Disclosures

- I have no financial relationships to disclose
  - I have a contract with BC Cancer as the Pain and Symptom Management and Palliative Care Physician
  - I am also a LEAP facilitator with Pallium (a Not-for-profit Organization) and am paid an honorarium for that.
- I have no biases to disclose

Outline

1. Disclaimer RE: the term “Cancer Pain”
2. Introduce the principles of pain management for patients with cancer.
3. A Case review:
   a. Starting
   b. Education
   c. Risk Mitigating Prescribing
   d. Managing S/Es
   e. Following up
   f. Adjuncts
   g. Reserving
   h. Converting
4. Quick notes on specific opioids
5. Financial Coverage
6. To answer any and all symptom management and/or palliative questions you may have. (Time allowing.)
• Let's talk first about what we mean by "Cancer Pain"...

Disclaimer

POLL #1: What do we mean by Cancer Pain?

1. More/better research data establishing the safety and efficacy of opioids for long term cancer pain vs long term Chronic Non-Cancer Pain.
2. Cancer generally hurts more than other pain syndromes.
3. Patients with cancer are more morally deserving of pain relief than others.
4. There is something unique about the cause of pain in cancer that makes it reasonably more likely to respond well to opioids long-term than other syndromes.
5. Patients with cancer are assumed to be terminally ill.

POLL #2: Why is Cancer Pain treated differently?

1. More/better research data establishing the safety and efficacy of opioids for long term cancer pain vs long term Chronic Non-Cancer Pain.
2. Cancer generally hurts more than other pain syndromes.
3. Patients with cancer are more morally deserving of pain relief than others.
4. There is something unique about the cause of pain in cancer that makes it reasonably more likely to respond well to opioids long-term than other syndromes.
5. Patients with cancer are assumed to be terminally ill.
Patients with cancer are assumed to be terminally ill...

- Decreased pain intensity
- Improved function
- Improved quality of life (QOL)

POLL #3: Do you feel more comfortable treating:

1. Cancer Pain ("pain from active tissue damage", usually assuming a shorter prognosis)
2. Non-Cancer Chronic Pain (more "neuropathic pain with components of central sensitization", usually assuming a longer prognosis)
3. I don’t feel very comfortable treating pain
How much do we learn about Pain in School?


How applicable is this to my practice?:

Who provides palliative care?

College of Physicians and Surgeons of British Columbia

Timely, responsive palliative care is every registrant’s responsibility

Who provides palliative care?
WHO Principles of Pain Management in Cancer

CASE

• 70 yo man with a recent Dx of NSCLC.
• Starting Chemo and RT for this soon.
• Now presents with new Pain in R hip and low back.
• Started 4 weeks ago, getting worse
  • Hip: 6-7/10 -> 8/10 (wt bearing), back: 2/10
  • Has been using Acetaminophen and rest and heat -> not working
• Caring him to feel a lot of anxiety and fear and preventing him from walking (which he previously enjoyed a lot)
• XR and bone scan confirm lytic lesion R prox femur and smaller lytic lesion L1
• All other blood work is normal. No other significant PMHx.
**Poll #4**: Do you use a standardized screening tool for symptoms in your patients with cancer? Or who are receiving a palliative approach to care? YES or NO?

**Poll #5**: What medication would you like to start this patient on for first line treatment of his pain?

- Hydromorphone 0.5mg po q4h regular + 0.5mg q1h prn
- Morphine 5mg po q4h prn
- Morphine 2.5mg po q4h regular + 2.5mg po q1h prn
- Hydromorphone 1mg po q1h prn

**Educating**

- What are some things we should discuss with the patient when starting opioids?
  - Screen for risk of Opioid Use Disorder
  - Address concerns/fears
  - Safety: Diving, do not share meds
  - Side effects
  - Keep pain diary and track prn use
  - Discuss BT Pain and when to use prns, and when to call (>3BTs/d)
  - Non-pharmacologic modalities of pain control
- F/U in a few days max (over the phone is fine)
Risk of Opioid Misuse or Abuse

General safe prescribing tips for everyone:

• Single prescriber, single pharmacy
• Blister pack all regular meds
• Limit prn availability
• Small quantity prescribing or partial dispensing

High Risk, mitigate risk by:

• Opioid Contracts
• Smaller dosing amounts and frequency (use dispensing machines, daily dispensing or DWI)
• Link prn dosing case per blister pack
• UDS (for misuse of other substances and ensuring no diversion of Rx’d med)
• Monitor closely
• Interdisciplinary approach, using Addictions Medicine skills

Bowel Protocol:

• Sennakot 36mg po qhs regular
• Increase to sennakot 36mg po BID if no BM x 1 day
• Add lactulose 15-30mL po daily (during the day not qhs) if not BM x 2 days

Managing S/Es: Nausea and Constipation

First Line Antiemetic for opioid-related nausea:

• Metoclopramide 5-10mg po q4h
• Hakdol 0.5mg po q4h pm

Bowel Protocol:

• Sennakot 36mg po qhs regular
• Increase to sennakot 36mg po BID if no BM x 1 day
• Add lactulose 15-30mL po daily (during the day not qhs) if not BM x 2 days

(PEG is not covered by Palliative Care Benefits (Plan P)).
Following Up: Breakthrough, Incident, and End-of-Dose Failure Pain

- Baseline = 2.5mg x 6 = 15mg/d
- BT - needing avg 6x per day = 15mg/d
- Can start long-acting
  - M-Eslon: 15mg po q12h
  - BT at 10% of total daily dose (30mg) = 3mg
  - Continue 2.5mg po q1h prn

Adding in Adjuvants

- Including:
  - Non-pharmacologic (radiation, surgery, nerve blocks, PT, OT, etc.)
  - Compound Topical Analgesic Creams or Mouth Rinses (morphine, methadone, ketamine, gabapentin, lidocaine, etc.)
  - Sufentanil (for incident pain)

- Dexamethasone:
  - DO NOT give past noon as it increases the risk of insomnia
  - It is long-acting and only needs to be dosed once a day qAM

Converting to SUBQ or IV

- Conversions:
  - Don’t forget SubQ hydromorphone or morphine is 2x the potency of oral
Opioid Rotations:
• Use the tables
• Minus 20-30% after the calculation
• Use a pharmacist to help you!

Rotating

Opioid neurotoxicity vs. Opioid overdose

Opioid Neurotoxicity

More common Presentation
- Miosis
- Hallucinations
- Agitation
- Somnolence
- Cognitive dysfunction
- Hypotension, tachycardia

Treatment
- Reduce opioid dose
- Switch opioid
- Hydrate

Opioid Overdose

Less common Presentation
- Miosis
- Respiratory depression
- Loss of consciousness

Treatment
- Depends on severity:
  - If mild to moderate: hold next opioid dose and reduce dose
  - If severe, naloxone

Quick Note on Fentanyl

6. Fentanyl patch
• should not be used in an acute or not-controlled pain.
• It is CONTRAINDIcATED.
Symptom Management Resources

- PDF of the algorithms for Pain, Nausea, Dyspnea: https://www.bcpp.ca/cpc/symptom-management-guidelines/
- Fraser Health Hospice Palliative Care Symptom Guidelines: https://www.fraserhealth.ca/employees/clinical-employees/hospice-palliative-care-medications
- BC Guidelines, Palliative Care: https://www2.gov.bc.ca/gov/content/health-professionals/palliative-care-guidelines
- Pallium Canada: https://pallium.ca/
- Virtual Hospice: http://www.virtualhospice.ca
- KidsGrief.ca, MyGrief.ca and lots of bereavement support
- Patient handouts on symptoms, goals of care, etc.
- Practice tests and videos for physicians
- http://www.methadone4pain.ca/