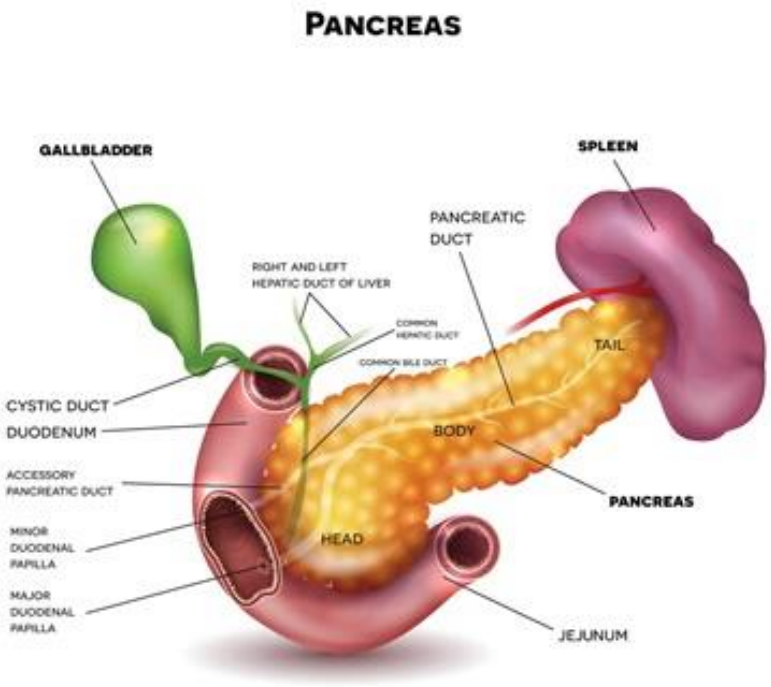
Pain in the pancreas patient – a brief overview

Rosie Hull Upper Gastrointestinal CNS



Assessment

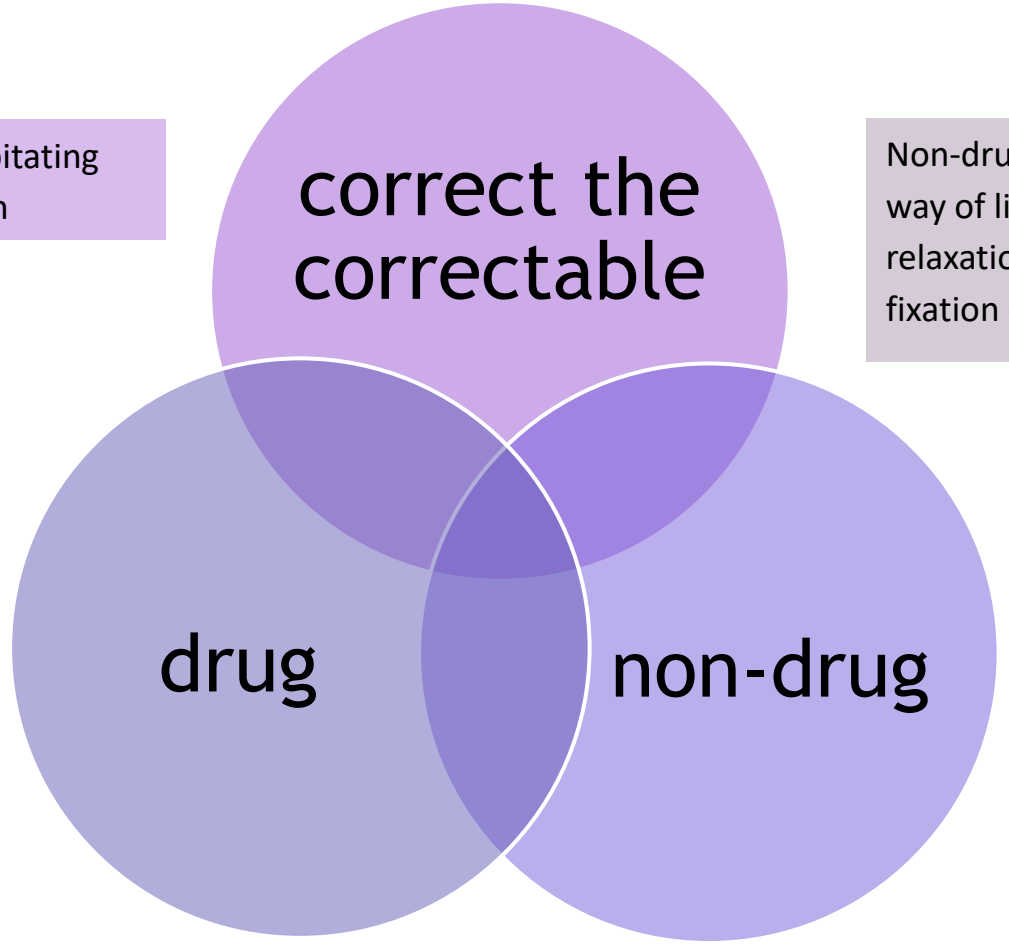
Always ask: what does the pain mean to you? What do you think is causing it? How does the pain make you feel?

This will also help you develop an understanding of the patients' knowledge on their disease and could help discuss difficult conversations.

Pain Assessment Model

S	**Site**	Where exactly is the pain?
O	**Onset**	What were they doing when the pain started?
C	**Character**	What does the pain feel like?
R	**Radiates**	Does the pain go anywhere else?
A	**Associated symptoms**	e.g. nausea/vomiting
T	**Time/duration**	How long have they had the pain?
E	**Exacerbating/ relieving factors**	Does anything make the pain better or worse?
S	**Severity**	Obtain an initial pain score

Correctable – SACT, tx precipitating factors ie cough/constipation



Non-drug – position, modification to way of life and environment, relaxation therapies, surgery i.e fixation of bone

Drug – relieve background pain using WHO ladder, px 'rescue' analgesia e.g fast acting, LT opioid –titrate against efficacy and tolerance, spinal analgesia

Types of pain

Background pain

Breakthrough pain

Nociceptive pain

Neuropathic pain

Visceral

Somatic

Bone pain

Total pain

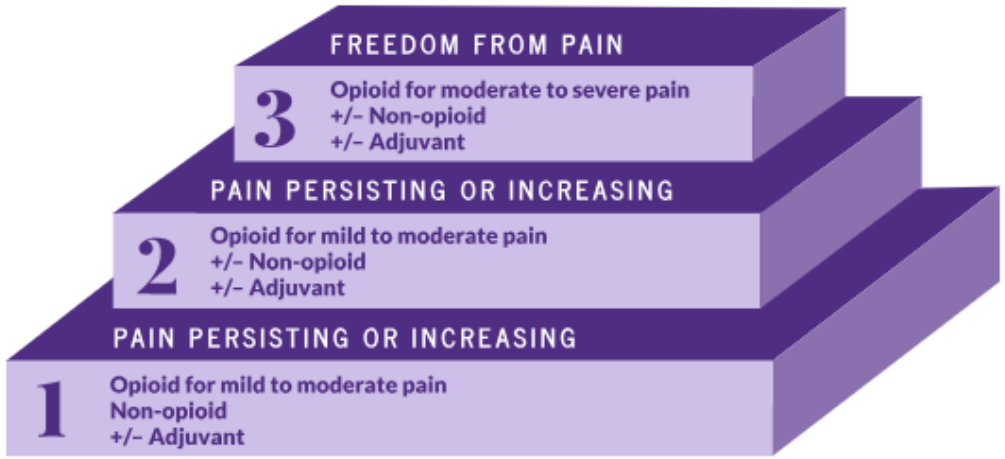
Topical pain

Case Study

- Background: 67 year old male, performance status 2, pmh: HTN, GORD
- Diagnosis: pancreas adenocarcinoma in tail of pancreas with multiple liver metastases, due to start first cycle palliative chemotherapy in 7 days
- Current medication: co-codamol 30/500mg QDS, lansoprazole 30mg OD, ramipril, Creon 25,000 units TDS with meals NKDA
- Symptoms:
  -constant dull ache abdomen, gradually worsening for 3 weeks
  -sharp stabbing in upper right abdomen radiating to shoulder blade
- no nausea or vomiting, BNO 3/7, reduced appetite, no other symptoms reported
- Social: lives with wife, expecting first grandchild in 2 months

Poll – What type of pain could he be suffering? (more than 1 correct answer)

- A Topical pain
- B Neuropathic pain
- C Visceral pain
- D Bone pain
- E Total pain
- F Background pain
- G Breakthrough pain



Plan:

- Stop – co/codamol 30/500mg
- Prescribed:
- QDS paracetamol 1g
- Zomorph 10mg BD
- morphine sulphate 5mg/2.5ml PRN
- Dexamethasone 8mg 5 days, then titrate by 2mg every 3 days

- Additional:
- Offered holistic needs assessment – time to talk about other concerns.
- Telephone follow up 4 days

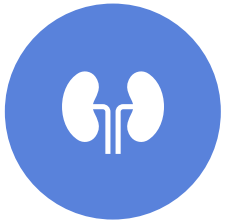
Take home points

SOCRATES - A CLEAR ASSESSMENT OF THE PATIENT TO GUIDE MANAGEMENT

DIFFERENT PAIN REQUIRES DIFFERENT MEDICATION

START WITH THE BASICS AND WORK UP

TREAT HOLISTICALLY WITH PATIENT FOCUS



PANCREATIC CANCER IS COMPLEX – DON'T BE AFRAID TO REFER ON!!

Malignant ascites in the pancreatic patient

Rosie Hull Upper Gastrointestinal CNS

Poll – what is your general understanding of ascites? (no right answer)

- No understanding - never heard of ascites before
- Limited understanding - have heard of it but not much else
- General understanding - know what it is and how to identify
- Good understanding - how to identify and a bit about how to treat
- Great understanding - feel really confident about the treatment and management of ascites

What is ascites?

Ascites is the pathological accumulation of fluid in the peritoneal cavity

Most commonly associated with chronic liver disease (85%) and malignancy (10%) (others include CCF and TB)

Graded:

1 or Mild- only detectable via USS

2 or Moderate- causing moderate distension

3 or Large- causing marked distension

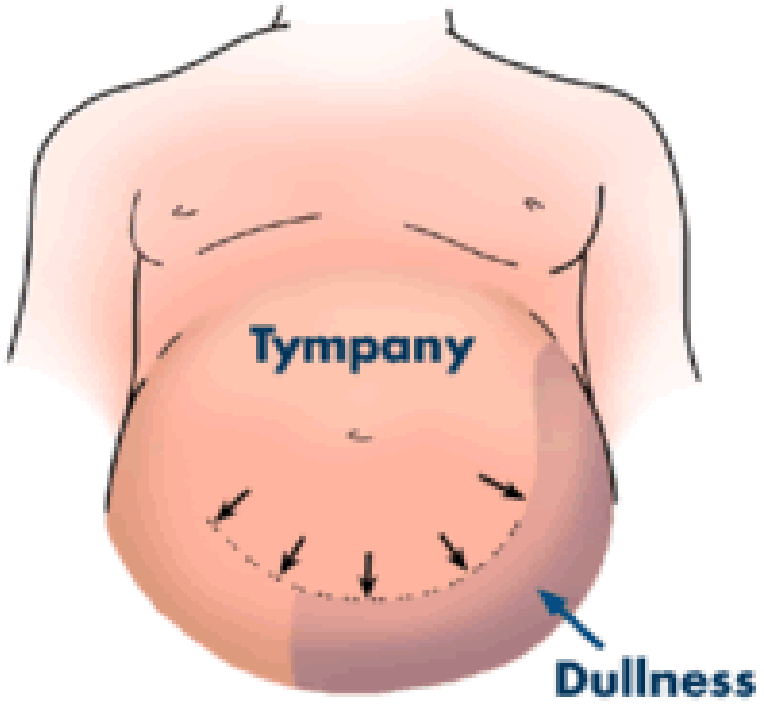
Most common tumour groups: ovarian, pancreas, liver, breast, colorectal.

Associated symptoms

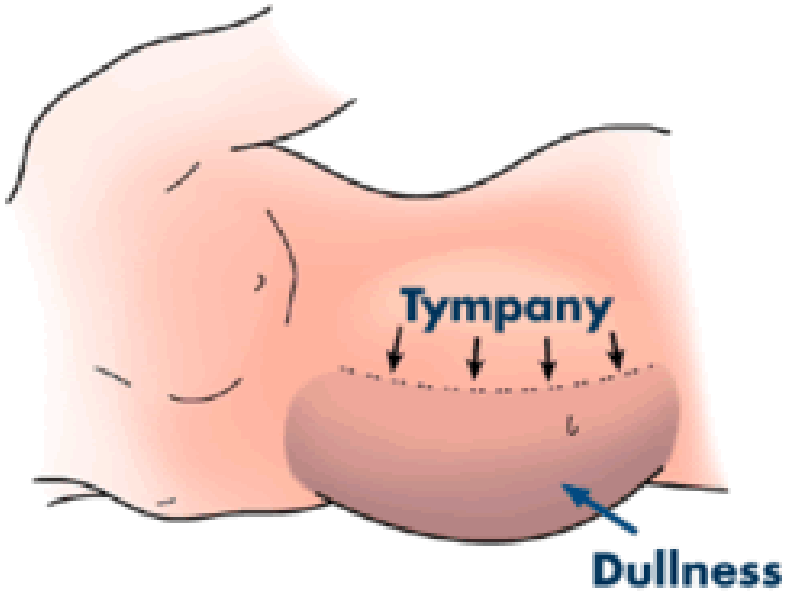
- Abdominal distention and discomfort
- Lack of appetite
- Reduced mobility
- Shortness of breath
- Pain
- Nausea
- Constipation
- Fatigue

How to assess for ascites

Flank dullness



Shifting dullness



How to treat it?

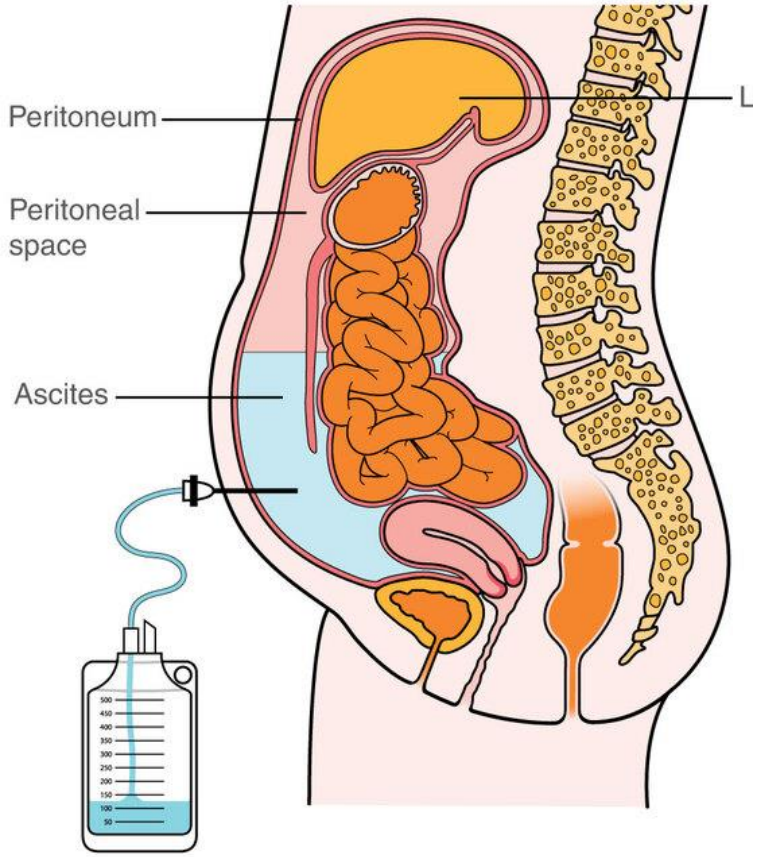
Paracentesis

- First presentation ? – diagnostic TAP
- Therapeutic ascitic drain, remove fluid to relieve intra abdominal pressure and improve symptoms / quality of life
- Usually need bloods within 7 days INR and FBC
- In for 6 hours or until dry –
- With malignant ascites assess on patient by patient – US guidance if clear signs of peritoneal disease (consider loculated ascites and contraindications)

Medicines management

- Consider diuretic – limited evidence for spironolactone
- Morphine Sulphate 2.5mg QDS for SOB
- Lorazepam 0.5mcg anxiety/SOB
- Systemic treatment
- Holistic therapies
- Modified diet (little and often)

Risks associated



- Post Paracentesis circulatory dysfunction leading to hyponatremia, renal failure - ensure no diuretics on the day of procedure and not for 48hrs post drain
- Intra abdominal injury (bowel/ bladder perforation)
- Haemorrhage- if severe stop
- Infection (secondary bacterial peritonitis rare)- local infection needs observing and possible antibiotics.
- SBP (Neutrophil >250mm) –Fluid leakage- apply dressing. If >24-48hrs may need stitch
- Reoccurring ascites
- Abdominal wall haematoma
- Failure to drain if ascites loculated

- **Manage expectations!**

Lymphoedema/ leg oedema

- Oedema is a build up of fluid in the bodies tissue
- Most commonly noted in legs

- How to treat?
- Treat the underlying cause (DVT, HF…etc)
- Manage with diuretics – mainly frusemide
- Elevate legs
- Massage
- Difficult to manage in malignancy, often an indicator of end stage disease

Take home points

Ascites is often a poor prognostic factor in pancreatic patients

Consider ascitic drain for symptom relief

Limited evidence for diuretics

Manage patient expectations

Early involvement of specialist palliative care teams for alternative symptom management

Clear and open communication with the patient