repeated measures. *n* analysed 30	Present Pain Intensity (PPI) with a vertical form of the visual analogy scale (VAS) (PPI-VAS)	38–50 minutes of massage therapy, which followed a standardized protocol.	Effects: immediate ($P < 0·001$) short-term ($P < 0·001$) intermediate ($P = 0·000$) long-term benefits ($P < 0·001$)	No participants reported any adverse events
Jane *et al.* (2011) Taiwan	To compare the efficacy of massage therapy (MT) with a social attention (SA) control condition on pain intensity	RCT of MT vs. SA. Assessments were undertaken pre- and posttest. *n* analysed 72.	Present Pain Intensity (PPI) with a vertical form of the visual analogy scale (VAS) (PPI-VAS)	45 minutes of MT, which followed a standardized protocol. 5-day research protocol, which included three sessions of MT or SA	Significant group differences at each time point; $P < 0·001$ (T1); $P < 0·001$ (T2); $P = 0·001$ (T3). Time effect of PPI-VAS between groups over time $P < 0·000$, Reduction in PPI-VAS converged over time.	Adverse events were not described in the article
Kutner *et al.* (2008) United States	To evaluate the efficacy of massage for decreasing pain and other symptoms	RCT of massage therapy or simple-touch therapy. Baseline assessment and sustained assessment was undertaken three times.	Memorial Pain Assessment Card and Brief Pain Inventory (BPI)	Six 30-minute massage or simple-touch sessions over 2 weeks.	Massage had immediately beneficial effects on pain (−1·87 points (95% CI −2·07 to 1·67)) massage therapy	Adverse events were infrequent and similar in both groups and did n

TENS

(+)

(+ / -)

Massage therapy

(-)

(+)

Massage therapy

(+)

未描述

(-)

Massage therapy

(-)

Table 3 (*Continued*).

Author	Study aim	Method/Design and sample	Pain measurement tools	Non-pharmacological intervention	Findings: Effects on pain	Findings: Adverse events
		Assessments were also undertaken immediately after each intervention. *n* analysed 380			was statistically superior to the control group (mean pain difference between study groups, −0·90 points (CI −1·19 to −0·61 points)) but not clinically significant. No sustained improvement in pain outcomes (BPI mean pain, 0·07 points (CI −0·23 to 0·37 points); BPI worst pain, −0·14 points (CI −0·59 to 0·31 points)).	seem to be related to treatments
Kwekkeboom *et al.* (2010) United States	To evaluate the feasibility of a patient-controlled cognitive behavioural intervention for pain and other symptoms.	One-group pre- and posttest design. Outcomes were assessed before and after using a cognitive behavioural strategy. *n* analysed 30	Brief Pain Inventory (BPI)	The intervention included recordings of 12 brief cognitive strategies provided on an MP3 player. Cognitive behavioural strategies included relaxation, distraction and imagery exercises in four categories. Two weeks intervention.	Immediate changes in symptom ratings from pre- to posttest treatment were significant $P < 0{\cdot}01$.	Adverse events were not reported
Lim *et al.* (2011) Canada	To document changes in symptoms after acupuncture or nurse-led supportive care in patients with incurable cancer	RCT of acupuncture or nurse-led supportive care. The assessments were undertaken before and after each intervention. In addition, scores were obtained via weekly telephone interviews for 6 weeks following completion of each intervention. *n* analysed 18	Edmonton Symptom Assessment System (ESAS)	Weekly acupuncture for 4 weeks or weekly nurse-led supportive sessions, which included counselling and discussion.	Mean change in ESAS score after acupuncture −1·5. At 6 weeks, +0·5. No significant pain reduction compared with the social attention group.	Two minor adverse events/ side effects. No significant or unexpected side effects.

cognitive behavioral intervention

放鬆、圖像

OPD

(+)

(未描述)

acupuncture

(-)

(+ -)

Author	Study aim	Method/Design and sample	Pain measurement tools	Non-pharmacological intervention	Findings: Effects on pain	Findings: Adverse events
Lopez-Sendin *et al.* (2012) Spain	To determine the effects of therapy, including massage and exercise, on pain and mood in patients with advanced terminal cancer.	RCT of physiotherapy or simple hand contact. Assessments were conducted at baseline, at 1 week and at a 2-week follow-up. *n* analysed 24	Memorial Pain Assessment Card and Brief Pain Inventory (BPI)	Six sessions of 30 –35 minutes duration over 2 weeks. The intervention consisted of different massage techniques and strain/ counter strain techniques over the tender points. In addition, the intervention included passive mobilization exercises.	Group × time interaction with greater improvements in physical therapy group for BPI worst pain ($P = 0.036$), BPI pain right now ($P = 0.027$) and BPI index ($P = 0.001$). No significant differences in BPI with respect to mean ($P = 0.127$) and least pain ($P = 0.027$)	Adverse events were not reported.
Soden *et al.* (2004) United Kingdom	The primary aim was to compare the longer term effects of a course of massage with or without an essential oil on pain scores. Secondary aims were to test the hypothesis that these therapies improve sleep quality, reduce anxiety and depression and improve overall quality of life	RCT of aromatherapy massage group or massage group or no intervention group. Pain and other symptoms were assessed before and after intervention and weekly during the intervention. *n* analysed 42	Visual Analogue Scale (VAS)	Standardized 30-minute back massage weekly for 4 weeks. The aromatherapy massage group had essential (lavender) oil applied and the other group normal massage oil.	No significant long-term benefits of aromatherapy or massage in terms of improving pain control, Significant effect in pain VAS score after the second treatment.	Adverse events were not reported.
Tsai *et al.* (2007) Taiwan	To examine the effect of EMG biofeedback-assisted relaxation on cancer-related pain.	RCT of EMG biofeedback-assisted relaxation or conventional care. Symptoms assessed before and after first and last EMG session. *n* analysed 24	Brief Pain Inventory (BPI)	Six EMG biofeedback-assisted relaxation sessions during a 4-week period.	The experimental group reported a statistically significant decrease in pain intensity from baseline, compared with the control group ($P < 0.001$)	Adverse events were not reported in the research.
Wyatt *et al.* (2012) United States	To evaluate the safety and efficacy of reflexology	RCT of reflexology or lay foot manipulation or conventional care. Outcomes were assessed at baseline interview, postintervention interview	Brief Pain Inventory (BPI) short form	30 minutes of stimulation to the nine essential breast cancer-specific reflexes while using reflexology-specific deep thumb-walking pressure.	No difference was found on breast cancer- specific HRQOL, depressive symptomatology state of anxiety, pain and nausea	No adverse events were reported on the standard forms used in the interventions

Massage, exercise

精油 massage

relaxation

reflexology

OPD

（未描述）

（ - ）

（未描述）

（ + ）

立即（ + ）

長期（ - ）

（未描述）

（ + ）

（ - ）

（ - ）

Author	Study aim	Method/Design and sample	Pain measurement tools	Non-pharmacological intervention	Findings: Effects on pain	Findings: Adverse events
		at study weeks 5 and 11. *n* analysed 385		The lay foot manipulation was designed to appear superficially similar to reflexology. Four weekly 30 minutes sessions		
Yamamoto and Nagata (2011) Japan	To clarify the effects of a warm water-footbath on relaxation, pain and mood in patients with cancer.	RCT of WW-footbath or no WW-footbath. Pre-test and posttest assessment. Heart rate variable measurement during intervention. *n* analysed 9	Visual Analogue Scale (VAS)	The 30-minute WW-footbath procedure was given to the patients	The posttest pain VAS score significantly decreased in the experimental group ($P = 0{\cdot}047$). No significant between-groups changes.	Adverse events were not reported in the research.

warm water-footbath

（＋）

（未描述）

步驟2:系統性文獻回顧的品質如何?(FAITH)

H-試驗結果是否相近-異質性?

Synthesis

The search produced nine RCT and two quasi-experimental studies that met the inclusion criteria and were included in this review. The results of the relevant studies were summarized using a narrative approach, because the studies were heterogeneous, differing in their purpose, interventions and outcome measurement tools (Lloyd Jones 2004, Centre for Reviews & Dissemination 2008, Whiting 2009, Polit & Beck 2011).

是，具異質性

建立成人癌症病人疼痛非藥物處置之臨床照護指引

黃惠美 / 台北榮民總醫院護理師
郭素真 / 台北榮民總醫院副護理長
王靜慧 / 台北榮民總醫院護理長
張議文 / 台北榮民總醫院副護理長
周幸生 / 台北榮民總醫院護理部副主任

成人癌症病人疼痛非藥物處置臨床指引

項目		指引項目內容	建議等級
綜論	1.1	癌症疼痛為原因複雜的健康問題，包含身心靈層面，其處置必須包含藥物與非藥物處置 (Grade A)[5, 13, 15]	A
	1.2	病人對疼痛處理常見的障礙為：擔心藥物成癮、止痛劑副作用以及疼痛程度增加代表疾病惡化 (Level Ⅰ)[16] (Grade A)[4]	A
	1.3	所有病人應有疼痛控制治療計畫，教育病人及家屬應同時是計畫中的一部份，並鼓勵其主動參與疼痛管理計畫 (Level Ⅰ)[3, 16] (Grade A)[6, 13]	A
	1.4	在選擇疼痛控制的方法時，需與病人及家屬共同討論，並將所需的費用及便利性一起納入考量，規劃出個別化之疼痛非藥物處置 (Grade A)[9, 13]	A
	1.5	應向病人及家屬保證大部分的疼痛是可以被安全、迅速及有效控制的 (Grade A)[15]	A
	1.6	教育病人和家屬處理疼痛是需團隊共同努力達成，團隊成員可能包括：腫瘤科醫師、護理師、疼痛專家、緩和照護醫護人員、神經科醫師、社工、心理師、心理醫師、物理治療師、心靈輔導員等 (Grade A)[1, 6, 15]	A
	1.7	專業人員對執行疼痛處置最常見的障礙為：不適當的疼痛評估及處置、對疼痛處置知識的不足以及病人不願意表達疼痛 (Level Ⅰ)[16] (Grade A)[4]	A
	1.8	透過基礎及繼續教育加強醫護人員的專業知識，可提升專業人員評估及處理癌症疼痛之能力及成果 (Level Ⅰ)[10, 16] (Grade A)[6, 15]	A
	1.9	所有癌症病人應先評估屬於急性或慢性疼痛，並了解導致疼痛之潛在機轉，再依此選擇適合的處方 (Grade A)[5, 15]	A
	1.10	癌症疼痛處置可使用單一措施也可併用多種措施 (Grade A)[5, 9, 15]	A
	1.11	癌症病人應會診安寧療護進行疼痛照護諮詢 (Level Ⅰ)[10]	A
	1.12	疼痛程度須先以藥物控制在中度以下，再施以非藥物處置輔助疼痛處置（專家焦點團體研究）	B

建立成人癌症病人疼痛非藥物處置之臨床照護指引

評估	2.1	癌症疼痛處置必須先經由完整的評估，找出原因並針對其處置，以達到最佳效果 (Level Ⅰ)[16](Grade A)[1,13,15]	A
	2.2	評估表應分爲意識清楚與意識不清楚兩類 (Grade A)[15]	A
	2.3	疼痛評估應包含生理層面、心理、社會層面及個人病史 (Grade A)[1,5,9,15,20]	A
	2.4	評估的目的是建立「疼痛診斷」和個別性的疼痛治療計畫 (Grade A)[15,20]	A
	2.5	評估應包含身體檢查 (Grade A)[1,6,15,20]	A
	2.6	評估應包含相關的實驗室檢驗與影像學檢查以瞭解疾病進展 (Grade A)[15]	A
	2.7	病人因生理或認知因素而無法以言語溝通疼痛強度，是疼痛評估和處理的一個重要障礙 (Level Ⅰ)[16](Grade A)[4,15]	A
	2.8	建議採多面向的策略，結合直接觀察、家屬和照護者提供的資訊、評值表達障礙病人對藥物及非藥物處置的反應 (Grade A)[4,13,15]	A
	2.9	文化和語言的評估：健康照護者在執行全面性的疼痛評估時，應察覺文化和語言差異 (Grade A)[4,15]	A
	2.10	評估病人和家屬讀寫能力，確保能了解所提供之教育 (Grade A)[13,15]	A
	2.11	鼓勵臨床人員測試目前研究已發展之自我敘述困難之疼痛評估策略或工具進行測試 (Grade A)[15,20]	A
	2.12	定時疼痛評估可增加護理人員的疼痛知識及病人疼痛處理滿意度 (Grade A)[15]	A

建立成人癌症病人疼痛非藥物處置之臨床照護指引 (心理策略-1)

3.2	音樂療法	
3.2.1	音樂治療不是治療癌症疼痛的最主要方法，但可作爲緩解癌症疼痛的輔助療法之一，以減輕疼痛和降低止痛劑需求 (Level Ⅰ)[8](Grade A)[6, 13]	A
3.2.2	可採取多元化的運用音樂治療策略，包含：聆聽與欣賞音樂、參與音樂活動或樂器演奏等 (Grade A)[13]	A
3.2.3	音樂治療強調以病人所喜歡的音樂爲主，需考量病人的個別性，可能受生活文化背景、過去生活經驗、疾病狀況、宗教信仰、教育程度、個人喜好、語言、年齡、情緒等因素影響 (Grade A)[13]	A
3.2.4	依據病人身體狀況、體力及注意力決定音樂治療之時間 (Grade A)[13]	A
3.2.5	藉由評估以瞭解病人所喜歡的音樂類型、對音樂治療的期待與希望達到之目標，共同討論可行的音樂治療的時間與方式，發展出適合病人的音樂治療計畫 (Grade A)[13]	A
3.2.6	採取聆聽音樂方式之音樂治療時，病人宜採最放鬆的姿勢，最好有單獨的房間，或輔以使用耳機，以減少外在環境之干擾 (專家焦點團體研究)	B

建立成人癌症病人疼痛非藥物處置之臨床照護指引 (心理策略-2)

3.3	催眠或放鬆	
3.3.1	催眠可以降低焦慮、提昇安適感及自信，但未顯著改善憂鬱狀況 (Level II)[18](Grade A)[13]	B
3.3.2	催眠需由專業人員執行 (Grade A)[13]	A
3.4	認知行爲方法	
3.4.1	使用認知策略治療癌症疼痛時，有分散注意力，放鬆，認知結構調整等功效 (Level Ⅰ)[7, 17](Grade A)[13]	A
3.4.2	認知行爲治療可減輕乳癌病人的疼痛 (Level Ⅰ)[21]	A
3.5	支持療法	
3.5.1	醫師、護理師、心理學家及社工可以幫助尋找資源、情感支持及與病人分享經驗，對癌症病人的疼痛減少有部分影響 (Grade A)[13]	A
3.5.2	支持療法，應視爲其他措施的輔助方法 (Level Ⅰ)[2](Grade A)[9, 13]：透過陪伴，握著病人的手就是一種安撫 (專家焦點團體研究)	A

建立成人癌症病人疼痛非藥物處置之臨床照護指引 (生理策略-1)

4.1	冷熱的應用	
4.1.1	熱敷應由護理人員執行，老人在使用時間及溫度上宜特別小心，以避免灼燙傷 (專家焦點團體研究)	B
4.1.2	所有類型的熱敷，應包裝好，以防止病人直接接觸而燙傷 (Grade A)[13]	A
4.1.3	熱敷不適用於已暴露在輻射治療的組織 (Grade A)[4, 13]	A
4.1.4	深層熱療的模式，如短波，微波透熱，超音波，遠紅外線等對筋骨痠痛的癌症患者有效，但應避免用在癌症腫瘤的位置 (Grade A)[13]	A
4.1.5	用熱策略可採用泡腳的方式暖和身體，且藉由泡腳與病人互動的過程之中，病人的身體也可以放鬆 (專家焦點團體研究)	B
4.1.6	冷敷可應用在骨頭痛、神經痛、腫脹的不舒服感、肝癌病人的燥熱、發炎性疼痛、頭頸部癌症病人的疼痛，及放射線治療之後的灼熱痛等 (專家焦點團體研究)	B
4.1.7	冰袋應密封，以防止漏水，並應符合身體輪廓，強度應爲舒適、安全爲主，且應充分包裝 (如 1 層毛巾或枕套)，以防皮膚過敏 (Grade A)[4, 13]	A
4.1.8	冷比熱所應用的時間較短，一般不超過 15 分鐘 (Grade A)[13]	A

建立成人癌症病人疼痛非藥物處置之臨床照護指引 (生理策略-2)

4.2	按摩、接觸療法	
4.2.1	按摩是舒適放鬆的措施，可幫助緩解一般疼痛，也可因增加血循而減少特定區域的疼痛 (Level Ⅰ)[14, 22](Grade A)[6, 13]；按摩效果最好的部位是雙下肢跟腰部 (專家焦點團體研究)	A
4.2.2	常見的按摩技術，有撫摸、揉捏及劃圓等，由具節奏方法進行並由遠端到近端執行 (Grade A)[13]；按摩的手法很重要，配合溫暖的說話語調可給予病人撫慰 (專家焦點團體研究)	A
4.2.3	接觸療法對疼痛緩解有效 (Level Ⅰ)[2](Grade A)[13]	A
4.2.4	接觸療法可以減少止痛藥使用量 (Level Ⅱ)[11]	B
4.2.5	在靠近癌症病變、淋巴結腫大、放射線治療範圍部位、醫療設備放置處 (如靜脈留置導管)，或結構組織異常處，如患者術後變化或有出血傾向等，不建議施行接觸療法 (Grade A)[9, 13]	A
4.2.6	接觸療法沒有副作用 (Level Ⅰ)[11]	B
4.2.7	肢體的接觸就是很大一個支持的力量 (Grade A)[13]；帶著家屬一起參與活動，可促進病人與家屬互動 (專家焦點團體研究)	A

建立成人癌症病人疼痛非藥物處置之臨床照護指引 (生理策略-3)

4.3 運動		
4.3.1	運動是亞急性和慢性疼痛的重要治療，因爲它可強化衰弱的肌肉、活化僵硬的關節、幫助恢復平衡、提高病人的舒適及調節心血管等功能 (Grade A)[13]	A
4.3.2	任何形式的運動應避免涉及負重的運動，因爲腫瘤的侵襲容易造成病理性骨折 (Grade A)[13]	A
4.3.3	擺位是另一個簡單的運動方法，可促進舒適並防止或減輕痛苦 (Grade A)[1, 6, 13]	A
4.3.4	照護人員應確保長期臥床病人身體擺位正確，並隨時調整及監測皮膚狀況 (Grade A)[13]	A
4.3.5	應避免長時間固定擺位以防止關節攣縮、肌肉萎縮、心血管失調及其他不良反應 (Grade A)[13]	A

建立成人癌症病人疼痛非藥物處置之臨床照護指引 (生理策略-4)

4.4 經皮電神經刺激 (TENS)		
4.4.1	TENS 是一種應用控制的低電壓，藉由皮膚電極的刺激傳輸以減輕疼痛的方法 (Grade B)[13]	B
4.4.2	TENS 對輕度疼痛有減緩效果 (Grade B)[6, 13]；使用在神經痛病人效果良好，尤其在大腿跟腰部位置 (專家焦點團體研究)	B
4.4.3	TENS 治療至少需執行 6 次，一個穴位每次約 30 分鐘左右方能達到效果 (專家焦點團體研究)	B
4.5 針灸		
4.5.1	針灸緩解疼痛之機制爲活化內啡肽分泌和干擾疼痛纖維的傳輸 (Grade B)[13]	B
4.5.2	針灸只能由合資格的醫師執行 (Grade A)[9]	A
4.5.3	針灸可作爲有效緩解疼痛的輔助或替代治療 (Level Ⅰ)[12] (Grade A)[6] (Grade B)[9, 13]	A
4.5.4	有出血傾向病人應謹愼地使用 (Grade A)[9]	A

討論

- 非藥物治療止痛方式，是否有副作用?
- 按摩、芳香療法，是否需要執照? 可否由護理人員執行?
- 精油老師及耗材費用? 自費? 可及性?
- 引導式心像 vs 冥想 vs 正念 mindfulness
- Special effect vs non-special effect
- Placebo effect 不要輕忽安慰劑效果

臨床運用

- 您是否同意選擇非藥物治療止痛方式為癌症病人減低疼痛。
  - 同意
  - 懷疑
  - 不同意

Thank you!