ESMO SUMMIT AFRICA 2020

Pain Control

Stein Kaasa MD, PhD
Head of Department of Oncology and Professor
Oslo University Hospital and Oslo University
CONFLICT OF INTEREST DISCLOSURE

Research Funding: Nutricia
Receipt of Honoraria: Fresenius Kabi and Nutricia
ESMO Designated Centres for Integrated Oncology and Palliative Care

- ESMO welcome African centres
- A Pan World Network for Oncology and Palliative Care
- Easy to apply
  - 13 criteria to fulfil
More cancer patients are...

- Cured
- Living longer with metastatic disease
- Receiving prolonged end-of-life care

- Many patients will potentially experience early and late side effects from various therapies and/or caused by the cancer
  - Pain
  - Fatigue
  - Reduced functions
Pain controle
Are we good enough?

- 50% of all cancer patients will experience significant pain
- 70% of advanced cancer patients will experience pain
- 50% of these are not sufficiently treated

Teunissen et al. *J. Pain Symptom Manage.* 2007
Thronæs et al *J.Supp Care in Cancer* 2015
There are simple solutions but are they implemented into public health?

- Key drugs paracetamol and morphine?
- What about the other opioids-do we need them?
- Simple or more complicated messages?
Six of several reasons for undertreatment of cancer pain

- Insufficient knowledge about the pathophysiology of symptoms and of principles of symptom treatments
- Lack of optimal communication with and about patients
- Lack of standardised diagnostic tools
- Inadequate implementation of evidence-based guidelines for symptom management into clinical practice
- Radiotherapy is an effective pain treatment
- What about chemotherapy?

A comprehensive clinical approach

- Focus on the tumour-oncologist approach
- Focus in the host – palliative and supportive care approach

The best clinical approach: Focus on the tumour and the host-"total care"
  - Can be achieved better by complementarity – oncology and palliative care
  - Integration of palliative care into all levels of cancer care
A classification of chronic pain for ICD-11

Rolf-Detlef Treede, Winfried Rief, Antonia Barke, Qasim Aziz, Michael I. Bennett, Rafael Benoliel, Milton Cohen, Stefan Evers, Nanna B. Finnerup, Michael B. First, Maria Adele Giamberardino, Stein Kaasa, Eva Kosek, Patricia Lavand’homme, Michael Nicholas, Serge Perrot, Joachim Scholz, Stephan Schug, Blair H. Smith, Peter Svensson, Johan W.S. Vlaeyen, Shuu-Jiun Wang

June 2015 • Volume 156 • Number 6
A classification of chronic pain

- «Persistent or recurring pain lasting longer than 3 months»
Chronic cancer pain

- Pain caused by the cancer
- Pain caused by cancer treatment
Chronic cancer pain

Subdivided into

- Location
  - Visceral
  - Bony
  - Somatosensory (neuropathic)
- Continuous (background pain)
- Intermittent (episodic pain)
CLINICAL PRACTICE GUIDELINES

Management of cancer pain in adult patients: ESMO Clinical Practice Guidelines†

M. Fallon¹, R. Giusti², F. Aielli³, P. Hoskin⁴, R. Rolke⁵, M. Sharma⁶ & C. I. Ripamonti⁷, on behalf of the ESMO Guidelines Committee*
### Table 2. Guidelines for the adequate assessment of the patient with pain at any stage of the disease

1. **Assess and re-assess the pain**
   - Causes, onset, type, site, absence/presence of radiating pain, duration, intensity, relief and temporal patterns of the pain, number of BtP, pain syndrome, inferred pathophysiology, pain at rest and/or moving
   - Presence of trigger factors and signs and symptoms associated with the pain
   - Presence of relieving factors
   - Use of analgesics and their efficacy and tolerability
   - Description of the pain quality:
     - Aching, throbbing, pressure; often associated with somatic pain in skin, muscle and bone
     - Aching, cramping, gnawing, sharp; often associated with visceral pain in organs or viscera
     - Shooting, sharp, stabbing, tingling, ringing; often associated with NP caused by nerve damage

2. **Assess and re-assess the patient**
   - Clinical situation by means of a complete/specific physical examination and the specific radiological and/or biochemical investigations
   - Interference of pain with the patient's daily activities, work, social life, sleep patterns, appetite, sexual functioning, mood, well-being and coping
   - Impact of the pain, the disease and the therapy on the physical, psychological and social conditions
   - Presence of a caregiver, psychological status, degree of awareness of the disease, anxiety and depression and suicidal ideation, his/her social environment, QoL, spiritual concerns/needs, problems in communication, personality disorders
   - Presence and intensity of signs, physical and/or emotional symptoms associated with cancer pain syndromes
   - Presence of comorbidities (i.e. diabetic, renal and/or hepatic failure, etc.)
   - Functional status
   - Presence of opipophobia or misconception related to pain treatment
   - Alcohol and/or substance abuse

3. **Assess and re-assess your ability to inform and to communicate with the patient and the family**
   - Spend time with the patient and the family to understand their needs

---

*BTtP,* breakthrough cancer pain; *NP,* neuropathic pain; *QoL,* quality of life.
Figure 1. Validated and most frequently used pain assessment tools.
Computer-Based PROMs

- Intelligent way of asking—the next questions follow according to answers of the previous
- May give decision support to:
  - Patients
  - Health care providers
  - Family members

EIR, electronic image records
Have you had any of these symptoms during the past week?

- **Pain**
- **Shortness of breath**
- **Tiredness**
- **Anxiety**
- **Numbness in fingers or toes**
- **Drowsiness**
- **Insomnia**

[More alternatives]
How severe has your pain been on average the past week?
How intense is the pain right here?

No pain

Worst possible pain
Recommendation:

- The intensity of pain and the treatment outcomes should be assessed regularly and consistently using the VAS or NRS using the question: ‘What has been your worst pain in the last 24 hours?’ [V, D].
Recommendation:
• The assessment of all components of suffering, such as psychosocial distress, should be considered and evaluated [II, B].
• The onset of pain should be prevented by means of around-the-clock (ATC) administration, taking into account the half-life, bioavailability and duration of action of different drugs [II, B].
The oral route of administration of analgesic drugs should be advocated as the first choice [IV, C].
• As an alternative to weak opioids, low doses of strong opioids could be an option, although this recommendation is not currently part of WHO guidance [II, C].
**Recommendations:**

- Laxatives must be routinely prescribed for both the prophylaxis and the management of OIC [I, A].
Recommendations:

- All patients with painful bone metastases should be offered EBRT and the prescription should be 8 Gy single dose [I, A].
Patients with recurrent bone pain after previous irradiation should be offered re-irradiation with a further dose of 8 Gy [I, A].
Figure 3. Treatment of cancer pain.
*Do not switch between weak opioids.
BTCP: breakthrough cancer pain; NRS: numerical rating scale NSAI, nonsteroidal anti-inflammatory drug; t.d., transdermal.
**Recommendations:**

- Patients should be informed about pain and pain management and should be encouraged to take an active role in their pain management [II, B].
Which of these recommendations are most relevant for Africa?

- The use of opioids?
- The use of radiotherapy?
How to implement optimal pain control into clinical practice?

Barriers?
Solutions?
78% of people in need of palliative care live in low- and middle-income countries.

Universal access to opioids
Opioid availability in Africa

- Reduced consumption the last years
- Related to the opioid epidemics in North America?
- How about governmental policy?
  - Opioid phobia
Figure 2: Health care includes silos at different levels

Is this model relevant at all – Common challenges?

- How to make the best choices?
- Where are most of the African cancer patients?
  - In hospitals
  - In primary health care
Pain treatment in Africa

- Education
  - In pain management and palliative care
  - For oncologists?
  - How can ESMO contribute?
  - Pain treatment and palliative care – two of the same?
What is patient centeredness?

«Care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions»

Institute of Medicine (US) 2001
Essential elements of palliative care in oncology practice-a complex intervention

- Symptom assessment and management
- Psychosocial assessment and management
- Spiritual and cultural assessment and management
- Communication and shared decision-making
How can we improve the care for all cancer patients?

- Improve early detection of cancer
- Use the optimal anticancer treatment according to local resources
- Offer pain control and palliative care to all cancer patients in need of it
- All of us need to work together
Integration of oncology and palliative care: a *Lancet Oncology* Commission

“There is now a strong consensus for integration of oncology and palliative care in contemporary cancer care...how to optimally plan and collaborate between oncology and palliative care services should form an essential component of patient-centred care.”