Managing pain in palliative care

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Palliative care – a reminder

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual
Palliative care

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten nor postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient’s illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness,
- in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications
Definition of PAIN

• An unpleasant sensory and emotional experience which we primarily associate with tissue damage or describe in terms of such damage or both.

(It is a combined sensory, emotional and cognitive phenomenon)
PAIN as an experience

- According to the person’s capacity to control it effectively and to ascribe a meaning to it e.g. pain post-op (accepted), pain from cancer (maybe not so accepted)
Concept of pain

- Nociception can be influenced by non-nociceptive pathophysiologic (e.g. abnormal nervous system processing) or psychological factors.

- It is **SUBJECTIVE** to the patient (patient is reporting a true experience), even in the absence of an obvious demonstrable origin. *Pain is what the patient says it is.*
Acute pain

- An event which alerts the organism to the presence of harmful stimuli in the internal or external environment
- Ends predictably
- May provoke an autonomic response
- May follow cancer therapy
- Incident pain/episodic
Chronic pain

• repetitive stimulus in which there is recurrent and/or progressive tissue injury, e.g. cancer, osteoarthritis
• “chronically painful”; persistent nociceptor activation
• ...hard to predict an end
• ...often gets worse
• evokes a different emotional response
• Often no meaning can be ascribed to it
Aetiology of pain

- **Tumour itself**
  - nerve root compression
  - liver capsule pain
  - bone metastases

- **Caused by treatment**
  - chronic post-operative
  - peripheral neuropathy following chemotherapy

- **Related to cancer/debility**
  - muscle spasm
  - pressure areas
  - herpes zoster
  - constipation

- **Unrelated concurrent disorders**
  - osteoporosis
  - angina
  - arthritis
  - UTIs
Pain threshold

• Useful concept in management of pain

• Encompasses the two models of physiology and psychology

• Central pathway connections and inhibitory pathways from the pre-frontal (emotional) cortex, hypothalamus: influence of emotions and arousal on patient’s pain tolerance threshold
Pain threshold

- Cannot be measured but can be modified
  - control of other symptoms
  - good quality sleep
  - feeling secure
  - psychological support
  - explanation
  - relaxation, massage
  - diversional activities
  - reduce anxiety/depression
Total Pain

Physical
- Cancer-disease itself
- Therapy side effects
- Non cancer pathology
- Chronic fatigue
- Insomnia

Spiritual
- Meaning of life
- Culture
- Religion/Belief
- Helplessness

Emotional
- Anger
- Anxiety
- Sadness
- Loss
- Fear
- Disfigurement

Social
- Relationships
- Roles
- Cultural Attitude
Pain assessment

• Why pain assessment?
  – To help with a diagnosis
  – To help with the appropriate treatment/management
  – To assess loss of function caused by the pain and the appropriate measures required to correct this
Principles of pain assessment

• Obtain a **detailed history**, including pain characteristics, intensity etc
• Do a **psycho-socio-spiritual** assessment
• Do a **physical examination**
• Provide a diagnosis
• Set short term realistic goals (aim to minimise pain)
• Review regularly
Pain assessment

• Associated phenomena
  – sweating, restlessness, vomiting, loss of sensation

• Analgesic history
  – what drug, dosage, effect

• Enquire about mobility, sleep, ADL, contact with children, social
Pain assessment

• Look out for non-malignant pains

• Ask patient what he thinks is the cause of pain, correct misconceptions, explain, reassure. Cancer~pain~cancer~death, therefore maybe pain~death

• Psychological assessment, fears, weakness, anxiety, worry, concerns...

• Spiritual assessment...
Measurement of pain

• Quantifying the intensity of pain is an essential part of initial and ongoing pain assessment

• A variety of validated pain scales are available to assist in the measurement of pain. It is recommended that the clinician select a method of assessing pain intensity and incorporate it into routine clinical use,
Pain measurement

• Uni-dimensional scales
  – verbal rating scale (VRS)
  – numeric rating scale (NRS)
  – visual analogue scale (VAS)

• The choice of pain scale may depend on the patient's age, ability to communicate, or other specific circumstances
10 - WORST PAIN POSSIBLE UNBEARABLE
Unable to do any activities because of pain.

9 - INTENSE, DREADFUL HORRIBLE
Unable to do most activities because of pain.

8 - MISERABLE DISTRESSING
Unable to do some activities because of pain.

7 - HURTS EVEN MORE
Unable to do most activities because of pain.

6 - HURTS LITTLE MORE
Unable to do some activities because of pain.

5 - NAGGING PAIN UNCOMFORTABLE TROUBLESOME
Can do most activities with rest periods.

4 - MILD PAIN ANNOYING
Pain is present but does not limit activity.

3 - HURTS LITTLE BIT
Pain is present but does not limit activity.

2 - NO PAIN

1 - HURTS LITTLE BIT
Pain is present but does not limit activity.

0 - NO PAIN

No Hurt
On a scale of “1 to Stepping on a Lego” how much pain are you in?

LEGO PAIN ASSESSMENT TOOL

0 1 2 3 4 5 6 7 8 9 10

NO PAIN
MILD PAIN
MODERATE PAIN
SERIOUS PAIN
SEVERE PAIN
WORST PAIN POSSIBLE

Alert, smiling
No issues
Frowns, can’t
Interferes
tears
Interferes
Unbearable
Death

No pain
Can be ignored
Slight pain
Interferes with tasks
Interferes with concentration
Unbearable
Death

https://www.thefuntimesguide.com
McGill Pain Questionnaire

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**Comments:**
Memorial Pain Assessment Card

Mood Scale

Worst mood  ———— Best mood

Pain Scale

Least possible pain ———— Worst possible pain

Relief Scale

No relief of pain ———— Complete relief of pain

Note: Card is folded along broken line so that each measure is presented to the patient separately in the numbered order.
Pain management - principles

• Set short term realistic goals, e.g. sleep at night, pain free on movement
• Includes prevention and prompt response not crises intervention, use as required medications
• Skilful prescribing tailor-made to patient and cause
• Keep an open mind; drug and non-drug measures
• Discuss and explain to patients and families
• Give support
• Involve the MDT – remember total pain may require total approach
• Review the outcomes regularly
Pain management

by the mouth, by the clock, by the ladder (individual)

• increasing the strength of analgesic following any increase in pain
• know well the properties of at least one drug at each level
• balance against distressing side-effects
• consider other routes of administration
• consider adjuvant therapy at each stage
• tailor make according to each patient’s response
WHO Analgesic Ladder

Step 1
Mild Pain
Non-opioid

Step 2
Moderate Pain
Weak opioid +/- non-opioid

Step 3
Severe Pain
Strong opioid +/- non-opioid

Adjuvants including steroids
Psychological aspects
Specific therapies
Pain in advancing cancer

• ¾ have pain
• ¼ have no pain
• 1/5 have one pain
• 4/5 have two or more pains
• 1/3 have four or more pains
Initiating morphine in opioid naïve patients

- start with small regular oral (if possible) of immediate release drug
- titration with slow release morphine is less effective than immediate release and is not recommended
- prescribe morphine elixir (immediate release) (2.5 to 5 mg) every four hours regularly and titrate
Morphine

- prescribe ‘when/as required’ doses of 1/5th to 1/6th of the regular 24 hour dose for ‘breakthrough’, ‘episodic’ or ‘incident’ pain
- document the amount of morphine taken
- once a stable dosing regimen is achieved (2 to 3 days) convert to a long-acting preparation
- calculate the total 24 hour dose of immediate release morphine required from ‘breakthrough’ and regular dosing, divide by two and give twice daily
- ‘when required’ doses of 1/5th to 1/6th of the regular 24 hour dose should be prescribed as immediate release once again for pain between doses
Morphine

• if the patient can no longer swallow
• give ½ the total 24 hour oral dose by continuous subcutaneous infusion
• ‘when/as required’ doses of 1/5th to 1/6th of the regular 24 hour dose should be prescribed once again for pain between doses
Opioid rotation

- Opioid rotation (or changing from one opioid to another) is often used when tolerance to the analgesic effects of opioids (stimulation of NMDA receptors) or severe adverse effects occur.
- Works because of the difference in the mix of opioid receptors stimulated by each individual opioid in each individual patient.
- Most often from morphine to oxycodone, fentanyl or methadone.
- Rotation should only occur under supervision and by a specialist as conversion doses are difficult to predict.
Practice points for morphine

• No upper dose – can be slowly up-titrated until effective dose reached (as long as the pain is opioid sensitive)

• Always start combination laxative (stool softener plus stimulant) e.g. Movicol® etc

• Nausea and drowsiness are common when starting, but usually settle within one week. Warn about driving
Oxycodone and hydromorphone

- better oral availability than morphine
- alternative to morphine
- also indicated if patient experiences side effects with morphine:
  - sedation
  - delirium
  - hallucinations
  - nausea and/or vomiting
  - pruritus
Oxycodone and hydromorphone

• Plasma concentrations increase with renal failure (by about 50%)

• Half life prolonged by about 1 hour in renal impairment

• Safer to use in renal impairment than morphine, but dose might need reducing in renal impairment. Avoid in severe impairment
Fentanyl transcutaneous patch

Indications

– Side effects from morphine (laxative dose can be halved once starting on fentanyl)
– Renal failure
– Poor compliance with oral medications or aversion to tablets
– Dysphagia
Methadone

• longer half-life than morphine and complex pharmacokinetics. Dose conversions are complex and the response is variable – seek specialist help

Pethidine

• has short duration of action (2-3 hrs)
• no place in palliative care
Barriers to pain assessment and adequate management

• Patient related
  – Reluctance to report pain
  – Reluctance to follow treatment recommendations
  – Fear of tolerance and addiction
  – Concern about side-effects
  – Belief that pain is an inevitable consequence and must be accepted
  – Fear of disease progression
  – Fear of injections
Barriers to pain assessment and adequate management

• Professional-related
  – Failure to evaluate and appreciate the severity of the pain problem
  – Poor assessment of pain
  – Knowledge deficits in cancer pain assessment and treatment and lack of perception thereof
  – Misconceptions re drug side-effects, drug combinations, tolerance, addiction.
Barriers to pain assessment and adequate management

• Institutional-related
  – Lack of a language of pain
  – Failure to use validated pain measurement tools in clinical practice
  – Lack of time committed to pain as a priority
  – Lack of economic resources committed to its treatment
  – Serious legal restrictions to drug prescribing and availability
Weak opioids

Tramadol

• in pain associated with cancer, morphine is more effective than tramadol
• oral tramadol is 5 times weaker than oral morphine.
• many side effects – often not any advantage in using it
Weak opioids

Codeine/dihydrocodeine

• 10 times weaker than morphine

• Metabolised to morphine (10%)
  – 5-10% Caucasians may be unable to metabolise to morphine
  – Combination with other opioids is illogical

• Once maximum codeine dose reached (240mg/24 hours) start patient on recommended morphine dose (2.5 – 5mg every four hours)