Pain:
Assessment and management in palliative care

Katherine Clark
Calvary Mater Newcastle
The University of Newcastle
• Mrs. KW
• Problem of pain in palliative care
• Pain Assessment
• Generic approaches to pain management
• Controversies in pain management
• Mrs. KW
• Discussion
• Mrs. KW
• Problem of pain in palliative care
• Pain Assessment
• Generic approaches to pain management
• Controversies in pain management
• Mrs. KW
• Discussion
Mrs. KW

- 63 year old woman with vulvar cancer referred to palliative care with poorly controlled pain

- Initially diagnosed in 2011 when presented with a poorly healing vulvar lesion; referred to comprehensive gyn-onc service

- Now presents with extensive ulcerated changes of the perineum with destruction of the anal sphincter and external urethral meatus
Mrs. KW

• **Current symptom problems include:**

  – Pain: constant and distressing discomfort of the perineum
  – Pain: burning pain over medial aspect of the right thigh
  – Pain: excruciating pain when incontinent of faeces
  – Pain: excruciating pain when pain when the ulcerated areas are touched
  – Anxiety
  – Low mood
  – Impaired capacity to self-care
• Mrs. KW

• Problem of pain in palliative care

• Pain Assessment

• Generic approaches to pain management

• Controversies in pain management

• Mrs. KW

• Discussion
Pain in palliative care

• It is well documented that people with both malignant and non-malignant diseases facing end of life are at risk of pain

• Despite this, pain and its management remains:
  – Under diagnosed
  – Under reported
  – Under treated
  – Complicated by misconceptions

• This is worrying given that pain has been objectively correlated with suffering with suffering itself contributing to loss of meaning and autonomy
Pain in palliative care

- Despite the frequency with which pain affects people, should be possible to achieve analgesia

- However, the inherent stability of this population demands that attention be paid to changes

- While it might be tempting to conclude that this is pain management as ‘others” provide it, palliative care data suggests otherwise
Pain in palliative care

- Australian data (n=3027) highlights that while one sub-group of referred people had low to moderate pain scores on admission to a palliative care service, despite regular monitoring by the service, pain scores trended upwards towards death.

- This correlates with other observations that pain escalates towards death.
Mrs. KW

Problem of pain in palliative care

Pain Assessment

Generic approaches to pain management

Controversies in pain management

Mrs. KW

Discussion
Assessing patient with pain

• Pain may be the result of (or contributed to by):
  – Disease
  – Co-morbidities
  – Iatrogenic effects
  – Chronic pain
  – Psychosocial issues

• The fact that multiple factors may contribute underpins that observation that many people with advanced disease will have at least 2 separate pain problems simultaneously
Assessing patient with pain

- Assessment requires a comprehensive and physical examination which must include allowing the patient to report:
  - Site
  - Character
  - Severity (worst, best, average)
  - Onset
  - Duration
  - Radiation
  - Exacerbating and relieving factors
  - Interference with activity, sleep, wellbeing!
  - Treatments
Assessment tools

- There are a variety of patient-reported tools with the simplest being numerical rating scales.

- In Australia, the most frequently used is the SAS.

- The aim of the SAS is to allow people to identify how their symptom experience affects them.

- It is important to allow when possible, people to self-report their problems.
Why should people be allowed to self-report?

- Observations highlight that while families tend to over-report symptoms, health professionals tend to under-estimate.

- More recently, data suggests that treatment requirements are mainly driven by the distress the problem is causing a patient rather than the problem’s intensity or frequency.

- A clear understanding of the problem from the person’s perspective will best inform palliation.
Pain assessment

Other investigations?
• Mrs. KW
• Problem of pain in palliative care
• Pain Assessment
• **Generic approaches to pain management**
• Controversies in pain management
• Mrs. KW
• Discussion
Approaching analgesia

• Complicated pain at the end of life requires a multi-model, often multidisciplinary approach

• Less than 50% of people are likely to achieve analgesia at rest with one agent with breakthrough identified as even more difficult

• Even while the WHO ladder has recently been challenged, it still remains a common-sense, rule-of-thumb approach to prescribing

• However, it does not replace an individualised personalised treatment plans
• Mrs. KW
• Problem of pain in palliative care
• Pain Assessment
• Generic approaches to pain management
• Controversies in pain management
• Mrs. KW
• Discussion
**Step 1 non-opioid analgesics**

<table>
<thead>
<tr>
<th>Paracetamol</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Probably centrally acting</td>
</tr>
<tr>
<td>• Not necessarily always indicated as an adjunct to opioids</td>
</tr>
<tr>
<td>• Dose reduction recommended for malnourished people or those at risk of liver failure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NSAIDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inhibit cyclo-oxygenase therefore reducing inflammation induced hyperalgesia</td>
</tr>
<tr>
<td>• May have significant nephrotoxic and GI adverse effects</td>
</tr>
<tr>
<td>• This dictates that particular caution should be payed</td>
</tr>
<tr>
<td>• For example, a recent study of people with cancer cachexia as confirmed that although 90% had normal creatinine the actual GFR of 60% was significantly impaired</td>
</tr>
</tbody>
</table>
**Step 3 opioid analgesics**

- Although opioids do not theoretically have a ceiling effect, opioid rotation is indicated if people either have ongoing adverse effects from the opioid or if they fail to achieve analgesia.

- Transdermal opioids should not be used for unstable pain.

- Limited evidence exists as how to best prescribe opioids in either renal or hepatic failure; a rule of thumb is that a GFR<30 should prompt caution with morphine, hydromorphone and oxycodone.

- Opioid dose conversion tables should be interpreted with caution.

- The optimal dose of breakthrough pain relief ordered remains unclear.
## Adjuvant analgesics

- Dexamethasone is routinely recommended for bone pain despite limited evidence to support the efficacy of this practise.

- Although pregabalin and gabapentin are considered inter-changeable, recent pharmacovigilence work hints that when people have severe pain, they are more likely to experience harm from gabapentin than pregabalin.

- Ketamine in a recent trial did not prove to be more effective than placebo when both arms received best supportive care.

- Octreotide did not provide superior palliation for the symptom complexes experienced by people with inoperable bowel obstructions.
• Mrs. KW
• Problem of pain in palliative care
• Pain Assessment
• Generic approaches to pain management
• Controversies in pain management
• Mrs. KW again
• Discussion
Mrs. KW again

• Mrs KW was commenced on a regular opioid with oxycodone SR 30mg BD; this was titrated to 40mg BD which allowed her to be comfortable at rest.

• She was then also commenced on mirtazapine 30mg for her low mood with the presumption that this may help with the neuropathic component of the pain.

• Simultaneously, the gyn-onc surgeons were consulted with the request that a de-functioning colostomy should be considered.

• This will proceed on Monday……..
• Mrs. KW
• Problem of pain in palliative care
• Pain Assessment
• Generic approaches to pain management
• Controversies in pain management
• Mrs. KW again
• Discussion
• Under recognition of pain

• Need for proactive, systematic and regular screening

• Patient education programs

• Psycho-social aspects the pain experience