Indian Society for Study of Pain, Cancer Pain Special Interest Group Guidelines on Palliative Care Aspects in Cancer Pain Management

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Abstract

The Indian Society for Study of Pain (ISSP), Cancer Pain Special Interest Group guidelines on palliative care aspects in cancer pain in adults provide a structured, stepwise approach which will help to improve the management of cancer pain and to provide the patients with a minimally acceptable quality of life. The guidelines have been developed based on the available literature and evidence, to suit the needs, patient population, and situations in India. A questionnaire based on the key elements of each sub draft addressing certain inconclusive areas where evidence was lacking was made available on the ISSP website and circulated by E-mail to all the ISSP and Indian Association of Palliative Care (IAPC) members. In a cancer care setting, approaches toward managing pain vary between ambulatory setting, home care setting, acute inpatient setting, and end-of-life care in hospice setting. We aim to expound the cancer pain management approaches in these settings. In an ambulatory palliative care setting, the WHO analgesic step ladder is used for cancer pain management. The patients with cancer pain require admission for acute inpatient palliative care unit for poorly controlled pain in ambulatory and home care settings, rapid opioid titration, titration of difficult drugs such as methadone, acute pain crisis, pain neuromodulation, and pain interventions. In a palliative home care setting, the cancer pain is usually assessed and managed by nurses and primary physicians with a limited input from the specialist physicians. In patients with cancer at the end of life, the pain should be assessed at least once a day. Moreover, physicians should be trained in assessing patients with pain who are unable to verbalize or have cognitive impairment.

Keywords: Acute inpatient palliative care, ambulatory palliative care, cancer pain management guidelines, cancer pain special interest group, end-of-life palliative care, home-based palliative care, hospice, Indian Association of Palliative Care, Indian Society for Study of Pain

Introduction

In general, cancer pain in a palliative care setting is recognized as a multidimensional experience with sensory, affective, cognitive, and behavioural dimensions. The patients with cancer receiving palliative care often experience moderate-to-severe pain.[1] It is usually multisite, variable in intensity at each site, complex underpinning pain pathophysiology, and complex presentation.[2] It has a strong affective dimension where the sensory component of pain is associated with anxiety, depression, distress, and suffering.[2] The cognitive dimension of pain presents as an unpleasant experience, negative emotions and can impact the persona of the individual experiencing the

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pain.[3] The patients could present with varied pain behaviors such as posturing, limitation of activities of daily living, social isolation, treatment avoidance, and poor compliance, which may impact the pain management and overall care of the patient.[4] In a cancer care setting, approaches toward managing pain vary between ambulatory setting, home care setting, acute inpatient setting, and end-of-life care in hospice setting. This chapter aims to expound the cancer pain management approaches in these settings. These guidelines are developed to improve the management of cancer pain and to provide the patients with a minimally acceptable quality of life.

Methods

Literature search [Appendix IV] was carried out using PubMed, Medline, Cochrane Database, Google Scholar, and OVID search engine. The search included studies published in the English language until November 2018. Where evidence is lacking, recommendations were made by consensus (good clinical practice), following extensive discussion among the committee members and considering the results of the questionnaire [Appendix V] circulated during the meeting, and also were made available on the Indian Society for Study of Pain (ISSP) website and circulated by E-mail to all the ISSP and Indian Association of Palliative Care (IAPC) members.

Guidelines for cancer pain management in ambulatory palliative care setting

In an ambulatory palliative care setting, the WHO analgesic step ladder is used for cancer pain management. The WHO analgesic ladder is a simple treatment algorithm for pain management. It is based on the patients' "level" of pain (mild, moderate, or severe) as determined through numerical rating scale for pain. Patients are treated using nonopioid analgesics, such as one of the nonsteroidal anti-inflammatory drugs or paracetamol (acetaminophen) for mild pain. If the pain persisted or got worse-to-moderate levels, a weak opioid analgesic would be introduced alone or in combination with a nonopioid or adjuvant analgesic. If the pain persisted or got worse-to-severe levels, a strong opioid analgesic would be introduced alone or in combination with a nonopioid or adjuvant analgesic.[5,6] The WHO analgesic ladder provides a stepwise approach for both pain specialists and nonpain specialists and as an easy guide for the management of pain. It avoids misuse of strong opioids, and strong opioids would be only used unless absolutely necessary. The framework provided by an apex scientific body like the WHO abated the fear of addiction and legal prosecution. It can be implemented anywhere in the world, especially in developing countries with few pain specialists. Studies have shown that using the WHO algorithm resulted in adequate pain relief for an adequate period of the time for significant number of patients.[7] The studies have shown that 76% of patients could achieve good pain relief using the principles of the ladder; a further 12% achieved satisfactory efficacy and 12% had inadequate efficacy.[8]

Guidelines for cancer pain management in acute inpatient palliative care setting

The patients with cancer pain require admission for acute inpatient palliative care unit for poorly controlled pain in ambulatory and home care settings, rapid opioid titration, titration of difficult drugs such as methadone, acute pain crisis, pain neuromodulation, and pain interventions.[9] Rapid oral opioid titration along with adjuvants is attempted for poorly controlled pain. Interventions aimed at correcting the treatable cause of pain are undertaken such as palliative radiotherapy, physiotherapy, or by correcting hypercalcemia, etc., These interventions are carried out during the inpatient admission. Acute pain crisis is managed with intravenous opioid trial, followed by maintenance opioid infusion.[10] The infusions are converted to oral and transdermal preparations once the stable pain relief is achieved. The patients with neuropathic pain crisis receive intravenous lignocaine or ketamine boluses, followed by maintenance dose with these drugs until neuromodulation is achieved. Certain drugs such as methadone used for mixed nociceptive neuropathic cancer pain may need inpatient admission for titration.[11] Patients with cancer pain not achieving adequate pain relief with Step 3 of the analgesic step ladder may benefit from the interventional pain management procedures.[12]

Guidelines for cancer pain management in home-based palliative care setting

In a palliative home care setting, the cancer pain is usually assessed and managed by nurses and primary physicians with a limited input from the specialist physicians. These assessments are infrequently done, which contribute to persistent pain, sleep disturbances, anxiety, depression, repeated hospitalizations, increased cost, and poor quality of life.[13] The patients at home are vulnerable to polypharmacy, increased over-the-counter medication use, and harmful adverse effects of the analgesics.[14]

The patients at home are managed similarly as ambulatory patients using the principles of the WHO analgesic step ladder.[6] In addition, these patients receive pain self-reporting guide and pain diaries for documenting pain scores and pain-related details. They also receive drug book for documenting daily use of background analgesics and breakthrough doses. It says the patient pain may worsen due to disease progression or due to some other catastrophic complications such as tumour rupture, and thus we may have to anticipate such things and provide the necessary analgesic prescriptions.[15] Patients and families are advised to get the analgesic prescriptions from the hospitals or general practitioners before they exhaust their medications. They are also linked to local pharmacy and their practitioners to ensure an adequate uninterrupted supply of analgesics.

Guidelines for cancer pain management in hospice and end-of-life care patients

Pain is often a hidden cause of distress and agitation at the end of life as patients during this period may not be able to verbalize pain or have some degree of cognitive impairment limiting pain reporting.[16] Misconceptions about pain at the end of life, appropriateness and side effects of analgesics, underreporting of pain by patients and families, and complex presentation of pain at the end of life could limit the use of analgesics.[17] Physicians often lack skills in identifying and assessing pain

Table 1: Summary of recommendations

Recommendations	Level of evidence
WHO 3-step analgesic ladder is recommended for cancer pain management in ambulatory palliative care setting (Grade B)	IIa
Acute pain crisis in inpatient settings should be managed with intravenous morphine (Grade B)	IIb
The subcutaneous or intravenous route of administration is recommended at the end of life (Grade D, GCP)	V

WHO: World Health Organization, GCP: Good clinical practice

in patients at the end of life with cognitive impairment. They also lack skills in choosing appropriate analgesics, route, and titration and breakthrough analgesics.[18] Patients at the end of life experience many symptoms at the end of life and quality of life and quality of death experience is a cumulative effect of symptom management and addressing nonsymptom-related issues.[19] The studies have shown that pain management at the end of life is inadequate and unrelieved pain could erode the dignity and comfort at the end of life.[20]

In patients with cancer at the end of life, the pain should be assessed at least once a day. The pain should be anticipated and an anticipatory prescription should be provided to all the patients admitted to hospice or admitted for end-of-life care. Moreover, physicians should be trained in assessing patients with pain who are unable to verbalize or have cognitive impairment.[21] The health-care providers should ensure access and availability of all medications needed for pain management. Analgesics and doses of analgesics prescribed for pain management must be based on careful evaluation of patients' pain. The doses of analgesics should be proportionate to patients' pain and response to treatment should be frequently reassessed. Although a patient is in the end of life, no attempt should be made to give a higher than required or inappropriate dose. The prn (pro re nata), sos (si opus sit) orders should be written up to cover intermittent pain and to cover breakthrough pain. In the end-of-life setting, the PRN doses should be used liberally and rapid readjustment of doses of background (round the clock) medication should be done. The route of analgesics delivery at the end of life may need to be changed to subcutaneous or intravenous route as the patient may not be able to take the drugs orally.[22] The palliative sedation should be considered at the end of life if pain becomes refractory to conventional analgesics.[23]

Conclusion

The Indian Society for Study of Pain (ISSP) cancer pain SIG guidelines on palliative care aspects for cancer pain in adults emphasizes the importance of palliative medicine specialist interventions from an early phase of illness till end of life in cancer pain management.

We believe that the ISSP cancer pain SIG guidelines on palliative care aspects for cancer pain in adults will help pain specialist, anaesthesiologists, palliative care specialists and others who are involved in cancer pain care, in the safe management of cancer pain [Table 1].

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Disclaimer

The contents of this publication are guidelines to clinical practice, based on the best available evidence at the time of development. These guidelines should neither be construed or serve as a standard of care.

These guidelines do not represent the minimum standard of practice, nor are they a substitution for good clinical judgment. These guidelines need to be used in conjunction with patient assessment and may be individualized as per patient need.

These guidelines were developed in 2018-2019 and may be reviewed again in 2024 or sooner, based on the availability of new evidences.

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Conflicts of interest

There are no conflicts of interest.

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Appendix IV: Literature search

The following terms or MESH terms were used either in combination or single:

"Pain"[Mesh], "Prevalence"[Mesh], "Signs and symptoms"[Mesh], "Syndrome"[Mesh], "Diagnosis"[Mesh], presentation, "Neoplasms"[Mesh], tumours, cancers, physical assessment", "Pain Measurement"[Mesh], "pain scale'', psychosocial, assessment, "cognitively impaired', "psychological distress", distress, "Emotions"[Mesh] "Nursing"[Mesh], "prime assessor", "Palliative Care"[Mesh], "supportive care'', "cancer pain management", "Patient-Centered Care"[Mesh], "Patient Care Team"[Mesh], "Patient Care Management"[Mesh], "Primary Health Care"[Mesh], "Physicians, Family"[Mesh]), interdisciplinary, Education"[Mesh], outcome, barrier, "World Health Organization"[Mesh], "Guideline "[Publication Type], "cancer pain ladder", "World Health Organization three step analgesic ladder"[Mesh], Drug Therapy"[Mesh], "Analgesics, Opioid"[Mesh], "administration and dosage"[Subheading], titration, "breakthrough pain", "Drug Tolerance"[Mesh], "Adjuvants, Pharmaceutic"[Mesh], "adjuvant analgesics", "pregabalin "[Substance Name], "Ketamine"[Mesh], "Dexamethasone"[Mesh], corticosteroid, "opioid rotation", "opioid switching", "alternative opioid", "Bisphosphonates"[Mesh], "Sedation score", "Morphine protocol", "Radiotherapy"[Mesh], "Soft Tissue Neoplasms"[Mesh], "Behaviour Therapy"[Mesh], "Cognitive Therapy"[Mesh], "Physical Therapy Modalities"[Mesh], "Acupuncture"[Mesh], "Massage"[Mesh], "Exercise"[Mesh], "Exercise"[Mesh], "Nerve Block"[Mesh], "Injections, Spinal"[Mesh], "intrathecal therapy", "Vertebroplasty"[Mesh], "follow-up", "Physician's Role "[Mesh], "community care", "home program*", "general practitioner", hospice, "pain clinic", "Outpatients"[Mesh], "Outpatient Clinics, Hospital"[Mesh], "Ambulatory Care"[Mesh]

Appendix V: Cancer pain management questionnaire

1. How many patients of cancer pain do you manage per month?
2. What is the most frequent cancer pain that you encounter in your daily practice?
3. What are the clinical presentations of cancer related pain?
4. What are the methods used for clinical assessment of cancer pain?
5. What are the principles of management of pain in patients with cancer?
6. What is the WHO Analgesic Ladder? What are its principles? How effective is it in clinical practice?
7. Do you follow WHO step ladder approach for cancer pain management?
8. What do you prefer for step II and step III of WHO ladder?
9. What non-pharmacological techniques do you use to manage Cancer Pain
10. Do you screen all patients of substance abuse? If yes, which scale do you use.
11. What medications do you use to manage cancer pain
12. What are the major side-effects you observe due to pharmacological management and how do you manage it?
13. What are the adjuvant analgesics in cancer pain management?
14. What are the pharmacological strategies for breakthrough pain and other acute pain crises?
15. What are the roles of anti-cancer therapy in the management of cancer pain?
16. Do you manage patients using Interventional Techniques? If yes, which interventional techniques and in what percentage of patients?
17. What are the relative efficacy and safety of current invasive treatments for the treatment of cancer-related pain?
18. Do you think current treatment guidelines for cancer pain management are sufficient? If no, what changes do you suggest?
19. According to you, what steps need to be taken to spread the awareness regarding cancer pain management?