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NURSING DIAGNOSES FOR PATIENTS WITH ONCOLOGIC PAIN BASED ON THE ICNP®

DIAGNÓSTICOS DE ENFERMAGEM PARA PACIENTES COM DOR ONCOLÓGICA BASEADOS NA CIPE®

DIAGNÓSTICOS DE ENFERMERÍA PARA PACIENTES CON DOLOR ONCOLÓGICO BASADOS EN LA CIPE®

Marisaulina Wanderley Abrantes de Carvalho¹, Maria Miriam Lima da Nóbrega², Ana Carolina Regis da Cunha³

ABSTRACT

Objective: to construct nursing diagnosis statements based on the International Classification for Nursing Practice (ICNP®), versions 1.0 and 1.1, for patients with oncologic pain. **Method:** exploratory and descriptive study conducted through the identification of terms on the axes of the ICNP®, for constructing diagnosis statements applicable to patients with oncologic pain. **Results:** by using the terms identified, 68 nursing diagnoses were constructed, divided into pain of physical origin (28 nursing diagnoses/outcomes), for instance, acute pain, chronic pain, fatigue; pain of psychogenic origin (29 nursing diagnoses/outcomes), for instance, hallucination, anguish, anxiety; and pain of sociocultural and spiritual origin (11 nursing diagnoses/outcomes), for instance, conflicting cultural beliefs, lack of social support, social isolation. **Conclusion:** it is expected that the use of these nursing diagnoses effectively contributes to the daily clinical practice, by means of a care aimed at the oncologic patient. **Descriptors:** Nursing; Nursing Diagnosis; Nursing Terminology; Pain; Oncologic Pain.

RESUMO

Objetivo: construir afirmativas de diagnósticos de enfermagem com base na Classificação Internacional para a Prática de Enfermagem (CIPE®), versões 1.0 e 1.1, para pacientes com dor oncológica. **Método:** estudo exploratório e descritivo desenvolvido a partir da identificação de termos nos eixos da CIPE®, para a construção de afirmativas diagnósticas aplicáveis a pacientes com dor oncológica. **Resultados:** a partir dos termos identificados, foram construídos 68 diagnósticos de enfermagem, divididos em dor de origem física (28 diagnósticos/resultados de enfermagem), por exemplo, dor aguda, dor crônica, fadiga; dor de origem psicogênica (29 diagnósticos/resultados de enfermagem), por exemplo, alucinação, angústia, ansiedade; e dor de origem sociocultural e espiritual (11 diagnósticos/resultados de enfermagem), por exemplo, crenças culturais conflitantes, falta de apoio social, isolamento social. **Conclusão:** espera-se que a utilização desses diagnósticos de enfermagem contribua de modo eficaz para a prática assistencial diária, por meio de um cuidado direcionado ao paciente oncológico. **Descritores:** Enfermagem; Diagnóstico de Enfermagem; Terminologia de Enfermagem; Dor; Dor Oncológica.

RESUMEN

Objetivo: construir afirmativas de diagnósticos de enfermería basados en la Clasificación Internacional para la Práctica de Enfermería (CIPE®), versiones 1.0 y 1.1, para pacientes con dolor oncológico. **Método:** estudio exploratorio y descriptivo desarrollado a través de la identificación de términos en los ejes de la CIPE®, para la construcción de afirmativas diagnósticas aplicables a pacientes con dolor oncológico. **Resultados:** mediante el uso de los términos identificados, se construyeron 68 diagnósticos de enfermería, divididos en dolor de origen físico (28 diagnósticos/resultados de enfermería), por ejemplo, dolor agudo, dolor crónico, fatiga; dolor de origen psicógeno (29 diagnósticos/resultados de enfermería), por ejemplo, alucinación, angustia, ansiedad; y dolor de origen sociocultural y espiritual (11 diagnósticos/resultados de enfermería), por ejemplo, creencias culturales en conflicto, falta de apoyo social, aislamiento social. **Conclusión:** se espera que el uso de estos diagnósticos de enfermería contribuya eficazmente a la práctica de atención diaria, por medio de un cuidado dirigido al paciente oncológico. **Descriptores:** Enfermería; Diagnóstico de Enfermería; Terminología de Enfermería; Dolor; Dolor Oncológico.

¹Nurse at the University Hospital Lauro Wanderley of the Federal University of Paraíba (UFPB). Ph.D. student at the Graduate Nursing Program (PPGENF) of UFPB. João Pessoa (PB), Brazil. Email: linawac@yahoo.com.br; ²Nurse. Ph.D. in Nursing. Professor at the Department of Public Health and Psychiatry Nursing and at the PPGENF/UFPB. Director of the ICNP® Center. Researcher from the National Council for Scientific and Technological Development (CNPq). João Pessoa (PB), Brazil. Email: miriam@ccs.ufpb.br; ³Undergraduate Nursing student at UFPB. João Pessoa (PB), Brazil. Email: anacarolinaregis@gmail.com

INTRODUCTION

Cancer, defined as a complex of chronic degenerative conditions consisting of more than two hundred different illnesses, each of them having its own characteristics, symptoms, and prognosis, is among the most feared and stigmatized diseases, for many people cancer represents a death sentence and the effects resulting from the very disease and its treatment, such as, for instance, pain, can modify a routine of life, affecting not only the patient who has a neoplasm, but also her/his family members, work environment, and social life.¹

Pain is identified by the World Health Organization (WHO), from 1986 to the present day, as an international priority. It means a problem regarding human existence, since it affects not only the physical body making it sick, but life in all of its dimensions, as the individual's relation to her/himself, her/his family, work and leisure.²

The International Council of Nurses (ICN) defines oncologic pain as:

Concurrent sensations of acute and chronic pain at various intensity levels associated with invasive spread of cancer cells in the body; consequence of cancer treatment, including chemotherapy, or cancer-related states, such as pain in the wound; oncologic pain is usually described as inaccurate, hurting, aching, frightening, or unbearable related to the feeling of intense pain, accompanied by difficulty to sleep, irritability, depression, grief, isolation, hopelessness, and abandonment.^{3;70}

During our experience as oncology nurses, we could see that the vast majority of oncologic patients suffers from acute or chronic pain and that this pain is often undertreated, not only by nurses, but also by other health professionals; an inadequate assessment and registration of pain complaints regarding these patients was observed, thus leading them to show a persistent painful condition that impact on quality of life and changes in their routine activities. It is known that pain must not be treated only with drugs and knowledge on the emotional and social aspects that permeate the problem is indispensable in determining the therapy and, also, the direct nurse's action is a determining factor in the quality of such care.

Nursing has sought, in recent decades, to systematize nursing care, by means of the nursing process, aiming at the quality of professional assistance. The use of nursing process has triggered the development of classification systems for some phases in this process, that is, for the elements of nursing

practice: nursing diagnoses, outcomes, and interventions. These classification systems are instruments that enable the use of a standardized language, which may be used in the process of reasoning, clinical judgment, and therapy and they ground the clinical documentation of professional practice.

The International Classification for Nursing Practice (ICNP[®]), version 1.0, has a classification structure consisting in seven axes, named Seven-Axis Model, which may facilitate user's access to the definitions and concepts of ICNP[®], through which we may construct both nursing diagnoses, interventions, and outcomes.³

OBJECTIVE

- To construct nursing diagnosis statements, based on the ICNP[®], versions 1.0 and 1.1, for patients with oncologic pain.

LITERATURE REVIEW

♦ Oncologic pain

Brazil is a country whose estimated new cases of cancer per year reaches half a million people, this is a very marked reality; the most disturbing fact is knowing that 40% of patients in active treatment and almost all with advanced disease will suffer from pain. Faced with such a tragic context, oncologic pain treatment must be a priority in cancer care services in our country. However, the reality in Brazil and other countries presents undertreatment. Several factors lead to this finding, they range from the very physical and mental state of patients to the training and preparation of health teams, the provision of painkillers and institutional and public policies aimed at the problem.⁴

Pain is a signal directly proportional to patient's quality of life and it is often described as something more terrible than the disease itself, it may even turn into the second leading cause of patient's fear after the diagnosis of cancer, since the first is death. When it is not well controlled, pain causes despair and powerlessness, disrupting families, triggering disputes, generating disharmony, and interfering with the quality of care and recovery provided to the patient.⁵

Pain is regarded as one of the most frequent and feared symptoms among oncologic patients. This, by itself, is pointed out as the most frequent and feared symptoms among these patients. It is estimated that 10% to 15% of cancer patients have pain with a significant intensity in cases of early disease, this number increases according to the emergence of metastasis and

the incidence of pain increases to 25% to 30% in the very advanced disease stages, 60% to 90% of patients report pain with a very expressive intensity. Around 9 million people around the world suffer from oncologic pain. Half of the patients feel pain at all cancer stages and 70% in advanced disease. Suffering is the result of experiencing pain associated with physical disability, isolation from family and society, financial concerns, fear of mutilation and death.⁶

Biological pain in a patient with cancer can occur due to many reasons, among which we may mention cancer itself through invasion of bones, viscera, central nervous system, peripheral nervous system, and soft tissues, and it can also be related to cancer, such as pressure ulcers, lymphedema, constipation, antitumor treatment, and pathologies presented before or within the period when the patient suffers from cancer, such as osteoarthritis, as well as due to anti-tumor treatment, such as mucositis and peripheral neuropathies.² In numbers, there are: 46-92% derive from the cancer itself, 12-29% are related to the cancer, 5-20% come from anti-tumor treatment, and 8-22% come from concurrent disorders.⁷

The lack of an effective control of oncologic pain is evidenced by some barriers categorized as: health policies and inadequate legislation, which pose constraints to the prescription of morphinic agents for pain control; lack of knowledge among health professionals, who underestimate patients' pain, use inadequate analgesic schemes, and attribute lower priority to palliative care procedures; and myths and misconceptions among patients and family members, especially in relation to morphinic painkillers, including fear of respiratory depression, drug tolerance, and dependence.⁸

Pain control is a multidisciplinary task involving many professionals and various therapies, the patient must be treated holistically and the relation caregiver/patient must be permeated with transparency and trust, since chronic exposure to pain can lead patients to adequate to the painful state, as a reaction way to make it easier to cope with pain, and, thus, the caregiver may confuse this reaction and assume that at this point the patient feels no pain.

Cancer pain may be classified as *nociceptive*, *neuropathic*, and *psychogenic*. Nociceptive pain, which emerges through thermal, mechanical, or chemical stimuli in free nerve endings of the peripheral nervous system, constitute examples: visceral pain caused by pathological processes in internal

organs, such as bladder and uterus; bone pain, when there is no involvement of nerve endings; neuropathic pain, which is caused by total or partial lesion in the neurocentral or peripheral system, or both, can be caused by infections, traumas, chemotherapy, surgery, radiation therapy, nerve compressions, among others.⁹ Psychogenic pain consists in intense and short pain episodes, which may be associated with movement, swallowing, obstruction, and other phenomena.¹⁰ Pain may also be mixed, i.e. the patient's basal pain may be controlled or not, with psychogenic pain episodes.

There are many instruments for pain assessment that may be based on age, intellectual level, and cultural aspects; they may be one-dimensional, such as the scales that assess only pain intensity based on previously established criteria; we may use the numeric visual scale (NVS) or the analog visual scale (AVS), where the use of figures, fruits, or situations is predominant for assessment. The instruments may also be multidimensional, which assess pain according to various parameters, to do this, the "McGill" questionnaire, the "Wisconsin Brief Pain Questionnaire", and the "Memorial Pain Assessment Card" are used, which, however, are very complex, poorly understood by patients, and difficult to apply to clinical practice.⁵

• International Classification for Nursing Practice

The ICNP[®] aims to provide a tool to describe and document nursing practices; use this tool as a basis for clinical decision making; provide nursing with a vocabulary and a single classification system that may be used to include nursing data in computerized information systems.³ The ICNP[®] consists of nursing practice elements: What nurses do (interventions) in face of certain needs (diagnoses) to produce certain results (nursing outcomes). This language provides nurses with: comparisons between clinical contexts, client populations, geographical areas, or times; nursing participation and identification in multidisciplinary health care teams; practice differentiation by preparation and experience levels in nursing.³

We may claim that the ICNP[®], version 1.0, constitutes more than a simple vocabulary, this is a means that, by crossing/mapping terms, may be used to develop new vocabularies (as compositional terminology), and it may identify relations between concepts and vocabularies, as a reference terminology. Thus, we acquired a richer and more accessible classification system. The

ICNP®, version 1.0, is more than a mere multi-axial structure, since it was developed by using web ontology language (OWL) within the environment to develop ontologies: Protégé.³

Nursing must contribute to this process of dynamism, using the ICNP® in its practice; participating as expert reviewers of changes recommended in this system; translating it into a language appropriate for local use; participating in its continued assessment; working together to develop overall strategies, goals, and objectives that ensure their global relevance.

The Seven-Axis Model of the ICNP®, derived from the junction of 16 axes from version beta 2, 8 for classifying phenomena and 8 for classifying actions, intends to facilitate a continued use of the ICNP®. Each axis of version 1.0 is defined as: Focus: area of relevant focus for nursing, e.g. blood, urine, mutilation; Judgement: clinical opinion or determination related to the focus of nursing practice, e.g. improvement, partial, state; Means: way or method to make an intervention, e.g. diaper, shower, and blanket; Action: intentional process applied to, or performed by, a client, e.g. treat, care, promote; Client: the person provided with nursing care; Time: the point, period, time, interval, and duration of an event, e.g. duration, frequency; and Location: anatomical or spatial orientation of a diagnosis.

To create the nursing diagnosis statements, in 2007, the ICN established as criteria including at least one term from the Focus axis and one term from the Judgement axis, and there may also be included, if needed, additional terms from the Client, Location, Means, and Time axes.³

METHOD

Study with a descriptive and exploratory nature, aimed to construct nursing diagnosis statements, based on the ICNP® for patients with oncologic pain.

This study was conducted according to these steps: identification of empirical indicators related to oncologic pain, which were obtained through the literature and the ICNP®, version 1.0; and the construction of nursing diagnosis statements.

To identify empirical indicators for oncologic pain in the literature, an assessment of pain was conducted regarding the physical, psychological, and sociocultural aspects. Concerning the physical aspect, the following indicators were found: nausea, fatigue, anorexia, appetite loss, facial expression,

verbal report, protective position, insomnia, sweating, vomiting, tachycardia, increased blood pressure, burning, pupil dilation, asthenia, and tachypnea; in the psychological aspect, there were: apathy, agitation, depression, irritability, crying, moaning, anger, hopelessness, despair, and guilt; and in the sociocultural aspect there were: diet change, social isolation, reduced interaction with the environment, and constraints on work and leisure activities.

In the ICNP®, version 1.0, we identified, in addition to those previously mentioned in the literature, the following terms from the Focus axis: denial, noncompliance, oncologic pain, disuse, family crisis, self-care, attitudes towards pain, attitude towards drug management, spiritual anguish, and adaptation.³

After identifying these terms, we used the recommendations by the ICN to compose the nursing diagnosis statements using the Seven-Axis Model from the ICNP®, version 1.0: include, necessarily, one term from the Focus axis and one term from the Judgement axis; include additional terms, as needed, from the Client, Location, and Time axes.

We constructed 68 nursing diagnosis statements through the empirical indicators identified, classified into oncologic pain of physical origin and oncologic pain of psychogenic origin, in the latter, the psychological, social, cultural, and spiritual factors are observed, influencing pain identification and treatment.

In compliance with the provisions of Resolution 196/1996 and the Code of Ethics of Nursing Professionals¹¹, annexed to Resolution COFEN 311/2007¹², the study was approved by the Research Ethics Committee of the University Hospital Lauro Wanderley of the Federal University of Paraíba (UFPB), under the Protocol 018/2009.

RESULTS

According to the literature analyzed and clinical experience, pain was classified as oncologic pain of physical origin and oncologic pain of psychogenic origin, in the latter, the psychological, social, cultural, and spiritual factors are observed and they influence on pain identification and treatment.

Initially, 156 nursing diagnosis statements/outcomes were constructed, which were mapped with the ICNP® Diagnosis Concepts Catalog, version 1.1¹³, obtaining 117 included in the nursing Diagnosis/Outcomes Catalog of the ICNP®, version 1.1, and 36 not included in this catalog. After analyzing the

nursing diagnoses, redundancies were reviewed and removed, in addition to positive real diagnosis, and, then, diagnoses were distributed according to the theoretical model for nursing care for oncologic pain, which was developed by means of empirical indicators found in the literature and the experience of clinical practice. In this model, pain was classified as oncologic pain of physical origin and pain of psychogenic origin, in the latter,

the psychological, social, cultural, and spiritual factors are observed and they influence on pain identification and treatment. For the physical aspects 28 nursing diagnoses/outcomes were identified, for pain of psychogenic origin, 29 nursing diagnoses/outcomes were constructed; and for the sociocultural and spiritual aspects of oncologic pain 11 nursing diagnoses/outcomes were constructed (Figure 1).

Physical aspects of oncologic pain			
Nursing diagnoses			
5	Impaired communication	19	Impaired mobility
6	Constipation	20	Nausea
7	Impaired swallowing	21	Altered sleep pattern
8	Acute pain	22	Impaired breathing pattern
9	Chronic pain	23	Altered blood pressure
10	Sleepiness state	24	Itching
11	Fatigue	25	Impaired rest
12	Lack of response to treatment	26	Urinary retention
13	Hyperthermia	27	Risk for urinary retention
14	Infection	28	Risk for constipation
15	Poor nutrition intake	29	Risk for Infection
16	Unrest	30	Disuse syndrome
17	Impaired skin integrity	31	Tachycardia
18	Impaired oral mucosa membrane	32	Edema
Psychological aspects of oncologic pain			
Nursing diagnoses			
5	Acceptance of health status	18	Self-care deficit
6	Hallucination	19	Delirium
7	Anguish	20	Depression
8	Anxiety	21	Hopelessness
9	Conflicting attitude towards the therapeutic regime	22	Personal identity disorder
10	Conflicting family attitude	23	Fear
11	Negative self-image	24	Noncompliance with treatment regimen
12	Low situational self-esteem	25	Denial
13	Decreased capacity to manage the therapy plan	26	Impaired fatherhood/motherhood
14	Decreased family capacity to manage the therapy plan	27	Altered perception
15	Impaired behavior of seeking for health	28	Anticipated mourning
16	impaired cognition	29	Impaired family process
17	Confusion	30	Chronic sadness
		31	Ineffective family coping
		32	Ineffective individual coping
		33	Impotence (lack of power)
Sociocultural and spiritual aspects of oncologic pain			
Nursing diagnoses			
1.	Conflicting cultural beliefs	6.	Risk of helplessness
2.	Lack of social support	7.	Impaired socialization
3.	Lack of knowledge on the disease	8.	Spiritual suffering
4.	Lack of knowledge on the therapy regimen	9.	Moral suffering
5.	Social isolation	10.	Risk for spiritual suffering
		11.	Risk for moral suffering

Figure 1. Distribution of empirical indicators and terms from the ICNP®, version 1.0, for patients with oncologic pain according to the physical, psychological, and sociocultural aspects and nursing diagnosis statements. João Pessoa, 2009.

DISCUSSION

The oncologic pain model covers pain of two origins: physical and psychogenic. The *Physical origin* is subdivided into neuropathic pain and nociceptive pain (somatic and visceral), which can be: 1) caused by the cancer itself - from 46% to 92%: tumor bone invasion, tumor visceral invasion, tumor invasion in the peripheral nervous system, direct extension to the soft parts, increased

intracranial pressure; 2) related to cancer - 12% to 29%: muscle spasm, lymphedema, decubitus sore, constipation; 3) related to anticancer treatment - 5% to 20%: postoperative (post-mastectomy and post-amputation), post-chemotherapy (mucositis, peripheral neuropathies, post-herpetic neuralgia, bladder spasms), post-radiation therapy (mucositis esophagitis, radiation proctitis, radiation dermatitis, actinic myelopathy, actinic fibrosis of the brachial and lumbar plexus); 4) concurrent disorders -

8% to 22%: osteoarthritis, spondyloarthrosis, among others.¹⁴

The *Psychogenic origin* is subdivided into: 1) cultural aspects based on cultural beliefs, worldview, diversity, and cultural values and behaviors; 2) social aspects where we observe deterioration of quality of life, social turmoil caused by the disease, and challenged dignity; 3) psychological aspects highlighted by anguish, guilt, depression, anxiety, hopelessness, despair.

The nursing diagnosis statements are distributed according to the oncologic pain model developed, but it must be clear that it is a guide to be followed by nurses, it does not eliminate, therefore, clinical experience, critical thinking, and decision making.

Out of the 28 nursing diagnosis statements constructed for the physical aspect of pain stand out the diagnoses of Acute pain, Chronic pain, Fatigue, Impaired nutritional intake, Nausea, Constipation, Impaired breathing pattern, and Impaired sleep.

The diagnosis of *Acute pain* arises suddenly and it has a limited duration, usually it plays the role of warning the individual about the existence of any lesion or general body dysfunction. It may have a predictable duration, it is self-limited and easily diagnosed, perhaps it occurs during and after some diagnostic procedures and some antineoplastic, surgical, and systemic treatments, as well as radiation therapy. This type of pain may have a duration longer than three months. Usually, *Chronic pain* has an indefinite duration, it is not self-limited, and it occurs more commonly due to damage caused by the tumor, it is not based only on the temporal pattern of pain duration, but mainly on the mechanism.⁴

Fatigue is defined as a disorder characterized by extreme tiredness and inability to function due to lack of energy and it can be acute or chronic. The concept of fatigue is not complete, but three empirical referents are important and they can define it: verbalization of fatigue/tiredness or exhaustion, decreased ability to fulfill routine activities, and lack of relief from these manifestations by applying usual strategies for energy recovery, all observed in an oncologic patient.¹⁵

Impaired nutrition intake is accentuated by lack of appetite, something which is very common among cancer patients and it occurs mainly due to metabolic changes, the disease itself, reduction or lack of physical activity, and pain, psychological status changes may worsen this state.¹⁴ The nursing diagnosis

Nausea is defined as the unpleasant feeling of unease or discomfort and it can be caused by painful process, nutritional deficiency, or use of opioids, which can also cause *Constipation*, the nursing diagnosis perceived in most cancer patients and oncologic pain, either by tumor invasion causing intestinal obstruction, water restriction, and other concurrent processes.

Morphine is a “gold standard” drug for patients with oncologic pain, the clinical nurse must be attentive to the nursing diagnosis *Impaired breathing pattern*, since a very aggressive pain management may lead to large sedation and fatal respiratory depression, it is important that patients are continuously followed up and monitored, adapting and individualizing doses and infusions, in order to optimize analgesia and reduce the occurrence of adverse effects and complications. In general, the complication is due to opioid overdose or interaction with other medications administered to the patient.¹⁶

Pain is regarded as a cause for insomnia, which, in turn, is a warning signal to the nursing diagnosis *Impaired sleep*. Sleep disturbance can lead to significant changes in the individual's physical, occupational, cognitive, and social functioning, in addition to substantially compromise quality of life.¹⁷

Out of the 29 nursing diagnosis statements constructed for the psychological aspect of pain stand out the diagnoses of Conflicting attitude towards the therapy regimen management, Low situational self-esteem, Impaired cognition, Self-care deficit, noncompliance with the therapy regimen, Denial, Anticipated mourning, Chronic sadness, Ineffective family coping, Ineffective individual coping, Impotence (lack of power), Hopelessness.

Terminally ill patients are generally lethargic and they show a decreased consciousness level, favoring the arise of the nursing diagnosis *Conflicting attitude towards medication management* which is understood as patient's difficulty to maintain effective analgesia at this disease stage. The fact that the patient using opioids in high doses has her/his cognition compromised is controversial, on the contrary, in some cases there is even a cognitive improvement resulting from pain relief.¹⁸

The nursing diagnosis *Self-care deficit* occurs when the human being is not competent to provide her/his self-care, thus requiring help.¹⁹

The nursing diagnosis *Hopelessness* is described as a mental breakdown with implicit

subcategories, such as: lack of hope and wish, perception of having no possibilities, and lack of meaning in life and strength.²⁰

Out of the 11 nursing diagnosis statements constructed for the psychological aspect of pain stand out the diagnoses Lack of knowledge on the disease and therapy regimen, Social isolation, Spiritual suffering.

FINAL REMARKS

Oncologic pain is observed in the life of the vast majority of cancer patients, this pain begins from the time of diagnosis, when the individual undergoes extensive invasive procedures with the purpose of staging the disease, including treatment, either surgical, chemotherapy, or radiation therapy and it may remain until the last days of her/his life, in terminal disease, which is characterized by pain due to tumor invasion.

Pain is a subjective symptom and, as such, it is difficult to assess, each person perceives, reacts, and conceives her/his pain in a unique and particular way, this fact makes it a great problem to be faced and leads the reasons that cause it to be correctly exposed. It is not hard to see that the professionals who provide these clients with care are somewhat immature regarding pain assessment and treatment, many do not recognize it as real, they do not see it as part of the disease or that it may constitute the very disease. The biomedical care model is still widely used, the client feels some pain and painkillers are administered, there is a gap in putting into practice the concept of total pain, where, in addition to the physical aspects, psychological, social, cultural, and spiritual aspects are observed in the individual who feels oncologic pain.

When starting this study, we had in mind constructing an ICNP® catalog covering nursing diagnoses/outcomes and interventions in a single instrument to provide oncologic patients suffering from pain with care. The nursing diagnosis statements/outcomes were constructed by means of that way of looking at oncologic pain, covering its multidimensional aspect and treating the client holistically. These statements have not been entirely exhausted, as individual aspects inherent to each patient were not included, these missing aspects are included in the nurse's clinical assessment and reasoning, because her/his worldview also influences on the construction of these statements.

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Corresponding Address

Marisaulina Wanderley Abrantes de Carvalho
Rua Silvino Lopes, 460 / Ap. 1901
Bairro Tambaú
CEP 58039-190 – João Pessoa (PB), Brazil

English/Portuguese

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