Pain Management Cases in Palliative Care

Barb Supanich, RSM, MD
Medical Director, Palliative Care
Holy Cross Hospital
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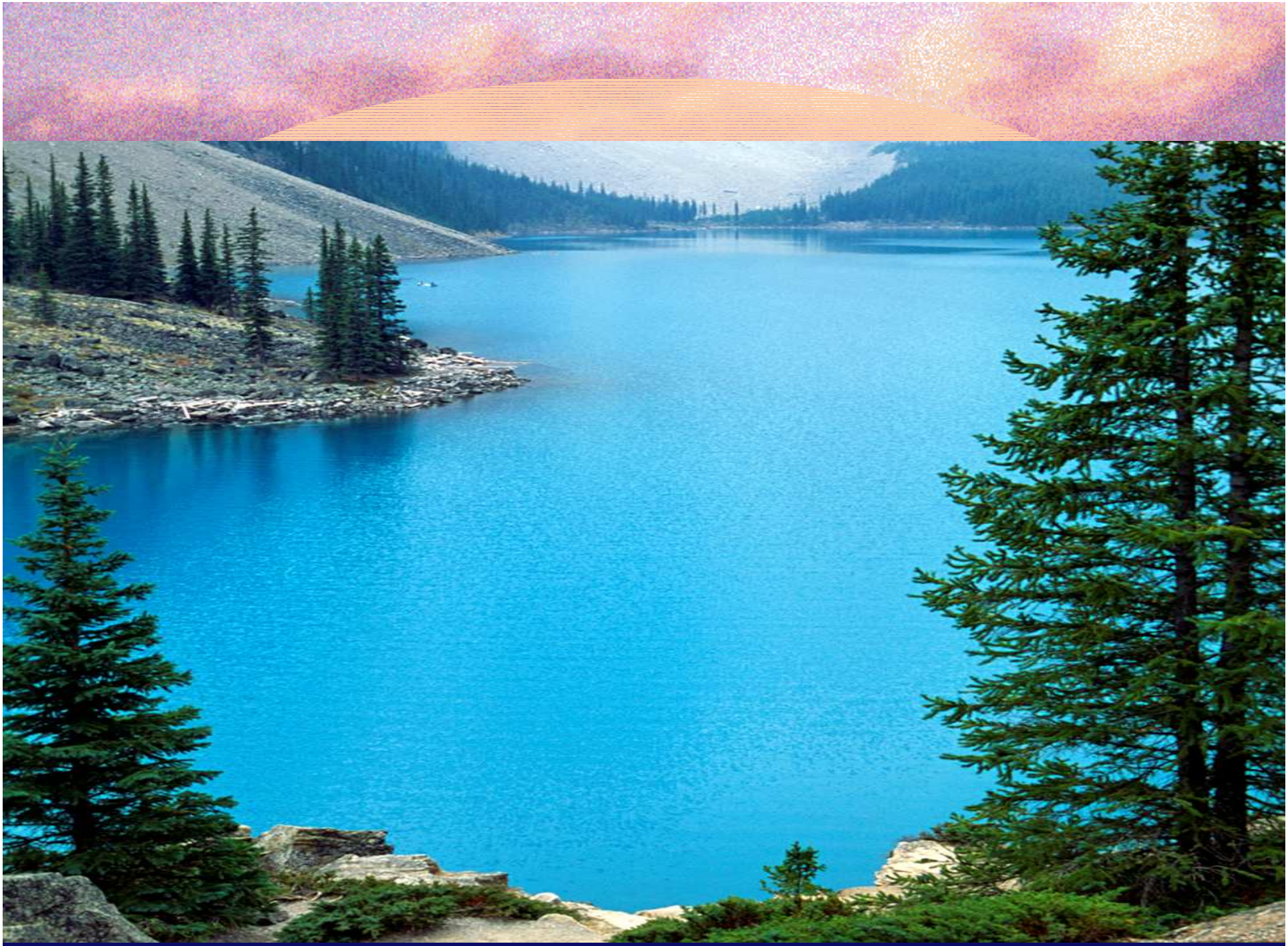
Learner Objectives

- Describe key elements of a comprehensive pain assessment.
- Explain distinctions between dependence, tolerance and addiction.
- Discuss pain management approaches in several recent Palliative Care Cases.



Comprehensive Pain Assessment

- "Pain is whatever the experiencing person says it is, existing whenever he/she says it does." (McCaffery, 1968)
  - Pain is a symptom, not a diagnosis
  - Believe the patient
- Onset
- Provocative or Palliative Features
- Quality
- Radiation or Related Symptoms
- Severity – intensity and effect on function
- Temporal Pattern

Total Pain Components

- P: physical symptoms or conditions
  - Arthritis, constipation, bladder spasms, decubiti, headache, thrush, as well as cancer pain
- A: anxiety, anger, depression, hopelessness, loneliness
- I: interpersonal issues – family tensions, financial issues
- N: nonacceptance of approaching death, spiritual or existential pain

Pain Assessment

- History and physical
- Numerical or visual analog scales
- Patient's description of pain and experience of pain
- Use of appropriate lab and radiologic studies
- Thorough assessment interview

Psychosocial-Spiritual Assessment

- Meaning of the pain to patient and family
- Previous experiences with pain and coping mechanisms
- Psychological symptoms with pain
  - Fear of disease worsening
  - Depression or anxiety
  - Hopelessness
  - Negative physician or nurse perceptions
  - Adjustments in leisure activities

Psychosocial-Spiritual Assessment

- Spiritual Angst or Despair
  - Meaning of pain and suffering
  - Retribution
  - Punishment
  - Spiritual cleansing
- Social and Relational Issues
  - Family roles
  - Physical appearance changes
  - Sexual relationship issues
  - Burden on family

Cultural Issues

- Know your own attitudes and beliefs
  - Admire stoics or encourage sharing of pain issues?
  - What are your thoughts or beliefs about pain meds?
  - What are your thoughts about those who abuse pain meds?
- Develop relationship with patient and family
- Build trust with patient and family
- Assess patient's cultural beliefs and practices regarding illness and treatment of pain

Cultural Issues

- Cultural approaches to pain management
  - Folk remedies
  - Other techniques or approaches for pain relief
- Ask – “Are you comfortable?” vs. “Are you in pain?”
- Family approach to understanding illness and pain
- Appropriate use of medical interpreters – verbal and written translation
- Ask how this patient may want to incorporate cultural approaches to pain management

Pain Myths

- Dying is always painful.
- Some kinds of pain can't be relieved.
- Pain meds always cause heavy sedation.
- I should "save" my use of strong pain relievers until real close to the end.
- I can get immune to the effects of pain meds.
- Once on pain meds, you always have to increase the dose.

Pain Myths

- Only injections give you good pain relief.
- Pain med use always leads to addiction.
- Withdrawal is always a problem with pain meds.
- Enduring pain and suffering can enhance one's character.
- Once they start giving you morphine, the end is near.
- People have to be in a hospital to receive effective pain management with morphine.

Pain Scales

- Simple descriptive pain intensity scale
- 0-10 scale
- Visual Analog Scale
- Faces Scale

Dependence

- Physical dependence ≠ addiction
  - Dependence is an expected result of LT opioid use
  - Adaptation manifested by development of a withdrawal syndrome following rapid dose reduction, abrupt cessation, administration of an antagonist (naloxone), or decreasing blood levels (underdose or miss doses).
  - Need to safely taper drug
    - No more than 50% of dose/day

Addiction vs. Pseudoaddiction

- Opioid Addiction
  - Primary, chronic, neurobiologic disease, with genetic, psychosocial and environmental factors
  - Exhibit following behaviors:
    - Impaired control over drug use
    - Compulsive use of drug
    - Continued use despite harm
    - Crave drug
  - Risk of iatrogenic addiction is rare in patients with no past history of substance abuse
- Pseudoaddiction
  - Behaviors are driven by inadequate treatment of pain
  - Behaviors disappear when pain is adequately treated

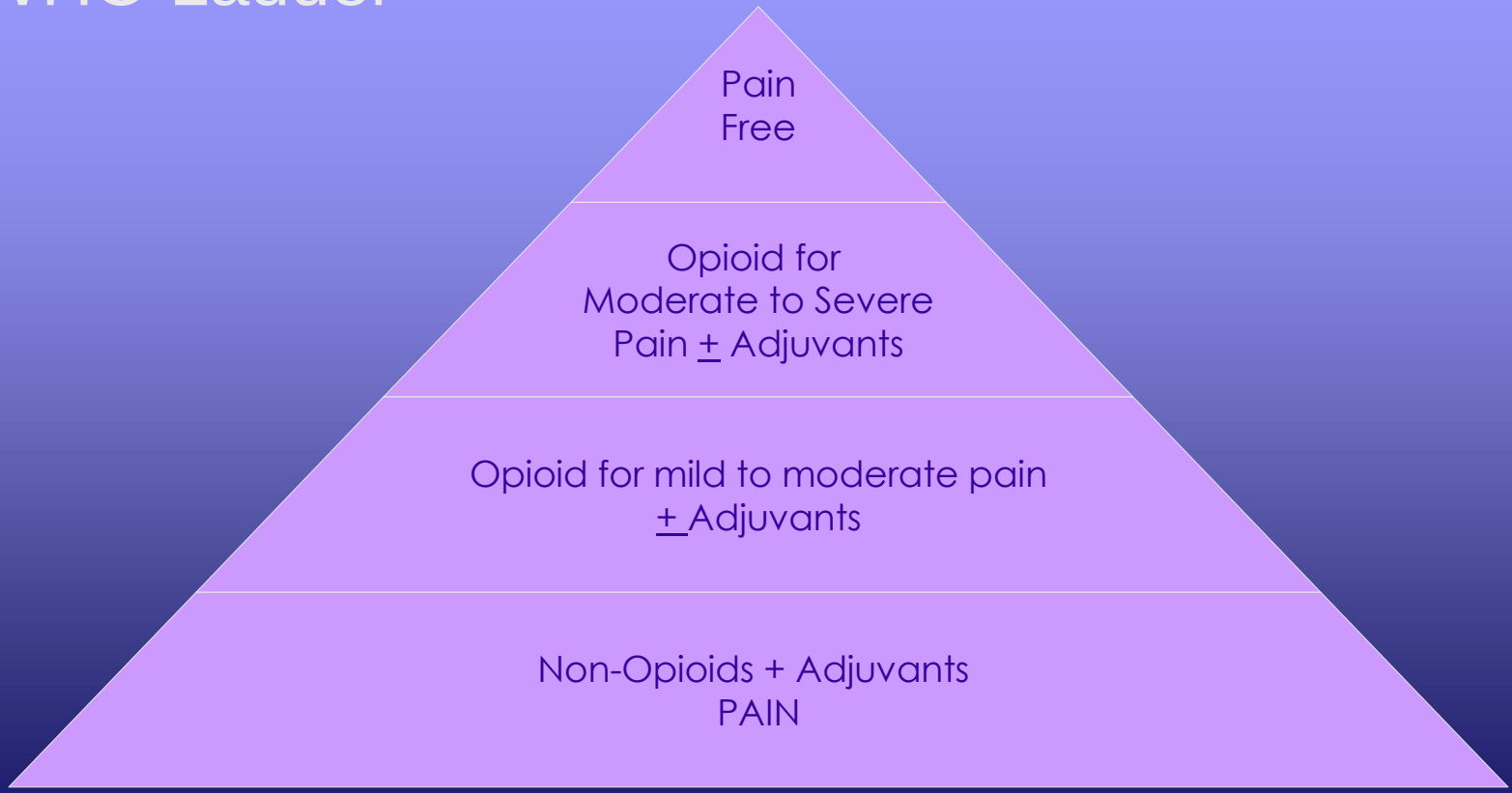
Tolerance

- Tolerance
  - State of adaptation in which exposure to drug induces changes that result in decrease in the drug's effects over time
  - So, patient requires higher doses to maintain same benefit
  - Therapeutic range of opioids is very wide

- Analgesic tolerance is very rare
  - Opioid doses remain stable if disease remains stable
  - Increased opioid requirement $\longrightarrow$ worsening disease progression

Effective Opioid Dosing

- WHO Ladder



5 Basic Concepts

- By the mouth
- By the clock
- By the WHO Ladder
- For the individual
- With attention to detail

When to Use Opioids

- Severe Pain
  - ≥ 6/10
- Pain is unresponsive to other pain meds
- Do not delay treatment of pain
  - X-rays, tests, etc.
- Adjust dose per patient response

Narcotic Routes

- For ACUTE pain, use short acting form
- Peak Effects:
  - ORAL: 1 HOUR
  - IV: 5-10 Minutes
  - SQ: 20-30 Minutes
- DO NOT USE IM ROUTE
- DO NOT USE LONG-ACTING FORMS
  - Fentanyl patch, MS Contin, OxyContin

Starting Route

- Severe Pain: ≥ 6/10
  - PAIN EMERGENCY
  - IV route preferred
  - SQ if IV not available immediately
- Mild to Moderate Pain: 3-6/10
  - Try oral first
  - May also require IV med

Starting Guidelines

- Learn patient's pain score and patient's pain goal
  - "I can live with a pain of 2-3/10"
- Opioid naïve or not …
- Reassess the patient's response after time to peak effect
- Don't confuse with duration of effect

Opioid Naïve, Met Ovarian CA

- Patient eats and drinks normally
- Pain score 4-6/10
- Start Morphine IR 10-15 mg p.o.
  - Reassess pt in one hour
- Pain score ↓ by 50% → continue same dose, every 4 hrs
- Pain score unchanged in 1 hr → repeat dose, reassess in one hr, not improved, ↑ dose by 50%.
- Cont to reassess pain every hour and if unchanged ↑dose by 50-100% until pain is relieved.
- Once dose is determined that relieves pain adequately, give this dose every 4 hrs.

On Opioids, Met Ovarian CA

- Pain Score 4-6/10
- Calculate total daily opioid intake
- Give 25 % of total daily opioid as oral IR
- Reassess in 1 hr
- Pain score ↓ 50% - cont same dose
  - Repeat dose at every 4 hr intervals
- Pain score unchanged
  - ↑dose by 50% and reevaluate in 1 hr
  - Pain now ↓ 50% - cont with this dose every 4 hrs
  - Repeat this approach until pain is relieved per pt

Pain Score 7/10 and Opioid Naïve

- This is an emergency!
- IV Morphine 2-5 mg every 15 minutes
  - Pain is ↓ by 50% or pt's pain goal is achieved
- Continue this effective dose of IV morphine every 4 hrs ATC
- Pain score unchanged –
  - Double dose of morphine IV, reassess every 15 minutes until pain is relieved
  - This dose is now the effective dose to be given every 4 hrs ATC
- May need to use PCA or IV drip with guard rail

Pain Score 7/10, Chronic opioids

- Calculate total IV Morphine equivalents taken over last 24 hours
- Administer 20% as IV Bolus
- Reassess pt in 15 minutes
- Pain relieved – cont this dose every 4 hrs ATC
- Unrelieved pain – repeat initial dose, reassess in 15 minutes, if unrelieved – give double dose, reassess in 15 minutes.
- Give dose that reduced pain by 50% or relieved it, every 4 hrs ATC.

Continuous Infusions

- E.g., patient needed 8 mg of Morphine IV to relieve acute pain crisis …
- 24 hr dose is 8 mg/4 hrs x 6 = 48 mg/24 hrs
- 10% of 24hr dose for bolus = 5 mg every 15 min
- Effective dose of 8 mg/4hrs = 2 mg /hr
- If on PCAA lockout for 4 hours would be 48 mg
  - 2mg/hr x 4 = 8 + 5mg x8 = 48

Palliative Care IV Drips

- Morphine IV Continuous Drip Example
  - Morphine 2mg/hr
  - Titrate by 1 mg/hr every 15 minutes (severe pain or dyspnea) or every 30 minutes (moderate pain or dyspnea) until symptoms of pain, dyspnea, moaning, restlessness are relieved or patient reports sx are more tolerable.

Choice of Opioids

- Morphine
  - Available in IV, SC, PO routes (IR and SR)
  - Metabolites accumulate in renal failure
  - Nausea can happen after first dose and easily treated
  - Itching – mast cell release, treat with vistaril or benadryl
  - Constipation – PREVENTION, Sennokot-S, Miralax.

Choice of Opioids

- Hydromorphone (Dilaudid):
- Available as IV or P.O.
- Relatively short-acting
- Good for elderly who have longer elimination times
- Better for patients with renal failure – no active metabolites
- It is one-fifth of morphine dosing

Opioid Choices

- Fentanyl
- Patches have been recalled by FDA
- Not to be used in opiate naïve patients
- Patch requires subcut fat to absorb safely
- 100 mg of oral morphine = 50 mcg/hr patch
- Kinetics are heat dependent - - fever will alter absorption rate and decrease length of effect of patch

Opioid Choices

- Methadone
- Long half-life
- Very potent
- Available IV and p.o.
- Neuropathic pain
- Good choice for patients with opioid tolerance

Misconceptions about Opioids

- Opioid use ≠ respiratory depression
  - Optimal dosing
  - Careful titration
  - Effective for treatment of dyspnea
- Dying patients have RR of 6-12/min
- Clinically significant resp depression
  - LOC **and** RR< 6/minute
  - Patient is arousable and/or RR > 6/min → **don't** give naloxone.

Opioid Myths

- Common symptoms of dying:
  - Decreased and/or erratic RR
  - Extreme weakness
  - Decreased alertness, confusion, restlessness
  - Decreased or no U.O.
  - Cool extremities
  - Terminal fevers
- Patients who have above symptoms and are on narcotics, like morphine, do not need naloxone.

Opioid Myths

- Nausea is experienced by ~ 30 % of opiate naïve patients.
- Oral opioids are very effective for patients who can safely swallow.
- Opioids do not cause euphoria at EOL, but pt's mood may improve due to improved pain control.
- Wide effective dose range for different patients.
- Don't cause imminent death
  - Unrelieved pain is physically and psychologically destructive

Other Palliative Care Tx's

- Prevent Constipation
  - start med like Sennokot at time of starting morphine
  - encourage appropriate dietary fiber and water
- Manage unwanted persistent sedation
  - d/c non-essential meds
  - evaluate and treat other potential causes
  - may decrease dose by 25%
  - trial of Ritalin (5 mg p.o. daily)
  - trial of Risperidone or Olanzapine or Haldol for delirium
  - switch to another opioid
  - try adjuvant therapies

Adjuvant Therapies

- Opioid – sparing strategies
  - analgesic adjuvants – acetaminophen, NSAIDS
  - other med adjuvants – carbamazepine, prednisone, amitriptyline, gabapentin, etc
  - alternate route
  - neurolytic procedures
  - anesthesia procedures (intrathecal pumps)
  - PM&R
  - Cognitive therapy
  - Complementary therapies
  - Prayer, meditation, music, massage, acupuncture, etc

Adjuvant Therapies

- Bone Pain
  - radiation therapy, steroids, NSAIDS, Calcitonin, bisphosphonates
- Neuropathic Pain
  - anticonvulsants, antidepressants, methadone, gabapentin, Lyrica

Summary

- Pain may present as agitation, withdrawal from social activities, or moaning and restlessness when patient is actively dying.
- Assess pain in a timely and thorough manner.
- Treat pain based on patient description and assessments.
- Treat pain per the WHO Ladder protocol.
- For all pain, treat with morphine dose that achieves goal of symptom relief and patient comfort.

Summary

- Treat nonphysical causes of pain
- Emotional, spiritual and social pain causes:
  - anxiety, depression
  - isolation and loneliness
  - fear
  - financial concerns
  - loss of faith
  - loss of meaning

Summary

- Physician – Nurse as Healer
  - lend strength to patients who are suffering from changes and losses in life
    - loss of relationships
    - loss of unrealized hopes and dreams
  - reinforce new definitions of hope as patients try to come to terms with the resolution of their lives
  - help patient transcend their current physical state with the search for a broader context of meaning.