Management of Total Cancer Pain: A Case of Young Adult

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ABSTRACT

Pain due to cancer is one of the most distressing symptoms experienced by the patients at some or the other time during the course of treatment or disease progression. The multidimensional nature of cancer pain is characterized by various dimensions including physical, social, psychological, and spiritual; which together constitute the term "total pain". Young cancer patients illustrate their unique psychological and developmental needs. This case report highlights the concept of "total cancer pain" in a young adult and demonstrates his distinctive social, spiritual, and psychological sufferings. The report emphasizes that addressing all these concerns is considerably significant in order to provide optimal pain relief to the patient. In the present scenario, it has been done by a skillful multiprofessional team communicating effectively with both the patient and the carer.

Key words: Cancer pain, Communication, Total pain, Young adult

INTRODUCTION

Cancer pain, which is severe and excruciating, comprises of not only physical component but psychological, social, emotional, and spiritual components as righteously described by Dame Cicely Saunders. She coined the concept of 'total pain' which encompasses all the above mentioned aspects of pain for an individual. The contribution of each component varies with each individual and his/her circumstances.[1] There are various factors which affect patient's perception of pain or 'pain threshold'. Factors like discomfort, fatigue, insomnia, fear, anxiety, anger, sadness, boredom, depression, mental isolation, and social abandonment lower pain threshold. On the other hand, factors like relief of other symptoms, analgesics, proper sleep, sympathy, companionship, understanding, relaxation, creative activity, reduction in anxiety, and elevation of mood elevate pain threshold.[2]

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Therefore, pain management for cancer patients requires critical pain assessment and thorough patient evaluation including psychological assessment. Traditionally, it has been managed by oral pharmacotherapy given according to the principles of the three-step World Health Organization (WHO) analgesic ladder for cancer pain relief, which provides adequate pain relief to approximately 70-80% patients. However, some patients with refractory pain may require interventions or other advanced techniques.[3]

The 'lost tribe' of teen and young adults comprise a heterogeneous group because of their special needs which are quite different from both the pediatric group and the older adults. They have unique psychological concerns like autonomy and involvement in decision making, loss of independence, identity, peer group isolation, knowledge of outcomes, body image, sexuality/fertility, etc., They not only have to struggle with normal developmental milestones relating to identity, body image, sexuality, professional and personal goals, autonomy from parents, peer relationships (e.g. intimate relationships and social support networks), parenthood etc.; but have to adapt to a serious and life-altering medical illness also. They have ongoing physical, social, and emotional challenges, like physical impairment, infertility, uncertainty, fears about recurrence, interruption of life plans, and discrimination

in the workplace and in finding insurance. The impact of cancer on each of these milestones may be profound.[4,5]

This case report highlights the physical and nonphysical challenges faced by a young cancer patient and the approach to manage the concerns.

CASE REPORT

A 33-year-old male patient diagnosed with carcinoma of left mandibular alveobuccal complex ($pT_{4a}N_2M_x$); presented to pain clinic, Dr. B.R.A. Institute Rotary Cancer Hospital, All India Institute of Medical Sciences, New Delhi with severe pain at left side of face and neck, swelling of the left jaw, and difficulty in swallowing. Computed tomography (CT) scan of face and paranasal sinuses revealed post-treatment changes with destruction and lytic areas in alveolar process of mandible, fracture, soft tissue thickening, and bulky heterogeneous left masseter muscle. It was suggestive of post-treatment osteomyelitis, pathological fracture of left mandible, and residual disease/recurrence of cancer.

On reviewing the past history, it was revealed that patient complained of oral ulcers on left mandibular gingival for 1 year. He was diagnosed with squamous cell carcinoma of left mandibular alveolus. He underwent commando surgery and postoperative radiotherapy - 60 Gy/30#/6 weeks. He was under regular follow-up with surgical oncology team, when suddenly he started complaining of increase in pain in left submandibular area. CT scan confirmed a fracture in left mandible. His pain medications stepped up from WHO ladder I to WHO ladder II.

Then, the patient was referred to our pain clinic for pain management. Pain was gradually increasing in intensity since last 1 month. It was severe, throbbing, and unbearable in nature (visual analog score (VAS) - 9/10), not relieved with weak opioids. It increased on stretching of facial muscles and prevented patient from talking, eating, and brushing his teeth. There was tenderness over the left mandibular region. Patient was not able to sleep for past few days due to pain.

He was young, educated, and working as an administrative officer in a multinational company. He was married, had a 2-year-old son and was living in a joint family. He had a habit of cigarette smoking (six to eight cigarettes/day), tobacco chewing (four to five packs/day) since 7-8 years and was used to consume alcohol occasionally.

Though the primary objective for him was pain management, when our team interacted with him in detail and realized that he is concerned about many other issues in his life. He was worried as to why "HE" had developed cancer and why is there such unbearable pain after treatment? Why surgery is again advised? Is there recurrence of cancer? He raised concerns about loss of job, worries about family, loss of role, and social status. He was angry at fate because of his sufferings. He was guilty of not being able to take care of his family especially his wife and 2-year-old child. Many a times, he felt helpless and frustrated that he could not bear his pain and was getting dependent on his family at the time when he should have been fulfilling their responsibilities. His family relations were very getting disturbed; he even got irritated at his 2-year-old child!!!

Regarding management of physical cancer pain, initially he was started on strong opioid, that is, morphine 5 mg 4-hourly along with nonsteroidal anti-inflammatory drugs (NSAIDs), pregabalin 75 mg twice daily, and antacids and stimulant laxatives for management of side effects. He was administered supportive therapy for infection in the jaw, that is, antibiotics, topical antifungal paint clotrimazole (for oral thrush) and povidine iodine gargles for mouth wash.

Morphine dose was increased in subsequent visits to 10 mg every 4-hourly. It was observed that only 30% pain was relieved with prescribed dose of morphine and patient was in deep stress and anxiety. Hence, it was decided to consider with interventional pain management. Patient underwent pulsed radiofrequency ablation of mandibular nerve with partial pain relief (VAS - 6/10). In addition, he was given Scrambler therapy which is specifically designed and clinically tested therapy to provide rapid, non-narcotic, noninvasive treatment for chronic neuropathic[6] and oncologic pain, including pain resistant to morphine and other drugs. Moreover, this therapy does not have any side effects and may improve quality of life of patients.[7]

However, despite our efforts the pain was difficult to control. There was a requirement of extra morphine tablets for uncontrolled baseline and frequent breakthrough pain. The dose was titrated accordingly and was stabilized at 120 mg controlled release morphine plus 30 mg plain morphine if necessary for breakthrough pain (SOS). Additionally, flupirtine (non-narcotic and non-NSAID) was given to potentiate the analgesic effect.

His psychosocial and spiritual concerns were also addressed. Our team tried to allay his anxiety by counseling him and his family; and aimed to provide him a clear view of disease, treatment and associated pain. Our team included not only pain and palliative care physicians, but experts from other

domains like surgical oncology, radiation oncology, and radiology. Contributions given by members of nursing staff, nongovernmental organizations (NGOs), and other family members were also significant.

DISCUSSION

A study conducted by Green and Hart-Johnson[8] demonstrated age-related difference in interference caused by pain in mood, relationships, sleep, enjoyment, and work. Younger cancer patients (age < 40 years) experienced more interference as compared to patients aged 41-59 years. Both groups experienced greater interference as compared to patients' ≥60-years-old. The difference was quite significant for mood interference due to pain. Also, younger patients were more concerned with financial burden of the disease.

Sugden[9] demonstrated the multifaceted nature of total pain through two distinctive case reports; in which he emphasized the need of effective communication and multidisciplinary team approach for comprehensive pain management.

The present case study demonstrates clearly the obvious physical dimension of pain along with psychological, social, and spiritual sufferings experienced by the patient. Psychological component is often referred to as emotional component of "total pain".[10] The patient's emotional pain was expressed by feelings like anxiousness, frustration, helplessness, and anger. The patient was extremely anxious about his disease and its progression. It has been seen that emotions like fear, anger, and sadness lower pain threshold.[2] He was anxious as to what will be the fate of his family if he dies. Hence, despite knowing in detail about his disease, he was in denial. He wanted to live his life in the same manner as before developing cancer.

The social component of "total pain" was also high. He was constantly preoccupied with thought of worries about his wife and son; and irrational behavior of his mother towards his wife. Literature states that family worries can adversely affect perception of "total pain" to a patient.[11] Our team patiently listened to all his concerns and provided psychological counseling. His wife was included in assessing his social perspective of pain. Financial burden of the disease was a major cause of worry for him. Also, he was uncomfortable with increasing dependence on his family and loss of social status. It was difficult for him to cope up with change in his role of family's breadwinner to a dependent patient. An open communication at both hospital and home by the home care team (NGO) helped him to relieve his burden. This case study reflects that good communication by healthcare providers with patient and carers helps them to accept their life situation more easily and reduces the psychological burden of pain.[12,13]

It seemed that pain was initially subsiding with morphine 5 mg 4-hourly doses, but it was fluctuating frequently. Hence, it was decided to start with interventional pain management. The interventions and medications provided good physical pain relief. However, he was too concerned with why there is recurrence of cancer and did not want to take treatment again. He was finding meaning of his existence, trying to understand his situation and was blaming God for his sufferings. These feelings demonstrated his high spiritual distress. Spirituality and religion are quite different. Spiritual beliefs are unique for every individual.[14] Although, spirituality has been defined in a diverse manner in literature, yet it is not clear how it is associated with spiritual pain. Spiritual suffering has been described as "complex interplay among various factors, including awareness of death, loss of relationships, loss of self, loss of purpose, loss of control, life affirming, transcending purpose, and internal sense of control".[15] Our team addressed his spiritual concerns as a part of routine care and he was able to accept his situation in a better manner, his anger decreased and was prepared to take the treatment again.

Collaborative communication, information sharing, and regular and routine screening for psychosocial, spiritual needs of the patient provided by multidisciplinary supportive team in a timely manner assisted patient and his family with their adjustment to cancer, and then to the challenges that developed over time.

CONCLUSION

"Total cancer pain" though relatively common; needs to be adequately addressed in a timely manner by the healthcare provider team for holistic management of the patient. This case report demonstrates that treating social, psychological, and others dimensions of pain is considerably important along with treating physical pain. Multidisciplinary approach, open communication, and involvement of family members are the key elements in managing these aspects.

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