Managing complicated pain & suffering:

Treating the spirit alongside the body

JESSICA ALLEN, DO
HOSPICE & PALLIATIVE CARE FELLOW
VIRGINIA COMMONWEALTH UNIVERSITY HEALTH SYSTEM

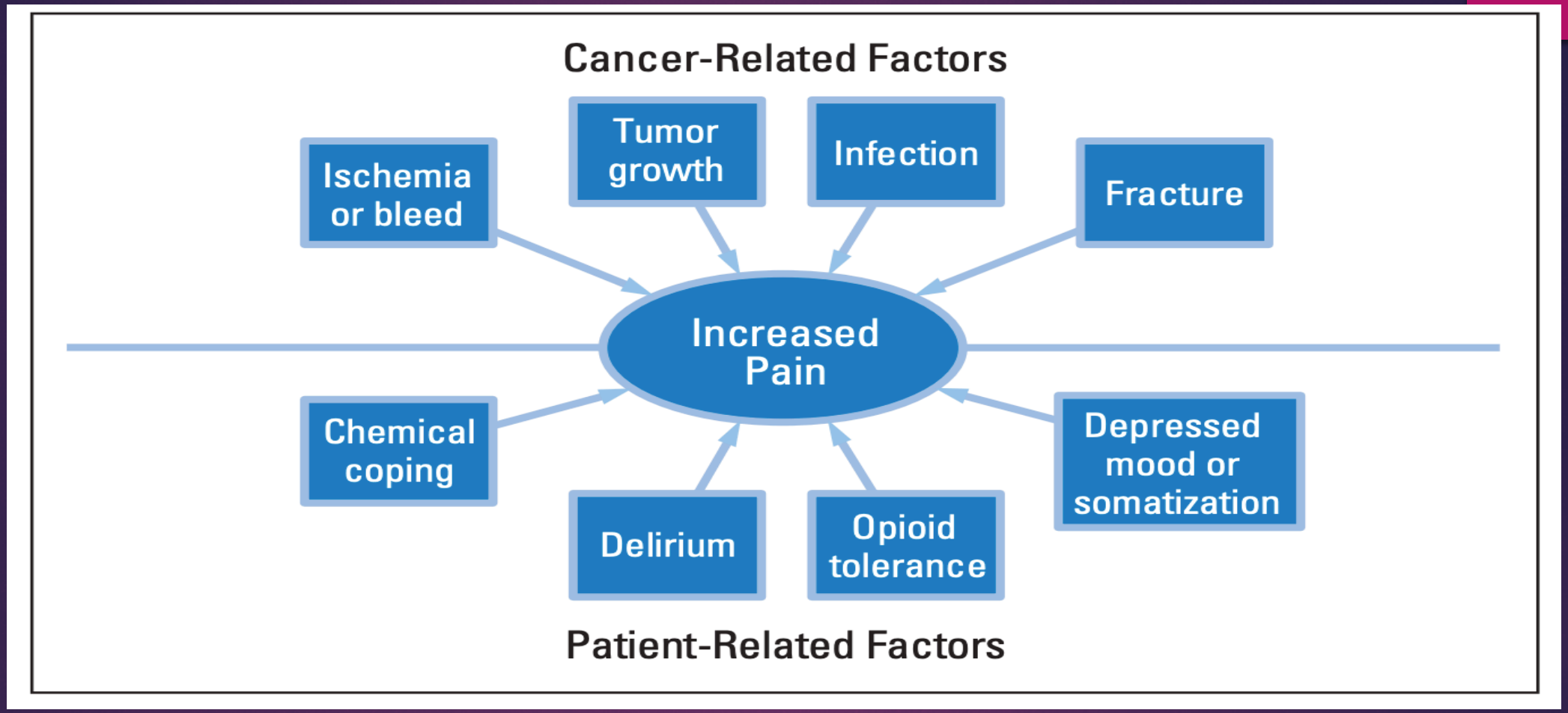
How do we define pain?

"Pain is a complex, multidimensional perception with affective as well as sensory features" *JPC*

"An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" *IASP*

How do we define suffering?

”Suffering refers to a perceived threat to the integrity of the self, helplessness in the face of that threat, and exhaustion of psychosocial and personal resources for coping” *JPC*



DEL FABBRO, EGIDIO. "ASSESSMENT AND MANAGEMENT OF CHEMICAL COPING IN PATIENTS WITH CANCER." *JOURNAL OF CLINICAL ONCOLOGY* 32.16 (2014): 1734-1738.

Initial consultation:

Ms. M is a 36 year old female with history of recurrent cervical cancer who was recently admitted from gynecology clinic for intractable pain and complaints of vaginal discharge following prolonged outside hospitalization.

Palliative care consulted for symptomatic support and assistance with pain management.

OUTSIDE HOSPITAL COURSE

Admitted for intractable abdominal pain 1 month prior

Imaging with multiple lumbar and sacral fractures

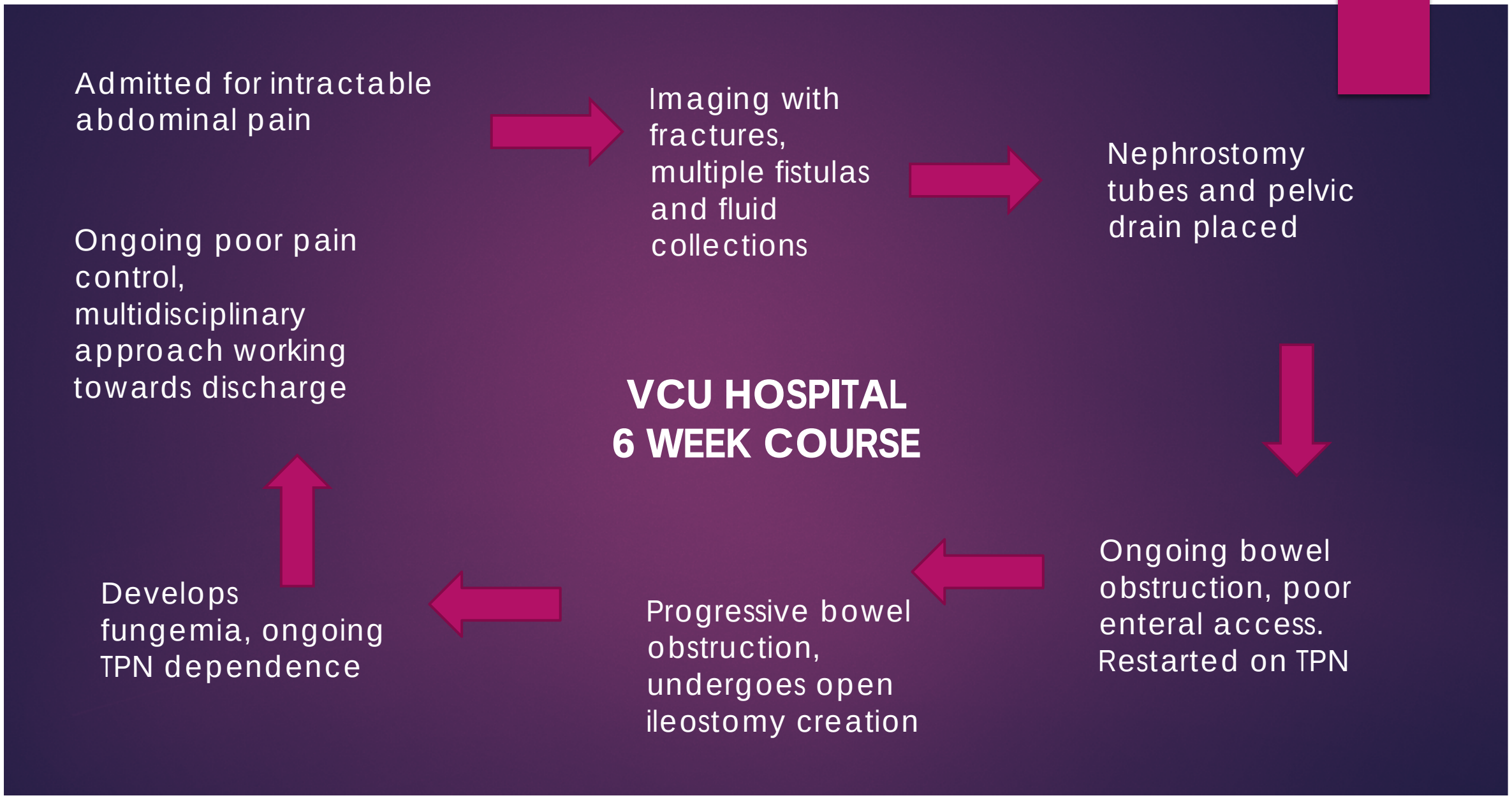
Progression of malignancy with mass extending to L5-S1 vertebral bodies, encasing nerve roots and vasculature

Develops malignant bowel obstruction, multiple fistulas

Poor enteral access, started on TPN

Rectal perforation, end colostomy formation

Dilaudid PCA with poor pain control left AMA


Admitted for intractable abdominal pain
Imaging with fractures, multiple fistulas and fluid collections
Nephrostomy tubes and pelvic drain placed
Ongoing bowel obstruction, poor enteral access. Restarted on TPN
Progressive bowel obstruction, undergoes open ileostomy creation
Develops fungemia, ongoing TPN dependence
Ongoing poor pain control, multidisciplinary approach working towards discharge
VCU HOSPITAL
6 WEEK COURSE

Physiological components

- Anatomic variations with multiple surgeries, adhesions, etc.
- Uncertain enteral absorption after ileostomy creation following bowel obstruction and fistulas
- Very low BMI with TPN dependency; impaired subcutaneous absorption
- High tolerance with prolonged use of opioids
- Allergy to fentanyl

** Multidisciplinary approach involving gynecology-oncology, palliative care, acute pain service, addiction medicine, pharmacy teams

Previous outpatient regimen (prior to OSH admission)

ff

- Methadone 20mg PO q8h, Oxycodone 20mg PO Q6H PRN, gabapentin, duloxetine, amitriptyline

*No longer receiving methadone at time of discharge; unclear if abruptly stopped or if tapered

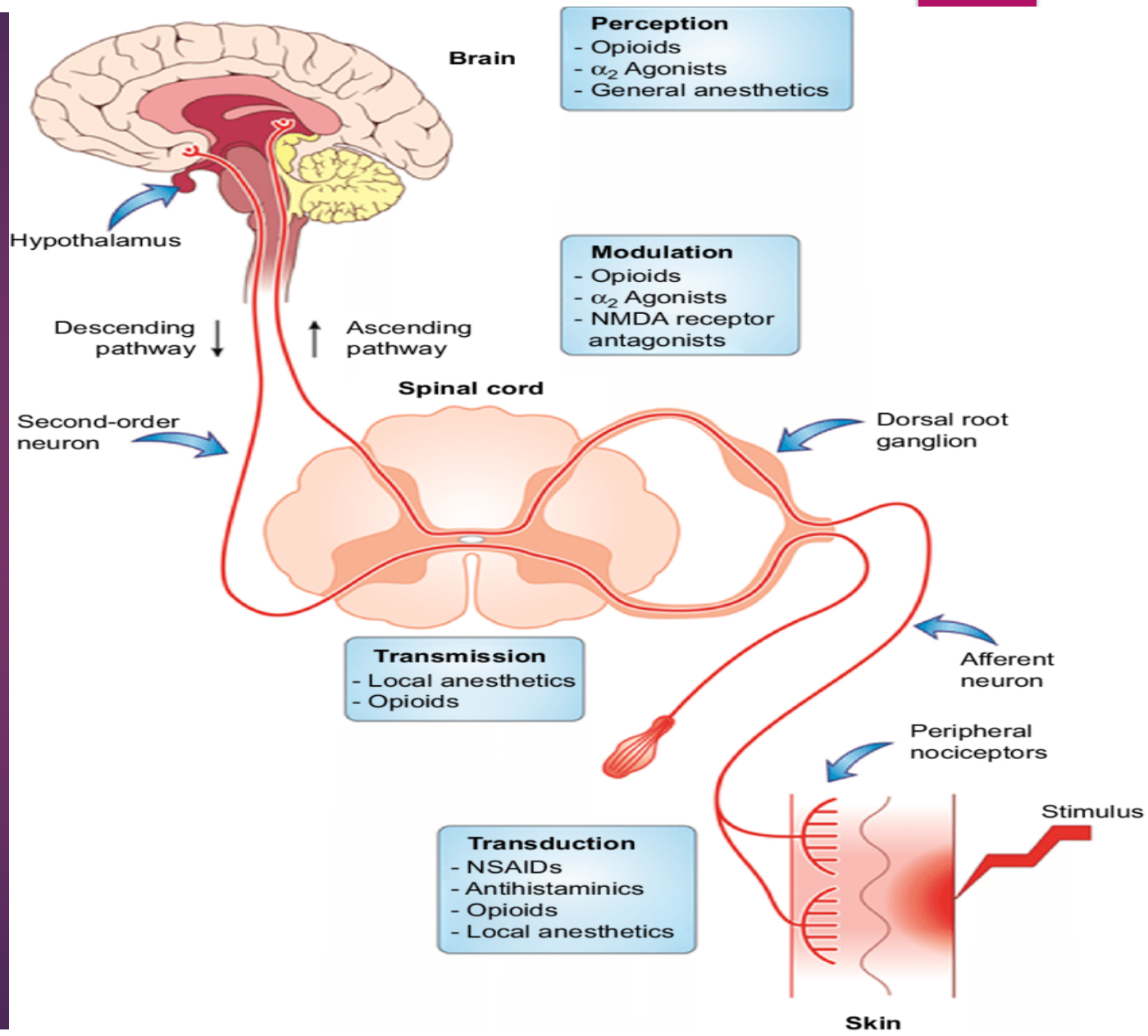
Initial inpatient pain regimen

- Dilaudid IV PCA/CADD poor pain control
- Ketamine IV, Lidocaine IV, rapidly escalating opioid requirements. Pain still uncontrolled despite multiple interventions

Pain pathways & types of pain

- Nociceptive or inflammatory
- Neuropathic pain
- Mixed

* Don't forget about existential pain



Dureja, Gur et al. Evidence and consensus recommendations for the pharmacological management of pain in India. Journal of Pain Research. Volume 10. 709-736. 2017. 10.2147/JPR.S128655.

Dilaudid PCA/CADD			Daily IV Dilaudid Requirements	PO Methadone	Additional agents
Basal rate	Patient controlled	Clinician bolus			
1mg/hr	0.6mg Q1H PRN	2mg Q3H PRN			IV Ketamine, lidocaine, tylenol
5mg/hr	0.6mg Q6min PRN	0.6mg Q1H PRN			Restart duloxetine, gabapentin, amitriptylline. Start suboxone
5.2 mg/hr	0.7mg Q6min PRN	1mg Q1H PRN			Zyprexa for anxiety; suboxone taper without significant benefit
4.5 mg/hr	0.7mg Q6min PRN	1mg Q1H PRN		10mg Q8H	Lidocaine off, ketamine wean, suboxone taper. PO morphine PRN
3.5 mg/hr	0.7mg Q6min PRN	1mg Q1H PRN	160mg		Uptitrate duloxetine, gabapentin, *methadone started
2.5 mg/hr	0.7mg Q15min PRN	1mg Q1H PRN			Trial of toradol
1.5mg/hr	0.7mg Q15min PRN	1mg Q1H PRN	70mg	15mg Q8H	Methadone increased
1mg/hr	0.7mg Q15min PRN	1mg Q1H PRN			
0.5mg/hr	0.7mg Q30min PRN	1.5mg Q1H PRN	25mg		Rotated off PO morphine; start PO Oxycodone
0.25mg/hr	0.7mg Q30min PRN	1.5mg Q1H PRN	36mg		
0mg/hr	0.7mg Q30min PRN	2mg Q1H PRN	Unknown**		**PICC clotted, no IV meds in approx 5 hours
0mg/hr	0mg	2mg Q1H PRN	4mg	20mg Q8H	Methadone increased

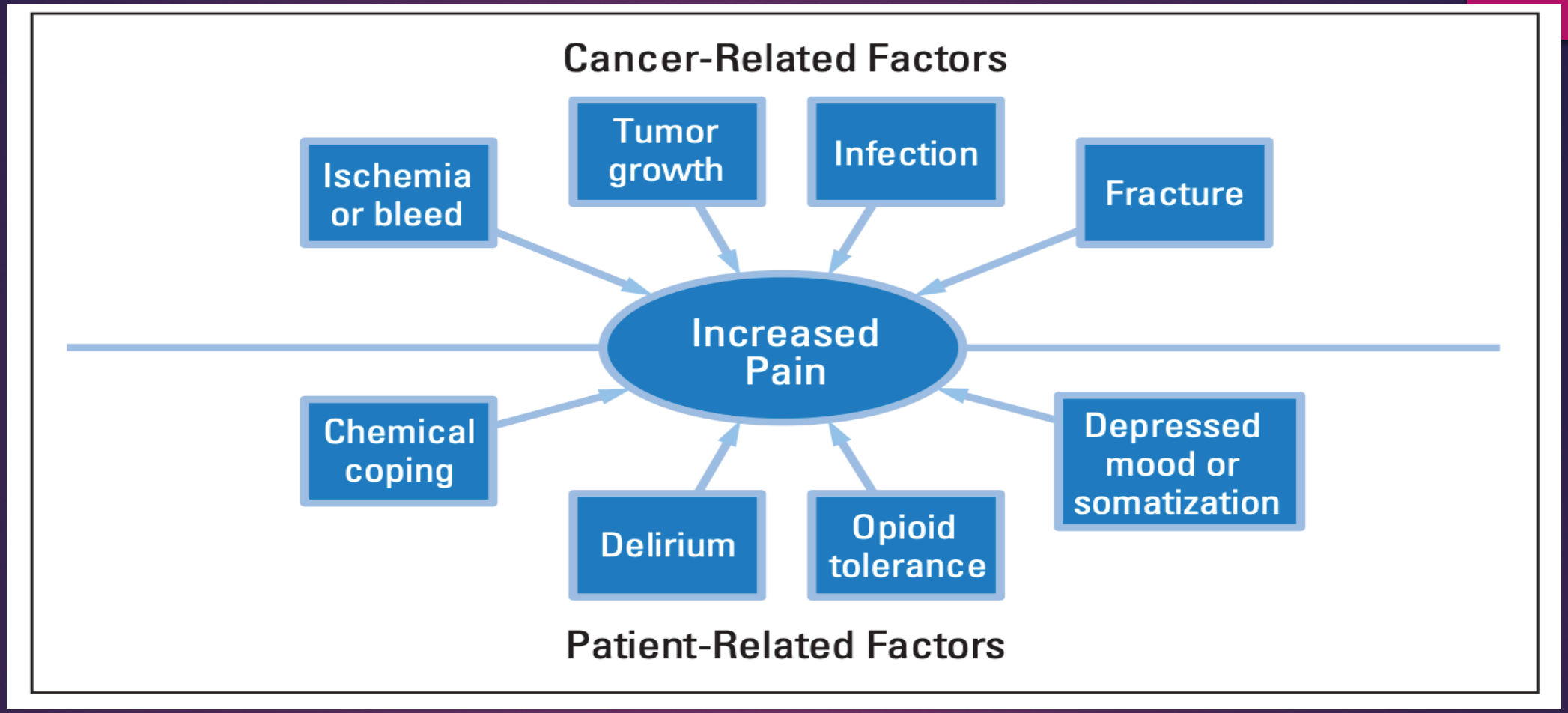
*At time of rotation:

- Dilaudid 160 mg IV/24 hours
- Ketamine 0.3 mg/hour
- Suboxone 0.2 BID-TID
- Neurontin 1800 mg/day
- Recent lidocaine
- Morphine concentrate 15 mg 7x day

Oral discharge regimen

- Methadone solution 20mg every 8 hours
- Oxycodone solution 20mg every 3 hours as needed
- Gabapentin 600mg every 8 hours
- Duloxetine 60mg daily
- Amitriptyline 50mg at bedtime
- Tylenol PRN, Celecoxib twice daily
- Lidocaine patches
- Olanzapine 5mg every 6 hours as needed for anxiety

* Methadone and Oxy concentrates required significant patient/family education for safe discharge planning, particularly given young child in home. Bought lock box for patient, lots of education with syringes and dosing given minimal room for error. Repetitive teaching with multiple teams



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Existential suffering

"Suffering refers to a perceived threat to the integrity of the self, helplessness in the face of that threat, and exhaustion of psychosocial and personal resources for coping"

- Significant collaboration with multiple teams, patient and her family
- Remained honest and transparent with patient/family
- Validated feelings of being overwhelmed and acknowledged severely challenging pain and nutritional management
- Continued support from all sides with consistent messaging and reassurance

Additional individual support

- Strong family support; remained at bedside throughout hospitalizations
- Other supportive services: art therapy, aromatherapy, movies/music, dogs on call
- Encouragement and reassurance during every encounter

* Patient was able to return home to be with her child and family for another 6 weeks prior to returning to inpatient setting

Key points

- Many complex factors contribute to overall distress and perception of pain, including existential suffering

- Comprehensive care plans need to address physical, psychological and emotional needs

- Pay attention to patient specific factors to ensure maximum efficacy of medications

- Ask for help. Many complex cases will need multidisciplinary support and collaboration

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