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Pancreatic Cancer: Symptom Assessment and Management

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Background

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- Often advanced at diagnosis.
- Prognosis is poor for locally advanced (33% 1 year survival) and advanced (9% 1 year survival) cancer.[1]
- HIGH symptom burden: pain, nausea, diarrhoea/constipation, fatigue.
- Few lines of palliative treatment options and those that there are come with side effects.

Its difficult to preserve quality of life alongside prolonging quantity of life.

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General Principles

- Its easier to manage symptoms if you start early - if a person has symptoms prior to starting chemotherapy they are definitely going to have symptoms with it.
- Involve AHPs from the start: dietitians, physio, OT, prehab, psychological support.
- Involve patients in decision making re: chemotherapy. Not everyone wants it but its easy to get swept along.
- Identify sources of urgent support - 98.3% of patients with pancreatic cancer have an unplanned admission to hospital in the last year of life (average is 2.57 admissions per patient). Our safety nets aren't working.[2]

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Pain

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Case Example

Geoffrey has been diagnosed with pancreatic cancer with local lymph node involvement and liver metastases and comes to see you with pain.

He has pain in his back and upper abdomen.

On closer questioning these pains seem to be the same pain and feel like a ‘tight band’ all the way around.

He described it as a fairly constant dull ache.

The pain is worse after eating and relieved to some extent by rubbing his back and heat packs.

He is not nauseas and his bowels are working regularly although he is avoiding eating very much because of the pain it causes.

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What kind of pain is this?

1. Nociceptive
2. Neuropathic
3. Bone
4. Psychogenic/ total pain

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Types of Pain

Nociceptive

- Somatic - caused by activation of pain receptors in skin or muscle. Usually well localised and sharp if at the skin level or aching if in the muscle. E.g. post-surgical pain.
- Visceral - caused by stretch of pain receptors surrounding body cavities. Usually dull and severe and poorly localised. E.g. Liver capsule pain.

Neuropathic - caused by damage to nerves (either by compression, infiltration or chemicals). Usually pain is sharp, burning, stinging or shooting. Can be extremely severe and often needs specific types of analgesic. E.g. sciatica.

Bone - caused by activation of pain receptors in and surrounding the bone. Typically pain is dull but well localised, and worsened by movement. E.g. bone metastases.

Psychogenic (total) - psychological distress can cause severe generalised pain, or worsen an existing pain beyond the severity of the cause. Does not respond well to medications, and requires a holistic approach to management.

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Mixed Pain Aetiology.

Nociceptive - Liver, nodal, local inflammation from tumour (this is the dull epigastric ache)

Neuropathic - radiating in tight band, relieved by heat and rubbing.

Bone? Unlikely but if the spine is tender then worth considering.

Psychogenic/total pain - everyone experiences pain in different ways. The psychological experience of pain is not proportionate to displayed anxiety.

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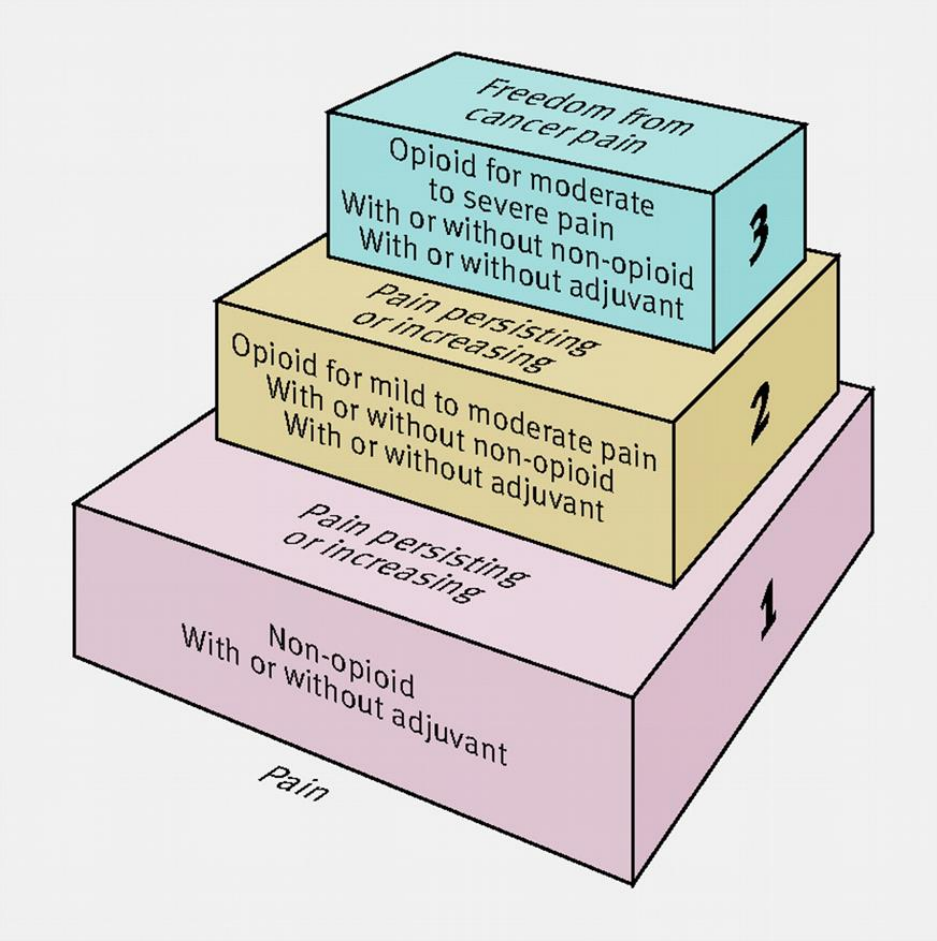
So Let's Treat it!

What's this[3]?



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So in this case…

Nociceptive - paracetamol, NSAID, opioid, dexamethasone.

Neuropathic - pregabalin/gabapentin, amitriptyline.

Psychogenic/total pain - amitriptyline, SSRI, psychosocial support.

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Strong Opioids

Morphine MR 5mg bd and/or morphine sulphate oral solution 2.5-5mg prn 2 hourly

Or (depending on renal function)

Oxycodone MR 5mg bd and/or oxynorm liquid 2.5-5mg prn 2 hourly.

Aim is to maintain pain control with ≤2 prns in every 24 hours. If more than 2 prn doses taken, increase the background dose.

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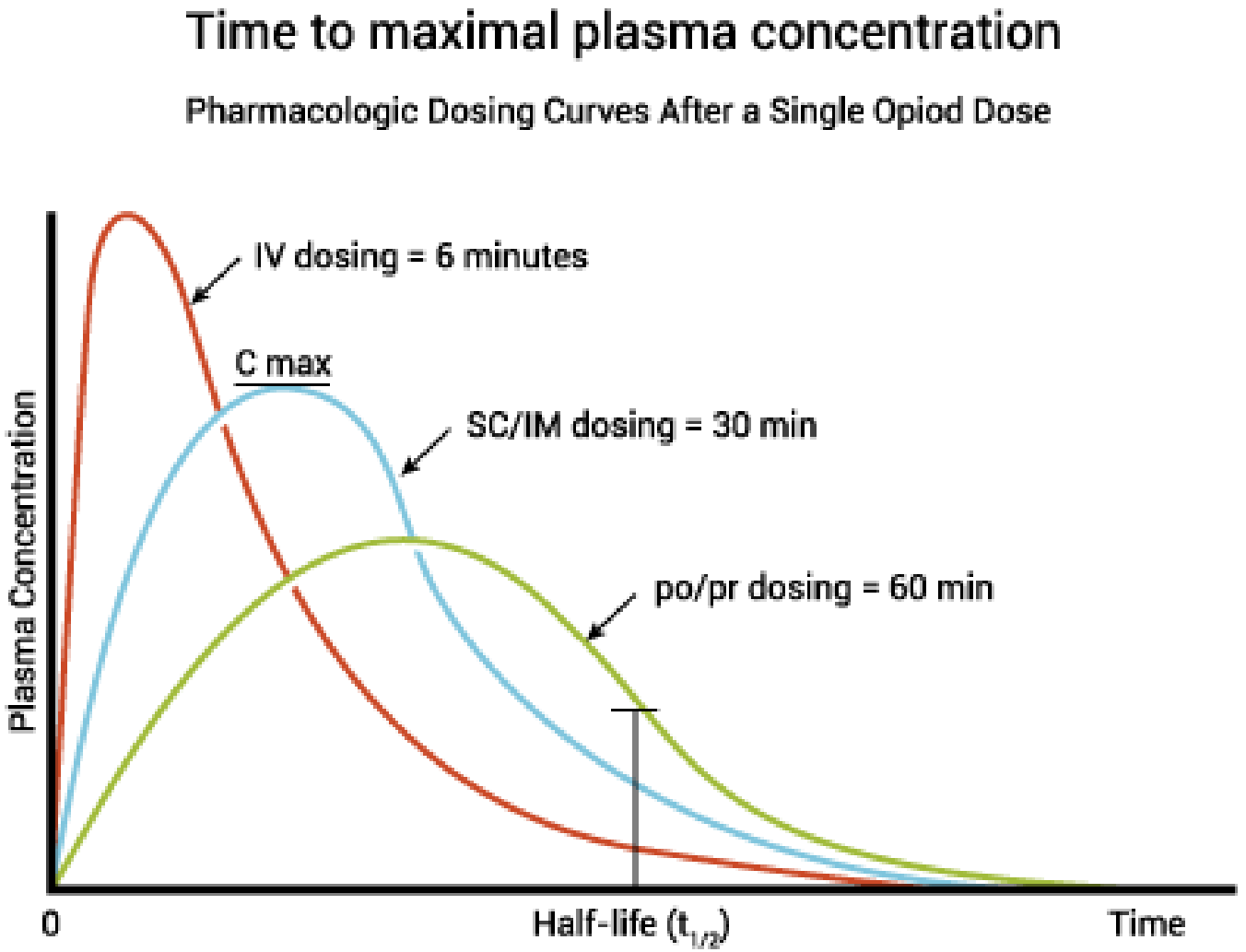
2 hourly PRNs[4]?



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Neuropathic Agents

Pregabalin 25mg bd, titrate every 3 days

(I know the BNF says 75mg bd to start with, them kids are CRAZY!)

Gabapentin 100mg tds, titrate every 3 days.

Amitriptyline 10-20mg nocte, titrate every 7 days.

Consider a “dexamethasone bridge”.

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Interventional Approaches

Local pain clinic opinion can be helpful - often the earlier the better.

Coeliac plexus blocks in some centres are done by gastroenterology via endoscopy.

These don’t tend to be permanent.

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Fatigue

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Cancer Causes Fatigue….

…but so does everything else.

Yes there are treatments which will help, but we need to exclude amenable factors first.

Amenable Factors

- Diet / nutrition
- Mobility / exercise
- Anaemia
- Infection
- Sleep hygiene (ask about bladders!!)
- Metabolic disturbances (calcium, sodium, B12, folate)
- Pain
- Anxiety +/- depression
- Endocrine - thyroid, adrenal
- Drugs - chemo, opioids, gabapentinoids, **antihypertensives, oral hypoglycaemics**

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If no amenable factors

Non Pharmacological:

- Physiotherapy guided exercise programme (aerobic exercise)[5]
- Dieticians - fortified nutrition
- Educational Interventions[6]
- Yoga

Pharmacological:

- Dexamethasone 8mg od, wean to stop in 10-14 days[7]
- Megestrol acetate 160mg od- avoid if history of VTE
- Fluoxetine 20mg od (some centres prefer mirtazapine)
- No evidence for psychostimulants

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Nausea

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Nausea

- Second most common symptom in cancer (behind pain).
- MASCC says use metoclopramide based on the limited evidence available.[8]
- Its not a bad shout - often pancreatic cancer comes with early satiety so metoclopramide is helpful.
- BUT prokinetics can give you diarrhoea…

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A likely familiar list of things that cause diarrhoea

- Malabsorption
- Chemo (irinotecan particularly)
- GI Inflammation (due to chemo, steroids, bacterial overgrowth)
- Pancreatic cancers

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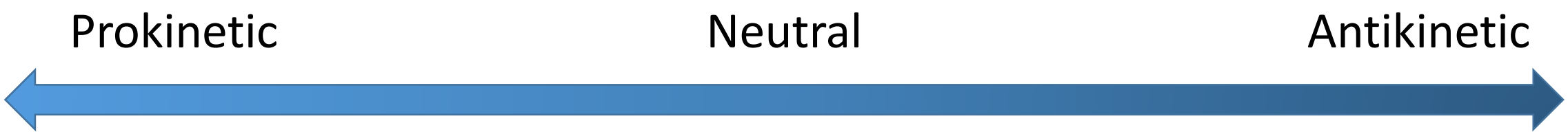
So *sometimes* bowels dictate antiemetic choice



Metoclopramide 10mg tds

OR

Domperidone 10mg tds

Cyclizine 50mg tds +/- Haloperidol 1-1.5mg nocte

OR

Levomepromazine 6mg bd

Ondansetron 4mg tds-qds

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However, a not unusual presentation might be:

Nausea which is low level and constant. No appetite but if the patient forces themselves to eat it can make the nausea worse or they feel ‘bloated’ as if the food just sits there. This isn’t so bad in the morning but gets worse as the day goes on. Occasional vomiting produces undigested food. Often accompanied by constipation and acid reflux.

This is GI dysmotility. Metoclopramide is the answer (and possibly dexamethasone).

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Constipation

Constipation (in the palliative setting)

Definition

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Non drug options to treat amenable factors

- Oral intake - 30g fibre a day, 1.5L fluid (OR jellies/ice cream etc)
- Mobility
- Privacy
- Posture / equipment aids

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After that…

Let’s Play Laxative Roulette!

What’s your favourite laxative?

Senna
Magrocol
Laxido
Docusate
Lactulose
Co-danthramer
Naloxegol
Magnesium Hydroxide

Fybogel
Phosphate enemas
Bisacodyl

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What Does the Evidence Tell us (so far)?

Senna	
Docusate	
Lactulose	
Movicol	
Co-Danthramer	
Magnesium Hydroxide	
Naloxegol	
Suppositories	

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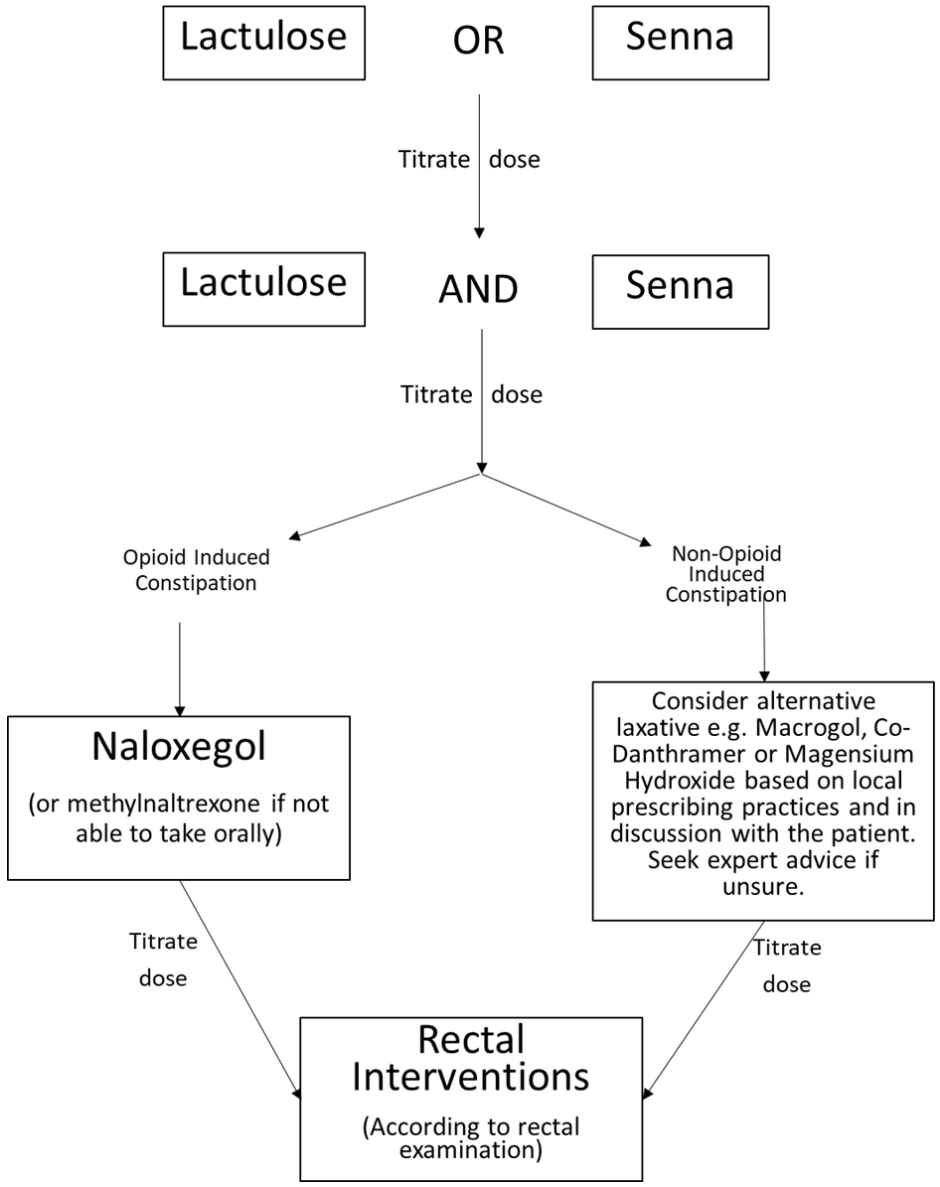
An ‘evidence based’ protocol[9]



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Summary

- Pancreatic cancer pain is mixed - don’t rely on opioids alone and use adjuvants early.
- Consider interventional pain approaches to supplement meds.
- Fatigue management is more in the management of amenable factors than wonder drugs - dexamethasone will work but it’ll be brief.
- Alternative drugs for fatigue like fluoxetine and megestrol are less evidence based but some patients find them effective.
- Metoclopramide is 1st line for nausea and vomiting but don’t forget your bowels.
- Constipation is what the patient says it is. Senna and/or lactulose are a good start for this in the palliative setting.

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Thank you

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