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Acute Pain in Palliative Care

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Outline

- Supportive and Palliative Care
- Causes of pain
- Treatment options
- Challenges and opportunities
- Summary

What is Palliative Care

- End of life care /Hospice Care
- Supportive Care
- Acute Palliative Care
- Survivorship

“Terminology Overload “

Supportive and Palliative Care Teams (SPCT)

Supportive Care :

- Management of complex refractory symptoms
- Early intervention to improve quality of life and compliance to treatment
- Holistic care
- Cancer survivors

End of Life Care :

- Decision making: Prognostication , ACP
- Co ordination of care
- Holistic care
- Individualised care planning in last days of life

"Palliative care is needs based ; not prognosis based "

Total Pain

- Concept of Total Pain

- Physical pain
1. Disease related
2. Post Treatment

- Psychosocial

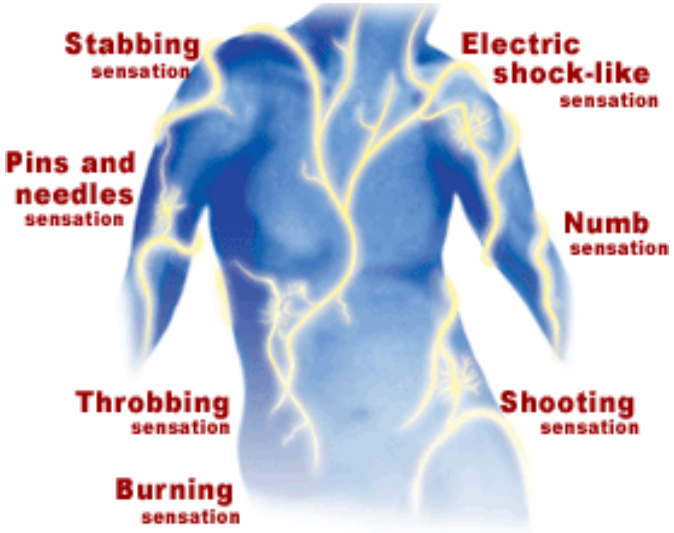
- Spiritual : “Why Me?”

Understanding of the Concept of "Total Pain": A Prerequisite for Pain Control. Mehta et al Journal of Hospice & Palliative Nursing. Issue: Volume 10(1), January/February 2008, pp. 26-32

Physical Pain

- Nociceptive
1. Somatic
2. Visceral

- Neuropathic
1. Nerve Injury
2. Nerve Compression



- Most cancer pains are of mixed aetiology

Pain -Classification

- **Persistent Background Pain**

Constant or continuous pain that is experienced by the patient for more tan 12hrs/day

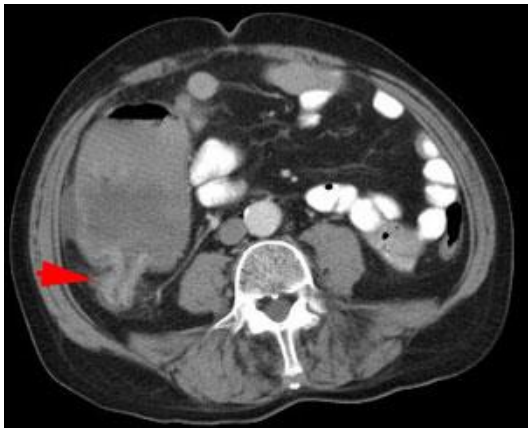
- **Breakthrough Pain (BTcP)**

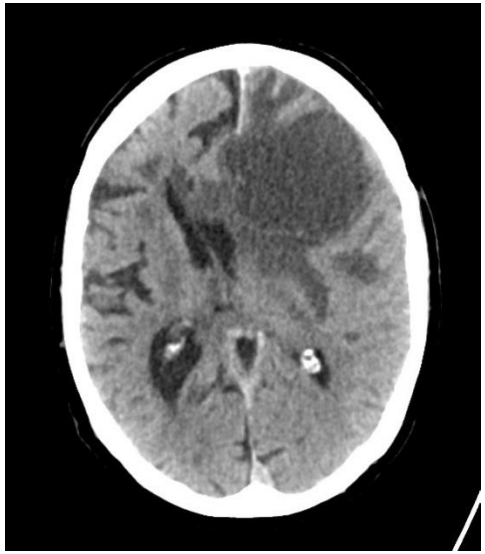
Pain flare that occur beyond the persistent pain

Pain –Causes

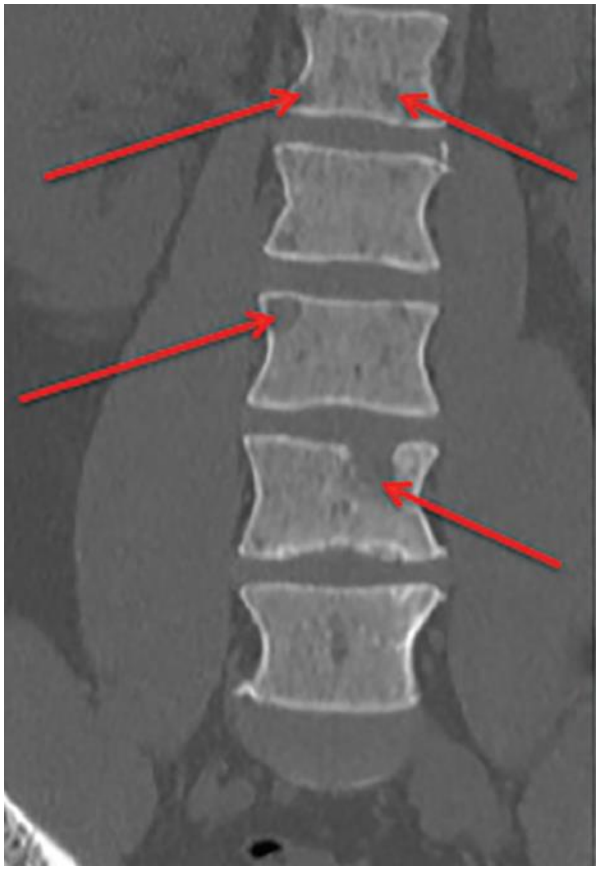
Disease related:

- Visceral pain : Tumour bulk, Mets, Lymph node disease
- Bowel Obstruction, haemorrhage
- Raised ICP (Cerebral Mets)



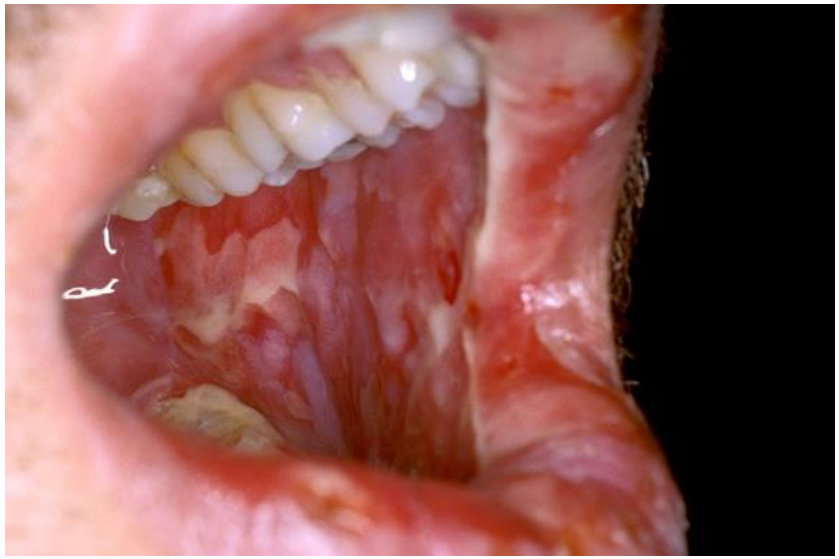


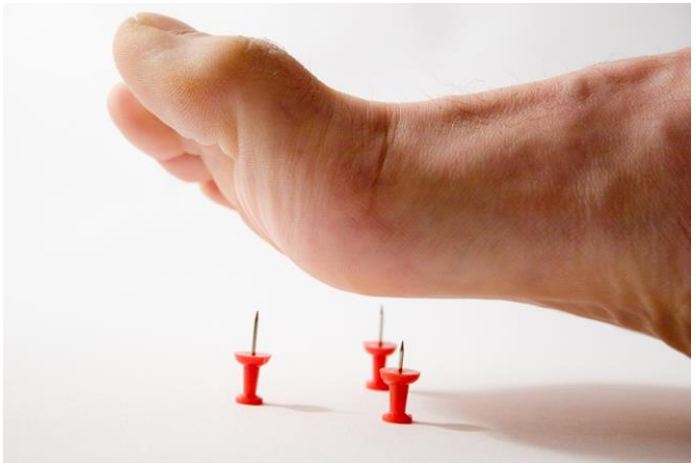
- Bone Pain
- Vertebral mets
- Pathological fracture
- Muscle spasms



Treatment Related

- Post XRT
- Peripheral neuropathy post chemotherapy
- Post Surgical pain
- Oral and GI Mucositis post Chemo and HSCT

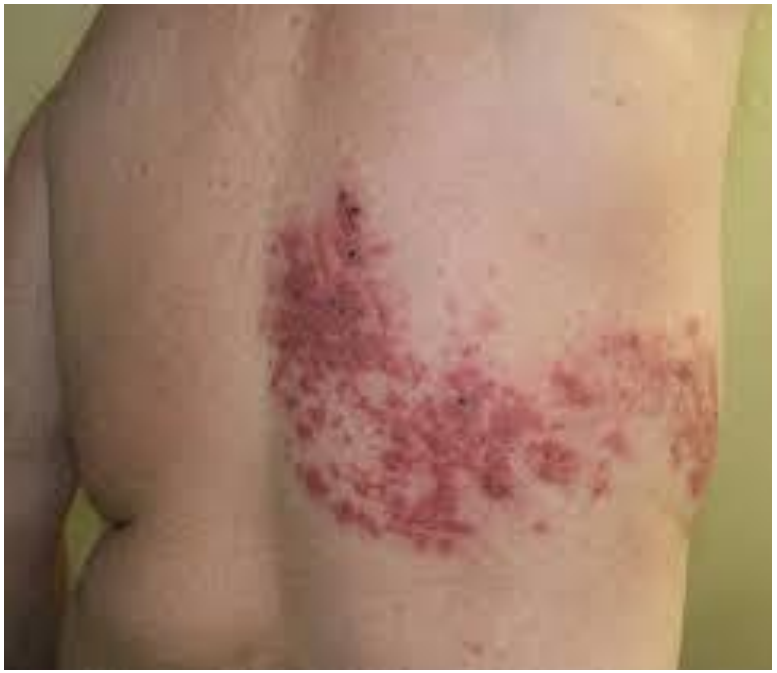




Concurrent Problems

- Constipation
- Pressure areas
- Herpes Zoster
- Co morbidities :

i. IHD-Angina
ii. Osteoporosis
iii. Arthritis



Barriers to Pain Control

- Perception : “patient not there yet !”
- Lack of robust evidence base
- Individual variations in practise

Pain Management

Pharmacological Therapies

Opioids

- **Common opioids :**

I. Morphine –PO, SC
II. Oxycodone-PO, SC
III. Alfentanyl –S/L , SC

- **Transdermal :**

I. Fentanyl patch
II. Buprenorphine

- **Less Common**

I. Methadone

- **Fast acting fentanyl preparations:**

I. Abstral - sublingual
II. Pecfent -Intranasal

Opioids -Challenges

- Stigma !
- Overreliance
- Long term effects

I. Tolerance
II. Risk of dependence
III. Immunosuppression
IV. Testosterone suppression

Co -Analgesics

- Anti-inflammatory :NSAIDS/Steroids
- Neuropathic agents

I. Anticonvulsants, TCA

II. SNRI-Duloxetine

Benzodiazepines :

I. Clonazepam

II. Lorazepam

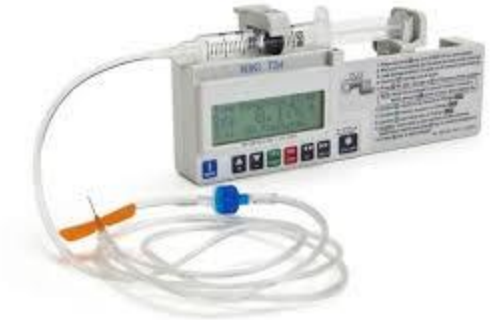
- Antispasmodics : Hyoscine
- Somatostatin Analogues : Octreotide

- Topical Agents :
- Lidocaine Plasters
- Capsacin patches

- Other Analgesia
- Ketamine

Continuous Subcut Infusions

Advantages:



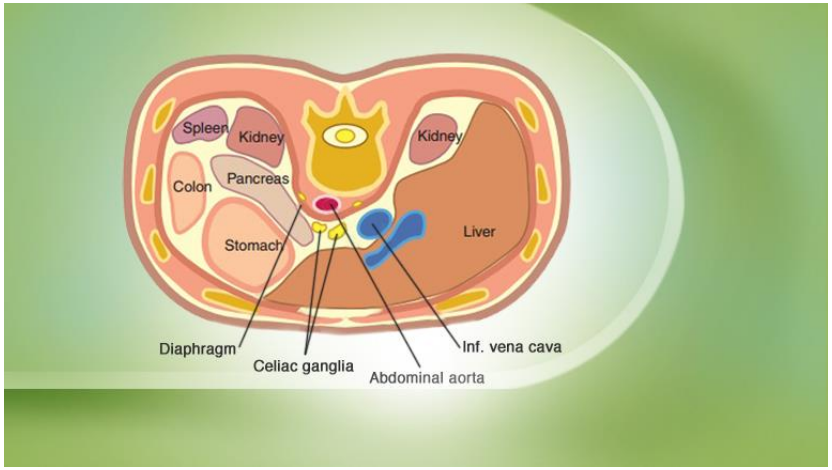
- Faster delivery Vs PO
- Safer than IV infusions
- Multidrug infusions
- Can be initiated in the community

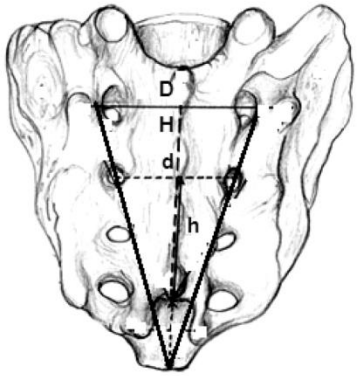
Limitations

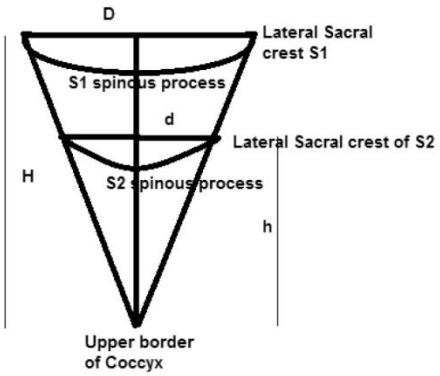
- S/C site reactions
- “Bulky”
- Social Stigma (synonymous with EOL care)

Interventional Procedures

- Collaboration with the pain team
- Coeliac plexus block
- Caudal Block
- Cordotomy
- Local nerve blocks







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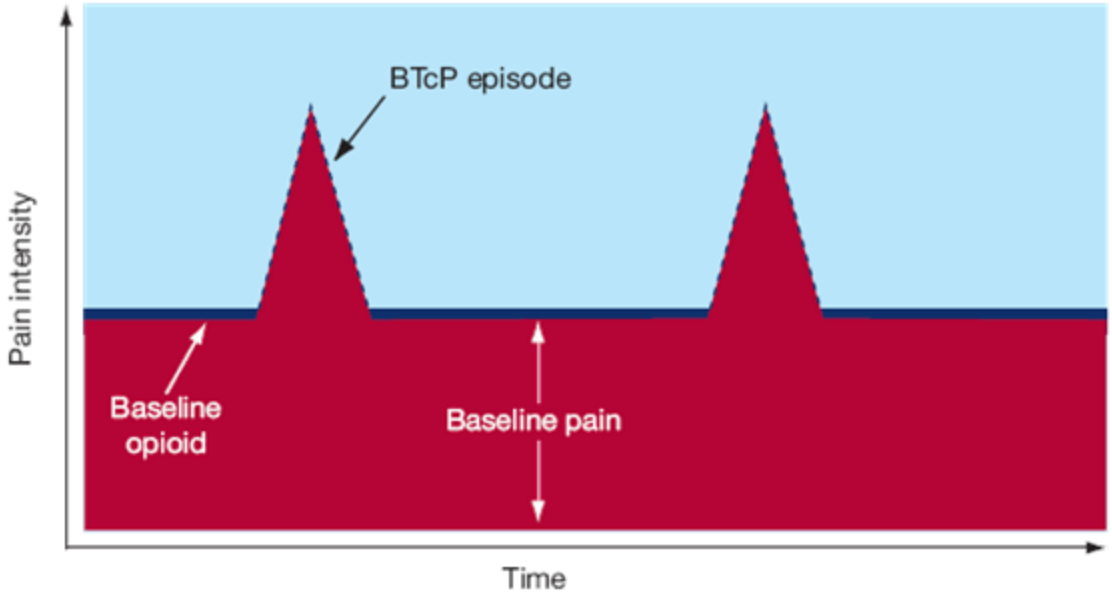


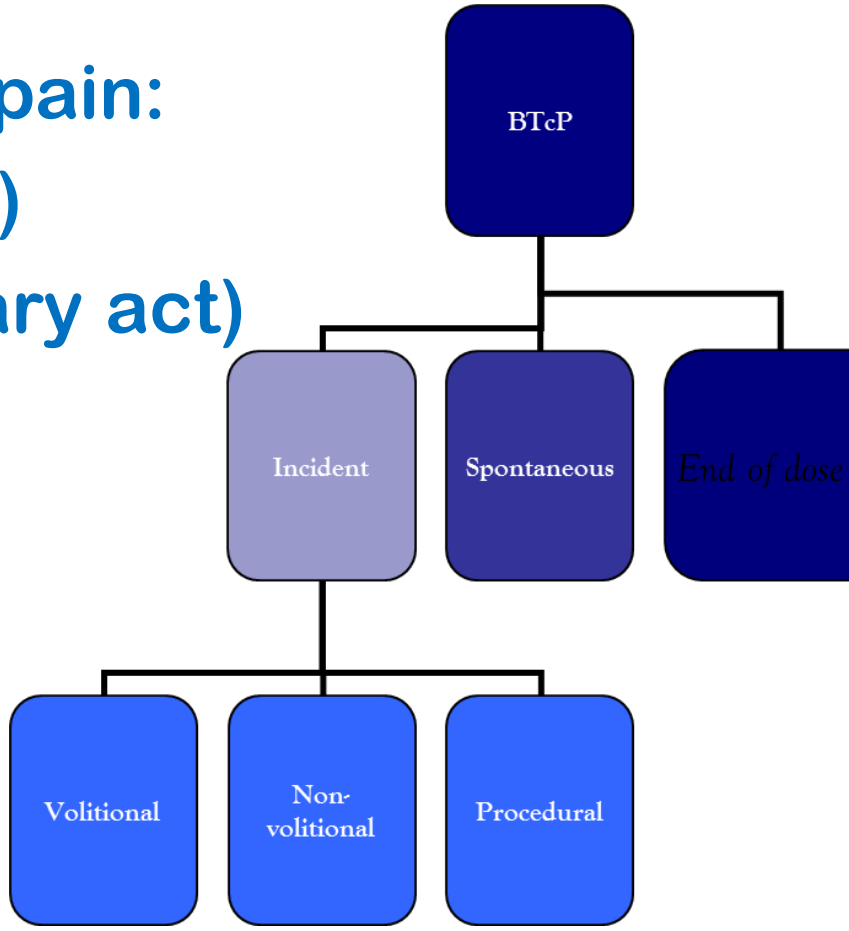
BTcP refers to the pain flares that occur beyond the baseline persistent pain[1]

Breakthrough Cancer Pain- BTcP

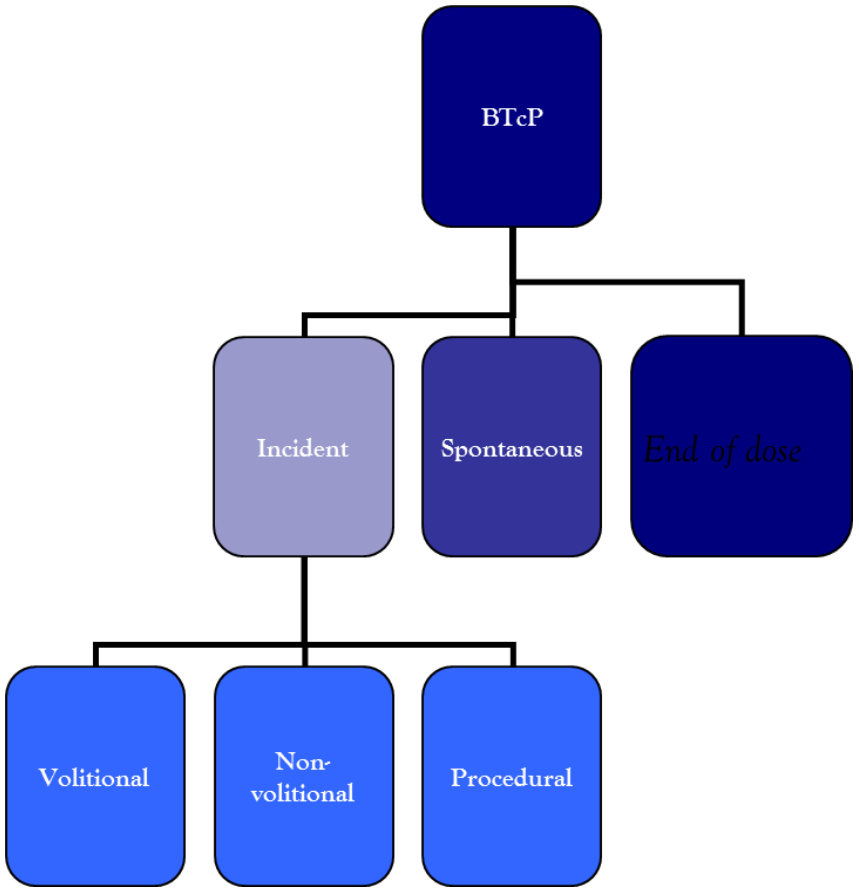
- Incident ('precipitated') pain:

1. volitional (voluntary act)
2. non-volitional (involuntary act)
3. procedural

(therapeutic intervention)



- Spontaneous ('idiopathic') pain:
- cannot be predicted
- End-of-dose failure:
  - related to analgesic dosing



Potential Impact of BTcP 1-3

Physical complications:

- Impact on mobility (e.g. walking)
- Sleeping difficulties
-

- Psychological complications:
- Mood disturbance
- Anxiety
- Depression

- Social complications:
- Unable to participate in daily life activities
- Unable to work

1. Caraceni et al. *Palliat Med* 2004;18:177-83
2. Hwang et al. *Pain* 2003;101:55-64
3. Portenoy et al. *Pain* 1999;81:129-34

Breakthrough Pain:BTcP

Clinical Features of BTcP

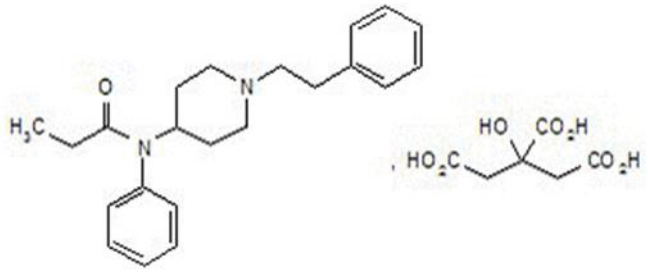
- Time to Peak severity :3-5 min
- Intensity : Severe to excruciating
- Duration :15-20 min

Immediate Release PO opioids

- Time to peak :15-30 min
- Duration -2-4 hrs

Fast Acting Fentanyl

- Highly lipophilic
- Potent Analgesic
- Rapid onset of action
- Various methods of delivery



Rapid Acting Fentanyl

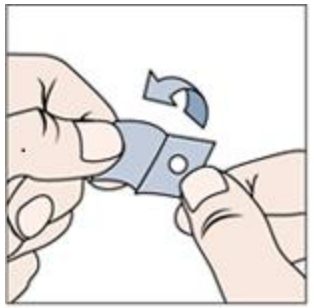
- OTFC
  - Actiq
  - Buccal(Effentora)
  - Sublingual (Abstral)
- Intranasal
  - Instanyl
  - Pecfent

Abstral®
(fentanyl) sublingual tablets

Fast Acting Fentanyl

- Abstral –sub Lingual
- Dose range 100-800mcg
- Pecfent –Intranasal Fentanyl
- Dose range -100-400mcg

- Onset of action 5-15 min
- Duration of action 1-2 hrs



STEP 1: Peel

STEP 2: Place

BTcP

- Pre-emption
- Patient Education
- Analgesia pre movement/ physical exertion
- *Fast acting fentanyl –Abstral, Pecfent

**(patient selection is important and use should be monitored closely)*

Non Pharmacological

- Physiotherapy
- CBT
- Complimentary therapy
- Virtual reality

Pain in the Dying phase

- Worsening Symptoms
- Co symptoms :
- Anxiety, confusion, agitation
- Use of CSCI and PRN meds
- “One chance to get it Right”

Acute Pain in Palliative Care

Key Messages :

- Pain in multifactorial
- Total Pain
- Combination therapy
- Non Pharmacological measures
- Use of technology
- Collaborative work with pain teams

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Thank You

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