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Difficult Pain Problems

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The problem

- Ethics
  - readiness to address pain and other intolerable symptoms is a medical and moral imperative
- Pain
  - 10-30% do not achieve adequate relief with routine approaches
  - management is challenging, exhausting, frustrating, time consuming
- Clinical demand
  - familiarity with pain assessment, physiology and a range of therapeutic strategies.

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Difficult pain syndromes

- No clear definition
- Several syndromes are widely recognized as being more resistant to conventional strategies
- Clinically characterized
  - chronic cancer pains
  - episodic pains

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Difficult chronic cancer pain syndromes: Neuropathic pains

- common in patients with advanced cancer
- most commonly caused by compression of neural structures
  - may be overt or occult
- Iatrogenic
  - cytotoxic induced painful peripheral neuropathies
  - post surgical

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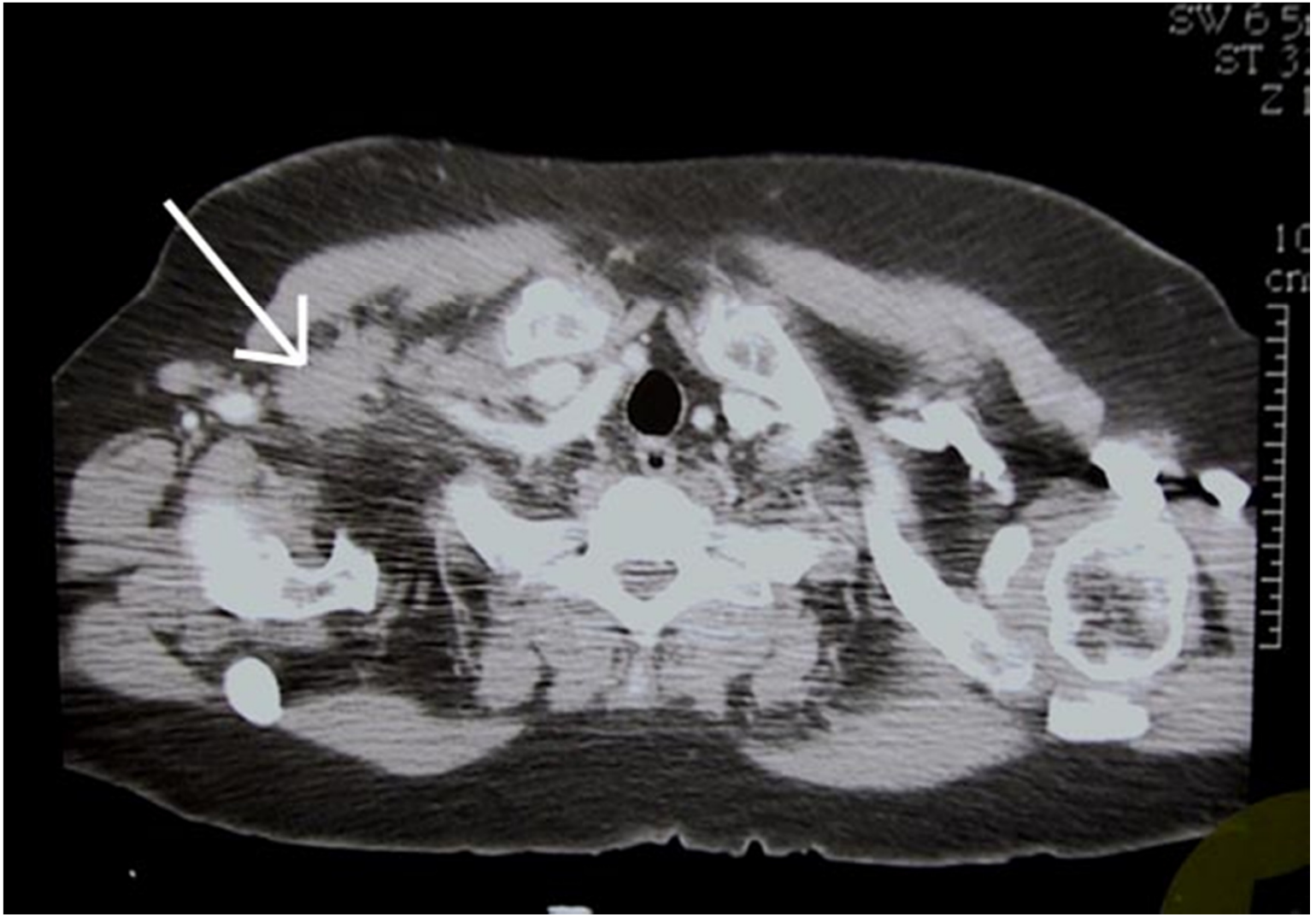
Difficult chronic cancer pain syndromes: Neuropathic pains



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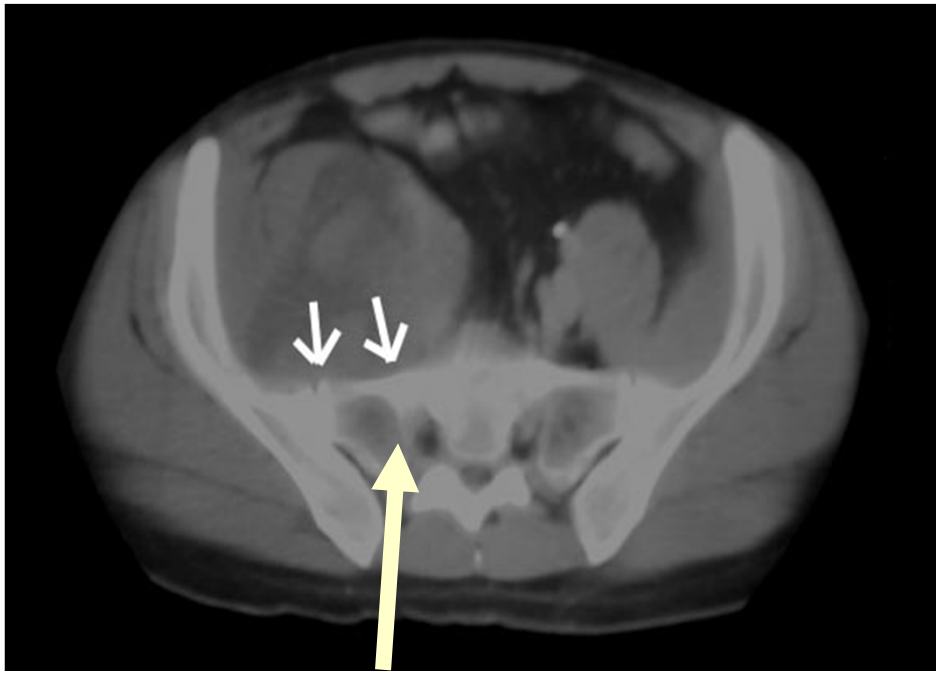
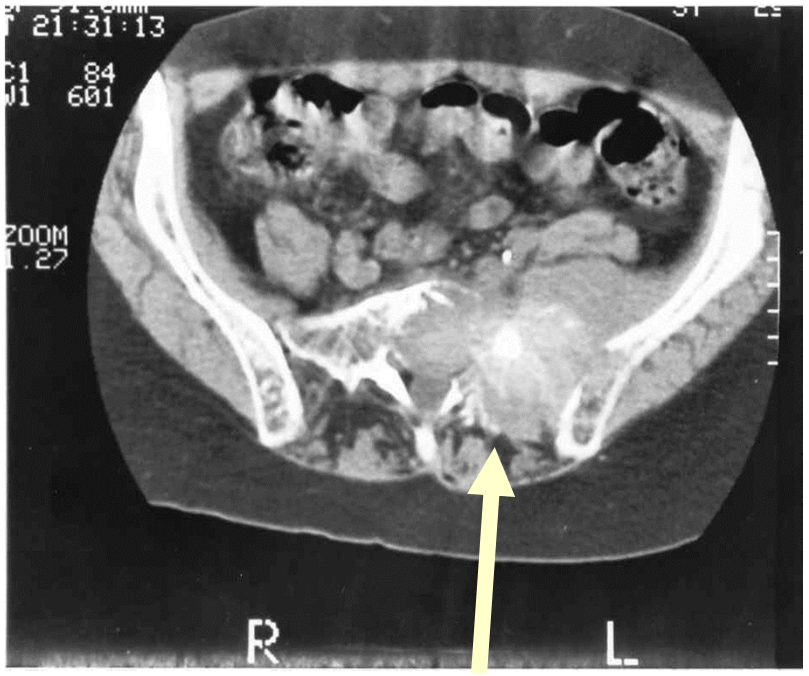
Difficult chronic cancer pain syndromes: Neuropathic pains



Nodal mass compressing lumbosacral plexus



Sacral mass infiltrating sacral nerve roots

Images courtesy of Prof. N. Cherny

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Difficult chronic cancer pain syndromes: Bone pain

- Very common
- Usually very responsive
- Difficult situations
  - metastases in weight bearing structures
  - fractures
  - metastases which compress neural structures traversing or adjacent to the bone

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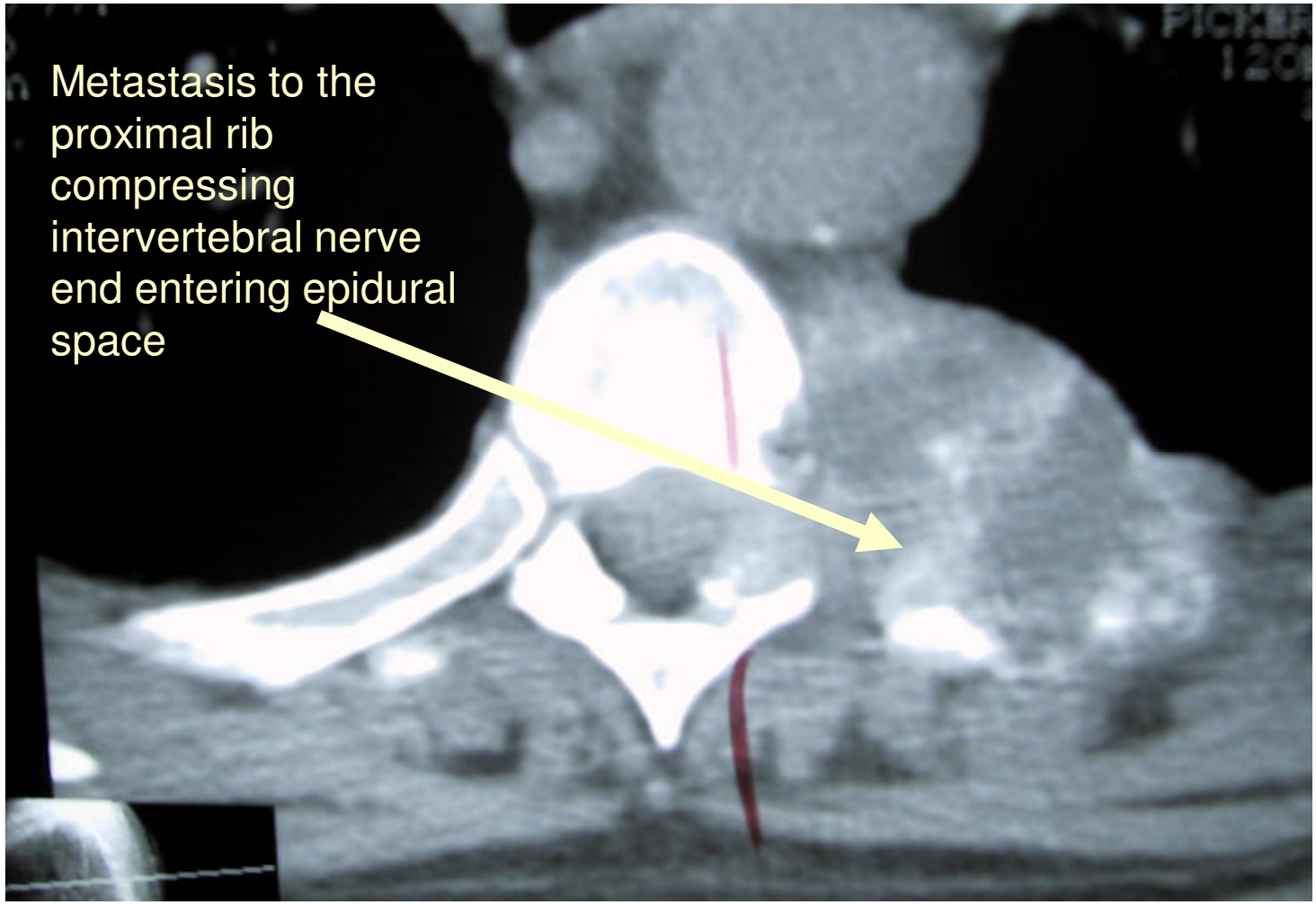
Difficult chronic cancer pain syndromes: Bone pain



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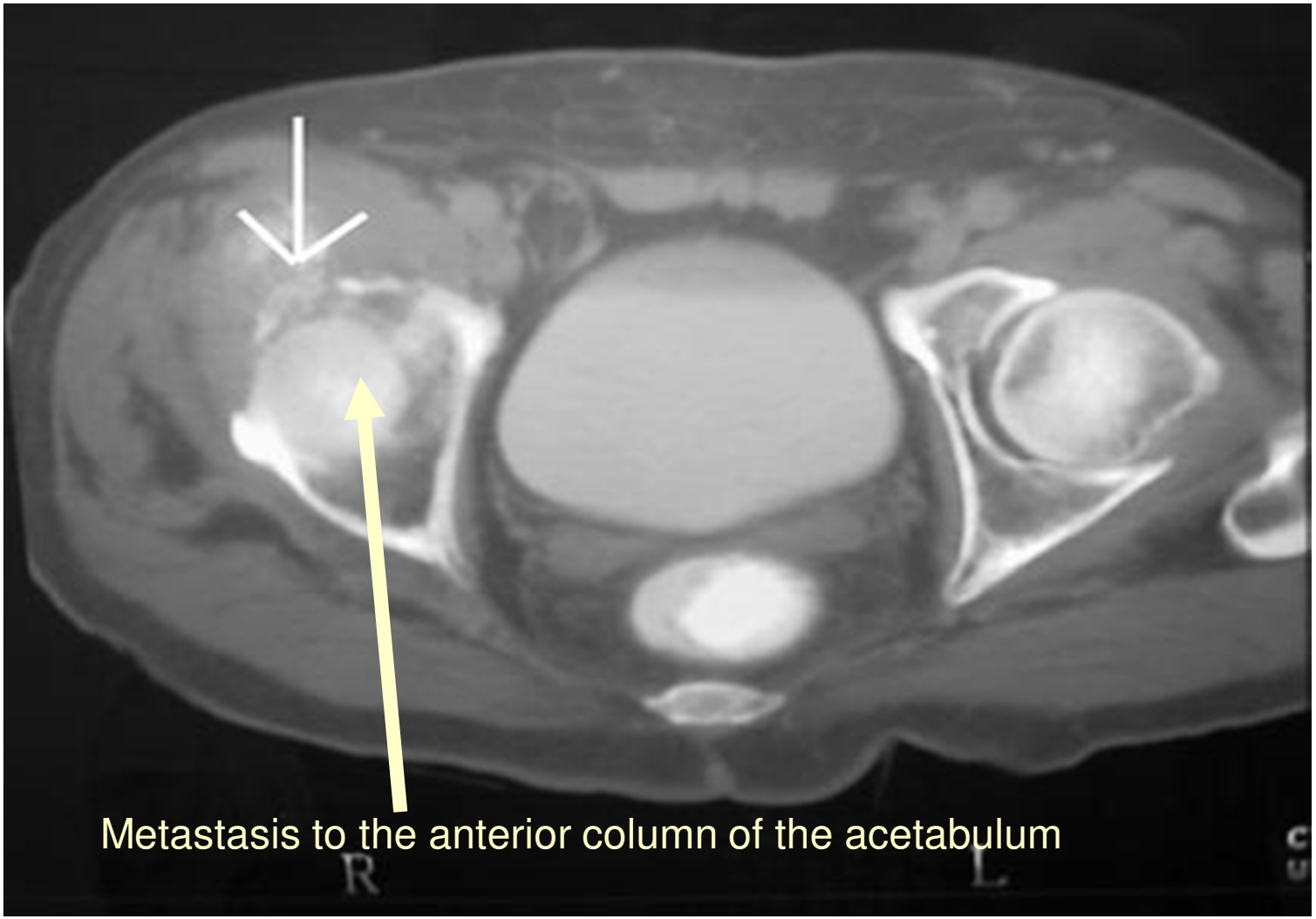
Difficult chronic cancer pain syndromes: Bone pain



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Difficult chronic cancer pain syndromes: Visceral pain syndromes

3 visceral syndromes stand out as being notoriously difficult to control:

1. pancreatic pain (midline retroperitoneal cancer pain)
2. bladder spasms
3. tenesmoid rectal pains

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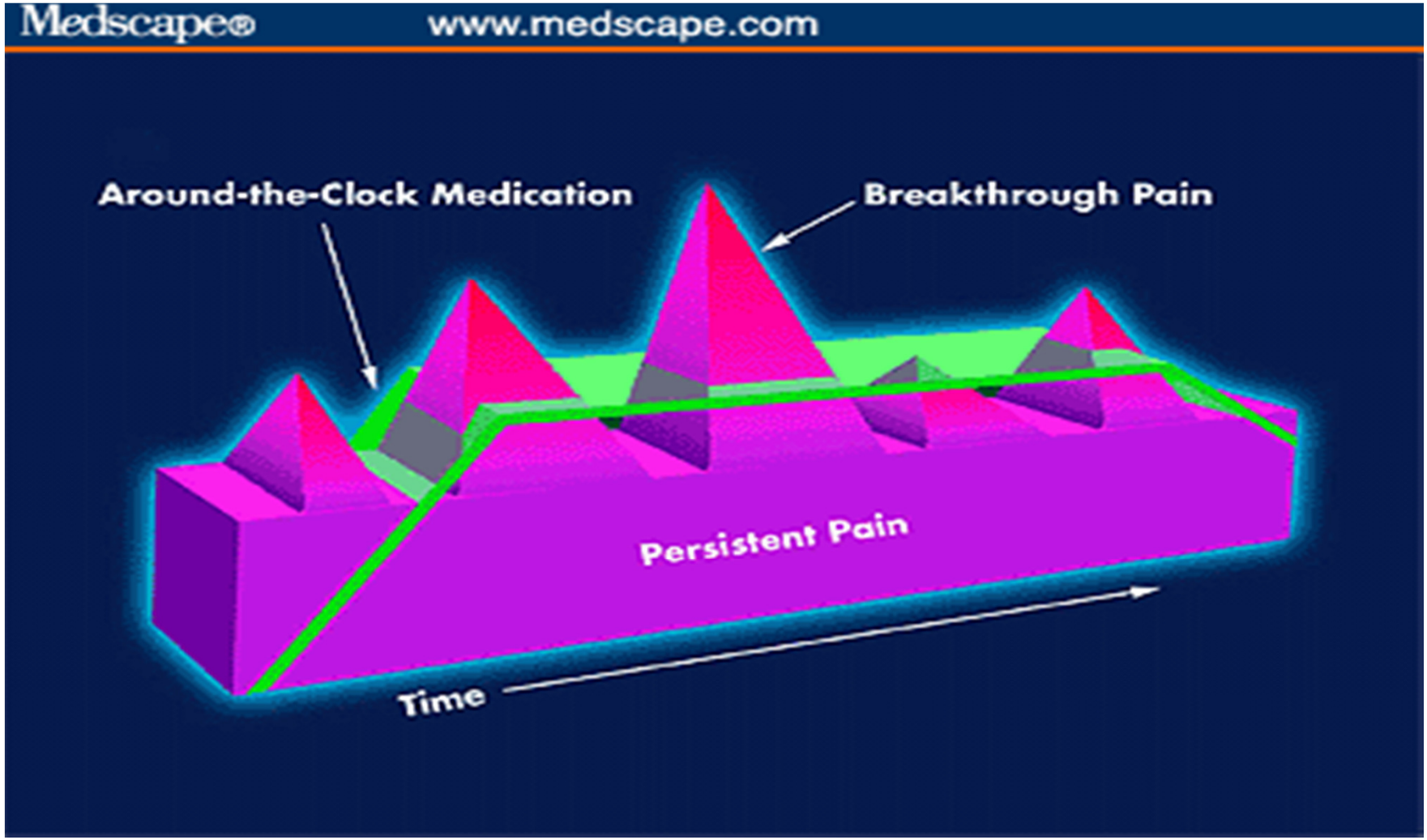

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Somatic, movement-related breakthrough pain

- *Volitional*
  - usually with skeletal metastases
  - episodes are generally predictable
- *Non-volitional*
  - triggers include laughing, sneezing, coughing or myoclonus
  - non-predictable
  - management must address the possibility of reducing the frequency of the non-volitional precipitant

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Neuropathic movement related breakthrough pain

- *Volitional*
  - specific volitional activities may ➔ exacerbate nerve compression
- *Non-volitional*
  - coughing and sneezing ➔ valsalva ➔ transient elevations in intracranial pressure called "plateau waves"

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Neuropathic, non-movement related breakthrough pain

- Transient episodes of spontaneous lancinating or burning pain are common.
- Frequency very variable.

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Visceral breakthrough pains

- *Volitional*
  - may occur with swallowing and digestion, micturition, defecation and sexual climax
- *Non-Volitional*
  - spontaneous muscular contractions of hollow organs
  - often associated with obstruction or inflammation of hollow viscus
  - common with:
    - esophagus
    - intestines
    - gall bladder
    - urinary bladder

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Clinical evaluation of the patients with difficult pain

- Clinician evaluation is critical
- At MSKCC a Pain Service consultation identified a previously undiagnosed etiology for the pain in 64% of 376 referred patients
  - in 36% a new neurological diagnosis
  - in 4% an unsuspected infection
  - substantial proportion of these patients received:

    radiotherapy, surgery or chemotherapy based on the findings of the pain consultant.

Gonzales GR, *et al*. Pain 1991;47(2):141-4.

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Stepwise approach to the management of difficult pain problems

1. Consider the role of primary therapies to address the underlying cause of the pain.
2. Titrate opioids up to maximal tolerated dose.
3. Manage side effects through appropriate drug therapy or by trials of alternative opioids.
4. Consider the role of adjuvant analgesics.
5. Consider regional anesthetic approaches.
6. Consider the role of invasive neuroablative interventions.
7. The use of sedation in the management of refractory pain at the end of life.