10. 退薬症状と対策

- オピオイドの急激な減量・中止により退薬症状が現れることがあるため、減量はゆっくりと行なう必要がある。

- モルヒネ→デュロテップなどのオピオイドローテーションの場合には退薬症状を生じることがある。(頻度:数%～10%)

□退薬症状と対処方法

＜精神症状＞ 倦怠感、不安感、イライラ感、興奮、不眠

＜身体症状＞ あくび、くしゃみ、頻脈、高血圧、発汗、悪心・嘔吐、下痢

6～12時間後より出現、1～3日後にピーク、

身体症状は1週間くらいで軽快、精神症状は数ヶ月続くこともある。

対処方法: 速放製剤の少量投与

□減量・中止の実際

2～3日毎、1日投与量の1/4～1/2を減量 → 最少投与量まで減量 → 投与間隔をあける (～24時間毎)

中止までの期間の目安(経口モルヒネ投与量として):

100mg/日以下 1週間以上 (少量でも2週間以上定期使用の場合は注意が必要)

100～300mg/日 2週間以上

300mg/日以上 3週間以上

□高用量のオピオイドローテーション(モルヒネ→デュロテップパッチ等)の場合

高用量オピオイドの場合は段階的に切り替える(部分的ローテーション)ことで退薬症状を防止するとともに、換算比の個体差による痛みの出現や副作用を軽減することが出来る。

(デュロテップパッチ10mgを超える場合を一応の目安とする)

2007.10作成

11. その他のオピオイド

・ 下記のオピオイドはモルヒネ使用が広く認められている現在、あえて選択する機会は少なくなっているため本マニュアルのフローチャートからは除外した。

・ 主治医が下記の使用を考えたとすれば、中途半端で不完全な除痛を避け、早期に良好な疼痛コントロールを達成するためにモルヒネ等の導入を強く勧めたい。

・ 下記薬剤は「薬品名」と「剤型」を挙げるに止め、使用法は省いた。

□WHO方式で認められているオピオイド
レペタン坐剤(0.2mg)
レペタン注(0.2mg)

□WHO方式で認められていないオピオイド
ソセゴン錠(25mg)
ペンタジン注(15mg)

2007.10作成

12. 非オピオイド

＊ 四国がんセンター院内採用薬に限定

製剤	常用量	作用時間	その他
アセトアミノフェン	1.5～3g 分3～4	効果発現:30分 Tmax:1～2時間 半減期:2.4時間	胃腸障害や腎障害を起こさない 抗炎症作用、抗血小板作用なし
ロキソニン錠 60mg	3T 分3	効果発現:30分 Tmax:50分 半減期:1.3時間	プロドラッグ
ハイペン錠 200mg	2～3T 分2～3	Tmax:1.4時間 半減期:6時間	COX2選択的阻害剤
ナイキサン錠 100mg	3～6T 分2～3	効果発現:10～60分 Tmax:2～4時間 半減期:14時間	腫瘍熱に有効
ボルタレン坐 25、50mg	1回25～50mg 1日2～3回	効果発現:10～90分 Tmax:1時間 半減期:1.3時間	鎮痛作用強い
ロピオン注 50mg/A	1回50mg 1日2～4回	半減期:5.8時間	1Aを生理食塩水50mlに入れ1日数回点滴静注(フィルターは使用しない) IVHの場合：脂肪乳剤(イントラリポス)に混入させたものを側管から24時間かけて点滴投与→発汗が少なく鎮痛効果が安定

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13. 神経ブロック

□神経ブロックが適応となる痛み

・局在性の痛み （痛みが数箇所に散在していても、ある特定の部位の痛みが他の部位よりも強く、鎮痛薬増量の原因となっている場合も適応となる）

・末梢性の痛み （中枢性疼痛でない）

・体動時痛

□神経ブロックの適応時期

・麻薬投与量がモルヒネ経口投与量換算で120mg/日を越えても 十分な鎮痛が得られない場合

・十分な副作用対策を行なっても副作用が強く、十分な麻薬を使用できない場合

□がん性疼痛での主なブロックの種類

・三叉神経ブロック-----顔面の痛み

・腹腔神経叢（内臓神経）ブロック-----胃がん、膵がんなどの腹腔内臓器に由来する上腹部の痛み

・下腸間膜神経叢ブロック-----下腹部の痛み

・上下腹神経叢ブロック-----骨盤内臓由来の痛み

・胸部くも膜下フェノールブロック-----片側、比較的限局された胸部の体性痛

・仙骨部くも膜下フェノールブロック（サドルブロック）-----会陰、肛門部の痛み

・経皮的コルドトミー-----C5より尾側の片側性の痛み

・持続くも膜下ブロック-----耐え難い下肢痛など

・持続硬膜外ブロック （頚部、胸部、腰部）

□条件

・患者の同意と協力が得られる

・全身状態が神経ブロックが出来る状態にある

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（参考資料） 鎮痛補助薬

＊ 四国がんセンター院内採用薬に限定

下記の鎮痛補助薬の薬剤選択、用法・用量については、以下の資料をもとに他施設の使用状況を参考にしながら集成したものです。鎮痛補助薬としてのエビデンスはまだ不十分と思われるため、これらの使用法を強く推奨するものにはなっていないことをご了承ください。これらの薬剤の使用を考慮される場合は緩和ケアチームにご相談くだされば幸いです。

（参考資料）
「がん疼痛治療のレシピ」 的場元弘
WHO 「がんの痛みからの解放」第2版
日本緩和医療学会 「がん疼痛ガイドライン」
国立がんセンター中央病院薬剤部 「オピオイドによるがん疼痛緩和」
淀川キリスト教病院 「緩和ケアマニュアル」改訂第5版

商品名（一般名）	規格	開始量	増量	維持量	副作用	禁忌	その他
□抗うつ薬 持続性疼痛：「しびれて痛む」「締め付けられるように痛む」「つっぱって痛む」「焼け付くように痛む」「ピリピリ痛む」							
トリプタノール錠（アミトリプチリン）	10mg	10～25mg vds	10～25mg 1～7日毎	40～60mg vds	眠気、口渇、心毒性、起立性低血圧、	緑内障、心筋梗塞の回復初期、尿閉	不安、焦燥、不眠の強い場合に有効（半減期28時間）抗うつ薬においては第一選択
アナフラニール注（イミプラミン）	25mg/2ml						生食、ブドウ糖に溶解し2～3時間で点滴（半減期21時間）
アナフラニール錠（イミプラミン）	10mg 25mg						
ノリトレン錠（ノルトリプチリン）	25mg						トリプタノールの代謝物で、鎮静作用・心毒性・抗コリン作用より少ない（半減期26時間）
アモキサン錠（アモキサピン）	10mg 25mg						三環系抗うつ薬の中では抗コリン作用軽度、作用発現も2～3日と比較的早い
□抗痙攣薬 発作性疼痛：「電気が走るように痛む」「鋭く痛む」「刺すように痛む」							
テグレトール錠（カルバマゼピン）	200mg	100～200mg vds	100～200mg 1～7日毎	100～600mg 分1～2	眠気、めまい、ふらつき、頭痛、吐き気、骨髄抑制	血液障害、第Ⅱ度以上の房室ブロック、高度の徐脈	（反復投与時の半減期：16～24時間）
バレリン錠（バルプロ酸ナトリウム）	200mg	200～400mg vds	200mg 1～7日毎	～1200mg 分2～3	眠気、ふらつき	重篤な肝疾患、カルバペネム系薬剤との併用	（半減期：12時間）
リボトリール錠（クロナゼパム）	0.5mg	0.5mg vds	0.5mg 1～7日毎	～3mg vds	眠気、めまい、ふらつき、	緑内障、重症筋無力症	（半減期：27時間）
アレビアチン注（フェニトイン）	250mg/5ml	100mg/日	25～50mg 1～7日毎	～400mg/日	眠気、吐き気、	洞性徐脈、高度の刺激伝導障害	静注速度：1ml/分以上かけて（1A5分以上）4倍希釈まで可→実際には生食100mlに希釈して使用可能（半減期：10時間）
ガバペン錠（ガバペンチン）	200mg	300～600mg 分3	300mg 1～7日毎	900mg～ 分3	眠気、めまい、頭痛、複視、倦怠感		腎機能低下時（CCr60以下）は減量 酸化マグネシウムとの併用時は2時間あける（半減期：6～7時間）
□抗不整脈薬 持続性疼痛、発作性疼痛の両方							
静注用キシロカイン2%（リドカイン）	100mg/5ml	500mg/日 持続皮下、持続静注	20～50% 1～3日毎	0.5～1mg/kg/hr	眠気、異常知覚、吐き気、振戦、めまい、	重篤な刺激伝導障害	キシロカインテスト：2mg/kgを生食50mlに溶解し15分間かけiv （淀川キリスト病院）
メキシチールカプセル（メキシレチン）	50mg	150～300mg 分3	100～150mg 1～3日毎	150～450mg 分3	吐き気、食欲不振、上腹部不快感、振戦、めまい、複視	重篤な刺激伝導障害、重篤な心不全、	（半減期：10時間）
□NMDA受容体拮抗剤 持続性疼痛、発作性疼痛の両方							
ケタラール注（塩酸ケタミン）	静注用：200mg/20ml 筋注用：500mg/10ml	50～150mg/日 持続皮下、持続静注	50～100mg 1～3日毎	50～200mg/日	眠気、ふらつき、めまい、悪夢、混乱	脳血管障害、高血圧、脳圧亢進、心不全、けいれん発作の既往	・適応外使用 ・200mg以上ではめまい・眠気多くなる ・持続皮下：皮膚刺激が強いことがある ・ケタミンシロップ処方：ケタミン（筋注または静注）を用い、1回量を単シロップ2ml添加し10mlとする。麻薬指定のためバイアル単位の処方とする。（冷蔵庫保存、使用期限2週間）
ケタミンシロップ（塩酸ケタミン）	院内製剤：1回量/10ml	12.5～50mg/回 1日4回					
セロクラール錠（イフェンプロジル）	10mg	60～180mg 分3	60mg 1～7日毎	60～300mg 分3	弱いα遮断作用→血圧低下、眠気	頭蓋内出血後止血が完成していない患者	（半減期：1.3時間）
□ステロイド 腫瘍周囲の浮腫・炎症によって出現する疼痛に有効							
リンデロン錠（ベタメタゾン）	0.5mg	2～4mg/日の少量から開始し、効果をみながら最小の維持量とする。			感染症、消化性潰瘍、活動性亢進、高血糖、骨粗鬆症、ムーンフェイス、		倦怠感、食欲不振、呼吸困難、発汗にも有効 ステロイドの効力比 リンデロン1mg＝デカドロン1mg＝プレドニン7mg
リンデロン注（ベタメタゾン）	4mg/1ml	脊髄圧迫、脳圧亢進、上大静脈症候群では8～16mg/日より開始することもあり、効果があれば有効最小量まで減量する					
デカドロン錠（デキサメタゾン）	0.5mg						
デカドロンエリキシル（デキサメタゾン）	0.1mg/1ml	脊髄圧迫による痛みの場合、さらに大量を使用する例もみられる。 例えば初回100mg/日（WHOより）					
デキサート注（デキサメタゾン）	2mg/0.5ml 8mg/2ml	1週間で効果なければ中止					
□その他							
ゾメタ注（ゾレドロン酸）	4mg/5ml ¥39,910	1回4mg、3～4週毎 生食、ブドウ糖100mlに溶解し、15分以上かけて点滴			発熱、一過性の骨痛、腎障害、低Ca血症、顎の骨壊死		＊骨転移痛に有効 腎機能低下時（CCr60以下）は減量必要（高Ca血症の場合は除く）
サンドスタチン注（オクトレオチド）	100μg/1ml ¥3,587	300μg/日を持続皮下注射（1日量を生食で全量10mlに希釈しシリンジポンプ用い0.4ml/hで注入）			吐き気、注射部位痛		＊消化管閉塞による嘔吐、痛みに有効 海外では静脈投与も行なわれているが、国内では適応外 効果は24時間以内に認められること多い 7日を目安として投与継続を検討 モルヒネ、フェンタニル配合→24時間OK
ブスコパン注（臭化ブチルスコポラミン）	20mg/1ml	60～120mg/日 持続皮下注または持続静注			口渇、視調節障害、排尿障害、心悸亢進	出血性大腸炎、緑内障、前立腺肥大による排尿障害、重篤な心疾患、麻痺性イレウス、	＊消化管閉塞によるせん痛

2007.10作成

Cancer patients' distresses and inquiries: proposal of four-level classification based on consultation service and questionnaire survey

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The present study was undertaken to understand the realities of cancer patients' and their family members' distresses and inquiries, including medical/physical, emotional/spiritual and social/economic problems, from scientific viewpoints. The initial step of the study was to develop the classification category for these distresses and inquiries. The category was proposed based on information from two different sources; one is the consultation records of the Patient Support and Inquiry Division, Shizuoka Cancer Center and the other is the database of the Questionnaire Survey, which consisted of more than 25 000 distresses from 7885 people who faced up to cancer. The four-level classification category was constructed from 16 primary categories, 35 secondary categories, 129 tertiary categories and 619 quaternary categories. The classification category made it possible to analyze the distresses of cancer patients and their family members. The present study demonstrated the differences between the patterns of distresses for the consultation service and the questionnaire survey. In consultation centers belonging to hospitals, such as the Patient Support and Inquiry Division in the Shizuoka Cancer Center, patients wanted to consult on distresses and inquiries related to medical care. In contrast, they rarely consulted on emotional/spiritual or social problems. Based on the present classification category, we are developing a database called 'Questions and Answers for Cancer Patients' Distresses'. The database enables medical staff to learn what distresses patients and their family members, and to implement high-quality consultation in cancer clinics. (*Cancer Sci* 2007; 98: 612–616)

Cancer patients and their families face a wide variety of distresses and inquiries, including medical/physical, emotional/spiritual and social/economic problems.[1,2] In Japan, in the last 25 years, the style of cancer clinics has changed a lot.[3] Almost every patient is told the truth in terms of cancer diagnosis and treatment; at the time of treatment, patients always give written informed consent to medical staff; and patients are fully justified in obtaining a second opinion when they encounter difficulties in making their own decisions concerning cancer treatment. Although these changes allow patients to participate in their own medical care, this style of medical care always increases distresses and inquiries to which cancer patients and their family members face. Therefore, support programs for patients suffering from cancer and their family members play a very important role in modern cancer clinics.

With the aim of knowing the realities of patients' and family members' distresses and to decrease them, we started a consultation service named 'YOROZU-SOUDANJO (One-stop Consultation Center for Everything You Need to Know about Cancer)' in the Patient Support and Inquiry Division of the Shizuoka Cancer Center. Data accumulated in this service provided important information to classify cancer patients' and their family members' distresses and inquiries, in terms of having a clear grasp of the essence of them. Simultaneously, we did a large-scale questionnaire survey for cancer patients in Japan in 2003. The purpose of this study was to collect actual voices of cancer patients and their family members and to develop methods to decrease their distresses. The interim report entitled 'A report on research into the anxieties and burdens of cancer sufferers – the views of 7885 people who faced up to cancer' was published.[1] The database in this survey also played an important role in categorizing cancer patients' distresses and inquiries.

The present study was undertaken to understand the realities of cancer patients' and their family members' distresses and inquiries from a scientific viewpoint. It is well recognized that cancer patients and their family members face a variety of distresses, but until now these were analyzed as personalized experiences, and were not systematized scientifically. The initial step was to set up a classification method for these distresses and inquiries, and we propose a classification category in the present study, which was applied to evaluate differences in the patterns of distresses between the consultation service and the questionnaire survey.

In 2006, the Japanese Government passed fundamental law for cancer control, and one of the important policies concerned the management of consultation services in the district cancer center hospitals. However, many medical staff face difficulties in knowing how to take care of patients and their family members or how to communicate with them, as information is not available on high-quality consultation for cancer patients and their family members. It is obvious that the people in charge of consultation are required to understand the realities of patients' and their family members' distresses and inquiries for effective management of their facilities. The present study will be useful for medical staff in implementing high-quality consultation services.

Materials and Methods

Consultation data accumulated in the Patient Support and Inquiry Division. The Patient Support and Inquiry Division in Shizuoka Cancer Center started to provide a consultation service in September 2002. The consultation was accomplished by two ways: of face-to-face consultation or telephone consultation, with clients deciding whether they wanted to remain anonymous or not. With the permission of clients, staff of the division (including medical

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social workers and nurses) made records of consultations using patients' electronic charts at the Shizuoka Cancer Center Hospital, which were strictly protected for privacy under the Medical Act in Japan. All records were classified based on the primary category developed by the method described below.

The administration office of the Shizuoka Cancer Center requested the number of consultations and primary-category classifications for evaluation of the activity of the division in each fiscal year; personal information regarding the client and the content of the consultation were not required. Between September 2002 and March 2005 a total of 22 079 consultations took place in the division, and information reported to the administration office was used in the present study.

Database of the questionnaire survey. The precise method for the questionnaire survey has been described elsewhere.[1] Briefly, the survey was executed in 53 medical institutions and 15 patient or patient-support groups. With regard to the ethical considerations of the questionnaire, the privacy of the participants was protected using anonymity methods with which it is not possible to determine individual names of respondents, and approval from ethical review committees and the written informed consent of respondents were obtained.

The total number of questionnaires sent out was 12 345, and the number of questionnaires returned was 7885; the response rate was 63.9%. Data used in the present study came from the pivotal part of the survey to elicit freely written responses from patients, describing in their own words what their distresses as cancer patients are. The questionnaire survey provided a total of 25 952 distresses from 7885 cancer patients who responded to the survey. The distresses were analyzed by the method described below.

Four-level classification category of cancer patients' distresses and inquiries. Because there was no previous study to classify cancer patients' and their family members' distresses and inquiries, we started to categorize each of the large number of distresses and inquiries described above. 'Primary category' was developed under the implementation of the consultation at the Patient Support and Inquiry Division. Each consultation was grouped according to key words presented by clients, and it was found that groups were divided into 16 categories, as described in Table 1.

The classification evolved further based on the database of the questionnaire survey. The total 25 952 distresses obtained by the questionnaire survey were compiled into short sentences including a few key words, and were classified by primary category. In each of 16 primary categories, each distress was further divided into small groups based on their key words, which constructed the quaternary category. Several groups of the quaternary category formed the tertiary category, and also several of the tertiary categories formed the secondary category. Four-level classification of cancer patients' distresses and inquiries was completed in this manner. The reason why four levels was required was to enable patients, their family members and medical staff to approach similar distresses. They could search a particular distress easily by following the items from the primary category to the lower level, step by step.

Results

Classification of cancer patients' distresses and inquiries. The 16 primary categories developed by the database of the consultation at the Patient Support and Inquiry Division are described in the left-sided vertical row in Table 1. Numbers of the secondary, tertiary and quaternary categories under every primary category are described in Table 1. Completed four-level classification generated by the database of the questionnaire survey comprised 35 secondary, 129 tertiary and 619 quaternary categories (Table 1).

An example of the database structure is demonstrated in Fig. 1. Full structures of the four-level classification were described in an interim report, which is available at the website of Shizuoka Cancer Center.[1]

Comparison of the details of consultation in the patient support and inquiry division with the results of the questionnaire survey. A total of 22 079 distresses collected by the consultation service in the Patient Support and Inquiry Division were categorized into 16 primary categories. As shown in Table 2, the primary categories were further divided into 11 matters related to medical care and five matters not related to medical care. The total 25 952 distresses obtained by the questionnaire survey were also classified by the same categorization. It is worth noting that the percentage of matters related to medical care in the consultation service was 80.1%, extremely high when compared to the percentage of those in the questionnaire survey (27.8%).

Figure 2 describes the percentage of consultations in the Patient Support and Inquiry Division and distresses in the questionnaire

Table 1. The 16 primary categories and numbers of the subsequent categories belonging to every primary category in the four-level classification of cancer patients' distresses and inquiries

Primary category	No. categories belonging to the primary categories		
	Secondary	Tertiary	Quaternary
1. Outpatient	2	4	9
2. Hospitalization/discharge/hospital change	3	7	18
3. Diagnosis/treatment	2	8	46
4. Palliative care	2	4	13
5. Notification, informed consent, second opinion	3	4	20
6. Medical coordination	2	2	2
7. Home care	1	2	3
8. Facility and equipment/access	2	3	9
9. Relationships with medical staff (own hospital)	2	5	24
10. Relationships with medical staff (other hospitals)	2	4	6
11. Symptoms, side-effects, sequelae	3	41	175
12. Anxiety and other mental problems	4	10	59
13. Way of living, reasons for living, sense of values	3	6	34
14. Work, economic burdens	2	10	73
15. Relationships with family and other people	2	19	128
16. Relay of document and others	0	0	0
Number of categories	35	129	619

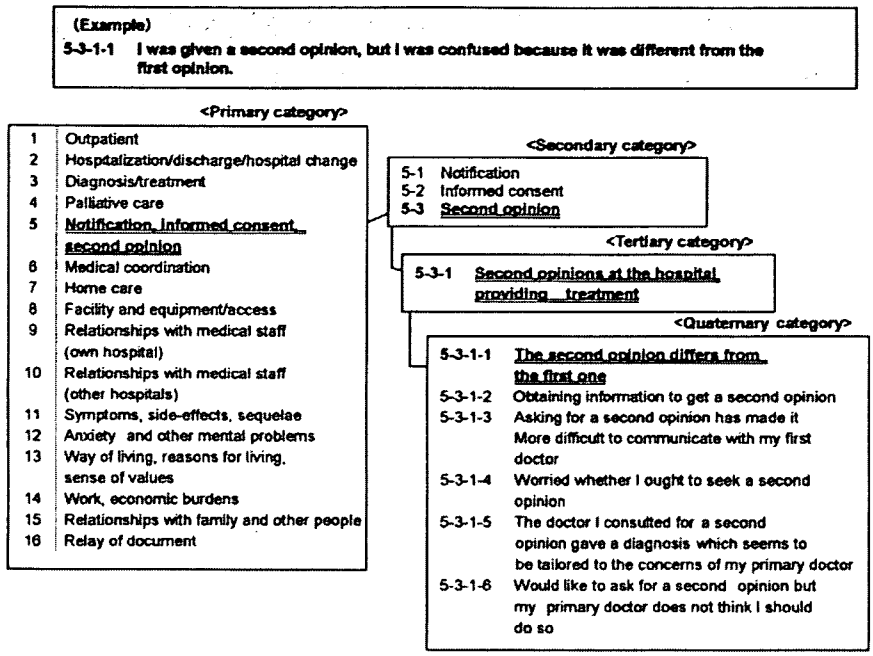

Fig. 1. An example of the structure of four-level classification of cancer patients' distresses and inquiries. The distress is related to the second opinion. In the primary category, it is a component of the fifth category of 'Notification, informed consent, second opinion'. The secondary category belonging to the fifth primary category was divided into three groups, and the patient's distress belongs to the third group of 'Second opinion' with a number of '5-3'. Only one tertiary category termed 'Second opinions at the hospital providing treatment' belongs to the secondary category '5-3', and the patient's distress was numbered as '5-3-1'. The tertiary category comprised six groups of quaternary categories, and the patient's distress fit the first group of 'The second opinion differs from the first one' with a number of '5-3-1-1'. The quaternary category '5-3-1-1' contained the example and other five distresses.

Table 2. Comparison of the details of the questionnaire survey with those of the consultation service analyzed by the four-level classification

Primary category	Questionnaire cases		Consultation cases	
	n	%	*n*	%
Matters related to medical care				
1. Outpatient	121	0.5	4 301	19.5
2. Hospitalization/discharge /hospital change	195	0.8	1 133	5.1
3. Diagnosis/treatment	1 738	6.7	4 257	19.3
4. Palliative care	158	0.6	586	2.7
5. Notification, informed consent, second opinion	291	1.1	5 092	23.1
6. Medical coordination	2	0.0	92	0.4
7. Home care	3	0.0	581	2.6
8. Facility and equipment/access	52	0.2	461	2.1
9. Relationships with medical staff (own hospital)	580	2.2	220	1.0
10. Relationships with medical staff (other hospitals)	156	0.6	173	0.8
11. Symptoms, side-effects, sequelae	3 915	15.1	782	3.5
Subtotal	7 211	27.8	17 678	80.1
Matters not related to medical care				
12. Anxiety and other mental problems	12 624	48.6	577	2.6
13. Way of living, reasons for living, sense of values	1 140	4.4	28	0.1
14. Work, economic burdens	2 055	7.9	1 732	7.8
15. Relationships with family and other people	2 922	11.3	98	0.4
16. Relay of document and others	0	0	1 966	8.9
Subtotal	18 741	72.2	4 401	19.8
Total	25 952	100	22 079	100

survey related to medical care compared with those not related to medical care, classified by primary category. In the case of the questionnaire survey, a large proportion of distresses were concerned with 'anxiety and other psychological problems', 'spiritual problems' and 'relationship with family members and other people'. In contrast, in the case of the consultation service, they occupied an only a small proportion, indicating that the details of the distresses and inquiries in the questionnaire survey were different from those in the consultation services carried out in the hospital.

For further understanding of the details of the classification, the list of top 20 distresses classified by tertiary category in the questionnaire survey is given in Table 3.

Discussion

With the aim of understanding the realities of cancer patients' and their family members' distresses and inquiries, including medical/physical, emotional/spiritual and social/economical problems, we proposed a classification category based on information from two different sources: one was the consultation records of the Patient Support and Inquiry Division, Shizuoka Cancer Center and the other was the database of the questionnaire survey conducted in 2003.[1] In order to make it easy to search for a particular distress by following the items from primary categories to the lower levels, step by step, the classification category was constructed from four-level

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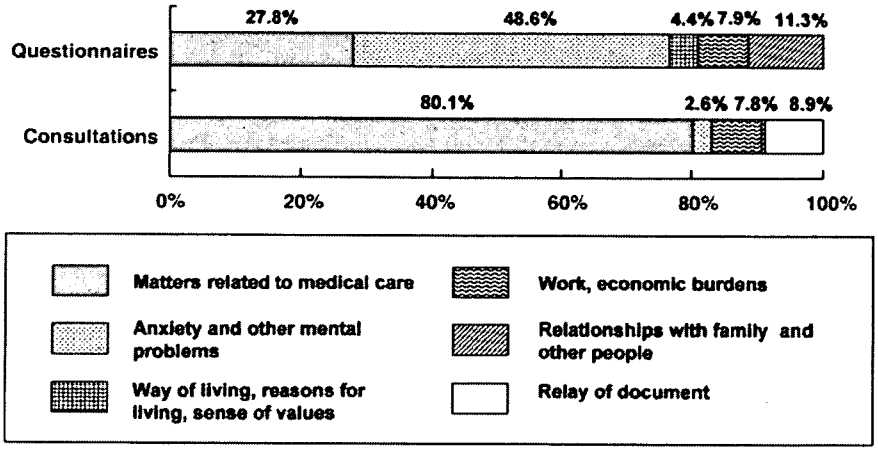

Fig. 2. Comparison of the percentage of the number of cases related to medical care with those not related to medical care in the questionnaire survey and the consultation service evaluated by the four-level classification.

Table 3. List of top 20 distresses of tertiary category described in the questionnaire survey

Rank	Title of tertiary category	No. distresses
1.	Anxiety over cancer spreading or recurrance	4 033
2.	Vague feeling of anxiety about the future	3 087
3.	Fear of death	2 177
4.	Mental panic and a loss of hope	2 116
5.	Side-effects of anticancer drugs	673
6.	Frequent thoughts about cancer	606
7.	Continuous unstable feeling	561
8.	Medical expenses	506
9.	Feelings regarding surgery	501
10.	Feelings regarding treatment	493
11.	Worries about children	470
12.	Worries about going back to work or continuing work	431
13.	Healthcare after treatment	429
14.	Worries about family	423
15.	Relationship with family members	412
16.	Cosmetic changes	380
17.	How to live as a cancer survivor	360
18.	Continuous symptoms	357
19.	Influence of cancer on work	336
20.	Relationship with spouse	323

The total number of distresses was 25 952.

classification of the primary, secondary, tertiary and quaternary categories.

The primary category was derived from the consultation records, which played an important role in understanding the whole image of cancer patients' and their family members' distresses and inquiries. The other categories were extended by analyzing more than 25 000 distresses obtained from the questionnaire survey. The final classification structure comprised 16 primary categories, 35 secondary categories, 129 tertiary categories and 619 quaternary categories. There was no precedent for classifying cancer patients' distresses and inquiries to this level, probably because people think they are too broad and too individual to make classifications.

It is worth noting that distresses collected by the questionnaire survey were derived from 7885 people who faced up to cancer. In Japan the number of cancer survivors was estimated to be 2.98 million people, so the data of the present study came from 0.26% of the total number of cancer survivors in Japan. In addition, the construction policy of this classification method made it possible to cover more than 25 000 distresses. Therefore, it is possible to assume that the classification is comprehensive, and that almost all questionnaires and inquiries experienced by cancer patients and their family members are able to be classified by this method.

Using the proposed classification category, we analyzed the differences between the patterns of distresses described at the consultation service in the Patient Support and Inquiry Division and those collected by the questionnaire survey. In the case of the consultation service, 80% of the consultation outcomes were related to issues of medical care. In contrast, in the case of the questionnaire survey, issues related to medical care were less than 30%, and approximately 50% were related to anxiety or other emotional problems. Furthermore, problems with spirituality and relationships with family members and other people occupied a considerable part of the questionnaire survey, 4.4 and 11.3%, respectively. These results suggest that in consultation services at hospitals, such as the Patient Support and Inquiry Division in the Shizuoka Cancer Center, patients want to consult on distresses and inquiries related to medical care. They rarely consult on matters of anxiety or other emotional or spiritual problems or problems regarding relationships with family members or other people.

It is possible to speculate that there are reasons why the different patterns of distresses arose between the two databases. The patients approached by the consultation service may have had practical problems that they wanted to solve, especially in the field of medical care. When they thought that medical staff of the consultation service were not able to make good suggestions, they did not want to approach them. Generally speaking, patients believed that it was difficult for medical staff to respond to their personal problems. In contrast, in the questionnaire survey, participants were passive, if anything, and they did not have problems that needed to be solved immediately. In this situation, there was a tendency for the participants to list distresses that were on their mind for a long time without any lucid solution; as described in Table 3, emotional/spiritual and social problems were examples. Based on the present results, we recommend that, in consultation services provided in hospitals, the medical staff are required to ask patients whether they have distresses related to emotional/spiritual or social problems, even though the staff will not be able to solve the problems. It is worth noting that to listen carefully to patients and to carry on a dialogue with them alleviates the distress. The scientific classification of the patients' distresses and inquiries makes it possible to analyze problems that patients and their family members will face up to.

To learn cancer patients' and family members' distresses is important according to the following reasons. First, it will help

cancer patients and their family members to know what sort of distresses they will face. It is useful for them to become brave in their fight against cancer. Second, it will help medical staff and people in society who deal with cancer to understand cancer patients' distresses and inquiries. Data presented by this study will be informative for people responsible for the medical, psychological and social care of cancer patients and their family members, and the classification of distresses will enable medical staff to be educated on this matter more effectively and precisely. Third, information plays an important role for healthy people in society to know cancer patients' distresses. This makes it possible for society to develop social infrastructure that will lead to the alleviation of patients' distresses.

With regard to the limitations of the present study, the classification category alone is not enough to alleviate various distresses of cancer patients and family members. Recommendations and suggestions for each distress will be required. Based on the present classification category, we are now developing a database called 'Questions and Answers for Cancer Patients' Distresses'.[2] The database enables medical staff to learn patients' and family members' distresses and to implement high-quality consultation in cancer clinics.

Acknowledgments

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がん疼痛コントロールマニュアル第４版あとがき

四国がんセンターでは平成１８年４月の新病院移転とともに緩和ケア病棟が発足し、緩和ケア支援の体制は大きく前進した。緩和ケアチーム活動も効を奏し、疼痛コントロールに対する院内の意識も大きく変わった。いまでは標準的な疼痛コントロールを逸脱した治療が行われる症例に遭遇することはほとんどなくなった。しかし決して疼痛コントロールに難渋する症例が減ったわけではなく、毎週の緩和ケアチーム回診では病棟スタッフとともに知恵を絞る作業が続いている。

四国がんセンターのがん疼痛コントロールマニュアル第３版は2005年１月の作成である。2年９ヶ月が経過し内容が少し古くなったので今回その後の進歩と我々自身の経験を踏まえて第４版を出すことにした。今回も内容は三好薬剤師を中心に緩和ケアチームのメンバー全員で検討した。構成では新たに「退薬症状と対策」の項を加え全項で細かく改変している。実地に即しさらに充実できたと思っている。第３版同様多くの医療者に利用していただければ幸いである。

第３版は四国がんセンターのホームページに公開していた。外部から参考になるとの声を多くいただきうれしく思っていた。今回もホームページに公開し広く医療者の参考に供することにする。２次利用は自由である。ただ四国がんセンターの医療者の便宜を優先し院内採用薬に限定しており、薬剤名は商品名を中心に記載している。掲載にもれた同種同効薬剤を否定するものではない。

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谷水　正人（代表）、井上　実穂、井上　るり子、閏木　裕美、菊内　由貴、芝　美栄、髙岡　聖子、中岡　初枝、成本　勝広、西岡　久美、藤井　知美、三好　京子

痛みの治療ノート（冊子版）の作成・印刷には、平成19年度厚生労働科学研究費補助金がん臨床研究事業「在宅医の早期参加による在宅緩和医療推進に関する研究」班　（主任研究者　江口研二、班員　谷水正人）の援助を得た。