

MANAGING ACUTE PAIN IN ADVANCED CANCER CARE

"Managing an Acute Pain Crisis in a Patient With Advanced Cancer," by Drs. Natalie Moryl and Kathleen Foley, and Nessa Coyle, PhD, appears in the current JAMA. The article uses a lengthy patient study and interviews with his physicians to illustrate the assessment and management of an acute pain crisis at the end of life. The article is available as a CME course.

The authors define a pain crisis as "an event in which the patient reports severe, uncontrolled pain that is causing the patient, family, or both severe distress. The pain may be acute in onset or may have progressed gradually to an intolerable threshold (as determined by the patient), but requires immediate intervention." They cite National Comprehensive Cancer Network pain management guidelines which identify a pain crisis as "an event in which patients have severe pain (a numerical estimate of at least 7 on a 10-point scale) that requires rapid opioid titration to provide analgesia."

"The assessment and management of an acute pain crisis in the setting of advanced illness are challenging," and the authors suggest following a five-point strategy.

1) Diagnose the pain, differentiate between reversible and intractable causes of pain, and determine the need for further workup. A sidebar in the article lists 15 points to following assessing a pain crisis in a patient who has advanced cancer.

The authors write, "In assessing both the pain experience and patients' desired goals of care, clinicians should use a communication approach that allows patients to lead the discussion, beginning with their understanding of the nature of the pain, its meaning to them, and how they prioritize its management in establishing treatment goals.

Patients can often distinguish pain from their experience of suffering, which frequently stems from their multiple concerns about being a burden to their loved ones, fear of dying, and concerns about their family. Anxiety, depression, existential distress, and delirium are common psychological symptoms that can occur in a patient with severe cancer pain and need to be addressed."

2) Choose an opioid, and monitor and treat its adverse effects. A sidebar lists six principles of selecting opioids. The article suggests starting those who have not been exposed to opioids on morphine, but avoiding morphine in patients "with renal disease or hepatic insufficiency."

For those patients, short half-life opioids such as hydromorphone or fentanyl may be appropriate.

Methadone is suggested when other opioids are insufficient, but it "inhibits the uptake of serotonin and norepinephrine. Therefore, methadone should be used with caution and consultation with a palliative care or pain consultation team is recommended."

The article includes two tables that deal with pain medications and their various ratios: 1) "Relative Single-Dose Potencies of Commonly Used Opioid Drugs for Pain and Their Oral-Intravenous Ratios"; and 2) Variability in Dose Ratios When Switching Oral Morphine, Oral Hydromorphone and Transdermal Fentanyl to Methadone."

3) Titrate and rotate opioids and coanalgesics as necessary. The authors include a sidebar which gives treatment guidelines for parenteral opioids in patients who have inadequate pain relief but no adverse effects from opioids, versus those who do have significant adverse effects.

Adjuvant coanalgesics, as defined by the article, are "different drugs and classes of drugs that may enhance the effects of opioids or nonsteroidal anti-inflammatory drugs," and they should be quickly considered in a pain crisis. A third table, "Adjuvant Drugs for Parenteral Use in Pain Crisis Management," lists drugs, dosages, indications, and additional comments.

4) Quickly call in experts to treat a pain crisis to prevent unnecessary suffering by the patient. The authors note that the use of methadone requires particular expertise which the house staff may not have. Delay in calling in an expert in its use may result in suffering which could have been prevented.

5) Identify and utilize the resources available in the institution. Of their case study patient, the authors write, "This case illustrates the critical need for a clinical pathway for an acute pain crisis and other symptom management in a dying patient. Such institutional guidelines are important for resource allocation both of staff time and ICU bed allocation, enabling continuous monitoring of the high-dose opioid and ketamine infusions.

Such guidelines for management of an acute pain crisis frame a standard of care, informing both the patient and the health care professionals of a recommended approach, and help to distinguish the appropriate use of rapidly escalating highdose opioids and other agents in a dying patient from inappropriate strategies of euthanasia and physician-assisted suicide."

In conclusion, the authors say, "The standpoint that a palliative care team should only become 'really involved' if the patients has a 'no code' status is contrary to the current concept of palliative care for which the goal is to move palliative care upstream as part of comprehensive care. . Holistic care of the patient and the family needs the expertise of the other team members providing psychological support and behavioral approaches as well as spiritual care. Most of palliative care in oncology is provided by oncological teams. Routine comprehensive symptom assessment and management may help identify the areas for which palliative care specialists may provide direct care to the patient; support the primary service; or facilitate communications between the patient, caregivers, and medical team. Institutional guidelines can provide structure for routine palliative care assessment to identify and address unmet palliative care needs and to transition patients to hospice care."