Barriers to Effective Cancer Pain Treatment

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The Mystery

- Most pain is poorly treated
- Most pain can be adequately managed
- Why do so many patients suffer needless pain?

Barriers to Effective Pain Treatment

- Poor Assessment
- Patient Issues
- Caregiver Bias-Knowledge deficit
- System problems
- Cultural issues
- Disease itself
- Overcoming Barriers

Assessment of Cancer Pain

Assessment Of Cancer Pain

Pain:
"A new pain in cancer patient is always because of cancer unless otherwise proved"-- Reddy

Components of Pain

- Sensory
- Intensity
- Quality
- Reactive
- Affective
- Motivational
- Interference with activities

Assessment

Visual numeric scale(0-10 scale) – Most commonly used-easy to interpret, universally accepted.

Visual Analogue Scale(0-10 cm)-Used mostly in research settings

Questionnaires:

Brief Pain Inventory:

- Captures pain at different times
- Functional interference is assessed
- Other symptoms are assessed
- Well tested, easy to administer

Assessment Of Pain

Anderson Symptom Assessment Scale (ASAS) :

- Easy to administer, captures other symptoms on a 0-10 scale format.
- Easy follow through and can act as a flow chart.

Anderson Symptom Assessment Scale (ASAS)

Brief Pain Inventory (Severity)

2. Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

0 No Pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine

Brief Pain Inventory (Interference)

7. Circle the number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

Activities Impaired by Increasing Pain

3	4	5	6	7	8
					relate
				walk	walk
		sleep	sleep	sleep	sleep
		active	active	active	active
		mood	mood	mood	mood
	work	work	work	work	work
enjoy	enjoy	enjoy	enjoy	enjoy	enjoy

> > > > worst pain rating > > > >

n = 186 Multi-institutional study

Assessment

- A thorough history & physical examination is essential
- Including Cancer Hx
- Psychosocial factors
- Relevant Imaging

Assessment Of Cancer Pain

- A thorough neurological examination is mandatory.

Gonzales, et al (1991), have reviewed a large series of patients in a cancer referral center,

- neurological consultation resulted in identification of a previously undiagnosed etiology for pain in 64% of patients,
- resulted in additional anti-tumor therapies (radiotherapy, surgery, or chemotherapy) for 18% of patients evaluated

Radiological Assessment

- Bone scan –detects mets as small as 2mm(non-specific)
- Plain films-useful to visualize fractures of long bones, small lesions cannot be visualized
- CT Scan
- MRI

Barriers: Patient factors

- Age/Sex/Minority- Demographic Issues
- Patient beliefs:
  - I'll get addicted to opioids
  - They won't work when I really need them
  - I don't want to bother the doctor
  - I don't want to bother my family
  - I want to be morally strong (stiff upper lip)
  - I don't want to complain
  - I won't get my chemo if I complain too much

PREDICTORS OF NEGATIVE PMI (UNDER TREATED)

TERM	ODDS RATIO
MINORITY VS. NON	3.1
DISCREPANCY (PT-MD)	2.3
CAUSE OF PAIN (CA VS NON)	2.0
PERFORMANCE STATUS	
GOOD VS POOR	1.8
AGE (70+ VS 18-52)	1.5
GENDER (F VS M)	1.5

Barriers: Patient factors II

- Denial - ↑ pain means my cancer is back/progressing
- Costs - Can't afford expensive medications
- Can't get to health care provider for treatment (rural)

Barriers: Oncologists Pain Control in Your Setting?

VERY POOR	7%
POOR	11%
FAIR	32%
GOOD	43%
VERY GOOD	7%

Common Practice Errors Pain Management

- Poor or Incomplete Assessment
- Inadequate Titration - Under Dosing
- No Preemptive Side Effect Management
- Inadequate Follow-up
- No Co-analgesic (Adjuvants)

Oncologist Issues

- Health Professionals not formally educated in pain management
- Pain management a low priority
- Dependent on subjective reporting
- Adequate assessment adds time, often not reimbursed or allotted
- Treatment often multi-disciplinary and complex, requires attention to side effects
- May require the use of controlled substances

System Barriers

- Availability of:
  - Medications
  - Pain Specialists
- Pain treatment follow up, not by "crisis management/ER visits"
- Pain Team in major hospitals

Cultural Factors

- Tools available: BPI validated in Germany, Japan, Taiwan, Hindi, Chinese
- Other factors very complex-beyond scope of talk

Runaway Disease...
is all cancer pain treatable?

- Diffuse bony mets/leptomeningeal disease/lumbosacral plexopathies/pancreatic
- Severe pain syndromes may require consideration of advanced techniques:
  - Intrathecal/Epidural infusions
  - Neurolytic blocks
- In some cases, only humaniarian solution is sedation (many options, opioids, haloperidol, benzodiazepines)
- Don't forget high dose steroids

Overcoming Barriers

- Make pain control a top priority issue
- Research/Funding
- Clinical Support
- Initiatives (MDACC Pain Care Improvement Task Force)

Pain Care Improvement Task Force: 4 Goals

- Assess Pain in 100% of in/outpts
- ↓ by 25% the number of patients reporting "mod-severe" pain
- ↑ by 50% the number of patients receiving pain related educational materials
- Pain addressed in the care plan (discharge plan) of 100% of patients

Pain Care Improvement Task Force: 4 Goals

- July 24th Team Meetings (IHI Format): 6 month timeline
- We provide goals, timeline, supportive materials
- Teams provide "local" initiative, "local" solutions
- Extranet site/datasharing/solution sharing

Pain Care Improvement Task Force: 4 Goals

- Standard Numerical Pain Rating Scale (11 pt scale incorporated onto all forms)
- Local mechanisms to ensure compliance
- Ask about pain-- not someone elses job!!!

Pain Care Improvement Task Force: 4 Goals

- **Acknowledge the good work going on here already: many here treating pain: chemotx, radiotx, surgery**

- the challenge is to optimize pain and symptom control for all of our patients

- **New pain "clinical pathway" nearly complete**
- **Based on NCCN guidelines**
- **Pain to be incorporated into existing pathways**
- **Team ideas locally**

Pain Care Improvement Task Force: 4 Goals

- ↑ by 50% the number of pts receiving pain related educational materials
  - New educational materials underway
  - Mailed to all new patients
  - Tiered materials
  - Website in development ;
  - www.mdanderson.org/paincontrol
    - ...details (intra/extranet, all pain linked here)

Pain Care Improvement Task Force: 4 Goals

- Pain addressed in the care plan (discharge plan) of 100% of pts
  - Local solutions
  - Stop ER bounce back pain crises!
  - Critical piece for JCAHO compliance

Pain Care Improvement Task Force

- Task Force: On going next 6 months
- Collaborative Kick Off July 24th
- Pain Care "Events" Upcoming
- Print Media
  - Bill of Rights
- MDACC Commitment to Better Pain Treatment!

Far and away the best prize that life offers is the chance to work hard at work worth doing.

-Theodore Roosevelt