Pain Management &
Palliative Care

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

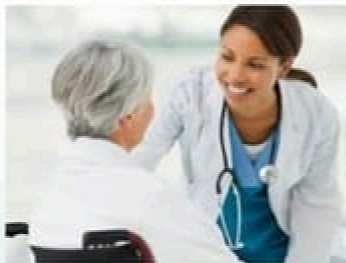
- "Pain is whatever the experiencing person says it is, existing whenever he/she says it does." (McCaffery, 1968)
  - Pain is a symptom, not a diagnosis
  - Believe the patient
- Onset
- Provocative or Palliative Features
- Quality
- Radiation or Related Symptoms
- Severity – intensity and effect on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

Total Pain Components

- P: physical symptoms or conditions
  - Arthritis, constipation, bladder spasms, headache, thrush, as well as cancer pain
- A: anxiety, anger, depression, hopelessness, loneliness
- I: interpersonal issues – family tensions, financial issues
- N: non acceptance 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

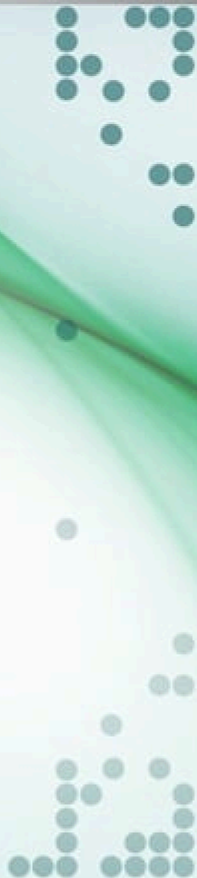
- Spiritual Angst or Despair
  - Meaning of pain and suffering
  - Retribution
  - Punishment
  - Spiritual cleansing
- Social and Relational Issues
  - Family roles
  - Physical appearance changes
  - Sexual relationship issues
  - Burden on family

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

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 → worsening disease progression

Effective Opioid Dosing

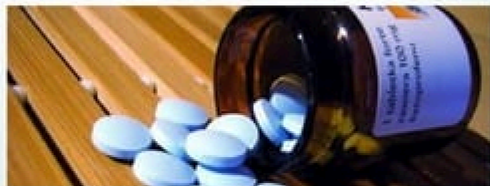
- WHO Ladder

When to Use Opioids

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

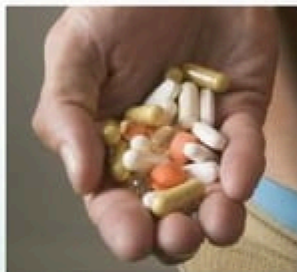
Narcotic Routes

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



Starting Route

- Severe Pain: ≥ 6/10
  - PAIN EMERGENCY
- 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

Choice of Opioids

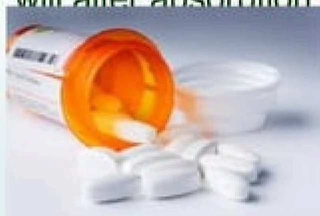
- Morphine
  - Available in IV, SC, PO routes (IR and SR)
  - Metabolites accumulate in renal failure
  - Nausea can happen after first dose and easily treated
  - Itching – mast cell release, treat with vistaril or benadryl
  - Constipation – PREVENTION, Sennokot-S, Miralax.

Choice of Opioids

- Hydromorphone:
- 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 subcutaneous 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
  - Loss Of Conciousness **and** RR< 6/minute
  - Patient is arousable and/or RR > 6/min → **don't** give naloxone.

Other Palliative Care Tx's

- Prevent Constipation
  - encourage appropriate dietary fiber and water
- Manage unwanted persistent sedation
  - stop non-essential meds
  - evaluate and treat other potential causes
  - may decrease dose by 25%
  - 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)
  - 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

- 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.

PALLIATIVE CARE

What is Palliative Care?

- Medical care that focuses on alleviating the intensity of symptoms of disease.
- Palliative care focuses on reducing the prominence and severity of symptoms.

What is Palliative Care?

- The World Health Organization describes palliative care as "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."

WHO Definition of Palliative Care

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or 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;

What is the goal of Palliative Care?

- The goal is to improve the quality of life for individuals who are suffering from severe diseases.
- Palliative care offers a diverse array of assistance and care to the patient.

The History of Palliative Care

- Started as a hospice movement in the 19th century, religious orders created hospices that provided care for the sick and dying in London and Ireland.

- In recent years, Palliative care has become a large movement, affecting much of the population.

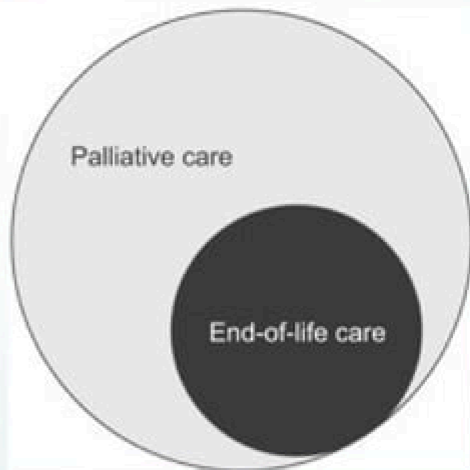
- Began as a volunteer-led movement in the United states and has developed into a vital part of the health care system.

Palliative vs. Hospice Care

- Palliative care can be provided from the time of diagnosis.
- Palliative care can be given simultaneously with curative treatment.
- Both services have foundations in the same philosophy of reducing the severity of the symptoms of a sickness or old age.
- Other countries do not make such a distinction

Palliative vs. Hospice Care

- Division made between these two terms in the United States
- Hospice is a “type” of palliative care for those who are at the end of their lives.



Who receives Palliative Care?

- Individuals struggling with various diseases
- Individuals with chronic diseases such as cancer, cardiac disease, kidney failure, Alzheimer's, HIV/AIDS and Amyotrophic Lateral Sclerosis (ALS)

Cancer and Palliative Care

- It is generally estimated that roughly 7.2 to 7.5 million people worldwide die from cancer each year.

- More than 70% of all cancer deaths occur in developing countries, where resources available for prevention, diagnosis and treatment of cancer are limited or nonexistent.

- More than 40% of all cancers can be prevented. Others can be detected early, treated and cured. Even with late-stage cancer, the suffering of patients can be relieved with good palliative care.

Palliative Care and Cancer Care

- Palliative care is given throughout a patient's experience with cancer.
- Care can begin at diagnosis and continue through treatment, follow-up care, and the end of life.

Palliative Care and Cancer

- "Everyone has a right to be treated, and die, with dignity.
- The relief of pain - physical, emotional, spiritual and social - is a human right," said Dr Catherine Le Galès-Camus, WHO Assistant Director-General for Noncommunicable Diseases and Mental Health.
- "Palliative care is an urgent need worldwide for people living with advanced stages of cancer, particularly in developing countries, where a high proportion of people with cancer are diagnosed when treatment is no longer effective."

Who Provides Palliative Care?

- Usually provided by a team of individuals
- Interdisciplinary group of professionals
- Team includes experts in multiple fields:
- Doctors
- Nurses
- social workers
- massage therapists
- Pharmacists
- Nutritionists

Approaches to Palliative Care

- Not a "one size fits all approach"
- Care is tailored to help the specific needs of the patient
- Since palliative care is utilized to help with various diseases, the care provided must fit the symptoms.

Palliative Care Patient Support Services

- Three categories of support:

1. **Pain management** is vital for comfort and to reduce patients' distress. Health care professionals and families can collaborate to identify the sources of pain and relieve them with drugs and other forms of therapy.

Palliative Care Patient Support Services

2. **Symptom management** involves treating symptoms other than pain such as nausea, weakness, bowel and bladder problems, mental confusion, fatigue, and difficulty breathing

3. **Emotional and spiritual support** is important for both the patient and family in dealing with the emotional demands of critical illness.

What does Palliative Care Provide to the Patient?

- Helps patients gain the strength and peace of mind to carry on with daily life
- Aid the ability to tolerate medical treatments
- Helps patients to better understand their choices for care

What Does Palliative Care Provide for the Patient's Family?

- Helps families understand the choices available for care
- Improves everyday life of patient; reducing the concern of loved ones
- Allows for valuable support system

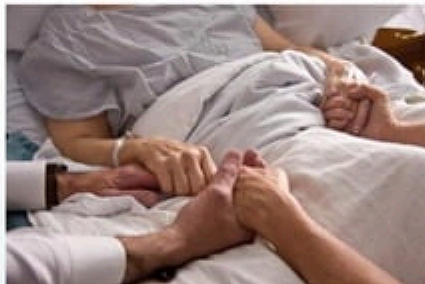


Image courtesy of mdanderson.org

Approaches to Palliative Care

A palliative care team delivers many forms of help to a patient suffering from a severe illness, including :

- Close communication with doctors
- Expert management of pain and other symptoms
- Help navigating the healthcare system
- Guidance with difficult and complex treatment choices
- Emotional and spiritual support for the patient and their family

Palliative Care Is Effective

- Successful palliative care teams require nurturing individuals who are willing to collaborate with one another.
- Researchers have studied the positive effects palliative care has on patients. Recent studies show that patients who receive palliative care report improvement in:
- Pain and other distressing symptoms, such as nausea or shortness of breath
- Communication with their doctors and family members
- Emotional and psychological state

Where to find Palliative Care?

- In most cases, palliative care is provided in the hospital.
- The process begins when doctors refer individuals to the palliative care team.
- In the hospital, palliative care is provided by a team of experts.
- The Palliative Care Provider Directory of Hospitals at www.getpalliativecare.org can locate hospitals which provide palliative care.

Settings for Palliative Care

- Outpatient practice
- Hospital Inpatient
  - Unit based
  - Consultation Team
- Home care
- Nursing Home
- Hospice

Cost of Palliative Care

- Most insurance plans cover all or part of the palliative care treatment given in hospitals.

- Medicare and Medical aid also typically cover palliative care.

Palliative Care is Growing

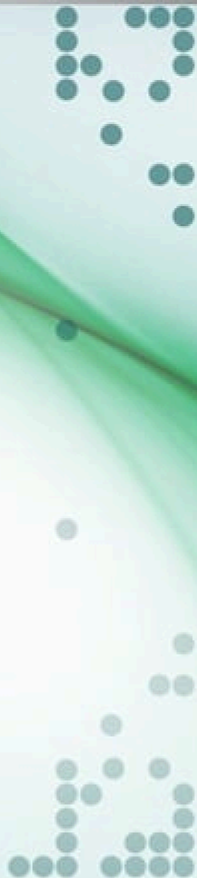
- Data suggest there is growth in palliative care programs throughout the nation's hospitals, larger hospitals, academic medical centers, not-for-profit hospitals, and VA hospitals are significantly more likely to develop a program compared to other hospitals.

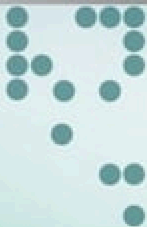
Countries with established systems

- Malaysia
  - In 1998, the Government began requiring every district and general hospital to introduce a palliative care provision.
- Mongolia
  - Palliative care incorporated into National health plan.
  - Palliative care module included in medical school curriculum.
- New Zealand
  - A palliative care education program has been established for care assistants.
  - 41 services are currently delivering palliative care throughout the country.

Countries with localized provisions

- China
- South Korea
- Philippines
- Vietnam





Countries with building capacity

- Brunei Darussalam
- Fiji
- Papua New Guinea

The countries are aiming to create conditions for the development of programs focused on palliative care.

Countries with no palliative care

- American Samoa
- Cook Islands
- French Polynesia
- Guam
- Kiribati
- Laos
- Marshall Islands
- Micronesia
- Nauru
- New Calendonia
- Niue
- Northern Mariana Islands
- Palau
- Pitcairn Islands
- Samoa
- Soloman Islands
- Tokelau
- Tonga
- Tuvalu
- Vanuatu
- Wallis and Futuna

THANK YOU