

Cancer Pain Treatment 2001 Where Are We?

Allen W. Burton M.D.

Associate Professor of Anesthesiology, Section Chief of Pain Management
University of Texas, MD Anderson Cancer Center

MDACC Facts: 2000

- Outpt clinic visits, treatments, procedures: 448,690
- Hospital Admissions: 17,497
- Pts in active treatment: 65,000
- New Patients: 18,000
- Annual Operating Revenue: \$1 B (\$150m from state) (\$124m charity care)
- 40% growth in past 4 years

THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER
Making Cancer History™

Cancer Pain: Modern Era

- Tumor related pain (60+%)
- Treatment related (20+%) (chemo, surgery, radiation)
- More aggressive chemo, patients live longer, "chronic disease"
- Cure worse than the disease??

Magnitude of the Problem

- 1308 outpts **36%** had pain limiting ability to fxn Cleeland CS NEJM 1994
- 1103 consecutive adm to MDACC **38%** severe pain Bresica FJ JPSM 1990
- Recent MDACC data:
 - 43% inpts pain limiting ability to fxn
 - 30% outpts 4 wks p dc limiting ability to fxn

Cancer Pain

...Patients experiencing moderate to severe pain...

Patients in active treatment

25%

Advanced cancer

90%

-Cleeland CS NEJM 1994

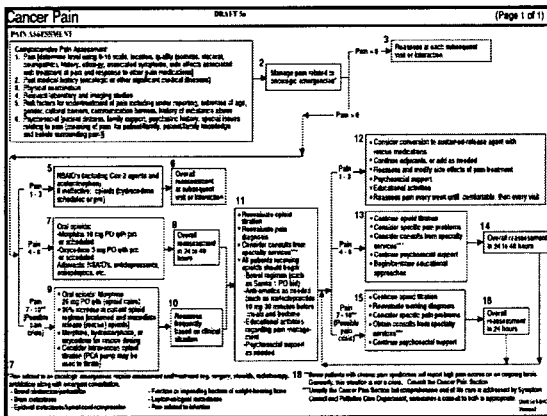
NCCN 2000 Pain Guidelines

Addresses "Anesthetic/Neurosurgical Consultation":

- Pain likely relievable by nerve block (CP)
- Failure to achieve analgesia without intolerable side effects
- Lists "commonly used" procedures

NCCN 2000 Pain Guidelines: Interventions

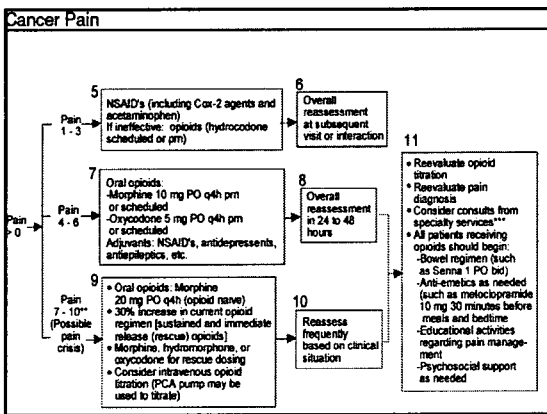
- "Commonly Used" Procedures:
 - Epidural/Intrathecal infusions (opioids/local/clonidine)
 - Neurodestructive procedures
 - Head and Neck-Periph nerve
 - Ulex-Brachial Plexus
 - Thoracic Wall-Epidural neurolytic
 - Abdominal-Celiac/Splanchnicectomy
 - Pelvic-Sup Hypogastric
 - Rectal Pain-Intrathecal neurolytic/myelotomy
 - Unilateral pain syndromes-cordotomy



Cancer Pain PAIN ASSESSMENT

Comprehensive Pain Assessment:

1. Pain (determine level using 0-10 scale, location, quality (somatic, visceral, neuropathic), history, etiology, associated symptoms, side effects associated with treatment of pain and response to other pain medications)
2. Past medical history (oncologic or other significant medical illnesses)
3. Physical examination
4. Relevant laboratory and imaging studies
5. Risk factors for undertreatment of pain including under reporting, extremes of age, gender, cultural barriers, communication barriers, history of substance abuse
6. Psychosocial (patient distress, family support, psychiatric history, special issues relating to pain (meaning of pain for patient/family, patient/family knowledge and beliefs surrounding pain))



Cancer Pain

- 11
 - Reevaluate opioid titration
 - Reevaluate pain diagnosis
 - Consider consults from specialty services***
 - All patients receiving opioids should begin:
 - Bowel regimen (such as Senna 1 PO bid)
 - Anti-emetics as needed (such as metoclopramide 10 mg 30 minutes before meals and bedtime)
 - Educational activities regarding pain management
 - Psychosocial support as needed
- 12
 - Consider conversion to sustained-release agent with rescue medications
 - Continue adjuvants, or add as needed
 - Reassess and modify side effects of pain treatment
 - Psychosocial support
 - Educational activities
 - Reassess pain every week until comfortable, then every visit
- 13
 - Continue opioid titration
 - Consider specific pain problems
 - Consider consults from specialty services***
 - Continue psychosocial support
 - Begin/continue educational approaches
- 14
 - Overall reassessment in 24 to 48 hours
- 15
 - Continue opioid titration
 - Reevaluate working diagnosis
 - Consider specific pain problems
 - Obtain consults from specialty services***
 - Continue psychosocial support
- 16
 - Overall reassessment in 24 hours

HOW DO WE DO IT?

MDACC Treatment Algorithm

- Assessment is the KEY!
 - Tumor related?
 - Therapy side effect?
 - Chronic pain in cancer patient?
 - Psychosocial assessment (relevant to optimize treatment, NOT a justification for withholding treatment!)
 - Physical Exam
 - Directed Studies

How Do We Do It?

MDACC Treatment Algorithm

- Syndrome amenable to block/intervention?
 - Visceral pain?
 - Compression Fx?



MDACC Treatment Algorithm

- Opioids cornerstone of cancer pain treatment
 - po if possible
 - iv valuable for rapid titration
 - "Newer" options: Methadone, Actiq, awaiting hydromorphone-SR
- Adjuvants
 - Cox 2 (rofecoxib, celecoxib, paracoxib, valdecoxib, etoricoxib)
 - Antidepressants (TCAs)
 - Anticonvulsants (gabapentin, oxcarbazepine, tiagabine, etc.)

MDACC Treatment Algorithm

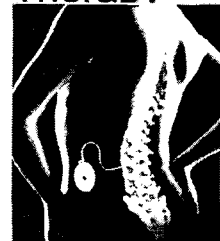
- Prophylactic Rx of constipation/nausea
 - Senekot-S/Colace/Lactulose
 - Metaclopramide
- Opioid Related Somnolence
 - Rotation
 - Psychostimulants
 - Neuraxial medication
- Opioid Related Delirium
 - Rotation/dose reduction
 - R/O other causes

MDACC Treatment Algorithm

- Intrathecal/Epidural therapy:
 - Intolerable opioid related side effects
 - Inadequate analgesia on optimal oral medications

Intrathecal Therapy

- Effective in CA Pain
- Expensive, but...
- Expensive condition



Intrathecal Opioids: Cancer Related Pain

Randomized comparison of Intrathecal Drug Delivery System (IDDS) + Comprehensive Medical Management (CMM) vs. CMM alone for unrelieved cancer pain

Staats, et al.

- RCT for patients with VAS > 5/10 on CMM
- Outcomes: VAS, Brief Pain Inventory, SF-12, Caregiver quality of life survey, and toxicity data (NCI toxicity criteria)
- Costs in each group
- 19 centers in 5 countries, 200 patients (goal)

Cancer Pain

- Oral opioids appropriately dosed
- Adjuvant Medications for pain and opioid side effects
- XRT/Chemo/Surgical Stabilization
- Psychosocial assessment/therapy
- Frequent Reassessment
- Consider Nerve Blocks for certain conditions (ie-Pancreatic CA/Comp Fx)
- Intrathecal/Epidural Therapy

THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER
Making Cancer History™

Cancer Pain: Future Directions

- Continual refinement of assessment
- Continue to break down barriers
- SP-Saporin and related compounds
- Ultra-Long Acting Local Anesthetics
- More opioids (hydromorphone-SR, et al.)
- More intrathecal choices

THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER
Making Cancer History™

