Pain management is a routine part of medical practice. Pain management in end stage disease and at end of life, however, requires some unique tools. At the March 12, 2009, Providence Hospice of Seattle CME event, Dr. Mimi Pattison of Franciscan Hospice and Palliative Care gave a comprehensive presentation on “Pain Management in Hospice Care.”

Dr. Pattison reviewed the different types of pain: nociceptive (somatic, visceral), neuropathic, sympathetic and the challenging “mixed” or “total pain.” Pain pathophysiology was explained, in terms of both acute and chronic pain. The role of multiple opiate receptor types was also discussed, as they are responsible for selectivity of drug action and mediate the actions of pharmacological antagonists.

Dr. Pattison emphasized the following principles of pain management:

◆ Treat persistent pain with around-the-clock scheduled short or long-acting meds.
◆ Treat breakthrough pain with short-acting agents as “rescue” therapy.
◆ Anticipate and treat opioid side effects, especially constipation.
◆ Don’t delay for investigations or disease treatment, as unmanaged pain leads to nervous system changes and can cause permanent damage and amplify pain symptoms.
◆ When possible, treat underlying cause (i.e. radiation for neoplasm).

The range of opioid medications explored included naturally-occurring (morphine, codeine), partially synthetic derivatives of morphine (i.e. hydromorphone,oxycodone, hydrocodone) and synthetic compounds (i.e. levorphanol, methadone, propoxyphene, fentanyl).

Dr. Pattison presented principles of treating persistent pain, emphasizing the importance of achieving effective pain relief around the clock and addressing breakthrough pain episodes. She outlined the use of intravenous lidocaine in advanced terminal illness for patients suffering with severe and/or neuropathic pain despite opioid and adjuvant pain treatment. She also explained the use of topical, oral or IV ketamine as a therapy for opioid-resistant pain, allodynia and hyperalgesia, through its calcium channel blocking effects.

Of special interest were Dr. Pattison’s comments about the treatment of opioid-induced hypersensitivity and neurotoxicity. Through case examples, she explored the symptoms such as escalating pain, that worsens with more opioid (which may be sole symptom), myoclonus, hyperesthesia and allodynia as indicators of hypersensitivity or toxicity. The time frame for development of opioid hypersensitivity or toxicity varies, often with a 2-8 week period. Her recommended treatment strategy for this difficult condition is opioid rotation. Patients may be extremely sensitive upon rotation to a new opioid. She recommends the “start low and go slow” approach to titration of the new opioid, acting as if the patient were again opioid naïve.

Dr. Pattison suggested the following guidelines for the titration of analgesics:

◆ “Start LOW and go SLOW ALWAYS.”
◆ Titrate by percents rather than milligrams.
◆ Treat basal pain rating less than 5/10 in patient with out sedation with titration upwardly by 25 to 50 percent.
◆ Treat basal pain rating greater than 5/10 with titration upwardly by 50 to 100 percent.
◆ Reassess frequently.

In assessing pain, it is important to distinguish between increases in basal pain vs. breakthrough pain. Breakthrough or incident pain can require a higher dose of medication than the basal rate.

Also covered in the presentation were other cancer pain interventions, such as neurolytic blockade (i.e celiac blockade), neuromodulation (i.e neurostimulation), disease modification (i.e. vertebroplasty, radio frequency ablation), surgery (ORIF/stabilization, vertebrectomy), neurosurgical ablative procedures (i.e. myelotomy, cordotomy), and neuroaxial medication delivery (i.e. epidural, intrathecal).
Suicide rate twice as high with cancer

Physicians offer clinical approach to discussing suicide with patients

The incidence of suicide in cancer patients has been found to be twice that of the general U.S. population, with increased risk in cancer patients 65 years and older.

That is according to a study published in the Journal of Clinical Oncology, which used two large databases for identification and comparison.

The retrospective cohort study of 3,594,750 patients diagnosed with cancer from 1973 to 2002 who were registered with a program of the National Cancer Institute, found the suicide rate among these subjects to be 31.4 per 100,000 person-years. In contrast, the national suicide rate for the general population during this period was 16.7 per 100,000 person-years.

Suicide risk was found to be highest in the first five years after diagnosis, but remained increased for more than 15 years. Lead author Stephanie Misono, MD, of the University of Washington, and colleagues also identified demographic factors and types of cancer linked with a higher risk for suicide.

Higher suicide rates demographics

◆ Male sex
◆ White race
◆ Older age at diagnosis

Sites of cancer associated with the highest suicide risk

◆ Lung and bronchus (standardized mortality ratio [SMR], 5.74; 95 percent confidence interval [CI], 5.30 to 6.22)
◆ Stomach (SMR, 4.68; 95 percent CI, 3.81 to 5.70)
◆ Oral cavity and pharynx (SMR, 3.66; 95 percent CI, 3.16 to 4.22)
◆ Larynx (SMR, 2.83; 95 percent CI, 2.31 to 3.44)

“Further examination of the psychological experience of patients with cancer, particularly that of patients with certain types of cancer, is warranted,” noted Misono.

Talking about suicide: A clinical approach

“Many people with advanced cancer are both fearful of death itself and also fearful about how they will die,” commented Timothy E. Quill, MD, in an accompanying editorial in the same issue of the Journal of Clinical Oncology. Drawing upon his clinical experience as director of the Palliative Care Program at the University of Rochester Medical Center, New York, Quill offered the following suggestions for how physicians can address the risk of suicide in patients with advanced disease:

◆ Show a willingness to discuss fears about death and suicidal thoughts; most patients will respond to an invitation to talk about such issues in a safe environment.

◆ Make clear what assistance is and is not available to the patient in the future. A physician commitment to facing the unknown together with the patient can be deeply reassuring.

◆ Systematically screen and provide treatment for potentially under-recognized and/or under-treated anxiety, depression, delirium, and pain. The incidence of these conditions in patients with cancer is very high at all stages.

◆ Ask regularly about suicidal thoughts and intentions, especially at times of transition in symptom burden and disease progression.

◆ Be aware of conditions that increase the risk for suicide, such as certain types of cancer. Check for risk factors such as prior attempts, clinical depression, panic disorder, and substance abuse history.

◆ Explore the underlying meaning of possible suicidal intent, such as any life-threatening act or inquiry about physician-assisted suicide. Check for confounding depression, anxiety, and pain.

◆ Include formal palliative care and psychiatric consultation as essential components in the approach to more challenging cases.

Quill concluded: “Lessening suffering of seriously ill patients through the diligent application of palliative measures and alleviating their aloneness and despair by maintaining an open, committed, receptive relationship may be the most important preventive measures with regard to suicide.”

Source: “Incidence of Suicide in Persons with Cancer,” Journal of Clinical Oncology; October 10, 2008; 26(29):4731-4738. Misono S, Weiss NS, Fann JR, Redman M, Yueh B; Departments of Otolaryngology/Head and Neck Surgery, Epidemiology, Psychiatry and Behavioral Sciences, and Health Services, University of Washington, Seattle; Public Health Sciences Division, Clinical Research Division, Fred Hutchinson Cancer Research Center, Seattle; Department of Otolaryngology, University of Minnesota, Minneapolis.

“Suicidal Thoughts and Actions in Cancer Patients: The Time for Exploration Is Now,” ibid.; pp. 4705-4707. Quill TE; Internal Medicine, Psychiatry, and Medical Humanities, Center for Ethics, Humanities, and Palliative Care, University of Rochester Medical Center, Rochester, New York.

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Clinicians offer strategies to reduce stress of surrogate decision making

Medical decisions for terminally ill patients are often made by designated surrogates—estimates run from 44 to 69 percent of decisions for nursing home residents to 75 percent of decisions made for patients hospitalized with life-threatening illness. Having a family member who is critically ill or dying is stressful in itself, notes a team of researchers from Seattle. The added stress of making medical decisions for that loved one can have a negative impact on surrogate health.

“If clinicians are aware of the challenges that surrogates may be facing, they may be able to implement interventions to address those challenges, facilitate decision making, and possibly preserve surrogate health,” write the authors of a report published in the Journal of General Internal Medicine.

Although clinicians will probably interact with many surrogates, few have received the training needed to understand surrogates’ interpretation of patient preferences and their own need for support, the authors note. “A first step toward addressing these challenges may be to understand what makes decision making more or less difficult from the surrogate’s perspective.”

The team analyzed the interview responses of 50 designated surrogates with a wide range of decision-making experiences on behalf of older, chronically ill veteran patients. Factors with a positive or negative influence on decision making fell into four domains: surrogate characteristics and life circumstances; surrogate social networks; surrogate-patient relationship/communication; and surrogate-clinician relationship/communication.

Clinician-related factors that helped decision making

◆ Clinician availability to answer questions and offer support
◆ Frank information in lay terms about the patient’s condition and prognosis, including: chances of recovery, illness progression, and what dying would be like upon withdrawal of life support
◆ Treatment recommendations based on clinician knowledge of the patient
◆ Reassurance that the decision made was a good one
◆ Respect from the care team; having one’s input listened to and valued

Factors that hampered decision making

◆ Encounters with too many clinicians
◆ Not being able to follow the patient’s preferences
◆ Difficulty in weighing patient preferences against the patient’s quality of life
◆ Surrogates’ own health issues

Psychosocial factors affecting surrogate decision making included: personal coping strategies and spiritual beliefs; support from family, community, and friends; and feeling committed to the patient’s wishes and educated sufficiently on the patient’s medical condition to make a “good” decision—all issues addressed during end-of-life care by the multidisciplinary support of hospice.

“If care that addresses and supports both patient and family concerns (i.e., hospice care) may produce better health outcomes for surrogates,” the authors write. “Recent studies of hospice use have identified lower mortality rates and lower rates of depression in family members of patients who had hospice care prior to death.”

Interventions support decision makers

Before decision making:

◆ Include future surrogates in advance care planning discussions while the patient is relatively stable. This may lessen later decision-making burden by addressing some of the social network and surrogate-patient relationship factors. For instance, familiarizing future surrogates and other family members with a patient’s preferences can help prevent future family conflict.

During decision making:

◆ Define the surrogate role as that of helping the clinician to make treatment recommendations for outcomes that best align with the patient’s goals and wishes.
◆ Designate one person to communicate information concerning the patient’s condition, prognosis, and treatment options.
◆ Identify and address surrogate stressors. For example, surrogates can be asked to identify the most difficult aspect of a current decision, whether there are additional causes of stress, and if a support system exists to help them.
◆ Refer surrogates to social workers, chaplains, palliative care teams, or ethics consult services when appropriate.
◆ Give surrogates enough time to make the decision they would be most comfortable living with.

After decision making:

◆ Offer reassurance that the surrogate made a good decision for the loved one. This may help bring the decision-making process to closure and reduce the potential stress of continued questioning or regret.

Adapted from Vig, et al,
Journal of General Internal Medicine

Pain management

Dr. Pattison emphasized the benefits of employing adjuvant medications in conjunction with opioid therapy:

- Steroids
- NSAIDS
- Antidepressants
- Anti-seizure medications
- Benzodiazepines

In addition to medical therapies, she also encouraged the holistic treatment of pain through the use of non-pharmacologic therapies, such as spiritual care, psycho-social care, grief counseling, bereavement counseling, and comfort/complimentary therapies (massage, music, aromatherapy, hypnosis, pet therapy, volunteer support).

Dr. Pattison concluded the lecture with words of experience about helping patients to experience “successful dying.” Her recommendations included early referral and preventive care, precision-focused team work, treatment of total pain, and “calling hospice sooner rather than later.”

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‘Case of the Month’ at www.dgim.pitt.edu/iepc

The University of Pittsburgh Institute to Enhance Palliative Care maintains a website offering palliative care information. Among the resources is the Case of the Month, a series of brief case studies in printable one- or two-page PDF format. Intended for individual use or as a stimulus for group discussion, the more than 50 studies are prepared by members of the University of Pittsburgh Medical Center’s (UPMC) multidisciplinary palliative care team.

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