A SPECIAL REPORT OF THE

NEW JERSEY COMMISSION ON CANCER RESEARCH

IN COLLABORATION WITH

The NEW JERSEY PAIN INITIATIVE

New Jersey Commission
on Cancer Research

CANCER PAIN MANAGMENT:
AN UPDATE FOR PRIMARY CARE PHYSICIANS

Overview

Pain is a major public health problem in the United States. An estimated 60 million people will experience pain severe enough to seek medical treatment. Low back pain, migraine headaches, arthritis and cancer are the most common diagnoses requiring consultation. With respect to cancer, it is estimated that 50% of patients, newly diagnosed or intermediate stage disease, experience moderate to severe pain. Patients with advanced disease experience pain at a rate of 60-90%. In 42% of these cases, pain is not adequately controlled. Regardless of the diagnosis, barriers to adequate pain treatment are prevalent in New Jersey. Concerns about addiction and legal limitations are the two primary barriers cited by healthcare providers. Education is essential in minimizing these barriers and promoting appropriate pain management practice.

Clinical Management of Cancer Pain

Cancer pain can be managed effectively in the vast majority of cancer patients. Although pain may not be entirely eliminated, effective pain management can improve the quality of a patient's life at all stages of their disease. Flexibility is the key to managing cancer pain. The Agency for Health Care Policy and Research (AHCPR) guidelines, summarized below, were created to provide a dynamic approach for clinicians.

Key Elements to Patient Management

- Discuss pain and its management with patients and their families.
- Encourage patients to be active participants in their care.
- Reassure patients who are reluctant to report pain that relief can be safe and effective.
- Consider the cost of drugs and technologies.
- Share pain assessment with other clinicians treating the patient.
- Know state/local regulations.

Initial Assessment should include:

- Detailed history, including patient self-report.
- Physical examination.
- Psychosocial assessment.
- Diagnostic evaluation.

Pain Assessment should be at:

- regular intervals after initiation of treatment.
- each new report of pain.
- a suitable interval after pharmacologic or non-pharmacologic interventions.

Pharmacologic Management:

Inadequate administration of opioid analgesics is the most common reason for poorly controlled cancer pain. For pain management to be effective, knowledge of pharmacology and the unique principles of opoid dosing must be understood.

Guidelines for Opioid Analgesic Use in Cancer Pain Management

- Choose an appropriate route and drug.
  The oral route is always preferred when the GI tract is functional.
- Start with the lowest appropriate dose.
- Titrate dose to effect of intolerable side effects.
  Dose titration is essential at the start of therapy and almost always is needed at multiple points during the patient's course. Titrate patients every 1-2 days, if necessary. Increase the dose by 25-50% when increasing.
- Use PRN doses for breakthrough pain.
  While fixed, around-the-clock dosing is widely accepted in the management of acute and chronic pain; PRN doses are necessary to treat breakthrough pain. The PRN dose is 25% of the fixed, around-the-clock dose given at half the fixed dose interval.

Non-pharmacologic Management:

Recent studies have demonstrated value to including non-invasive physical and psychosocial modalities concurrently with drugs. Physical modalities include heat, cold, massage, pressure and vibration, exercise, repositioning, immobilization, transcutaneous electric nerve stimulation and acupunture. Psychosocial interventions include relaxation and imagery, hypnosis, cognitive distraction, short term psychotherapy and support groups. Many of these techniques involve direct and active participation by the patient who, in turn, gain a sense of control and improved coping skills.

Barriers to Effective Pain Management

Recent media reports have described the appropriate use and misuse of opioids by chronic pain sufferers and by individuals with a substance abuse disorder. In the case of the latter, media sensationalism contributes to the fear of addiction for healthcare providers and patients alike. A patient's need for escalating dose of a narcotic, due to a cancer or other chronic illness, is most often due to progression of the disease rather than addiction. Patients with stable disease can be maintained on the same dose for extremely long periods of time. In a retrospective study of nearly 40,000 hospitalized patients, Porter and Jick found only four of 11,882 patients treated with at least one strong opioid became addicted, and only one of these cases seemed significant. Other studies, including one by Perry and Heidrich at St. Barnabas Medical Center in Livingston, NJ support these earlier findings. Understanding the difference between tolerance, physical dependence, abstinence syndrome and addiction is essential to effective practice.

- **TOLERANCE** is a physical phenomenon. It develops when increasing doses of an opioid analgesic are required to produce the same effect. It occurs more rapidly with parenteral administration than with oral use. Increasing the dose or frequency of administration may be necessary to maintain analgesia.

- **DEPENDENCE** is a physical phenomenon. It occurs when opioid use is abruptly discontinued or when an opioid antagonist is administered. It develops with opioids as well as the administration of other drug classes. It is important to taper dosages before discontinuing the opioid and to avoid antagonist or agonist-antagonist drugs.
- **ABSTINENCE SYNDRONE** is a physical phenomenon. It can occur in any physically-dependent patient. It occurs when there is a discontinuation or rapid decrease in the dose of an opioid, because the cause of pain is effectively eliminated. It can be avoided if titration occurs on a planned schedule.
- **ADDICTION** or *psychological dependence* is a psychological phenomenon. It describes a pattern of compulsive drug-seeking behavior, which leads to an overwhelming involvement with the use and procurement of an opioid.

Patients experiencing pain, who also have a history of substance abuse disorder, require an interdisciplinary assessment and management by specialists in pain, addiction and psychiatry. Mutually agreed upon goals must be established and are recommended to be in the form of a written contract. Rules concerning prescription renewal, lost or stolen prescriptions or forgery, single physician/pharmacist prescribing/dispensing, frequency of visits, and random drug screening should be included. It is important to distinguish among active abusers, individuals in methadone maintenance programs and those in recovery.

State/Local Laws & Regulations

Regulatory complexity has also been a barrier to pain management and has contributed to the reluctance of practitioners to prescribe opioids for chronic pain patients. The previous law placed limits based on the amount of dosage units within 30 days. A regulatory revision by the Board of Medical Examiners in November 1997 began to address this issue. The new regulation (N.J.A.C. 13:35-7) states "a practitioner may exceed the 120 dosage unit limitation, but not a 30 day supply, for a patient who is suffering from cancer pain, intractable pain or terminal illness."

The following guidelines provide for a patient's right to adequate and efficient treatment for chronic pain under NJAC 13:35-7. **A treatment plan will:**

- Document the provision of effective pain management tailored to the needs of the patient.
- Indicate a detailed discussion with patient, guardian or authorized representative, including benefits and risks of the controlled substance.
- Include objectives for evaluating treatment success (i.e. pain relief or improved function), and further diagnostic/treatment plans, as indicated.

Practitioners are required to:

- Review a treatment course and objectives at a minimum of every three months.
- Evaluate for physical/psychological dependence.
- Decrease or discontinue the use of controlled substances or assess for alternative treatment modalities, if clinically indicated.
- Re-evaluate and/or refer for consultation/evaluation/treatment if treatment objectives are not achieved.
- Develop written agreements concerning controlled substance use and the consequences of misuse.

Written documentation shall also include:

- Patient name, address and date of birth.
- Medical indication for controlled substance.
- Complete name of controlled substance.
- Dosage, strength and frequency of medication.
- Medical history, physical exam.
- Completion of scheduled consultations and evaluations.

- Evidence of informed consent.
- Contracts between practitioner and patient.
- Periodic review.
- Practitioner's DEA # and state license #.

In an effort to dispel the myths and break down the barriers associated with pain management, continued education and regulatory review are imperative.

Guest Editors for this Newsletter are Diana W. Vamos, R.Ph. and Michael P. Kane, R.Ph. from the Department of Pharmacology at the Cancer Institute of New Jersey, New Brunswick, NJ

Helpful Websites

New Jersey Pain Initiative	www.njpainrelief.org
Agency for Health Care Research and Quality	www.ahcpr.gov
American Alliance of Cancer Pain Initiatives	www.aacpi.org
American Pain Foundation	www.painfoundation.org
American Pain Society	www.ampainsoc.org
Joint Commission on Accreditation of HealthcareOrganizations	www.jcaho.org
American Cancer Society	www.cancer.org
National Cancer Istitute	www.nci.nih..gov

Any questions, comments or requests about cancer pain management should be directed to Kristina Thomson, NJ Pain Initiative, 732 297-8000

This newsletter was produced by Ann Marie Hill, Executive Director of the New Jersey Commission on Cancer Research and Kristina Thomson, Director of the New Jersey Pain Initiative as an oncology update for practicing physicians and health professionals in New Jersey. Any questions, comments or requests for further information on the NJ Pain Initiative should be directed to Kristina Thomson at (732) 297-8000. Additional comments or ideas for other reports should be forwarded to the Commission Offices, 28 West State Street, PO Box 360, Trenton, NJ 08625-0360 Phone (609) 633-6552 Fax (609) 633-6814, email: njccr@doh.state.nj.us

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