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NHS Foundation Trust

Supporting your patient

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Overview of session

- Symptom management of common symptoms
- Signs someone is approaching the end of their life
- Case study
- Poll

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Emotive subject

Time out is ok

Confidential

Listen to, and respect, each others' views – it's okay to have different views

No question is a silly question

Pancreatic Cancer. Why are symptom so complex?

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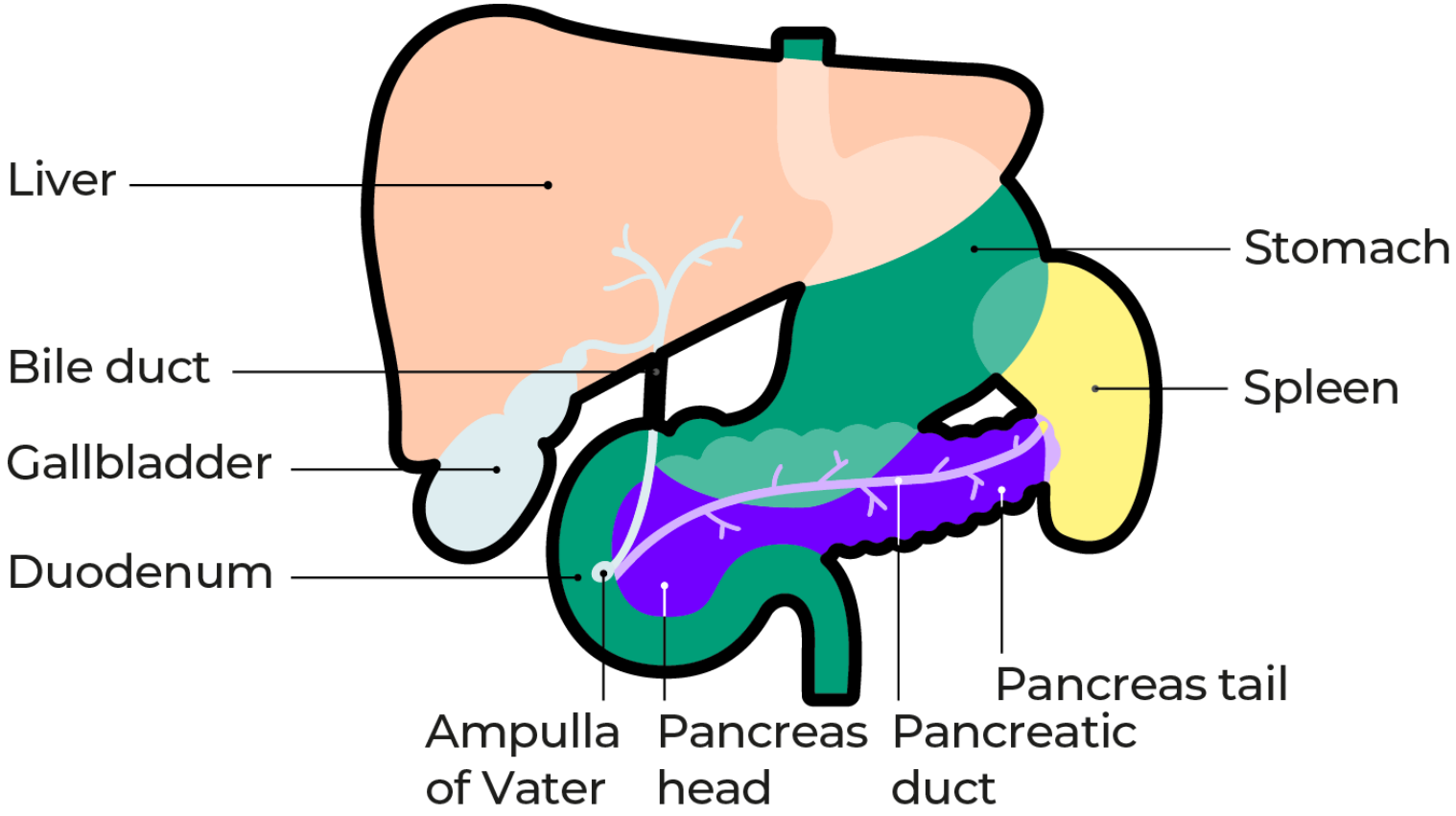

Pain

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.

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.

Types of pain

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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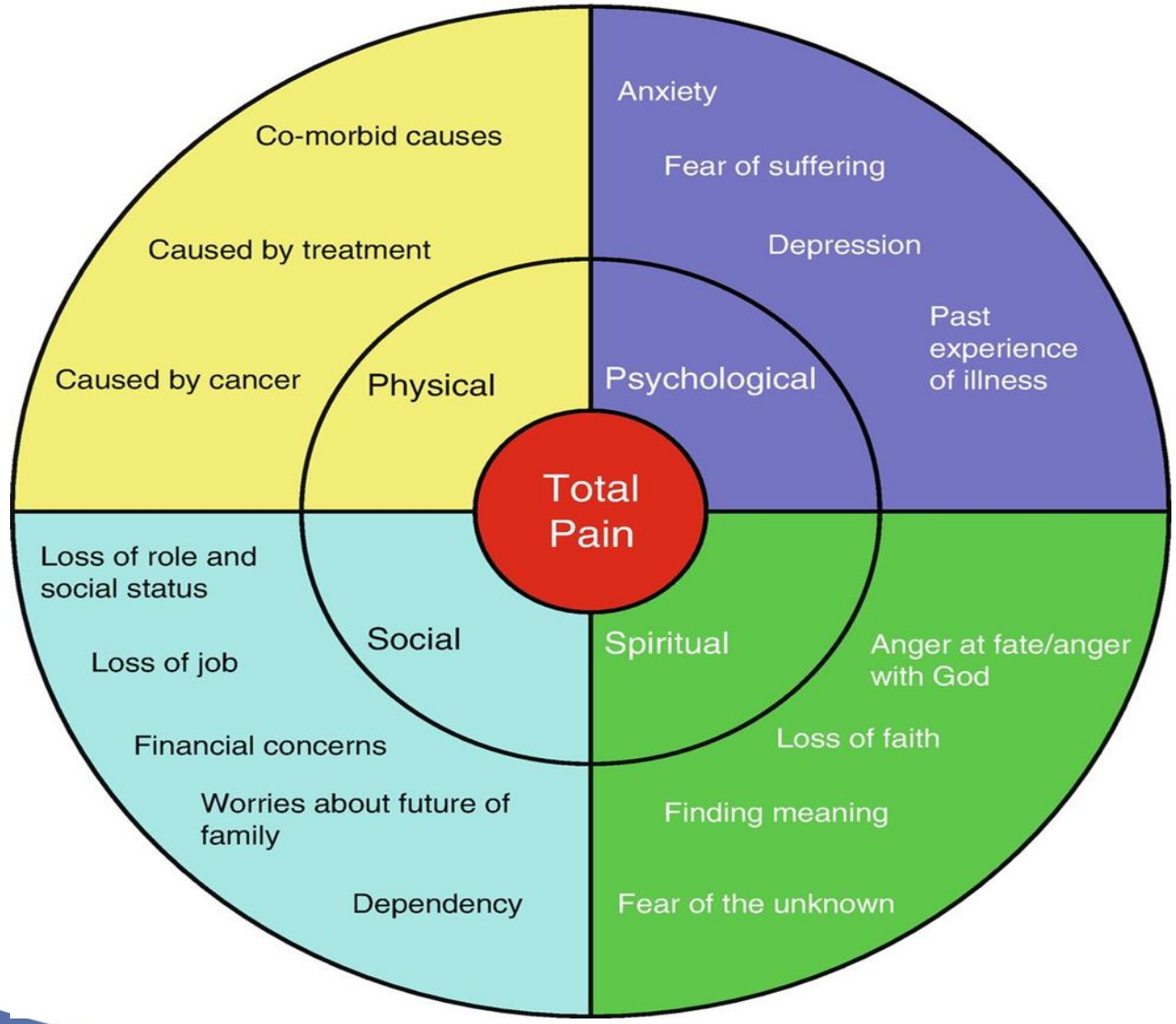
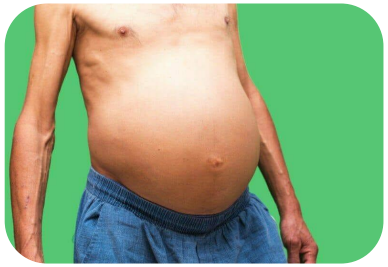
Types of pain



But there are other pains for this group of patients…

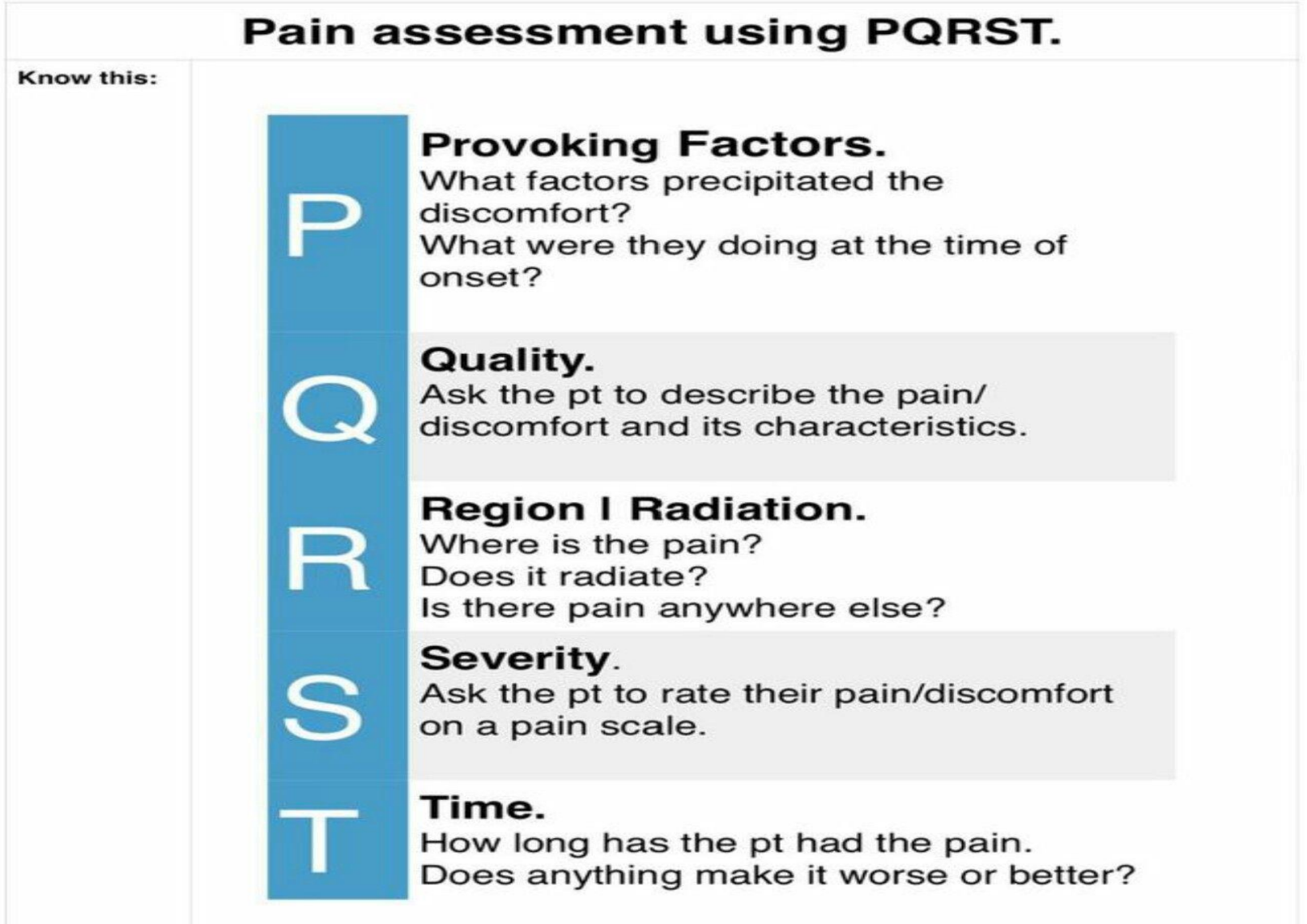
Treatment

Digestive pain and colic



Ascites

Pain assessment tool



Pain assessment using PQRST.

Know this:

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

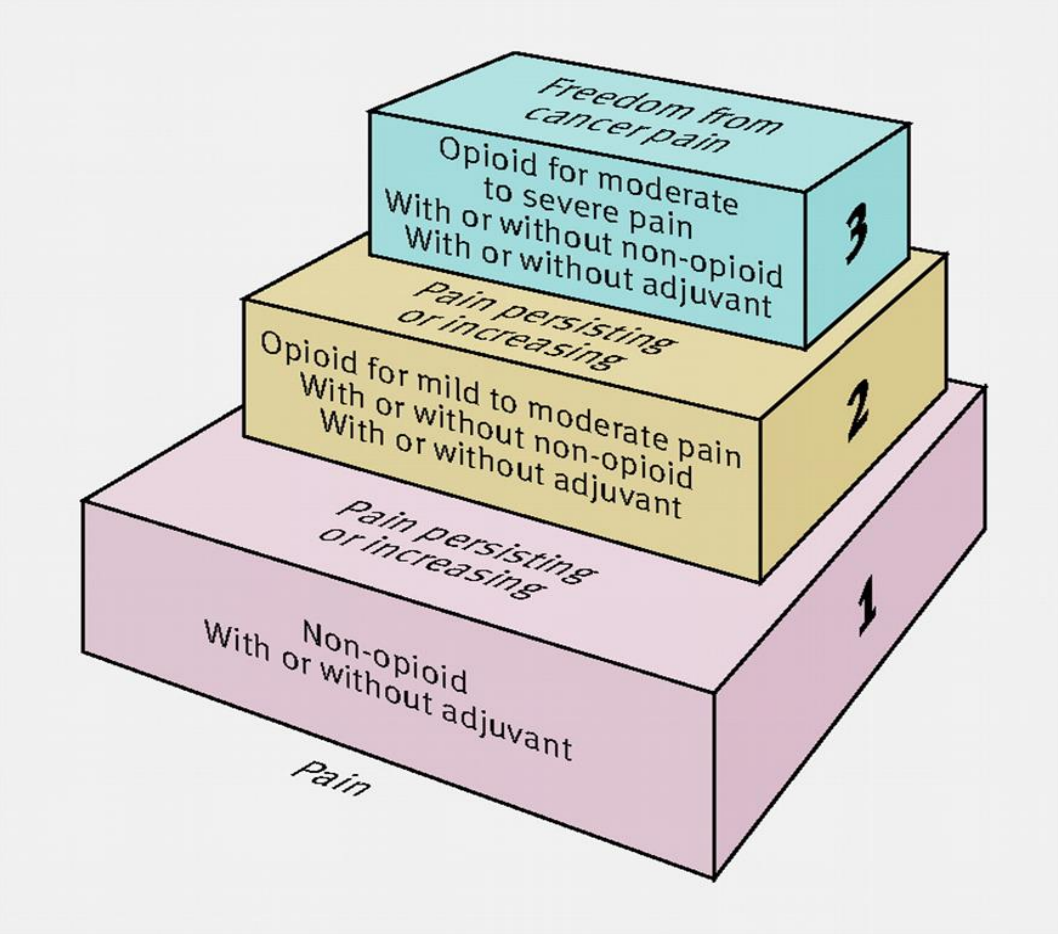
Q — **Quality.**
Ask the pt to describe the pain/ discomfort and its characteristics.

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?

Lets treat it



Strong opioid

- 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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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".

Anti-inflammatory meds (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?

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!!!!

Let not forget psychological aspect

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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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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Other approaches

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

Complementary therapies- often available through hospices

TENS

Remember the other sites of pain

<u>Chemotherapy induced peripheral neuropathy</u>

Neuropathic agents, exercise, reflexology, 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

Nausea & vomiting

Nausea and vomiting

Biochemical	Gastritis
Constipation	Infection
cough	Intestinal obstruction
Drugs	Pain
Functional obstruction	Treatment
Gastric outlet onstruction	Renal failure

Anti-emetics

- The choice of anti-emetic will be influenced by the cause of vomiting. They may be administered by a variety of routes. The oral or subcutaneous routes are the preferred options in palliative care.

Anti-emetics

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Drug	Indication of use	Dose (PO)	CSCI/ 24 hrs	Other info
Cyclizine	Movement related N&V Obstruction	50mg TDS	150mg	
Haloperidol	Chemical cause- opioids	1.5-5mg nocte (max 10mg)	1-5mg/ 24 hrs	Twice as potent when administered parentally
Dexamethasone	Obstruction	8-16mg		IV
Levomepromazine	Unknown cause of N&V	6-25mg	6.5-25mg	
Metoclopramide	Useful in gastric stasis	10mg-20mg tds	30-120mg	Do not use in complete bowel obstruction
Ondansetron	XRT induced N&V	4-8mg BD/TDS	8-24mg	Constipation
Olanzapine	Chemo induced N&V	2.5-10mg	2.5-10mg	Used of licence

Constipation

- Constipation is a very common symptom in palliative care patients which can adversely affect their quality of life. Patients and healthcare professionals often differ in their assessment.
- It is important to explore the views of the patient and whether they believe themselves to be constipated.
- Before starting any laxative medicine clinical assessment should exclude bowel obstruction.
- It may be appropriate to check the patient's blood biochemistry and perform a digital rectal examination.

Laxative therapy

Oral

- Latulose 10-15mls BD
- Senna 7.5-15mgs nocte
- Sodium docusate 200mg BD/ TDS
- Naloxegol 25mg mane

PR intervention

- Glycerol 4g suppositories
- Bisacodyl suppositories 10mg
- Phosphate enema

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Diarrhoea

- How long have you had diarrhoea?
- How many times a day and night are you opening your bowels?
- Are you taking any medicines?
- What does your poo look like?
- Does it happen at particular times such as after you have eaten or after your cancer treatment?
- Are you taking any medicines to help?
- How much is your diarrhoea stopping you from doing day to day things?

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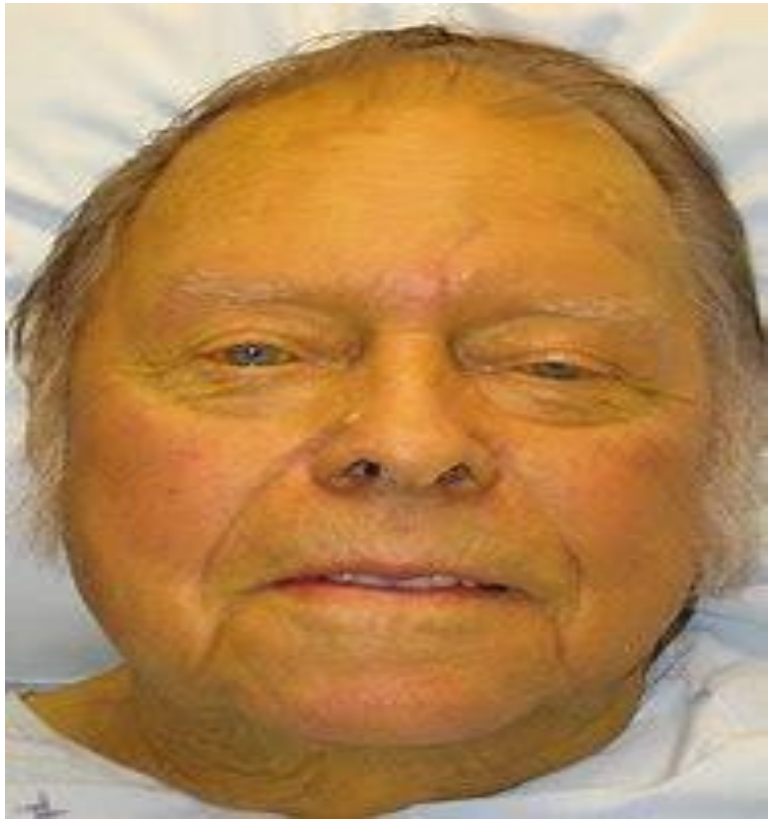
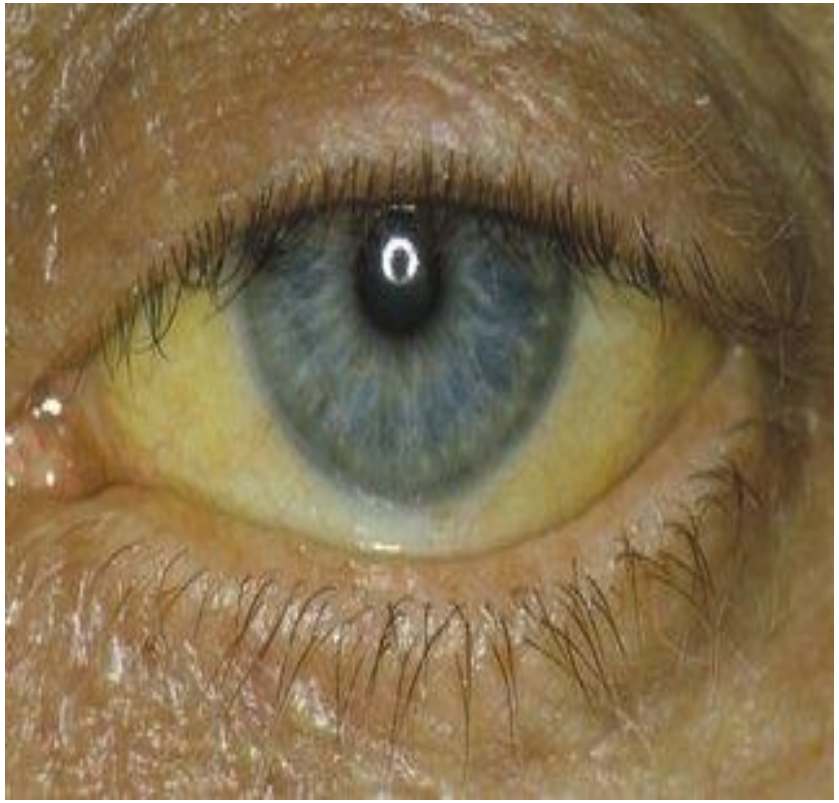
Fatigue

- Common symptom
- Important to look at reversible causes
- Consider pharmacological and non pharmacological treatments

Jaundice



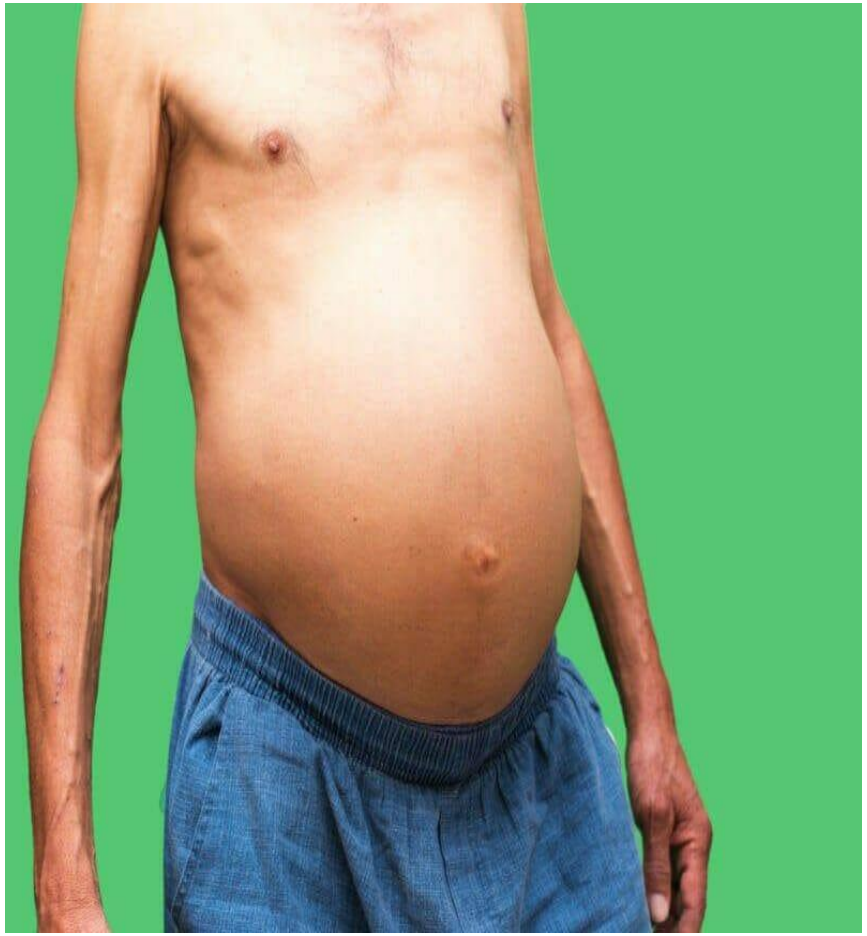


Ascites

- An accumulation of fluid within the peritoneal cavity
- Associated with poor quality of life and poor prognosis

Treatment

- Diuretics
- Drainage



End of life & Dying

End of life

Early Clinical signs:

- Decreased performance status
- Decreased consciousness
- Decreased oral intake

Biochemical Markers:

- Raised WCC
- Low Albumin
- Deteriorating Renal/Liver Function

Late signs (hours to days of life):

- Pulseless at radial artery
- Respiration with mandibular movement
- Decreased urine output
- Cheyne-Stokes breathing
- Apnoeic episodes
- Peripheral cyanosis
- “Death rattle”

Dying

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When a person is judged to be within a few hours or days of death.

HOWEVER…

It is important to note that there is no time scale for dying.

People can be dying for more than 2-3 days. It varies from person to person due to factors such as age and existing co-morbidities.

Case Study