

# OPTIMISTIC

TRANSFORMING CARE

# OPTIMISTIC Providers Learning Community Webinar

12/5/18

# Learner Information

**Launch Date:** 12/5/2018

**Expiration Date:** 12/5/2018

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# Pain Management in the Outpatient Palliative Population

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12/5/18

# Objectives

1. Understand How the Difference Between Palliative Care and Hospice Care Impacts Management of Pain
2. Define the Two Main Types of Pain: Nociceptive and Neuropathic. Understand Therapeutic Challenges Associated with Each
3. Name At Least Three Non Pharmacologic Approaches to Pain Management
4. List the Most Common Goals and Hazards Associated with the Use of Opioid Drugs in Palliative Patients

# Palliative Care (PC) – Definition

- Specialized medical care for patients with serious illnesses. It focuses on providing relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis. The goal is to improve the quality of life for both the patient and the family.
- PC is provided by a team of doctors, nurses and other specialists who work together with the patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be used in conjunction with curative treatment.

# Hospice – Definition

- Team oriented approach to medical care, symptom management, and emotional and spiritual support tailored to the needs of a patient with a terminal illness or injury.
- Eligibility for Medicare Benefit: Patient is eligible for hospice care if two MD's (One should be a Hospice MD) determine the patient has a prognosis of six months or less.

# Further Definition of Palliative & Hospice Care

- Both Palliative Care and Hospice Care provide symptom management, enhance quality of life and respect patient's desires and preferences. Hospice care is specifically devoted to End of Life care.
- So, ALL Hospice Care is also Palliative Care, but NOT ALL Palliative Care is also Hospice Care.

# Primary Tenets of Palliative Care

- Establishing Goals of Care that are in line with Patient's Values and Preferences
- Consistent and Sustained Communication
- Symptom Management



# Pain Definition

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage.”

International Association for the Study of Pain

# Types of Pain

- Nociceptive Pain
  - Involve direct activation of nociceptors
  - Somatic Pain
    - Bones, joints, connective tissues, muscles
    - Aching, dull or sharp, well localized, response well to analgesic
  - Visceral Pain
    - Organs (i.e.. Heart, liver, pancreas, GI, etc.)
    - Constant crampy, aching, poorly localized, referred pain

# Types of Pain

- Neuropathic Pain

- Complication of injury to the peripheral or central nervous system
- Direct invasion or injury to nerve
- Burning, stinging, shooting pain, numbness
- Poor response to analgesics
- Peripheral: Mono and Polyneuropathies (i.e.. diabetic neuropathy, trigeminal neuralgia)
- Central: celiac plexopathy, phantom limb pn
- Sympathetic: complex regional pain syndrome

# Pain Assessment

- Pain Causality and Patient Goals
  - Ask, “Why do you think you are having pain?”
  - Ask, “What is your goal for pain relief?”
  - Numerical goal (e.g. 2-3/10) or
  - Functional goal (e.g. sleep 6 hours)

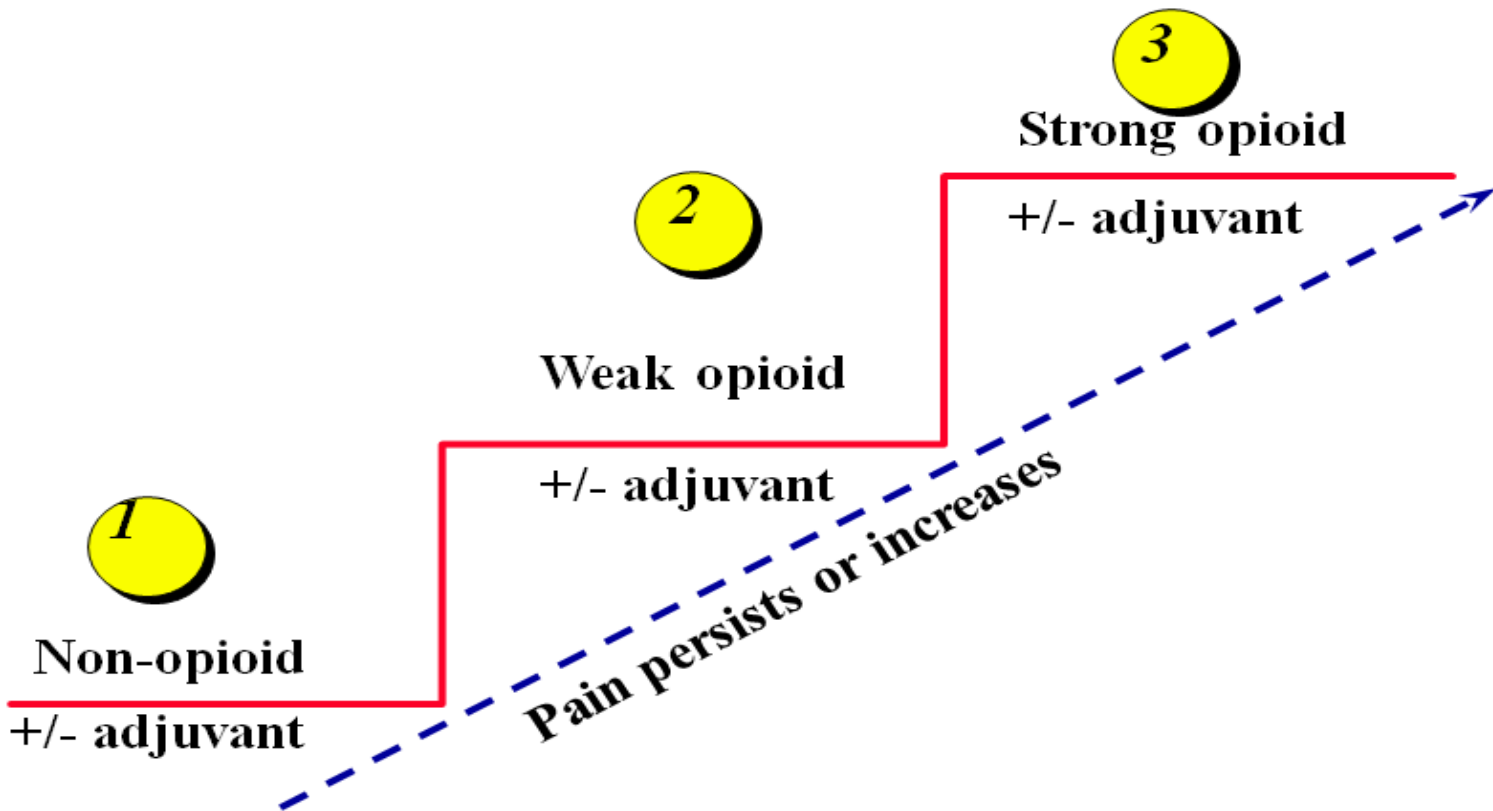
# Pain Assessment is NOT...

- Relying on changes in vital signs
- Deciding a patient does not “look in pain”
- Knowing how much a procedure or disease “should hurt”
- Assuming a sleeping patient does not have pain
- Assuming a patient will tell you they are in pain

# Pharmacologic Agents for Pain Management

- Analgesics:
  - Opioids
  - NSAIDs (non-selective and selective NSAIDs; COX2 inhibitors)
  - Acetaminophen
- Adjunctive Analgesics:
  - Antidepressants
  - Anticonvulsants
- Other Analgesics
  - Topical Agents
  - Skeletal muscle relaxants
  - Steroids
  - Interventional Techniques
    - Nerve blocks
    - Injections

# W.H.O. ANALGESIC LADDER



# Principles of Opioid Use

- Persistent pain: use around the clock (ATC) scheduled long acting agents
- Breakthrough pain: treat with short acting “rescue” agents
- Route, dosage, and schedule are picked based on patient’s needs
- Use least invasive route (i.e. oral if possible)
- Titrate to achieve maximum desire of pain relief
- Follow patients closely



# Opioids: Duration of Action

- Opioid preparations differ in duration of action based on their own characteristics and how they are prepared (chemically packaged).
  - Ultra short
  - Short
  - Long

# Short Acting Opioids

- Parenteral or Oral

- morphine
- hydromorphone (Dilaudid<sup>®</sup>)
- codeine

- Oral only

- oxycodone (Percocet<sup>®</sup>, Tylox<sup>®</sup>)
- hydrocodone (Vicodin<sup>®</sup>, Lortab<sup>®</sup>, Norco<sup>®</sup>)
- Note: hydrocodone is only available as a combination product.

# Short Acting Opioids

- Oral dosing:
  - onset in 20-30 min
  - peak effect in 60-90 minutes
  - duration of effect 2-4 hours
  - Can be dose escalated or re-administered every 2-4 hours for poorly controlled pain as long as the daily Acetaminophen dose stays < 4 grams

# Long Acting Opioid Preparations

- Oral

- MS Contin<sup>®</sup>
- Oramorph SR<sup>®</sup>
- Kadian<sup>®</sup>
- Avinza<sup>®</sup>
- Oxycontin<sup>®</sup>
- Methadone
- Exalgo<sup>®</sup>
- Opana ER<sup>®</sup>

- Transdermal

- Fentanyl Patch (Duragesic<sup>®</sup>)

# Long Acting Oral Preparations

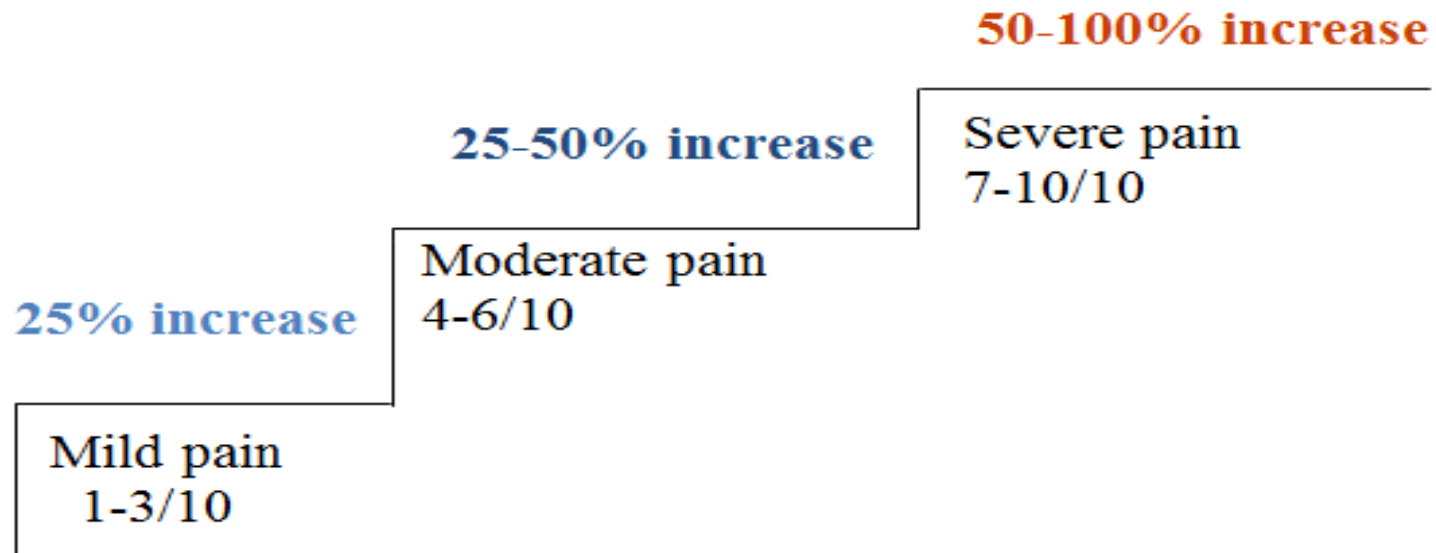
- All provide 8, 12, or 24 hours of analgesia
- Minimum dosing interval is q 8 hours
- All provide onset of analgesia within 2 hours
- All can be dose escalated every 24 hours

# Transdermal Fentanyl Duragesic®

- Slow onset of action: 13-24 hours
- Duration of action: 48-72 hours
- Should only dose escalate q 3 days
- Fentanyl stays in circulation for up to 24 hours after patch removal
- Place on hairless, non-irradiated skin
- Subcutaneous fat stores influence absorption

# Opioid Dose Escalation

**Always increase by a percentage of the present dose based upon patient's age, pain rating and current assessment**



# Frequency of Dose Escalation

- The frequency of dose escalation (oral opioids) depends on the particular opioid
- Short acting oral: q 2-4
- Long acting oral, except methadone: q 24 hours
- Methadone: q 72 hours
- Transdermal fentanyl: q 48-72 hours



# Management Tips

- Any patient who has chronic severe pain that needs daily opioids needs to be on a long acting preparation
- All patients started on an opioid should be started on a bowel regimen

# Additional Management Tips

- When progressing to a long acting or parenteral opioid from a short acting opioid
  - One needs to know the amount of short acting or break through medication the patient has had in the last 12 to 24 hours.

# Non Pharmacologic Agents for Pain Management

- Cognitive Behavioral Therapy
- Meditation & Relaxation
- Guided Imagery
- Acupuncture
- TENS
- Therapeutic Massage

# Summary

- Goals of Pain Management
  - Comfort, Patient/Family Satisfaction
  - Avoidance of ED Visits/Admissions
- Requirements for Meeting Goals
  - Thorough Assessment
  - Discussion of Expectations

# Summary

- Challenges
  - Misperceptions/Cultural Issues
  - Medication Side Effects
- Solutions
  - Education
  - Communication
  - Awareness
  - Intervention

# Summary

- Safety Concerns
  - Diversion
  - Dependency
- Prevention
  - Pain Medication Contract
  - INSPECT Inquiry
  - Documentation

# Summary

- Questions or Comments?
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