CLiP

15 minute Worksheet

Helping the patient with pain

9: Persisting pain

Advanced level

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Aim of this worksheet

To understand the principles in managing persisting pain.

How to use this worksheet

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- If you think any information is wrong or out of date let us know.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. She had problems with her bowels for several months before some rectal bleeding made her see her GP. Investigations revealed a carcinoma of the sigmoid colon with liver metastases. She copes, with some denial, and refuses to tell her sons. She has been troubled with a persistent, burning perineal pain which has not responded to increased opioid doses.

Pat's perineal pain is getting steadily worse. It is still burning and the area is so sensitive she can't sit down. She is still adamant the boys should not be told and she has been getting increasingly unsettled.

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INFORMATION PAGE: Persisting pain

Dealing with persistent pain

Is the diagnosis correct?
Are the analgesics appropriate?
Is there a new pain?
Is the patient taking the drugs correctly?
Have you asked your local palliative care team?
Have the basic principles been followed?
Has a secondary analgesic been used?
Have other treatment options been considered (Surgery, radiotherapy etc.)?
Is the patient anxious, frightened or depressed?

Do opioids always work?

When opioid doses are increased without any effect on the pain, the pain should be reassessed.
There are several types of pain that respond poorly to opioids: skeletal instability, colic (bowel, ureter. bladder), skin damage, muscle / ligament strain or damage, neuropathic pain (eg. neuralgia), and pain associated with inflammation (eg. infection). A few patients get opioid hyperalgesia which will worsen pain (resolved by switching opioids).

In cancer, many pains have several causes and several types of pain are present at the same time. So, it is often worth trying an opioid as a first step in cancer pain.

Pain associated with unpleasant sensory change

Neuropathic pain: this does not rely on pain receptors and is due to nerve damage. This is thought to cause persisting changes in the chemical neurotransmitters in the spinal cord. Typical descriptions of the pain by patients are "burning", "shooting", "sandpaper", "pins and needles". There is usually altered sensation such as hypersensitivity or pain on light touch (allodynia). Trigeminal neuralgia and post shingles neuralgia are two examples. Neuropathic pain will respond to opioids, but becomes less responsive to the opioids as the weeks and months pass, and often needs secondary analgesic drugs.

You can create an 'analgesic staircase' for this pain, for example
1.Amitriptyline. 2. Amitriptyline plus gabapentin. 3. Amitriptyline plus valproate. 4.Specialist measures
NB. Specialist measures include ketamine or spinal analegia and require specialist input.

An analgesic staircase must be specific to the individual's pain.

Drugs with a secondary analgesic action (also called co-analgesics or adjuvant analgesics)

Action understood: antibiotics, antispasmodics (drugs that relax smooth muscle), antispastics (drugs that relax skeletal muscle), corticosteroids.
Action poorly understood: adrenergic pathway modifiers (eg. clonidine), anticonvulsants and antidepressants. These drugs may work by restoring the number of spinal cord neurotransmitters altered as a consequence of nerve destruction.

Examples:
Bowel colic is stopped by an antispasmodic which relaxes the smooth muscle of the bowel eg. hyoscine butylbromide.
Neuropathic pain can be helped by some anticonvulsants (eg. gabapentin) and some antidepressants such as amitryptyline and duloxetine).
Muscle spasm pain is seen in conditions such as multiple sclerosis and can be eased by an antispastic (eg. baclofen) which relaxes the skeletal muscles.
Cellulitis is a skin infection which can cause local pain- it needs an antibiotic and amoxicillin is first choice.
Nerve compression pain caused by tumour can be eased by reducing the swelling (oedema) around the tumour using corticosteroids- dexamethasone is usually the first choice.

The effects of persisting pain on Pat

Pain is not just a sensation but is also an unpleasant experience. When it persists it can become increasingly distressing with many effects.

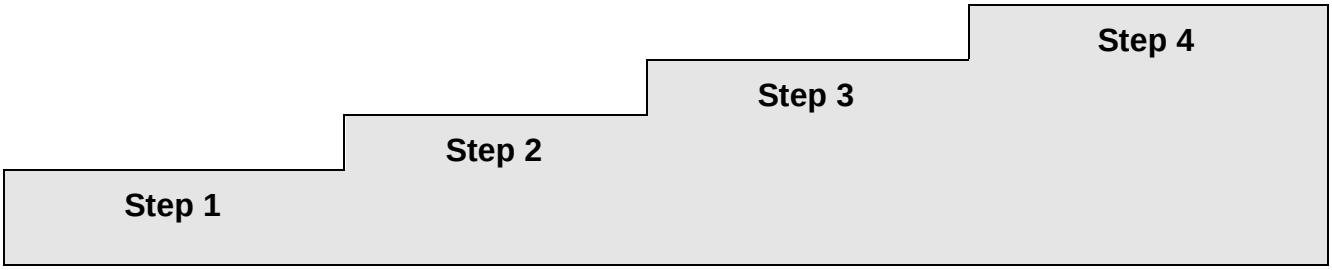
Pat's feelings: frustration or anger may be a response, but as it continues Pat may become troubled by anxiety, fear, low mood or even depression.

Pat's social life: severe, persistent pain often restricts activity, but the feelings Pat has may also reduce social contact because she has less wish to socialise or meet new people- even friends may be turned away. This increases her isolation.

Pat's family: the stress of persistent pain spreads to partners and relatives making relationships difficult. She has already refused to tell her sons about her illness and they will be even more frightened and worried by her pain problems which she will not be able to hide.

Professionals: failure to relieve a problem may result in a sense of failure and inadequacy at the persistence of the pain despite all their efforts. This results in reduced contact with the professionals or the 'side-room syndrome' where patients are placed in a single room (ostensibly for themselves, but as much because the problem is less visible).

Write an analgesic staircase for Pat's perineal pain
(include anything you think could help, not just drugs)



Some pains need drugs with a secondary action.
What would work best for the following? Link up the pair.
(the first has been done for you).

Bowel colic	baclofen (skeletal muscle relaxant)
Neuropathic pain	flucloxacillin (antibiotic)
Muscle spasm	dexamethasone (corticosteroid)
Cellulitis (skin infection)	amitriptyline (antidepressant)
Nerve compression pain due to tumour	hyoscine butylbromide (bowel muscle relaxant)

Think about the effects of Pat's persistent pain

Effect on Pat's feelings	Effects on Pat's social life	Effects on Pat's family	Effects on professionals

FURTHER ACTIVITY: Persisting pain

For a patient with persistent pain, observe the effects on the patient and on you.

FURTHER READING: Persisting pain

Journal articles

Bell RF, Eccleston C, Kalso E. Ketamine as adjuvant to opioids for cancer pain. A qualitative systematic review. *Journal of Pain and Symptom Management*. 2003; **26**(3): 867–75.

Breibart W, Passik SD, Casper DJ. Psychological and psychiatric interventions in pain control. In: *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, p784-800.

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.

Chu LF, Angst MS, Clark D. Opioid induced hyperalgesia in humans: molecular mechanisms and clinical considerations. *Clinical Journal of Pain*. 2008; **24**(6): 479–96.

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Finnerup NB, Otto M, McQuay HJ, Jensen TS, Sindrup SH. Algorithm for neuropathic pain treatment: an evidence based proposal. *Pain.* 2005; **118**(3): 289–305.

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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.

Keskinbora K, Pekel AF, Aydinli I. Gabapentin and an opioid combination versus opioid alone for the management of neuropathic cancer pain: a randomized open trial. *Journal of Pain and Symptom Management*. 2007; **34**(2): 183–9.

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

Shaiova L. Difficult pain syndromes: bone pain, visceral pain, and neuropathic pain. *Cancer Journal.* 2006; **12**(5): 330-40.

Williams H. Assessing, diagnosing and managing neuropathic pain. *Nursing Times.* 2006; **102**(16): 22-4.

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.

Further resources

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.