GP Education Session
7 March 2016

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Opioid, e.g. morphine

anti-nausea

4 KEY DRUGS for treating symptoms at the end of life

Sedative

Anti-secretory

- **Talk to local palliative care team for advice on opioid conversions**
- **OME 30 = D 10 No need to start an antiemetic if starting low dose sc opioids**
- **Continue patches when commencing a syringe driver (check with PCT if unsure)**
- **Breakthrough pain dose?**

Opioid, e.g. morphine

Regular

Breakthrough is usually 1/6 of regular

anti-nausea

4 KEY DRUGS for treating symptoms at the end of life

Sedative

Anti-secretory

- **Talk to PCT (42442) for advice on opioid conversions**
- **OME 30 = D 10 = Alf 1**
- **Alfentanil is cheap and safest for those with renal impairment.**
- **No need to start an antiemetic if starting low dose sc opioids**
- **Continue patches when commencing a syringe driver (check with PCT if unsure)**
- **Breakthrough pain dose?**

Conversion question

- A 70-year-old woman is discharged from hospital and comes complaining of uncontrolled chest pain. Investigations revealed a diagnosis of lung cancer. Her current medication comprises maximum dose codeine and paracetamol. What is the most appropriate dose of sustained release morphine for this patient?

A. 5 mg BD

B. 10 mg BD

C. 15 mg BD

D. 30 mg BD

E. 60 mg BD

MRCP style question

- A 70-year-old woman is admitted to hospital with uncontrolled chest pain. Investigations reveal a diagnosis of lung cancer. Her current medication comprises maximum dose codeine and paracetamol. What is the most appropriate dose of sustained release morphine for this patient?

A. 5 mg BD

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D. 30 mg BD

E. 60 mg BD

- **Max dose codeine is 240 mg**
- **This is equivalent to 24 mg OME**
- **Going for option C is safer than option D**
- **You would always co-prescribe breakthrough oramorph – what dose?**

Vingette 1

- A 54 year old school teacher, divorced and awaiting confirmation of retirement entitlement presents with severe rectal pain and bleeding on defeacation. Investigations confirm rectal cancer and she is due to start neoadjuvant chemo-radiation in 10 days time. She has tried paracetamol with no effect and has not slept for 4 nights.

Nociceptive Pain

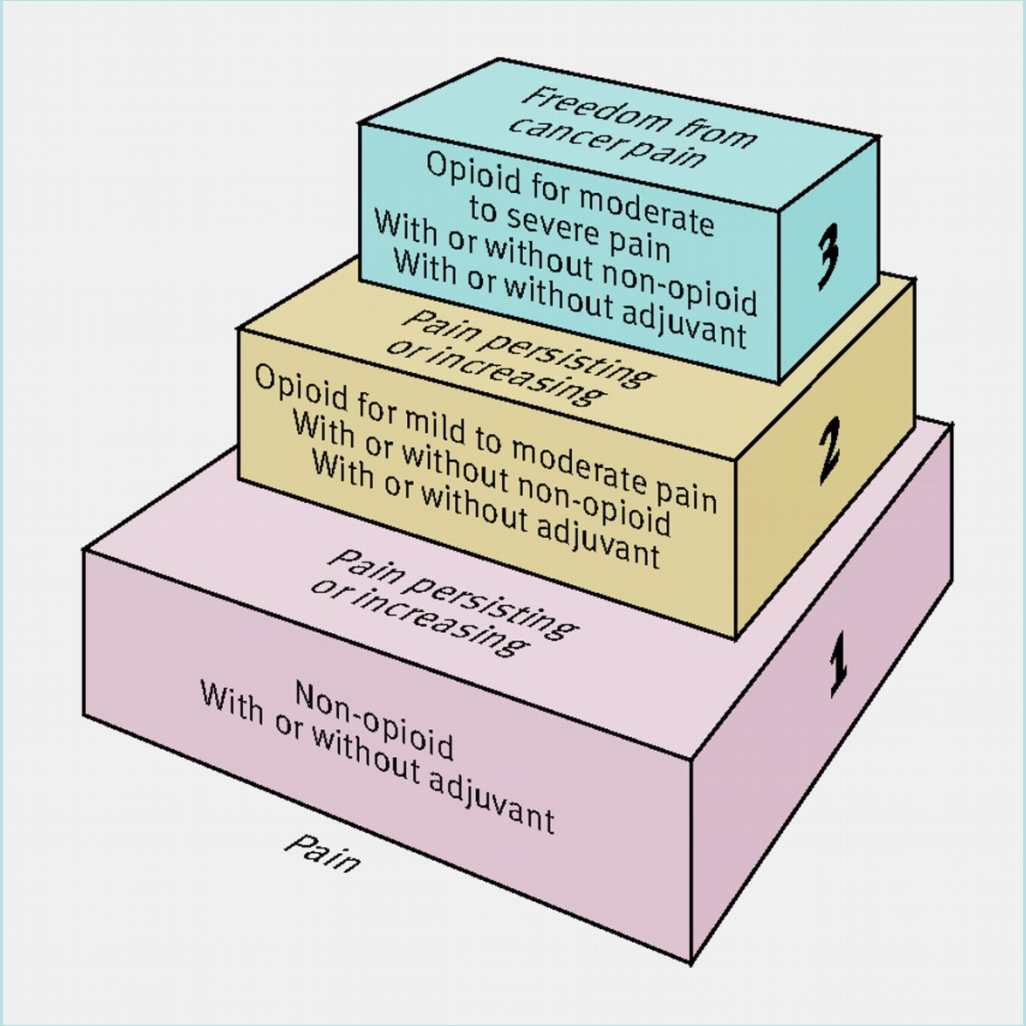
Somatic Pain

- Arises from bone, muscle, cutaneous and connective tissue
- Localised
- Typically clinically described as throbbing, aching or stabbing

Visceral Pain

- Arises from internal organs
- Generalised / diffuse
- Clinically, typically described as cramping or gnawing

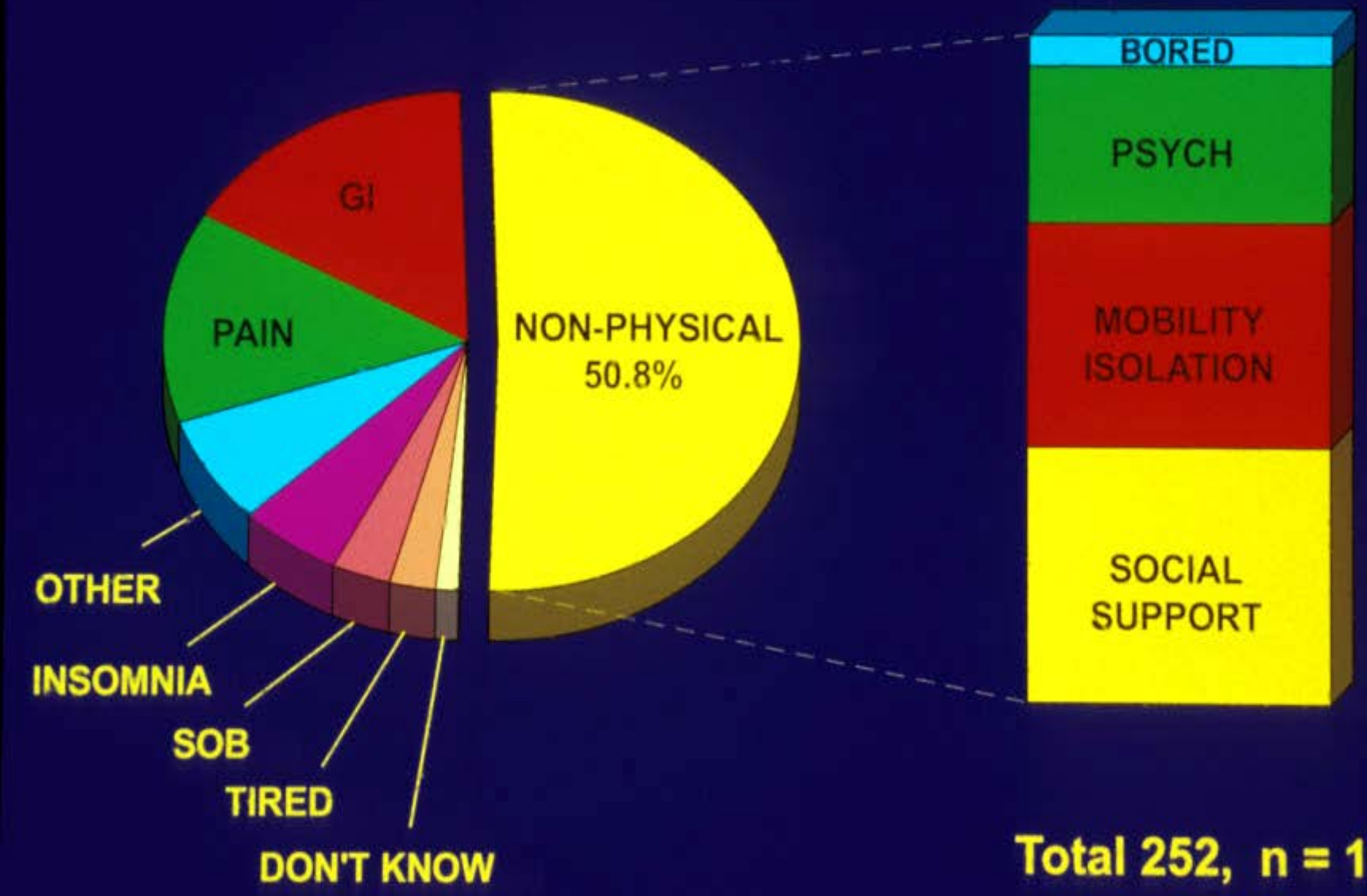
Fig 2 WHO analgesic "ladder" (for how to interpret it, see the section "Principles of pain management" in the main text)



Cormie, P J et al. BMJ 2008;337:a2154

BMJ

PATIENT IDENTIFIED PROBLEMS



Total 252, n = 118

WHAT DO PEOPLE WANT?

- Treated as human being
- Empowerment
- Information
- Choice
- Continuity of care
- Equal access
- Physical needs
- Psychosocial needs
- Social needs
- Spiritual needs

- Individual
- Heard, valued, consented
- Honest, sensitive, all media
- All options of care, place of death
- Health and social care
- Comparable quality
- Acceptable, achievable
- Listen, understand, care of carers
- £, work, transport
- Explore

Cancerlink questionnaire (patients), expert recipients, CHI/Audit Commission

- Nociceptive pain
- WHO 3 step ladder
- Oral Morphine
- Side effects
- Social support
- Psychological assessment
- Drug review

Side effects of strong opioids *when used for analgesia*

Common initial

- Drowsiness
- Lightheadedness/ feeling unsteady
- Delirium

Common and ongoing

- Drowsiness
- Lightheadedness/ feeling unsteady
- Delirium
- Constipation
- Dry Mouth

Laxation

- Avoid bulk-forming laxatives in cancer patients (e.g. ispaghula husk)
- Prefer to titrate movicol (if able to drink a cup of water)
- Thereafter, use docusate +/- senna

Vignette 2

- An 81 year old man presents with persistent tingling pain over his L chest wall with exacerbations about 6 times a day that last 10-20 minutes during which he is reduced to tears and immobilised. He is sleepy and constipated with codeine.

Neuropathic Pain

"Arises from neural tissue"

What patient says…

- Continuous → 'burning'
- Spontaneous → 'shooting' or 'electric'

What you might find…

- Allodynia → Pain due to a stimulus that does not normally provoke pain
- Hyperpathia → A pain *syndrome* characterized by an abnormally painful reaction (often explosive in character), especially a repetitive stimulus
- Hyperalgesia → Increased pain from a stimulus that normally provokes pain

Neuropathic Pain

…persistent tingling pain over his L chest wall…

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Drug Management of neuropathic pain

- Gabapentin; Pregabalin; Amitriptyline
- Topical Lidocaine 5%
- TENS
- Nerve blocks
  - Percutaneous cordotomy

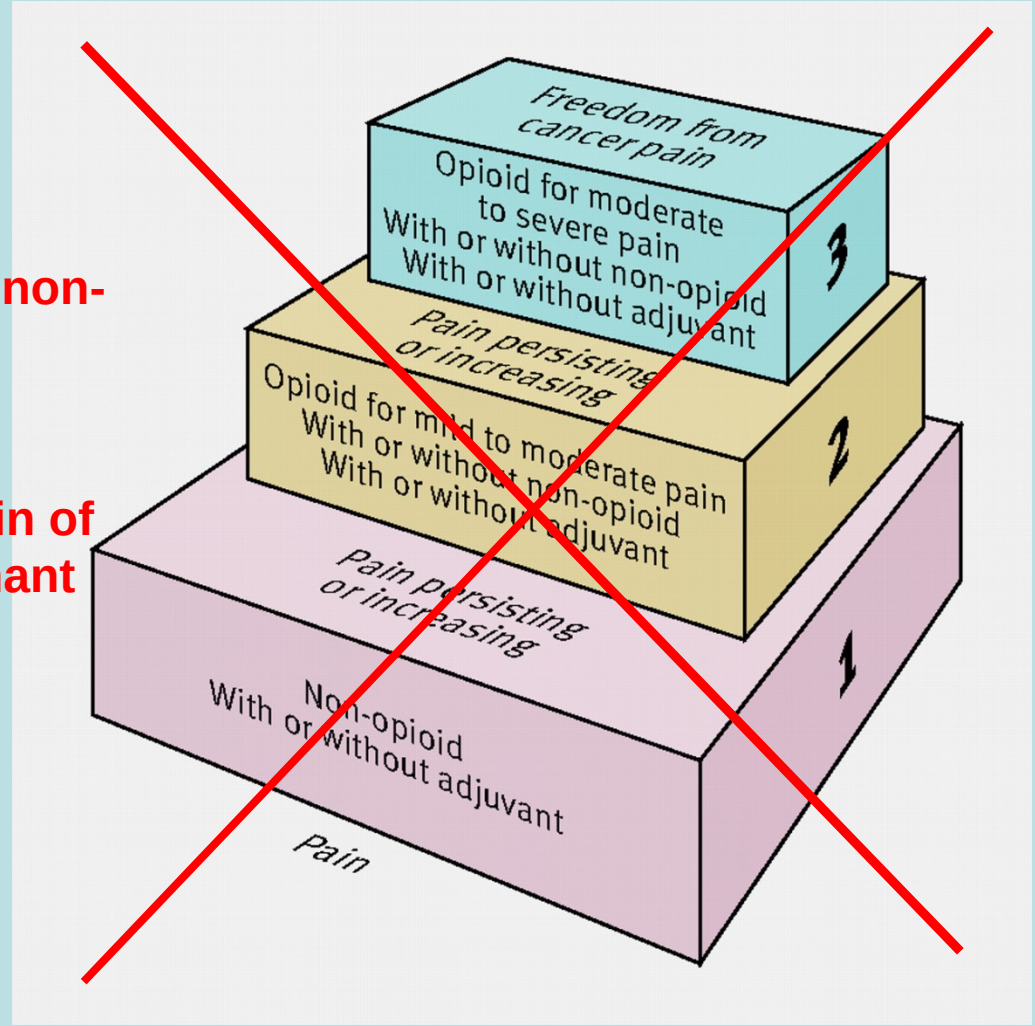
The evidence for beneficial effects of opioids is weak (poor trials). “Analgesic efficacy of opioids in chronic neuropathic pain is subject to considerable uncertainty” **McNicol ED Cochrane Database of SRs 2013**

Fig 2 WHO analgesic "ladder" (for how to interpret it, see the section "Principles of pain management" in the main text)

If…

a)Chronic AND non-malignant pain

b) Chronic neuropathic pain of dubious malignant aetiology



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BMJ

Chronic non-malignant pain

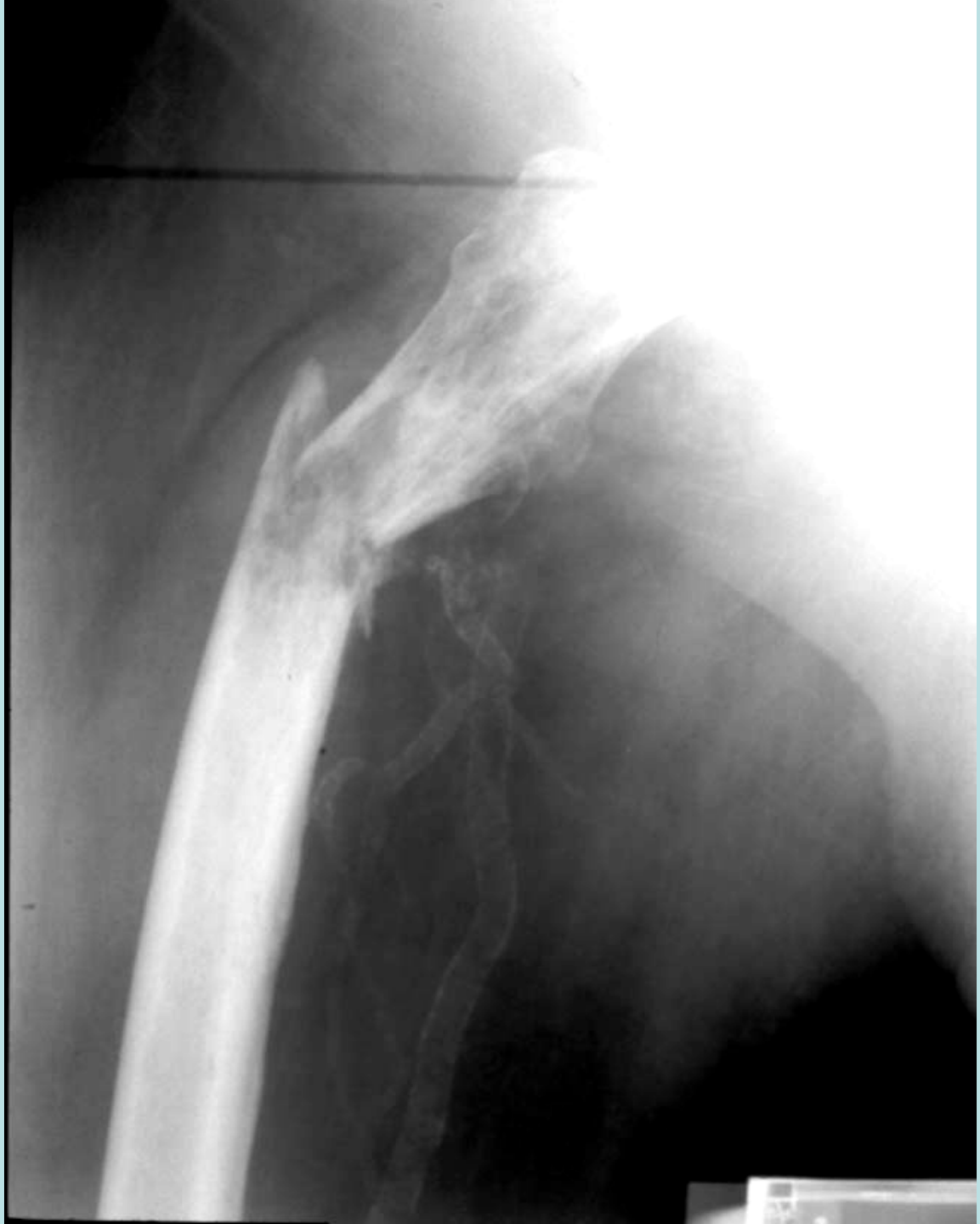
- Multi-modal approach
- Tramadol (serotonergic and adrenergic) and Tapentadol (NrU Inhib) are “strong opioids”
- Think of 60 mg oral morphine equivalent as a “safe” maximum
  - = 25 mcg/hr transdermal fentanyl
  - = 25 mcg/hr transdermal buprenorphine

Longer term risks of chronic strong opioid use

- Tolerance + addiction more likely in the chronic non-cancer population
- Interferes with hypothalamic-pituitary axis
  - Decrease in sex hormones
  - Worsening bone health
- Interferes with immunity

Vignette 3

- A 62 year old woman is in hospital during her last days with the support of her son and daughter-in-law. She understands her prognosis is ‘days to weeks’ and her dyspnoea from her lung cancer is controlled although it confines her largely to bed.
- Yesterday she fell and since then has had pain in her thigh where she has a large bruise and some deformity. She is keen to have treatment for the pain but moving is excruciating and she would like to suffer as little as possible.



- Insight
  - Clinical team
  - Patient
  - Family
- Opioids: background and incident
- NSAIDS
  - Side effects
- Splint
- Nerve block

Vignette 4

- A 44 year old business man has gastric cancer with liver metastases. His pain is well controlled usually and he maintains his independence, still working in the family business.
- This last week he has noticed a degree of pain and difficulty breathing and seeks your advice.

- History
- Examination
- Investigations
- Diff diagnosis
- Treatment

- Diagnose cause – if you can
- Examine
- **Hepatic capsule pain**
- **Specific indication: corticosteroids**
- Opioids
- PPI
- Psychosocial support

Vignette 5

- A 68 year old retired solicitor has lived with metastatic breast cancer for 3 years. She usually takes MST 60mg bd, paracetamol and ibuprofen with good effect. She was started on Dexamethasone 8mg, for appetite, 2 weeks ago by her oncologist. She was initially well but since the 4th day of taking them she has been vomiting and is in pain.

- Prognosis please!
- Iatrogenic harm
- SCSD conversions
- Breakthrough doses
- Prophylaxis

- Prognosis
- Iatrogenic harm
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- SCSD conversions
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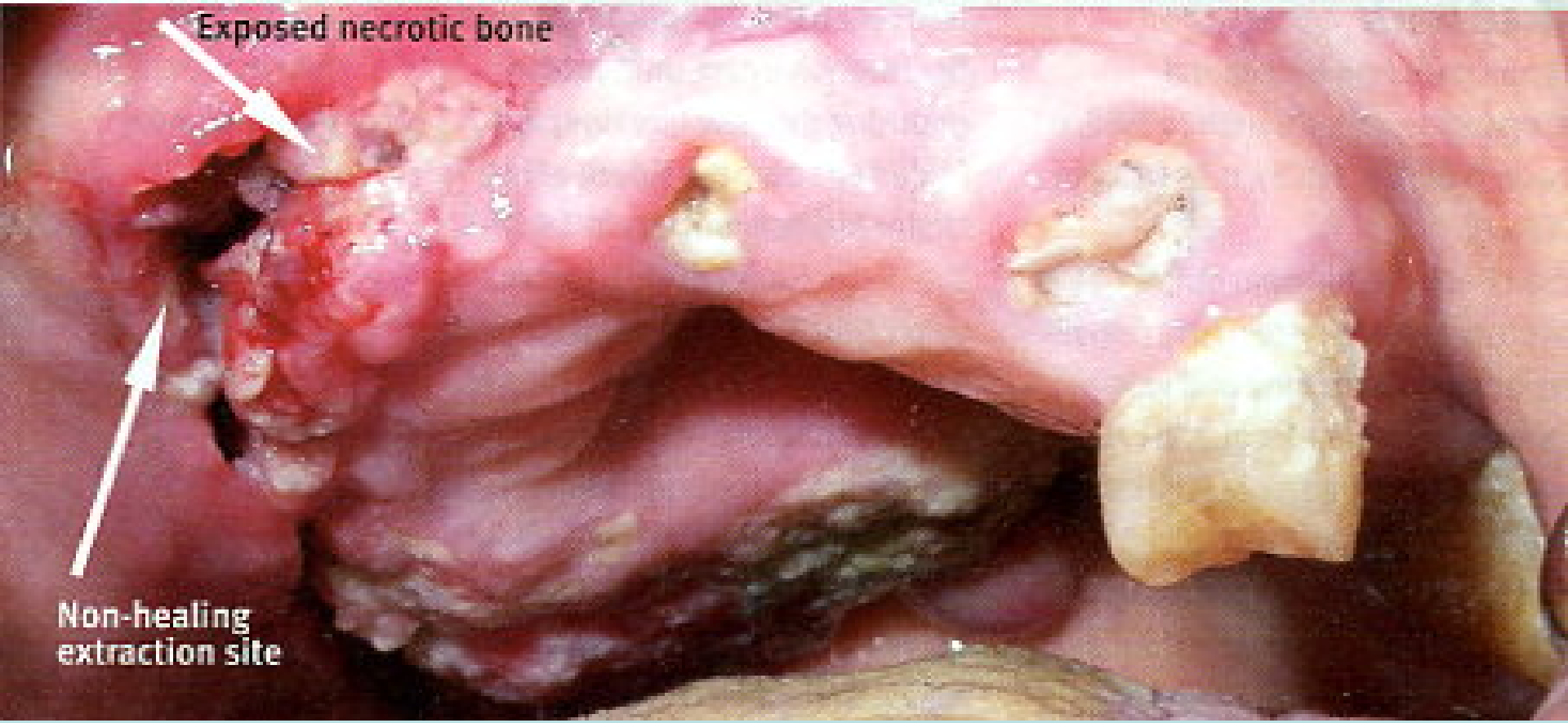
Bisphosphonates

- Inhibit osteoclast bone resorption
- Reduce bone metastases
- Reduce hypercalcaemia
- Don’t reduce incidence of MSCC
- Increase survival?
- Protect vs aromatase inhibitors
- IV>oral, effect wears off

Osteonecrosis



58 yrs, breast cancer treated with Zoledronate 2/12 post maxillary extraction BMJ 13 Jan 2007

Vignette 6

- A 28 year old reformed alcoholic has been diagnosed with pancreatic cancer and prescribed MST 20mg bd. His GP thinks he is acting oddly, complaining loudly of pain when anyone is around and asking for more and more prescriptions. His dose is escalating rapidly and the GP asks your advice as to whether you think the patient is really in pain or abusing his medication.

- Pancreatic pain – classical
  - Abdo, to back, leans forward
  - Unrelenting
  - Associated DM, Diarrhoea, Paraneoplastic pathology
- Trust
- Abuse or underdosing?
- Explore adjuvants and blocks
- Specialist
- Opiophobia

Vignette 7

- 67 yo married woman dying at home from stage 4 ovarian malignancy. Complaining of nausea and vomiting: about 200-300 ml a day. Passing some flatus. Currently on a 12 mcg/hr transdermal fentanyl patch, but finding abdominal pain (griping) a problem and cannot keep 5 mg oramorph down

Inoperable bowel obstruction

- Vomiting presents late if large bowel obstruction
- Try metoclopramide (SYRINGE DRIVER!)
- Then try drugs to shut down bowel
  - Cyclizine
  - Bucopan
- Dexamethasone subcut (cochrane review)

- Vomiting presents early if small bowel obstruction
- NG tube to drain?
- Octreotide
  - Somatostatin analogue that decreases intraluminal output

At risk of sudden fatal haemorrahge…?

- Head and neck cancer; upper GI cancer; cancer eroding thoracic aorta
- To tell or not to tell?
- Midazolam
  - Buccolam 10mg/2ml
  - 10 mg vial available at home
- STAY WITH THE PATIENT - keep him/her calm

Summary

- Good assessments: history and examination
- Be aware of WHO ladder limitation in chronic non-cancer pain
- Therapeutic decisions ought to be based on your assessment of patient’s prognosis

Questions?

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- 25 patch fentanyl
- Dying but still needs more analgesi
- 1. Continue the patch (90 OME)
- 2. start CSCI 5 mg diamorphine (15 OME)

105 OME. Breakthrough 15 – 20 mg OME

= 5 mg diamorphine sc