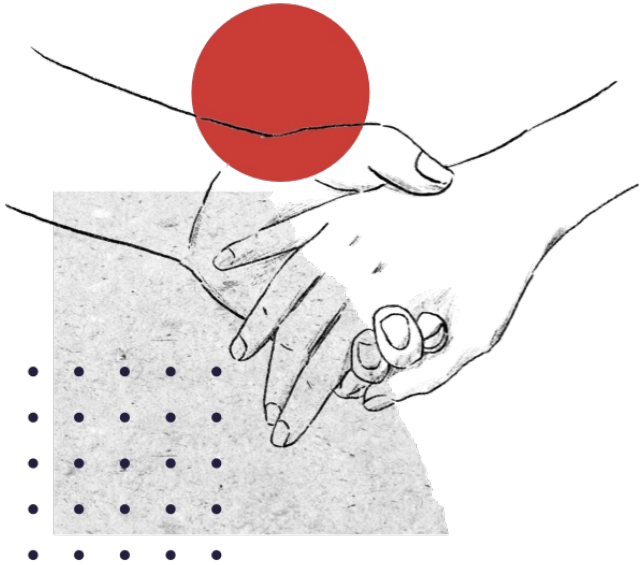


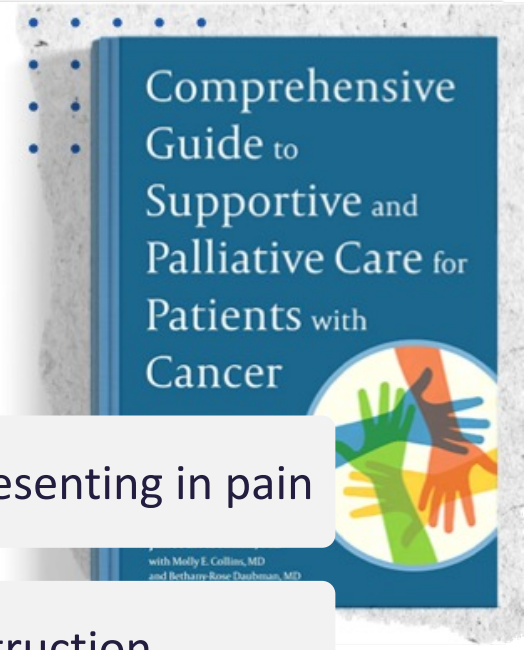
Managing Pain in Cancer Patients

Janet Abrahm, MD, FACP, FAAHPM

Professor of Medicine, HMS

Institute Physician, DFCI

2023-4 Pall Care Curriculum



- Participate in the assessment, diagnosis and management of a variety of patients presenting in pain
- Approach to patients with nausea, vomiting, constipation, and malignant bowel obstruction
- Recognize and treat psychological disorders in your cancer patients
- Communication and special topics
- End of life care, grief, bereavement, burnout

Today's Goals

- Participate in the assessment, diagnosis and management of a variety of patients presenting in pain
- Use the 'pink book'
- Discuss Health Equity as it related to the care of patients with pain
- Your questions!

- You are asked to see Lashonda Smith, a professional golfer who had Stage III A triple negative right sided breast cancer 6+ nodes treated with mastectomy/ axillary dissection
- Completed her adjuvant chemo and XRT 2 years ago
- Competing abroad
- Now: pain 9/10 in right arm and shoulder; atrophy right hypothenar muscle
- She was evaluated recently in the ED and given Tramadol 50 mg po tid prn

30Lower is better06/2/2210:15 AM06/9/22 9:28 AM06/30/22 9:38 AM09/1/22 9:30 AM010/21/22 8:52 AM012/1/2211:51 AM11/26/2310:47 AM37/6/2312:59 PM

Esym or PROMS

Pain		**3 Abnormal**
Nausea		**1**
Vomiting		**1**
Diarrhea		**0**
Constipation		**0**
Shortness of breath		**1**
Fatigue		**2**
Anxiety		**0**

Would they have asked that if her name was Melanie?

If the ED clinician was a non-Hispanic white or a person of color,

would that alter their assessment of her complaint?

Would it alter Lashonda's pain report to them?

Or if she perceived them as male or as female?

Would they have asked that if her name was Melanie

and she was white?

Would she have been treated sooner?

Received the appropriate opioid dose?

… LS …

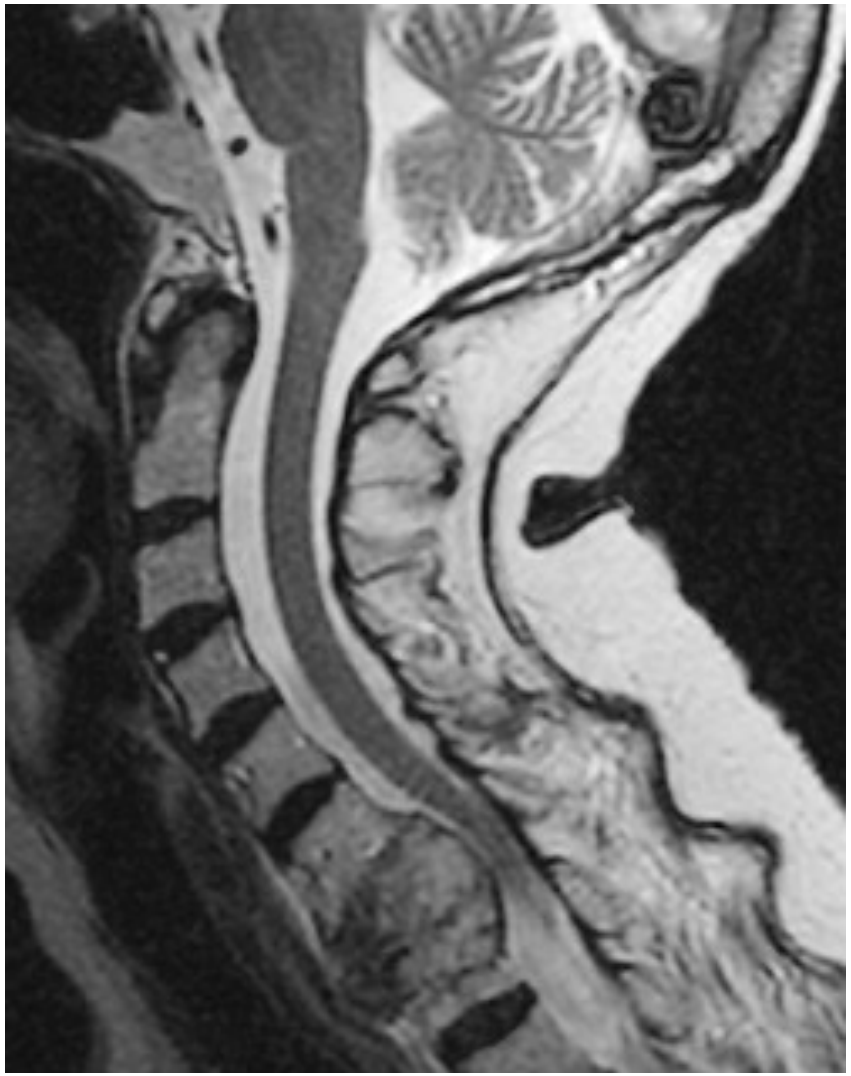
- On further questioning, she described the pain as burning, shooting down her right arm
- Her pain ranges from 6/10 to 15/10
- She has not slept well x2 weeks due to pain
- The pain interferes with her ADLs, work and family responsibilities
- She denied any trauma, unusual activity, persistent cough, or fever
- Acetaminophen 1000 mg 3x/day and Tramadol 50 mg po 3x/day have provided little relief

Explore Prior Evaluation/Treatment

- Interventional procedures
- Side Effects of pain therapies
- Why did Lashonda wait so long to report it? What does she think is causing it?
- Identify new possible etiologies

Where's the Lesion??

- Spinal cord compression
- Jugular foramen metastasis
- Brachial plexus infiltration
- Lung metastasis growing into brachial plexus
- Radiation fibrosis?



MRI OF LESION

Janet Abrahm, M.D.

Cancer Pain Syndromes

Treatment related

- Hand/foot syndrome
- Peripheral neuropathies
- Oral mucositis
  - Radiation
  - Chemotherapy
  - Neutropenia
  - Thrush
- Radiation plexopathy (brachial plexopathy)
- Myalgias
  - Aromatase inhibitors

Foley, KM. Acute and chronic cancer pain syndromes: Oxford Textbook of Palliative Medicine, Third Edition. New York: Oxford University Press 2004. pp. 298-316.

Cancer Pain Syndromes

Disease related

- Pathological fracture
- Tumor hemorrhage
- Obstruction/perforation of hollow viscus
- **Bone metastasis (Odontoid, C7 and T12 syndromes)**
- **Leptomeningeal metastases**
- **Spinal cord compression**

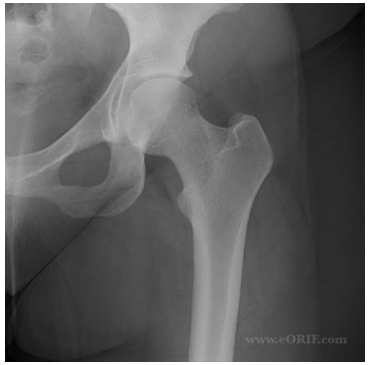
Foley, KM. Acute and chronic cancer pain syndromes: Oxford Textbook of Palliative Medicine, Third Edition. New York: Oxford University Press 2004. pp. 298-316.

Referred Pain Syndromes

Referred Pain Syndromes

Leptomeningeal disease

C7-T1



T12

Odontoid / atlas

Lashonda's management plan

Radiation therapy to lesion

- Dexamethasone during and after XRT

Systemic antineoplastic therapy

Pain management

- Opioid: Fentanyl with prn morphine rescue*
- Gabapentin / pregabalin*
- * Is she likely to have any difficulty filling these prescriptions in her local pharmacy?
- Laxative regimen to prevent constipation

Counseling

Which doesn't belong … and why?

- Metamucil
- Miralax
- Senna
- Dulcolax

What meds are best for her?

She chronically has hard stools

She has not had a bowel movement in 5 days

She is lactose intolerant

3 days later, she hasn't responded to anything else and she's still on opioids

Newer agents??

Time for a Break!

SSSTTRREEETTTCCCHHH!!!!!

Enrique…

Enrique is a 65 yo man with metastatic colon cancer and marked hepatomegaly

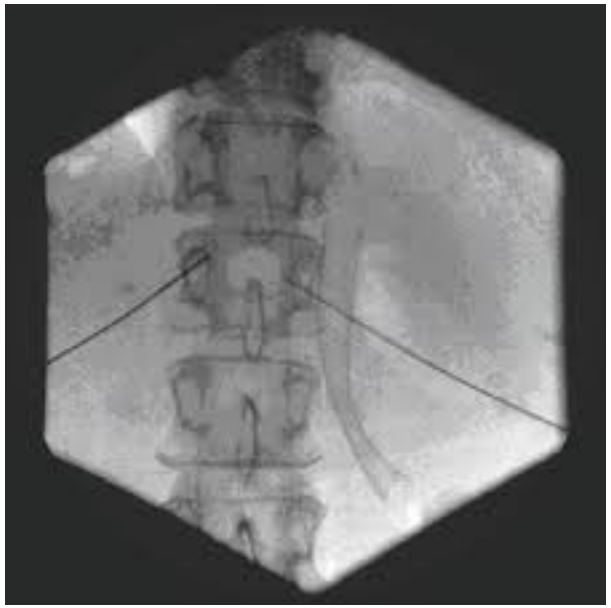
He is presents to clinic with complaints of severe RUQ pain

Corticosteroids are added for pain due to distention of the liver capsule

Opioid selection / delivery

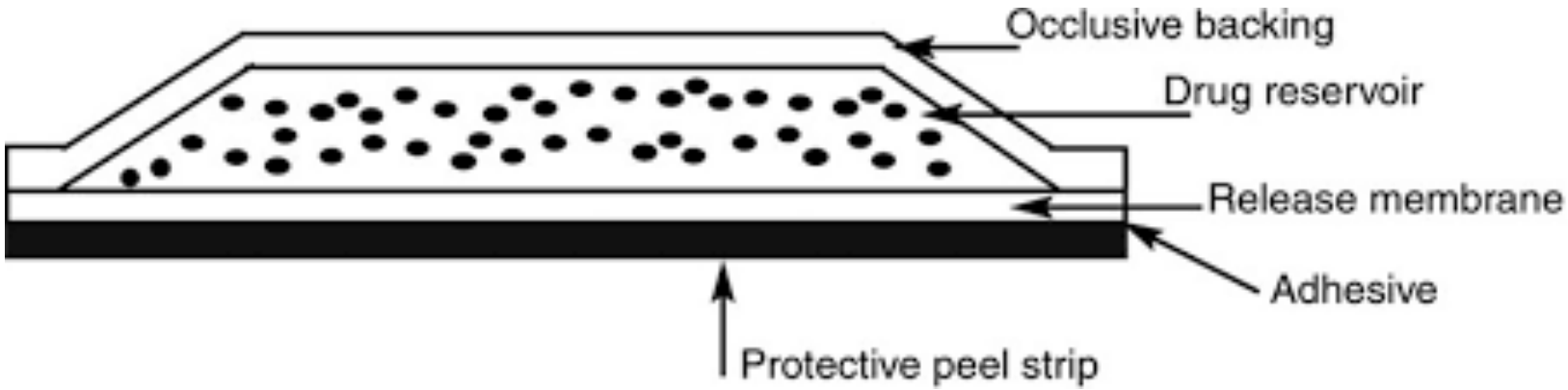
- Enrique has no significant PMH except for cancer.
- Used to drink beer on weekends; does not smoke, denied past or present use of illicit drugs.
- Reports nausea with the use of codeine after his surgery by has no known drug allergies. Currently taking APAP
- LEP with Spanish as his preferred language
- Are you concerned that there will be barriers to getting him the medications he needs in a timely manner?

Celiac block?



PRN to SR morphine

- Enrique took 5, 15 mg MSIR tablets daily over the past 2 days with adequate relief for 1-2h
  - Total OME: 75 mg / 24 h
  - Sustained release morphine: 30 mg po q8h
  - Rescue 7.5-15 mg po q3h prn



Enrique's daughter asks about a pain patch

What dose patch would you start with?
Where would he put it?

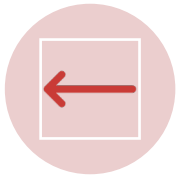
How can you help them decide?

Source of pain: nociceptive vs neuropathic

Pattern of pain: chronic vs intermittent

Absorption barriers

What worked/didn't work before



Renal/hepatic function

Health literacy

Cost

Availability in their neighborhood

Opioid Options for Enrique

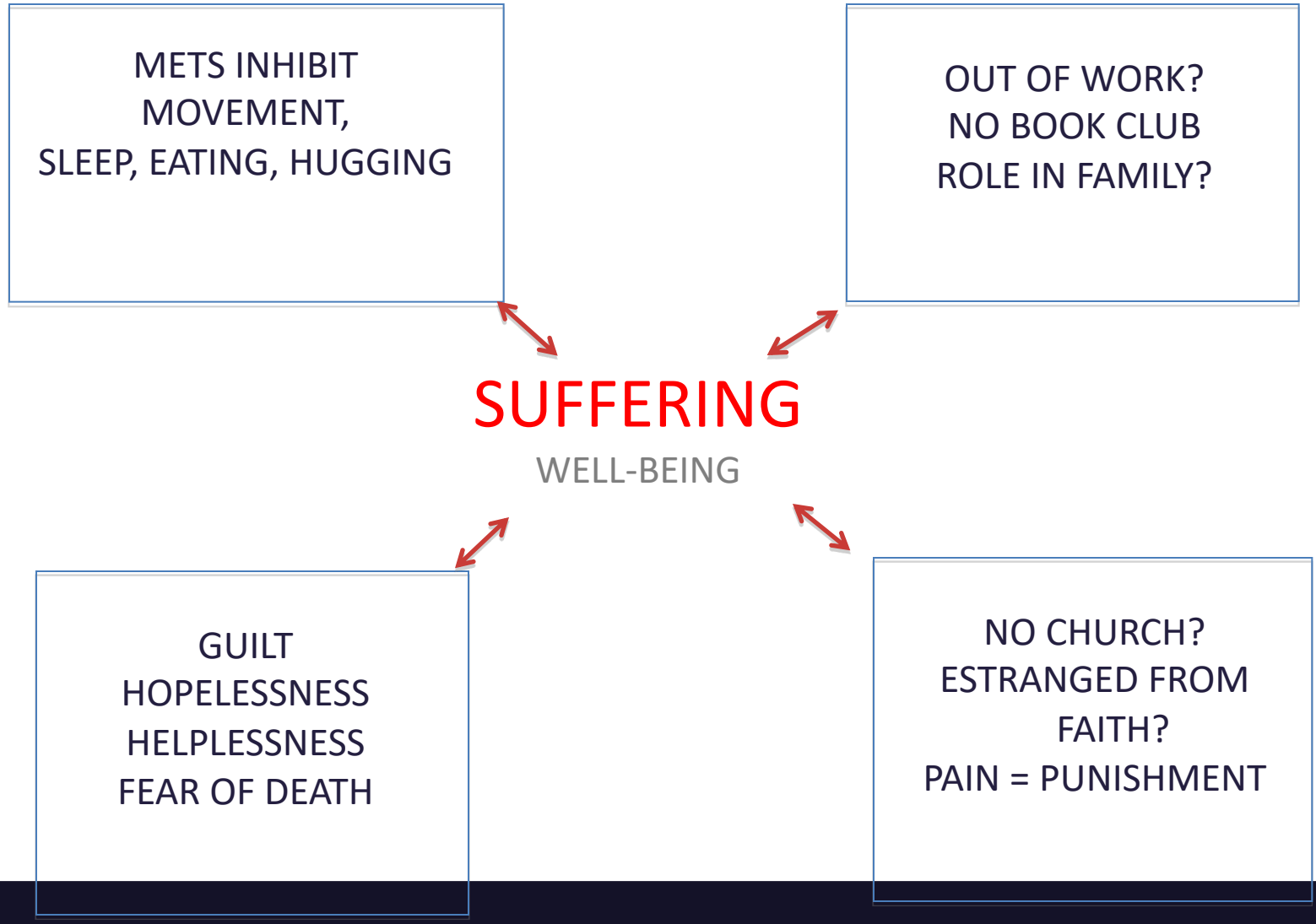
	Morphine SR	Fentanyl Patch
Cost	$	$$
Absorption	Oral	Fat pad
Health Literacy	Needed	Nurse can place
Renal Failure	Active metabolite buildup	No dose change needed

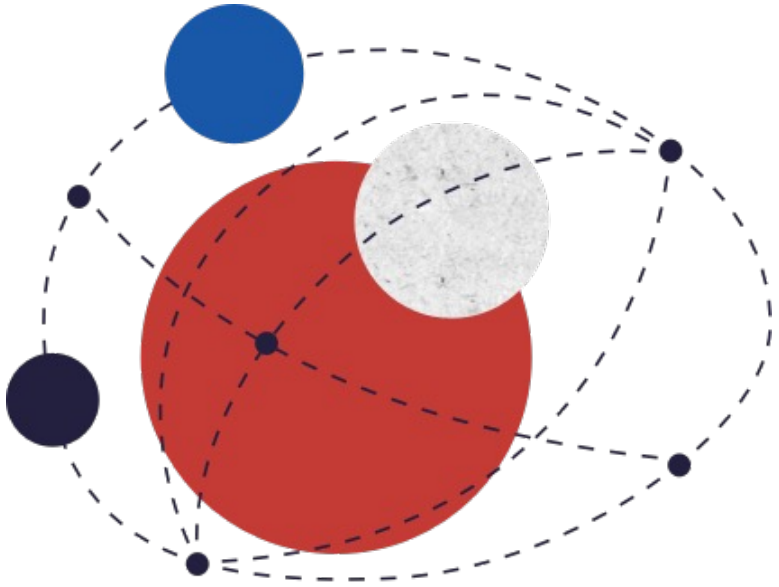
Geoffrey England

- 1 year after his diagnosis of non-small cell lung cancer, Geoffrey presents with a 2-week h/o worsening L anterior chest pain – “It feels like the pain in my ribs; it hurts when I cough and with any twisting movement.”
- His pain ranges from 3/10 to 6/10. Since he’s right-handed, the pain does not interfere with his ADLs, work and family responsibilities
- Ibuprofen 600 mg po tid has provided some relief
- Rib films reveal changes c/w metastatic disease and XRT is planned

What else is contributing to Geoffrey's pain?

Geoffrey's Altered Personhood

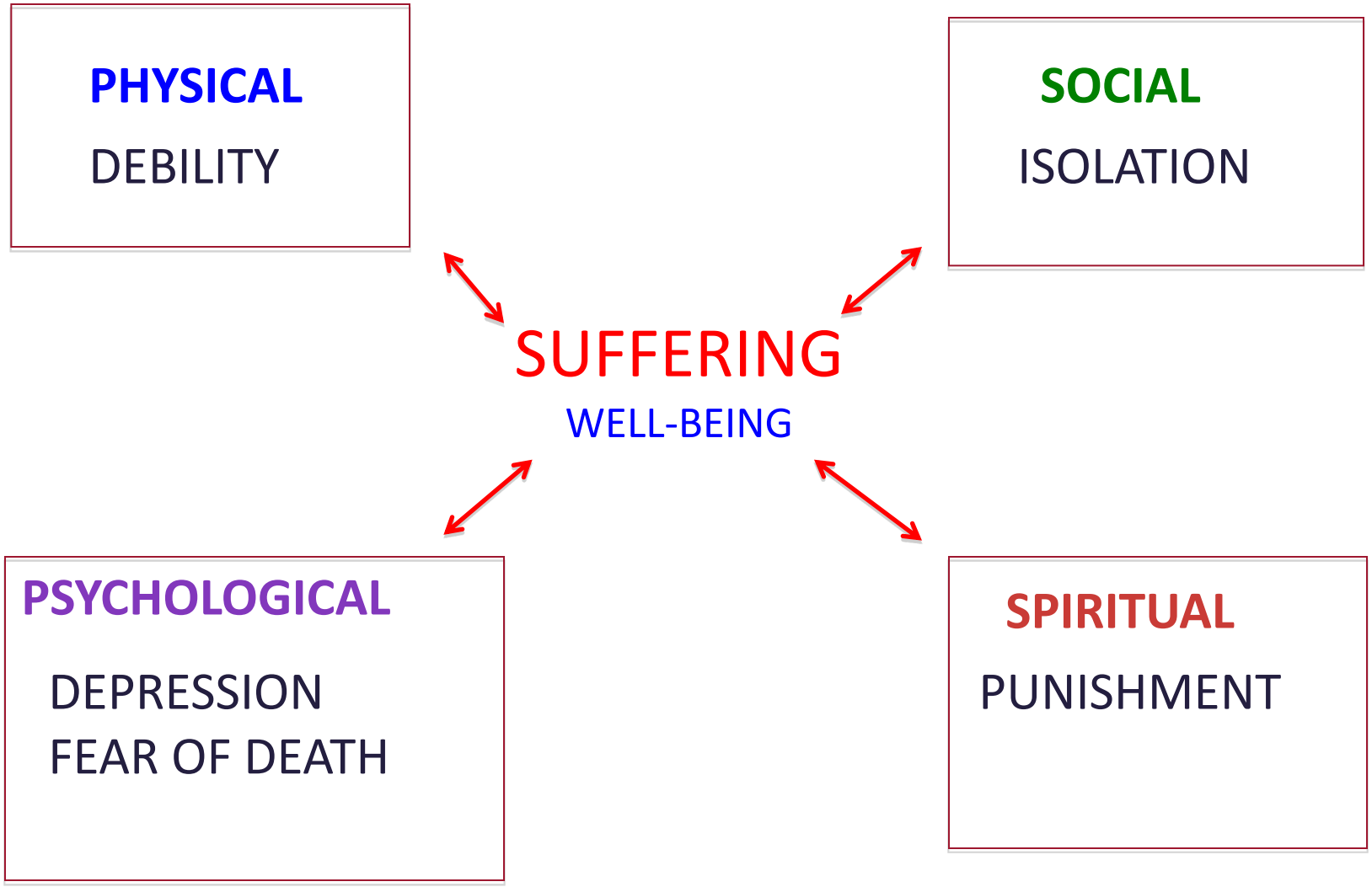




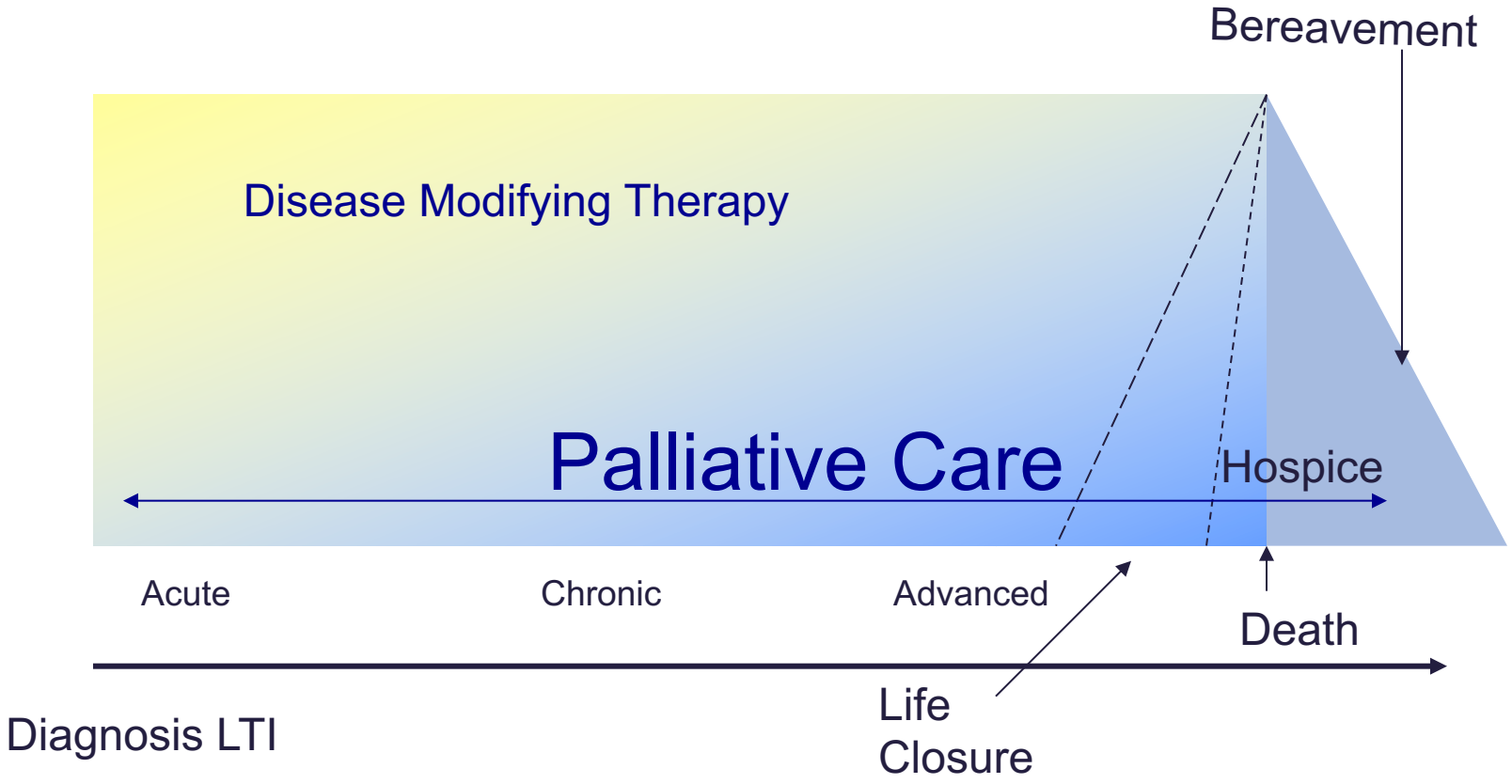
SUFFERING

WHAT ASPECTS OF GEOFFREY'S PERSONHOOD ARE BEING AFFECTED BY HIS PAIN?

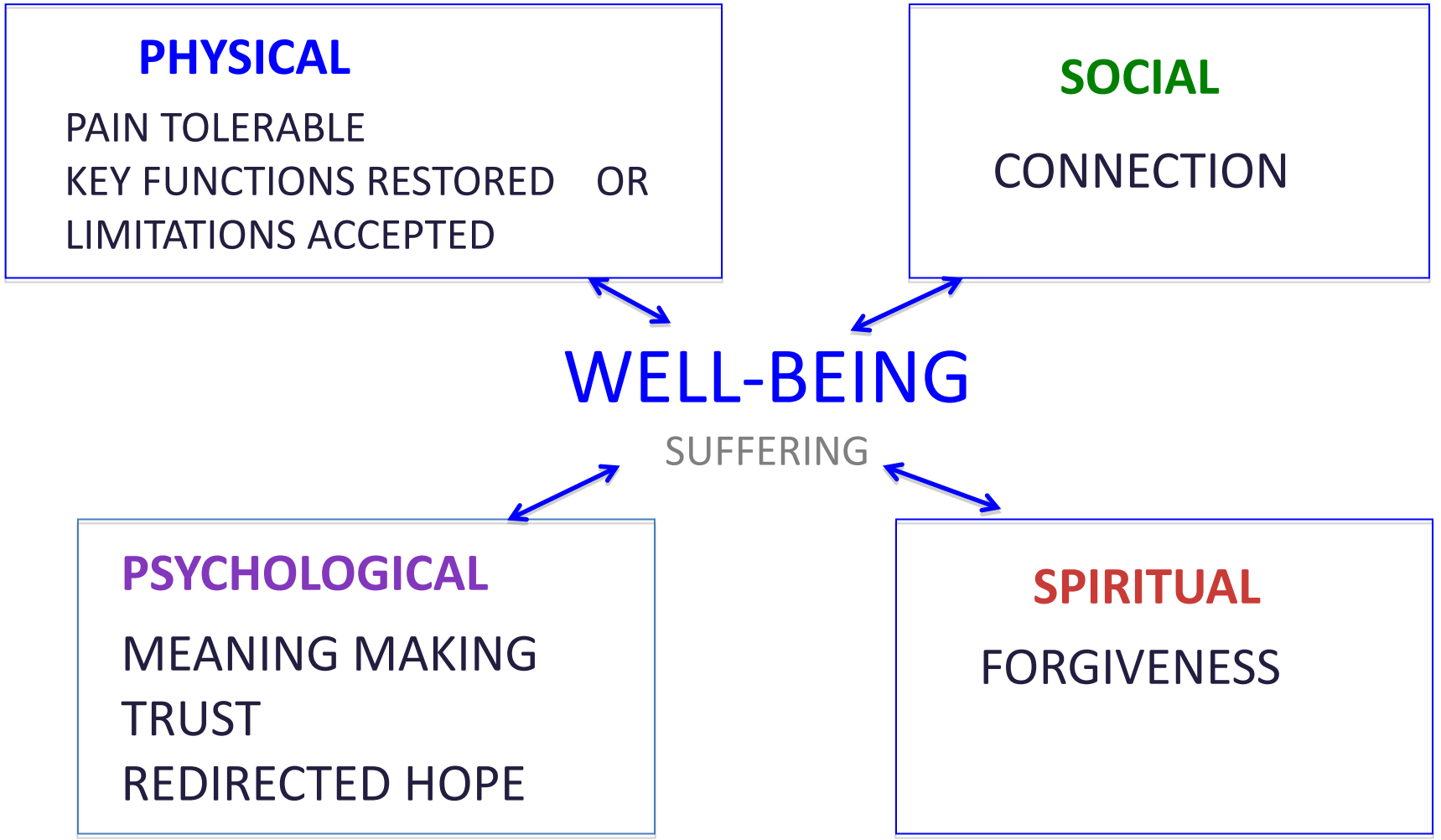
Suffering…


PHYSICAL
DEBILITY
SOCIAL
ISOLATION
SUFFERING
WELL-BEING
PSYCHOLOGICAL
DEPRESSION
FEAR OF DEATH
SPIRITUAL
PUNISHMENT

Palliative Care for Quality of Life



Healing



Cassell EJ. The Nature of Healing, Oxford Univ Press, 2013

Treatment Options for Cancer Patients with Bone Pain

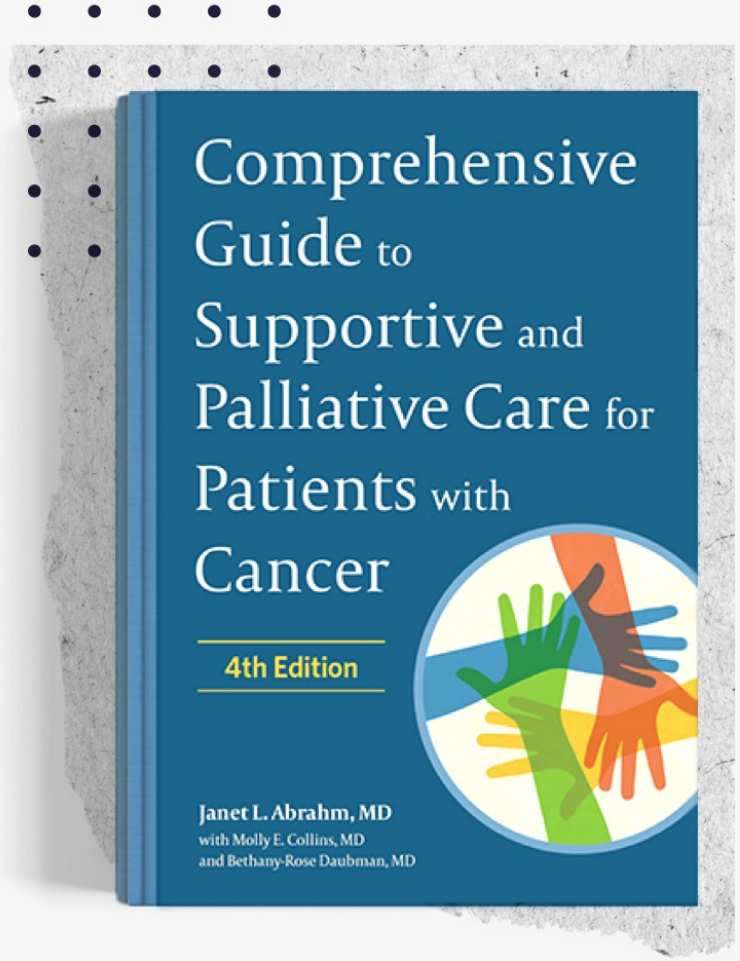
- Bisphosphonates/RANK-L Inhibitors**
- Radiation therapy
  - External beam
  - SRS / IMRT
- Vertebroplasty / Kyphoplasty
- Radionucleotides (consult nuclear med)
  - Alpha emitters: alpharadin
  - Beta emitters: samarium, strontium, rhenium
  - Lutetium-177–PSMA-617
- Cryoablation
- Radiofrequency ablation

Geoffrey's pain management plan

- Opioid
- NSAID
- Bisphosphonate or RANK-L inhibitor
- Counseling, etc

Time for a Break!

SSSTTRREEETTTCCCHHH!!!!!



Susannah

- 35 yo former dancer with metastatic ovarian cancer, pleural effusion.
- At home, on a hydromorphone PCA and lorazepam for pain and dyspnea
- Sleeping most of the time; hard to arouse
- When awakened by her partner, her pain is “10/10”

Screening for alcohol or other substance use disorders

- AUDIT-C
- Opioid Risk Tool

Identifying risk factors and incorporating patient risk into treatment and monitoring plan

Patients may medicate distress with opioids or benzodiazepines

Counseling and careful monitoring is critical to ensuring safe and effective pain management

Identifying Risk of Medication Misuse

Continued Assessment-- the 4 A's

Analgesia

- Use VAS or other measurement tool

Activities of daily living (functioning)

Adverse events

Aberrant drug-taking behaviors

- Repeated dose escalation
- Non-compliance
- Hoarding drugs
- Acquiring drugs from other medical sources, etc.

Opioid Therapy and Risk of OUD

- Incidence of OUD in patients prescribed opioids for pain management vary widely
  - 0.10% to 34%

Item	Mark Each Box That Applies	Item Score If Female	Item Score If Male
1. Family history of substance abuse			
Alcohol	[]	1	3
Illegal drugs	[]	2	3
Prescription drugs	[]	4	4
2. Personal history of substance abuse			
Alcohol	[]	3	3
Illegal drugs	[]	4	4
Prescription drugs	[]	5	5
3. Age (mark box if 16–45)	[]	1	1
4. History of preadolescent sexual abuse	[]	3	0
5. Psychological disease			
Attention deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia	[]	2	2
Depression	[]	1	1
Total		—	—
Total score risk category			
Low risk: 0–3			
Moderate risk: 4–7			
High risk: ≥8			

JAMA Network Open. 2019;2(5):e193365. doi:10.1001/jamanetworkopen.2019.3365

What risk mitigation strategies can you implement in the clinic setting for Susannah?

Principles of Outpatient Management

- Use an **opioid prescribing agreement** as a teaching tool with all patients regardless of risk or history
- Strategies for patients who show signs of ADTB and/or OUD
  - Institute more frequent visits
  - Urine toxicology screening
  - Set quantity limits
  - Involve family/care givers
  - **Refer to palliative care for co-management**

Harold

Harold is a 45 yo engineer with recurrent retroperitoneal germ cell tumor

He is using a 100ug/hr fentanyl patch q72 hours with prn hydromorphone 4-8 mg po q3h prn breakthrough pain

His pain is well-controlled, but his thinking is ”fuzzy”

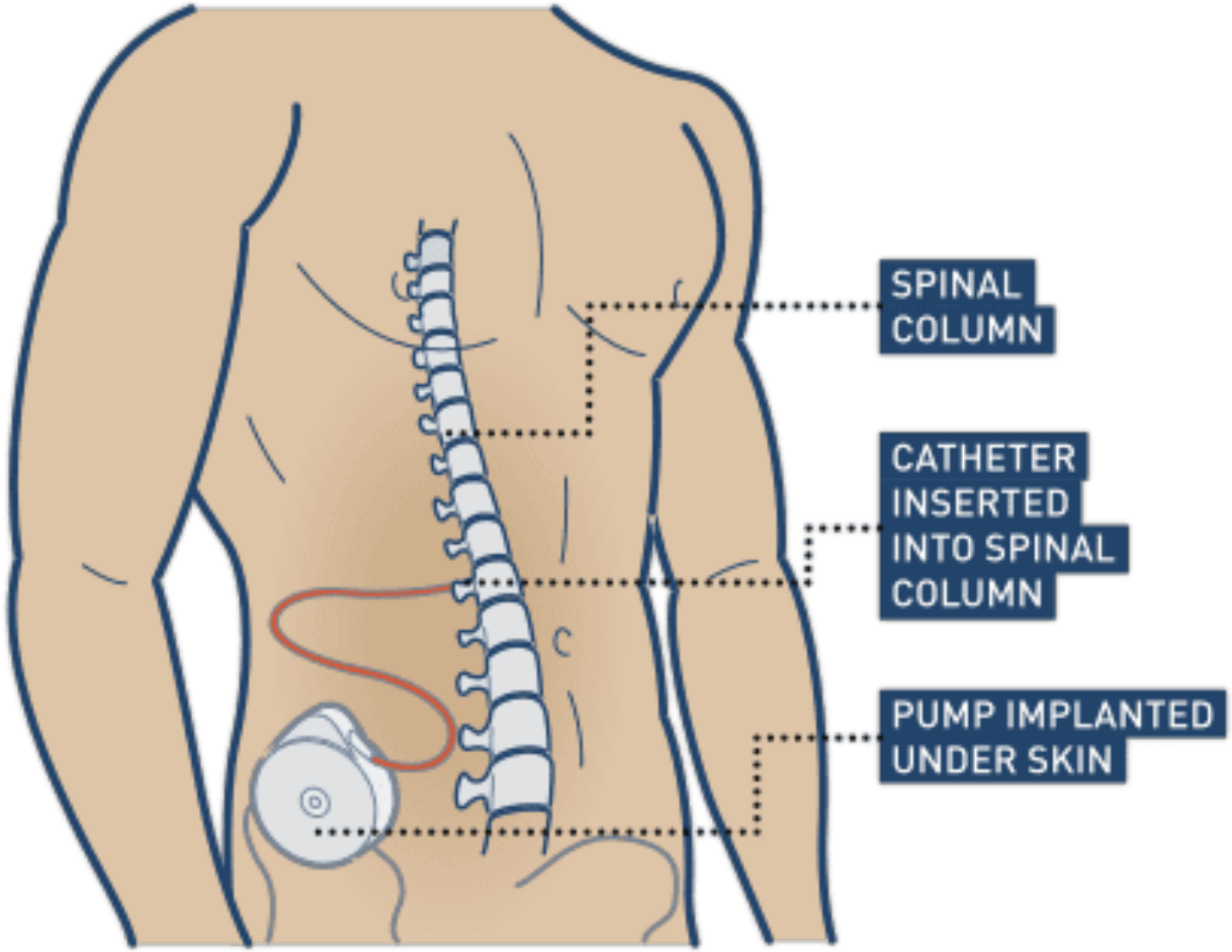
Which do you recommend?

- Narcan (diluted)
- Lower the opioid dose
- Modafinil (Provigil)
- Methylphenidate (Ritalin)
- Switch to another opioid

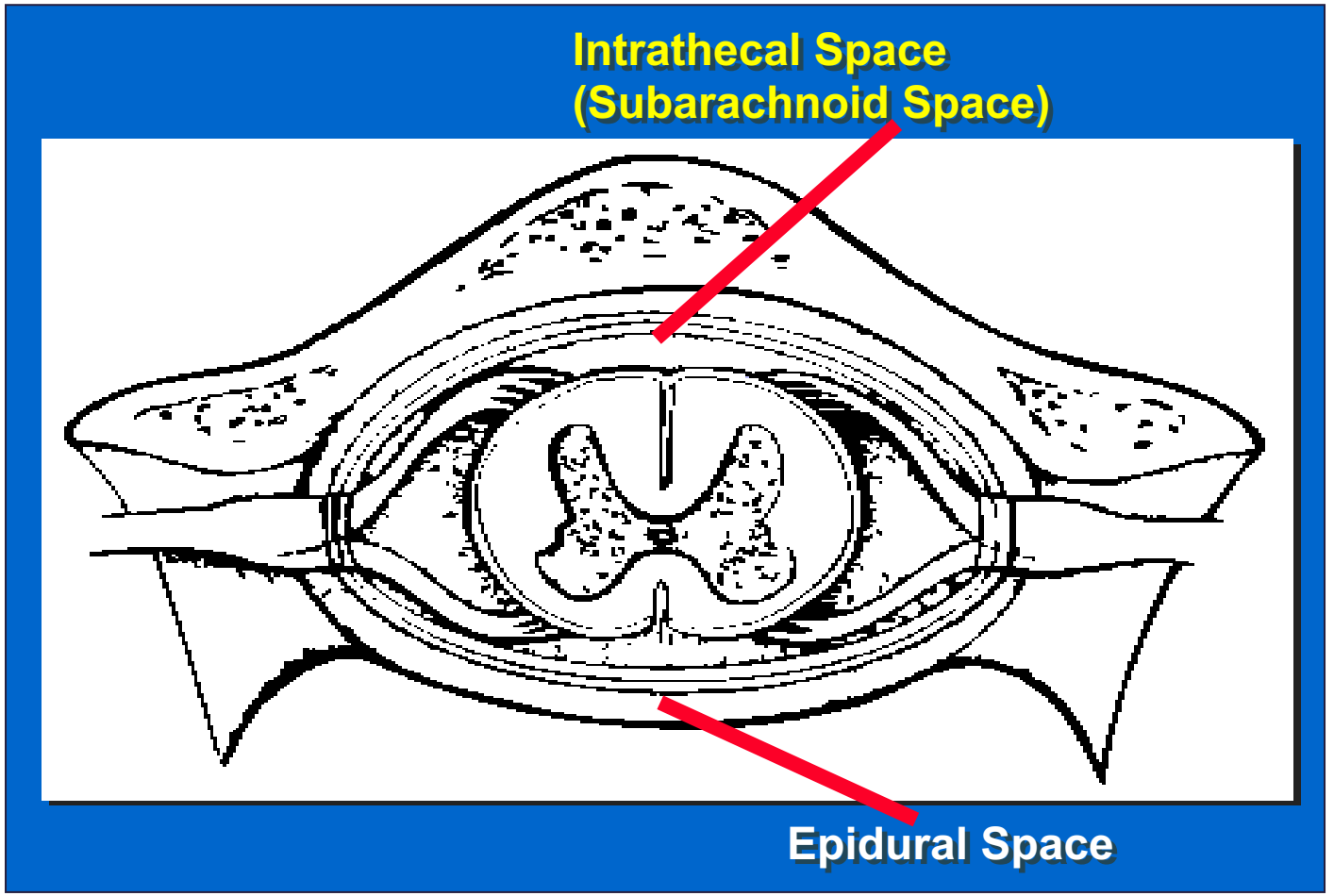
Gerald

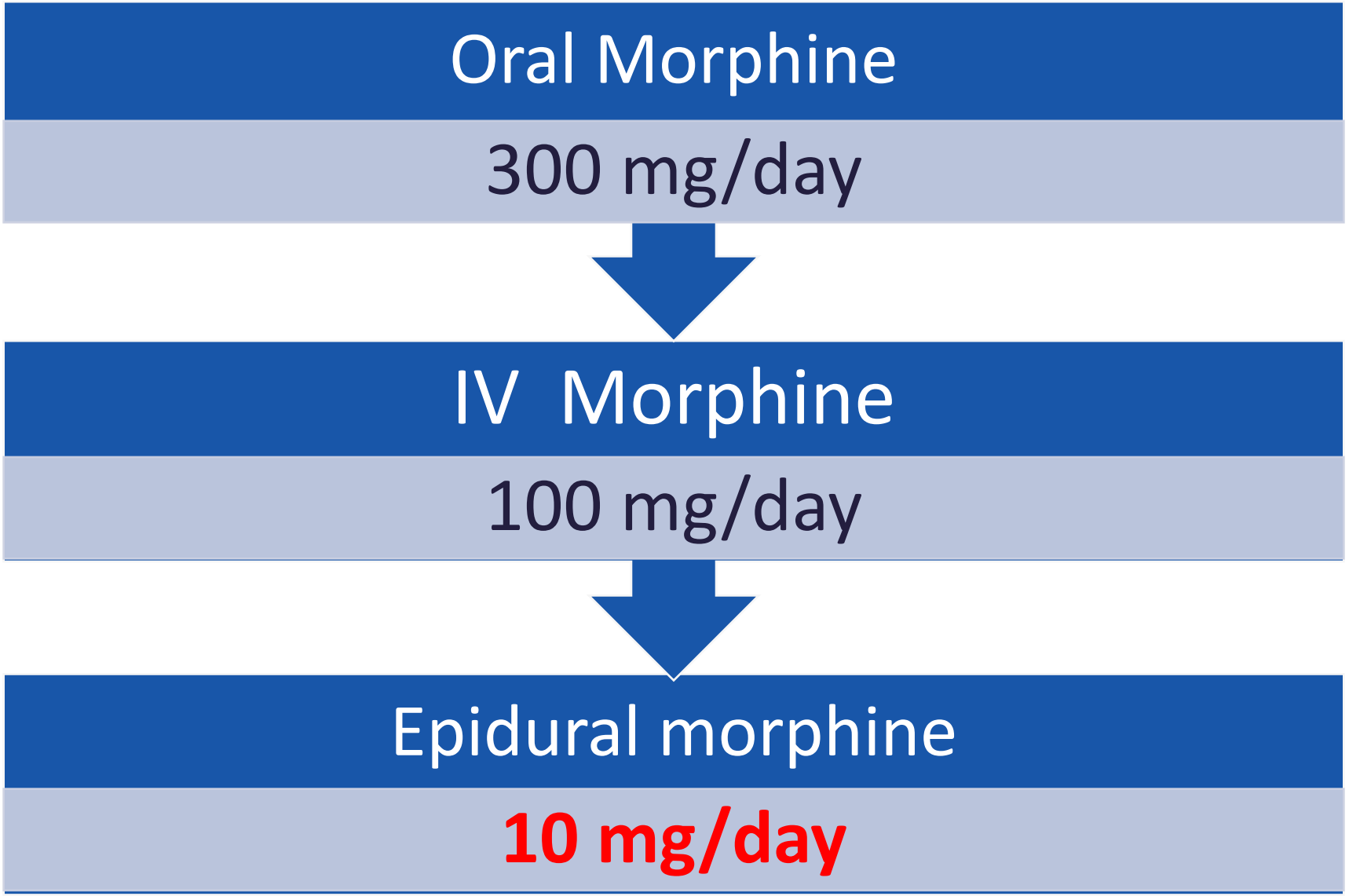
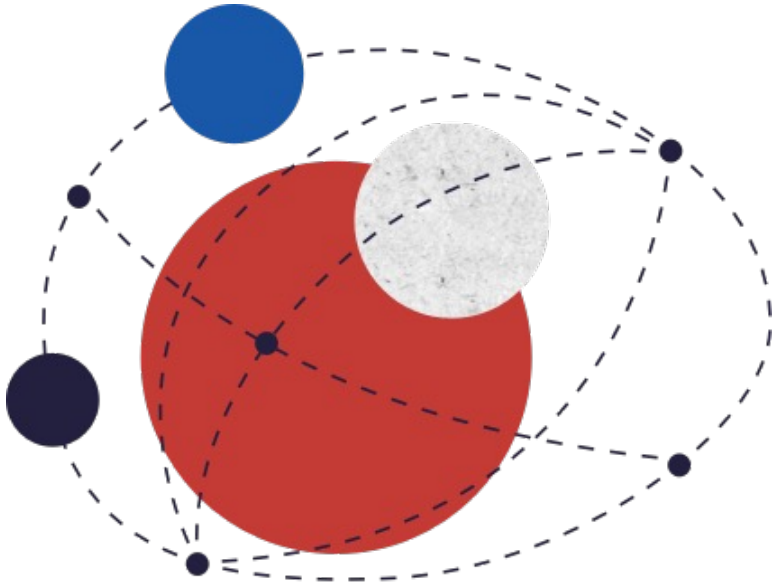
Methadone

When would you recommend an epidural infusion or intrathecal pump?



Intraspinal Opioid Analgesia





Krames ES. Intraspinal opioid therapy for chronic nonmalignant pain: current practice and clinical guidelines. *J Pain Symptom Manage*. 1996 Jun;11(6):333-52