Pain and Symptom Management in Pancreatic Cancer

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Patient and Liaison Services (PALS)
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Pain and Symptom Management in Pancreatic Cancer

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Objectives

- Discuss Common Symptoms and Concerns
- Discuss Supportive Care Approaches
- Some Barriers to Symptom Relief

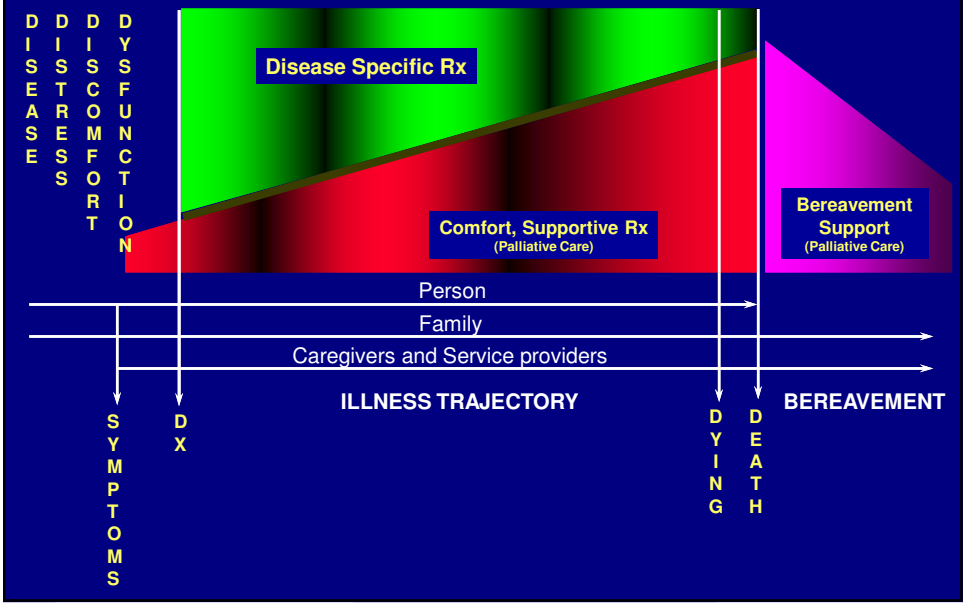
Palliative Care

Palliative Care

- Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness, whatever the diagnosis.
- The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

Center to Advance Palliative Care 2011

The Continuum of Palliative Care



PAIN

Pain

- Physical pain is affected by emotions
- There are no objective tests for pain
- The most accurate assessment of pain is based on what the patient says

Effects of Pain on Quality of Life

Physical:

- Poor Sleep
- Decreased strength and endurance
- Nausea and poor appetite

Psychosocial:

- Depression
- Anxiety
- Irritability
- Difficulty concentrating
- Reduced social relationships

Classification of Pain

Nociceptive Pain

Feeling of pain transmitted along healthy nerves

Somatic: Fractures, bone cancer, arthritis, skin infections etc.
Typically well-localized (One finger test)

Visceral: Pancreatitis, peptic ulcer, heart attack etc.

- Hard to localize
- From compression, stretching or injury to internal organs
- Often described as “deep”, “squeezing,” “aching,” “pressure.”
- May be associated with nausea and sweating.

Neuropathic Pain

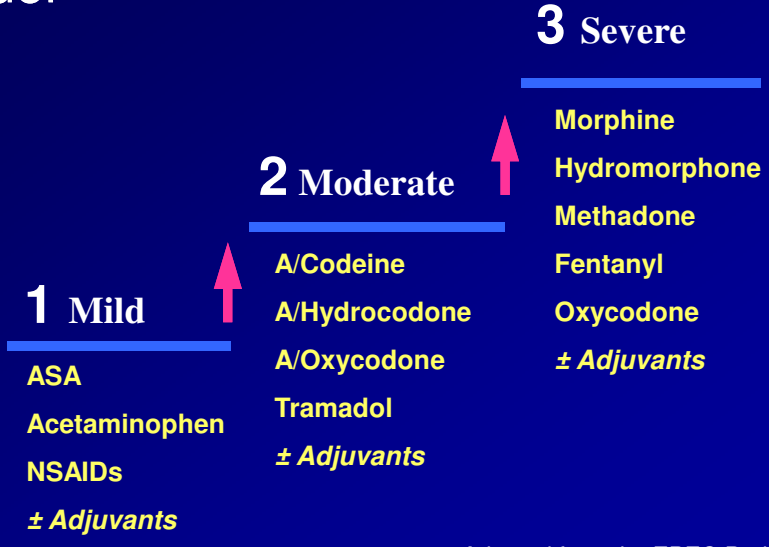
- From injury to the nervous system
  - Post surgical pain, shingles, diabetic neuropathy, phantom limb pain etc.
- Constant and burning
  - Antidepressants or anticonvulsants can be helpful
- Shooting pain
  - Typically sharp or shock-like
  - Lasts seconds to minutes
  - Anticonvulsant medications may be very helpful
- .

Treating Pain with Opioids

What's so Great about Opioids?

- They relieve most types of pain
- No maximum dose
- Do not damage liver, kidneys or stomach
- No increased risk of bleeding.

WHO 3-step Analgesic Ladder



Adapted from the EPEC Project

Opioid Effectiveness

- Most common reason an opioid is ineffective is reluctance to increase dose till pain is relieved
- No upper limit to doses of opioids
- Increase dose until
  - Pain is relieved
  - There are bad side effects

Difficult Pain

- If increasing dose → bad side effects
  - Try a different
    - route of administration
    - Opioid
    - Type of pain medicine
  - Nonmedical approach
  - Therapy to treat adverse effects

Other Routes for Pain Relief

- IV PCA (Patient Controlled Analgesia)
  - The Button
- Nerve Blocks
  - Celiac Plexus Block
- Spinal Opioids
  - Intrathecal or epidural

Six Opioids for Chronic Pain

- Morphine: Most Commonly Used
- Oxycodone: Oral only
- Oxymorphone
- Hydromorphone: Dilaudid
  - Short-acting & long-acting pills
- Fentanyl
  - Patch or oral fentanyl products
  - 100x stronger than morphine
- Methadone: inexpensive, long acting
  - Bad reputation

Fentanyl Patch

Fentanyl patch is useful for chronic, stable pain

- Difficult to adjust for rapidly increasing pain
  - Takes 18 hours to reach full strength
- Listed for 3 days but many change every 2 days

Very Strong, should be used with care!

Do not cut the patch and ensure it sticks to skin

Multiple patches should not touch each other

Long- & Short-acting Opioids

Opioid Dosing & Breakthrough Pain

- Patients who use opioids for severe chronic cancer pain need scheduled dosing using a long acting opioid
  - MS Contin, OxyContin, fentanyl Patch, Opana ER,
  - Exalgo, methadone
- These patients also use “as needed” doses of short acting opioids for breakthrough pain (BTP)
  - Morphine, oxycodone, hydromorphone, Opana
  - Actiq, Fentora, Abstral, Onsolis, Lazanda (Oral fentanyl)

Long-acting Opioids

- Same drug as the short-acting but in a timed release form
- Goal is to prevent as much pain as possible with a stable blood level of the opioid
- Breakthrough medication about 0 – 2 times a day is expected.
- Never works as fast as we want

Opioid Side Effects

Common	Uncommon
Constipation	Bad dreams / hallucinations
Dry mouth	Dysphoria / delirium
Nausea / vomiting	Myoclonus / seizures
Sedation	Pruritus / urticaria
Sweats	Respiratory depression
	Urinary retention

Opioid Allergy

- Adverse effects, not allergic reactions
  - Nausea / vomiting, constipation, drowsiness, confusion
- True allergies
  - Bronchospasm (Closing throat)
  - Rash

Dependence not Addiction

Physical Dependence

- The body misses the drug if stopped too quickly
- Abrupt withdrawal may → abstinence syndrome
  - "Cold Turkey"
    - Sweats, Abdominal pain, back pain, runny nose, diarrhea
  - Take an extra as-needed dose
  - If improved CALL YOUR DOCTOR!

Addiction

- Psychological dependence
- Compulsive use in spite of harm
- Loss of control over drugs
- Loss of interest in pleasurable activities
- An uncommon outcome of pain management
  - particularly, if no history of substance abuse

Adjuvant Pain Medications

- Medications that work with opioids to help treat pain
  - may themselves be normally used for pain and so used alone

Adjuvant (Non-opioid) Pain Medications

- Acetaminophen
- Non-steroidal anti-inflammatory drugs
- Corticosteroids
- Antispasmodics
- Tricyclic antidepressants
- Anticonvulsants
- NMDA antagonists (ketamine)
- Anesthetics

Nonsteroidal Anti-inflammatory Drugs (NSAIDs)

- All have analgesic ceiling
- Effective for bone, inflammatory pain
- Highest incidence of adverse events
  - Stomach problems
  - Kidney problems
  - Bleeding problems

Adapted from EPEC

Steroids

- Many uses
  - Bone & Inflammatory pain
  - Improved appetite
  - Improved energy
  - Feeling of well-being etc.
- Many Side Effects

Constant Neuropathic Pain

- Usually Burning, Tingling
- Antidepressants
  - Amitriptyline: limited usefulness in frail, elderly
  - Desipramine: tricyclic of choice in seriously ill
  - Duloxetine (Cymbalta)
- Anticonvulsants
  - Pregabalin (Lyrica)
  - Gabapentin (Neurontin)
    - minimal adverse effects
    - drowsiness, tolerance develops within days

Shooting, Stabbing, Neuropathic Pain

- Anticonvulsants
  - Pregabalin
  - Gabapentin
- Monitor blood levels of drug for risk of toxicity
  - Oxcarbazepine
  - Carbamazepine
  - Valproic Acid

Barriers to Pain Management

Barriers exist within and among three different groups:

Health care systems

Health care professionals

Patients and families/caregivers

Barriers to Good Pain Management: Patients/Families/Caregivers

Fears of:

- Looking weak
- Distracting physicians
- Means disease is worse
- Being seen as a bad patient
- Doses get “too high”
- Addiction
- Side effects of opioids

Non-Pain Symptoms

Constipation

- Medications
  - opioids
  - calcium-channel blockers
  - anticholinergic
- Decreased motility
- Ileus
- Mechanical obstruction
- Metabolic abnormalities
- Spinal cord compression
- Dehydration
- Autonomic dysfunction
- Malignancy

Constipation

- Common to all opioids
  - Opioid effects on gut
  - Tolerance usually does not develop
- Much easier to prevent than treat
- Ask when get opioid what to do if constipated

Constipation

- Diet usually not enough
- No over-the-counter bulk forming agents
- Stool softeners
  - Sodium docusate (Colace, etc)
- Stimulant laxative
  - senna, bisacodyl, casanthranol
  - Combine with a stool softener
    - senna + docusate sodium
    - casanthranol + docusate sodium

Constipation

- Osmotic laxative
  - Lactulose or Sorbitol 15-30 ml QD to Q4h
  - Bisacodyl 5-15 mg PO/PR QD-BID
  - Polyethylene glycol (MiraLax, GlycoLax)
- Prokinetic agent
  - Metoclopramide
- Other measures
  - Mineral oil, magnesium hydroxide, magnesium citrate, suppositories, enemas
  - Methylnaltrexone (Relistor) (Injection)

Nausea / Vomiting

- Nausea
  - Subjective sensation
- Vomiting
  - Visible action

Causes of Nausea / Vomiting

- Metastases
- Meningeal irritation
- Movement
- Mental anxiety
- Medications
- Mucosal irritation
- Mechanical obstruction
- Motility
- Metabolic
- Microbes
- Myocardial

Management of Nausea / Vomiting

- Dopamine antagonists
- Antihistamines
- Anticholinergics
- Serotonin antagonists
- Prokinetic agents
- Antacids
- Cytoprotective agents
- Other medications

Dopamine Antagonists

- Haloperidol (Haldol)
- Prochlorperazine (Compazine)
- Promethazine (Phenergan)
- Metoclopramide (Reglan)

Treatment of Nausea/ Vomiting

- Seratonin antagonists
  - Ondansetron, granisetron, dolasetron
- Antihistamines
  - Diphenhydramine, Meclizine, Hydroxyzine
- Anticholinergics
  - Scopolamine patch
- H2 receptor blockers
  - Cimetidine, famotidine, ranitidine, etc.
- Proton Pump Inhibitors
  - Omeprazole, lansoprazole

Other Medications

- Dexamethasone (and other steroids)
- Dronabinol
- Lorazepam
- Misoprostol

- Octreotide (Last ditch of drying out the gut)

Dyspnea (Breathlessness)

- May be described as
  - shortness of breath
  - Suffocating feeling
  - inability to get enough air

Dyspnea (Breathlessness)

- The only reliable measure is patient self-report
- Nothing to do with
  - Respiratory rate,
  - Pulse-Oximetry
  - Blood gas determinations

Causes of Dyspnea

- Anxiety
- Airway obstruction
- Bronchospasm
- Hypoxemia
- Pleural effusion
- Pneumonia
- Pulmonary edema
- Pulmonary embolism
- Thick secretions
- Anemia
- Metabolic
- Family / financial / legal / spiritual / practical issues

Management of Dyspnea

- Treat the underlying cause
- Symptomatic management
  - Oxygen: potent symbol of medical care
    - Pulse oximetry not helpful
  - Opioids
  - Anxiolytics
  - Nonpharmacologic interventions
    - Fan

Anorexia / Cachexia

- Anorexia
  - Loss of appetite
- Cachexia
  - Loss of weight and energy, fatigue

Management of Anorexia/ Cachexia

- Assess, manage related conditions
- Educate, support patient and family
- Favorite foods / nutritional supplements

Management of Anorexia /Cachexia

- Corticosteroids (short term)
- Progestational agents (megestrol acetate)
- Dronabinol
- Trials of many medications

Management of Fatigue /Weakness

- Education, support
- Clarify role of underlying illness
- Promote energy conservation
- Permission to rest
- Evaluate medications
- Improve fluid & electrolyte intake

Management of Fatigue /Weakness

- Dexamethasone
  - feeling of well-being, increased energy
  - effect may wane after 4-6 weeks
  - continue until death
- Methylphenidate (Ritalin)

Poor Fluid Balance / Edema

- Often associated with advanced illness
- Low blood protein (albumin)
  - Decreased ability to hold liquid in blood
- Blockage of veins or lymph system
  - May contribute

Fluid Balance / Edema

- Urine output will often be low
- Limit or avoid IV fluids
- Drink some fluids with salt
- Skin care

Psychiatric Symptoms

Depression & Anxiety

- Very Common
- Under-diagnosed
- Effective management is possible

Depression

- ¼ up to ¾ of patients
- Intense suffering
- Not inevitable
- Treatable in most cases
  - Especially if caught early
- Watch for suicidal patient

Risk Factors

- Pancreatic Cancer
- Progressive physical weakness
- Uncontrolled Pain
  - Spiritual pain
- Preexisting risk factors
  - prior history, family history, social stress
  - suicide attempts, substance use

Diagnosing Depression in Advanced Illness

- Physical symptoms always present
  - Poor appetite, poor sleep, low energy
- Look for psychological symptoms
  - pain not responding as expected
  - sad mood / flat affect, anxious, irritable
  - worthlessness, hopelessness, guilt
  - Lack of enjoyment, lost self-esteem

Management of Depression

- Psychotherapeutic interventions
  - cognitive approaches
  - behavioral interventions
- Medications
- Combination of psychotherapy, medication

Medical Management

- Stimulants
  - Rapid effect
  - Methylphenidate, 5 or 10 mg q am,
    - Also Modafinil or dextroamphetamine
  - Alone or with antidepressent
  - May continue indefinitely
- SSRIs & atypical antidepressants
  - 2–4 weeks to kick in
  - Highly effective (70%)
  - Well tolerated

Anxiety

- Fear, uncertainty about future
- Physical, psychological, social, spiritual, practical issues
- Presentation
  - agitation, insomnia, restlessness,
  - sweating, fast heart rate, fast breathing
  - panic disorder, worry, tension

Management of Anxiety

- Counseling, supportive therapy
- Atypical antidepressants
- Benzodiazepines
  - short vs long half-life
    - diazepam
    - Clonazepam
    - lorazepam
    - alprazolam, oxazepam

Summary

- Many symptoms can make patients miserable
- Treat them
  - Maximize effects of disease-specific treatments
  - Care for patients after disease-specific treatments stopped
- Palliative care teams can be effective in treating difficult symptoms at all stages of disease

Questions?

Thank you for your participation!

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If you have questions, please contact our Patient and Liaison Services (PALS) program at

(877) 272-6226 or e-mail pals@pancan.org.

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