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PAIN & PALLIATIVE CARE

Surgery

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ABSTRACT

Cancer incidence is rising every day. Initially, patients are offered curative treatment in the form of surgery, chemotherapy, radiotherapy etc... At certain point of the course of the disease, both patient and doctor realise that curative treatment is no longer useful and death is inevitable. Many times they leave the patient to suffer. Patients are frequently exhausted economically, physically and emotionally. They need lot of psychological and economical support. A holistic approach is needed. Lot of misconceptions surrounds morphine's use which leads to gross underutilization of this drug. This article highlights various aspects of palliative care and use of morphine for pain relief.

KEYWORDS

Cancer pain, Palliative care, Morphine, Holistic approach, Euthanasia

INTRODUCTION

Whoever is born in this world is bound to die. But as long as we live we should live and enjoy life, even when we know that we are going to die shortly. That is the principle of palliative care.

Now a days palliative care has progressed enormously and much research has been done. Many specialty associations have been formed to concentrate and improve on palliative care.

Palliative care is **"Active total care of patients and their family by a multi professional team at a time when the patient's disease is no longer responding to curative treatment and life expectancy is relatively short"**. The aim of the palliative care is to give best possible quality of life to the patient and family.

It is said that 1 in 1000 person develop a cancer in his life time and 80% of these require palliative care. The meaning of palliam in Latin is to cloak or to cover. When we cannot treat a symptom, the best we can do is to cover it so that it is not apparent.

Palliative care is a holistic approach. It not only takes care of physical symptoms but also psychological, social and spiritual aspects. Hospice care is a concept where a team of professionals give this comprehensive care under one roof.

Goals of palliative care:

1. Relief of pain and other distressing symptoms.
2. Psychological and spiritual support
3. Prepare the patients to accept the in evitable death.
4. Support to help the family to cope up during patient's illness.

Palliative care provides the fallowing services:

1. Community nursing services
2. Home care
3. Medical consultations
4. Out patient clinics
5. Bereavement support
6. Volunteer's help
7. Education
8. Research

In cancer, when first diagnosis the role of anti-cancer treatment predominates over palliative care. However, as disease progresses towards death, the role of anti-cancer treatment gradually diminishes and that of palliative care increases. To create awareness, world palliative care day is observed on **8th October** of every year.

PSYCHOLOGICAL ASPECTS

Communication

Communication is a very important aspect in palliative care. You must listen to whatever patient has to say, no matter how absurd it is. You accept the patient: tell him that you may be dying, but you are important to us. Affirm him: no matter whatever happens, we will not desert you. These are the things dying patient wants. Communication not only involves verbal but also nonverbal modes. So, be careful about your facial expression and body language. Show him that you are interested in him. Doctor should try to spend as much as time as possible with the patient.

Charisma is sometimes useful to break routine-ness. It also creates awareness amongst public as public are interested in hearing to the celebrities. For e.g. if celebrities spend some time with these patients in hospices, it will create awareness amongst public by getting wide publicity in print and social media. This also boosts up morale of the patients.

When patient looses hope for life this should be replaced by another hope: hope of good palliative care.

By the time all specific anti cancer treatments are exhausted patient is also exhausted economically. They should be informed about possible economic support available e.g., prime minister's relief fund, social charitable organizations etc…

ETHICS in palliative care

Breaking the "BAD" news: When cancer is first diagnosed often doctor faces the dilemma whether the fact should be revealed or not. He thinks revealing the fact destroys the hope of the patient. However, telling lies destroys the trust and confidence of the patients in the doctor. In palliative care, it has been universally accepted that doctor should tell the truth always. The question is not "whether to tell or not" but "when to tell or how to tell". With good discussion patient gradually accept the truth and also co-operates with the doctor in treatment.

When nothing is possible do not just prolong the life. It is just prolonging the suffering. For e.g., giving I.V. fluids just to prolong life or enthusiastic cardio-pulmonary support and resuscitation are not warranted. Do not make treatment worse than disease.

Euthanasia is another ethical (and legal) problem. As on date euthanasia is not legalized in India and should not be offered. With good palliative care, less and less number of patients ask for it.

Physical symptoms

Cancer patients have a number of symptoms. Pain is the most important amongst them. Other common symptoms are Constipation, Vomiting, Dyspnoea, Anorexia, Cachexia, Hiccoughs, Ascites, Hypercalcaemia, Spinal cord –compression, Lymphoedema, Pruritus, Sec. mental disorders etc...

Pain is **"Unpleasant sensory and emotional experience associated**

with actual or potential tissue damage or described in terms of such damage" as defined by International Association for Study of Pain (IASP-1986). According to this definition a stimulus is not a must for pain. It considers pain as a psycho-somatic phenomenon.

Cancer Pain: Causes:	**Types**
1) Cancer itself	Nociceptive
2) Cancer treatment	Neurogenic
3) Investigative procedure	Sympathetic
4) Independent causes	

Myths about cancer pain: There are a number of misconceptions amongst doctors as well as patients about cancer pain, which leads to in-efficient management.

- Cancer pain is inevitable & untreatable
- Analgesics should be taken only if absolutely necessary
- Tolerance develops rapidly leaving nothing when things are really bad
- Addiction (Morphine)
- Tablets are ineffective
- Analgesics SOS
- Recommended doses shouldn't be exceeded (Standard doses derived from experience of post-operative pain management)
- Side effects: Stop the drug
- Morphine should be reserved for "really terminal"
- Non-drug measures are futile

Causes of unrelieved cancer pain

If patient's pain is not relieved consider these factors

- Cancer Pain Myths mentioned above
- Failure to give total care
- Ignoring psychological aspects

Pain - Management

- Examination to find out what is the real and exact cause of pain.
- Explanation to the patient itself decreases the pain to some extent.
- Modification of pathological process: RT/CT/Surgery
- Elevation of pain threshold (see below)
- Interruption of pain pathways: Local anaesthesia, Neurolysis, Blocks
- Life style modification
- Immobilization (in cases of pathological fractures etc..)

Pain – Threshold. If all these are not addressed in the management of pain, response will be sub-optimal.

Decreased	**Increased**
Insomnia	Relief of other symptoms
Discomfort	Sleep
Fatigue	Sympathy
Anxiety	Understanding
Fear	Companionship
Anger	Creative activity
Sadness	Relaxation
Depression	Anxiolysis
Mental isolation	Elevation of mood
Social abandonment	Analgesics, Antidepressants

Pain – Assessment of severity

Assessment of severity of pain is required to know the response to treatment and compare the results.

- **Type:** Nociceptive /Neurogenic /Sympathetic
- **Intensity:** Visual Analogue Scale (VAS)

(**Other methods:** Verbal rating/ verbal analogue/numeric analogue)

In visual analogue scale, a scale is marked at equi-distance from 1 to 10. 1 stands for no pain and 10 stands for maximum intensity of pain. Patient is asked to move the bead to indicate intensity of his pain in the range.

Aims of analgesic treatment

- To increase pain free hours of sleep: when this is achieved the next step is,
- To relieve pain at rest: when this is achieved, next aim is,
- To relieve pain at activity – may not be achieved always

Principles of cancer pain treatment

1) Cancer pain is continuous: hence, treatment also continuous. It is wrong to prescribe analgesics SOS to cancer patients.
2) SOS dose in addition to usual dose if pain increases in between.
3) Titrate the dose of analgesic
4) No maximum dose for oral morphine
5) Changing from one weak opioid to another will not help.
6) Never combine a weak opioid with a strong opioid.

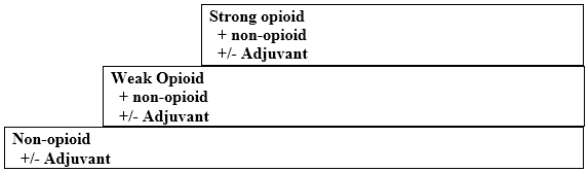
Principles of analgesic use

1) By mouth: as far as possible oral route must be used.
2) By clock: given at regular interval continuously and prophylactically. Not as SOS.
3) By ladder (see below for WHO Ladder)
4) Individualized: Dose should be titrated for each patient. There is no maximum dose for morphine. It has been given from 10mg to 1200 mg in different settings.

Analgesics

1) NSAIDs
2) Weak opioids
3) Strong opioids
4) Co-analgesics

WHO's "3 step analgesic ladder"



The analgesics are given in step wise manner. First, a non-opioid with or without an adjuvant is prescribed. This is continued as long as it can control the pain efficiently. If pain relief is not satisfactory or pain becomes uncontrollable after a period of control, then go to next step of the ladder i.e., add a weak opioid. If pain is not controlled with these drugs then, replace weak opioid with a strong opioid (step 3). It is a mistake to combine a weak opioid with a strong opioid. However, non-opioid and adjuvant may be used in all the three levels of ladder. Same principles apply for pediatric & geriatric patients also. Non-opioids are NSAID drugs.

Weak Opioids: Commonly used ones are Codeine and Tramadol.

Morphine

- Started at 5 or 10mg.
- Given 4th hourly.
- Double dose at bed time (to avoid getting up after 4 hours).
- Titrated against response: 50% increments.
- Always co-prescribe a laxative and continue as long as morphine is used.
- Anti-emetic & Anti-histaminic for first few days.

It is very important to give morphine strictly 4th hourly. Sustained release tablets (SR: 30 mg) are available which can be given 12th hourly.

Morphine exists to be given & not merely to be withheld. It is the strong opioid of choice for cancer pain. It is readily absorbed thru' all routes. Morphine is metabolized in the liver. Its duration of action is 3-6 hrs. The ***Advantages*** of morphine are: Cheap, Well absorbed, Well tolerated, Easy to take, Effective in 85% of patients, Wide therapeutic range, No cumulative toxicity, Avoids injections & infusions, Self administered.

Pain occurring during the treatment of pain with morphine in between is called ***break through pain***. It is treated by an additional dose of pain. Those pains which respond to morphine are called ***morphine responsive.*** Usually nociceptive pains are morphine responsive. There are certain pains which respond to morphine only partially. They are called ***semi responsive.*** Fallowing are the examples: Soft tissue, Muscle compression, Bone metastasis, Neuropathic, Raised ICT, Movement related. Certain types of pains are totally resistant to morphine. They are called ***morphine resistant pains.*** E.g., Headache (Tension, Migraine) uscle spasm, Nerve destruction pain, Sympathetic pain, Movement induced pain. Some types of pain are responsive but apparently resistant. These are known as ***morphine pseudo resistant***

pains. The causes for pseudo resistance are many e.g., under dosing, poor alimentary absorption (rare), vomiting, ignoring psychological aspects. Please note that there is no maximum dose for morphine. **The dose of morphine is the dose that controls the patient's pain while causing tolerable side effects.**

Morphine – Side effects: Initial side effects include Nausea, vomiting, Drowsiness, Delirium, Pruritus, Unsteadiness. These disappear after sometime with continuation of use. Some symptoms continues and persists as long as morphine is used. These are Constipation, Inactivity, Drowsiness. Occassional side effects include, urinary retention, myoclonus and sweating.

Morphine – Over dose results in Severe sedation or narcosis, Loss of consciousness, Respiratory depression.

Reversal of over dose: Nalaxone: 0.01-0.02mg IV in 3 min up to 5 doses. Repeat i.v. dose to maintain adequate respiration or continuous infusion of 2/3rd of initial successful dose/hr titrated against response. Respiratory & circulatory supports are required.

Neuropathic pain

Pain in an area of abnormal or absent sensation is always neuropathic. It may be due to nerve compression or nerve injury.

Causes: Carcinoma, Treatment, Related to carcinoma or debility, Concurrent causes.

CONCLUSIONS

Palliative care neither hastens nor delays the death. It regards dying as a natural process. Palliative care puts life into their days: Not days into their life. Palliative care seeks to prevent "LAST" days becoming "LOST" days. Pain relief should not be seen as a last resort or as failure.Pain relief should be accepted as an essential part of cancer treatment.

AIMS OF CANCER CARE SHOULD BE

- To cure some times
- To relieve often
- To comfort always

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