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

The Continuum of Palliative Care illustrates the progression of disease-specific and comfort-supportive care, as well as the impact on the person, family, and caregivers. It shows how palliative care is integrated into the continuum of care throughout the illness trajectory, from diagnosis (DX) through dying (DYING) and bereavement (BEREAVEMENT).

Disease Specific Rx

Comfort, Supportive Rx (Palliative Care)

Bereavement Support (Palliative Care)

Person

Family

Caregivers and Service providers

ILLNESS TRAJECTORY
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

1 Mild
- ASA
- Acetaminophen
- NSAIDs
- ± Adjuvants

2 Moderate
- A/Codeine
- A/Hydrocodone
- A/Oxycodone
- Tramadol
- ± Adjuvants

3 Severe
- Morphine
- Hydromorphone
- Methadone
- Fentanyl
- Oxycodone
- ± Adjuvants

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

Adapted from the EPEC Project
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

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**
- Constipation
- Dry mouth
- Nausea / vomiting
- Sedation
- Sweats

**Uncommon**
- Bad dreams / hallucinations
- Dysphoria / delirium
- Myoclonus / seizures
- Pruritus / urticaria
- 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

- Serotonin 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

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**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!

Pancreatic Cancer Action Network
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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.