VCU Palliative Care ECHO*

March 28, 2019

Basics of Cancer Pain Management

*ECHO: Extension of Community Healthcare Outcomes

Continuing Medical Education

February 28, 2019 | 12:00 PM | teleECHO Conference

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February 28, 2019 | 12:00 PM | teleECHO Conference

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Danielle Noreika, MD
Egidio Del Fabbro, MD

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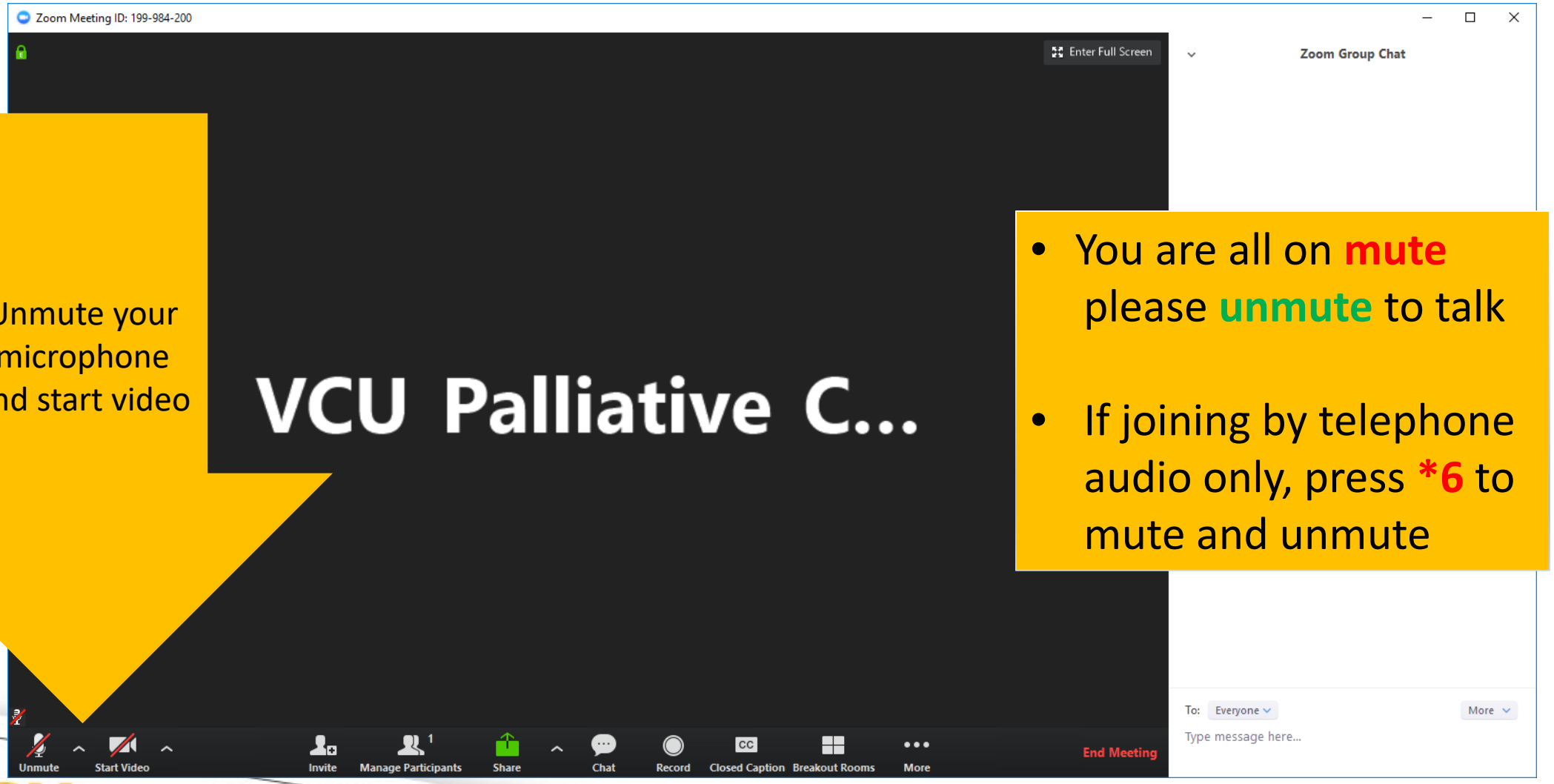
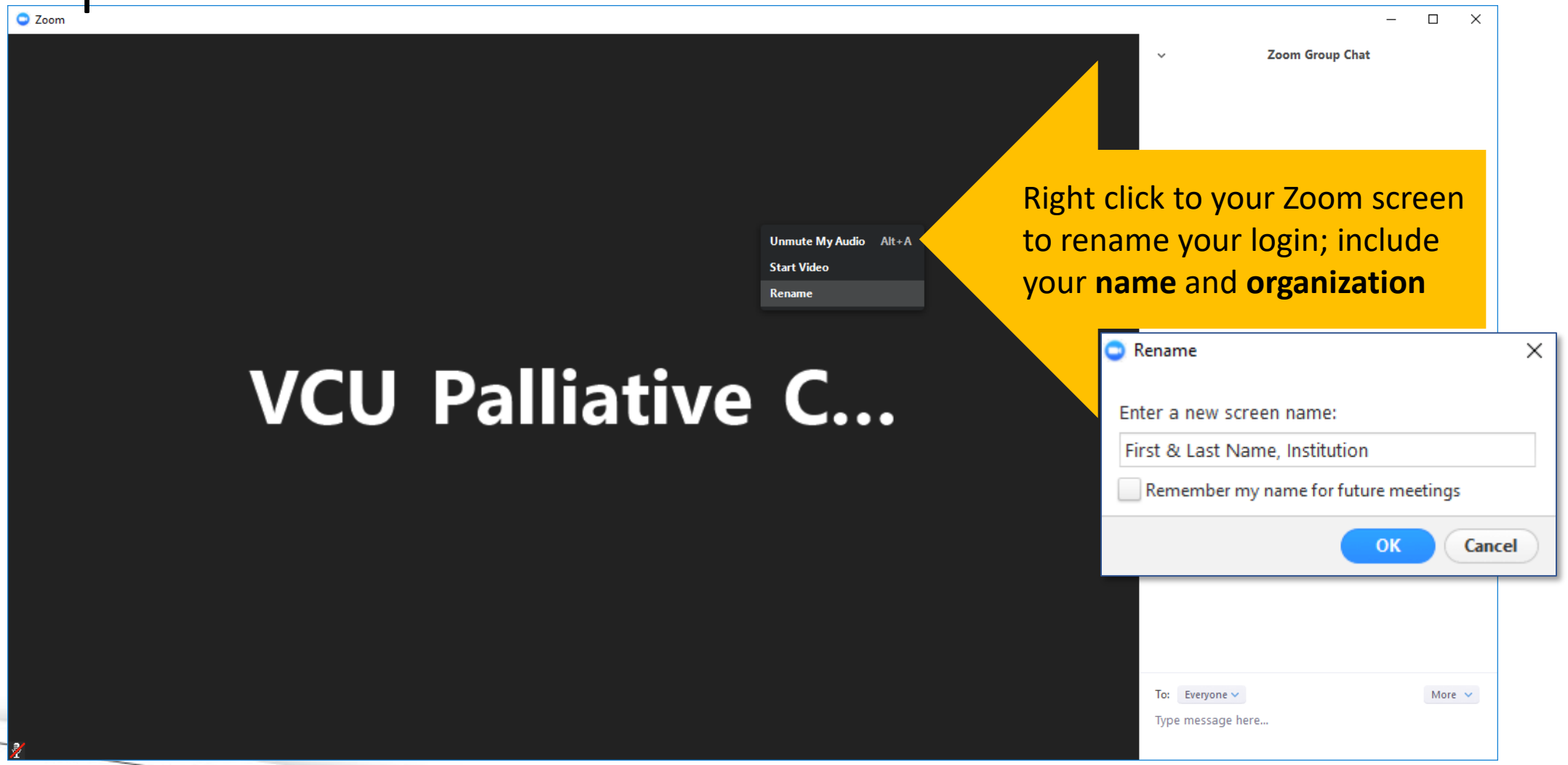
Helpful Reminders



Unmute your microphone and start video

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

Helpful Reminders



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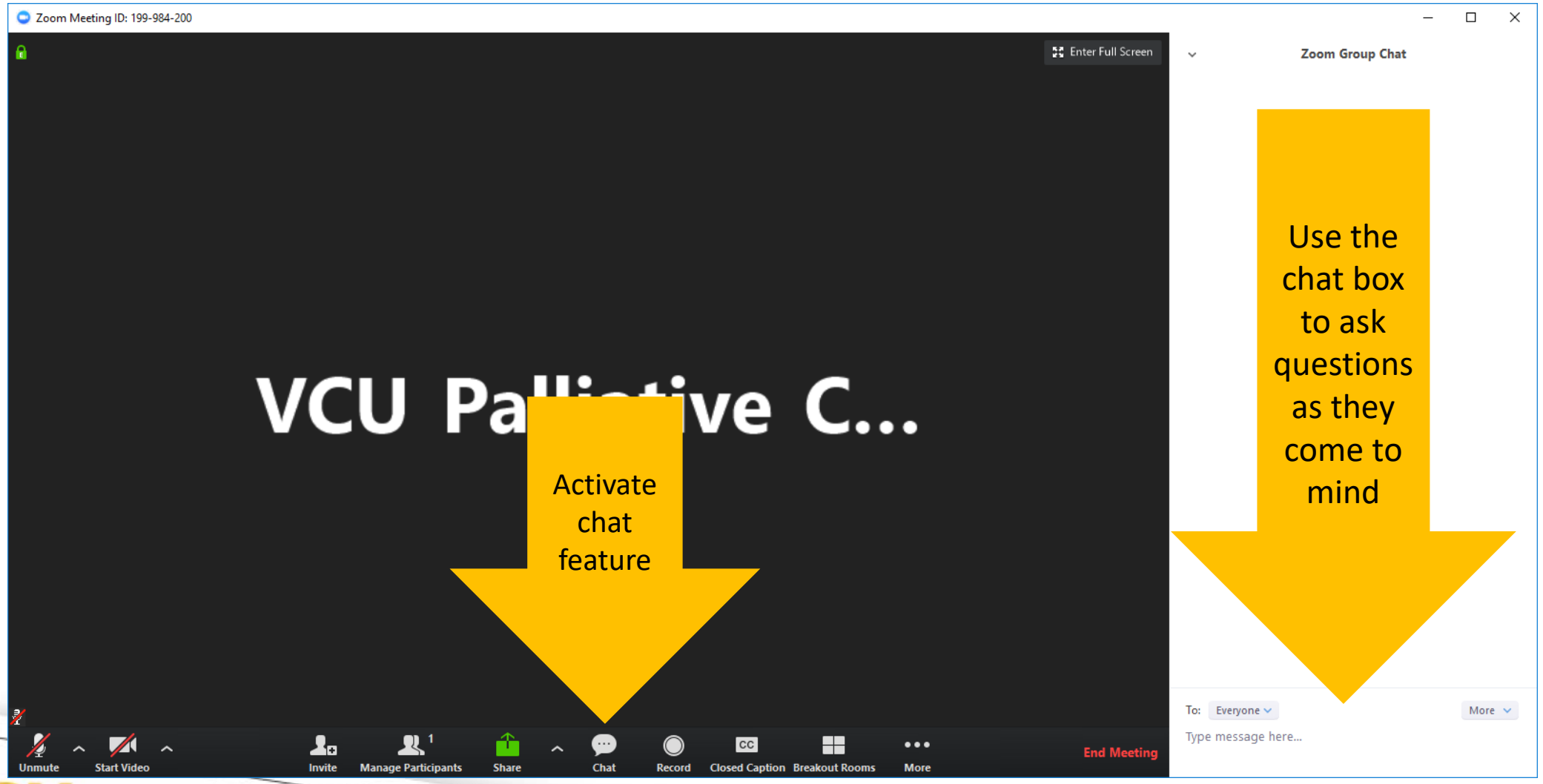


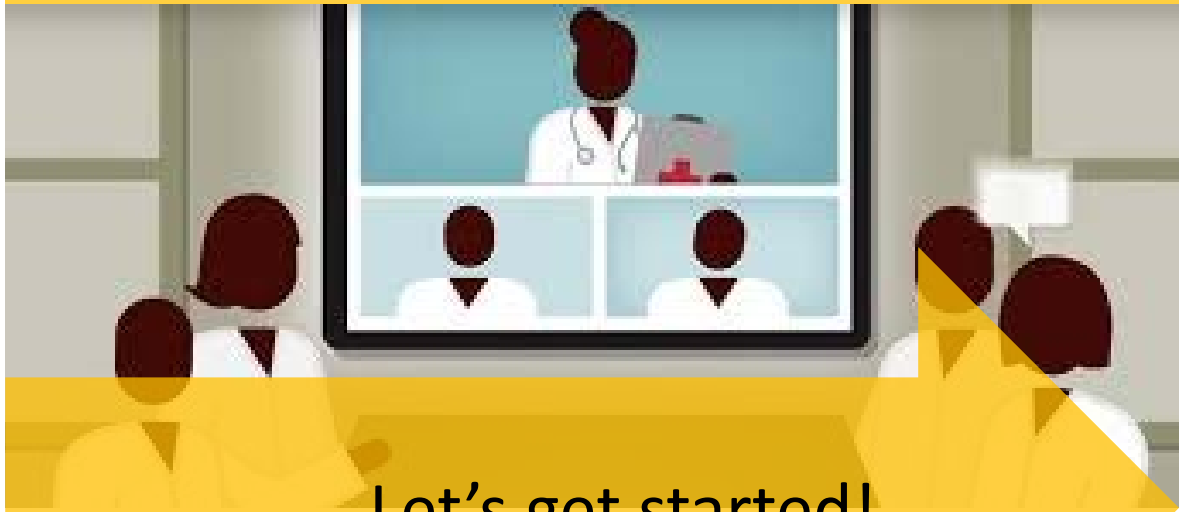
What to Expect

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

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

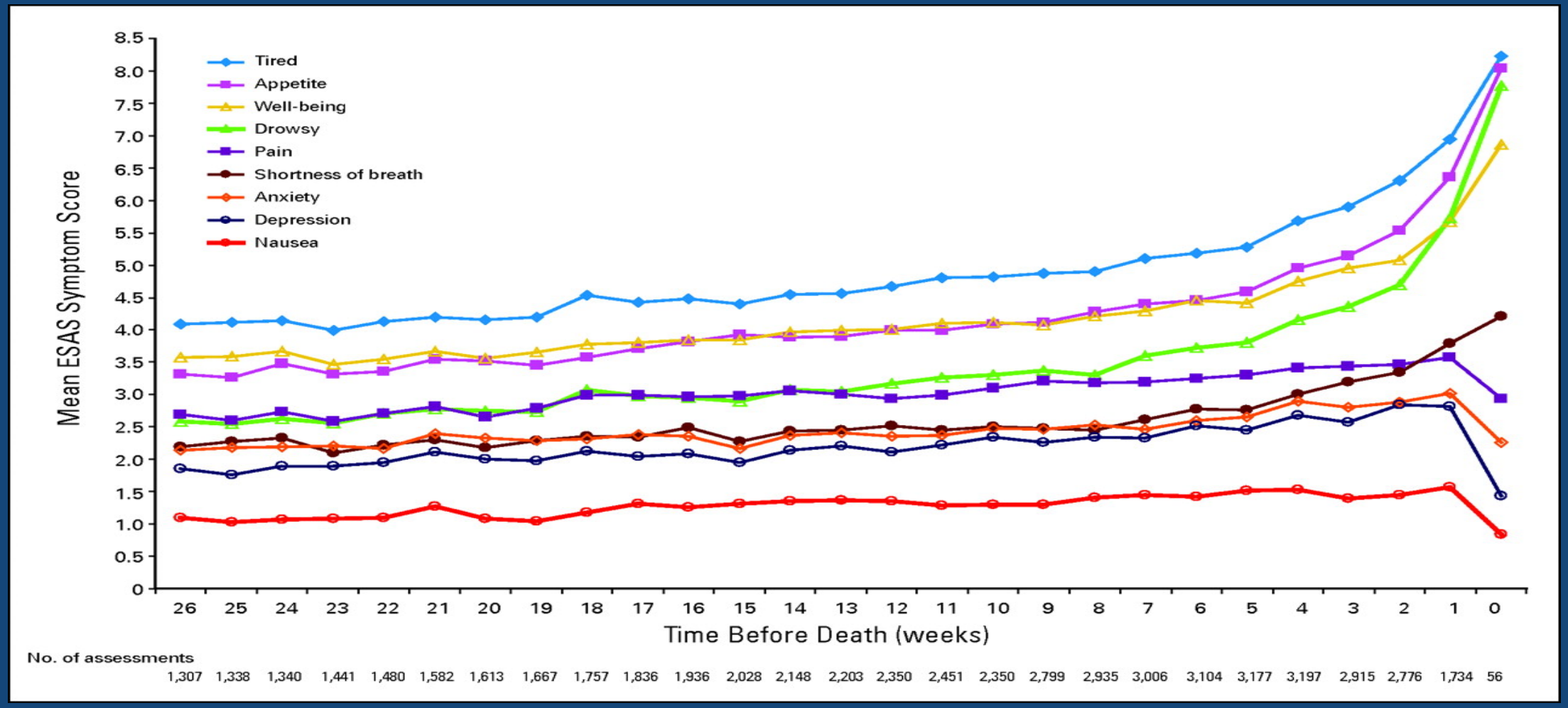
Overview

- Assessment
- Education
- Risk Mitigation
- Harm Reduction
- Opioid side-effects

Edmonton Symptom Assessment Scale

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
Not tired	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
Not nauseated	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
Not depressed	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
Not anxious	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Not drowsy	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
Best appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
Best feeling of well-being	0	1	2	3	4	5	6	7	8	9	10	Worst possible feeling of well-being
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
Other =Insomnia	0	1	2	3	4	5	6	7	8	9	10	

Mean ESAS scores over time of 10752 patients



Hsien Seow et al. JCO 2011;29:1151-1158

Pain Interference – Short Form 8a (PROMIS)

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ91	How much did pain interfere with your day to day activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ222	How much did pain interfere with work around the home?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ313	How much did pain interfere with your ability to participate in social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ34	How much did pain interfere with your enjoyment of life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ125	How much did pain interfere with the things you usually do for fun?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ366	How much did pain interfere with your enjoyment of social activities?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ347	How much did pain interfere with your household chores?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ138	How much did pain interfere with your family life?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Validated Risk Assessment Tools

Acronym of tool[α]	Number of questions	Completion	Time to complete
SOAPP®-R	24 items	Self-report	< 10 minutes
DIRE	7 items	Clinician administered	< 5 minutes
ORT	5 items	Clinician administered	< 5 minutes
COMM	40 items	Self-report	< 10 minutes
CAGE	4 items	Either	< 5 minutes
PDUQ	42 items	Clinician administered	20 minutes
STAR	14 items	Self-report	< 5 minutes
SISAP	5 items	Clinician administered	< 5 minutes
PMQ	26 items	Self-report	< 10 minutes

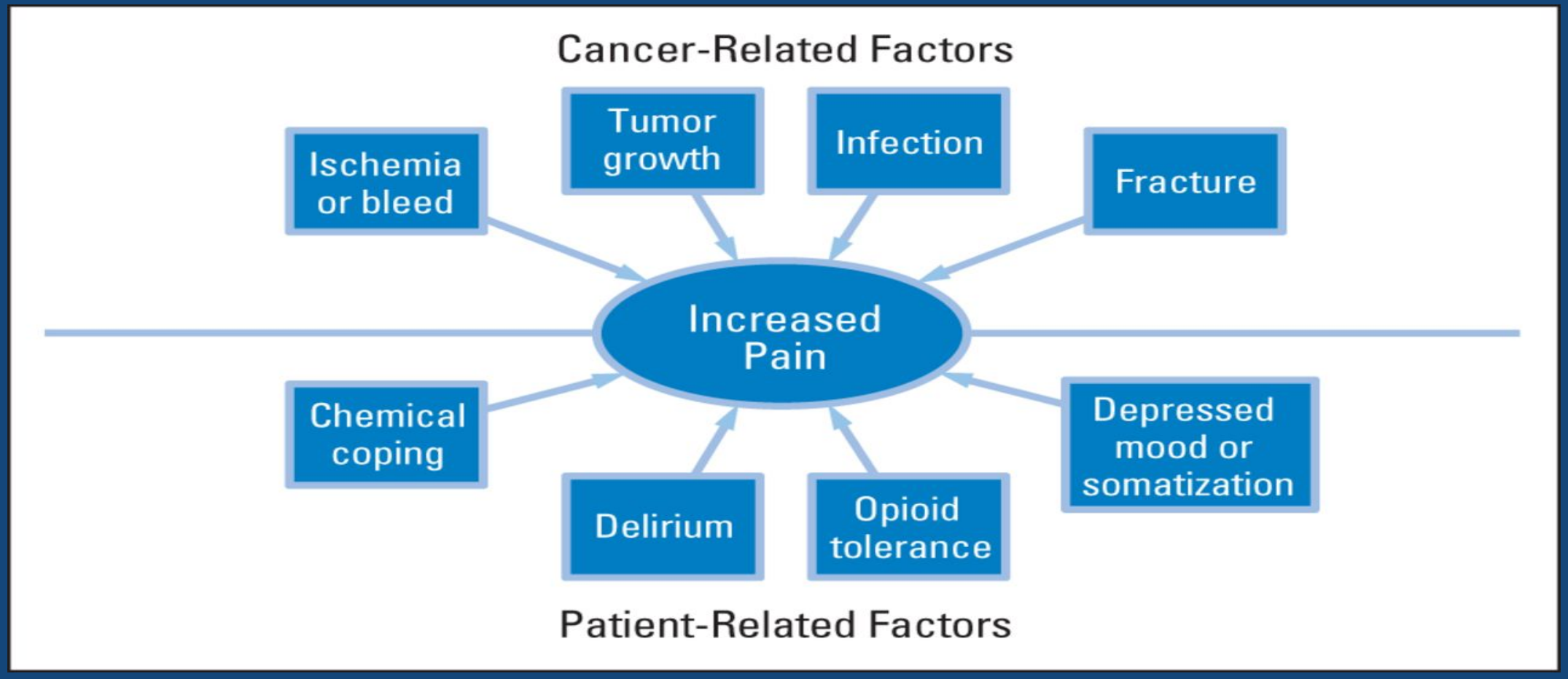
α - SOAPP®-R (Screener and Opioid Assessment for Patient's in Pain-revised); DIRE (Diagnosis, Intractability, Risk, and Efficacy); ORT (Webster's Opioid Risk Tool); COMM (Current Opioid Misuse Measure); CAGE (Cut-down, Annoyed, Guilt, Eye-opener); PDUQ (Prescription Drug Use Questionnaire); STAR (Screening 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

Substance Abuse and Rehabilitation *Carmichael, Morgan , Del Fabbro 2016*

Cancer- and patient-related factors contributing to pain

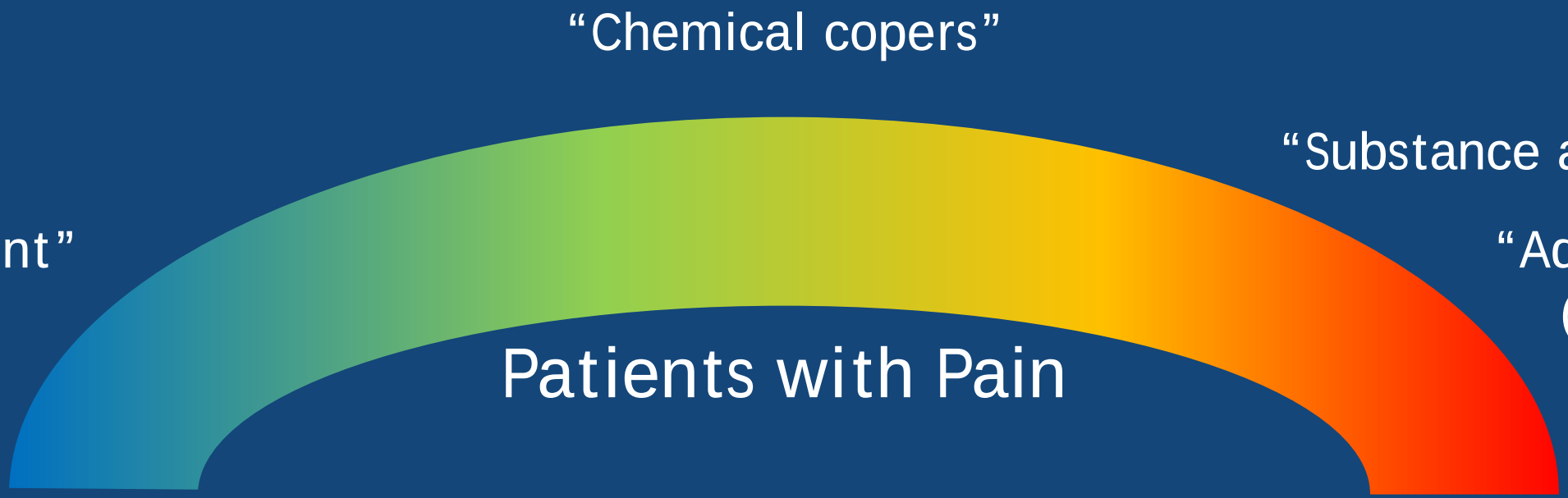


Del Fabbro E JCO 2014;32:1734-1738

JOURNAL OF CLINICAL ONCOLOGY
Official Journal of the American Society of Clinical Oncology

All addicts are Chemical Copers, but not all Chemical Copers are addicts

Population is Heterogeneous



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

Bruera Pain 1989,Bruera JPSM 1995,Fainsinger JPSM 2005, Bohnert JAMA 2005,Walton PHR 2015,

Opioid use after Curative-intent Surgery

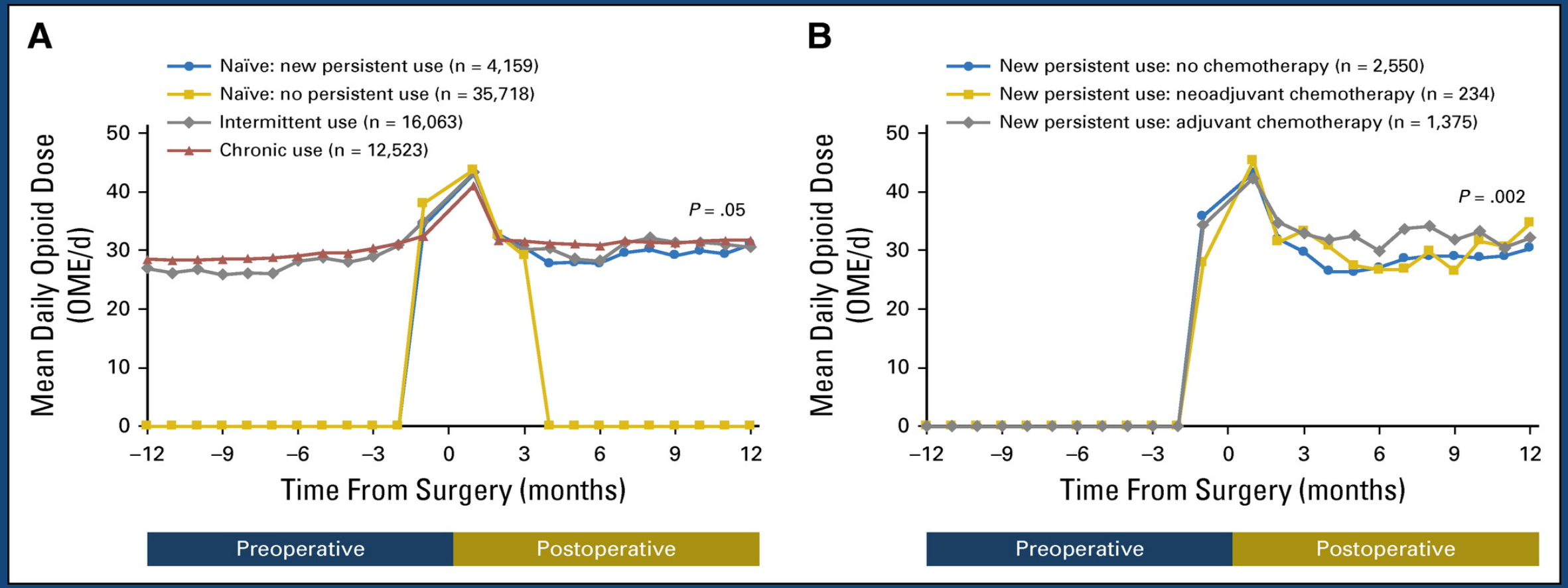


Fig 2. (A) Trajectory of daily opioid dose stratified by perioperative opioid use. Mean daily opioid dose for each group was calculated every 30 days from 1 year before surgery to 1 year after surgery, while adjusting for preoperative opioid prescriptions, initial opioid prescribed, procedure type, adjuvant 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

Jay Soong-Jin Lee et al *JCO* **2017,** 35, 4042-4049.

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 1. Approach to Managing Opioid Risk and Chemical Coping in Patients With Cancer Based on Universal Precautions

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

NOTE. Data adapted.[35,36,37]
Abbreviations: ORT, Opioid Risk Tool; SOAPP, Screener and Opioid Assessment for Patients With Pain; STAR, Screening Tool for Addiction Risk; UDS, urine drug screen.

Del Fabbro JCO 2014
J Clin Oncol 32: 1734-1738

Management Strategies

Key Domains

1. Education
2. Harm reduction
3. Managing psychological & spiritual distress
4. Risk mitigation

Education

Printed

Digital

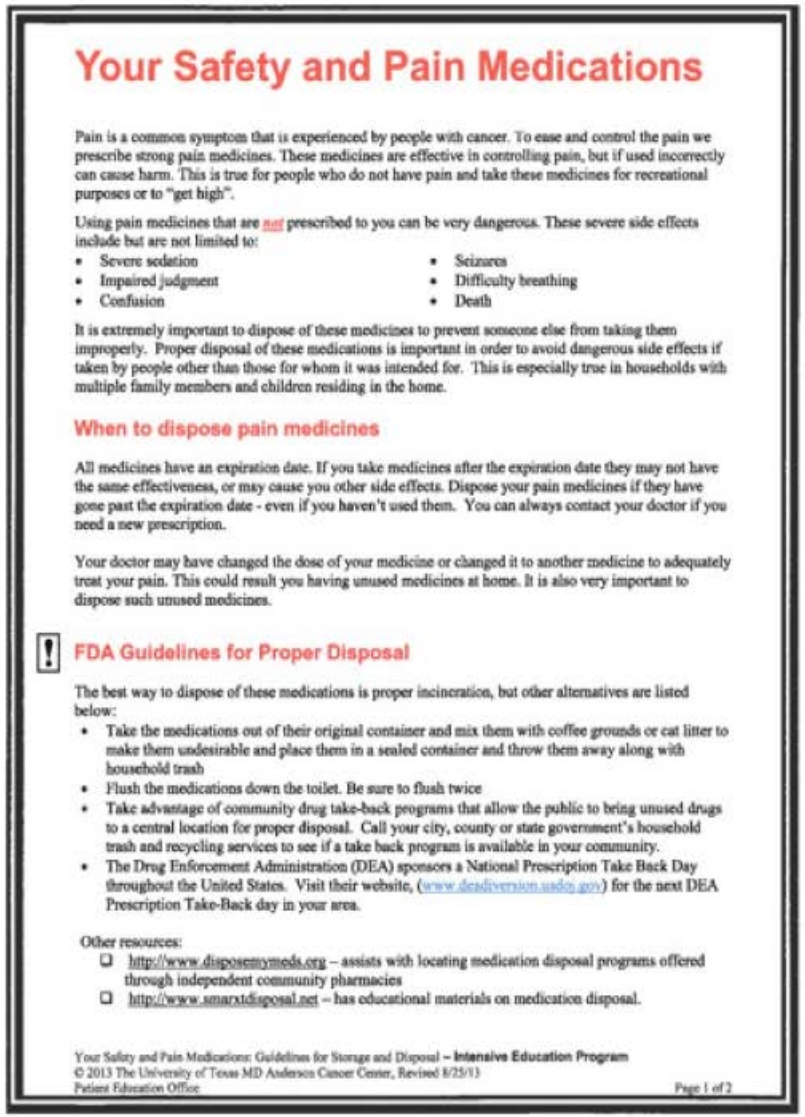
Social Media

Reddy Oncologist 2014,De La Cruz Oncologist 2017

Management Strategies

Education

- Proper opioid disposal methods (76% vs. 28%; p ≤ .0001)
- Share opioids with someone else (3% vs. 8%; p = .0311)
- Practice unsafe use of opioids (18% vs. 25% p = .0344)
- Danger of opioids when taken by others (p = .0099)
- Unused medication at home (38% vs. 47%; p = .0497)
- Keep medications in a safe place (hidden, 75% vs. 70%; locked, 14% vs. 10%; p = .0025)



Your Safety and Pain Medications

Pain is a common symptom that is experienced by people with cancer. To ease and control the pain we prescribe strong pain medicines. These medicines are effective in controlling pain, but if used incorrectly can cause harm. This is true for people who do not have pain and take these medicines for recreational purposes or to "get high".

Using pain medicines that are *not* prescribed to you can be very dangerous. These severe side effects include but are not limited to:

- Severe sedation
- Impaired judgment
- Confusion
- Seizures
- Difficulty breathing
- Death

It is extremely important to dispose of these medicines to prevent someone else from taking them improperly. Proper disposal of these medications is important in order to avoid dangerous side effects if taken by people other than those for whom it was intended for. This is especially true in households with multiple family members and children residing in the home.

When to dispose pain medicines

All medicines have an expiration date. If you take medicines after the expiration date they may not have the same effectiveness, or may cause you other side effects. Dispose your pain medicines if they have gone past the expiration date - even if you haven't used them. You can always contact your doctor if you need a new prescription.

Your doctor may have changed the dose of your medicine or changed it to another medicine to adequately treat your pain. This could result you having unused medicines at home. It is also very important to dispose such unused medicines.

FDA Guidelines for Proper Disposal

The best way to dispose of these medications is proper incineration, but other alternatives are listed below:

- Take the medications out of their original container and mix them with coffee grounds or cat litter to make them undesirable and place them in a sealed container and throw them away along with household trash
- Flush the medications down the toilet. Be sure to flush twice
- Take advantage of community drug take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Call your city, county or state government's household trash and recycling services to see if a take back program is available in your community.
- The Drug Enforcement Administration (DEA) sponsors a National Prescription Take Back Day throughout the United States. Visit their website, (www.deadiversion.usdoj.gov) for the next DEA Prescription Take-Back day in your area.

Other resources:

- ☐ http://www.disposemymeds.org – assists with locating medication disposal programs offered through independent community pharmacies
- ☐ http://www.smarxtdisposal.net – has educational materials on medication disposal.

Proper Storage

Storing your pain medicines properly is just as important as disposal, because of the dangers of drug abuse as well as the severe harm that these medications can cause. Take the following steps to prevent improper use of these medications:

- You want to make sure they are out of reach to children and pets.
- Store the medications where they are not visible to others besides yourself or a designated caregiver who helps manage your medications.
- If you live in an unsafe neighborhood, keep your medications under lock and key.
- Keep track of the number of medications that you have used. Report any missing medications to law enforcement authorities.
- Do not tell people that you are taking strong pain medications.

Do's and Don'ts of Pain Medication Use

Do	Don't
• Always take pain medicine only as directed. Never change how you take the medicine, in any way, or take other medicines without first asking the doctor who prescribed your pain medicine.	• Never cut, chew, crush, or dissolve extended release pain medicine tablets or capsules. We may ask you to halve some immediate release tablets.
• Only get prescriptions for pain medicine from our supportive care center.	• Never cut a pain patch and do not expose a pain patch to a source of heat, like a heating pad, while the patch is attached to your skin.
• If you must get pain medicine anywhere else, such as in an emergency or from a dentist, you must tell our supportive care center nurses.	• Never share, sell, or trade your pain medicine with anyone. Never use someone else's medicines for pain or any other condition.
• All other doctors should be told of the pain medicines you are taking and that supportive care is prescribing them to you.	• Never use pain medicines to help you sleep, or combine pains with any sleep-aid drugs, such as tranquilizers or sedatives.
• We routinely ask for testing of your urine, saliva, or blood for drugs. You also may be asked to bring the unused portions of all drugs that you have been prescribed to clinic.	• Never use illegal drugs, such as cocaine, heroin, crystal meth, or others. Marijuana, even where legal, or alcohol — wine, beer, or hard liquor — may not be used without your pain medicine prescriber's permission.
• Only ask for pain medicine refills during regular office or clinic hours. Early refills for a replacement for lost, stolen, or spoiled pain medicine may not be allowed, depending what happened.	• Do not drive a car or operate dangerous equipment while taking pains until you know how you react to the medicine and your pain prescriber says it is okay.

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

Kirsh et al. Palliat Supp Care 2007
Wermeling Drug Deliv and Tranls Res 2013
Strang et al. Drug Alcohol Depend 2016

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

Arthur Oncologist 2017

Triggers

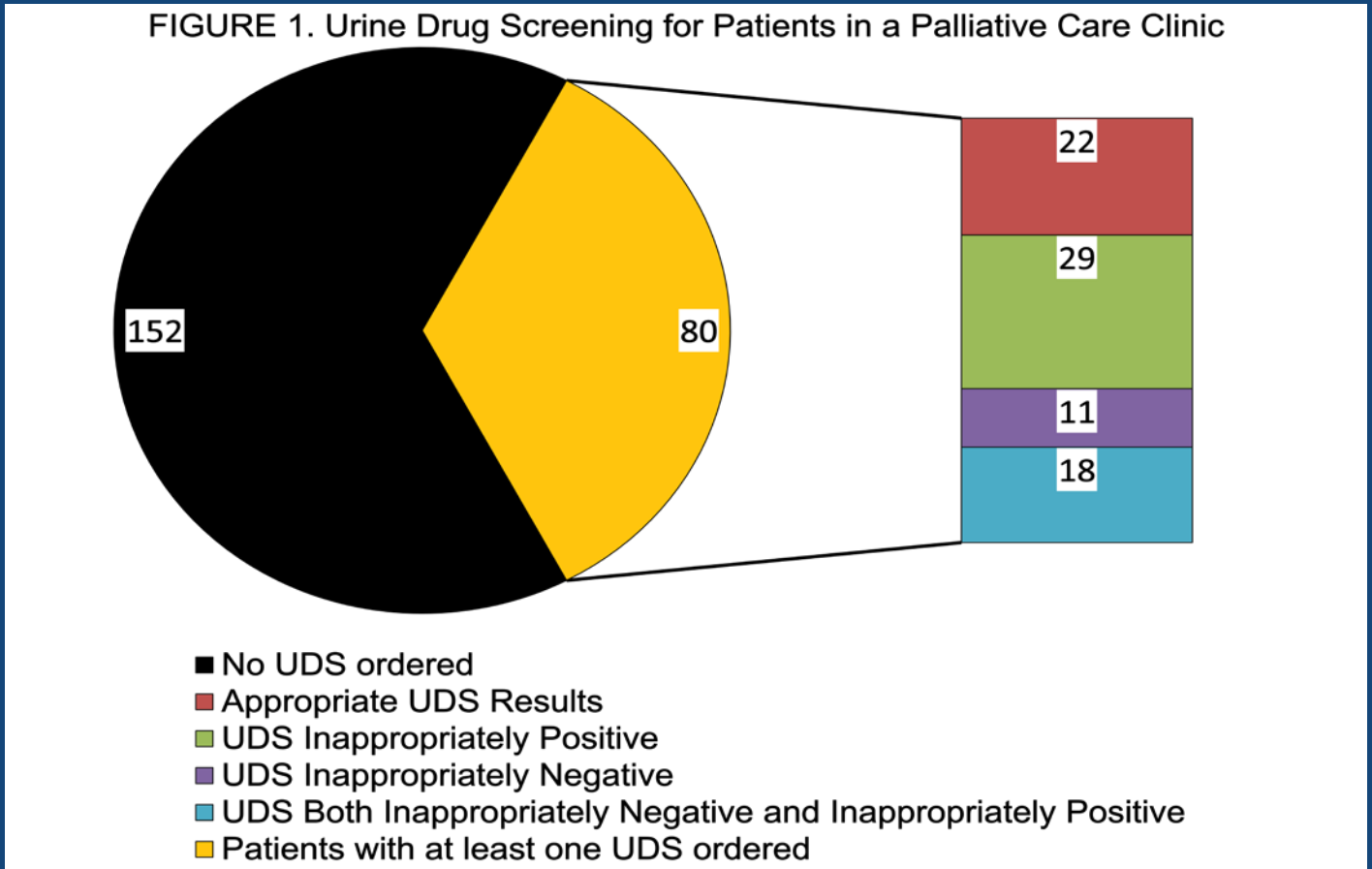
- Abnormal UDS results
- Multiple early refills requested
- Running out of opioids early
- Lost prescriptions
- medications multiple providers

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

egidio.delfabbro@vcuhealth.org

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

BON SECOURS MERCY HEALTH

80 y/o Female

- diagnosed with bladder cancer 12/2016.
- 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 intra medullary nailing of the proximal right femur

4/5/2017
admitted to MRMC

- intractable back pain

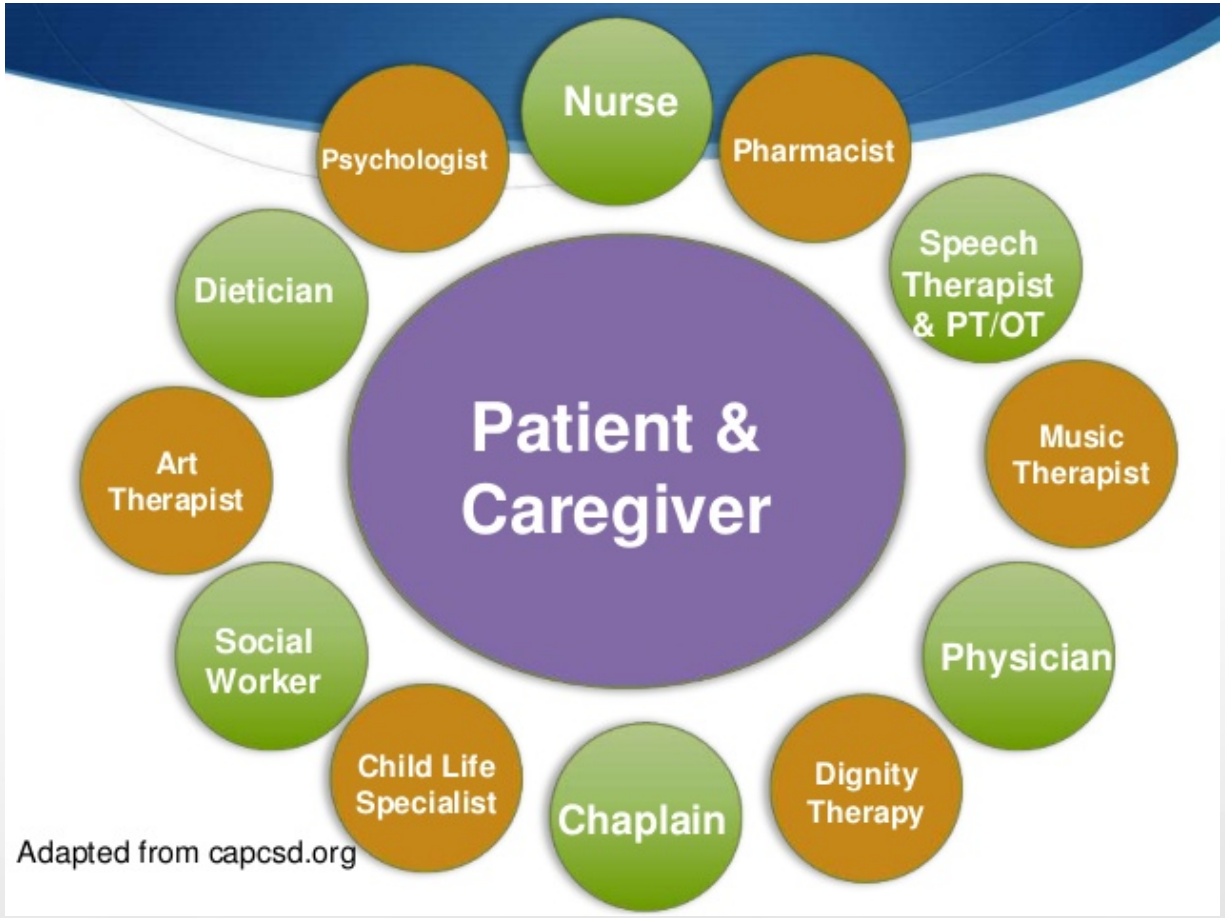
- scheduled for XRT on day of admission to help stabilize the bone in and around the metallic fixation hardware.

- 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?



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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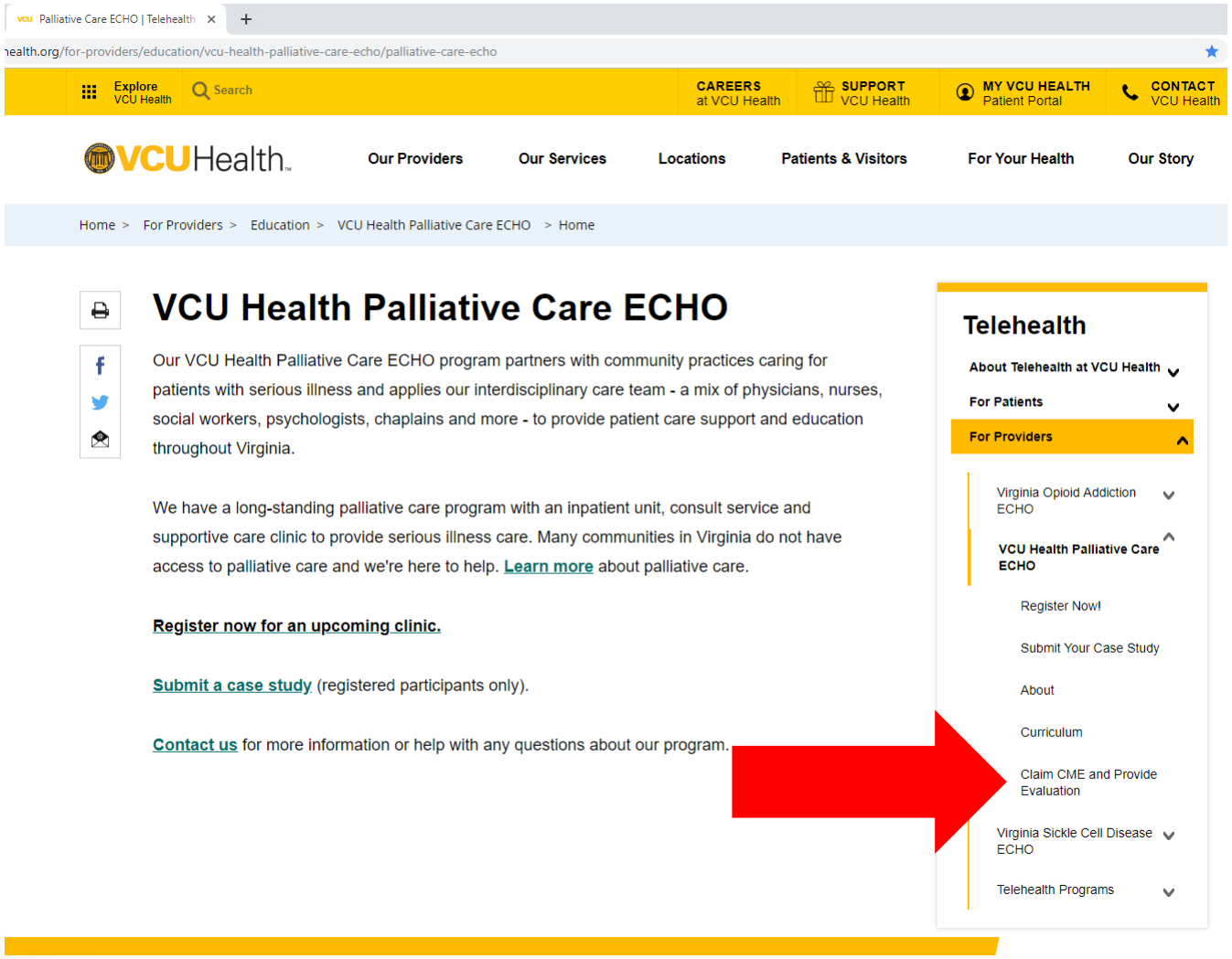
Click “Claim CME and Provide Evaluation”



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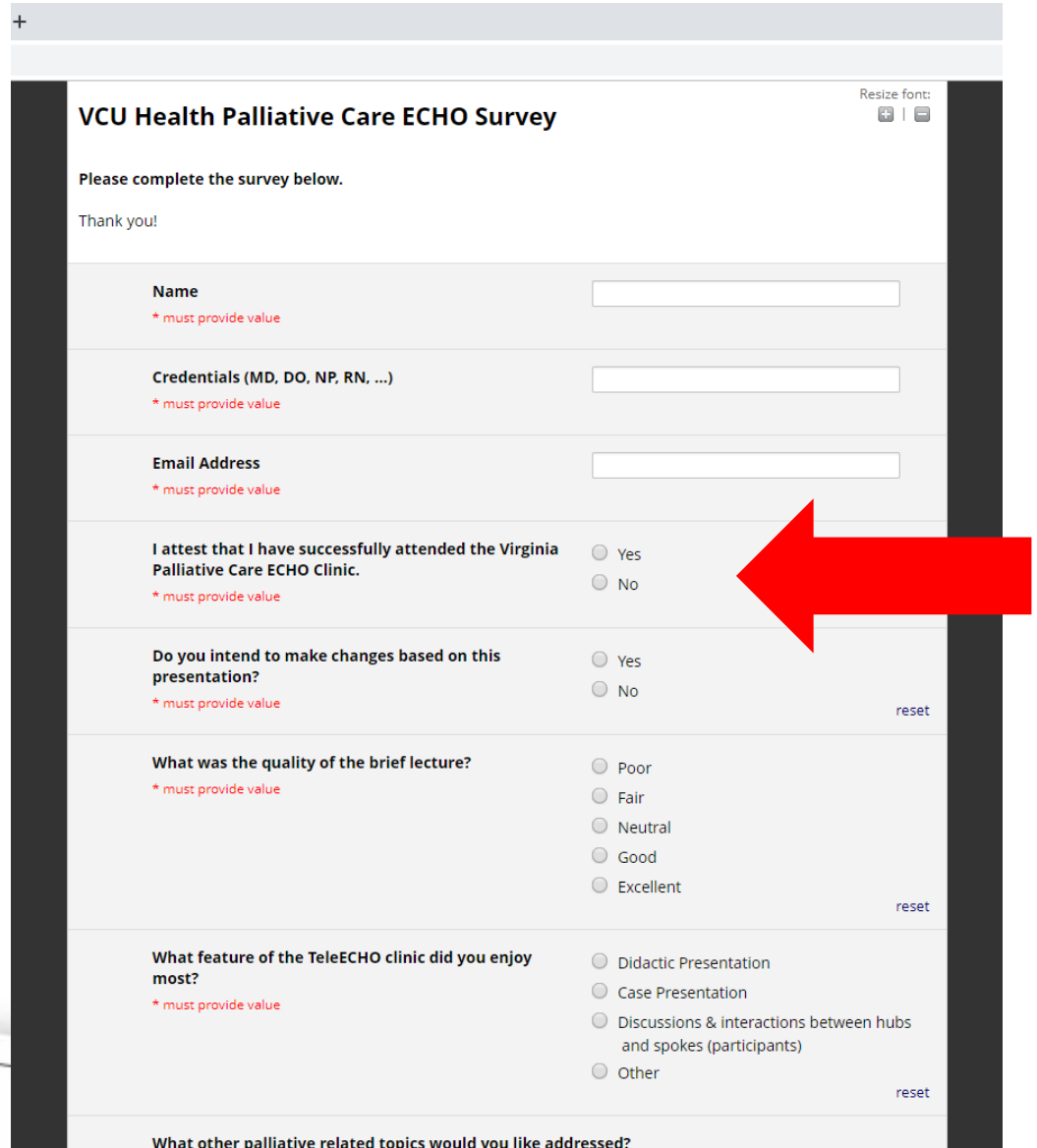

VCU Health Palliative Care ECHO Survey

Resize font:

Please complete the survey below.

Thank you!

Name
* must provide value

Credentials (MD, DO, NP, RN, ...)
* must provide value

Email Address
* must provide value

I attest that I have successfully attended the Virginia Palliative Care ECHO Clinic.
* must provide value
- Yes
- No

Do you intend to make changes based on this presentation?
* must provide value
- Yes
- No

reset

What was the quality of the brief lecture?
* must provide value
- Poor
- Fair
- Neutral
- Good
- Excellent

reset

What feature of the TeleECHO clinic did you enjoy most?
* must provide value
- Didactic Presentation
- Case Presentation
- Discussions & interactions between hubs and spokes (participants)
- Other

reset

What other palliative related topics would you like addressed?

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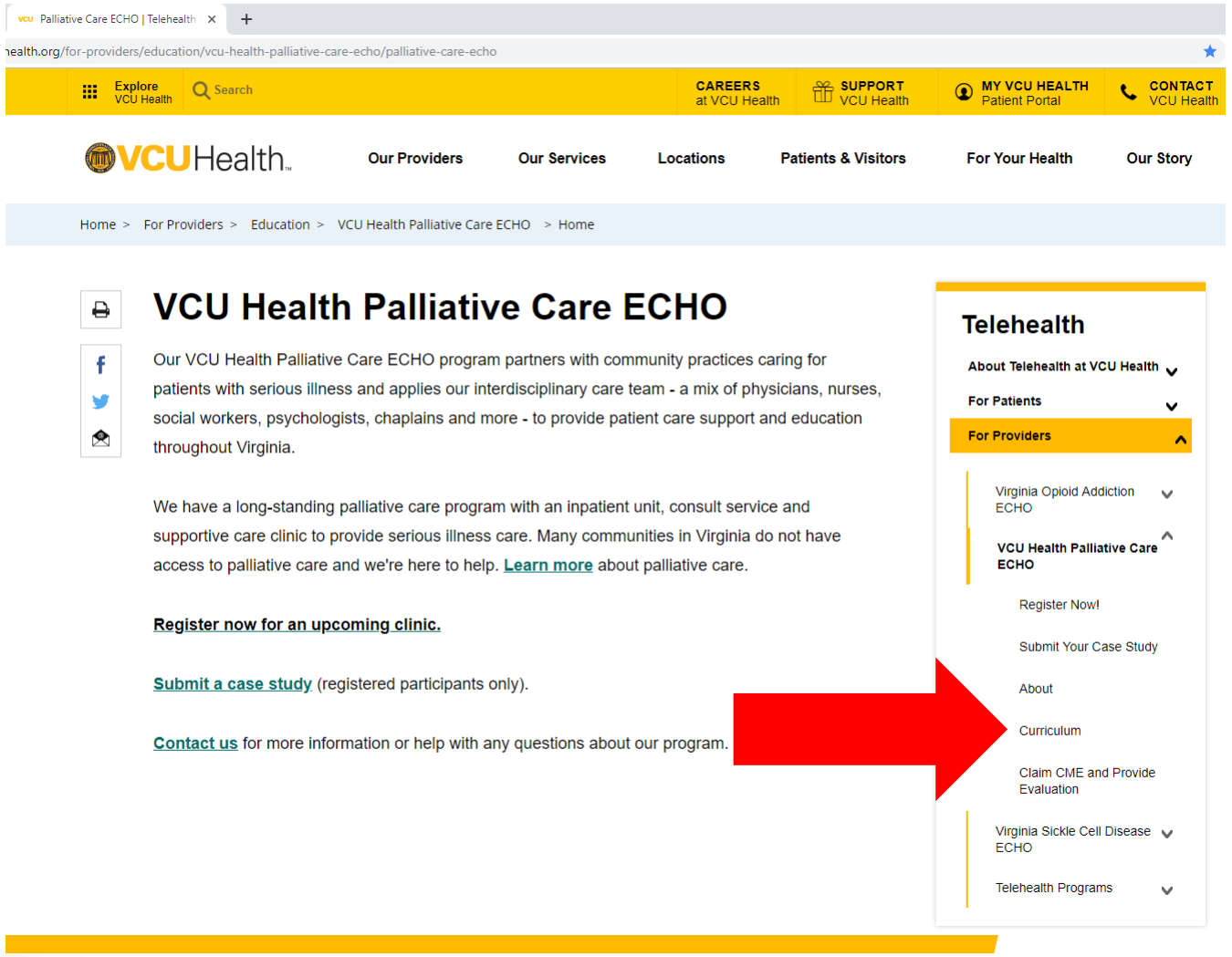
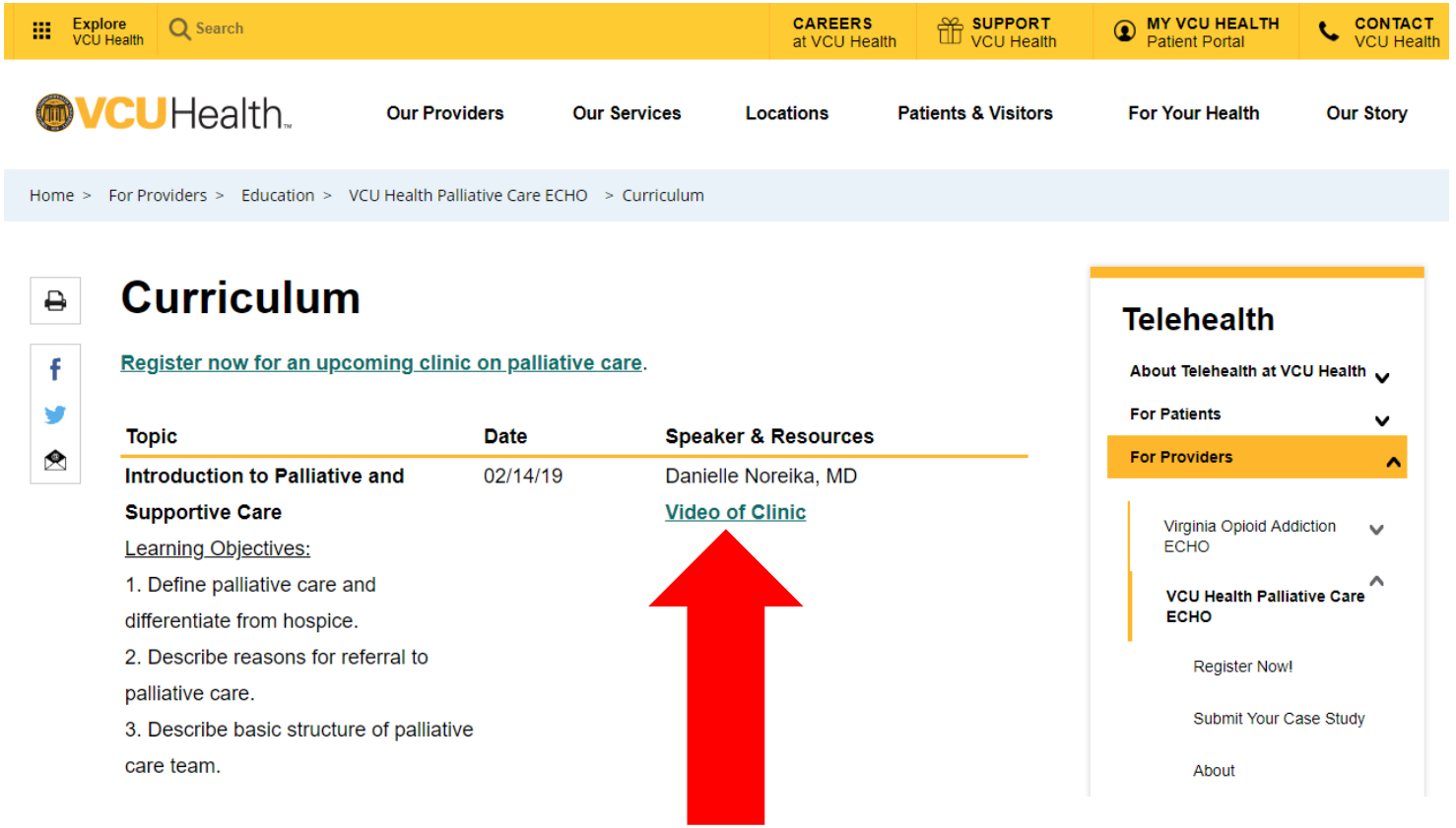
Click “Curriculum”



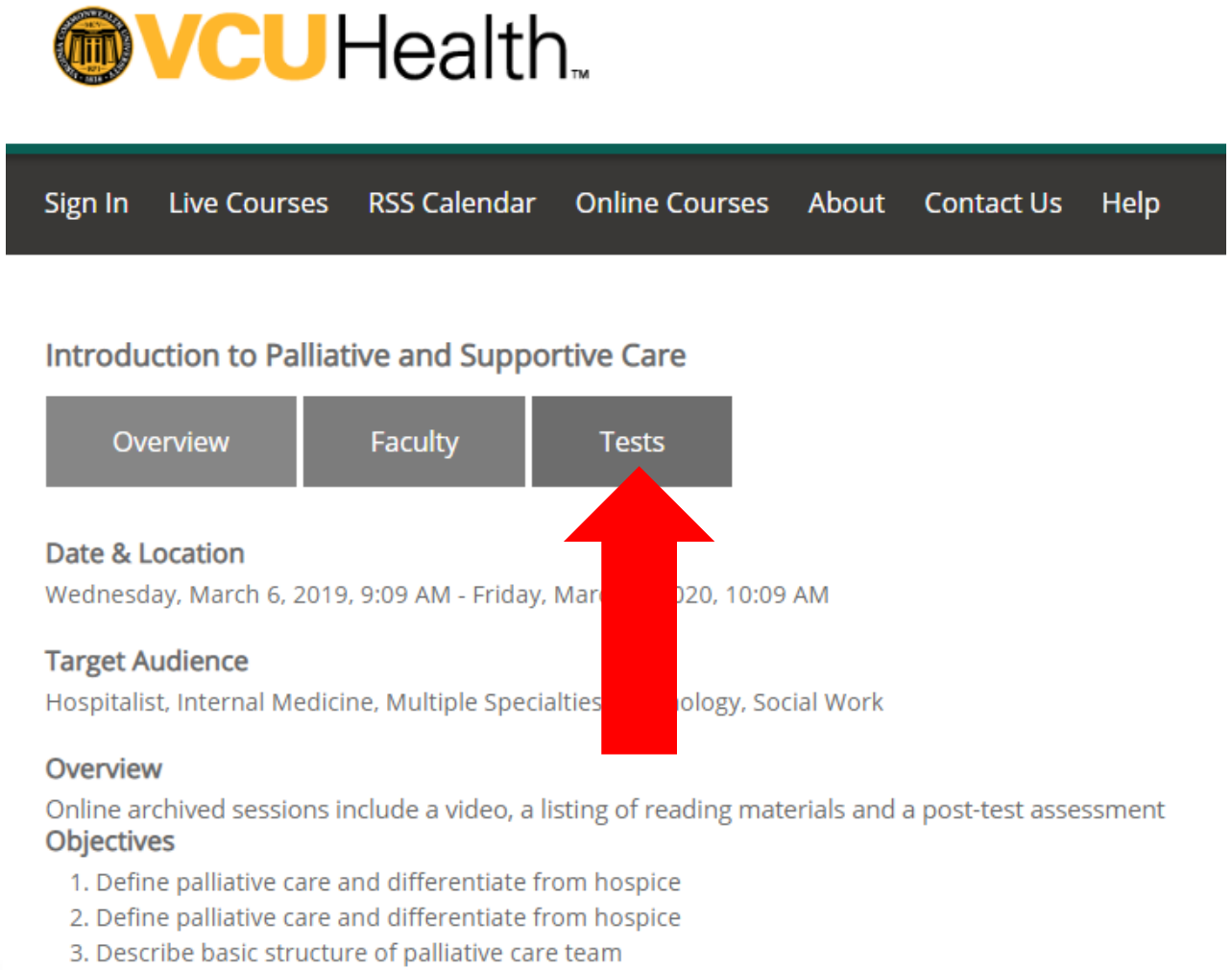
View previously recorded ECHOs for CME

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