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# Edmonton Classification System for Cancer Pain (ECS-CP) Quick User Guide

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The Edmonton Classification System for Cancer Pain (ECS -CP) Quick User Guide provides a brief outline on how to use the ECS-CP.

An initial pain classification assessment, using the ECS-CP, is generally conducted prior to pain management (e.g. on admission to a palliative consultation service). Subsequent assessments may be conducted if the patient's condition changes or as additional information regarding the five pain features is obtained. The classification should be used to guide the interdisciplinary team in using different pharmacological and non - pharmacological approaches to optimize pain control.

The more detailed and complete Administration Manual consists of four key sections: (1) Background, (2) Edmonton Classification System for Cancer Pain, (3) Case Studies and (4) Frequently Asked Questions. Refer to the Administration Manual if you need information beyond what is provided here in the Quick User Guide.

### Edmonton Classification System for Cancer Pain

Patient Name: \_\_\_\_\_

Patient ID #: \_\_\_\_\_

*For each of the following features, circle the response that is most appropriate, based on your clinical assessment of the patient.*

**1. Mechanism of Pain**

- No** No pain syndrome
- Nc** Any nociceptive combination of visceral and/or bone or soft tissue pain
- Ne** Neuropathic pain syndrome with or without any combination of nociceptive pain
- Nx** Insufficient information to classify

**2. Incident Pain**

- Io** No incident pain
- Ii** Incident pain present
- Ix** Insufficient information to classify

**3. Psychological Distress**

- Po** No psychological distress
- Pp** Psychological distress present
- Px** Insufficient information to classify

**4. Addictive Behavior**

- Ao** No addictive behavior
- Aa** Addictive behavior present
- Ax** Insufficient information to classify

**5. Cognitive Function**

- Co** No impairment. Patient able to provide accurate present and past pain history unimpaired
- Ci** Partial Impairment. Sufficient impairment to affect patient's ability to provide accurate present and/or past pain history
- Cu** Total impairment. Patient unresponsive, delirious or demented to stage of being unable to provide any present and past pain history
- Cx** Insufficient information to classify

**ECS-CP profile: N\_\_ I\_\_ P\_\_ A\_\_ C\_\_** (combination of the 5 responses, one for each category)

Assessed by: \_\_\_\_\_ Date: \_\_\_\_\_

SAMPLE

## DEFINITION OF TERMS

### Mechanism of Pain

The ECS-CP classification system is based on a hierarchy of mechanism of pain features, in which neuropathic pain represents a greater management challenge than nociceptive pain. If a patient presents with one or more pains involving multiple pain mechanisms, then the default classification would be the one with the greatest management challenge. For example if a patient presents with two different cancer related pains, one of which is neuropathic pain, you would classify the mechanism of pain as neuropathic. This is also addressed in the descriptor for neuropathic pain (Ne), which refers to "neuropathic pain syndrome with or without any combination of nociceptive pain." The assessment of the mechanism is a judgment decision made by the clinician, based on history, physical examination and available diagnostic imaging. The use of screening tools such as the Leeds Assessment of Neuropathic Symptoms and Signs (LANSS) may enhance accuracy of the classification of the mechanism.

### Incident Pain

Pain can be defined as incident pain when a patient has background pain of no more than moderate intensity with intermittent episodes of moderate to severe pain, usually having a rapid onset and often a known trigger.

Guidelines for Use: There are six key characteristics of incident pain, as defined in the ECS-CP:

- Relationship with background pain: The intensity of incident pain is significantly greater than background pain.
- Severity: The intensity of incident pain is moderate to severe.
- Predictability: The trigger is often known, such as movement, defecation, urination, swallowing and dressing change. However, clinically significant episodic pain (i.e. no predictable trigger) can be included (e.g. bladder or bowel spasm).
- Onset: Its onset is rapid, with intensity often peaking within 5 minutes.
- Transiency: Incident pain is transient, and may return to baseline shortly after the trigger is stopped or removed.
- Recurrence: It is intermittent, recurring when the trigger returns.

### Psychological Distress

Psychological distress, within the context of the pain experience, is defined as a patient's inner state of suffering resulting from physical, psychological, social, spiritual and/or practical factors that may compromise the patient's coping ability and complicate the expression of pain and/or other symptoms.

Guidelines for Use: There are five key characteristics of psychological distress, as defined in the ECS-CP:

- Relationship with pain: The definition of psychological distress is limited to patients who are experiencing psychological distress within the context of the pain experience and who appear to express their suffering through physical symptoms.
- Relationship with suffering: Psychological distress is an expression of suffering, often referred to as total pain.
- Multidimensional: Psychological distress is multidimensional in nature, influencing many spheres of a patient's

experience, including but not necessarily limited to physical, psychological, social, and spiritual factors.

- Relationship with coping: Psychological distress may impair a patient's ability to cope with his/her illness.
- Physical symptom expression: Psychological distress is often expressed as an exacerbation of pain and/or other symptoms, which may be conceptualized as a form of somatization.

Assessment of psychological distress may include, but is not necessarily limited to, the following:

- Assessment of patient's experience in multidimensional domains.
- Patient's behavioral presentation and symptom reporting profile.
- Collateral history from primary caregivers.

### Addictive Behavior

Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

Guidelines for Use: There are five key characteristics of addictive behavior, as defined in the ECS-CP:

- Chronicity: It is a chronic disorder, which may have periods of relapse and remission.
- Multidimensional: It is multidimensional in its development and expression, including genetic, psychosocial and environmental factors.
- Compulsivity.
- Persistent use despite harm.
- Craving.

This definition is limited to the following:

- A remote history of prior alcohol/substance use may not be considered relevant as a complicating factor in ongoing pain assessment and management.
- Substances of abuse include alcohol, prescription medications, non-prescription medications, and illicit drugs.
- It does not include chronic tobacco use.

Assessment of addictive behavior may include, but is not necessarily limited to, the following:

- Use of CAGE as screening tool for possible alcohol abuse.
- Patient's behavioral presentation over a series of visits.
- A strong clinical history of substance abuse provided by the patient.
- Collateral history from primary caregivers.

### Cognitive Function

The assessment of cognition is at the discretion of the clinician and is focused on the ability to provide a pain history since the ECS-CP is a pain classification system. Other global cognitive assessment measures, such as the Mini-Mental Status Examination (MMSE), SOMCT/BOMCT, Sweet 16, or the Montreal Cognitive Assessment (MOCA), may also be included as part of the screening process, if appropriate.