Individualizing a cancer pain management strategy: Beyond the basics

HOT SPOT

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What's new?

- Both new knowledge regarding the pathophysiology of cancer pain and an increased understanding of the neuropathic contribution have led to refined approaches in cancer pain assessment and management while reinforcing basic principles that have previously outlined an approach.
- The WHO "ladder" was a successful strategy as a response to worldwide poor cancer pain control by outlining a basic step-wise approach for clinicians.
- In a similar way that "restaging", provides guidance to oncology teams in their decision making, ongoing assessment of pain management plan efficacy serves to guide the appropriate use of adjuvant medications (anticonvulsants, antidepressants, or corticosteroids) and adjuvant interventions (nerve blocks, vertebroplasty and intraspinal analgesia)
- The result can be a targeted and individualized pain management plan.

Screening

- Rapidly identifies patients with pain who require a more thorough assessment.
- In general, use of a valid and reliable symptom screening tool (ESAS) is an efficient strategy to identify patients experiencing physical and/or psychosocial distress.
- Earlier symptom intervention may prevent escalation and eventual crisis.

Assessment

Basic

- Determine type of pain, its onset, intensity, duration, location, temporal pattern, triggering and relieving factors and other associated symptoms.
- Review the use of current and past analgesics, their effectiveness or lack thereof, as well as side effects and reasons for discontinuation/change.
- Determine the patient's current functional status.
- Complete a targeted physical exam and determine if additional radiological or biochemical investigations are appropriate.

Individualize

- Assess whether the pain interferes with the patient's activities at work/home, social life, mood or relationships with others.
- Determine the level of caregiver support.
- Assess the patient's knowledge of the disease process, psychological status (anxiety, depression or suicidal ideation), social environment at home, quality of life, and spiritual needs.
- Evaluate the patient's and caregiver's knowledge of analgesics and whether there are concerns related to the use of opioids.

Management

Basic

- Establish and implement a plan:
  - Do not delay treatment of pain
  - Develop a plan consistent with the patient's/caregiver's goals and expectations
  - Implement pharmacologic pain management therapy appropriate to the clinical situation (see specific medication guidance below)
  - Educate patient and caregiver.

Individualize

- Reassess patient and modify the care plan:
  - Assess effectiveness of the pain management strategy
  - Assess for side effects of therapy
  - Consider adjuvant strategies
  - Start psychosocial interventions as appropriate.

Principles of pharmacologic treatment of cancer pain

Basic

- Choose a medication and a routine appropriate for the patient's level of pain:
  - If pain is moderate or severe and constant, begin with around the clock opioid administration
  - Consider choosing hydromorphone if patient's renal function is compromised.
- Choose an appropriate dose:
  Initial dosage of morphine (or equivalent) in opioid-naïve patient:
  - Fit patient: Morphine 5mg po q4h or equivalent
  - Frail patient: Morphine 2.5mg po q4h or equivalent
  - Can titrate daily until pain relief or unacceptable side effects.

  For patients already using opioids routinely:
  - Ensure adequate breakthrough (10% of total daily dose q1h prn)
  - Continue to titrate as necessary
  - Individualize!

Individualize

- Often pain is not fully relieved by opioids alone. This may be a clue a neuropathic component is present.
- Consider earlier addition of a neuropathic adjuvant medication.
- For certain types of pain and clinical scenarios (e.g., nociceptive visceral pain associated with pancreatic cancer or vertebral mets in multiple myeloma), consider early adjuvant intervention.

Helpful hints/facts

- Use of fentanyl patches is contraindicated in opioid-naïve patients.
- One Percocet is equivalent to 10mg of po morphine.
- Patients on routine Tylenol 3 are not opioid-naïve.
- Use route of administration most appropriate for the patient.
- Prevent, anticipate and manage side effects.

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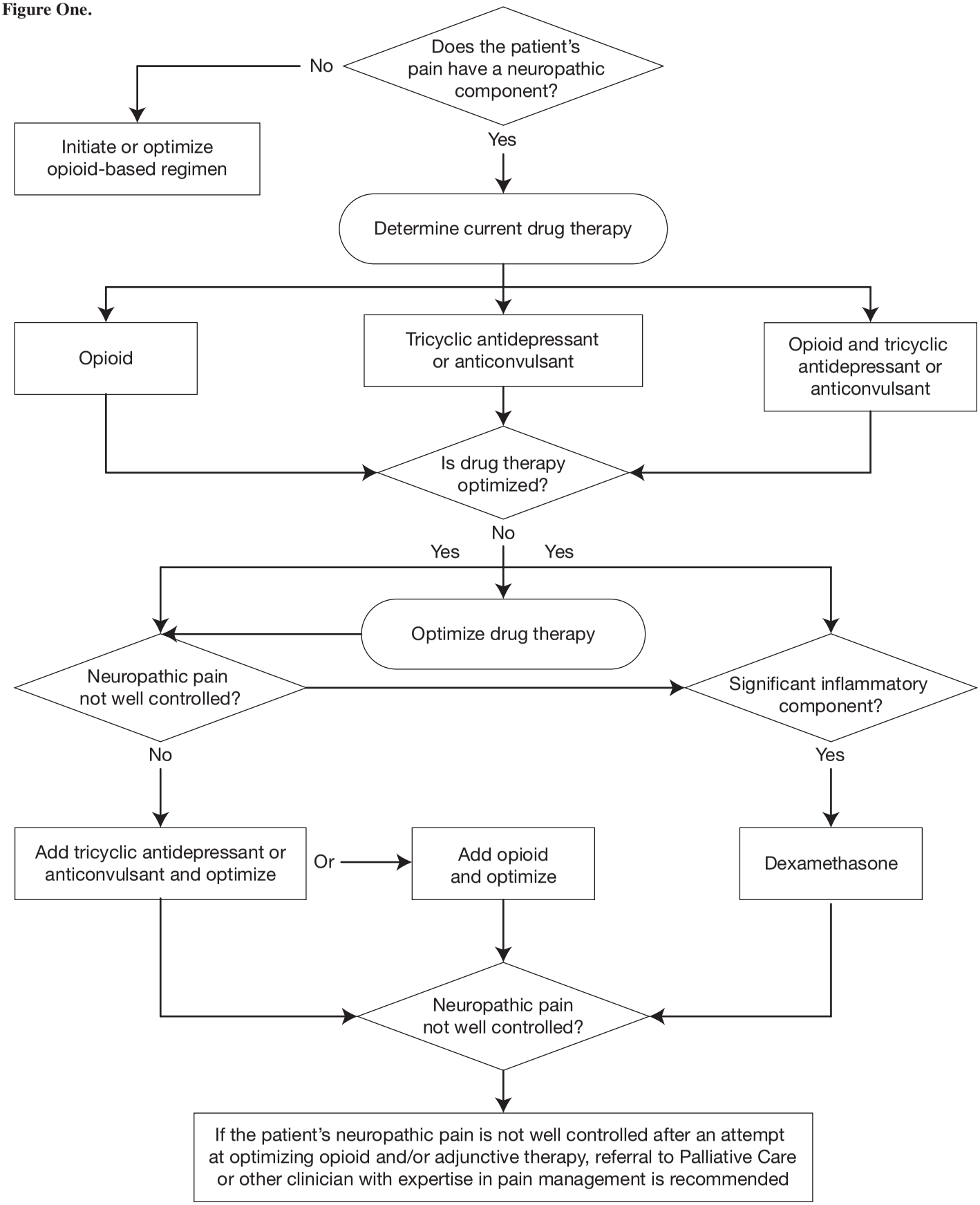
Figure One.


Does the patient's pain have a neuropathic component?
No
Initiate or optimize opioid-based regimen
Yes
Determine current drug therapy
Opioid
Tricyclic antidepressant or anticonvulsant
Opioid and tricyclic antidepressant or anticonvulsant
Is drug therapy optimized?
No
Yes
Yes
Optimize drug therapy
Neuropathic pain not well controlled?
Significant inflammatory component?
No
Yes
Add tricyclic antidepressant or anticonvulsant and optimize
Or
Add opioid and optimize
Dexamethasone
Neuropathic pain not well controlled?
If the patient's neuropathic pain is not well controlled after an attempt at optimizing opioid and/or adjunctive therapy, referral to Palliative Care or other clinician with expertise in pain management is recommended