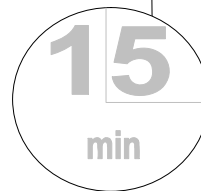


CLIP

15 minute Worksheet



Helping the patient with pain

9: Persisting pain

Advanced level

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Aim of this worksheet

To understand the principles in managing persisting pain.

How to use this worksheet

- You can work through this worksheet by yourself, or with a tutor.
- Read the case study below, then work on the questions overleaf.
- The work page is on the right side, the information page is on the left.
- Work any way you want: you can try answering from your own knowledge (in which case fold over the information page), you can use the information page (this is not cheating- you learn as you find the information), or you can use other sources of information
- It should take you about 15 minutes. If anything is unclear, discuss it with a colleague.
- If you think any information is wrong or out of date let us know
- Use the activity on the back page and take this learning into your workplace

Case study

Pat is a 36 year old woman, married with two sons aged 12 and 9. She had problems with her bowels for several months before some rectal bleeding made her see her GP. Investigations revealed a carcinoma of the sigmoid colon with liver metastases. She copes with some denial and refuses to tell her sons. She has been troubled with a persistent, burning perineal pain which has not responded to increased opioid doses.

Pat's perineal pain is getting steadily worse. It is still burning and the area is so sensitive she can't sit down. She is still adamant the boys should not be told and she has been getting increasingly unsettled.

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Dealing with persistent pain

Is the diagnosis correct?	Have the basic principles been followed?
Are the analgesics appropriate?	Has a secondary analgesic been used?
Is there a new pain?	Have other treatment options been considered (Surgery, radiotherapy etc.)?
Is the patient taking the drugs correctly?	Is the patient anxious, frightened or depressed?
Have you asked your local palliative care team?	

Do opioids always work?

When opioid doses are increased without any effect on the pain, the pain should be reassessed.

There are several types of pain that respond poorly to opioids: skeletal instability, colic (bowel, ureter, bladder), skin damage, muscle / ligament strain or damage, neuropathic pain (eg. neuralgia), and pain associated with inflammation (eg. infection).

In cancer, many pains have several causes and several types of pain are present at the same time. So, it is often worth trying an opioid as a first step in cancer pain.

Pain associated with unpleasant sensory change

Neuropathic pain: this does not rely on pain receptors and is due to nerve damage. This is thought to cause persisting changes in the chemical neurotransmitters in the spinal cord. Typical descriptions of the pain by patients are "burning", "shooting", "sandpaper", "pins and needles". There is usually altered sensation such as hypersensitivity or pain on light touch (allodynia). Trigeminal neuralgia and post shingles neuralgia are two examples. Neuropathic pain will respond to opioids, but becomes less responsive to the opioids as the weeks and months pass, and often needs co-analgesic drugs.

You can create an 'analgesic staircase' for this pain:

1. Amitriptyline. 2. Amitriptyline plus carbamazepine or gabapentin. 3. Ketamine. 4. Spinal analgesia

NB. steps 3 and 4 need input from a specialist pain or palliative care team.

An analgesic staircase must be specific to the individual's pain.

Secondary analgesics (also called adjuvant analgesics or co-analgesics)

Action understood: antibiotics, antispasmodics (drugs that relax smooth muscle), antispastics (drugs that relax skeletal muscle), corticosteroids.

Action poorly understood: adrenergic pathway modifiers (eg. clonidine), anticonvulsants, membrane stabilising drugs (flecainide) and antidepressants. These drugs may work by restoring the amount of spinal cord neurotransmitters altered as a consequence of nerve destruction.

Examples:

Bowel colic is stopped by an antispasmodic which relaxes the smooth muscle of the bowel eg. hyoscine butylbromide.

Neuropathic pain can be helped by tricyclic antidepressants of which amitriptyline is the first choice.

Muscle spasm is seen in conditions such as multiple sclerosis and can be eased by an antispastic (eg. baclofen) which relaxes the skeletal muscles.

Cellulitis is a skin infection which can cause local pain- it needs an antibiotic and flucloxacillin is first choice.

Nerve compression pain caused by tumour can be eased by reducing the swelling (oedema) around the tumour using corticosteroids- dexamethasone is usually the first choice.

The effects of persisting pain on Pat

Pain is not just a sensation but is also an unpleasant experience. When it persists it can become increasingly distressing with many effects:

Pat's feelings: frustration or anger may be a response, but as it continues Pat may become troubled by anxiety, fear, low mood or even depression.

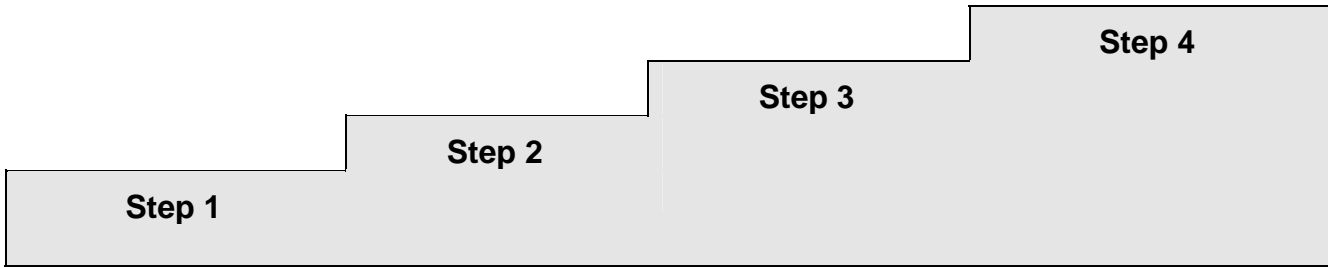
Pat's social life: severe, persistent pain often restricts activity, but the feelings Pat has may also reduce social contact because she has less wish to socialise or meet new people- even friends may be turned away. This increases her isolation.

Pat's family: the stress of persistent pain spreads to partners and relatives making relationships difficult. She has already refused to tell her sons about her illness and they will be even more frightened and worried by her pain problems which she will not be able to hide.

Professionals: failure to relieve a problem may result in a sense of failure and inadequacy at the persistence of the pain despite all their efforts. This results in reduced contact with the professionals or the 'side-room syndrome' where patients are placed in a single room (ostensibly for themselves, but as much because the problem is less visible).

Write

Write an analgesic staircase for Pat's perineal pain (include anything you think could help, not just drugs)



Write

Some pains need drugs other than primary analgesics. What would work best for the following- link up the pair (the first has been done for you).

<p>Bowel colic</p> <p>Neuropathic pain</p> <p>Muscle spasm</p> <p>Cellulitis (skin infection)</p> <p>Nerve compression pain due to tumour</p>		<p>baclofen (skeletal muscle relaxant)</p> <p>flucloxacillin (antibiotic)</p> <p>dexamethasone (corticosteroid)</p> <p>amitriptyline (antidepressant)</p> <p>hyoscine butylbromide (bowel muscle relaxant)</p>
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Reflect

Think about the effects of Pat's persistent pain

Effect on Pat's feelings	Effects on Pat's social life	Effects on Pat's family	Effects on professionals

FURTHER ACTIVITY: Persisting pain

For a patient with persistent pain:

-observe the effects on the patient and on you.

FURTHER READING: Persisting pain

Journal articles

Attal N. Chronic neuropathic pain: mechanisms and treatment. *Clinical Journal of Pain*. 2000; **16**(3 Suppl):S118-30.

DelleMijn P. Are opioids effective in relieving neuropathic pain? *Pain*. 1999; **80**(3): 453-62.

Enarson MC. Hays H. Woodroffe MA. Clinical experience with oral ketamine. *Journal of Pain and Symptom Management*. 1999; **17**(5): 384-6.

Eisenberg E. McNicol E. Carr DB. Opioids for neuropathic pain. *Cochrane Database of Systematic Reviews*. 2006; **3**:CD006146.

Gilron I. Watson CP. Cahill CM. Moulin DE. Neuropathic pain: a practical guide for the clinician. *CMAJ Canadian Medical Association Journal*. 2006; **175**(3): 265-75.

Hanks GW. Conno F. Cherny N. Hanna M. Kalso E. McQuay HJ. Mercadante S. Meynadier J. Poulain P. Ripamonti C. Radbruch L. Casas JR. Sawe J. Twycross RG. Ventafridda V. Expert Working Group of the Research Network of the European Association for Palliative Care. Morphine and alternative opioids in cancer pain: the EAPC recommendations. *British Journal of Cancer*. 2001; **84**(5): 587-93.

Hanks GW. Forbes K. Opioid responsiveness. *Acta Anaesthesiologica Scandinavica*. 1997; **41**: 154-8.

Rabben T. Skjelbred P. Oye I. Prolonged analgesic effect of ketamine, an N-methyl-D-aspartate receptor inhibitor, in patients with chronic pain. *Journal of Pharmacology & Experimental Therapeutics*. 1999; **289**(2):1060-6.

Rice ASC, Maton S, Postherpetic Neuralgia Study Group. Gabapentin in postherpetic neuralgia: a randomised, double blind, placebo controlled trial. *Pain*, 2001; **94**: 215-224.

Shaiova L. Difficult pain syndromes: bone pain, visceral pain, and neuropathic pain. *Cancer Journal*. 2006; **12**(5): 330-40.

Watson CP. The treatment of neuropathic pain: antidepressants and opioids. *Clinical Journal of Pain*. 2000; **16**(2 Suppl): S49-55.

Williams H. Assessing, diagnosing and managing neuropathic pain. *Nursing Times*. 2006; **102**(16): 22-4.

Resource books and websites

A Guide to Symptom Relief in Palliative Care, 5th ed. Regnard C, Hockley J. Abingdon: Radcliffe Medical Press, 2004

Cancer Pain Relief and Palliative Care. Geneva : WHO, 1990.

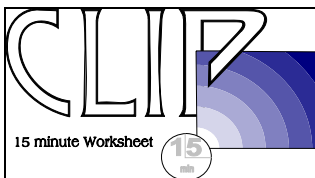
Oral Morphine, Information for Patients, Families and Friends. Twycross R., Lack S.A. Beaconsfield Publishers. 1988.

Oxford Textbook of Palliative Medicine 3rd ed. Doyle D, Hanks G, Cherny NI, Calman K eds. Oxford : Oxford University Press, 2003.

PCF3- Palliative Care Formulary, 3rd ed. Twycross RG, Wilcock A. Oxford: Radcliffe Medical Press, 2003. Also on www.palliativedrugs.com

Symptom Management in Advanced Cancer, 3rd edition. 2001. Twycross RG, Wilcock A. Abingdon: Radcliffe Medical Press.

Wall and Melzack's textbook of pain, 5th ed. Stephen B. McMahon and Martin Koltzenburg, eds. Edinburgh : Elsevier Churchill Livingstone, 2006.



**Current
Learning
In
Palliative care**
An accessible
learning programme
for health care
professionals

15 minute worksheets are available on:

- An introduction to palliative care
- Helping the patient with pain
- Helping the patient with symptoms other than pain
- Moving the ill patient
- Psychological needs
- Helping patients with reduced hydration and nutrition
- Procedures in palliative care
- Understanding and helping the person with learning disabilities
- The last hours and days
- Bereavement

Also available online on

www.helpthehospices.org.uk (click on 'e-learning')