VCU Palliative Care ECHO*

March 28, 2019
Basics of Cancer Pain Management

*ECHO: Extension of Community Healthcare Outcomes
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The following Planning Committee and Presenting Faculty Members report relevant financial relationships to disclose:

The following Planning Committee and Presenting Faculty Members report having no relevant financial relationships:

Danielle Noreika, MD
Egidio Del Fabbro, MD

No commercial or in-kind support was provided for this activity
Helpful Reminders

- You are all on mute please unmute to talk
- If joining by telephone audio only, press *6 to mute and unmute

Unmute your microphone and start video
Helpful Reminders

Right click to your Zoom screen to rename your login; include your name and organization.
Helpful Reminders

Activate chat feature

Use the chat box to ask questions as they come to mind
What to Expect

I. Didactic Presentation
   20 minutes + Q&A

II. Case Discussions (x2)
   • Case Presentation
     5 min.
   • Clarifying questions from spokes, then hub
     2 min. each
   • Recommendations from spokes, then hub
     2 min. each
   • Summary (hub)
     5 min.

III. Closing and Questions

• Bi-weekly tele-ECHO sessions (1.5 hours)
• Didactic presentations developed by inter-professional experts in palliative care
• Website: www.vcuhealth.org/pcecho
• Email: pcecho@vcuhealth.org

Let’s get started!
# Hub Introductions

## VCU Team

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Director</strong></td>
<td>Danielle Noreika, MD, FACP, FAAHPM Medical Director/Fellowship Director VCU Palliative Care</td>
</tr>
<tr>
<td><strong>Clinical Experts</strong></td>
<td>Egidio Del Fabbro, MD – VCU Palliative Care Chair</td>
</tr>
<tr>
<td></td>
<td>Jason Callahan, MDiv – Palliative Care Specialty Certified</td>
</tr>
<tr>
<td></td>
<td>Tamara Orr, PhD, LCP – Clinical Psychologist</td>
</tr>
<tr>
<td></td>
<td>Diane Kane, LCSW – Palliative Care Specialty Certified</td>
</tr>
<tr>
<td></td>
<td>Felicia Hope Barner – RN</td>
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<tr>
<td></td>
<td>Candace Blades, JD, RN – Advance Care Planning Coordinator</td>
</tr>
<tr>
<td></td>
<td>Brian Cassel, PhD – Palliative Care Outcomes Researcher</td>
</tr>
<tr>
<td><strong>Support Staff</strong></td>
<td>Teri Dulong-Rae / Bhakti Dave, MPH</td>
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<tr>
<td></td>
<td>David Collins, MHA</td>
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<tr>
<td></td>
<td>Frank Green</td>
</tr>
<tr>
<td>Program Manager</td>
<td></td>
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<tr>
<td>Practice Administrator</td>
<td></td>
</tr>
<tr>
<td>IT Support</td>
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</tbody>
</table>
Spoke Participant Introductions

Name and Institution
Basics of Cancer Pain Management

Egidio Del Fabbro, MD
March 28, 2019
Objectives

The participant will be able to:

1) Define basic evaluation of pain assessment in cancer patients
2) Differentiate cancer pain from non-cancer pain assessment
3) Define broad strategies of cancer pain management
Overview of Opioids and Cancer-Related Pain

Egidio Del Fabbro MD
Chair, Palliative Care Program
Virginia Commonwealth University
Massey Cancer Center
Overview

• Assessment
• Education
• Risk Mitigation
• Harm Reduction
• Opioid side-effects
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Scale</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>No pain</td>
<td>0-10</td>
<td>Worst possible pain</td>
</tr>
<tr>
<td>Not tired</td>
<td>0-10</td>
<td>Worst possible tiredness</td>
</tr>
<tr>
<td>Not nauseated</td>
<td>0-10</td>
<td>Worst possible nausea</td>
</tr>
<tr>
<td>Not depressed</td>
<td>0-10</td>
<td>Worst possible depression</td>
</tr>
<tr>
<td>Not anxious</td>
<td>0-10</td>
<td>Worst possible anxiety</td>
</tr>
<tr>
<td>Not drowsy</td>
<td>0-10</td>
<td>Worst possible drowsiness</td>
</tr>
<tr>
<td>Best appetite</td>
<td>0-10</td>
<td>Worst possible appetite</td>
</tr>
<tr>
<td>Best feeling of well-being</td>
<td>0-10</td>
<td>Worst possible feeling of well-being</td>
</tr>
<tr>
<td>No shortness of breath</td>
<td>0-10</td>
<td>Worst possible shortness of breath</td>
</tr>
<tr>
<td>Other = Insomnia</td>
<td>0-10</td>
<td></td>
</tr>
</tbody>
</table>
Mean ESAS scores over time of 10752 patients
# Pain Interference - Short Form 8a (PROMIS)

## In the past 7 days...

<table>
<thead>
<tr>
<th>Pain Interference Question</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much did pain interfere with your day to day activities?</td>
<td></td>
<td></td>
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<tr>
<td>How much did pain interfere with work around the home?</td>
<td></td>
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<tr>
<td>How much did pain interfere with your ability to participate in social activities?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much did pain interfere with your enjoyment of life?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much did pain interfere with the things you usually do for fun?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much did pain interfere with your enjoyment of social activities?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much did pain interfere with your household chores?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much did pain interfere with your family life?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acronym of tool&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Number of questions</td>
<td>Completion</td>
<td>Time to complete</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------</td>
<td>--------------------</td>
<td>------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOAPP®-R</td>
<td>24 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIRE</td>
<td>7 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORT</td>
<td>5 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMM</td>
<td>40 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAGE</td>
<td>4 items</td>
<td>Either</td>
<td>&lt; 5 minutes</td>
<td></td>
<td></td>
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<tr>
<td>PDUQ</td>
<td>42 items</td>
<td>Clinician administered</td>
<td>20 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAR</td>
<td>14 items</td>
<td>Self-report</td>
<td>&lt; 5 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SISAP</td>
<td>5 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMQ</td>
<td>26 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> - SOAPP®-R (Screen and Opioid Assessment for Patient’s in Pain-revised); DIRE (Diagnosis, Intractability, Risk, and Efficacy); ORT (Webster’s Opioid Risk Tool); COMM (Current Opioid Misuse Measure); CAGE (Cut-down, Annoyed, Guilt, Eye-opener); PDUQ (Prescription Drug Use Questionnaire); STAR (Screening Tool for Addiction Risk); SISAP (Screening Instrument for Substance Abuse Potential); PMQ (Pain Medication Questionnaire)
Identifying and assessing risk of opioid abuse in cancer: an integrative review

- 691 articles using search terms
- 34 case studies, case series, retrospective observational studies, narrative reviews
- Screening questionnaires for opioid abuse or alcohol, urine drug screens to identify opioid misuse or abuse, prescription drug-monitoring programs, universal precautions
- 7 opioid specific 13 CAGE questionnaire to assess the risk of “chemical coping”
- Screening questionnaires one in five may be at risk of opioid-use disorder
- Several studies demonstrated associations between high-risk patients and clinical outcomes, such as aberrant behavior, prolonged opioid use, higher morphine-equivalent daily dose, greater health care utilization, and symptom burden
Cancer- and patient-related factors contributing to pain

Cancer-Related Factors
- Ischemia or bleed
- Tumor growth
- Infection
- Fracture

Increased Pain

Patient-Related Factors
- Chemical coping
- Delirium
- Opioid tolerance
- Depressed mood or somatization

Del Fabbro E JCO 2014;32:1734-1738
All addicts are Chemical Copers, but not all Chemical Copers are addicts

Population is Heterogeneous

Patients with Pain

Adapted from: Passik, Kirsch. Exp Clin Psychopharmacol 2008
Complications of chemical coping

- Opioid induced neurotoxicity
- Combining drugs of abuse
- Overdose
- Death
- Medico legal problems
- Addiction
- Poor quality of life, increased symptom burden
- Diversion

Opioid use after Curative-intent Surgery

Fig 2. (A) Trajectory of daily opioid dose stratified by perioperative opioid use. Mean daily opioid dose for each group was calculated every 30 days from 1 year before surgery to 1 year after surgery, while adjusting for preoperative opioid prescriptions, initial opioid prescribed, procedure type, adjuvant and neoadjuvant therapy, and patient characteristics. One year after surgery, patients who developed new persistent opioid use continued filling opioid prescriptions with daily doses similar to intermittent and chronic opioid users (P = .05). (B) Trajectory of daily opioid dose stratified by timing of chemotherapy. Patients who developed new persistent opioid use and received adjuvant chemotherapy had higher daily opioid doses compared with those who received no chemotherapy (P = .002). All groups, however, continued filling prescriptions with high daily doses, equivalent to five to six tablets per day of 5-mg hydrocodone. OME, oral morphine equivalent.
Management

Who should be referred to a multidisciplinary clinic?

- High doses
- Complex e.g. cancer pain + treatment related pain + chronic pain
- Complex opioid regimen
- Aberrant behavior
Aberrant behaviors associated with opioid misuse

- Request opioid refill earlier
- Use of street drugs
- Abnormal urine drug test
- Excessive dose increase
- Resistance to changes in opioids
- Impaired functioning in daily activities
- Lost or stolen opioid
- Seeking opioids from multiple providers
- Request for specific opioids
- Family concerned about patient’s inappropriate opioid use
- Tampering or forging opioid prescriptions
Universal Precautions for patients with cancer

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Differential diagnosis: identify tumor-related causes of pain and patient-related factors influencing pain perception and expression</td>
</tr>
<tr>
<td>2</td>
<td>History of risk factors for chemical coping: tobacco use, depression, history of substance abuse, personality disorder, somatization, sexual abuse</td>
</tr>
<tr>
<td>3</td>
<td>Screening instrument at first visit to identify those at high risk (e.g., CAGE, SOAPP, ORT, STAR)</td>
</tr>
<tr>
<td>4</td>
<td>Informed consent including patient education about addiction, tolerance, and opioid adverse effects and treatment plan that de-emphasizes opioids as sole treatment for pain</td>
</tr>
<tr>
<td>5</td>
<td>Opioid agreement (written or verbal) that includes outline of patient obligations (e.g., receive opioids prescriptions from single provider, no early refills, random UDS)</td>
</tr>
<tr>
<td>6</td>
<td>Pre- and postassessment of pain level and function; routine assessment of four As: analgesia, activities of daily living, adverse effects, and aberrant behavior[^38]</td>
</tr>
<tr>
<td>7</td>
<td>Psychological support, motivational interviews, and increased vigilance and structure for those at high risk for opioid misuse (e.g., pill counts, shorter intervals between visits); consider integrated comanaged model with interdisciplinarity palliative care or chronic pain team</td>
</tr>
<tr>
<td>8</td>
<td>Periodically review differential diagnosis; contribution of tumor- and patient-related factors to pain may have changed (e.g., patients with no evidence of disease should receive stable scheduled dose or tapered opioids, whereas patients with progressive advanced cancer will require additional breakthrough-dose opioids)</td>
</tr>
<tr>
<td>9</td>
<td>Documentation of all prescriptions, office visits, agreements, and instructions</td>
</tr>
<tr>
<td>10</td>
<td>Ethical concerns: discharging patient with advanced cancer and substance misuse; comanagement with substance abuse specialists should be initial step</td>
</tr>
</tbody>
</table>

NOTE. Data adapted[^35][^36][^37]

[^38]: Pre- and postassessment of pain level and function; routine assessment of four As: analgesia, activities of daily living, adverse effects, and aberrant behavior.

Abbreviations: ORT, Opioid Risk Tool; SOAPP, Screener and Opioid Assessment for Patients With Pain; STAR, Screening Tool for Addiction Risk; UDS, urine drug screen.
Management Strategies
Key Domains

1. Education

2. Harm reduction

3. Managing psychological & spiritual distress

4. Risk mitigation
Education

Printed
Digital
Social Media

Reddy Oncologist 2014, De La Cruz Oncologist 2017
Management Strategies

Education

- Proper opioid disposal methods (76% vs. 28%; \( p \leq 0.0001 \))
- Share opioids with someone else (3% vs. 8%; \( p = 0.0311 \))
- Practice unsafe use of opioids (18% vs. 25% \( p = 0.0344 \))
- Danger of opioids when taken by others (\( p = 0.0099 \))
- Unused medication at home (38% vs. 47%; \( p = 0.0497 \))
- Keep medications in a safe place (hidden, 75% vs. 70%; locked, 14% vs. 10%; \( p = 0.0025 \))

Reddy et al. Oncologist 2017
Management Strategies
Harm Reduction

• Opioid prescription
  • Use long-acting opioids and limit IR
  • methadone and buprenorphine
  • Rotate to lower equianalgesic dose
  • Avoid demand PCA, use basal and clinician bolus only
  • Non-opioids for pain

• Selective Naloxone use?
  • For high risk of overdose?
  • Parenteral (IV, IM, SC; 0.4-1 mg), nasal (1 mg per nostril)
  • Caregivers need to be taught; repeat if no response
  • More research needed on outcomes
Outpatient Opioid Rotation

- 120/512 (23%) underwent opioid rotation (OR)
- Uncontrolled pain (83%) most common indication
- 74/114 (65%) patients had a successful OR
- OR= improved pain, wellbeing, insomnia and depression
- Fentanyl transdermal to methadone most common
- MEDD decreased in patients with successful OR (P=0.04)

Reddy, The Oncologist, 2013
Comorbid psychiatric conditions & psychological interventions

• Co-occurring opioid use disorder and chronic pain
  >90% co-morbid psychiatric conditions
• Cognitive behavioral therapy, mindfulness based therapy
• Relaxation techniques, biofeedback, and distraction techniques
• Brief motivational interviewing
Management Strategies
Compassionate High Alert Team (CHAT) Program

Triggers
- Abnormal UDS results
- Multiple early refills requested
- Running out of opioids early
- Lost prescriptions
- Medications multiple providers

Approach
- Education about safe opioid use
- Longitudinal counseling
- Sensitive communication
- Frequent monitoring
- Structured documentation
- Personalized treatment
- Logistical and caregiver support
Are Oncology patients at risk?
Urine drug screen (UDS) findings in a supportive care clinic

Rauenzahn, Cassel, Del Fabbro MASCC 2015
Opioids & sex-hormones

In Cancer patients low Testosterone is associated with

• Higher Opioid dose  *Bruera 2004, Dev 2014*

• Fatigue, depression, poor HRQoL scores  *Strasser 2006*

• Poor appetite, increased IL-6, ghrelin  *Garcia 2006*

• Decreased survival  *Del Fabbro JPSM 2010*
Opportunities for improved pain Mx

- Education of patients, family, providers (pamphlets -social media)
- Screening with brief questionnaire
- Psychological support, brief motivational interviewing
- Opioid sparing interventions rotation, modify PCA’s
- Long acting opioids, Non-Opioids & Non-pharmacologic for pain
- Methadone role in rotation, combination Rx for neuropathic pain
- Risk mitigation with UDS,PMP
- ‘Adapted‘ Universal precautions -no evidence despite gold standard
- Testosterone and Opioids
Case Presentation

Cynthia Straub, Bon Secours
Case 1: Pain and Symptom Management

Are there any other pain management ideas I didn’t use before Palliative Sedating this patient?
Patient Presentation

ECHO

3/28/19

Cynthia Straub, FNP-C, ACHPN
80 y/o Female


- s/p bladder resection (no chemotherapy due to age and toxicity of Cisplatin)

- patient opted not to seek immunotherapy as she has Polymyalgia Rheumatica in remission

- 2/2017 evaluated at UVA and signed on for Phase III clinical trial of atezolizumab vs. Observation as adjuvant therapy for muscle-invasive bladder cancer after surgery. Began c/o right hip pain and found to have metastatic disease, undergone intramedullary nailing of the proximal right femur
4/5/2017
admitted to MRMC

• intractable back pain

• scheduled for XRT on day of admission to help stabilize the bone in and around the metallic fixation hardware.

• MRI L-Spine: metastatic disease with superior endplate compression fracture at L3, transcortical spread at L3 demonstrated into anterior and left lateral epidural space especially within subarticular zone, subtle transcortical spread also suggested in the left anterior epidural space at S2.
HOW WOULD YOU MANAGE HER PAIN?

• 1. PCA Dilaudid (later changed to Fentanyl)

• 2. Decadron 4mg IV QD (increased to every 12 hours)

• 3. Specialty Mattress

• 4. Asked radiation to add single fraction to L-spine

• 5. Asked IR to evaluate for Kyphoplasty

• 4/7/17:
  • 6. added Methadone, Toradol, lidoderm, Ativan
HOW WOULD YOU MANAGE HER PAIN?

Adapted from capcsd.org
4/10/17

• unable to undergo XRT due to pain
• patient expresses that she does not want to be a burden, wants to be able to ambulate. PT/OT assessment.

4/11/17

• meeting with patient, family, Palliative and Hospice interdisciplinary team to discuss pain management and end of life care.
• escalate treatment for anxiety

4/12/17

• add IV Ketamine
4/12/17 - 4/14/17

- titrating Ketamine up.
- no relief

- 4/14/17 Palliative Sedation
  - Discussed expectations, family time.
  - “what’s taking so long?”

- 4/15/17 pt died
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www.vcuhealth.org/pcecho

Click “Claim CME and Provide Evaluation”
Submit your evaluation to claim your CME
View previously recorded ECHOs for CME

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www.vcuhealth.org/pcecho

Click “Curriculum”
View previously recorded ECHOs for CME

Select the session you would like to view
View previously recorded ECHOs for CME

Click “Tests” to view video of the session and take a short quiz for continuing education credit.
THANK YOU!

We hope to see you at our next ECHO