Complicated pain

Dr Stephanie Lippett

UK incidence & prevalence of cancer pain

- 1% of UK population are living with cancer at present
- 70% of cancer patients experience pain
- 70-90% of patients with advanced cancer have chronic pain
- Cancer pain can be relieved in 80-90% of cases.

1. Cancer Research Campaign 1998
2. Mercadante, Cancer , 1999
3. Portenoy and Lesage, Lancet, 19999
4. Sykes et al., BMJ 1997

Cancer pain: room for improvement

In the last year of life

- 88% of cancer patients experienced pain
- 66% found the pain very distressing
- 61% experienced pain in the last week of life
- 47% received no/partial pain relief

Addington-Hall and McCarthy, Palliative Medicine Ann Oncol, 1995

CAUSES OF PAIN IN PATIENTS WITH CANCER

- Pain caused by cancer and other medical illnesses may be caused by either direct effect of the disease

OR

- By the treatment associated with the disease which injure organs,muscles and nerves.

CAUSES OF PAIN IN PATIENTS WITH CANCER

- 46% direct effect of cancer
- 29% indirect effects of constipation, pressure sores, inactivity, infection
- 8% concurrent disease e.g. arthritis
- 5% cancer treatment e.g. chemotherapy, surgery, radiotherapy
- 12% unknown

PAIN ASSESSMENT

- Patient self-report must be the primary source of information, because symptoms are inherently subjective.
- Assessment is to allow patients to describe aspects of their pain and condition
- Evaluation of pain in advanced cancer is primarily clinical and is based on PROBABILITY AND PATTERN RECOGNITION

PAIN ASSESSMENT

Remember that:

- mood
- morale
- Meaning of the pain to patient

all modulate the pain

PAIN ASSESSMENT

• Physical	PQRST
• Functional	effects on daily living
• Psychological	mood/relationship/support
• Spiritual	fears/hopelessness/guilt

WHAT DO WE ASK?

P	Palliative factors Precipitating factors
Q	Quality of pain
R	Radiation of pain
S	Site & severity of pain
T	Timing factors

Twycross, Introducing Palliative Care 1999

HOW DO WE MEASURE SEVERITY?

Verbal rating scale	Numerical rating scale	Visual analogue scale (100mm)	Pain faces
Severe	7-10	>54	
Moderate	5-6	>30 mm	
Mild	1-4	-	
None	0	-	

WHO steps

Step 1: Mild Pain
Non-opioids (e.g. aspirin or paracetamol+/- adjuvants

Step 2: Moderate Pain
'weak opioids (e.g codeine) +/- non opioids +/- adjuvants

Step 3: Severe Pain
'strong' opioid (eg Morphine, fentanyl) +/- non-opioid +/- adjuvants

BONE PAIN

- Often dull pain/aching
- Can be severe
- Can be incident-related
- There can be reactive muscle spasm

TREATMENT

- Analgesics – WHO ladder
- Radiotherapy (choice when localised metastatic bone pain)
- Treatment of underlying cause eg., chemo in breast cancer
- Bisphosphonates (not 1st line)
- Steroids

Bone pain DRUGS

- Don’t forget paracetamol
- NSAID’S – (? ppi cover)
- WHO steps
- opioids
- May not fully respond to strong opioid

BACK PAIN

- Vertebra most common site for bone metastases (eg., lung, breast, prostate)
- ALWAYS consider spine cord compression if there are any symptoms or signs (limb weakness, sensory impairment, brisk reflexes, loss of sphincter control)

INTESTINAL PAIN

- Colicky in nature, may be on top of a more constant pain
- Think about:
  - constipation
  - diarrhoea
  - nausea/vomiting
- Drugs – opioids/antispasmodics (Buscopan)
- Remember: prokinetics like metoclopramide are likely to exacerbate the pain

HEPATIC PAIN

- Liver capsule stretch
- Dull, aching, RUQ
- May radiate to shoulder
- Drugs – steroids, opioids

PELVIC PAIN

- neuropathic pain is common

NEUROPATHIC PAIN

40% of cancer patients get neuropathic pain

Most likely cancers causing it are:

- Mesothelioma
- Head/neck cancer
- Pancreatic
- Pelvic
- Haematological

DIAGNOSING

- Tingling/pins and needles
- Burning
- Shooting/stabbing
- Any loss/alteration of sensation
- Allodynia – pain evoked by stimulus that's not normally painful
- Often only partially opiate-responsive

TREATING

- Talk to patient
- First is trial of opiates or adjustment of regimen
- NSAID
- Tricyclic antidepressant (amitriptyline)
- Duloxetine possible alternative.
- Anticonvulsant (gabapentin,pregabalin)
- Ketamine (palliative specialist initiation)
- Others (nerve block etc,.)

GOOD PRACTICE IN CANCER PAIN MANAGEMENT

- Don't change to an alternative analgesic before optimising the dose and timing of the previous one
- Combine analgesics appropriately
- Don't be reluctant to prescribe morphine

Summary

Assessment

Multifactorial

- patient assessment
- team members needed
- cause not always apparent

Management

Analgesics according to WHO principles

Integrate appropriate strategies