Total Pain Management

Pain has been noted as a constant companion of humanity since written records were kept. With the development of scientific method in the last 200 years understanding and control of this basic human experience has seemed possible. Yet even in this decade many still suffer in great distress with unrelieved pain. This is partly through a lack of knowledge but also through a lack of care and diligence on the part of medical and nursing professionals.

Among those who suffer advancing disease and in particular, cancers such as mesothelioma, the fear of pain and suffering looms large. The question is usually asked how much will I suffer, rather than will I have pain at all. There is an expectation of pain.

Pain serves a purpose to warn us of impending injury, trauma or illness. It draws attention to particular circumstances and is often so alarming that some action must be taken. However, there are times when pain ceases to have this important function. Pain that is unrelieved despite appropriate responses, where there is no obvious cause or no remedy for the apparent cause, ceases to serve a warning or protective function. Instead it becomes a problem or even an illness in itself.

Those who suffer unrelieved ongoing pain cease to display the signs most of us would recognise as indicating 'acute pain' (e.g. pallor, sweating, restlessness, grimacing, vomiting, and crying) instead unrelieved chronic pain may cause the sufferer to display signs closer to depression (e.g. hopelessness, anger, irritability, passivity, withdrawal, and inactivity). Yet their suffering may be much worse than the acute pain victim.

Total Suffering

Understanding the concept of suffering has improved the care of those bearing chronic malignant (i.e. caused by cancer) pain. Unrelieved pain makes inroads into all parts of our lives. It causes personal, family and social disruption, impairs one's ability to work or interact, to work and manage finances, and may confirm or challenge our spiritual and religious beliefs. The total burden of pain must be measured in the 'total suffering' of an individual. That is the price paid in psychological, social, spiritual terms.

Likewise, pain is modulated by the effect our social, psychological and spiritual circumstances have upon us. Those who are struggling financially, emotionally (e.g. with depression or anxiety), living with damaged relationships or in spiritual distress will experience pain more keenly than those who do not carry such burdens.

Unrelieved pain cannot be viewed as an isolated physical experience. It is only by seeing it in the context of 'total suffering' and by understanding the ebb and flow between pain and the broader arena one's life that it can be effectively managed.
Those wishing to assist the sufferer must take a holistic approach.

Recognising the patient as a competent individual, allowing them control and a say in their own management, offering clear explanations and making them a member of their own treatment team is all part of this holistic process.

Setting a goal

In cancer pain expecting complete relief from pain is unrealistic. The nature of an ever evolving and changing malignancy means pain is a frequent companion. The aim is usually to keep pain to a level where it does not intrude excessively into one's day (say 2:10 on a scale where 10 is the worst pain ever experienced and 0 is no pain at all). This means that the patient, not an ever present and eroding pain, can control the choices made in any given day.

Modern pain management

Effective management of pain requires the cooperation of the patient and the skills of several people working as a team. In cancer pain management, this means a palliative care team containing a medical specialist with experience in this field working with specialised nurses, counsellors, chaplains, pharmacists, and occupational and physiotherapists in addition to anaesthetists, radiotherapists and oncologists. Complex care is coordinated through the palliative care team - understanding the aspects of pain unique to each individual are paramount to successful care. That is, an understanding of the 'total suffering' of the individual. Palliative care teams may be accessed through community home visits, outpatient attendance or hospital admission.

To assist the patient each team member draws on the skills of their particular speciality area. Patients may require emotional, financial or spiritual support, others caring assistance with family or personal relationships. Skills in relaxation, gentle exercise, or managing particular aids may need to be acquired. Some may even need to learn new ways to sit, walk or get in and out of bed! However, none of these very important activities will have meaning if nothing is done to modify the physical hurt that pain produces.

To address all theses issues rapidly and effectively, brief admission to a palliative care unit may be of great benefit. Even though the cancer may not be curable, admission to such a unit does not mean a patient is at the end of life. Such units assist patients for many months or years prior to life's end. Within the palliative care unit the focus remains on how to live well and, when the time is right, how to die well. Their goal is improvement in a patient's quality of life.

Understanding physical pain

Each of us will have experienced different pain sensations at varying points in our lives – the different sensations indicating perhaps problems of differing nature. Cancer can produce pains of differing natures depending on how the malignancy behaves. It is essential to understand the character of the pain experience as treatment depends very much on the pain's nature.

Importantly, not all cancer sufferers experience pain. At the end of life some 15% of patient have not had a problem with pain at all. However, the other 85% of patients do have pain and often 2 or 3 different types of pain at any one point in time.

Pain can be recognised in 3 broad types – somatic (that is coming from the muscles and soft tissues of the body), bony (from the skeletal structures) and neuropathic (when the nerves themselves are directly involved). Subdividing pain is this way allows the prescription of the right type of pain relieving medication. Some of these pains, especially the neuropathic type, may respond very poorly to the usual strong painkillers such as morphine (which comes as a surprise to patients - along with some doctors and nurses too).

Medications for managing pain

There is a large pool of medication available to assist with pain control. It is normal to start out with weaker analgesics (painkillers) such as Panadol or Panadeine used intermittently as pain demands but later taken regularly each day. When or if this is ineffective then stronger analgesics are usually prescribed such as Panadeine Forte, Digesic or Tramadol. It may be appropriate to add in non-steroidal anti-inflammatory drugs (NSAIDs) e.g. Nurofen or the stronger varieties available on prescription (which are good for pleurisy, bone or liver capsule pain).

Unfortunately all of these drugs are limited in their maximal dose and ultimately most patients require narcotic drugs for more effective relief. The best known of these is morphine (MS Contin, Kapanol, Ordine or Sevredol) but there are many others e.g. oxycodone (Oxycontin, Oxynorm or Endone), hydromorphone (Jurnista or Dilaudid), fentanyl (Durogesic patches, Actiq lozenges), or methadone (Physeptone).

As previously mentioned, sometimes even very large doses of narcotic drugs do not control pain well. This is often a great disappointment. However there are a number of other agents that can be very effectively employed. These include medications normally used for quite different reasons e.g. steroids (Dexamethasone), anti-depressants (Endep, Cymbalta), anti-epileptics (Neurontin, Lyrica), local anaesthetic derivatives (Mexitil), muscle relaxants (Baclofen), and blood pressure medication (Clonidine).

Problems

When narcotics are prescribed there will always be side effects. The commonest ones are nausea, constipation, drowsiness and sometimes confusion. The prescribing doctor should always educate the patient and family in what to expect and give extra medication to assist with these side effects, which will often ease after the first few days of taking the medication. They are, nonetheless a common reason for patients ceasing their narcotic. Side effects can almost always be successfully managed.

Likewise fear of addiction is a common barrier to effective narcotic use. Patients with cancer pain seldom experience addiction (much less than 1% of patients) and reassurance about this is important. Withholding medication may also occur because a patient is fearful that there won't be anything stronger to use later "when things might get really bad" – this too is an unfounded anxiety – there are always ways to assist.

Pain relieving procedures

There are circumstances where a procedure may provide better pain control than medication or when used in combination may allow a lower drug dose to be used. These usually take the form of nerve blocks to individual nerve roots, nerve plexuses or occasionally whole regions e.g. an epidural.

Radiotherapy is also an effective tool for pain management and may greatly reduce pain especially if it is of bony or somatic origin. Relief may take days or weeks to arrive in this circumstance and so treatment is usually combined with ongoing medication. Chemotherapy can also be of assistance by shrinking the offending tumour – this may often be incomplete or temporary and can take some time to be effective.

Poorly relieved difficult pain.

Successful pain control will be established in more than 95% of patients. Unfortunately there are those who continue to suffer with hard to relieve pain. Within this smaller group it may not be possible to contain pain without major issues such as severe drowsiness or being compromised by loss of function. Where control is difficult to establish meaningful care always continues. No patient (or family) should feel alone or abandoned at any point in his or her cancer journey – especially in such a circumstance. For this to occur is an unacceptable failure of medical care.

For the very few who struggle with ongoing severe pain sometimes the only escape lies in palliative sedation therapy. This is when the only alternative to severe pain is to be given enough sedative to stay asleep all the time and thus avoid the pain. This is a drastic and final measure instituted only in the last days of life and always associated with the end of life due to disease progression.

Summary

Pain, fear and suffering in advancing cancer give rise to anxiety and despair. Pain management can free patients and their families from a terrible burden, provide ongoing support and aid in improving quality of life. In part success depends on involving patients as part of the team involved in their own care. This allows for flexibility and negotiation.

Early contact with palliative care services can do much to ease the burden that advancing cancer places upon patients and those who love them. Patients should not be afraid to request palliative care involvement or to discuss the issue further with their treating specialist.

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