Institute of Eminence

Cancer Pain

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Learning Objective

- What is Pain??
- What is “Total Pain”?
- Assessment of Pain, & History Taking
- WHO Analgesic ladder
- Opioids

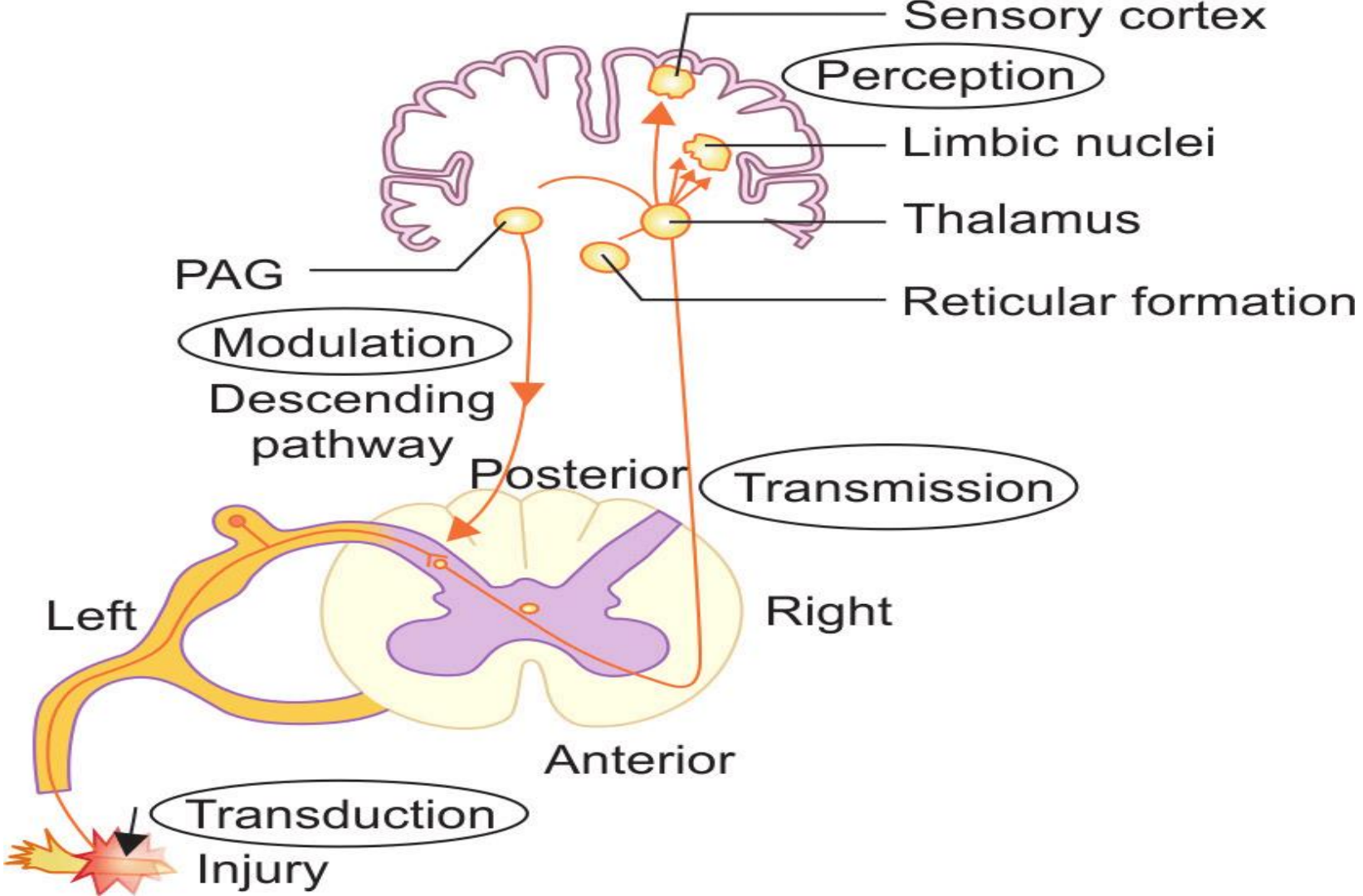
Case scenario

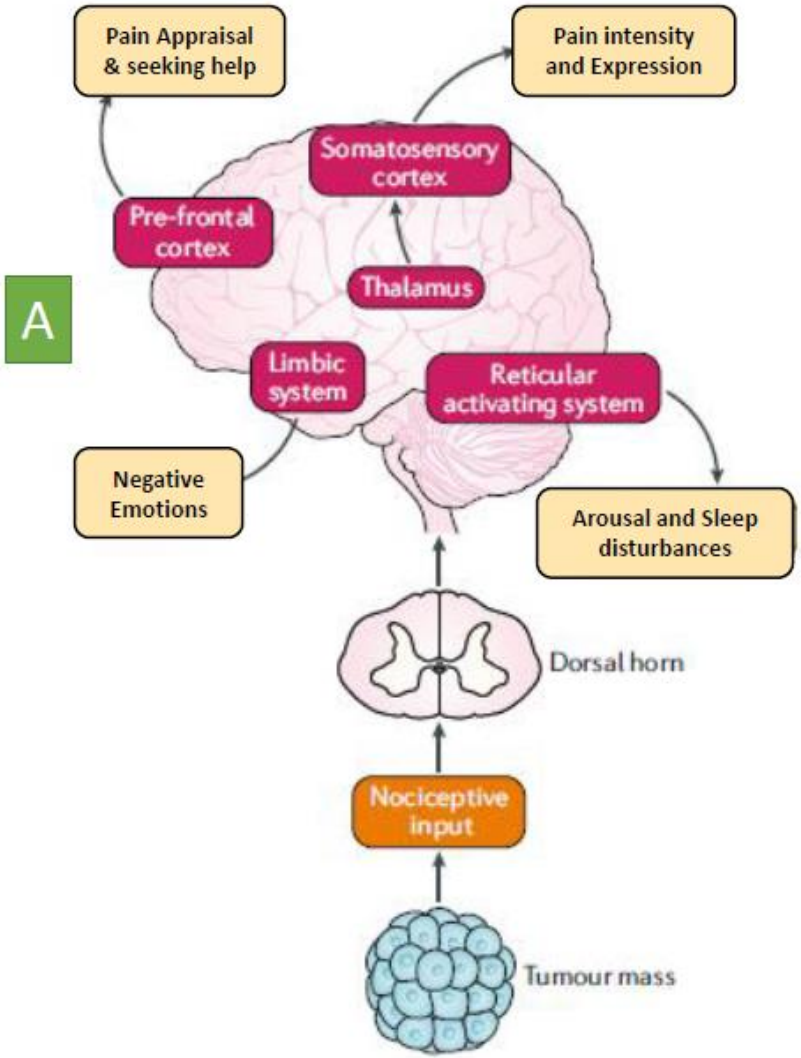
- 45 year lady with metastatic breast cancer
- Have undergone Surgery, CT
- Severe chest and back pain
- Unable to sleep
- Activity, cough etc increase her pain
- She has 15 and 12 years daughters
- Husband- school teacher
- Diclofenac and tramadol- little help

What is 'Pain'?

- Keep this in mind
  - It is a subjective experience
  - So, it differs between persons
  - It differs with time and situation even in the same person

- Definition of Pain
  - By IASP *"An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage,".*
  - By Robert Twycross *"Pain is what the patient says hurts" him or her*


Sensory cortex
Perception
Limbic nuclei
Thalamus
PAG
Reticular formation
Modulation
Descending pathway
Posterior
Transmission
Left
Right
Anterior
Transduction
Injury



Experience of Pain is the summative outcome of Somatosensory Cortex interactions with …

- Frontal, Cingulate, insular cortices
- Limbic System
- Modulator/ inhibitory System

Total Pain: how patients experience pain

Identifying Bio-psycho-social factors influencing pain

- A 45 year old father of two young daughters
- Diagnosed to have carcinoma of lung with metastasis
- He is having lower back and right sided chest pain
- He is irritable, sad, anxious and unable to sleep
- He is worried about his two school going children
- He thinks that God is punishing him

Identifying Bio-psycho-social factors influencing pain

Young man, father of the two young daughters → Emotional/ psychologica Social

Diagnosis of cancer → Emotional/ psychological Biological

Pain over the chest and back → Biological

Irritability and anxiety → Emotional/ psychological

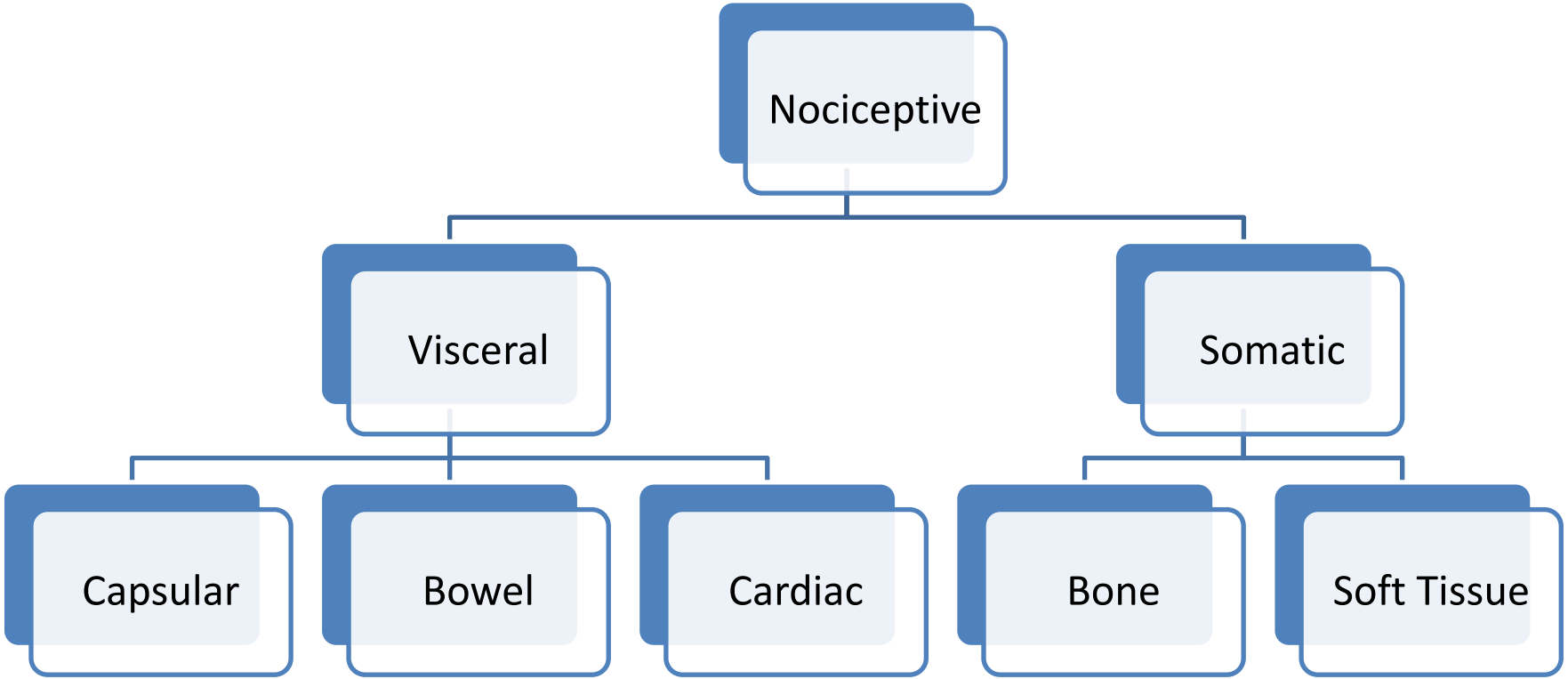
Worried about the future of the daughters → Emotional/ psychologica Social

God is punishing him → Spiritual/existential

Classification of Pain

Pain can be described by its:

- ***Duration*** – acute or chronic
- ***Mechanism*** – nociceptive or neuropathic
- ***Origin*** – somatic or visceral
- ***Situation*** – incidental pain, breakthrough pain, procedural pain


Nociceptive
Visceral
Somatic
Capsular
Bowel
Cardiac
Bone
Soft Tissue

Nociceptive pain: somatic pain

***Somatic pain*:** stimulation of nociceptors in the skin, soft tissues, muscle, or bone

- Pain usually is in a particular location
- Aching, throbbing, or persistent pain
- Causes: bone or soft tissue infiltration

Nociceptive pain: visceral pain

***Visceral pain*:** stimulation of nociceptors in internal organs and hollow viscera organs

- Pain is often not in a single location
- Described as pressure, cramping, or squeezing pain
- Causes: blockage, swelling, stretching, or inflammation of the organs from any cause

Neuropathic pain

Neuropathic pain: caused by damage to nerve pathways

- Described as burning, prickling, stinging, pins and needles, insects crawling under skin, numbness, hypersensitivity, shooting, or electric shock
- Causes: infiltration by cancer, HIV infection, or herpes zoster, drug-related peripheral neuropathy, central nervous system injury, diabetes or surgery

Features of neuropathic pain :

- Hyperalgesia : increased response to a normally painful stimuli
- Allodynia : a painful response to a stimuli like light touch that does not normally cause pain

ASSESSMENT OF PAIN

General guidelines for performing an assessment

- Establish a trusting relationship with the patient
  - Addressing the immediate need of the patient
  - Active listening
  - Empathetic touch
  - Non-judgemental attitude
- Starting with open questions and then moving on to more specific ones
- Encouraging the patient to do the talking and actively listening
- Look for verbal and non-verbal cues from the patient while performing assessment
- At the end, summarise your finding back to the patient

Assessment of pain

Site	Where does it pain?
Frequency	Continuous or Intermittent If intermittent then, • How often in a day? • How long does it last?
Impact on activity	Does it affect your work/activities of daily living? Does it affect your sleep?
Medication history	What drugs do you take for the pain? What is the route? How often do you take? Does it give you relief? How long does the relief last? Are there any side effects?

Pain History OPQRST

Onset	**When did the pain start?**
Provocative/Palliative factors	• What makes the pain worse? • What makes the pain better?
Quality	What exactly is it like? • Dull aching pain • Sharp pain • Burning pain • Lancinating pain, etc
Radiation	Does it spread anywhere?
Severity	How severe it is? • Mild • Moderate • Severe OR apply numerical rating scale (NRS)
Temporal factors	Does it come and go? Is it worse at any particular time of the day or the night?

Assessment of ‘Pain’

- Site of pain
- Onset of pain
- Characteristics of pain
- Radiation of pain
- Associated symptoms
- Timing of pain
- Exacerbating/Alleviating factors of pain
- Severity of pain

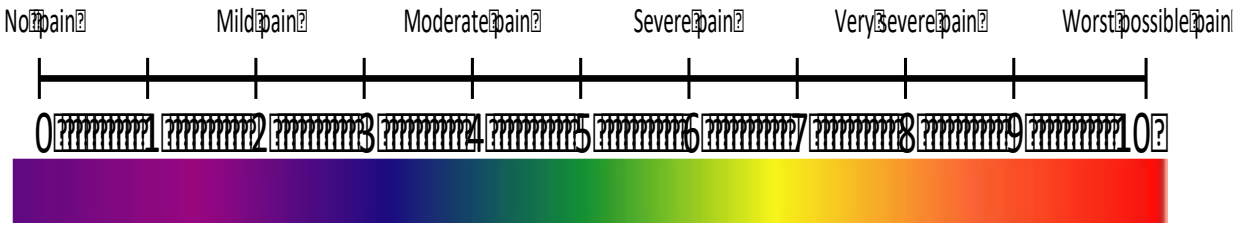
Assessing the severity of pain

- Self-report of pain is the best report
- No one can exactly grade the intensity of pain like the person experiencing the pain.

Pain scales

- **Numerical rating scale**
- **Wong-Bakers FACES Pain rating scale**
- **Categorical scale**
  - Mild pain
  - Moderate pain
  - Severe pain

Numeric pain rating scale



- Pain levels from 0-10 can be explained verbally to the patient using a scale in which 0 is no pain and 10 is the worst possible pain imaginable
- Patients are asked to rate their pain from 0 to 10
- Record the pain level to make treatment decisions, follow-up, and compare between examinations

How to assess pain in children

Age	Scale
Neonates	CRIES scale
2month-3years	FLACC scale
3-6 years	Faces Pain Scale
>7 years	NRS/VAS scale

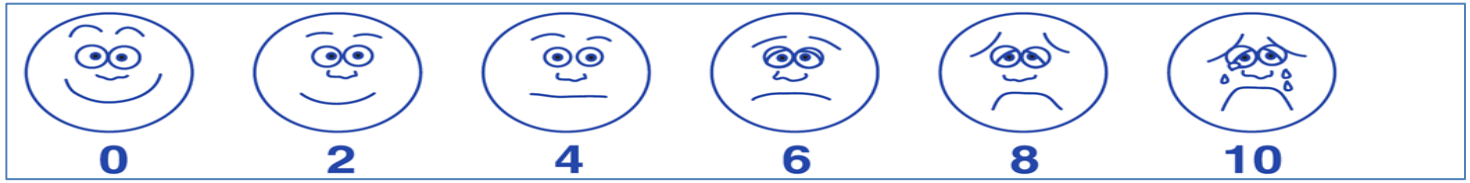
FLACC scale

- Use in children less than 3 years of age or older children who can't talk

	SCORING		
CATEGORIES	**0**	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting, back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

Each of the five categories: (**F**) Face; (**L**) Legs; (**A**) Activity; (**C**) Cry; (**C**) Consolability, is scored from 0–2 which results in a total score between 0 and 10 (*Merkel et al. 1997*)

Wong-Baker FACES scale



- Use in children who can talk (usually 3 years and older)
- Explain to the child that each face is for a person who feels happy because he has no pain, or a little sad because he has a little pain, or very sad because he has a lot of pain
- Ask the child to pick one face that best describes his or her current pain intensity
- Record the number of the pain level that the child reports to make treatment decisions, follow-up, and compare between examinations

Why Cancer Pain??

Do all cancer patients have pain ?

- Pain is 1st symptom in 20-50% of all cancer patients.
- Moderate to severe pain experienced by 40% to 50% of cancer patients.
- Very severe pain experienced by 25% to 30% of cancer patients .
- 75-90% of terminal stage cancer experience moderate to severe pain.

Portenoy et al. Management of cancer pain. Lancet 1999; 353: 1695-700

Pain is related to the type of cancer

- Head and neck (67–91%)
- Prostate (56–94%)
- Uterine (30–90%)
- Genitourinary (58–90%)
- Breast (40–89%)
- Pancreatic (72–85%)

Valeberg BT, Rustoen T, Bjordal K, Hanestad BR, Paul S, Miaskowski C. Self-reported prevalence, etiology, and characteristics of pain in oncology outpatients. Eur J Pain 2008;12:582–90.

Cause of cancer pain

- The cancer itself 65-75%
- The treatment of cancer 15-20%
- Unrelated to the cancer 3-10%
- The debility of cancer

Cause of cancer pain

- The cancer itself 65-75%
  - Tumor involvement of bone
  - Tumor involvement of nervous tissue
  - Tumor involvement of viscera
  - Tumor involvement of blood vessels

Distribution of pain Characteristics in cancer patients

	N=118	
Somatic	16	13.6%
Neuropathic	30	25.4%
Visceral	20	16.9%
Mixed	52	44.1%

Paice et al., J. Pain Sympt.Sept 97

Number of pain sites reported by 100 cancer patients

One site	20%
Two sites	30%
Three sites	18%
Four sites	16%
Five sites	8%
Six sites	2%
Seven sites	4%
Eight sites	2%

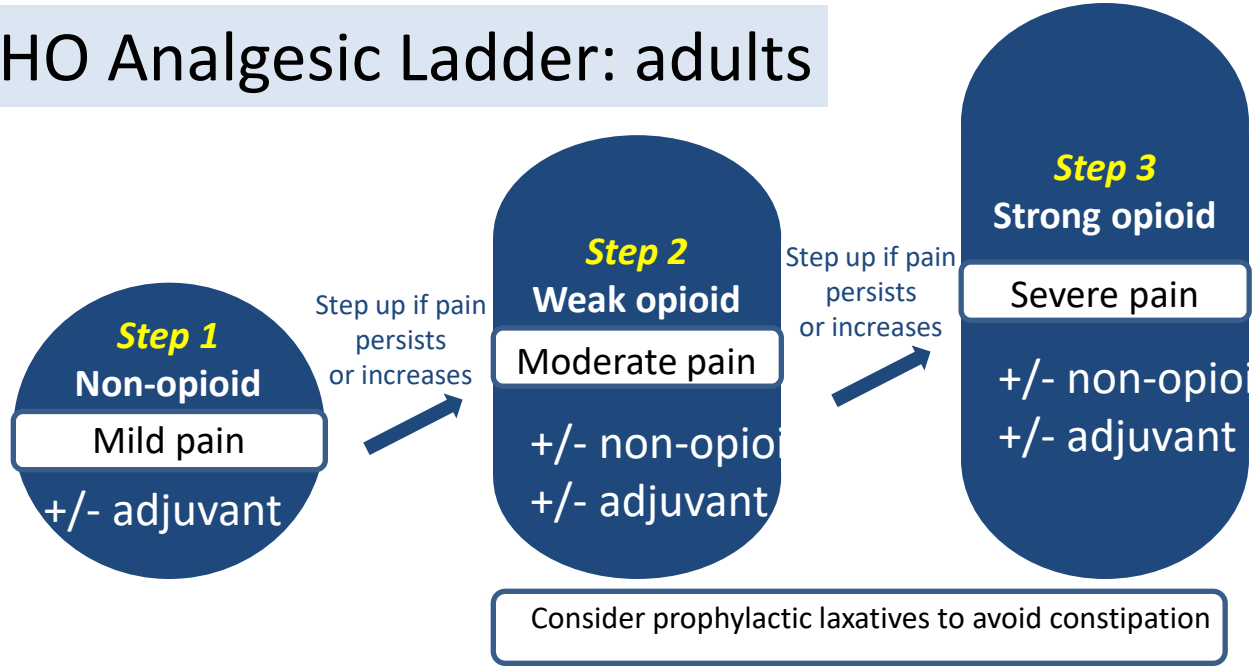
Tools

- **Drugs**
- **Interventions**

Principles of pain management

- Aim is prompt treatment of pain and to prevent its recurrence
- Achieve realistic goal of pain relief
- ***By the mouth***
- ***By the clock***
- ***By the ladder***
- ***By the individual***
- ***Adjuvant drugs***

WHO Analgesic Ladder: adults



Non-opioids	ibuprofen or other NSAID, paracetamol (acetaminophen), or aspirin
Weak opioids	codeine, tramadol, or tapentadol
Strong opioids	morphine, fentanyl, oxycodone, hydromorphone, buprenorphine
Adjuvants	antidepressant, anticonvulsant, antispasmodic, muscle relaxant, bisphosphonate, or corticosteroid

Combining an opioid and non-opioid is effective, but do not combine drugs of the same class.

Time doses based on drug half-life ("dose by the clock"); do not wait for pain to recur

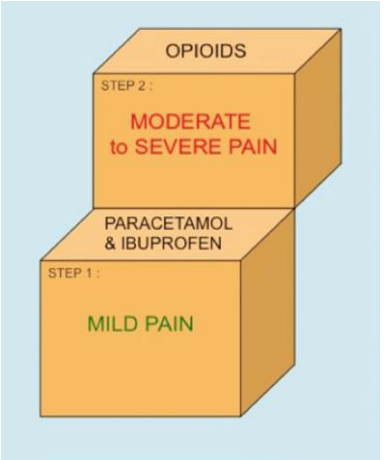
Adapted by Treat the Pain from World Health Organization http://www.who.int/cancer/palliative/painladder/en/ (accessed 7 November

34

The Two Step Ladder

- Step 1: Mild Pain
  - Acetaminophen
  - Ibuprofen
- Step 2: Moderate to Severe Pain
  - Morphine (Strong Opioid)

- Avoid weak Opioids (Tramadol, Codeine)
  - Lack of evidence and concerns about safety in children
- Avoid Pethidine: due to CNS toxicity



Step 1 – mild pain: non-opioids

Paracetamol

- Adult dose: 500mg-1g by mouth every 6 hours; maximum daily dose 4g
- Note: Hepatotoxicity can occur if more than the maximum dose is given per day
- Paracetamol can be combined with NSAID

Step 1 – mild pain: non-opioids

Ibuprofen (NSAID)

- Adult dose: 400mg by mouth every 6-8 hours; maximum daily dose 1.2g
- Give with food and avoid in asthmatic patients
- The maximum dosing limit should be lowered in patients with liver impairment

Step 1 – mild pain: non-opioids

Diclofenac (NSAID)

- Adult dose: 50mg by mouth every 8 hours; maximum daily dose 150mg
- Give with food and avoid in asthmatic patients

Cautions with NSAIDs

NSAIDs can cause serious side effects, particularly after using for a longer period

- Gastro-intestinal (GI) bleeding or renal toxicity
  - Always add H2 blocker or PPI when prescribing NSAIDs
- Avoid in patients with renal impairment, Heart failure

Step 2: Opioids

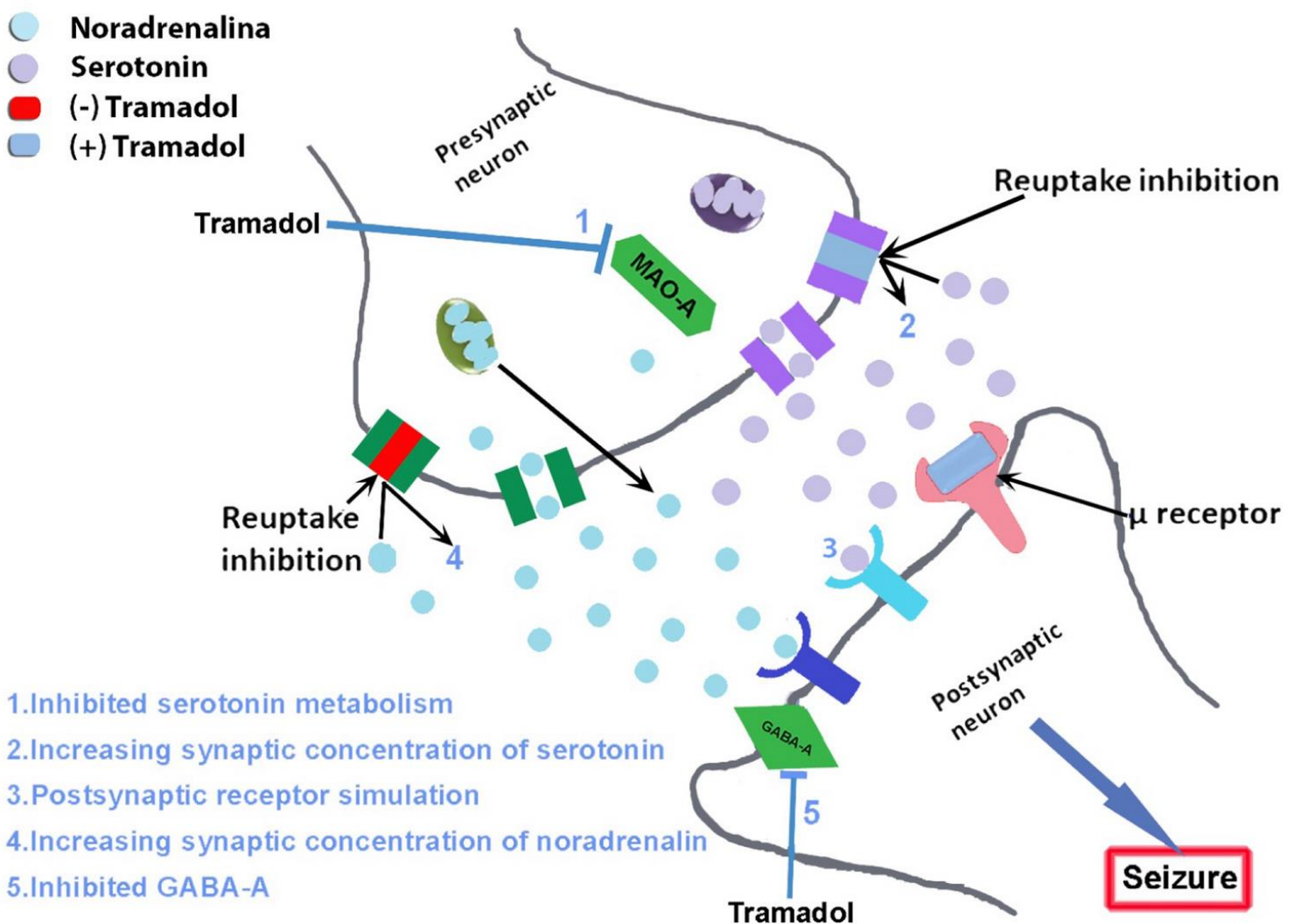
Codeine
Tramadol
Tapentadol

Methadone
Morphine
Oxycodone
Fentanyl
Hydrocodone
Hydormorphone

Step 2 – moderate pain: weak opioids

Tramadol

- Adult dose: 50-100mg by mouth every 4-6 hours
- Start with a regular dose and increase if no response (dose limit: 400mg/day)
- Use with caution in epileptic cases, especially if patient is taking other drugs that lower the seizure threshold
- May cause serotonin syndrome in patients on other serotonergic medications


Noradrenalina
Serotonin
(-) Tramadol
(+) Tramadol
Presynaptic neuron
Tramadol
1
MAO-A
Reuptake inhibition
2
Reuptake inhibition
4
3
μ receptor
Postsynaptic neuron
GABA-A
5
Tramadol
Seizure
1.Inhibited serotonin metabolism
2.Increasing synaptic concentration of serotonin
3.Postsynaptic receptor simulation
4.Increasing synaptic concentration of noradrenalin
5.Inhibited GABA-A

Step 2 – moderate pain: weak opioids

Low-dose morphine

- Some palliative care experts recommend using low-dose morphine in step 2 because it is associated with fewer side effects compared to other weak opioids

Step 3 – severe pain: strong opioids

Morphine

- “Gold standard” against which other opioid analgesics are measured
- When used correctly, patients don’t become dependent or addicted, tolerance is uncommon, and respiratory depression doesn’t usually occur

Pharmacology

- Morphine is the principle medical alkaloid derived from the poppy plant
- Pure agonist, acts on the opioid receptors in the CNS (brain and spinal cord)
- Oral preparation is only 1/3 bioavailable
- Metabolized mainly in the liver into morphine-3-glucuronide (M3G) and morphine-6-glucuronide (M6G) which are excreted in the urine.

Pharmacology

- M3G does not have a role in analgesia
- M6G has analgesic action and more potent than morphine; hence caution in prescribing to those with renal dysfunction

- Route of choice : oral- simple, effective, convenient

- Other route: SC, IV, IM, rectal, subarachnoid, epidural, topical

What Opioid Analgesic to Use?

- Pharmacokinetics
- Patient co-morbidities (Kidney and liver Disease)
- Intensity of pain
- Previous experience with opioid analgesics
  - Considerable inter-individual variability in response to each opioid
  - Adverse events
- Etiology of pain
  - Nociceptive
  - Neuropathic
  - Opioid Induced Hyperalgesia
- Total daily dose of pain medications

OPIOID NAÏVE AND OPIOID TOLERANT

Opioid tolerant: patients who are taking, for 1 week or longer, at least:

- 60 mg oral morphine/day;
- 25 µg transdermal fentanyl/hour;
- 30 mg oral oxycodone/day;
- 8 mg oral hydromorphone/day;
- 20 mg oral methadone/day;
- 10 mg IM methadone/day;
- 25 mg oral oxymorphone/day; or
- An equianalgesic dose of any other opioid.

OPIOID NAIVE

- Patients who do not meet the above definition of opioid tolerant, and who have not taken opioid doses at least as much as those listed above for 1 week or longer.

OPIOIDS

- Mainstay of Cancer Pain management.
- Effective in treating > 85% cancer pain
  - Right Opioid
  - Right Dose
  - Right Route
  - Right Frequency (Around –the – clock)
- Limiting factors:
  - Side effects
  - Availability
  - Tolerance, addiction
  - Not effective in few conditions.

Short Acting Opioids

Oral dosing:

- onset in 20-30 min
- peak effect in 60-90 minutes
- duration of effect 3-4 hours
- Can be dose escalated or re-administered every 2-4 hours for poorly controlled pain
- General guideline:
  - Moderate pain: increase 25-50%
  - Severe pain: increase by 50-100%

Short Acting Opioids

Parenteral or Oral:

- morphine
- hydromorphone (Dilaudid ®)
- Codeine

- Onset & duration of action depends on route administration

Oral only:

- oxycodone (Percocet ® , Tylox ®)
- hydrocodone (Vicodin ® Lortab ®, Lorcet ®)
- propoxyphene (Darvon ®, Wygesic ®)

- Note: hydrocodone is only available as a combination product.

Long Acting Opioids

- Oral
  - morphine:
    - MS Contin®
    - Kadian®
    - Oramorph SR
  - oxycodone
    - Oxycontin®
    - Oxycodone SR
  - oxymorphone
    - Opana SR
  - methadone

- Transdermal
  - Fentanyl Patch (Duragesic®) –
  - Dosing Q 72 hours

When prescribing/initiating morphine

- Start with 5-10mg PO 4th hourly

- 6am -- -- 10am -- -- 2pm ----- 6pm ---- 10pm

- Provide for breakthrough pain - same as 4th hourly dose between the regular dose

- 4th hourly dose to be increased by 50% every 24 hours till pain relief is adequate or increase in dosage can be made depending upon the number of rescue doses of morphine needed

- There is no standard dose of oral morphine

- Always prescribe a laxative to prevent constipation

- Prescribe for nausea and vomiting for the initial 3-5 days as a preventive measure
- Never start on sustained release preparation of morphine

Oral Morphine Initiation

- Assessment every 24-48 hours or 5-7 days
- Encourage breakthrough pain dose if needed
- Maintain Morphine diary for 24 hours Morphine requirement
- Once stable IR Morphine dose attained, change to SR Morphine

Goal of Pain Management

Titrate dose until adequate pain control is achieved or intolerable adverse effects manifest

Prescribing sustained release tablet

- Given only after stabilizing on immediate release tablets
- Effective daily dose of IR tablets is calculated
- Half this dose is given as BD
- Example morphine 10mg 4^{th} hourly = 60mg in 24 hrs
- Sustained release (SR) tablet : 30 mg BD

Situation

- ***Incident pain*** – occurs only in certain circumstances (e.g. after a particular movement)
- ***Breakthrough pain*** – a sudden, temporary flare of severe pain that occurs on a background of otherwise controlled pain
- ***Procedural pain*** – related to procedures or interventions

Management of incident pain with examples

1. Oral morphine 20-30 mins prior to wound dressing
2. NSAID taken prior to movement, when appropriate
3. Inj. Ketamine (0.25-0.5mg/kg) taken 10-15 minutes prior to procedure

Common side effects of oral morphine

1. **Opioid induced constipation** : stimulant laxative eg. Bisacodyl or stool softener like docusate

2. **Opioid induced nausea & vomiting** : Haloperidol or Metoclopramide

3. **Opioid induced pruritus** : antihistaminics

Warning signs of morphine toxicity

Over drowsiness, hallucination, confusion

Over drowsiness occurs when morphine is prescribed for a less severe pain or a pain non-responsive to morphine

If toxicity occurs, reduce the dose
The patient may need to miss several doses

Indication of Naloxone

1. RR less than 8 breath/min, difficulty to rouse and clinically cyanosed

or
respiratory rate less than 10-12 breath/min, difficulty to rouse and SpO2 <90%

Treatment

Dilute Naloxone 0.4mg in 10ml of 0.9% NS.

Administer 0.5ml IV every 2 minutes until respiratory status improves satisfactorily

Opioid induced hallucination or delirium

Reduce dose of opioid, consider adding haloperidol 2.5-5mg HS

Opioid induced Myoclonus

Modifying drug regimen and parenteral rehydration where appropriate

Treatment : Clonazepam 1-2mg/24hrs

Type of pain where oral morphine may not be effective and adjuvants analgesics need to be given

Type of pain	Management
Muscular Pain	Muscle Relaxant/ Trigger Point Injections (TPI)
Colicky Pain	Antispasmodics
Bone Pain	Opioids + NSAID +- Corticosteroids
Pain due to constipation	Laxatives
Neuropathic Pain	Neuropathic Pain medications
Cutaneous hyperalgesia	Topical agents

Alternative opioid to morphine

Rarely when patients develop intolerable side effects such as nausea, itching, confusion, myoclonic jerks, bronchospasm etc an alternative opioid might be of help

Fentanyl –transdermal patch (tdp)

Indication :

1. Dysphagia
2. Intolerable side effects of oral morphine
3. Renal failure
4. Tablet phobia/ poor compliance

Fentanyl –transdermal patch (tdp) contt..

Fentanyl is a selective mu receptor agonist

Its available as 72 hr tdp preparation eg. 12.5,25,50,75 or 100 mcg/hr over 3 days

Peak plasma concentration are achieved after 12 hrs and a depot remains in the skin for about 24hrs after the patch is removed

Breakthrough doses of opioid will be necessary during the first 12-24 hrs of application

Those on fentanyl patch may require oral morphine on a sos basis

Fentanyl –transdermal patch

- Patches has to be used on dry non-inflamed, non-irradiated and l
  skin
- Rate of absorption may change in the presence of fever, external heat or following a hot water bath
- A reduction in the dosage of laxative may be necessary when converting from morphine to fentanyl as the later causes less constipation
- One in ten patient who had pain controlled by morphine may experience a withdrawal reaction when converted to fentanyl

Conversion rules

Codeine and tramadol to oral morphine

Conversion factor is 10

Eg. A patient who is on codeine tablet of 40mg 4 hourly gets a total dose of 240 mg/24 hrs

To convert this to morphine : $\frac{\text{Total codeine dose in 24hrs}}{10} = \frac{240}{10} = 24$ mg

This gives a dose as 5mg 4th hourly

Similarly for tramadol also

Oral morphine to fentanyl patch

RULE OF THUMB = $\frac{\text{total 24hour morphine dose}}{3}$

Step 1 : calculate 24 hours dose eg A

Step 2 : As fentanyl is 100 times potent so $\frac{\text{total 24 hrs dose}}{100}$ = dose of fentanyl in 24 hrs = A/100

Step 3 : Hourly dose of fentanyl = $\frac{A/100}{24}$ = A/2400 in mg = A*1000/2400 in mcg

Eg 24 hrs morphine dose = A = 60mg = 60000mcg

Fentanyl Patch for this patient will be = 60000/24*100 = 25 mcg patch

THUMB RULE 60/3 – 20 , so nearest patch will be 25mcg

Opiod Equianalgesic Dose

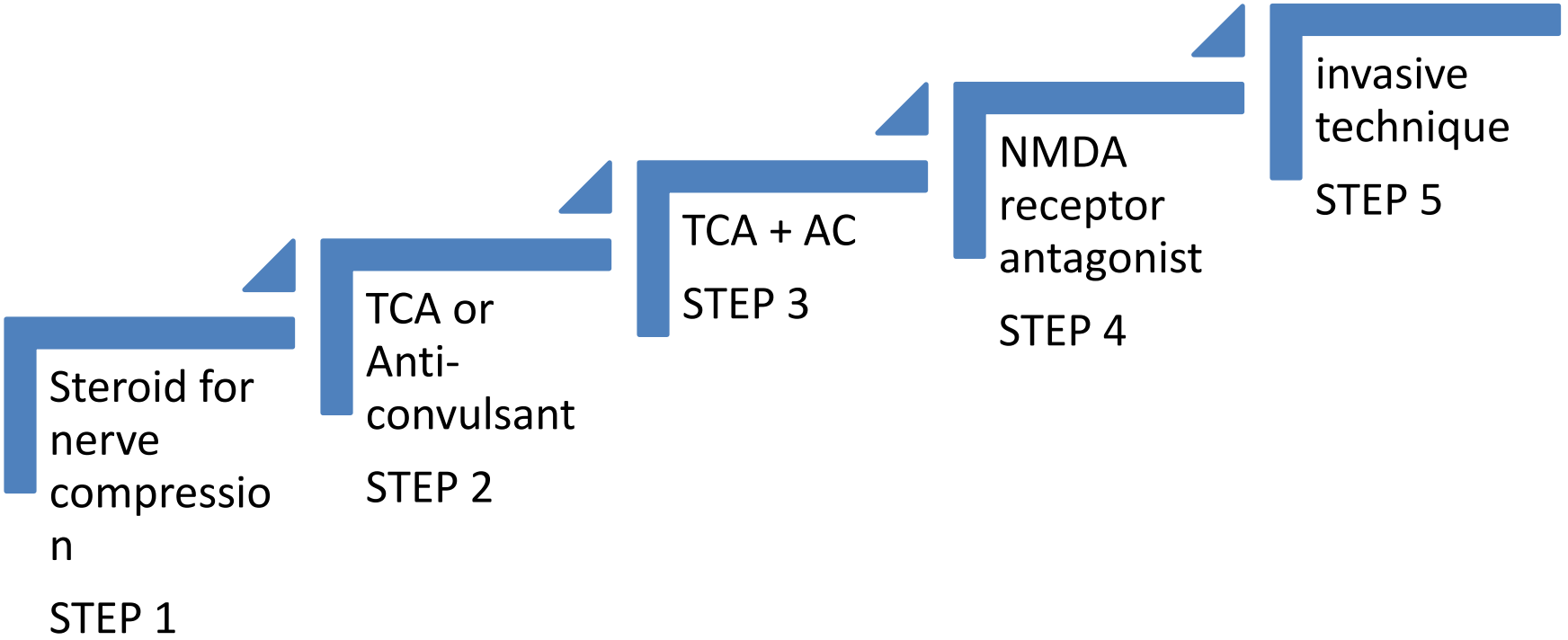
Drug	Equianalgesic parenteral dose	Starting iv dose	iv:po ratio	Starting dose po /transdermal	Duration of Action
Morphine	10 mg	Bolus dose=0.05-0.1 mg q 2-4 hours Continuous infusion=0.01-0.04 mg/kg/hr	1:2 to 1:3	0.15-0.3 mg/kg/dose q 4 hours	3-4 hours
Hydromorphone	1.5 mg	0.015-0.02 mg/kg q 4	1:5	0.06 mg/kg q 3 to 4 hours	2-4 hours
Oxycodone	5-10 mg	N/A		0.1-0.2 mg/kg q 3 to 4	3-4 hours
Fentanyl	100mcg	1 to 2 mcg/kg/hr as continuous infusion		25 mcg patch	72 hours
Methadone	1 mg	0.1 mg/kg q 4 to 8 hours	1:2	0.2 mg/kgq 4 to 8 hours	12 to 150 hours

Neuropathic Pain in Cancer

- Antidepressant: TCA (Amitryptiline)
  SNRI (Duloxetine, Venlafaxine)
- Anticonvulsant: Gabapentin, Pregabalin
- Topicals: 5% Lidocaine, Capsaicin
- Opioids- Tramadol, Morphine
- NMDA Antagonists- Ketamine, Dextramethorphan

Treatment of Neuropathic Pain

In neuropathic pain due to cancer , try opioid first



Adjuvant analgesics

Cancer related bone pain – bisphosphonates

Skeletal muscle spasm – skeletal muscle relaxants

Smooth muscle spasm – antispasmodic

Cancer related edema – corticosteroid

Others

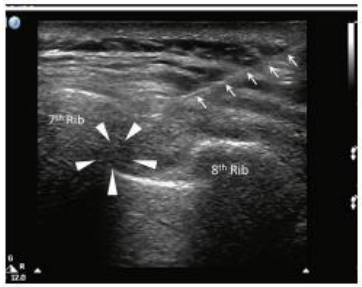
Peripheral sensitization – corticosteroids

Ectopic foci caused by nerve damage – anti-epileptics

Central sensitization – NMDA receptor channel blockers, some anti-epileptics

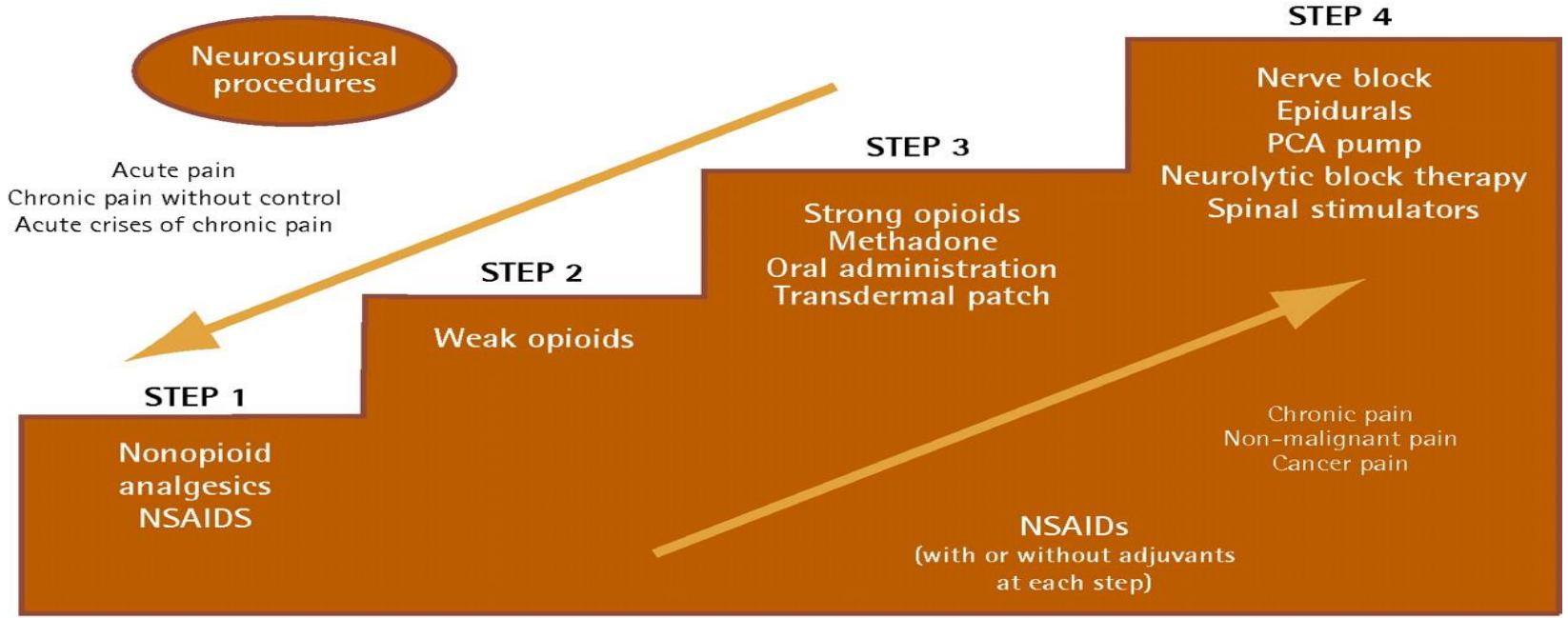
Altered descending pain modulation – anti depressants

Interventional Pain Treatment



Adapted WHO pain ladder.

Figure 2. New adaptation of the analgesic ladder

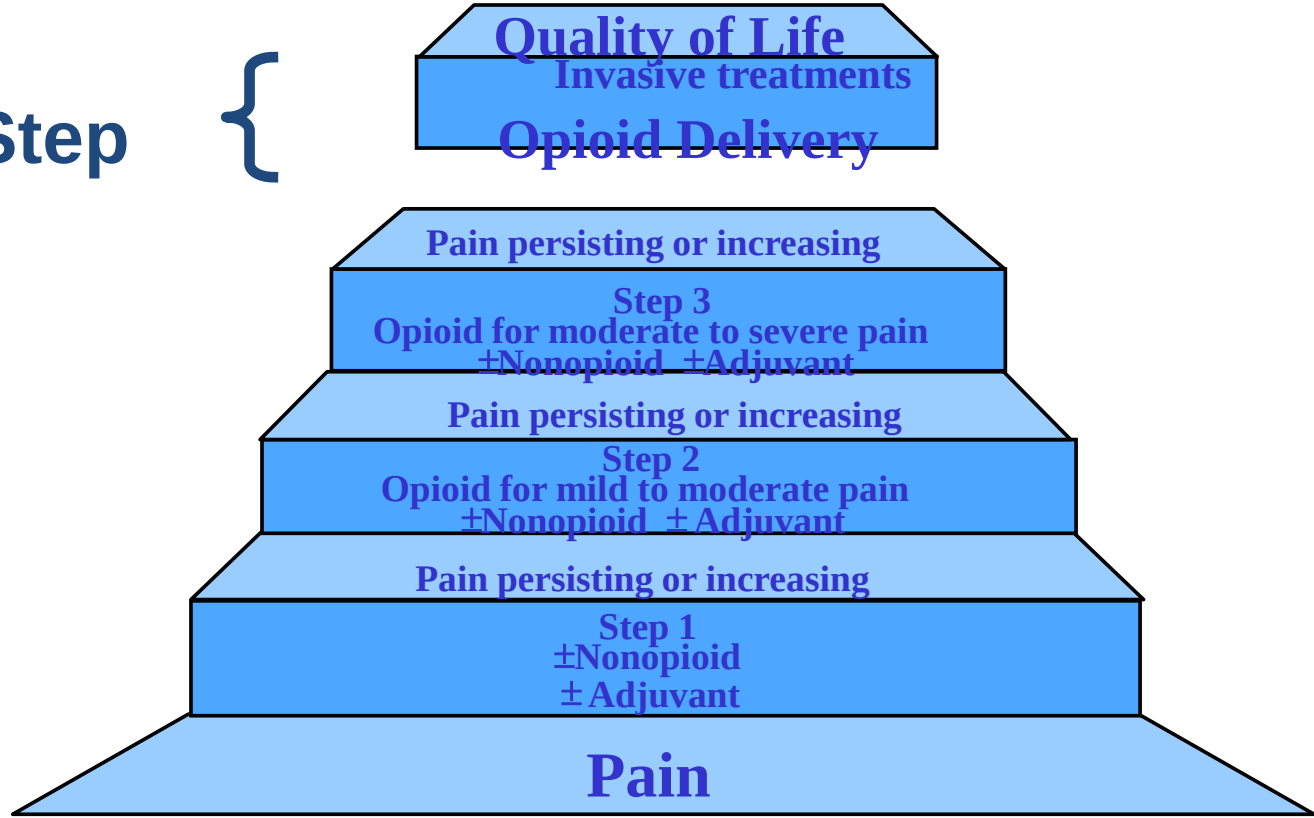


NSAID—nonsteroidal anti-inflammatory drug, PCA—patient-controlled analgesia.

Modified WHO Analgesic Ladder

Proposed 4th Step

The WHO Ladder

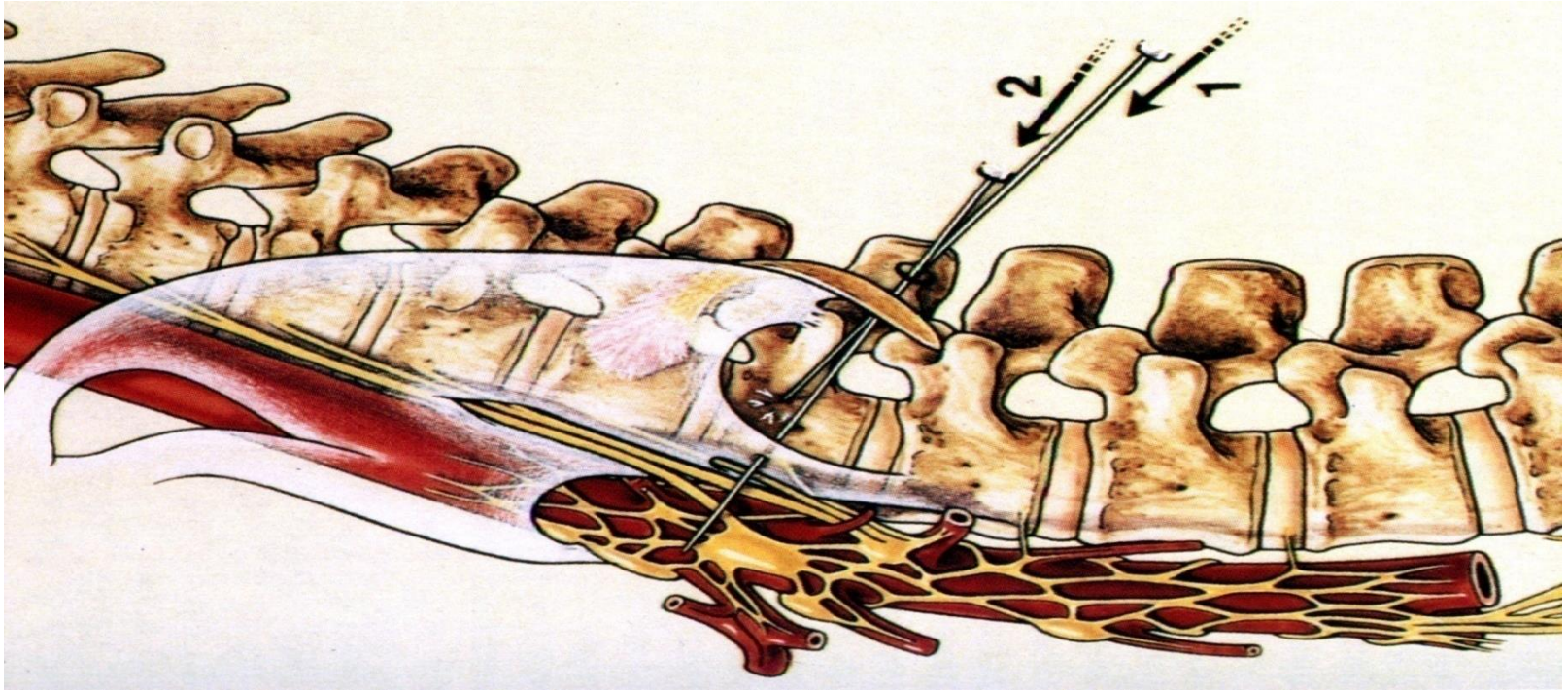


Deer, et al., 1999

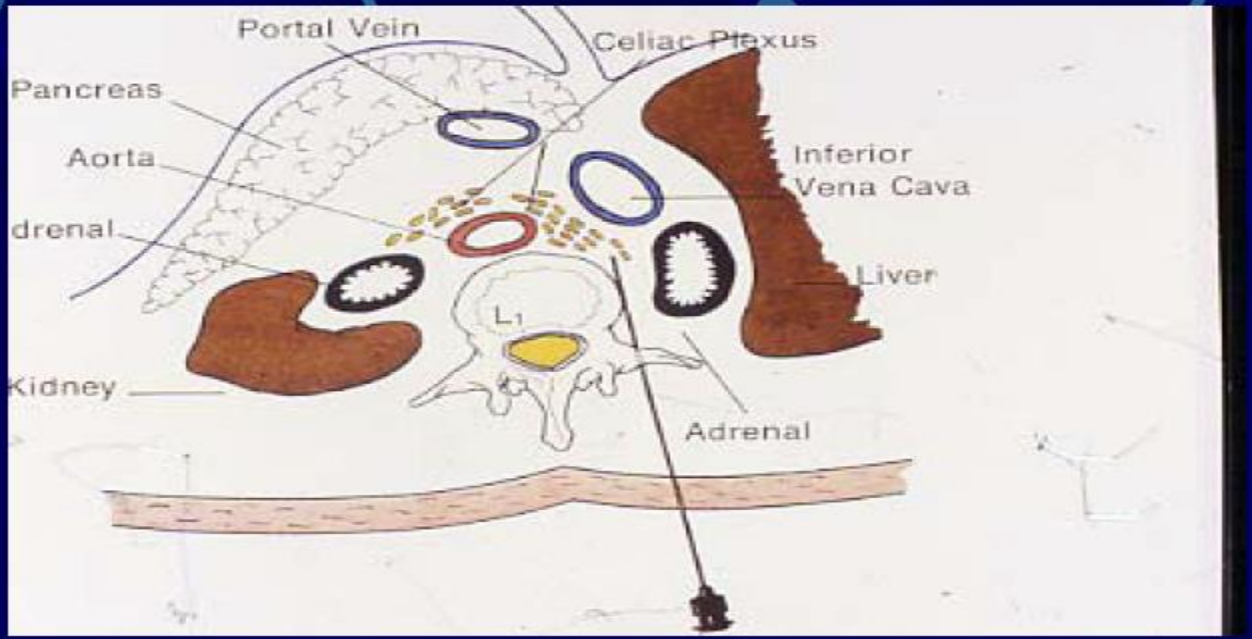
Invasive therapies for cancer pain

- Peripheral and sympathetic nerve blocks: steroids, alcohol/phenol, RF ablation, cryoanalgesia
- Neuraxial delivery: epidural and intrathecal analgesia
- Vertebroplasty and kyphoplasty
- Spinal cord and peripheral nerve stimulation
- Cordotomy

Celiac Plexus



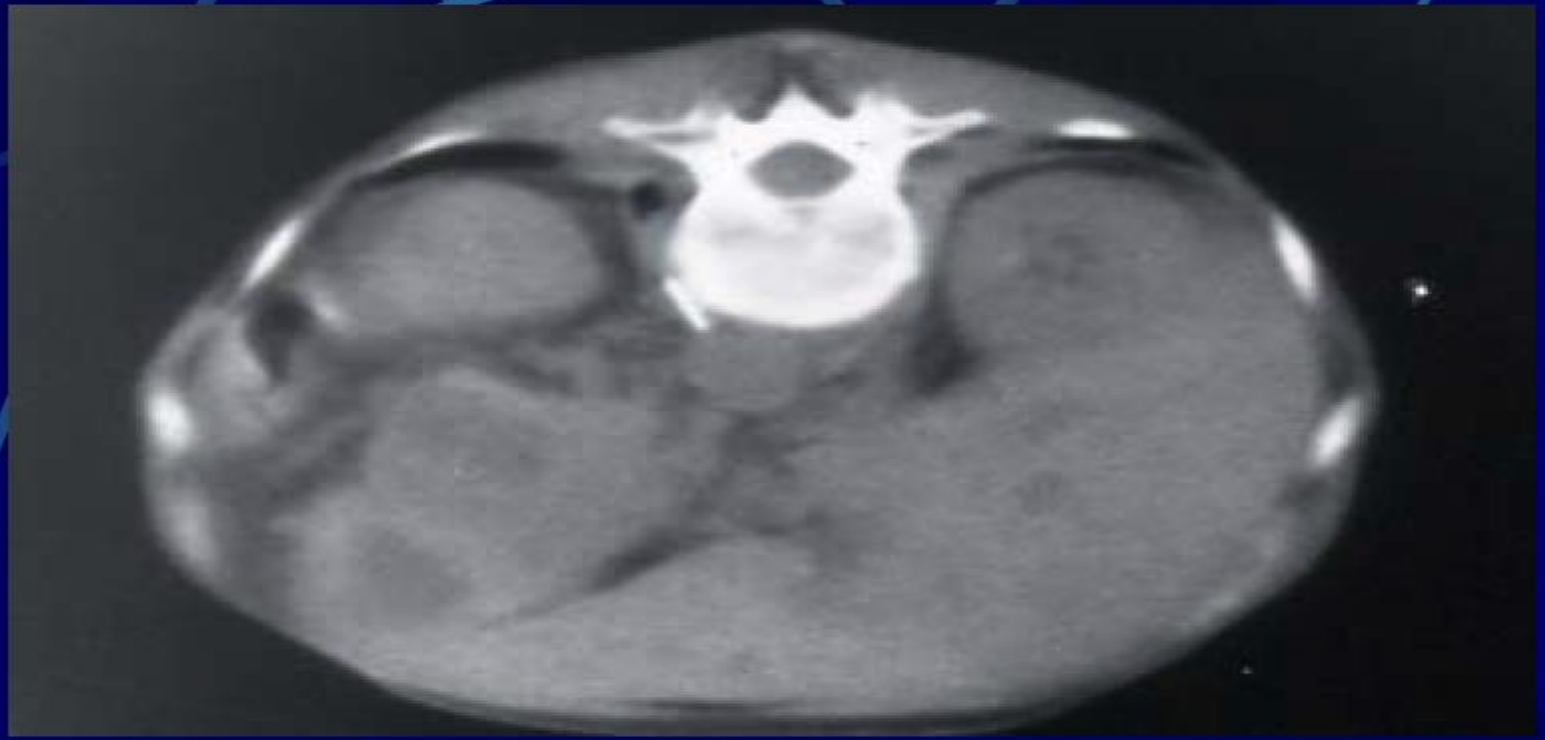
Anatomical location of Celiac Plexus



AP and Lateral view of Celiac Plexus Block

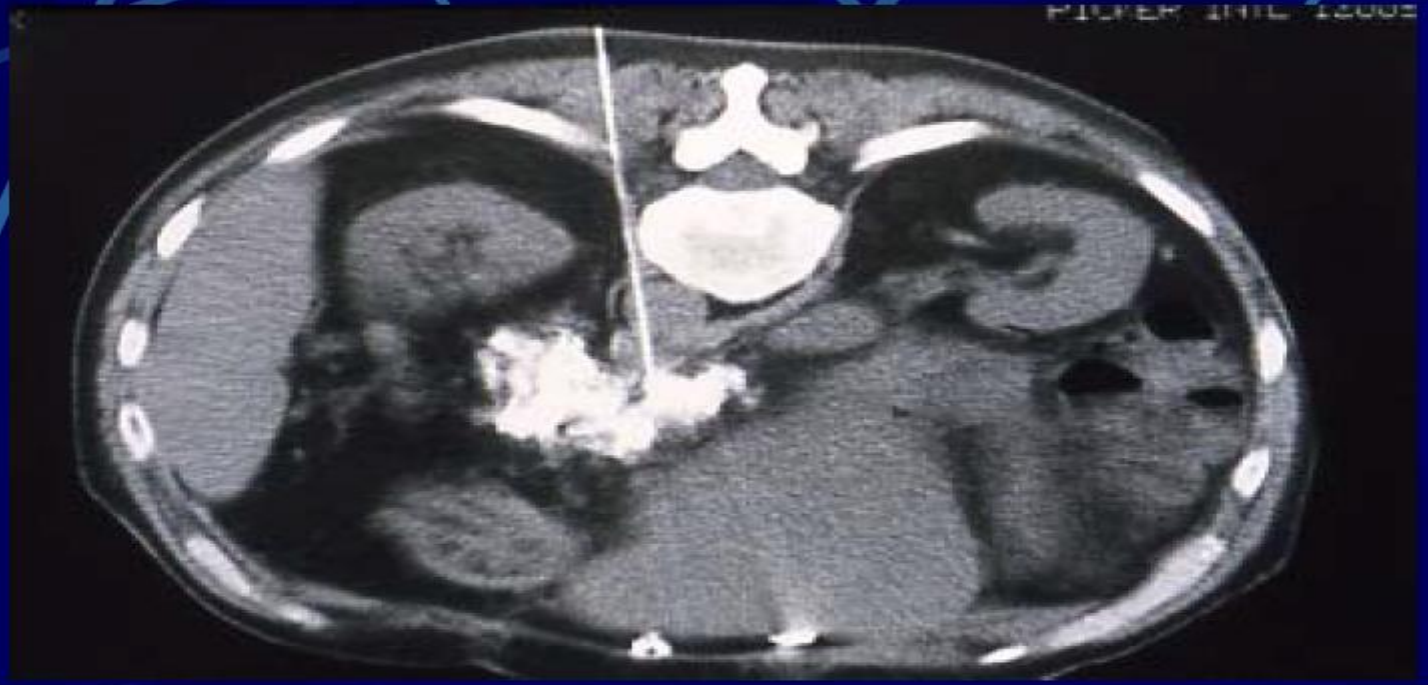
CT Guided Posterior Approach

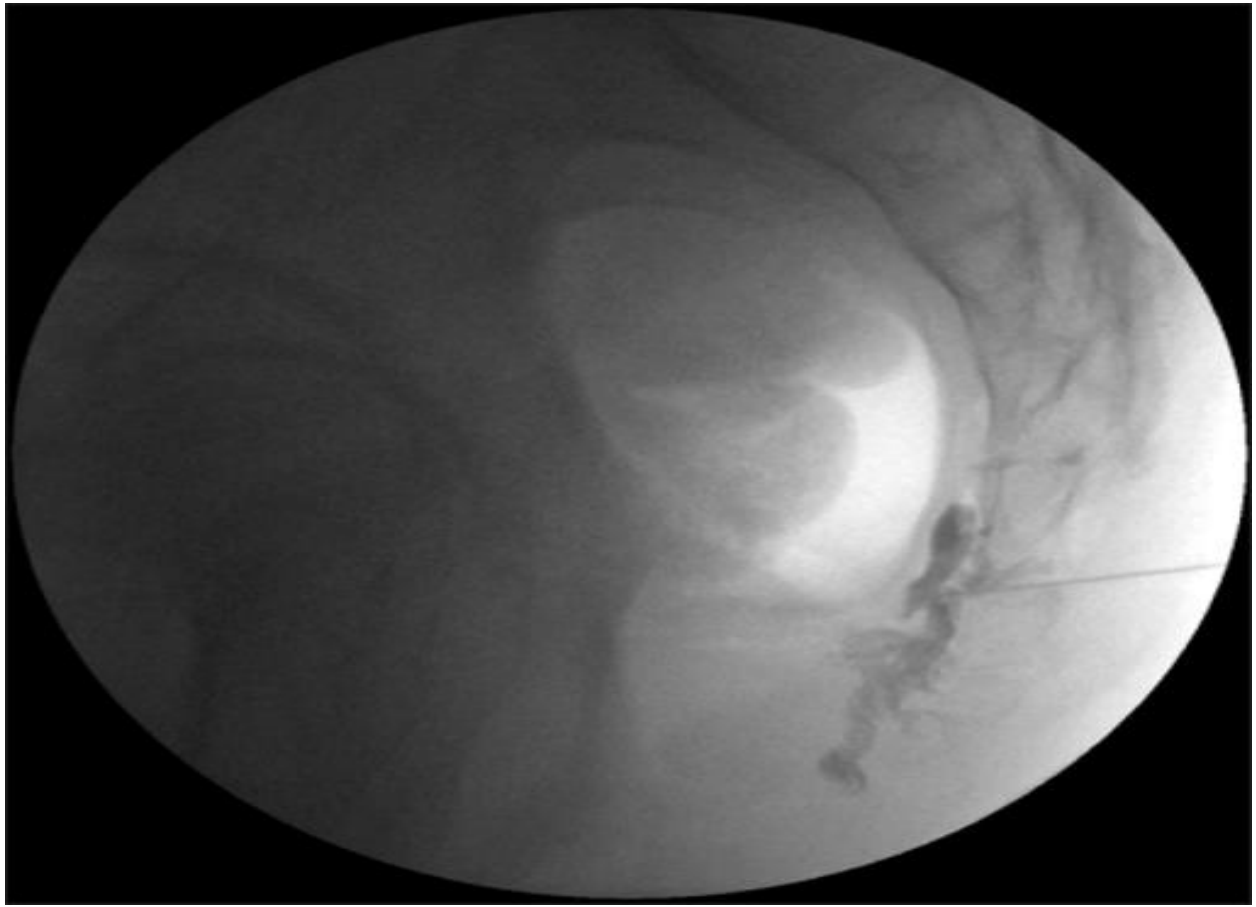
CT Guided Retrocrural



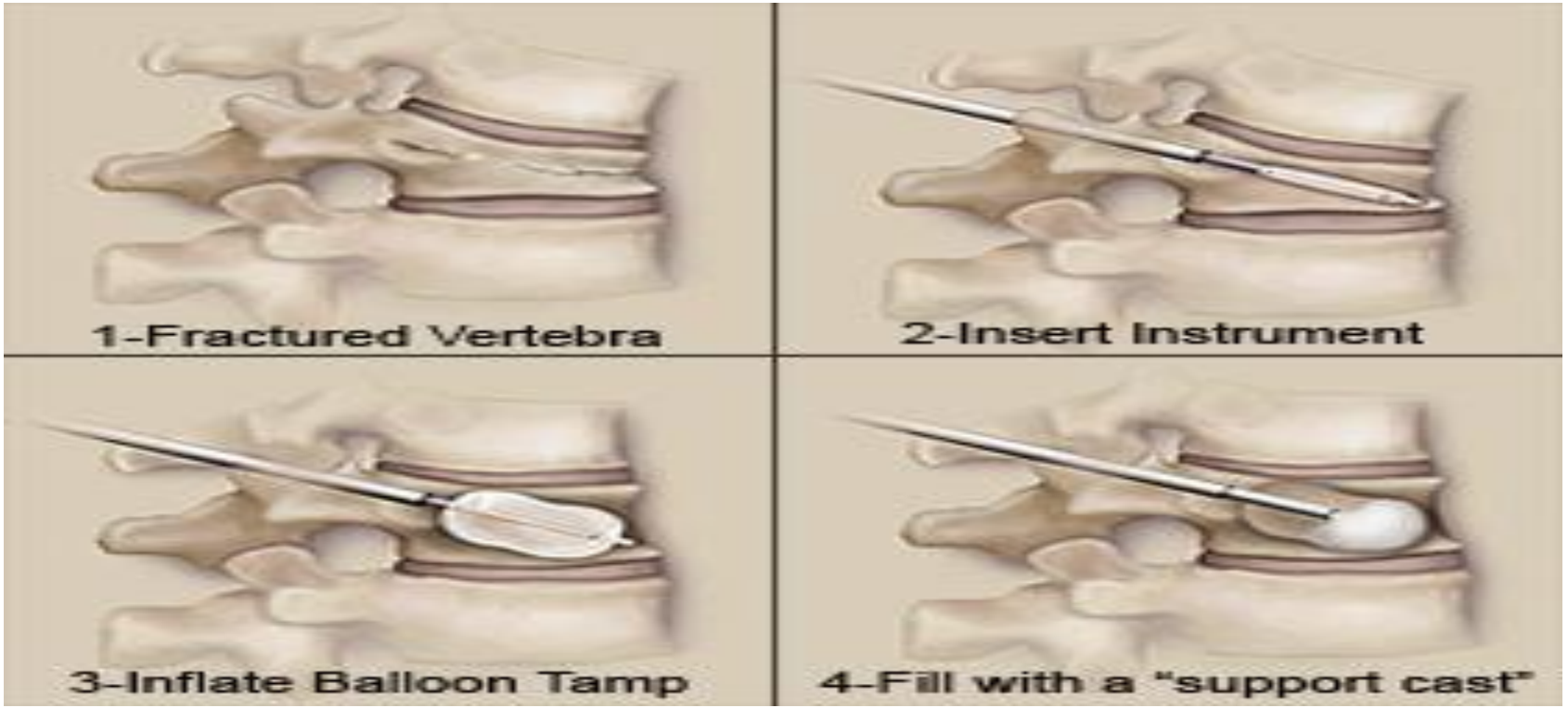
CT Guided Celiac Block – Single needle technique

CT Guided Trans-aortic approach

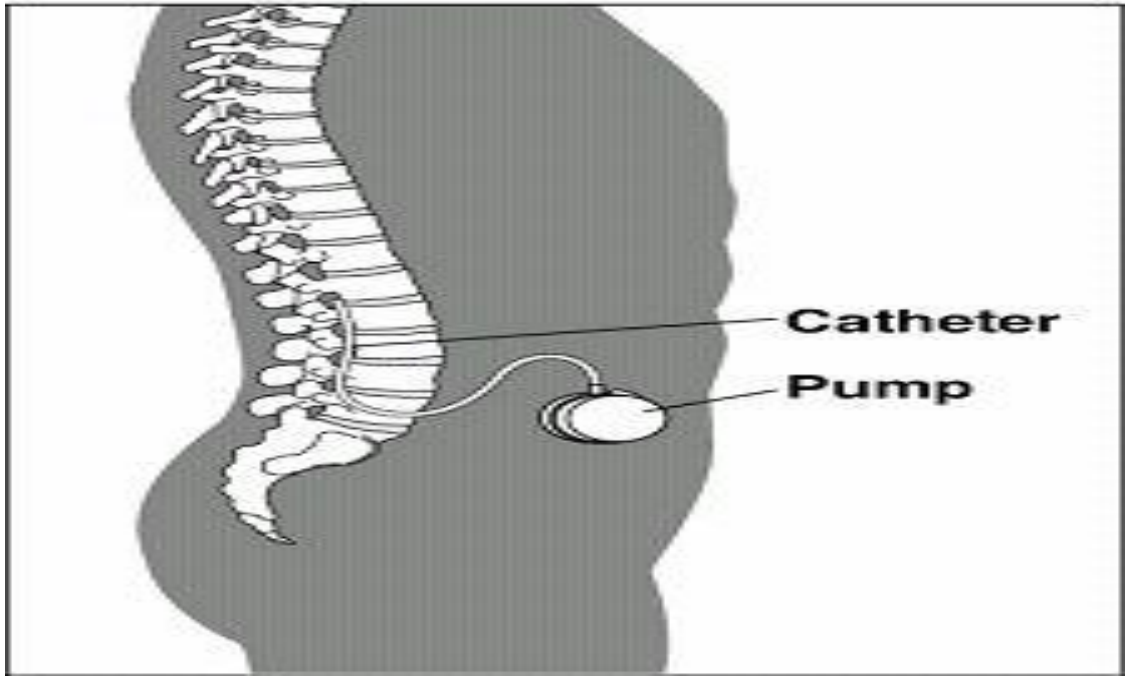




Kyphoplasty/Vertebroplasty

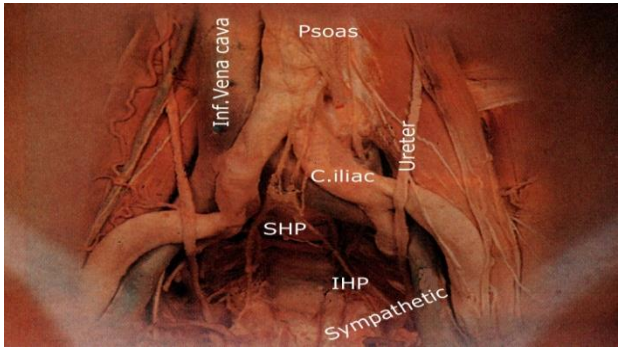


Intrathecal Pain Pumps



Superior hypogastric plexus destruction

- **Pelvic visceral pain**
- **Bladder, prostate, cervix, uterus, ovary, colon& rectum**
- **75% success**



Lateral view of Superior hypogastric plexus block

PAIN IS VERY OFTEN POORLY TREATED

BARRIERS

- Lack of knowledge and commitment
- Myths about addiction
- Other barriers
  - Patient related
  - System related
  - Profession related

Barriers to Effective Pain Management

- Not recognizing the importance of pain
- Prejudices about pain
- Fears of abuse and addiction
- Unpleasant experiences with pain therapy (intolerable side effects: nausea, drowsiness, fatigue, constipation)
- Regulatory restrictions
- Insufficient knowledge of pharmacological therapy

Case scenario

- 45 year lady with metastatic breast cancer
- Have undergone Surgery, CT
- Severe chest and back pain
- Unable to sleep
- Activity, cough etc increase her pain
- She has 15 and 12 years daughters
- Husband- school teacher
- Diclofenac and tramadol- little help

www.neuronpainclinic.com

You Tube: Neuron Pain Clinic

Facebook page: Neuron Pain & Spine Clinic

Google page: Neuron Pain & Spine Clinic

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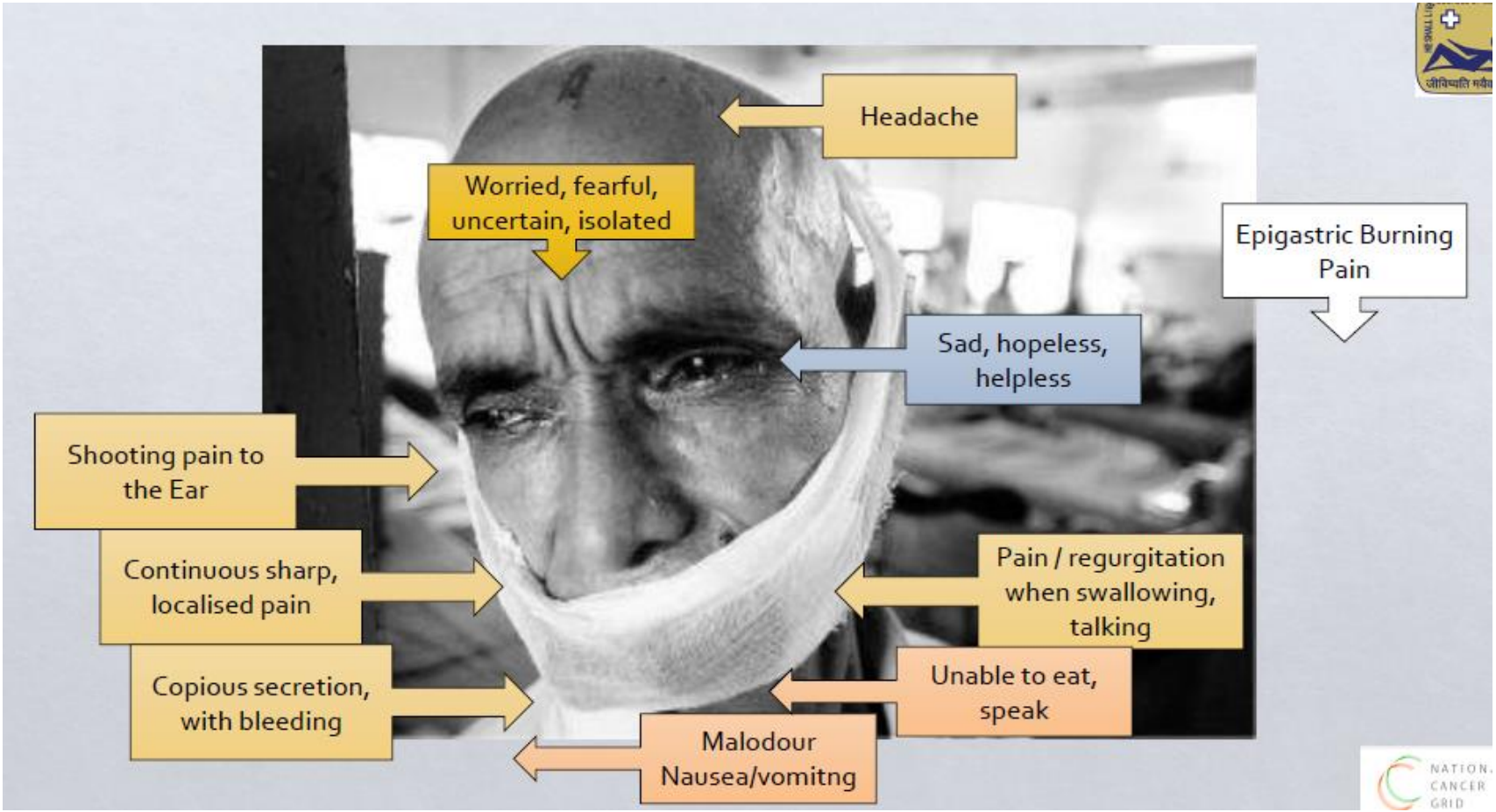
Take Home Message

1. Cancer pain is under-reported & under-treated
2. Caused by cancer and its treatment and debility
3. Comprehensive pain assessment is must
4. WHO analgesic ladder is a easy way managing most of the pain
5. Remember the thumb rules of converting different forms of opioid


Headache
Worried, fearful, uncertain, isolated
Epigastric Burning Pain
Sad, hopeless, helpless
Shooting pain to the Ear
Continuous sharp, localised pain
Pain / regurgitation when swallowing, talking
Copious secretion, with bleeding
Unable to eat, speak
Malodour
Nausea/vomitng