HammondCare

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Overview of the Australian Cancer Pain Guidelines

CNSA Workshop, September 2015

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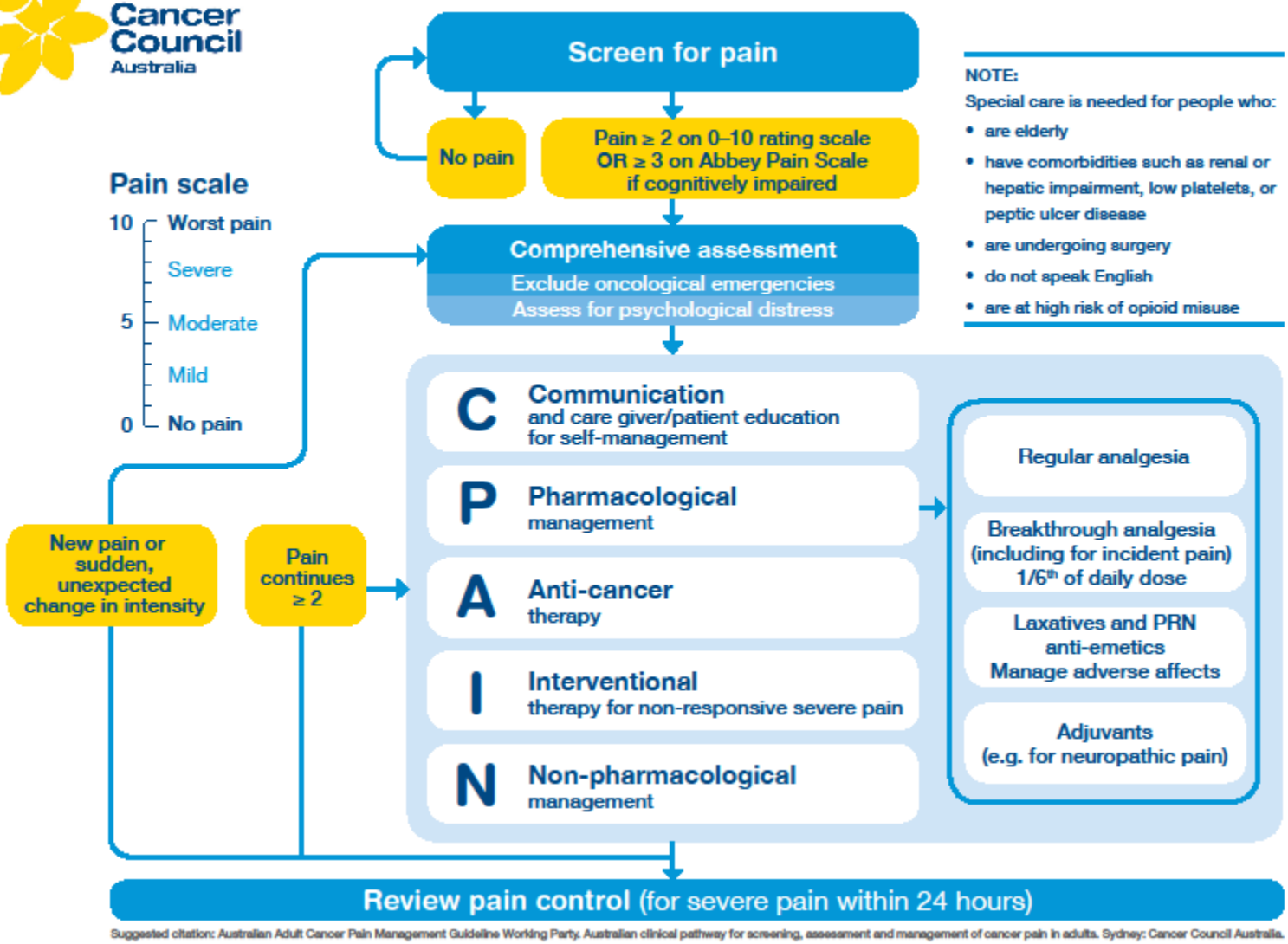
AUSTRALIAN CLINICAL PATHWAY FOR SCREENING, ASSESSMENT AND MANAGEMENT OF CANCER PAIN IN ADULTS

Cancer Council Australia



Suggested citation: Australian Adult Cancer Pain Management Guideline Working Party. Australian clinical pathway for screening, assessment and management of cancer pain in adults. Sydney: Cancer Council Australia.

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Cancer Guidelines Wiki

View ▼

Cancer pain management in adults

Guideline developer:
Australian Adult Cancer Pain Management Guideline Working Party

Cite this guideline

Download

Patient resources

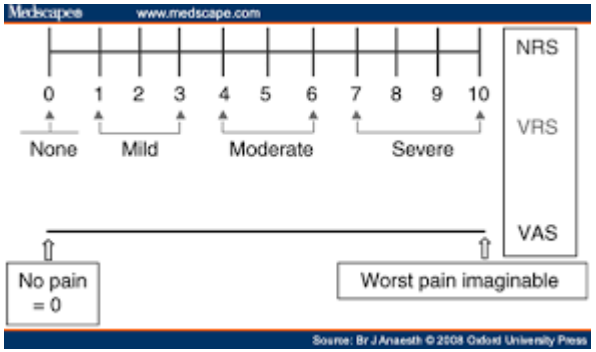
- Pain management goals
- Pain management goals instruction sheet

Australian Cancer Pain Guideline

- http://wiki.cancer.org.au/australia/Guidelines:Cancer_pain_management
- New platform
- Readily updated
- Widely accessible
- Available at point of care

Screening

- Patient-centred outcome measures
- Use validated tool
  - Pain Numeric Rating Scale
  - Abbey Pain Scale
  - Categorical Scale – mild, moderate, severe
- Good evidence for improved reporting of unmet needs, improved quality of life (Etkind JPSM 2014)



Assessment
Pain experience

- P- precipitating and relieving factors
  - Include relief with non-pharmacological and pharmacological treatments
- Q- quality of pain and quality of life
  - Nociceptive, neuropathic or mixed
  - Interference with mood, walking, working, relationships, sleep, enjoyment of life, overall
- R- radiation
- S- site
- T- time course
- Are you worried about something in particular? Elicit fears and meaning attributed to pain
- What is it important for me to know to are for you in the best possible way? (Chochinov)

Nociceptive versus Neuropathic

Nociceptive	Neuropathic
Ache	Burning
Stabbing	Shooting
Throbbing	Tingling
Squeezing	Numbness
Gnawing	Associated with allodynia, hyperalgesia

Evidence – pharmacological management

- Mild pain –NSAIDS and paracetamol Level 1A
- Moderate pain – low dose strong opioids or weak opioids like codeine
- Severe pain – opioids – morphine, oxycodone, and hydromorphone (**fentanyl when stable**)
- Titrate with long or short acting opioid
- Regular analgesia
- Breakthrough analgesia 1/6 of 24 hour dose
- Adverse event prevention

When to use which opioid

- Morphine cheap, numerous formulations – do not use if renal failure
- Hydromorphone – more potent (5-7.5x potency of morphine)
- Oxycodone (some kappa receptor activity)
- Oxycodone – naloxone – avoid or stop if hepatic impairment
- Fentanyl in stable pain only, not in acute pain. 12mcg/hour equals 30-45mg morphine.
- Methadone –complex pain refractory to other interventions
- Tapentadol – limited experience
- Tramadol Mu and Serotonergic /Noradrenergic R activity

- Norspan (buprenorphine – parital mu agaonist) – low dose elderly in RACF

Opioid rotation?

- Improve efficacy
  - incomplete cross tolerance
  - different receptors
  - individual differences in metabolism
- Reduce side effects
- Reduce dose by 25-50%
- Change route of administration
  - unable to tolerate po
  - 95% response rate if oxycodone and morphine available in ca pain
  - Riley 2015

Adverse effects

- Preempt and prevent!
  - Constipation - Regular laxative
  - Nausea and vomiting - Prn anti-emetic, if persists beyond a week, rotate opioid
- CNS adverse effects – sedation, confusion, hallucinations, nightmares
  - Start low dose, reduce dose if occurs, switch opioids
- Respiratory depression – rapid tolerance to this adverse effect occurs, start low dose
- Itch – switch opioids, consider H1 antagonist
- Myoclonus – reduce dose, rehydrate, switch opioids
- Urinary retention

Opioid Risk Assessment

- Stratify risk
- Structure therapy commensurate with risk
- Assess drug related behaviours
- Respond to aberrant behaviour
- Document and communicate
- No evidence in cancer pain

- High risk for misuse if
  - Previous history of substance abuse
  - Family history substance abuse
  - Psychiatric disorder

Opioid Risk Tool[13]

Mark each box that applies	Female	Male
1. Family history of substance abuse		
• Alcohol	☐ 1	☐ 3
• Illegal drugs	☐ 2	☐ 3
• Prescription drugs	☐ 4	☐ 4
2. Personal history of substance abuse		
• Alcohol	☐ 3	☐ 3
• Illegal drugs	☐ 4	☐ 4
• Prescription drugs	☐ 5	☐ 5
3. Age (mark box if 16-45 years)	☐ 1	☐ 1
4. History of preadolescent sexual abuse	☐ 3	☐ 0
5. Psychological disease		
• ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
• Depression	☐ 1	☐ 1

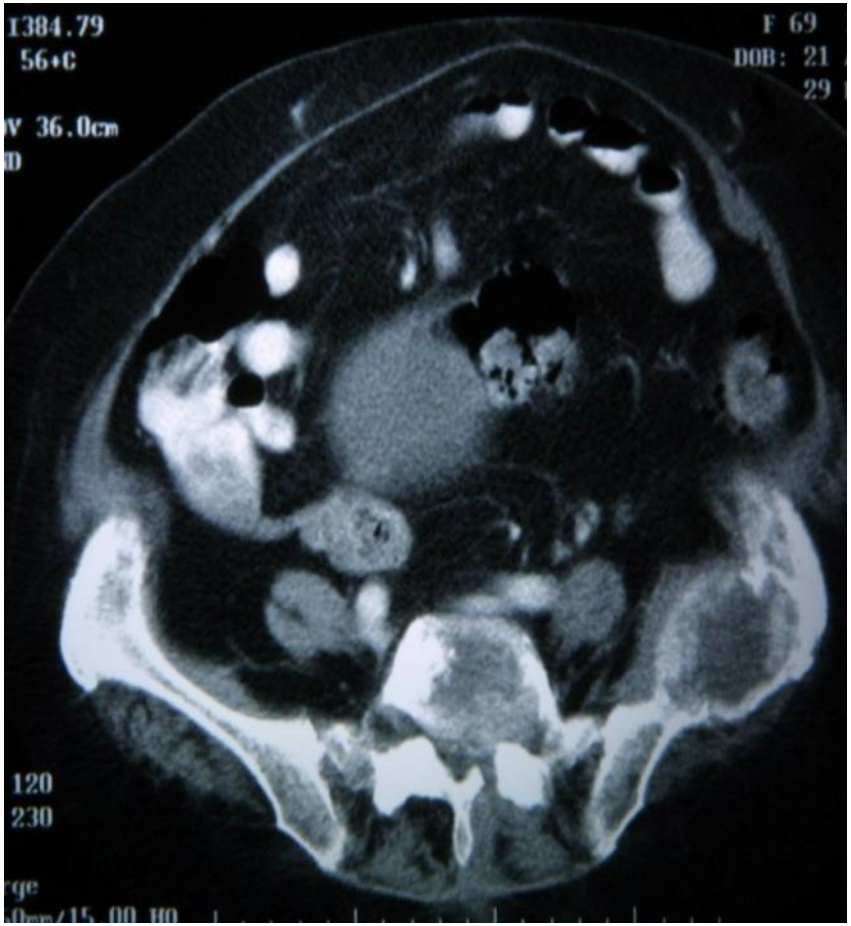
ADD = attention deficit disorder
OCD = obsessive-compulsive disorder

» Portenoy 2014, Anghelescu 2013

Neuropathic pain

- Optimise opioids
- Anticonvulsants – pregabalin (gabapentin)
  start low – 25mg nocte for elderly
  - Dizziness, drowsiness main adverse effects
  - On PBS
  - Specific ligand of alpha 2 delta subunit of ca channel
  - NNT higher and NNH lower than for non-malignant pain
- Antidepressants - duloxetine

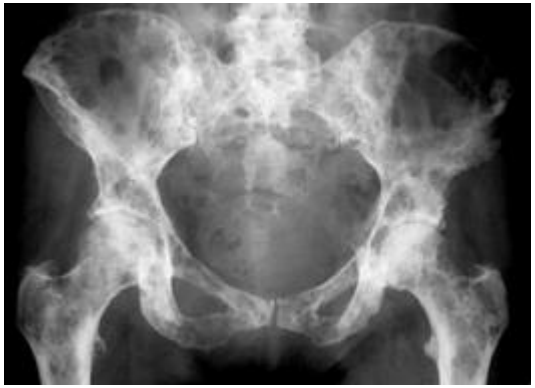
Lytic Bony metastases needing RT



- Duration of radiotherapy
  - Randomised trials support single large fraction for acute pain control
  - Unlikely to be long lasting, unless disease control obtained by other means
    - Consider longer courses if longer life expectancy and neural involvement
  - Expect bone marrow suppression afterwards, and be careful with chemotherapy
  - Follow up with bisphosphonates / denosumab

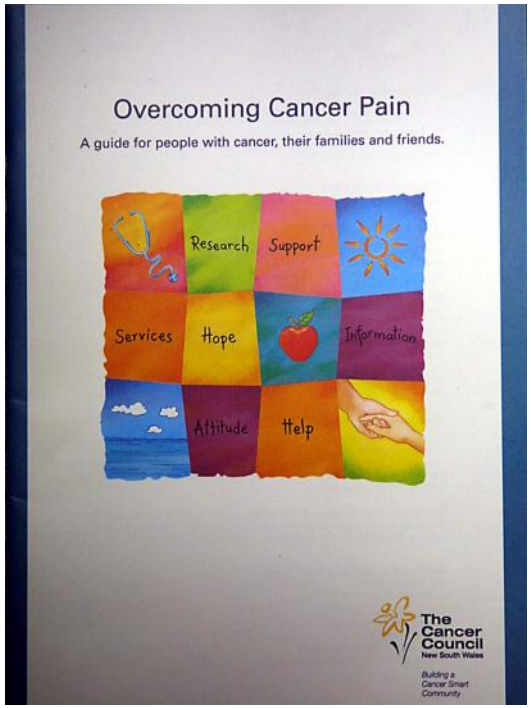
Bone Pain

- Denosumab – RANK ligand inhibitor
  - Given sc by GP monthly, can cause symptomatic hypocalcaemia
  - Available for breast and prostate cancer
- Zometa – iv by oncologist
  - Need to ensure renal function adequate
  - Both risk ONJ, beware bone mets in jaw
  - Check by dentist before treatment



Patient education

- As effective in clinical trials as analgesics
- Self management strategies: pain diary, script – how to explain your pain, management plan, goal setting
- Explode the myths –
  - people with pain and cancer do not become addicted to morphine
  - Starting morphine does not mean you are dying
  - You don't get used to it such that it does not work if the pain gets worse
  - Side effects do exist but can be managed



Non-pharmacological strategies

- CBT
- Hypnosis
- Relaxation
- Imagery
- Distraction
- Physical strategies eg exercise (Evidence level 3-4)
- Prayer

Interventional strategies

- Coeliac plexus blocks in pancreatic ca
- Intrathecal therapy for pain not responsive to comprehensive medical management
- Evidence for other strategies weak or absent

Our mission

Our passion is improving quality of life for people in need