Current Concepts in Cancer Pain Management

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Physiatry is the Medical specialty dedicated to improving patients Function functional ability,
• When we say pain we really mean pain and all it’s sequela including fatigue, sleep depravation, depression, immobility and the subsequent effects on the our patients heart, bones, kidneys etc.
A young woman describing her father’s struggle

“Aggressive treatment left him with chronic, debilitating pain. Once active, he struggled to get around his own home. It was not the cancer that got him. It was the pain.”
When people hear the words “you have cancer” life is suddenly divided into distinct parts. There was their life before cancer, and then there is their life after cancer.

13.7 million living Americans are cancer survivors. More than half are younger than 70 years old.

A new book “Picture Your Life After Cancer” by the American Cancer Society” focuses on living with cancer.

Susan Schwalb “what cancer made me do was is to pedal faster...
I decided I had to have more of what I wanted in life, and I better move fast”.

Dr. David Posner associate chief of Pulmonary Medicine at Lenox Hill Hospital and himself a cancer survivor “My Salvation has been my family and my work”.

“Why would you let pain interfere with your patients ability to continue living their lives as fully as possible?”
Patients report pain and it is poorly managed.

Patients report pain and loss of function.

Family members helpless and tortured watching their loved one suffer.

Especially since they know that there are treatments available.
1. Cancer Pain is more of a problem than we realize

*Journal of Clinical Oncology:
Dr. Michael Fisher University of Texas Anderson Cancer Ctr.*

Palliative and Supportive Care
Prospective, Observational Study of Pain and Analgesic Prescribing in Medical Oncology Outpatients With Breast, Colorectal, Lung, or Prostate Cancer
- Michael J. Fisch, Ju-Whei Lee, Matthias Weiss, Lynne I. Wagner,

3000 cancer patients studied
2/3 said they were in pain
40% did not receive adequate treatments for pain.
Many physicians unwilling to prescribe narcotics
1/3 of cancer specialists waited until just before death to prescribed

Pain is the fifth vital sign! Temperature, heart rate, respiration, blood pressure, pain

Why? Oncologist have finished cancer treatments
Internists too busy to monitor narcotic use.

Improved treatments mean more than half of cancer patients survive 5 years.

Improve your patients quality of life quality of life

A change in pain level may indicate a change in the disease and warrant investigation.
If the pain is not adequately control the patient can not effectively identify changes.
Functional losses

The list of damage that pain does to quality of life includes:

- sleep is disturbed
- ability to work is impaired
- exhaustion can become a constant companion
- sadness, depression and worry are commonly felt emotions
- appetite diminishes and therefor reduced nutrition
- simple pleasures such as enjoying one's family are impaired or given up
- trips and vacations are uncomfortable or impossible
- reluctance to move or exercise is experienced
- feelings of isolation from the world increase
- family and friends who are caregivers become exhausted.
The added value of assessing the 'most troublesome' symptom among patients with cancer in the palliative phase.

Hoekstra J, Vernooij-Dassen MJ, de Vos R, Bindels PJ.

Source
Department of General Practice, Division of Clinical Methods & Public Health, Academic Medical Center-University of Amsterdam, Meibergdreef 15, 1105 AZ, Amsterdam, The Netherlands. marjokehoekstra@hotmail.com

Abstract
OBJECTIVE:
In this study among patients with cancer in the palliative phase, we analyzed whether assessing the symptom, which is causing the most trouble in the patient's every day life ('most troublesome' symptom) had added value apart from the presence and severity of symptoms, which are most commonly assessed in clinical practice.

METHODS:
Patients with cancer (lung, gastro-intestinal, breast cancer) in the palliative phase from two non-academic hospitals were included in the study. Using the Symptom Monitor tool, 10 physical symptoms were assessed with regard to presence and severity. The Symptom Monitor has an extra added item indicating as the 'most troublesome' symptom. This item was monitored to determine whether it had added value apart from the presence of symptoms and 'most severe' symptom. The severity score on the indicated 'most troublesome' symptom was subtracted from the severity score of the 'most severe' symptom. The generated delta score of 0 indicated no added value, whereas a score of one or more indicated that the 'most troublesome' symptom would have been missed if not specifically asked for by the physician, because its severity was lower that the 'most severe' symptom.
RESULTS:

One hundred and forty-six patients reported 590 symptoms to be present. In total, 227 symptoms were reported as 'most severe' symptom (n = 138 patients).

Among these, fatigue (n = 52) and pain (n = 24) were reported most frequently as 'most severe' symptom.

In total, 134 patients indicated a symptom as 'most troublesome'. Fatigue (n = 33; 25%) and pain (n = 22; 16%) were also indicated by most of these patients as the 'most troublesome' symptom. One hundred and fifty-two comparisons could be made between the 'most severe' and the 'most troublesome' symptom. In 102 (67%) of the comparisons assessing the 'most troublesome' symptom had no added value: the score for 'most severe' symptom did not differ from the score for the 'most troublesome' symptom revealing a delta score of 0. In 23 times (15%) of the 152 comparisons made, the delta score was 1 and in 27 (18%) of the comparisons the delta score was 2 or more indicating that assessing the 'most troublesome' symptom substantially had added value.

CONCLUSION:

In patients in the palliative phase of their disease, extra attention for the 'most troublesome' symptom is needed.

In our study, in almost 1/3 of the cases, this symptom would have been missed the physicians attention if not specifically asked for.

PRACTICE IMPLICATIONS:

We recommend not only to assess the presence and severity of symptoms, but furthermore to assess the patient's 'most troublesome' symptom in addition.

Breakthrough cancer pain - still a challenge.

Pain Unit, Alicante University General Hospital, Alicante, Spain.

Breakthrough cancer pain is defined as transient pain exacerbation in patients with stable and controlled basal pain.

Although variable, the prevalence of breakthrough cancer pain is high (33%-95%).

According to the American Pain Foundation, breakthrough pain is observed in 50%-90% of all hospitalized cancer patients, in 89% of all patients admitted to homes for the elderly and terminal-patient care centers, and in 35% of all ambulatory care cancer patients.

The management of breakthrough cancer pain should involve an interdisciplinary and multimodal approach.

The introduction of new fentanyl formulations has represented a great advance and has notably improved treatment.

Among these, the pectin-based intranasal formulation adjusts very well to the profile of breakthrough pain attacks, is effective, has a good toxicity profile, and allows for convenient dosing - affording rapid and effective analgesia with the added advantage of being easily administered by caregivers when patients are unable to collaborate.
Pain, which can be caused by the disease itself or by treatments, is common in people with cancer, although not all people with cancer will experience pain.

Approximately 30% to 50% of people with cancer experience pain while undergoing treatment, and 70% to 90% of people with advanced cancer experience pain.
RESULTS Seventy-three percent of patients had pain at admission. Cancer of the cervix was frequently (68%) associated with severe pain, as were prostate (52%) and rectal/sigmoid tumors (49%). Severe pain was more probable in those with bone metastasis, those admitted from home, and in those younger than 55 years of age.

The majority (71.7%) of patients had a stable dosing pattern, and only 4.2% of the patients required dose increases of at least 10% per day.

CONCLUSION This study demonstrated the wide variability in opioid doses required. No reliable predictor of opioid requirement was identified, and this lack of predictability of cancer pain severity underscores the need for ongoing assessment.
Cheville et al Prevalence and treatment patterns in patients with metastatic breast cancer
Rehabilitation services under utilized in the outpatient setting even when patients themselves identified functional needs.

Neither physiatrist’s or internist’s receive training in palliative care
Oncologists do not receive training in rehabilitation.

Oncologist see their primary focus of care is in treating disease, prolonging life and transitioning to palliative care

Physiatrists’ did not believe that a short life expectancy was as relative to the discussion about rehabilitation as oncologists 35.1% to 8.4%

Key: When asked, patients report pain, loss of function and poor management of their pain

This is not “I hurt my back I need drugs”.

These are patients with breast cancer, mastectomy, chemotherapy and radiation therapy fighting to survive and live what is left of their lives fully.
What causes the pain and loss of function?

a. The cancer
b. The treatments
   Tests
   Chemotherapy
   Radiation therapy
   Surgery
Chemotherapy can cause numerous side effects, depending on the medication being used. Some of the more common side effects that cause pain include mouth sores (mucositis), peripheral neuropathy (numb and sometimes painful sensations in the feet, legs, fingers, hands and arms), constipation, diarrhea, nausea, vomiting and abdominal cramps. Some people also experience bone and joint pain from chemotherapy medications and from some medications used to offset the impact of the chemotherapy on blood counts and on the risk of infection.

Surgical treatments will, in some instances produce pain after they are completed. Your physician and nurse will provide medications and techniques to help you manage surgery-related pain.

Procedures related to cancer pain, such as biopsies, blood draws, lumbar punctures, laser treatments, etc. can cause pain.
No matter what the cause, most types of cancer pain can be managed with drug and non-drug therapies. However, cancer pain is not always adequately managed. While competent health care professionals should assume that people with cancer will need assistance to manage pain and ask you about it, if they do not, you or your family members must speak up and insist on having your pain relieved. Some physicians may not always prescribe the right medications or sufficient doses of the medication. If this happens, ask for more assistance and, if you choose, ask that a pain specialist work with you to develop a plan to manage your pain. Pain specialists are physicians and nurses who are experts in the field of pain management.

Interesting to me that when I started calling oncologists to discuss my interest every single one said that their patients pain was adequately managed.

I am not here to tell you how to practice medicine. Don’t shot the messenger. I am here to challenge you that maybe your patients are not as well managed as you think. Because the literature suggests it is not.
2: Treatment improves quality of life, monitor disease and improves outcome

a. Improved quality of life
   a. We do not want to send our patients home to live longer lives in pain.
   b. We do not want to send our sick patients to radiation treatments which requires uncomfortable travel, uncomfortable positions on uncomfortable tables for uncomfortable treatments and another trip home without pain medication.
   c. We do not want to give our patients toxic chemotherapy without treating the pain manifestations without help.
   d. We would not give injections or perform surgery without anesthesia?

b. Monitor the disease
   a. Pain may herald worsening of the disease. If pain is always a 10 the patient can not gage it. If you have helped reduce it to a 5 and suddenly it is a 10 with loss of function something is up.

c. Improve survival
   a. That is the goal
Cancer patients benefit from rehabilitation

*Patrick W. Mantyh*

Cancer pain and its impact on diagnosis, survival and quality of life

**Cancer pain significantly affects the diagnosis, quality of life and survival of patients with cancer.**

During the past decade, preclinical and clinical data has begun to provide insight into the mechanisms that drive and mask cancer pain and the mechanisms by which anti-neoplastic agents induce peripheral neuropathy. Developing a mechanism-based understanding and mechanism-based therapies to treat cancer-associated pain and sensory neuropathy, and incorporating these into mainstream cancer research and therapy, will be crucial to improving the quality of life and survival of patients with cancer.

It's important to understand, too, that cancer pain can undermine your ability to fight your cancer.

If pain has you in its grip, your appetite diminishes. This means you may not be receiving sufficient nutrition to retain energy which, in turn, leads to exhaustion and feelings of sadness and depression. As this cycle continues, a person is worn down gradually, may become more vulnerable to infection, and the ability to withstand necessary cancer treatments may diminish.
In general, Cancer Survival rates have almost doubled across the board.

Journal of Clinical Oncology
ASCO American Society of Clinical Oncology
2004 ASCO Annual Meeting
Vol 22, No 14S July 15 Supplement 2004: 8030
B.M. Kinzbrunner, D.C. Tanis
Vitas Healthcare Corporation
Miami FL

5168 patients.

Results: Median survival for patients with severe or moderate pain was significantly shorter than those with mild or no pain.

Patients with severe pain that was reduced to < 5/10 had significant longer median survival than those who did not have reduction in pain.
Spinal Cord Journal 2007;45:671-677

Tang et Al. Prognostic Indicators in metastatic spinal cord compression

Patients who made functional gains in rehab. had longer survival


Axelesson B, Sjode PO, Quality of life of cancer patients and their spouses

Patients with increased function live longer
Patients with better self-rated health had longer survival

Randomized Clinical Trial of an Implantable Drug Delivery System Compared With Comprehensive Medical Management for Refractory Cancer Pain: Impact on Pain, Drug-Related Toxicity, and Survival

The IDDS group had significant reductions in fatigue and depressed level of consciousness ($P < .05$). IDDS patients had improved survival, with 53.9% alive at 6 months compared with 37.2% of the CMM group ($P = .06$).

CONCLUSION: IDDSs (Intrathecal drug delivery System) improved clinical success in pain control, reduced pain, significantly relieved common drug toxicities, and improved survival in patients with refractory cancer pain.
3. Who treats the pain?

a. Internists: Limited training
b. Oncologists: Limited training
c. Physiatrists: Limited training
d. Pain specialists: Limited training but often injection orientated

1. Oncologists’ and Physiatrists’ Attitudes Regarding Rehabilitation for patients with Advanced Cancer

Gylae Spill, MD, Fay Hlbocky, MS, PHD, Christopher Daugherty, MD
MacLean Ctr. for Clinical Medicine Rehabilitation Institute of Chicago
Archives of Physical Medicine Vol.4, 96-108, February 2012

Physiatrists more concerned with function and quality of life for patient with cancer
Medical oncologists' attitudes and practice in cancer pain management: a national survey.

Breuer B, Fleishman SB, Cruciani RA, Portenoy RK.

Source
Beth Israel Medical Center, New York, NY 10003, USA. bbreuer@chpnet.org

Abstract

PURPOSE: To evaluate the attitudes, knowledge, and practices of US medical oncologists that are related to management of cancer pain.

METHODS: An anonymous survey was mailed to a geographically representative sample of medical oncologists randomly selected from the American Medical Association's Physician Master File.

RESULTS: From a total of 2,000 oncologists, 354 responded to the original questionnaire and 256 responded to one of two subsequent shortened versions (overall response rate, 32%). Responders were demographically similar to all US medical oncologists. Using numeric rating scales of 0 to 10, oncologists rated their specialty highly for the ability to manage cancer pain (median, 7; interquartile range [IQR], 6 to 8) but rated their peers as more conservative prescribers than themselves (median, 3; IQR, 2 to 5). The quality of pain management training during medical school and residency was rated as 3 (IQR, 1 to 5) and 5 (IQR, 3 to 7), respectively. The most important barriers to pain management were poor assessment (median, 6; IQR, 4 to 7) and patient reluctance to take opioids (median, 6; IQR, 5 to 7) or report pain (median, 6; IQR, 4 to 7). Other barriers included physician reluctance to prescribe opioids (median, 5; IQR, 3 to 7) and perceived excessive regulation (median, 4; IQR, 2 to 7).

In response to two vignettes describing challenging clinical scenarios, 60% and 87%, respectively, endorsed treatment decisions that would be considered unacceptable by pain specialists. Frequent referrals to pain or palliative care specialists were reported by only 14% and 16%, respectively.

CONCLUSION: These data suggest that, for more than 20 years, a focus on cancer pain has not adequately addressed the perception of treatment barriers or limitations in pain-related knowledge and practice within the oncology community. Additional efforts are needed to achieve meaningful progress.
Why we are failing?


Lesage P. and Portenoy RK. Cancer Control:

This can be attributed to several factors:

Physicians may not be adequately educated about pain control or they may be more focused on control of the disease than on control of pain and other symptoms; patients may be reluctant to report their pain; and both physicians and patients may be reluctant to use morphine and other opioids for pain control because they fear addiction, which is extremely rare in people with cancer.


Source
Department of Health Services, University of Washington, Seattle, WA, USA.

Abstract
BACKGROUND: Despite advances in early detection and effective treatment, cancer remains one of the most feared diseases. Among the most common side effects of cancer and treatments for cancer are pain, depression, and fatigue. Although research is producing increasingly hopeful insights into the causes and cures for cancer, efforts to manage the side effects of the disease and its treatments have not kept pace. The challenge that faces us is how to increase awareness of the importance of recognizing and actively addressing cancer-related distress. The National Institutes of Health (NIH) convened a State-of-the-Science Conference on Symptom Management in Cancer: Pain, Depression, and Fatigue to examine the current state of knowledge regarding the management of pain, depression, and fatigue in individuals with cancer and to identify directions for future research. Specifically, the conference examined how to identify individuals who are at risk for cancer-related pain, depression, and/or fatigue; what treatments work best to address these symptoms when they occur; and what is the best way to deliver interventions across the continuum of care.

State-of-the-Science Process: A non-advocate, non-Federal, 14-member panel of experts representing the fields of oncology, radiology, psychology, nursing, public health, social work, and epidemiology prepared the statement. In addition, 24 experts in medical oncology, geriatrics, pharmacology, psychology, and neurology presented data to the panel and to the conference audience during the first 1.5 days of the conference. The panel then prepared its statement, addressing the five predetermined questions and drawing on submitted literature, the speakers' presentations, and discussions held at the conference. The statement was presented to the conference audience, followed by a press conference to allow the panel to respond to questions from the media. After its release at the conference, the draft statement was made available on the Internet. The panel's final statement is available at http://consensus.nih.gov.

Continued
CONCLUSIONS: The panel concluded that the available evidence supports a variety of interventions for treating cancer patients' pain, depression, and fatigue. Clinicians should routinely use brief assessment tools to ask patients about pain, depression, and fatigue and to initiate evidence-based treatments. Assessment should include discussion about common symptoms experienced by cancer patients, and these discussions should continue over the duration of the illness. Impediments to effective symptom management in cancer patients can arise from different sources and interactions among providers, patients and their families, and the health care system.

Numerous factors could interfere with adequate symptom management. Among these factors are incomplete effectiveness of some treatments, a lack of sufficient knowledge regarding effective treatment strategies, patient reluctance to report symptoms to caregivers, a belief that such symptoms are simply a part of the cancer experience that must be tolerated, and inadequate coverage and reimbursement for some treatments. Additional research is needed on the definition, occurrence, the treatment of pain, depression, and fatigue, alone and in combination, in adequately funded prospective studies. The panel also concluded that the state of the science in cancer symptom management should be reassessed periodically.
INTRODUCTION:
Healthcare providers frequently lack the knowledge and skills to provide optimal pain management for cancer survivors. Scientific evidence and clinical guidelines are lacking in the management of chronic, persistent pain in survivors. The purpose of this article is to describe pain-related issues of cancer survivors using case presentations of selected patients enrolled in a randomized trial to eliminate barriers to pain management.

MATERIALS AND METHODS:
Case presentations were selected from a National Cancer Institute-funded study that utilizes patient and professional educational content derived from the clinical guidelines of the National Comprehensive Cancer Network. Case presentation criteria included a pain rating of $\geq 6$ and diagnosis of Stage I, II, or III of the following cancers: breast, colon, lung, or prostate cancer. Cases are presented based on the study’s framework of patient, professional, and system-related barriers to optimal pain relief.

RESULTS:
Across all three case presentations, barriers such as fear of side effects from pain medications, fear of addiction, lack of professional knowledge of the basic principles of pain management, and lack of timely access to pain medications due to reimbursement issues are prevalent in cancer survivorship.

CONCLUSIONS: Chronic pain syndromes related to cancer treatments are common in cancer survivors. Patient, professional, and system-related barriers that are seen during active treatment continue to hinder optimal pain relief during survivorship.

IMPLICATIONS FOR CANCER SURVIVORS: Healthcare providers must acknowledge the impact of chronic, persistent pain on the quality of cancer survivorship. Clinical as well as scientific efforts to increase knowledge in chronic pain management will improve the symptom management of cancer survivors.
Cancer-related pain: a pan-European survey of prevalence, treatment, and patient attitudes.


Source
Faculty of Medicine, University of Oslo and Department of Anaesthesiology, Rikshospitalet University Hospital, Oslo, Norway.

Abstract
BACKGROUND:
The European Pain in Cancer survey sought to increase understanding of cancer-related pain and treatment across Europe.

PATIENTS AND METHODS:
Patients with all stages of cancer participated in a two-phase telephone survey conducted in 11 European countries and Israel in 2006-2007. The survey screened for patients experiencing pain at least weekly, then randomly selected adult patients with pain of at least moderate intensity occurring several times per week for the last month completed a detailed attitudinal questionnaire.

RESULTS:
Of 5084 adult patients contacted, 56% suffered moderate-to-severe pain at least monthly. Of 573 patients randomly selected for the second survey phase, 77% were receiving prescription-only analgesics, with 41% taking strong opioids either alone or with other drugs for cancer-related pain. Of those prescribed analgesics, 63% experienced breakthrough pain. In all, 69% reported pain-related difficulties with everyday activities; however, 50% believed that their quality of life was not considered a priority in their overall care by their health care professional.

CONCLUSIONS:
Across Europe and Israel, treatment of cancer pain is suboptimal. Pain and pain relief should be considered integral to the diagnosis and treatment of cancer; management guidelines should be revised to improve pain control in patients with cancer.
Reluctance of doctors to ask about pain or offer treatments. Some doctors and other health care professionals may not specifically ask about pain, which should be a normal part of every visit with your doctor. People with cancer should be asked if they are having any pain. If they are, the doctor should stop there and deal with the issue. Some doctors don't know enough about proper pain treatment. If this is the case, your doctor might refer you to a pain specialist. Other doctors may be concerned about prescribing pain medications because these drugs can be abused. However, people in pain are very unlikely to abuse pain medications.

Reluctance of patients to speak up about pain. A second factor might be a person's own reluctance. Some people might not want to "bother" their doctors with the information, or they may fear that the pain means that their cancer is getting worse. Some are reluctant to report it or report it as thoroughly as they should because they're worried about what doctors or others might think of them if they complain. They might feel that because they have cancer, they're supposed to have pain and be able to deal with it. That simply isn't true.

Fear of addiction. Another factor might be a person's fear of becoming addicted to pain medications. This is something that we know doesn't typically happen if you take medications for pain. If you take them when you're not in pain or to get high, then, yes, you can get addicted. But the risk of addiction for people who take pain medications in an appropriate fashion — for pain — is very low, so this shouldn't be a concern.

Fear of side effects. Some people fear the side effects of pain medications. Many are afraid of being sleepy, being unable to communicate with family and friends, acting strangely, or being seen as dependent on medications. People are also sometimes afraid that taking morphine may shorten their life. There is no evidence of any of these happening if the medication is dosed appropriately. And although strong pain medications can cause drowsiness when you first take them, that side effect usually goes away with steady dosing.

Fear of cost. What a cop out. The care of cancer is expensive. Yes pain medications are expensive but so is chemotherapy and radiation therapy. How about the cost of not treating the pain? ER visits for pain, hospitalization for pain, home expenses since patient is unable to care for themselves, etc.
Barriers to Effective Pain Management

• Problems related to health care professionals:
  ◦ Inadequate knowledge of pain management.
  ◦ Poor assessment of pain.[4-6]
  ◦ Concern about regulation of controlled substances.
  ◦ Fear of patient addiction.[5]
  ◦ Concern about side effects of analgesics.[4]
  ◦ Concern about patients becoming tolerant to analgesics.

• Problems related to patients:
  ◦ Reluctance to report pain.
  ◦ Concern about distracting physicians from treatment of underlying disease.
  ◦ Fear that pain means disease is worse.
  ◦ Concern about not being a “good” patient.
  ◦ Reluctance to take pain medications.
  ◦ Fear of addiction or of being thought of as an addict. (This fear may be more pronounced in minority patients.)[7]
  ◦ Worries about unmanageable side effects (such as constipation, nausea, or clouding of thought).
  ◦ Concern about becoming tolerant to pain medications.
  ◦ Poor adherence to the prescribed analgesic regimen.[8]
  ◦ Financial barriers.[5]
• Problems related to the health care system:
  ◦ Low priority given to cancer pain treatment.[4]
  ◦ Inadequate reimbursement for pain assessment and treatment.
  ◦ The most appropriate treatment may not be reimbursed or may be too costly for patients and families.[5]
  ◦ Restrictive regulation of controlled substances.
  ◦ Problems of availability of treatment or access to it.
  ◦ Opioids unavailable in the patient’s pharmacy.
  ◦ Unaffordable medication.
Recommendations:

Flexibility is the key to managing cancer pain. As patients vary in diagnosis, stage of disease, responses to pain and interventions, and personal preferences, so must pain management. The recommended clinical approach outlined below emphasizes a focus on patient involvement.

1. **Ask about pain regularly.** Assess pain and associated symptoms systematically using brief assessment tools. Assessment should include discussion about common symptoms experienced by cancer patients and how each symptom will be treated.[2,3] Asking a patient to identify his or her most troublesome symptom is also of clinical value because the most troublesome symptom is not always the most severe, as demonstrated in a survey of 146 patients in the palliative phase of treatment for lung, gastrointestinal, or breast cancer.[9]

2. **Believe patient and family reports of pain and what relieves the pain.** (Caveats include patients with significant psychological/existential distress and patients with cognitive impairment.)[10,11]

3. **Choose pain-control options appropriate for the patient, family, and setting.**

4. **Deliver interventions in a timely, logical, coordinated fashion.**

5. **Empower patients and their families.** Enable patients to control their course as much as possible.
Effective pain management is best achieved by a team approach involving patients, their families, and health care providers.

The clinician should:

- Initiate prophylactic anti-constipation measures in all patients (except those with diarrhea) before or during opiate administration. (Refer to the Constipation section in the Side Effects of Opioids section of this summary for more information.)
- Discuss pain and its management with patients and their families.
- Encourage patients to be active participants in their care.
- Reassure patients who are reluctant to report pain that there are many safe and effective ways to relieve pain.
- Consider the cost of proposed drugs and technologies.
- Share documented pain assessment and management with other clinicians treating the patient.
- Know state/local regulations for controlled substances.

In this summary, unless otherwise stated, evidence and practice issues as they relate to adults are discussed. The evidence and application to practice related to children may differ significantly from information related to adults. When specific information about the care of children is available, it is summarized under its own heading.

Fear of oncologists that offering narcotics suggests they are giving up on treating their patients cancer?
Polypharmacy

low doses reduce side effects while working synergistically at multiple sites along the pain pathway

a. Nsaid's joint pain
b. Muscle relaxants muscle pain
c. Sleeping medications
d. Nor epinephrine uptake inhibitors non narcotic pain signal blockers (also anti-depressant)
e. Narcotics mu receptor pain control
   Short acting
   Timed released

Nsaid's

Motrin qid
Naprosyn, Indocin, bid
Meloxicam q d
Celebrex, Naprolan, Vimovo q d
Muscle relaxants

a. Flexeril-Cyclobenzaprine hs improve sleep
b. Amrix timed release flexeril
c. Skelaxin-Metaxalone less sedation
d. Baclofen central muscle relaxant

Sleeping aids

a. Ambien-Zolpidem
b. Xanax-Alprazolam
c. Trazodone
d. Thorazine-Chlorpromazine
e. Seroquel-quetiapine fumarate

Sleep deprivation is horrific all on its own

Nor uptake inhibitors

a. Gabapentin-Neurontin
b. Gralise
c. Nortriptyline-Hydrochloride salt, Amitriptyline
d. Cymbalta-Duloxetine
e. Tramadol
f. Lyrica-Pregabalin
g. Savella - Milnacipran

Also have anti-depressant effects
Narcotics

a. Short acting
   a. Percocet - Oxycodone
   b. Vicodin - Hydromorphone
   c. Dilaudid - Hydromorphone
   d. Morphine IR

b. Timed released
   a. MSER
   b. Fentanyl patch
   c. Butrans-patch Buprenorphine
   d. Oxycontin - Oxycodone
   b. Opana - Morphine
   c. Avinza - Morphine
   d. Exalgo - Hydromorphone
c. Breakthrough

a. Percocet, Vicodin, dilauded 45 minutes
   Misses the episode completely
   Only has euphoric affect

b. Actique 30 min
   dental decay
   b. Accidental child exposure
   c. site irritation
   d. Diabetic sugar issues
   e. only 25% absorbed rapidly 75% swallowed

c. Fentora 15-20 min Better
   a. limited absorption ~ 50% in stomach
   b. site irritation
   c. Sugar

d. Subsys 5 min Best
Breakthrough Pain

**Definition:** BTCP is a transitory exacerbation, or flare, of mild to severe pain in patients with otherwise stable persistent pain

- **Characteristics:** (two studies, n=41 & n=11)
  - Time to peak intensity – 3-5 minutes
  - Duration (median) – 30 min
  - Episodes per day (median) – 4
  - Idiopathic or incident related (predictable or unpredictable)

- BTCP has been associated with poor medical outcomes and an increased burden on the healthcare system

- When assessing chronic adult pain, it is important to assess chronic pain as well as the frequency, onset, intensity, and duration of breakthrough cancer pain episodes

**Key:** Percocet, Vicodin and Dilaudid complete miss the episode
Actique and fentanyl get there late
Subsys hits it early and hits hard.
Temporal Characteristics of BTCP*

Note: BTCP episodes can last up to 240 minutes.

Median duration: 30 minutes

Time-to-peak intensity: 3 minutes

BTCP Episode

Baseline Pain in Cancer Patients

- SUBSYS may be appropriate for BTCP episodes with early time-to-peak intensity:
  - 5 min – 1st time point measured
  - 30 min – primary endpoint
- Potential to cover >80% of a median BTCP episode in some patients

SUBSYS® (fentanyl sublingual spray) [prescribing information]. Phoenix, AZ: INSYS Therapeutics, Inc.; March 2012

5. Cancer Pain Management Works

Cancer-related pain: a pan-European survey of prevalence, treatment, and patient attitudes.
Breivik H, Cherny N, Collett B, de Conno F, Filbet M, Foubert AJ, Cohen R, Dow L. Faculty of Medicine, University of Oslo and Department of Anaesthesiology, Rikshospitalet University Hospital, Oslo, Norway. harald.breivik@medisin.uio.no

Abstract

BACKGROUND:
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PATIENTS AND METHODS:
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CONCLUSIONS:
Across Europe and Israel, treatment of cancer pain is suboptimal. Pain and pain relief should be considered integral to the diagnosis and treatment of cancer; management guidelines should be revised to improve pain control in patients with cancer.


Chronic cancer pain can be successfully treated by about 95% of people with the drug and non-drug therapies that are currently available [Along with chronic cancer pain, sometimes people have acute flares of pain when not all pain is controlled by the medication or therapy. This pain, usually called breakthrough pain, can also be controlled by medications.

Effect of Neurolytic Celiac Plexus Block on Pain Relief, Quality of Life, and Survival in Patients With Unresectable Pancreatic Cancer
A previous study found that up to 85% of patients with advanced pancreatic cancer experience severe pain with advanced disease. Our results suggest that application of a pain management protocol, with or without NCPB, can maintain pain intensity in the "mild" category over time in most patients, even those with advanced disease.
The International Association for the Study of Pain defines pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Cancer pain can be managed effectively through relatively simple means in up to 90% of the eight million Americans who have cancer or a history of cancer. Unfortunately, pain associated with cancer is frequently under treated. [1]
CONSTIPATION

1. Diet: Fiber, fluids
2. Exercise Isometric, core
3. Laxatives
   Stimulants: Ducolax, Senokot
   Lubricants: Mineral oil
   Softeners: Colace
   Osmotic: Miralax
   Opioid antagonists: Relistor
Win Win Win

a. Patients feel better
b. Patients function better
c. Family members feel less helpless
d. Survival improves
e. Disease monitoring improves
Conclusion

a. Cancer pain is more prevalent than we realize

b. We have effective FDA approved treatments

c. These treatments are effective on multiple levels
   a. Control pain
   b. Improve function
   c. Improve quality of life
   d. Improve outcome
Abstract
While Judaism espouses the infinite value of human life, Judaism recognizes that all life is finite and, as such, its teachings are compatible with the principles of palliative medicine and end-of-life care as they are currently practiced. Jewish medical ethics as derived from Jewish law, has definitions for the four cardinal values of secular medical ethics: autonomy, beneficence, non maleficence, and justice, with the major difference between Jewish law and secular medical ethics being that orthodox or traditional Jews are perceived to limit their autonomy by choosing, with the assistance and advice of their rabbis, to follow God's law as defined by the Bible and post-Biblical sources. With an understanding of Jewish medical ethics as defined by Jewish law, various issues pertaining to the care of Jewish patients who are near the end-of-life can be better understood. Jewish tradition contains within its textual sources the concept of terminal illness. The shortening of life through suicide, assisted suicide, or euthanasia is categorically forbidden. For patients who are terminally ill, treatments that are not potentially curative may be refused, especially when harm may result. Under certain circumstances, treatments may be withheld, but active treatment already started may not usually be withdrawn. While patients should generally not be lied to regarding their conditions, withholding information or even providing false information may be appropriate when it is felt that the truth will cause significant harm. Pain and suffering must be treated aggressively, even if there is an indirect risk of unintentionally shortening life. Finally, patients may execute advance directives, providing that the patient's rabbi is involved in the process.

We are here to help people live long productive and healthy lives.
Keys to DEA:

- pain diagnosis
- Patient defines pain scale
- Access risk w. ORT
- Agreement
- REMS