CLiP

15 minute Worksheet

Helping the patient with pain

10: Managing severe pain

Advanced level

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Aim of this worksheet

To understand the principles in managing severe pain.

How to use this worksheet

- You can work through this worksheet by yourself, or with a tutor.
- Read the case study below, and then turn to the Work page overleaf.
- Work any way you want. You can start with the exercises on the Work page using your own knowledge. The answers are on the Information page - this is not cheating since you learn as you find the information. Alternatively you may prefer to start by reading the Information page before moving to the exercises on the Work page.
- This CLiP worksheet should take about 15 minutes to complete, but will take longer if you are working with colleagues or in a group. If anything is unclear, discuss it with a colleague.
- If you think any information is wrong or out of date let us know.
- Take this learning into your workplace using the activity on the back page.

Case study

Pat is a 36 year old woman, married with two sons aged 12 and 9. Investigations revealed a carcinoma of the sigmoid colon with liver metastases. She copes, with some denial, and refuses to tell her sons. She has a persistent, burning perineal pain which has not responded to increased opioid doses and is getting steadily worse.

One evening you are asked to see her urgently and find her very distressed. She is on the bed, on her knees, rocking to and fro, saying the pain is 'all over'.

v10

INFORMATION PAGE: Managing severe pain

What can cause severe pain?

There are many reasons why pain may become suddenly severe:

- *A change in the analgesia:* this may be due to a recent change in opioid (opioid conversion ratios are only approximations), not taking an analgesic (eg. because of vomiting or adverse effects), or a change in the uptake or elimination of an analgesic (eg. loss of adhesion of a fentanyl patch).
- *Inflammation:* due to infection (eg. pleurisy due to a chest infection), irritation (eg. pleurisy due to a pulmonary embolus or peritonitis due to a bowel perforation), or chemical damage (eg. drug-induced gastrointestinal mucosal damage or a perianal skin burn caused by dantron).
- *Ischaemia:* due to peripheral vascular disease, or myocardial ischaemia.
- *Tissue distension:* eg. a bleed into a liver metastasis causing liver capsule pain.
- *Muscle spasm:* eg. colic or skeletal muscular spasms.
- *Tissue rupture:* eg. bone fractures due to metastatic disease, or fistula formation.
- *Reduced ability to cope:* due to fear, depression or past experiences.

In Pat, there is nothing to suggest a new pain. Her comment that the pain is 'all over' is typical of so-called 'overwhelming pain'. This is when pain is accompanied by marked fear and the whole experience becomes too intense to make sense of it all. Her persisting pain may have steadily reduced her ability to cope until no coping skills were left and the situation became overwhelming.

A plan of action

Immediately: to achieve sufficient comfort to allow an initial assessment you need to:

-find a comfortable position for Pat

–give Pat her usual 'as required' dose of analgesic. This may be best by injection for speed of onset, and is calculated as 5% (IV or SC), or 10% (oral) of the total oral morphine dose.

– try and reduce her fear with reassurance, company and distraction. In overwhelming pain this may be insufficient and the level of fear needs medication such as lorazepam 0.5mg sublingually or midazolam 2.5mg SC or buccally (between cheek and teeth- without a needle!). She needs to get enough to relax her, but not so much that she falls asleep and cannot tell you about her pain.

Within 1 hour: exclude causes that need urgent management or can be treated simply

Examples that need urgent management are myocardial infarction, pulmonary embolus, bone fracture, spinal cord compression and peritonitis.

An example of a severe pain that can be treated simply is colic.

Within 4 hours: achieve comfort at rest by:

-increasing the regular analgesia by 50%;

-checking whether this is a new pain (see CliP worksheet on *Diagnosing the Pain*);

-contacting a palliative care or pain specialist to advise on planning the next step. This is essential if the pain is unchanged at this stage.

Within 24 hours: plan for stable pain control by:

-ensuring a good nights sleep for Pat

–reviewing the support and treatment she will need to cope with any anxiety or low mood. Persistence of psychological problems will delay the resolution of the pain for several weeks and to avoid disappointment this needs to be understood by patient, partner and staff. See the CliP worksheets on *Helping the Anxious Person* and *Helping the Withdrawn Patient*.

An analgesic staircase for the drugs used in severe pain

This should include many of the approaches you have already written down in the plan of action above:

Step 1: give usual 'as required' dose. Give a benzodiazepine if fear is prominent. Lorazepam 0.5mg orally can be helpful, but if the situation is urgent buccal midazolam 2.5-5mg works within 10minutes.

Step 2: give any simple treatments (eg. hyoscine butylbromide for colic), otherwise increase regular analgesia by 50%.

Step 3: Refer to pain or palliative care specialist to

- review pain
- consider the use of ketamine, possibly also with a switch to methadone.

Step 4: consider spinal analgesia or a nerve block. If the pain remains severe, sedation may be needed until the procedure can be organised.

A postscript on ketamine

Ketamine is a 40 yr old anaesthetic drug which in the last 10 years has been noted to be an unusual analgesic. It is particularly useful for persistent movement-related pains and some neuropathic pains. It can be given orally, buccally and by subcutaneous infusion. It is usually well tolerated at low doses but at higher doses (>400mg/24hrs) or with titration that is too rapid, it can cause drowsiness, euphoria or dysphoria, hallucinations and hypertension.

Reflect

Think about
- why Pat is saying her pain is 'all over'
- what could have caused her pain to go out of control

Write

Write a plan of action for helping Pat

- Immediately *Goal: to achieve sufficient comfort to allow an initial assessment*
  Your action:

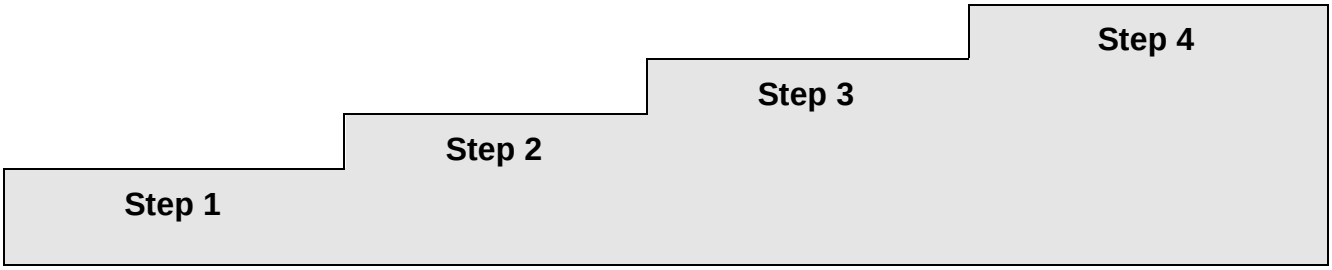
- Within 1 hour *Goal: to exclude causes requiring urgent management*
  Your action:

- Within 4 hours *Goal: to achieve comfort at rest*
  Your action:

- Within 24 hours *Goal: to plan for stable pain control*
  Your action:

Write

Write an analgesic staircase for the drugs you might have to use for Pat's severe pain



FURTHER ACTIVITY: Managing severe pain

Think back to a patient with severe pain.

- How frightened was the patient?
- How quickly was the pain brought under control?

FURTHER READING: Managing severe pain

Journal articles

Attal N. Chronic neuropathic pain: mechanisms and treatment. *Clinical Journal of Pain.* 2000; **16**(3 Suppl):S118-30.

Caraceni A, Martini C, Zecca E, Portenoy RK, Ashby MA, *et al.* Working Group of an IASP Task Force on Cancer Pain. Breakthrough pain characteristics and syndromes in patients with cancer pain. An international survey. *Palliative Medicine*. 2004; **18**(3): 177–83.

Dellemijn P. Are opioids effective in relieving neuropathic pain? *Pain.* 1999; **80**(3): 453-62.

Enarson MC, Hays H, Woodroffe MA. Clinical experience with oral ketamine. *Journal of Pain and Symptom Management.* 1999; **17**(5): 384-6.

Fitzgibbon EJ, Viola R. Parenteral ketamine as an analgesic adjuvant for severe pain: development and retrospective audit of a protocol for a palliative care unit. *Journal of Palliative Medicine.* 2005; **8**(1): 49-57.

Hanks GW, *et al.* Expert Working Group of the Research Network of the European Association for Palliative Care. Morphine and alternative opioids in cancer pain: the EAPC recommendations. *British Journal of Cancer.* 2001; **84**(5): 587-93.

Hanks GW, Forbes K. Opioid responsiveness. *Acta Anaesthesiologica Scandinavica.* 1997; **41**: 154-8.

Moryl N, Kogan M, Comfort C, Obbens E. Methadone in the treatment of pain and terminal delirum in advanced cancer patients. *Palliative & Supportive Care.* 2005; **3**(4): 311-7.

Rabben T, Skjelbred P, Oye I. Prolonged analgesic effect of ketamine, an N-methyl-D-aspartate receptor inhibitor, in patients with chronic pain. *Journal of Pharmacology & Experimental Therapeutics.* 1999; **289**(2):1060-6.

Rice ASC, Maton S, Postherpetic Neuralgia Study Group. Gabapentin in postherpetic neuralgia: a randomised, double blind, placebo controlled trial. *Pain*, 2001; **94**: 215-224.

Watson CP. The treatment of neuropathic pain: antidepressants and opioids. *Clinical Journal of Pain.* 2000; **16**(2 Suppl): S49-55.

William L, Macleod R. Management of breakthrough pain in patients with cancer. *Drugs*. 2008; **68**(7): 913–24.

Zeppetella G, Ribeiro MD. Opioids for the management of breakthrough (episodic) pain in cancer patients. *Cochrane Database of Systematic Reviews*. 2006; **1**: CD004311.

Zeppetella G. Opioids for cancer breakthrough pain: a pilot study reporting patient assessment of time to meaningful pain relief. *Journal of Pain and Symptom Management*. 2008; **35**(5): 563–7.

Resource books and websites

A Guide to Symptom Relief in Palliative Care, 6th ed. Regnard C, Dean M. Oxford: Radcliffe Medical Press, 2010

e-lfh: e-Learning for Healthcare contains a range of online self-learning programmes, including several relating to end-of-life care (e-ecla). Registration is required but is free. http://www.e-lfh.org.uk/projects/e-elca/index.html

PCF6- Palliative Care Formulary, 6th ed. Twycross RG, Wilcock A, Howard P. www.palliativedrugs.com

Twycross RG. (1999) *Morphine and the Relief of Cancer Pain: information for patients, families and friends*. Beaconsfield: Beaconsfield Publishers.

Oxford Textbook of Palliative Medicine 4th ed. Hanks G, Cherny NI, Christakis NA, Fallon M, Kaasa S, Portenoy RK. eds. Oxford : Oxford University Press, 2010.

Symptom Management in Advanced Cancer, 4th edition. Twycross RG, Wilcock A, Stark-Toller C. Oxford: Radcliffe Press, 2009

Wall and Melzack's Textbook of pain, 5th ed. McMahon SB, Koltzenburg M, eds. Edinburgh : Elsevier Churchill Livingstone, 2005.