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# What is pain within pancreatic cancer?

## The impacts it can have on its patients

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# Case study

- Ellen
- Advanced metastatic pancreatic cancer
- Complex pain

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# Ellen

- Married
- Mother
- Daughter & sister
- Teacher
- Activities outside of home
- Faith
- Low in mood & feels hopeless

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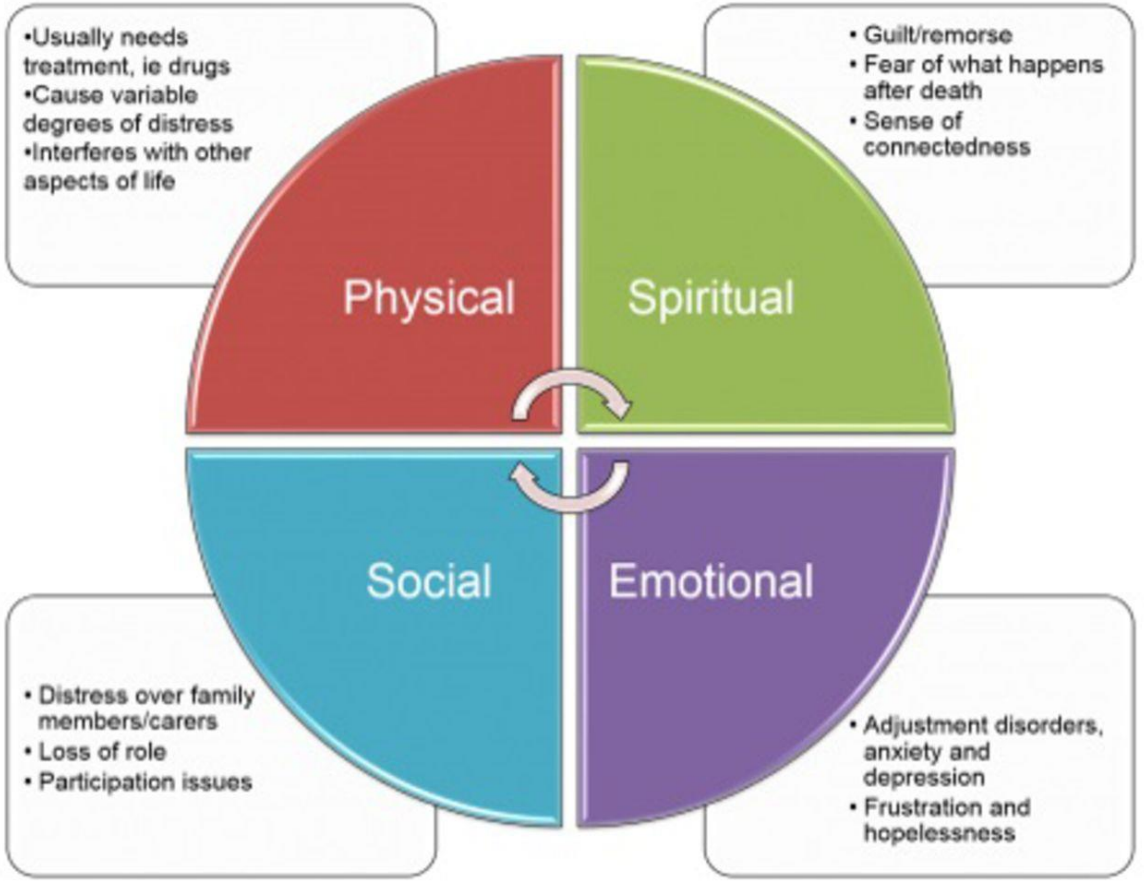
# Total Pain Concept



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# Types and Causes of Pain in Pancreatic Cancer

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Consultant in Palliative Medicine, The Clatterbridge Cancer Centre
National Clinical Lead for Enhanced Supportive Care, UKASCC

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# Pancreatic Cancer

- Often advanced at diagnosis
- Pain is a common feature
- Pain often better controlled if you manage it early
- But the type of pain changes over time and often combinations of approaches are needed to effectively manage pain rather than 1 single approach

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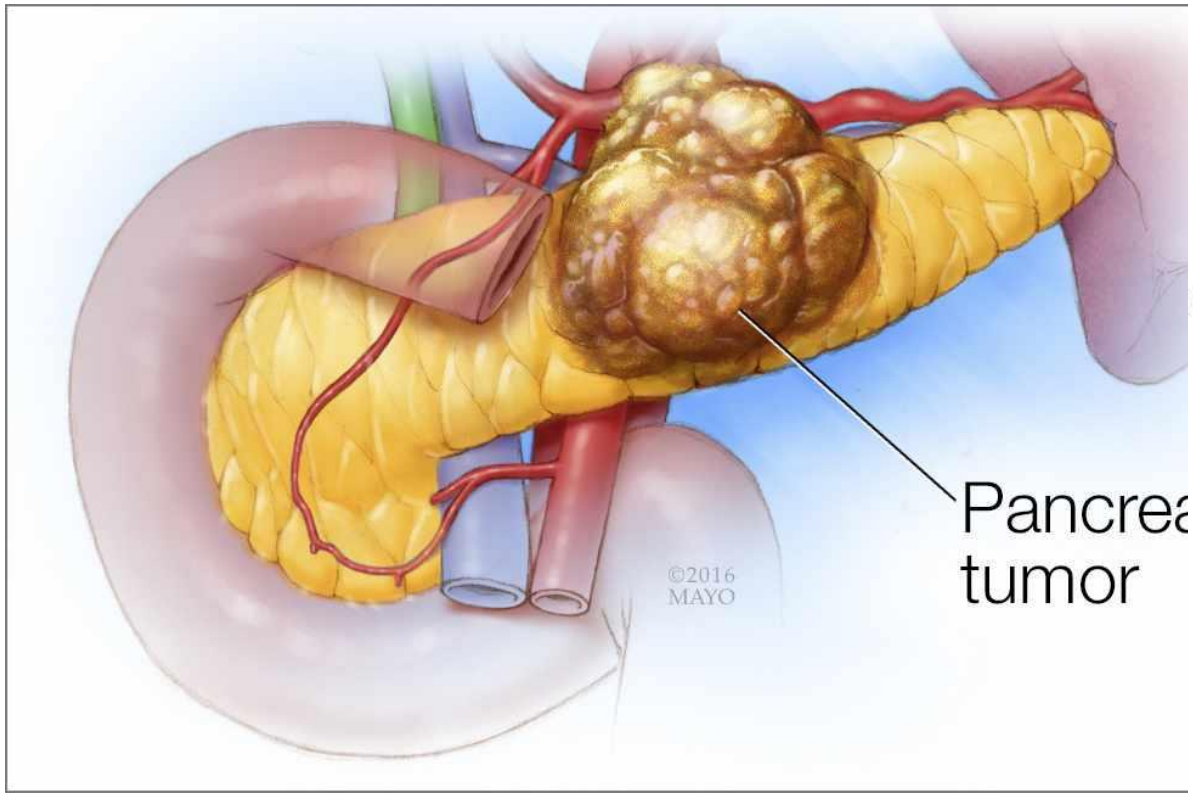
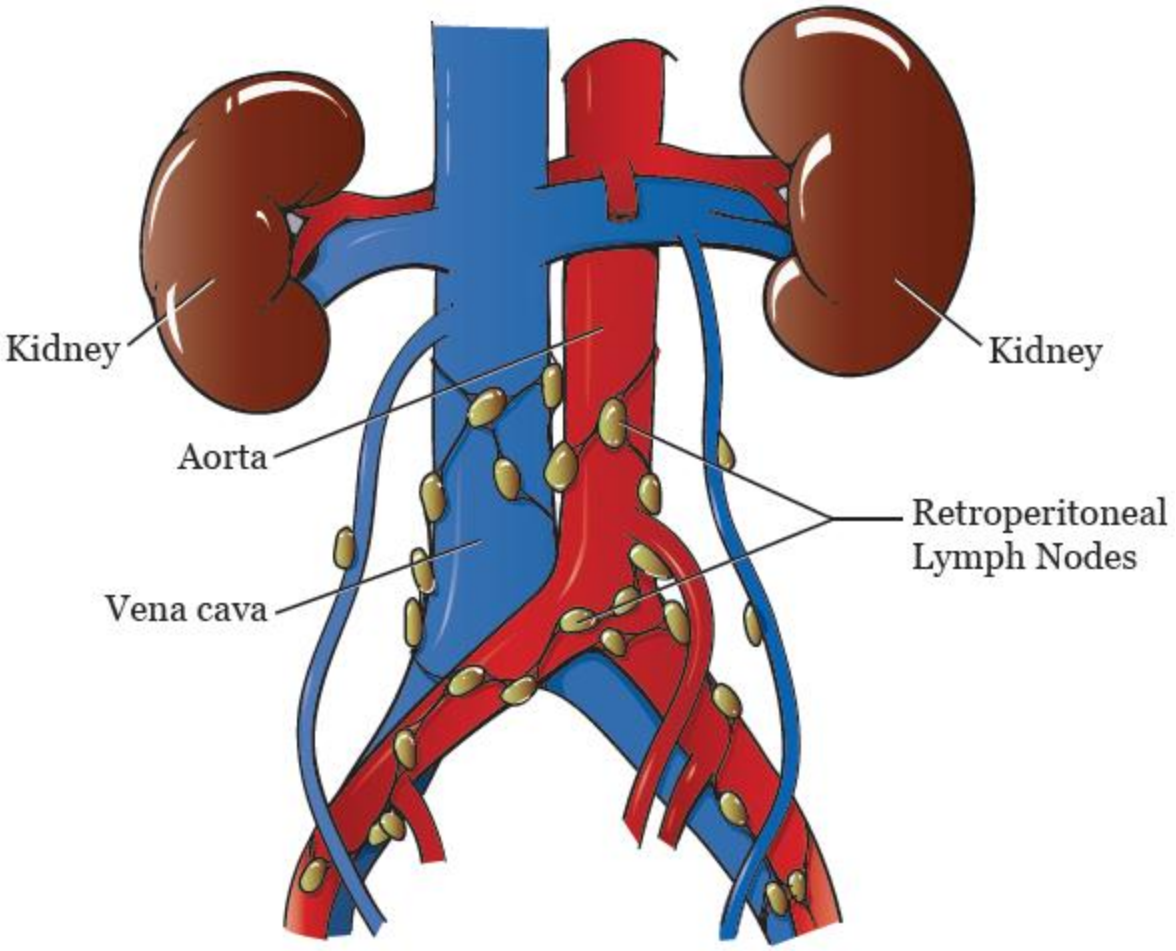
# Why is it so complicated?



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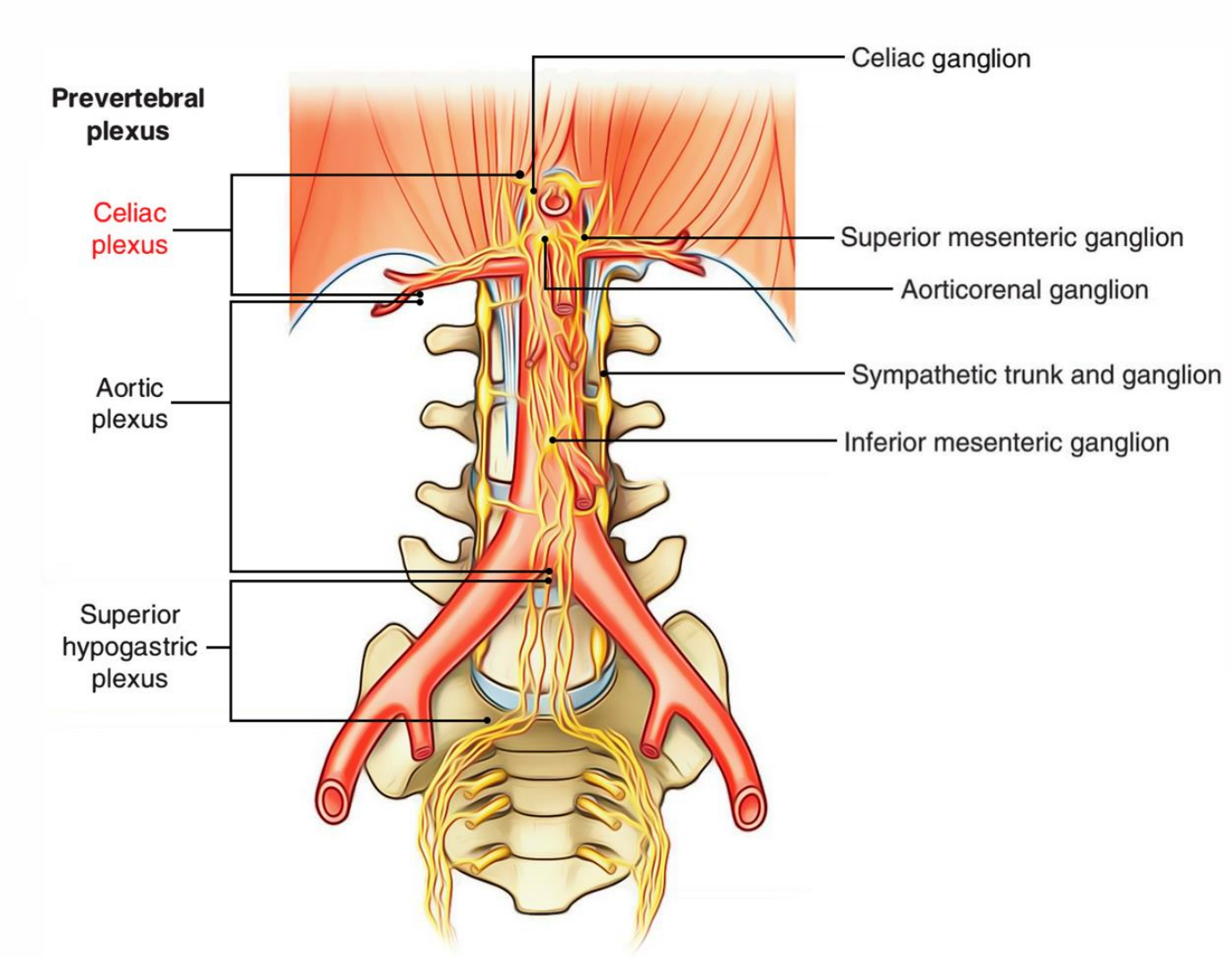

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# Metastatic sites

- Liver
- Lymph nodes
- Bones

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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 also has pain in his right upper quadrant when he takes a deep breath or bends over to tie his shoes.

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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.

**Psychological (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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# Pancreatic Cancer

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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# But there are other pains as well for these people

Chemotherapy induced peripheral neuropathy

Constipation/digestive pain and cramp

Psychological distress leads to worse pain

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# Summary

Pancreatic cancer pain is tricky because of the anatomy

Visceral, nociceptive, neuropathic elements are all present combined with psychological influence

The treatments cause pain also requiring distinct management

We will talk about how to manage all of these types of pain…

But first we will take a break

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# Take a Break

See you in 5!

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# How to assess pain?

## Who is responsible for managing it?

Sinead Benson

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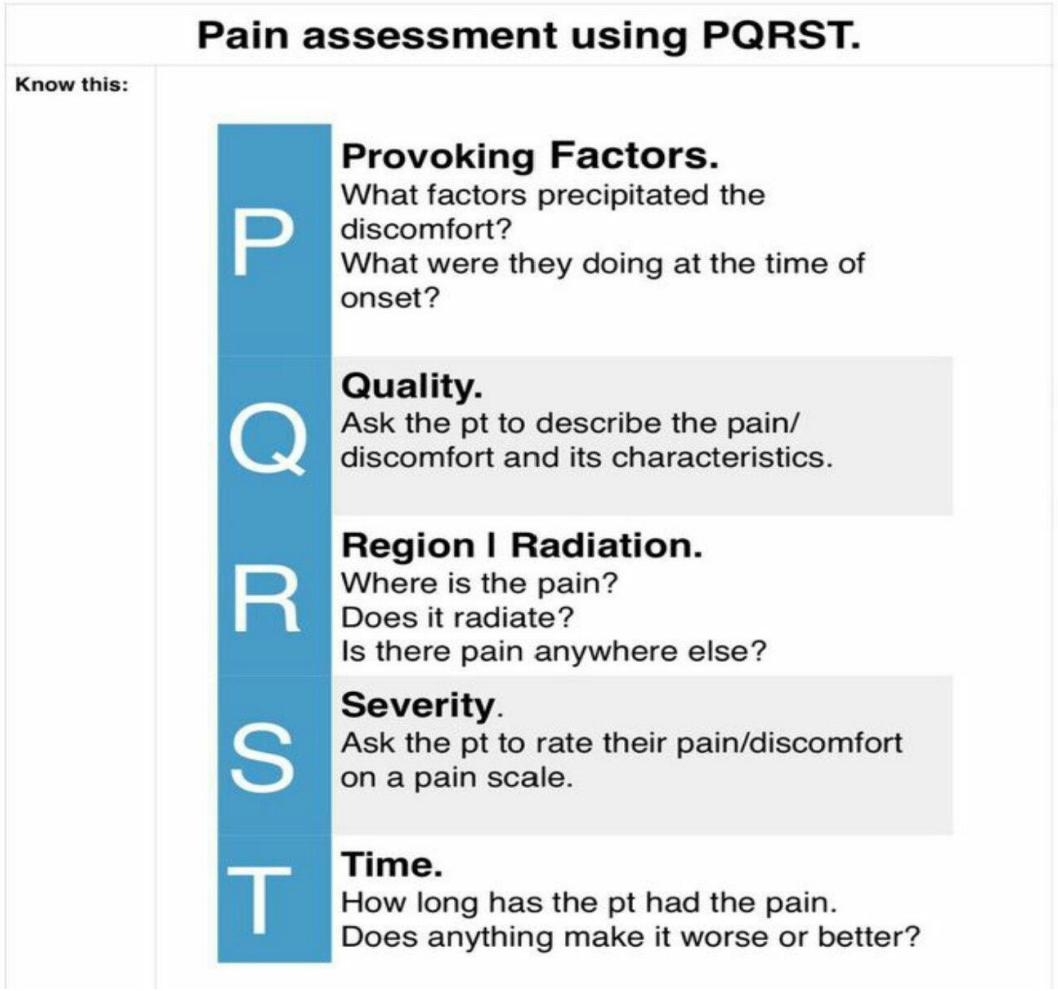
# Pain Assessment



**Pain assessment using PQRST.**

Know this:

**P** — **Provoking Factors.**
What factors precipitated the discomfort?
What were they doing at the time of onset?

**Q** — **Quality.**
Ask the pt to describe the pain/ discomfort and its characteristics.

**R** — **Region I Radiation.**
Where is the pain?
Does it radiate?
Is there pain anywhere else?

**S** — **Severity**.
Ask the pt to rate their pain/discomfort on a pain scale.

**T** — **Time.**
How long has the pt had the pain.
Does anything make it worse or better?

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# Provoking Factors

- What were you doing when the pain started?
- What caused/ trigger it?
- What makes it better or worse?

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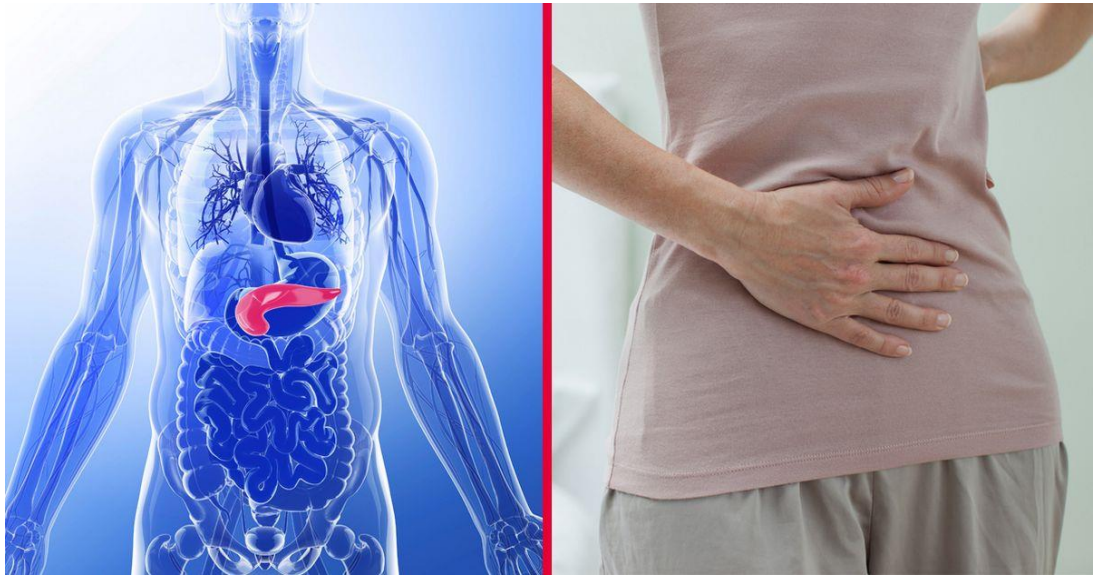
# Quality



What does it feel like?

Can you describe the pain?

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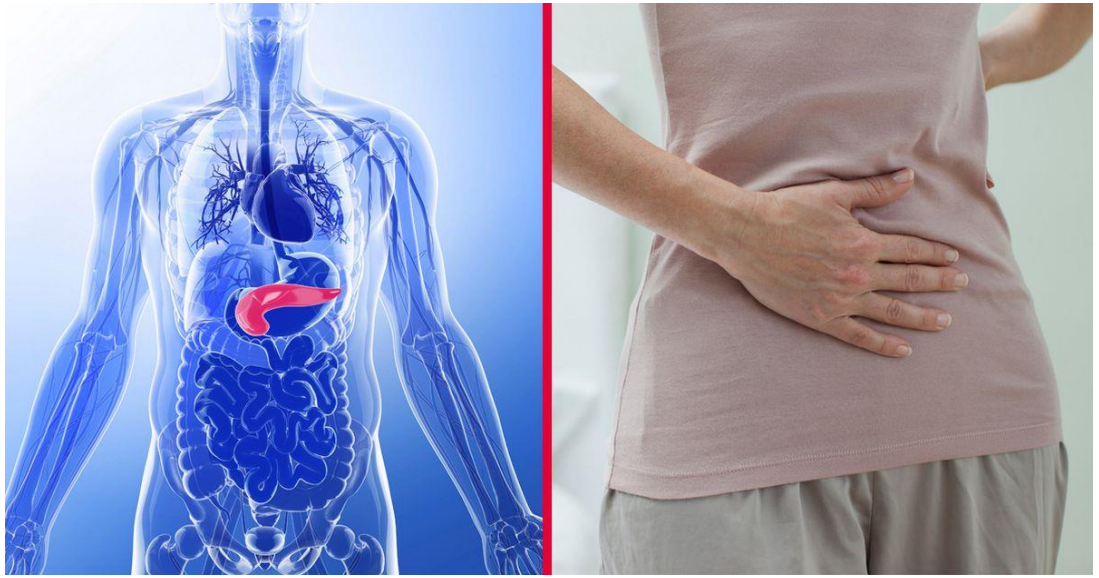
# Region/ Radiation



Where is the pain located?

Does the pain radiate?

Does it feel like it travels around?

It is localised to one area?

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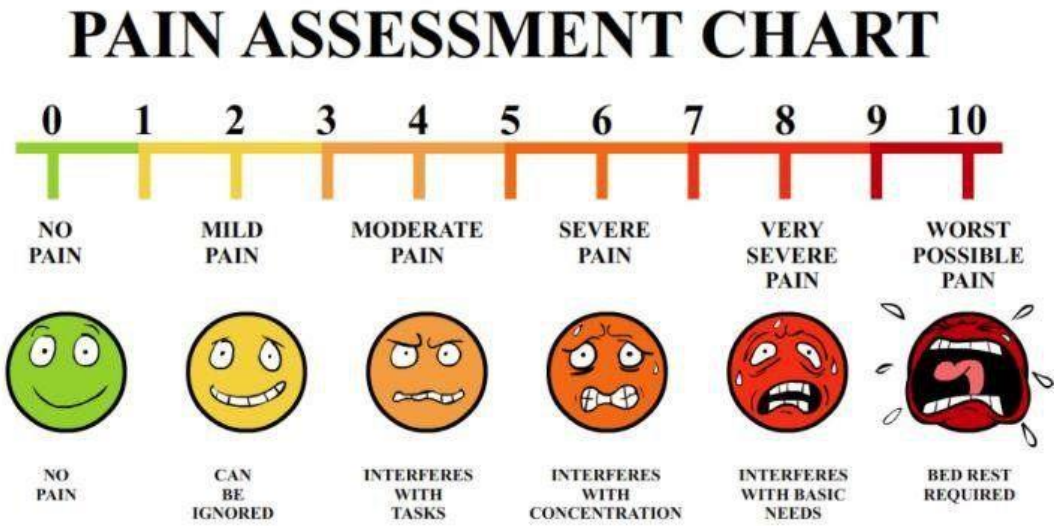
# Severity

- Use a tool that is appropriate
- Score pain at each assessment
- How bad is it at its worst?
- How long does each episode last?
- How does it interfere with activities?



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# Time

- When/ at what time did the pain start?
- How long does each episode last?
- How often does it occur?
- Is it sudden or gradual?
- Does it interrupt sleep?
- Is it ever accompanied by any other symptoms?

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# Who is responsible for management?

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# Treatment Methods for Pain in Pancreatic Cancer

Dan Monnery

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# Pancreatic Cancer

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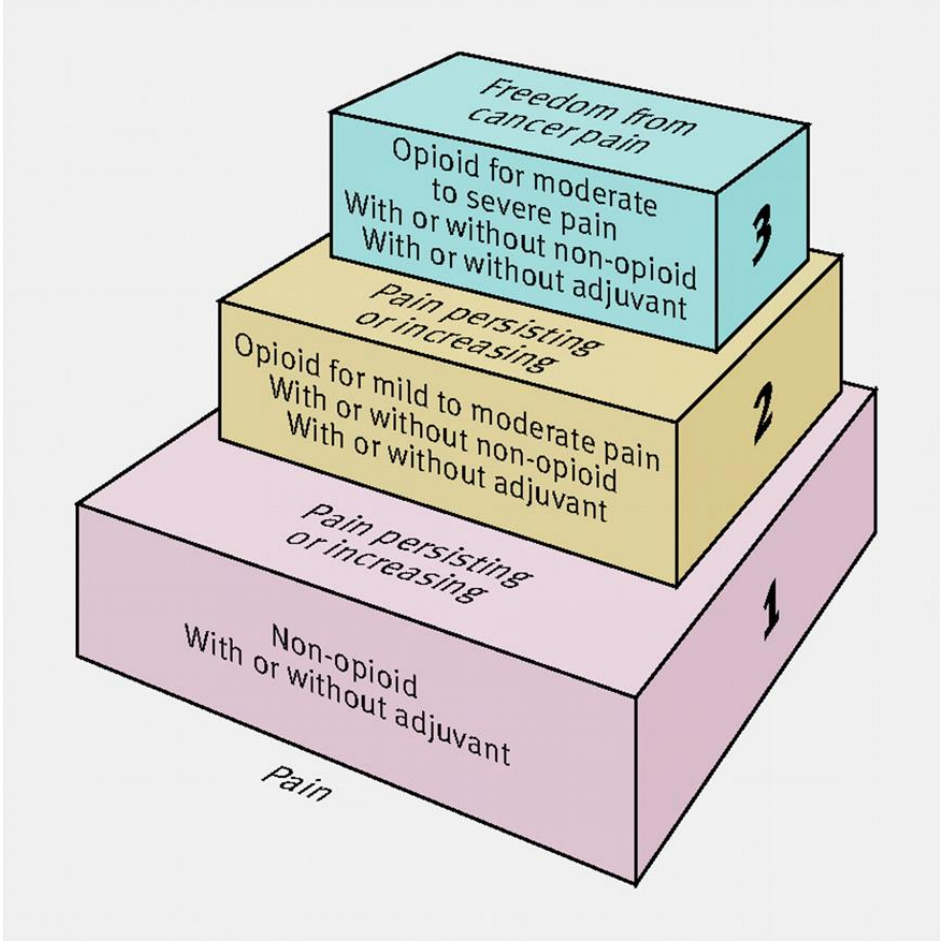
# So Let's Treat it!

# What's this?



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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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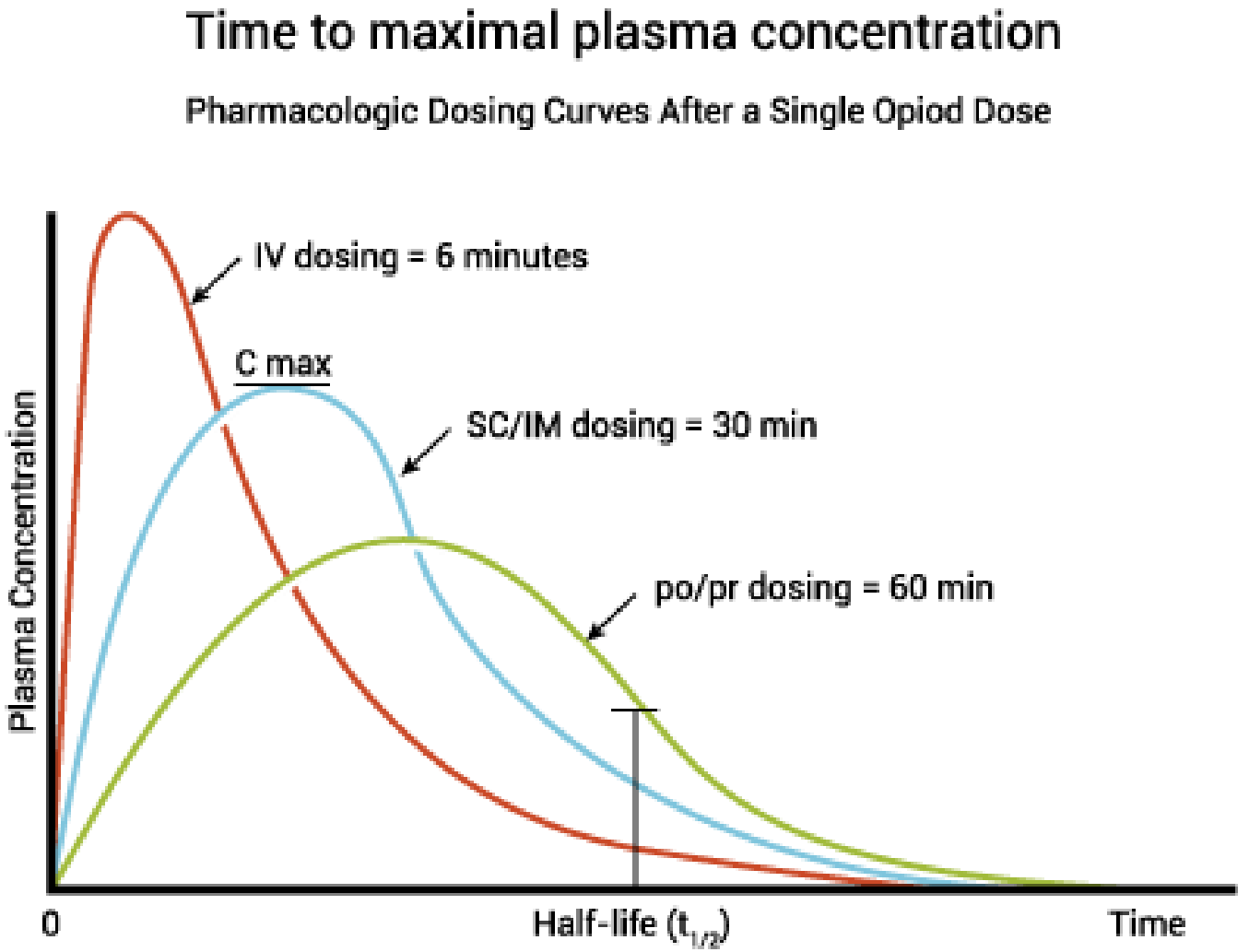
# 2 hourly PRNs?



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# Neuropathic Agents

Pregabalin 25mg bd, titrate every 3 days

(I know the BNF says 75mg bd to start with, that's too much!)

Gabapentin 100mg tds, titrate every 3 days.

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

Consider a "dexamethasone bridge".

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# Anti-inflammatories (NSAIDs)

They do have a role- remember tumours and metastases are naturally inflammatory and secrete pro-inflammatory mediators

Blocking the production and reception of these can help pain

But what to choose?

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# NSAIDs

Depends on the least worst side effects for your patient

Naproxen causes least fluid retention so is my first choice

BUT certain situations dictate other choices:

- Bleeding- COX2 inhibitor
- Clotting- Ibuprofen
- Bleeding AND Clotting- Nabumetone
- Non oral route- diclofenac or ketorolac

Keep an eye on kidneys

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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.

Other options include spinal anaesthesia from local pain clinics

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# Lets not forget psychological perspective

Psychology impacts pain- both in generating it and in allowing (or preventing) the person responding to it.

Communicate clearly and sensitively

Consider social support

Deal with added stressors- work, finances, carer burden

Find peer support

Use psycho-oncology services as needed

Consider antidepressants

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# Other approaches

Heat and cold- heat helps neuropathic pain, cold helps inflammatory pain

Complementary therapies- often available through hospices

TENS

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# But remember the other pains we discussed?

<u>Chemotherapy induced peripheral neuropathy</u>

Neuropathic agents, exercise, physiotherapy and OT, topical creams (capsaicin or menthol)

<u>Constipation/digestive pain and cramp</u>

Correct PERT, appropriate laxatives if needed.

For colic without constipation hyoscine butylbromide and sometimes stronger anticholinergics e.g. glycopyrronium oral solution

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# Summary

Pancreatic cancer pain is a mixed pain, it requires a mixed methods approach of pharmacological and non-pharmacological

There is better success in small doses of multiple complementary medications than big doses of one or two in my opinion

Remember the influence of psychology on pain. Look for it and manage it

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# Thank you

Time for Questions

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