Interdisciplinary Cancer Pain and Palliative Care

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Disclosures

- No relevant conflicts of interest to disclose
- No off-label Rx to be discussed
- “The education of the doctor which goes on after he has his degree is, after all, the most important part of his education.” Jim Shaw Billings
Learning Objectives

- Describe the burden of pain and collateral symptoms throughout the spectrum of the cancer experience
- Discuss the confluence of interdisciplinary strategies for cancer patients
- Outline various multimodal treatment approaches including intramodal aspects of each
- Review interdisciplinary care models including physical modalities, psychosocial approaches, integrative (cam) treatments
- Define the evolved current and future model of palliative care
Cancer/Pain Care

- Evolution of cancer care: (Prevention) + Early diagnosis + Personalized treatment → Improved survival and QoL
- Evolution of cancer pain care: WHO 3-step Ladder → 21st century integrative strategies
- Multidisciplinary multimodal management
- Consilience and cancer/pain care
- 1.6 / 0.6 / 14.5+ / 65%↑@5y (NCI. ACS.)
Cancer Pain – Types

- Acute/chronic/persistent/episodic
- Basal/breakthrough
- Nociceptive/neuropathic/inflammatory/mixed
- Pain throughout the cancer experience:
  - Pain at diagnosis
  - Painful diagnostic bx and/or resective surgery
  - Pain due to chemo/radiation
  - Pain due to disease progression/metastasis
  - Pain due to noncancer reasons
  - Painful survivorship
  - Painful end-of-life
Pain Affects Patients Throughout the Disease Experience

Most patients with cancer experience cancer-related pain. Significant pain can be present at any stage of disease, and may be present for long periods of time, even for the duration of disease.

Prevalence of pain in patients with cancer: a systematic review of the past 40 years

- Meta-analysis 54 studies
- Subgroups: prevalence (95% CI)
  - After curative treatment 33% (21%-46%)
  - Advanced metastatic/incurable 64% (58%-69%)
  - All disease stages: 64% (43%-63%)
  - Of those with pain, ≥33% rated as mod-severe

<table>
<thead>
<tr>
<th>Type of cancer</th>
<th>Groups 2–4</th>
<th>No. of reports</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/neck</td>
<td>70% (51% to 88%)</td>
<td>3</td>
<td>95</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>59% (44% to 74%)</td>
<td>9</td>
<td>564</td>
</tr>
<tr>
<td>Lung/bronchus</td>
<td>55% (44% to 67%)</td>
<td>7</td>
<td>1546</td>
</tr>
<tr>
<td>Breast</td>
<td>54% (44% to 64%)</td>
<td>7</td>
<td>420</td>
</tr>
<tr>
<td>Urogenital</td>
<td>52% (40% to 60%)</td>
<td>4</td>
<td>336</td>
</tr>
<tr>
<td>Gynaecological</td>
<td>60% (50% to 71%)</td>
<td>6</td>
<td>372</td>
</tr>
</tbody>
</table>
Cancer Pain – Etiology

- **Disease**
  - Invasion of bone, soft tissues, vascular vessels, hollow organs, or nerves and nervous system

- **Treatment**
  - Chemotherapy-induced peripheral neuropathy
  - Radiation-induced tissue damage
  - Surgery-induced nerve damage and pain syndromes

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### Table 1
Incidence of developing chronic postoperative pain by type of surgery

<table>
<thead>
<tr>
<th>Type of Surgery</th>
<th>Reported Incidence of Chronic Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limb amputation</td>
<td>30–80%</td>
</tr>
<tr>
<td>Thoracotomy</td>
<td>22–70%</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>3–56%</td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>0–37%</td>
</tr>
</tbody>
</table>

Modified from Perkins and Kehlet [9].

### Table 2
Factors which predict chronic pain postoperatively

- **a.** Preoperative factors: chronic preoperative pain >1-month duration; repeated surgery; psychological traits including passive coping skills; worker’s compensation claims
- **b.** Intraoperative factors: type of surgery, risk of nerve trauma
- **c.** Postoperative factors: severe pain poorly controlled; radiation therapy to the area; chemotherapy; anxiety

Modified from Perkins and Kehlet [9].
Components of Pain

- Chronic pain
  - Persistent baseline pain
  - Episodic breakthrough pain (BTP)

- Each component of pain should be independently assessed and managed in context

Cancer Related Pain Amplifiers

↑ Pain Intensity

- Tumor Growth
- Infection
- Ischemia
- Fracture
- Chemical Coping
- Mood Change
- Delirium
- Opioid Tolerance

Patient Related Pain Amplifiers

Bruera
“Total” Pain (Saunders)

- What the patient really has, a sum of
  - Physical pains (often multiple)
  - Psychological issues (eg, anxiety, anger)
  - Social problems (eg, isolation, financial stress, changing interpersonal context)
  - Spiritual (eg, absence of meaning and hope)

- This complexity means
  - There are multiple ways to intervene.
  - Effective teamwork is essential!
Cancer Survivorship

- **Acute:**
  - Dx—treatment completion

- **Extended:**
  - Initial treatment completion—partial/complete remission (with regular follow-up with/without maintenance anticancer therapies)

- **Permanent:**
  - Follows extended phase—low likelihood of recurrence

Symptom Burden Among Cancer Survivors

NHIS QOL survey 1,904 survivors vs 29,000 controls

- Survivors
  - Ongoing pain 34%*
  - Psychologic distress 26%*
  - Insomnia 30%*
  
- Controls
  - 18%
  - 16%
  - 17%

* p < 0.001

Multivariate: Worse symptoms with younger age and more comorbidities

Mao JJ et al. JABFM 2007;20:434-443
Cancer Survivorship Spectrum

Early
- Prevention
  - Clinical Cancer Prevention
  - Epidemiology
  - Symptom Research
  - Pain
  - Symptoms
- Intensive Care
- Internal Medicine
- Genomics
- Toxicity
- Behavioral Science
- Quantitative Sciences

Mid
- Nursing
- Palliative Care
- Emergency Care
- Pediatrics
- Health Disparities

Late
- Rehab Medicine
- Psychiatry
- Adult & Pediatric Survivorship Programs

Survivorship
- Quantitative Sciences
- Behavioral Science
- Genomics
- Health Disparities
- Pediatrics
- Emergency Care
- Palliative Care
- Rehab Medicine
- Psychiatry
- Adult & Pediatric Survivorship Programs
- Genomics
- Toxicity
- Behavioral Science
- Symptom Research
- Epidemiology
- Clinical Cancer Prevention
- Prevention

Cancer Survivorship Spectrum
Pain Treatment Guidelines

- American Academy of Pain Medicine / American Pain Society
- National Comprehensive Cancer Network (NCCN)
- European Society for Medical Oncology (ESMO)
- Agency for Healthcare Research and Quality (AHRQ)
- American Society of Clinical Oncology (ASCO)
- European Association for Palliative Care (EAPC)
- WHO
WHO
3-Step Ladder

By the Ladder

Pain persisting or increasing

Freedom from cancer pain

Pain

(± with or without)

1. Non-opioid ± Adjuvant
2. Weak opioid ± Non-opioid ± Adjuvant
3. Strong opioid ± Non-opioid ± Adjuvant

WHO-8
4-Step Model

Treatment of Cancer Pain

Freedom from cancer pain

Interventional
- Blocks (somatic, sympathetic)
- Spinal medications
- Spinal cord stimulator
- Surgical

Pain persisting or increasing
Opioid for moderate to severe pain
± Non-opioid
± Adjuvant

Pain persisting or increasing
Opioid for mild to moderate pain
± Non-opioid
± Adjuvant

Pain persisting or increasing
Non-opioid
± Adjuvant

Pain
NCCN Guidelines for Adult Cancer Pain (2008)

RESPONSE TO SEVERE, MODERATE, OR INCREASED PAIN WITH SHORT-ACTING OPIOIDS
Monitor for acute and chronic adverse effects. (See Management of Opioid Side Effects PAIN-F)

To quantify pain intensity, see Pain Intensity Rating (PAIN-A)

<table>
<thead>
<tr>
<th>Initial Dose</th>
<th>Subsequent Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 5-15 mg oral immediate-release morphine sulfate or equivalent</td>
<td>Pain score unchanged or increased</td>
</tr>
<tr>
<td>Reassess efficacy and side effects at 60 min</td>
<td>Increase dose by 50-100%</td>
</tr>
<tr>
<td>Calculate previous 24 h total oral requirement and administer 10-20%</td>
<td>Pain score decreased to 0-3</td>
</tr>
<tr>
<td>Taking opioids</td>
<td>Repeat same dose</td>
</tr>
<tr>
<td>Not taking opioids</td>
<td>Reassess at 60 minutes</td>
</tr>
<tr>
<td>Pain ≥ 4 or As clinically indicated for pain crisis</td>
<td>If inadequate response after 2-3 dosing cycles, consider IV titration or comprehensive pain assessment (See PAIN-C)</td>
</tr>
<tr>
<td>Intravenous bolus (peak effect 15 min) administered by healthcare provider or patient-controlled analgesia</td>
<td>24 h follow-up</td>
</tr>
<tr>
<td>Not taking opioids</td>
<td>Calculate total 24 h dose</td>
</tr>
<tr>
<td>Dose 2-5 mg intravenous morphine sulfate or equivalent</td>
<td>Convert to long-acting</td>
</tr>
<tr>
<td>Reassess efficacy and side effects at 15 min</td>
<td>Calculate 10-20% of 24 h</td>
</tr>
<tr>
<td>Calculate previous 24 h total requirement, convert to total IV equivalent and administer 10-20%</td>
<td>Pain score unchanged or increased</td>
</tr>
<tr>
<td>Taking opioids</td>
<td>Increase dose by 50-100%</td>
</tr>
<tr>
<td>Not taking opioids</td>
<td>Pain score decreased to 0-3</td>
</tr>
<tr>
<td>Pain score decreased to 0-3</td>
<td>Repeat same dose</td>
</tr>
<tr>
<td>Reassess in 2-3 h to determine effective dose</td>
<td></td>
</tr>
<tr>
<td>If inadequate response after 2-3 dosing cycles, consider alternate strategy or comprehensive pain assessment (See PAIN-C)</td>
<td></td>
</tr>
<tr>
<td>Reassess at 15 minutes</td>
<td></td>
</tr>
</tbody>
</table>

Subcutaneous can be substituted for intravenous, however subcutaneous route delays onset of effect by up to 30 minutes.

Inadequate response includes insufficient pain relief as well as the presence of adverse effects due to analgesia.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

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21st Century Integrative Paradigm

Education

Psychological Therapy

Spiritual Therapy

Complementary-Alternative Medicine

Education

Neurodestruction

Electrical

Chemical

Neuromodulation

Balanced Analgesic Approach

Opioid Trial

Opioids

Simple Pharmacotherapy / Rational Poly-Pharmacotherapy

Inflammatory Modulation Procedures

Non-Invasive / Invasive Diagnostics

Physical-Manual-Occupational Rehabilitative Modalities

LCDriver adaptation from Daniel Bennett, MD. 2012
Cancer Pain Treatment: Mechanism Based/Personalized

- Medical Assessment (tumor pain? therapy side effect? noncancer pain?)
- Physical exam/indicated studies/differential Dx
- PsychoSocialSpiritual assessment/therapy
- Global impact assessment
- Oral analgesic regimen appropriately dosed for balance
- Functionality optimization
- Radio-/chemo-/surgical therapy as indicated
- Nerve blocks/RFA/neurolytic techniques
- Intraspinal pharmaco/electro neuromodulation
- Frequent reassessment for optimal ongoing outcomes
- Palliative approaches to collateral symptom burden
- Balanced integrative treatment strategies
Chronic Cancer Pain Treatment Strategies

- **Multidisciplinary**
  - Primary care, pain specialist (anes/PMR/neuro), physical medicine, surgeon, psychologist, palliative care, clinical pharmacist, physical therapist, occupational therapist, social worker, chaplain, et al

- **Multimodal**
  - ‘Adjuvant’ medications/topical formulations
  - Procedures/injections/RF/implantables, etc
  - Opioids
  - Integrative “holistic” approaches (ie, massage, meditation, acupuncture/pressure, diet, yoga, etc)
# Potential Barriers to Adequate Pain Management (and Palliative Care) in Cancer Patients

## Related To Healthcare Professionals
- Not primary focus
- “Lower priority” relative to primary oncology care
- Inadequate knowledge of pain management
- Poor assessment of pain
- Concern about regulation of controlled substances
- Fear of patient addiction
- Concern about side effects of analgesics
- Concern about patients becoming tolerant to analgesics

## Related to Patients
- Reluctance to report pain
- Concern about distracting physicians from treatment of underlying disease
- Fear that pain means disease is worse
- Concern about not being a “good” patient vs “complainer”
- Reluctance for fear of addiction (may be more pronounced in minorities)
- Worries about unmanageable side effects
- Poor adherence with the prescribed analgesic regimen
- “Expect cancer to be painful”

## Related to the Healthcare System
- Low priority given to cancer pain treatment
- Inadequate reimbursement
- The most appropriate treatment may not be reimbursed or may be too costly for patients and families
- Restrictive regulation of controlled substances
- Problems of availability of treatment or access to it
- Opioids unavailable in the patient’s pharmacy
- Inexpensive alternatives
- “Overuse → increased costs”
- “Fear of prosecution”

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Cancer Pain Pharmacotherapy

- Cancer therapy
- Opioid analgesics
  - Oral, transmucosal, parenteral, transdermal, neuraxial, ?
- Nonopioid analgesics
  - Acetaminophen/APAP/paracetamol
  - NSAIDs
- Adjuvant analgesics
  - Antidepressants anticonvulsants
  - Local anesthetics capsaicin
  - NMDA antagonists sympatholytic agents calcium channel blockers steroids, bisphosphonates
  - Psychotropics . . .
  - Toxins
  - Cancer therapy
Commonly Prescribed Opioids

- “IR”
  - Regular-Release
    - Morphine
    - Tramadol
    - Tapentadol
    - Oxycodone
    - Oxymorphone
    - Hydromorphone
    - Fentanyl
    - Hydrocodone
    - Codeine
    - Buprenorphine
    - Butorphanol, Nalbuphine

- “ER” (SR, CR, LA)
  - Extended-Release
    - Morphine
    - Tramadol
    - Tapentadol
    - Oxycodone
    - Oxymorphone
    - Hydromorphone
    - Fentanyl
    - Buprenorphine
    - Hydrocodone
    - Methadone
Strategies – Pearls – Questions

- Long (ER) and short acting (RR) opioids
  - Better compliance with ER ???
  - Breakthrough pain/rescue ???
  - Opioid risk assessment ???
- Blended/balanced polypharmacy congruent with pathophysiology
  - Appropriate adjuvant coanalgesics
- Treat constipation et al side effects prophylactically
  - Softeners/polyethylene glycol/methylnaltrexone
- Opioid rotation for side effects/lack of efficacy
- Procedural interventional approaches ???
Methadone

- Dual action: mu-agonist/NMDA antagonist
- Better response for neuropathic pain
- 6-8 h analgesic $\alpha^{-t\frac{1}{2}}, 48-60+$ h elimination $\beta^{-t\frac{1}{2}}$
- Careful dosing because of long $t\frac{1}{2}$. Usual dosing interval 6-12 h
- Difficult titration (up to 1 week to reach steady-state)
- Rotation to or from methadone is challenging
- Dose-response relationship between methadone and other opioids is not linear
- Other long-acting opioids are actually short-acting drugs in a time-release matrix
- Can be very effective in experienced hands.
- Potent. Less tolerance? Cost-effective

Rapid-Onset Fentanyl for Breakthrough Pain or Rescue

- Breakthrough pain in opioid-tolerant cancer patients
- Rapid onset (≈10 minutes)
- Useful in emergency setting as an alternative to IV
- 200 mcg approximately equal to MS 2 mg IV
- No exact equianalgesic conversion. (Start low and titrate to effect)
- Proper administration important!
- OTFC lozenge: 200, 400, 600, 800, 1200, 1600 mcg
- Buccal tablet: 100, 200, 300, 400, 600, 800 mcg
- Mucosal film: 200, 400, 600, 800, 1200 mcg
- Sublingual tablet: 100, 200, 400, 600, 800 mcg
- Nasal spray: 100, 200, 400, 600, 800 mcg
- Sublingual spray: 100, 200, 400, 600, 800, 1200, 1600 mcg
- TIRF REMS and access ???
- $$$$$ and access ???
Opioid Adverse Effects: Usually Dose-Related, Drug-Specific

- **Common**
  - Constipation
  - Dry mouth
  - Nausea, vomiting
  - Sedation
  - Sweating

- **Less common**
  - Respiratory depression
  - Pruritus, urticaria
  - Urinary retention
  - Opioid-induced endocrinopathy
  - Opioid-induced neurotoxicity
Opioid Rotation

- Rationale for opioid rotation
  - Differences in receptor activity, cross-tolerance
  - Different intrinsic activity, metabolites
- Development of intolerable side effects despite adequate analgesia
- Choice of rotation empirical although strong opioids should be rotated with other strong opioids
- Reduce equianalgesic dose by 25%–50% with provisos:
  - Reduce less if pain severe
  - Reduce more if medically frail
  - Reduce fentanyl less
  - Reduce methadone more: 75%–90%

# Opioid Equianalgesic Dose Conversion

<table>
<thead>
<tr>
<th>OPIOID</th>
<th>CONVERSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>0.15</td>
</tr>
<tr>
<td>Fentanyl transdermal (mcg/hr)</td>
<td>2.4</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4</td>
</tr>
<tr>
<td>Methadone</td>
<td>4</td>
</tr>
<tr>
<td>1-20 mg/day</td>
<td>4</td>
</tr>
<tr>
<td>21-40 mg/day</td>
<td>8</td>
</tr>
<tr>
<td>41-60 mg/day</td>
<td>10</td>
</tr>
<tr>
<td>≥61-80 mg/day</td>
<td>12</td>
</tr>
<tr>
<td>Morphine</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>0.4</td>
</tr>
<tr>
<td>Tramadol</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Collateral Opioid Issues and Questions

- Physiologic/psychologic dependence
- Tolerance/pseudotolerance
- Addiction/pseudoaddiction
- Realistic expectations/hope
  - Cure/comfort/care
- Risk evaluation and mitigation strategies
- Legislative and regulatory policies
- $$$$$

???????????????
Prevalence of Opioid Misuse in Cancer

- Lifetime risk of developing cancer in men is slightly less than 1 in 2, and for women a little more than 1 in 3
- 50%-65% pts with cancer will live at least 2 years
- 14.5 million cancer survivors in the US
- Prevalence of cancer pain
  - After curative treatment: 33%
  - Undergoing cancer treatment: 59%
  - Advanced/metastatic/terminal: 64%
- 1/3 patients graded their pain as moderate or severe
- Prevalence of addiction to opioids is 0-7.7% in cancer patients(?)

http://www.cancer.org/research/cancerfactsstatistics/cancerfactsfigures2016/index
Prevalence of Substance Abuse – U.S.

• Almost 35% of the US population has used illicit drugs

• 6%-15% have substance use disorder

• Almost 2 million Americans abused/dependent on prescription opioids in 2014

Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)

CDC Guidelines for Prescribing Opioids for Chronic Pain – 2016

- Recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care

- Patients within the scope of this guideline include cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, and are under cancer surveillance only

- Based upon systematic review of the best available evidence, along with input from experts, and further review and deliberation by a federally chartered advisory committee

- What about active cancer patients with concurrent addiction or history of addiction or chemical coping?
Procedural Interventional Pain Management

- Trigger point injections (myofascial pain)
- Joint injections (joint pain)
- Epidural steroid injections (neck, back pain)
- Nerve root blocks and transforaminal injections (neck, back pain, migraines)
- Spinal facet joint and nerve injections (HA, neck and back pain)
- Sacroiliac joint injections (back, hip pain)
- Peripheral nerve injections (migraines, trigeminal neuralgia, shingles pain, localized pain, postsurgical incisional pain, postsurgical neuropathic pain, localized neuropathic pain, muscle spasms)
- Discography (diagnostic)
- Radio-frequency lesioning (rhizotomy) (neck, back pain)
- Kyphoplasty/vertebroplasty (pathologic vertebral fractures)
- Spinal cord simulation (neck, back, arm, leg pain, or migraines)
- Spinal infusion/spinal pumps (chronic pain)
- Sympathetic blocks (SMPS syndrome, shingles pain)
- Neurolytics of celiac plexus, superior hypogastric plexus, ganglion impar (abdominopelvic pain)
- Surgery
Physical Medicine & Rehabilitation

- PT/OT
- Core strengthening
- Musculoskeletal conditioning: strength and flexibility
- ADL functionality recovery, preservation, enhancement
- Massage therapy
Psycho-Socio-Spiritual Care

- Assessment: diagnostic/prognostic
- Supportive counseling – individual, family, group
- Adaptive coping strategies/motivational interviewing
- Cognitive Behavioral Therapy – CBT
- Proactive behavior therapy
- Biofeedback/neurofeedback
- Mindfulness/self-hypnosis/relaxation/distraction
- Vocational rehabilitation counseling/referral
- Supportive/interventional social work
- Supportive/interventional pastoral care et al spiritual modalities
- Educational intervention
Integrative (CAM) Approaches

- Acupuncture
- Biofeedback
- CAM therapies
- Mind-body approaches
- Mindful meditation/refocus
- Nutrition/diet/vitamins/supplements
- Tai chi
- Yoga
- Massage therapy
- Art/music therapy
Bad Medicine
Percentage of those 12 and older who admit illegal drug use within the previous year

<table>
<thead>
<tr>
<th>Drug</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>10.3%</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>6.1%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2.1%</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>1.5%</td>
</tr>
<tr>
<td>Inhalants</td>
<td>0.8%</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

Note: 2008 data (most recent available)
Source: National Survey on Drug Use and Health
Factors Influencing Pain and Its Relief

- Dynamic patient/disease-related factors
- Evolving clinical scenarios
- Disease progression/humoral factors
- Pain type/mechanism
- Concurrent collateral symptoms
- Personality et al psychological influences
- Sociocultural factors
- Spiritual issues/karma/yin-yang
- Mind-body dynamism
Factors Influencing Pain and Its Relief (cont’d)

- Specific medication issues
- Receptor affinity
- Drug interactions
- Metabolite effects and interactions
- CNS Neuroplasticity
- Pharmacogenetics: polymorphisms (opioid receptors, metabolizing enzymes, etc)
- Epigenetics/transposons
- Other ‘science’ issues
- Tolerance/hyperalgesia
- Rx misuse, abuse, diversion, addiction
Complex Symptom Burden Experienced by Cancer Patients

**Pain**
- Neurasthenia – Fatigue
- Anxiety ↔ Depression

**Dysphagia** - Mucositis
- Lack of appetite – Anorexia – Weight loss – Cachexia
- Nausea... Vomiting... Dehydration
- Constipation... Diarrhea
- Shortness of breath / Dyspnea / Breathlessness
- Drowsiness... Confusion... Agitation... Delirium
Palliative Care = Patient-Centered Care for People Facing Serious & Chronic Illness

Palliative care...

- Focuses on relief from symptoms, pain, and stress
- Improves QOL for both patient and family
- Teams include physicians, nurses and other specialists who work with patient’s doctor to provide an extra layer of support
- Appropriate at any age and any stage in a serious illness and can be provided concurrent with curative treatment
- Delivers value to people, providers, and systems by improving care quality and efficiency and reducing costs
How We Define Palliative Care Matters

- Palliative care is about improving quality of life, providing an extra layer of support, and having a team focus to patient care.

- Palliative care is about helping both the family as well as the patient with serious illness.

- Differentiate from hospice or EOL care
  (Avoid defining palliative care by what it is NOT)
Palliative care is person-centered, family-focused care that provides a patient with relief from the symptoms, pain, and stress of serious illness; is provided by a team that provides an additional layer of support; and is appropriate for a patient of any age and at any stage of a serious illness.

Growing evidence shows that palliative care can reduce medical costs in addition to helping a patient recover from a serious illness more quickly and easily.
Multidisciplinary Multitargeted Multimodal Treatment is the Key to Successful Pain and Symptom Management in the Cancer Patient!

Cancer pain et al symptoms may impact QoL

A. During active treatment of tumor
B. During or after therapy as a lingering side-effect of the disease or treatment
C. By exacerbation from disease, patient, or other factors
D. As a component of a bio-psycho-social-spiritual-mind/body milieu
E. All of the above
Pain and palliative care for cancer patients should be

A. Patient-centered to improve QoL by relieving pain and symptom burden and distress
B. Provided by a multidisciplinary supportive team
C. Appropriate at any stage of illness/disease and not limited to hospice or end of life care
D. Provided parallel to curative efforts
E. All of the above
“Pain is a more terrible lord of mankind than even death itself.”

Albert Schweitzer

Cure sometimes –

Comfort and Care always