

NEWS in Brief



CHRONIC PAIN AFTER BREAST CANCER SURGERY

Researchers from the University of Copenhagen have found that nearly half of breast cancer survivors suffer persistent pain years after cancer surgery.

Pain two to three years later was most common for younger women and those who had axillary lymph node dissection, Rune Gärtner, MD, of the University of Copenhagen, and colleagues reported.

The researchers noted that prior retrospective and single-centre studies have found a chronic pain rate of about 50% after breast cancer resection. They wanted to identify high-risk patients, which might help doctors start therapy earlier. They noted that pain management needed a multi-disciplinary approach, that included surgeons, medical

oncologists, radiation oncologists, pain specialists, psychologists and psychiatrists, social workers, and rehabilitation medicine specialists. An editorial noted that post-surgical pain can be due to nerve damage during surgery (causing intercosto-brachial neuralgia, neuroma pain, phantom breast pain) or due to compression injury of the brachial plexus (from lymphoedema or a second primary tumor). The researchers also noted that although sentinel node dissection has reduced pain complaints after surgery, attention should focus on nerve-sparing techniques.

The researchers conducted a population-based prospective, cross-sectional study of Danish women who received surgery (and adjuvant therapy where indicated) in 2005 and 2006. There were 3,754 women (aged 18 to 70 years) who responded to the study questionnaire, an average 26 months after surgery (ranging from 13 to 41 months). None had breast cancer recurrence. 47% of the patients reported pain in at least one body area. Of these, 13% had severe pain (a score of at least 8 on the 10-point scale). For 77%, pain was a daily norm. 39% had moderate pain (4 to 7 points). Only about 25% of the women with pain sought treatment for it (20% had contacted a physician; 28% had taken analgesics; 26% had physiotherapy or other pain treatment). The most common sites of pain were the breast area (86%), axilla (63%), arm (57%), and side of the body (56%). It was noted there were few women on aromatase inhibitor

treatment, which is known to cause muscular and joint pain.

Factors that predicted persistent pain were: (a) Younger age (OR 3.62 for ages 18-39, compared to ages 60-69, $P < 0.001$); (b) Axillary lymph node dissection (OR 1.77, compared to sentinel lymph node dissection, $P < 0.001$); (c) Radiotherapy (OR 1.50 to 1.35, $P = 0.03$).

Sensory disturbances (allodynia, after-sensations, burning, or sensory loss) appeared to be linked to chronic pain. 58% of women reported sensory disturbances. 65% of them also reported pain. Women under age 40 (compared to ages 60-69) were at highest risk for sensory disturbances (OR 5.00 to 6.06, depending on type of surgery, $P < 0.001$). Axillary lymph node dissection was also associated with increased risk of chronic pain compared to sentinel lymph node dissection (OR 4.97, $P < 0.001$).

The limitations of the study included (a) the pain was reported at a single point, and further study is needed to determine how pain and sensory disturbances will change over time, and (b) limited generalisability to more ethnically and socio-economically diverse populations (although the study probably provides a plausible estimate). **SMA**

Sources: (1) Gärtner R, et al. Prevalence of and factors associated with persistent pain following breast cancer surgery. *JAMA* Nov 11, 2009; 302: 1985-92. (2) Loftus LS, Laronga C. Evaluating patients with chronic pain after breast cancer surgery: the search for relief. (editorial in same issue) *JAMA* 2009; 302: 2034-35.

NEWS

USE OF STATINS MAY DECREASE RISK OF GALLSTONE REQUIRING SURGERY

Lowering cholesterol with statins may help cut the risk of developing gallstones that require surgery, researchers found. But to enjoy the benefit, patients had to be on statins for about 12 to 18 months, according to researchers from the University Hospital in Basel, Switzerland

They examined data from the UK-based General Practice Research Database. There were 27,035 patients who had a previous cholecystectomy, and 106,531 controls (matched by age, sex, general practice, calendar time, and years in the database). There were 2,396 patients and 8,868 controls who had a history of statin use. About 75% of the patients and controls were female, with a mean age of 53.4 years. Current statin use was found in 1% of patients and 0.8% of controls (1 to 4 prescriptions), 2.6% of patients and 2.4% of controls (5 to 19 prescriptions), and 3.2% of patients and 3.7% of controls (20 or more prescriptions).

After adjustment for some confounders, current statin use was associated with a lower risk of gallstone disease requiring cholecystectomy in those who had filled at least 5 prescriptions. Patients who were taking statins had a 22% lower risk of gallstone disease followed by cholecystectomy, compared to those not on statins (OR 0.78, 95% CI 0.73 to 0.83). There was no benefit in patients who had filled fewer than 5 prescriptions, compared to those who had filled 5-19 prescriptions, who showed a 15% reduced risk (OR 0.85, 95% CI 0.77 to 0.93). Those who had filled 20 or more prescriptions showed a 36% reduced risk (OR 0.64, 95% CI 0.59 to 0.70). The findings were consistent across age, gender, BMI categories, and statin class. The association was significant regardless of whether the patient had normal cholesterol levels or had hypercholesterolemia.

The researchers said that their findings may be of clinical relevance, because gallstone disease was a major

healthcare burden, with 10-20% of white adults in industrial nations developing gallstones. They pointed out that in the US, for example, over 700,000 cholecystectomies are performed each year. The article states that 80-90% of gallstones are formed from cholesterol-saturated bile (the rest consisting mainly of polymerised calcium bilirubinate) – thus, it has been proposed that lowering cholesterol may lessen the chance of forming gallstones (NB: studies looking at the association have yielded mixed results).

The main limitation of the study was the possibility of wrong classification of outcome. Original medical records were not reviewed and there could have been a lack of adjustment for potentially relevant lifestyle factors. In addition, the observational study design could not prove a causal relationship. **SMA**

Source: Bodmer M, et al. Statin use and risk of gallstone disease followed by cholecystectomy. JAMA Nov 11, 2009; 302: 2001-07.