PALLIATIVE CHALLENGE:
DIFFICULT CANCER PAIN IN HOSPICE CARE

GOALS/OUTCOMES

• Is this situation an outlier?
• What is the pathophysiology?
• What is the problem here?
• An approach to successful management of difficult cancer pain
• The team—what would be do without it?

WHAT IS MEANT BY “DIFFICULT” CANCER PAIN?

• Most cancer pain easily managed with first line pharmacologic approaches
• 10-20% of patients have pain not easily relieved with standard measures
• A number of factors may be at play:
  • Type of pain stimulus—neuropathic, bone pain
  • Individual patient characteristics—SNPs
  • Aberrant responses—ON, “windup”, central hyperalgesia
  • Psycho-social-spiritual factors
• Let’s explore some of these together in the form of some cases
MY PERSPECTIVE:

- Hospice doc for 30 years, full time for 10
- IPU and home hospice
- I live under the per diem in a medium size program under a medium size health system, which is quite generous
- Patient care comes first
- Nevertheless, we watch our pennies
- Constricted universe of treatment possibilities, particularly re interventional pain modalities

5 COMMON SITUATIONS:

- “Windup” phenomenon and crisis level pain
- Neuropathic pain
- Complex (multifactor) cancer pain
- Incident to/breakthrough pain (usually bony pain)
- Opioid induced neurotoxicity

SCENARIO #1: CRISIS LEVEL PAIN

- 68 y/o man with metastatic renal cell cancer to skeleton, liver, lungs—treatment refractory
- Home hospice care for 2 weeks
- Pain abdomen, right shoulder and back 8/10 on admission
- PPS 40 minus cachectic; LE “weeks to short months”
- Oral oxycodone escalated by oncologist from 160 mg/day to 320 mg/day over 2 weeks; adjunctive ibuprofen
- No substance misuse issues; good home support
- Pain today in above locations 9-10/10—“excruciating”
REFLECT UPON THIS:

• What else would you like to know?
• Where should this man be managed?
• What is the first thing to do?
• Which opioid do you want to use?
• Any adjuncts?
• How, specifically, do you want to approach this problem?

WINDUP: WHAT DO YOU NEED TO KNOW?

• Chronic pain in the periphery results in repetitive firing of C fibers
• This results in augmentation of activity in the dorsal horn of the spinal cord and a strong increase in the magnitude of responses evoked by subsequent stimuli
• Mediated through up-regulation of the NMDA receptor
• “Pain begets more pain”
• To alleviate, must get “on top of” the pain, and if possible, downregulate the NMDA receptor

References: Bruera et al: Textbook of Palliative Medicine, 2006

SCENARIO #2: NEUROPATHIC PAIN

• 70 yo woman with right upper lobe mass
• WT loss, anorexia, declining performance status
• Comorbid heart failure, COPD, depression
• Declined bronchoscopic or needle bx—referred to hospice care
• Dysesthetic pain right arm, associated with weakness. Best 5/10; worst 9/10; average 7/10.
• Lives alone, widow, one estranged adult son
WHAT TO DO?

- Why is she having such severe pain in her arm?
- What palliative modalities might be helpful?
- Where should she be managed?
- Pharmacologic approach?

MALIGNANT BRACHIAL PLEXOPATHY: THE ESSENTIALS

- Most commonly lung and breast cancer
- Pancoast syndrome: Superior sulcus lung cancer. Full syndrome includes Horner’s syndrome due to autonomic chain involvement + brachial plexopathy
- Dysesthetic upper extremity pain +/- weakness/atrophy is presenting feature—may precede neoplastic awareness
- Pain can be severe, unrelenting, and very challenging to manage
- Management is pharmacologic. There are no good IR interventions for brachial plexopathy
- DDx: Radiation induced brachial plexopathy
SCENARIO #3: COMPLEX (MULTIFACTOR) CANCER PAIN

- Billy, 72 yo retired banker
- Stage 4 pancreatic cancer, with biliary obstruction
- S/P Whipple; disease progression despite 3 lines of chemo
- Bilateral DVT's; PET shows extensive metastatic disease in liver and regional nodes
- Home hospice reluctantly accepted by patient; “Full code”
- BMI 18 (usual 23); Pain average 6-7/10 in epigastrium and back; worst 10/10; best 3-4/10 (when sleeping); PPS 50%
- Other symptoms: Sadness, itching, insomnia, easy fatigability, constipation
- Oncologist managing pain with up to 8 Norco 5-325/day—requesting hospice physician become attending

THINK ABOUT IT:

- What are the symptoms that need to be addressed?
- In what order?
- What is the mechanism of Billy’s pain?
- How should pain be managed under hospice care?
- What about the other symptoms?
- Who else on the team might be helpful in managing his “total” pain
CELIAC PLEXUS BLOCK FOR PAIN IN PANCREATIC CANCER: THE EVIDENCE

- Meta-analysis 2011 of endoscopically guided block and celiac plexus neurolysis
  - “EUS guided CPN was 72.5% effective in managing pain due to pancreatic cancer”

- Cochrane review: vs opioid rx, advantage ~0.4 pain scores. But….opioid consumption lower with celiac plexus block

SCENARIO #4: “INCIDENT TO” PAIN

- John, 84 yo with metastatic, castrate resistant prostate cancer for 10 years
- Now widespread bony metastases
- Severe pain in right hip, right scapula
- At rest 2-3/10, when transferring or walking 8/10
- PPS 60%, but declining
- Lives with wife, son, d-i-l and grandchildren in adequate size home
- Loves to garden and fish—cannot do so because of pain
- Referred to hospice by his urologist after refusing oncology referral for consideration for chemotherapy

SOME CONSIDERATIONS:

- What would be the options for pain management for this man?
- How does that affect hospice admission?
- What might be done immediately to give him some relief?
RADIOPHARMACEUTICALS/ BISPHOSPHANATES/DENOSUMAB?

• Radium-223: Prolongs survival; increased time to “first skeletal event”; “better quality of life” during drug admin; well tolerated.
• Bisphosphonate: Not approved for this indication; little evidence of efficacy; jaw osteonecrosis.
• Denosumab: Monoclonal antibody binding to ligand leading to osteoclast activity; no evidence on pain; delays time to metastasis or skeletal events but does not prolong survival; jaw osteonecrosis.
• All of these are mega-$\ldots$

PALLIATIVE RADIATION FOR BONE PAIN: THE ESSENTIALS

• Achieves pain relief in >75% of patients.
• Pain relief begins within first few treatments, but requires 4-6 weeks for maximal relief.
• Single large fraction considered as effective as multiple fractions and is preferable in patients with expected survival measured in short months.


SCENARIO #5: OPIOID INDUCED NEUROTOXICITY

• 52yo woman with at least stage 3B ovarian cancer—disease progression despite multi lines chemo.
• Hospice patient for 2 months.
• Malignant ascites; cachectic; PPS 30%.
• Some confusion; pain “severe”—excruciating in abdomen despite continuous morphine dose escalation.
• Family reports more confusion, restlessness, and “twitching” last PM, which your assessment confirms.
• Family distraught and in conflict—alpha daughter wants Mom “back in the hospital, so they can figure out what is going on.”
WHAT’S UP?

- What is causing this woman’s (and families’) distress?
- Where should she be managed?
- How should she be managed?
- How should this family be supported in this difficult situation?

ANDREW FISCHER, M DIV

- Spiritual support, par excellence
- Will share with us the many ways he supports the management of difficult pain and other symptoms

THOUGHT EXPERIMENT

Focus Up, Everyone!
IS THIS WHAT YOU SAW?

WHY DOES THIS MATTER?

• We are holistic beings
• We are fundamentally made for connection
• We, as care providers, are in a unique position

WHAT CAN WE DO?

• Guided Meditation
• Music Therapy
• Healing touch
• Presence
• Practice Empathy
WHAT CAN WE DO? (CONT.)

• Listen
• No, seriously…LISTEN!

BENEFITS

• To the patient
• To the individual

TEAMWORK MAKES THE DREAM WORK
LET'S WORK TOGETHER

• You are not alone
• Your work does not exist in a vacuum
• You don’t have to do it all by yourself
• Reach Out!

FINAL THOUGHT

• “To cure sometimes,
  To relieve often,
  To comfort always.”
  — Edward Livingston Trudeau