1

Disclosures

- I have no financial relationships to disclose
  - I have a contract with BC Cancer as the Pain and Symptom Management and Palliative Care Physician
  - I am also a LEAP facilitator with Pallium (a Not-for-profit Organization) and am paid an honorarium for that.
- I have no biases to disclose

2

Outline

1. Disclaimer RE: the term "Cancer Pain"
2. Introduce the principles of pain management for patients with cancer.
3. A Case review:
   a. Starting
   b. Education
   c. Risk Mitigating Prescribing
   d. Managing S/Es
   e. Following-up
   f. Adjuvants
   g. Rotating
   h. Converting
4. Quick notes on specific opioids
5. Financial Coverage
6. To answer any and all symptom management and/or palliative questions you may have. (Time-allowing.)

3

Disclaimer

- Lets talk first about what we mean by "**Cancer Pain**"…

College of Physicians and Surgeons of British Columbia

PRACTICE STANDARD

Preamble

This document is a practice standard of the Board of the College of Physicians and Surge of British Columbia.

College's position

Opioids and sedative medications have high-risk profiles. Historically, prescribing these medications has contributed to the rise in people living with substance use disorder (SUI

The profession has a collective ethical responsibility to mitigate its contribution to problematic prescription medication use, particularly the over-prescribing of opioids anc sedatives. The fundamental purpose of this standard is **primary prevention** of overdose addiction, and other harms of the use of opioids and sedatives. Registrants are expected follow the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, which is complementary to, and should be read in conjunction with, this standard.

This standard does not apply to active cancer care, palliative care, and managemen substance use disorders. Registrants are expected to follow relevant clinical guidelines

Practice Guideline > MMWR Recomm Rep. 2022 Nov 4;71(3):1-95.

doi: 10.15585/mmwr.rr7103a1.

CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022

Deborah Dowell, Kathleen R Ragan, Christopher M Jones, Grant T Baldwin, Roger Chou

PMID: 36327391 PMCID: PMC9639433 DOI: 10.15585/mmwr.rr7103a1

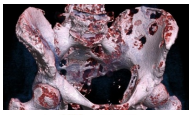
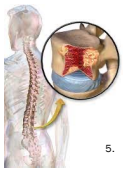
Free PMC article

Abstract

This guideline provides recommendations for clinicians providing pain care, including those prescribing opioids, for outpatients aged ≥18 years. It updates the CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016 (MMWR Recomm Rep 2016;65[No. RR-1]:1-49) and includes recommendations for managing acute (duration of <1 month), subacute (duration of 1–3 months), and chronic (duration of >3 months) pain. The recommendations do not apply to pain related to sickle cell disease or cancer or to patients receiving palliative or end-of-life care. The

4

POLL #1: What do we mean by Cancer Pain?

1. 
2. 
3. 
4. 
5. 

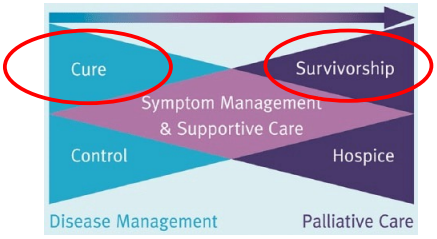
5

POLL #2: Why is Cancer Pain treated differently?

1. More/better research data establishing the safety and efficacy of opioids for long term cancer pain vs long term Chronic Non-Cancer Pain.
2. Cancer generally hurts more than other pain syndromes.
3. Patients with cancer are more morally deserving of pain relief than others.
4. There is something unique about the cause of pain in cancer that makes it reasonably more likely to respond well to opioids long-term than other syndromes.
5. Patients with cancer are assumed to be terminally ill.

6

Bow Tie Model of Palliative Care



7

Patients with cancer are assumed to be terminally ill…

Benefits:

- Decreased pain intensity
- Improved function
- Improved quality of life (QOL)

Table 4 Long-Term Risks of Opioids

Opioid overdose	Can potentially be fatal. Increase in deaths reported
Respiratory problems	May cause or worsen sleep apnea
Physical dependence	Suddenly stopping the medication can cause withdrawal symptoms
Opioid-induced hyperalgesia	Makes the pain worse, especially at higher doses
Drowsiness	Potentially causes falls and broken bones
Constipation	Causes abdominal discomfort
Low testosterone	Leads to low energy, depression, and low sex drive
Low estrogen and progesterone	Increase risk of osteoporosis, infertility, low sex drive

References: 1, 16.

8

POLL #3: Do you feel more comfortable treating:

1. Cancer Pain (“*pain from active tissue damage”, usually assuming a shorter prognosis*)
2. Non-Cancer Chronic Pain (*more “neuropathic pain with components of central sensitization”, usually assuming a longer prognosis.*)
3. I don’t feel very comfortable treating pain

9

How much do we learn about Pain in School?

TABLE 2

Average total hours for designated mandatory formal content by discipline*

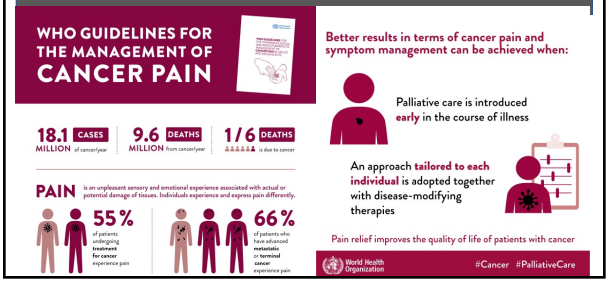
Faculty or department	Site responses, n	Total hours, mean ± SD	Range	Mean student, n*
Dentistry	5	15±10	0–24	47
Medicine	9	16±11	0–38	133
Nursing	9	31±42	0–109	133
Occupational therapy	3	28±25	0–48	47
Pharmacy	5	13±13	2–33	123
Physical therapy	7	41±16	18–69	55
Veterinary medicine	4	87±98	27–200	66

*Outlier of 20 h at the University of Toronto Centre for the Study of Pain Interfaculty Pain Curriculum was excluded; only additional hours for this site were included

Watt-Watson J, et al. A survey of prelicensure pain curricula in health science faculties in Canadian universities. Pain Res Manag. 2009 Nov-Dec;14(6):439-44. doi: 10.1155/2009/307932. PMID: 20011714; PMCID: PMC2807771.

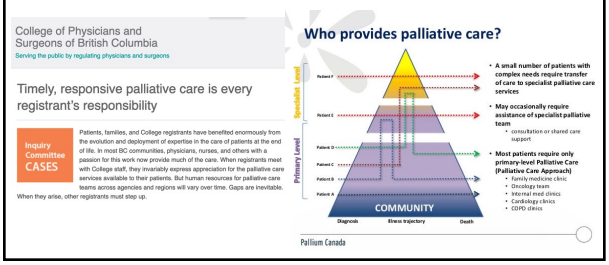
10

How applicable is this to my practice?:



11

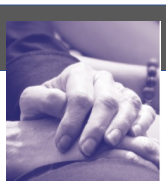
How applicable is this to my practice?:



12

BC CANCER

Pain & Symptom Management

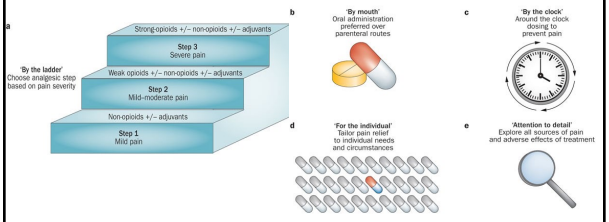


Our clinics help improve the quality of life for individuals living with cancer and for their caregivers.

http://www.bccancer.bc.ca/our-services/services/pain-symptom-management

13

WHO Principles of Pain Management in Cancer



14

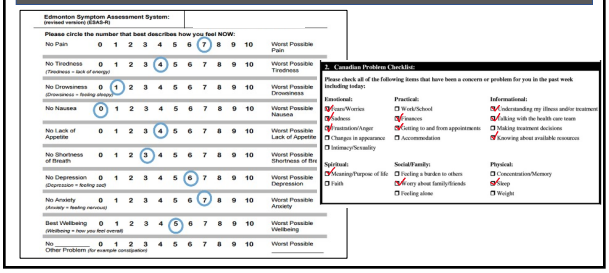
CASE

- 70 yo man with a recent Dx of NSCLC.
- Starting Chemo and RT for this soon.
- Now presents with: new Pain in R hip and low back.
  - Started 4 weeks ago, getting worse
  - Hip: 6-7/10 -> 8/10 (wt bearing), back: 2/10
  - Has been using Acetaminophen and rest and heat -> not working
  - Caring him to feel a lot of anxiety and fear and preventing him from walking (which he previously enjoyed a lot)
- XR and bone scan confirm: lytic lesion R prox femur and smaller lytic lesion L1
- All other blood work is normal. No other significant PMHx.

15

ESAS

POLL #4: Do you use a standardized screening tool for symptoms in your patients with cancer? Or who are receiving a palliative approach to care? YES or NO?



Edmonton Symptom Assessment System: (revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	(7)	8	9	10	Worst Possible Pain
No Tiredness (Tiredness = lack of energy)	0	1	2	3	(4)	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness (Drowsiness = feeling sleepy)	0	(1)	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	(0)	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	(4)	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	(3)	4	5	6	7	8	9	10	Worst Possible Shortness of Bre
No Depression (Depression = feeling sad)	0	1	2	3	4	5	(6)	7	8	9	10	Worst Possible Depression
No Anxiety (Anxiety = feeling nervous)	0	1	2	3	4	5	6	(7)	8	9	10	Worst Possible Anxiety
Best Wellbeing (Wellbeing = how you feel overall)	0	1	2	3	4	(5)	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem (for example constipation)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

2. Canadian Problem Checklist:

Please check all of the following items that have been a concern or problem for you in the past week including today:

Emotional:	Practical:	Informational:
☑ Fears/Worries	☐ Work/School	☑ Understanding my illness and/or treatment
☑ Sadness	☑ Finances	☑ Talking with the health care team
☑ Frustration/Anger	☑ Getting to and from appointments	☐ Making treatment decisions
☐ Changes in appearance	☐ Accommodation	☑ Knowing about available resources
☐ Intimacy/Sexuality		
Spiritual:	**Social/Family:**	**Physical:**
☑ Meaning/Purpose of life	☐ Feeling a burden to others	☐ Concentration/Memory
☐ Faith	☑ Worry about family/friends	☑ Sleep
	☐ Feeling alone	☐ Weight

16

Starting

- **POLL #5**: What medication would you like to start this patient on for first line treatment of his pain?
  - Hydromorphone 0.5mg po q4h regular + 0.5mg q1h prn
  - Morphine 5mg po q4h prn
  - Morphine 2.5mg po q4h regular + 2.5mg po q1h prn
  - Hydromorphone 1mg po q1h prn

17

Educating

- What are some things we should discuss with the patient when starting opioids?:
  - Screen for risk of Opioid Use Disorder
  - Address concerns/fears
  - Safety: Diving, do not share meds
  - Side effects
  - Keep pain diary and track prn use
  - Discuss BT Pain and when to use prns, and when to call (>3BTs/d)
  - Non-pharmacologic modalities of pain control
- F/U in a few days max (over the phone is fine)

18

Risk of Opioid Misuse or Abuse

General safe prescribing tips for everyone:
- Single prescriber, single pharmacy
- Blister pack all regular meds
- Limit prn availability
- Small quantity prescribing or partial dispensing

If High Risk, mitigate risk by:
- Opioid Contracts
- Smaller dosing amounts and frequency (med dispensing machines, daily dispensing or DWI)
- Limit prn dosing (use prn blister pack)
- UDS (for misuse of other substances and ensuring no diversion of Rx'ed med)
- Monitor closely
- Interdisciplinary approach, using Addictions Medicine also

Opioid Risk Tool

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

19

Article Text
Article Info
Citation Tools
Share
Rapid Responses
Article metrics

Original research

PDF
PDF + Supplementary Material

Opioid safety recommendations in adult palliative medicine: a North American Delphi expert consensus

Jenny Lau [1, 2], Paolo Mazzotta [2, 3], Ciara Whelan [2, 3], Mohamed Abdelaal [1, 4], Hance Clarke [5, 6], Andrea D Furlan [7, 8, 9, 10], Andrew Smith [10, 11, 12], Amna Husain [2, 3], Robin Fainsinger [13], David Hui [14], Nadiya Sunderji [15, 16] and Camilla Zimmermann [1, 4, 17]

Correspondence to Dr Paolo Mazzotta, Temmy Latner Centre for Palliative Care, Sinai Health System, Toronto, Ontario, Canada; pmazzotta1@gmail.com; Dr Jenny Lau, Division of Palliative Care, Department of Supportive Care, Princess Margaret Cancer Centre, Toronto, Ontario, Canada; jenny.lau@uhn.ca

Abstract

Objectives Despite the escalating public health emergency related to opioid-related deaths in Canada and the USA, opioids are essential for palliative care (PC) symptom management.

Opioid safety is the prevention, identification and management of opioid-related harms. The Delphi technique was used to develop expert consensus recommendations about how to promote opioid safety in adults receiving PC in Canada and the USA.

20

Managing S/Es: Nausea and Constipation

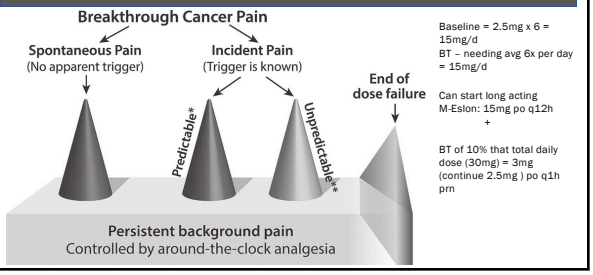
First Line Antiemetic for opioid-related nausea:
- Metoclopramide 5-10mg po q4h
  OR
- Haldol 0.5mg po q4h prn

Bowel Protocol:
- Sennakot 36mg po qhs regular
- Increase to sennakot 36mg po BID if no BM x 1 day
- Add lactulose 15-30mL po daily (during the day not qhs) if not BM x 2 days

- (PEG is not covered by Palliative Care Benefits (Plan P))…

21

Following Up: Breakthrough, Incident, and End-of-Dose-Failure Pain



Baseline = 2.5mg x 6 = 15mg/d
BT – needing avg 6x per day = 15mg/d

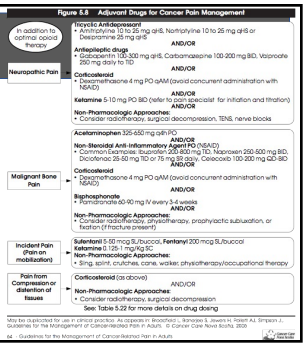
Can start long acting
M-Eslon: 15mg po q12h
+

BT of 10% that total daily dose (30mg) = 3mg (continue 2.5mg) po q1h prn

22

Adding in Adjuvants

- Including:
  - Non-pharmacologic (radiation, surgery, nerve blocks, PT, OT, etc.)
  - Compounded Topical Analgesic Creams or Mouth Rinses (morphine, methadone, ketamine, gabapentin, lidocaine, etc.)
  - Sufentanil (for incident pain)
- Dexamethasone:
  - DO NOT give past noon as it increases the risk of insomnia
  - It is long acting and only needs to be dosed once a day qAM



23

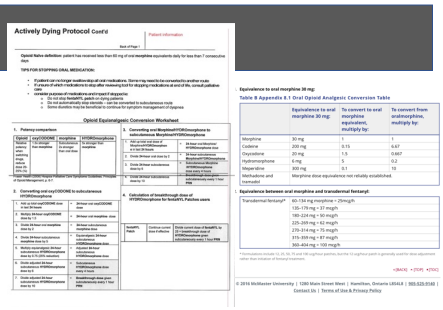
Converting to SUBQ or IV

- Conversions:
  - Don't forget SubQ hydromorphone or morphine is **2x the potency** of oral

24

Rotating

- Opioid Rotations:
  - Use the tables
  - Minus 20-30% after the calculation
  - Use a pharmacist to help you!


Actively Dying Protocol Cont'd

Opioid Equianalgesic Conversion Worksheet

Table 8 Appendix 8.1 Oral Opioid Analgesic Conversion Table

	Equivalence to oral morphine 30 mg:	To convert to oral morphine equivalent, multiply by:	To convert from oralmorphine, multiply by:
Morphine	30 mg	1	1
Codeine	200 mg	0.15	6.67
Oxycodone	20 mg	1.5	0.667
Hydromorphone	6 mg	5	0.2
Meperidine	300 mg	0.1	10
Methadone and tramadol	Morphine dose equivalence not reliably established.		

Equivalence between oral morphine and transdermal fentanyl:

Transdermal fentanyl*	60-134 mg morphine = 25mg/h
	135–179 mg = 37 mg/h
	180–224 mg = 50 mg/h
	225–269 mg = 62 mg/h
	270–314 mg = 75 mg/h
	315–359 mg = 87 mg/h
	360–404 mg = 100 mg/h

25

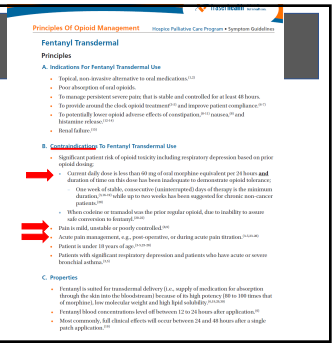
Opioid neurotoxicity vs. Opioid overdose

Opioid Neurotoxicity	Opioid Overdose
More common Presentation – Myoclonus – Hallucinations – Agitation – Somnolence – Cognitive dysfunction – Hyperalgesia, allodynia **Treatment** – Reduce opioid dose – Switch opioid – Hydrate	**Less common Presentation** – Miosis – Respiratory depression – Loss of consciousness **Treatment** – Depends on severity – If mild to moderate: hold next opioid dose and reduce dose – If severe, naloxone

26

Quick Note on Fentanyl

6. Fentanyl patch
   - should not be used in a acute or not-controlled pain.
   - It is CONTRAINDICATED


Principles Of Opioid Management — Hospice Palliative Care Program • Symptom Guidelines

Fentanyl Transdermal

Principles

A. Indications For Fentanyl Transdermal Use

- Topical, non-invasive alternative to oral medications.[1,2]
- Poor absorption of oral opioids.
- To manage persistent severe pain; that is stable and controlled for at least 48 hours.
- To provide around the clock opioid treatment[3,4] and improve patient compliance.[4-7]
- To potentially lower opioid adverse effects of constipation,[8,9] nausea,[9] and histamine release.[1,2,4,5]
- Renal failure.[3,5]

B. Contraindications To Fentanyl Transdermal Use

- Significant patient risk of opioid toxicity including respiratory depression based on prior opioid dosing:
  - Current daily dose is less than 60 mg of oral morphine equivalent per 24 hours; **and** duration of time on this dose has been inadequate to demonstrate opioid tolerance;
    - One week of stable, consecutive (uninterrupted) days of therapy is the minimum duration,[3,10,11] while up to two weeks has been suggested for chronic non-cancer patients.[10]
  - When codeine or tramadol was the prior regular opioid, due to inability to assure safe conversion to fentanyl.[3,10,11]
- Pain is mild, unstable or poorly controlled.[4,6]
- Acute pain management, e.g., post-operative, or during acute pain titration.[3,4,11,12]
- Patient is under 18 years of age.[3,4,11,12]
- Patients with significant respiratory depression and patients who have acute or severe bronchial asthma.[3,11]

C. Properties

- Fentanyl is suited for transdermal delivery [i.e., supply of medication for absorption through the skin into the bloodstream] because of its high potency [80 to 100 times that of morphine], low molecular weight and high lipid solubility.[3,13,14]
- Fentanyl blood concentrations level off between 12 to 24 hours after application.[4]
- Most commonly, full clinical effects will occur between 24 and 48 hours after a single patch application.[3,6]

27

Quick Note on Methadone

Methadone for Analgesia

Physicians with limited experience with the use of methadone for analgesia are strongly encouraged to consult with an experienced colleague before starting a patient on methadone. It is not recommended to initiate methadone in patients who are considered opioid-naïve (no prior exposure to, or intermittent use of, opioids), except in certain palliative or end-of-life care situations.

To prescribe methadone for analgesia, physicians must use the regular duplicate prescription pad. To prescribe methadone for opioid use disorder, physicians must use the methadone controlled prescription pad. Please ensure timely ordering of prescription pads in order to maintain continuity of care for patients.

Methadone for Pain in Palliative Care

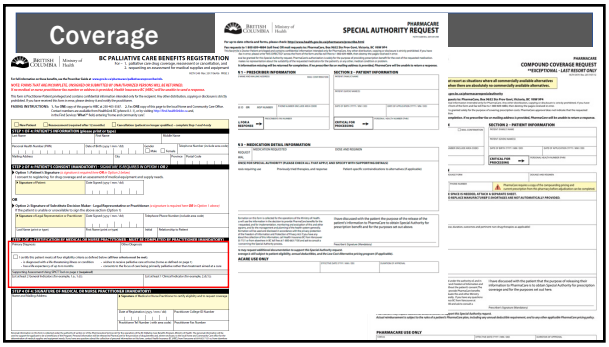
Methadone4Pain.ca is a series of three education modules for physicians, nurses and pharmacists seeking to improve their knowledge in prescribing and managing patients prescribed methadone for pain in palliative care.

Continuing Professional Education Credits

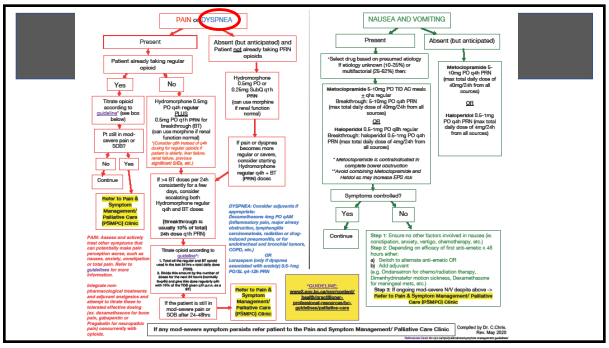
- College of Family Physicians of Canada for up to 2 Mainpro+ credits
- Royal College of Physicians and Surgeons Accredited Group Learning Activity (Section 1)

28

Coverage



29



30

Symptom Management Resources

- PDF of the algorithms for Pain, Nausea, Dyspnea
- B .C. Inter-professional Palliative Symptom Management Guidelines, 2017: https://www.bc-cpc.ca/cpc/symptom-management-guidelines/
- Fraser Health Hospice Palliative Care Symptom Guidelines: https://www.fraserhealth.ca/employees/clinical-resources/hospice-palliative-care#.XCAD_M17nIU
- BC Guidelines.ca, Palliative Care: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/palliative-care
- Opioid Safety Recommendations in Adult Palliative Medicine. Summary Version: https://archive.cspcp.ca/opioid-safety-recommendations-in-adult-palliative-medicine/
- **Pallium Canada: https://pallium.ca/**
  - LEAP Courses
  - Pallium Handbook
- **Virtual Hospice: http://www.virtualhospice.ca**
  - KidsGrief.ca, MyGrief.ca and lots of other bereavement support
  - Patient handouts on symptoms, goals of care, etc.
  - Practice tools and videos for physicians
  - http://www.methadone4pain.ca/

Questions?

31