

The Assessment of Cancer Treatment-Related Pain

An Interdisciplinary Approach to the Assessment and Management of Cancer Treatment Related Pain

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*I'm afraid
the cancer is back.*

The pain just won't go away.




Objectives

- Describe common presentations of CTRP
- Discuss an approach to assessment of this type of pain including common characteristics of CTRP
- Describe red flags that support suspicion of disease recurrence versus CTRP

Case: Sheila

- Came to the Cancer Pain clinic in October 2007

Case: Sheila

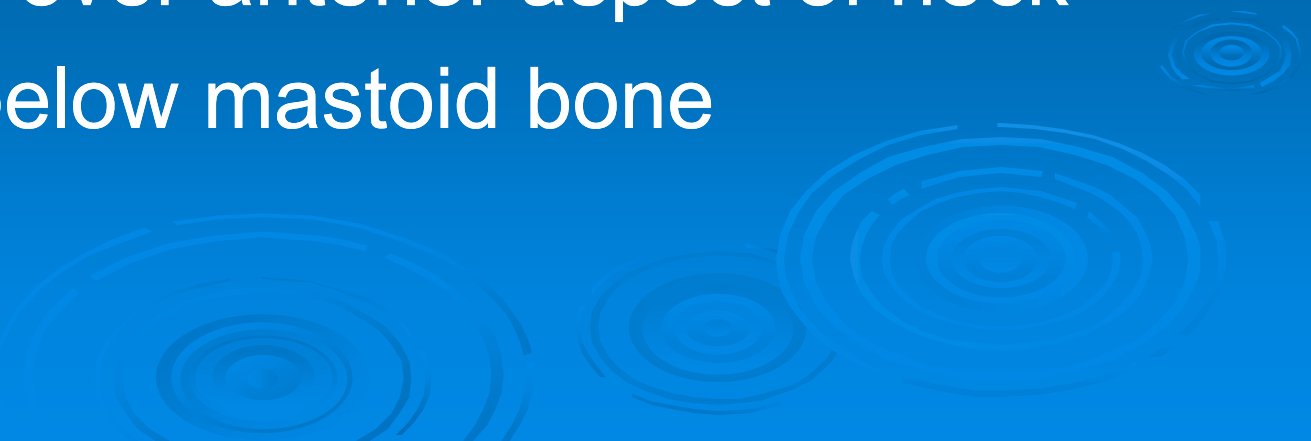
- 53 year old woman with a squamous cell cancer of the oral cavity, left side
 - Neck dissection January 2006 followed by radiation treatment
 - Second dissection and flap procedure in September 2006
 - Pain began after 2nd surgery
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She was told the pain “would go away” or that it was “the price of being alive”.

“You just have to live with it”



Sheila

- Pain began immediately after 1st, then 2nd surgery
 - Constant aching to her left, lateral neck with a pulling sensation
 - Frequent lancinating pain, not burning
 - Numbness over anterior aspect of neck
 - Allodynia below mastoid bone
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- Several months later, pain to posterior cervical area, inter-scapular region and in both shoulders: constant aching
- Rates “25/10”
- No evidence of recurrence

Recurrence or CTRP?



Prevalence of cancer pain

Over 70% of persons with cancer will have moderate to severe pain



Cancer treatment related pain (CTRP)

- Older literature stated that pain was largely due to recurrent or persistent cancer
- A recent survey of ambulatory patients at a major cancer centre found that $\frac{1}{2}$ of the “cancer pain” occurred in the absence of demonstrable recurrence
- Therefore, CTRP may be responsible for a substantial amount of the pain in the patient living with cancer

Cancer treatment related pain (CTRP)

- Over recent years, the number of “cancer survivors” has increased
 - Due to aging population as well as
↓mortality in some tumour types due to earlier detection & more effective adjuvant therapy
- A comprehensive approach to cancer treatment (surgery, radiation, curative, palliative & adjuvant chemotherapy) may come with the price of morbidity, one of which is CTRP

Why does CTRP deserve attention?

- It can be as severe as cancer pain
- It may limit treatment delivery
- It may be confused with cancer as the underlying source of pain
- It is a source of morbidity that may limit function and quality of life
- It is often neuropathic in origin requiring the use of adjuvant analgesics that may be unfamiliar to treating physicians

Back to Sheila



Medications

- Topical anti-inflammatory ointment
- Ibuprofen PRN
- Acetaminophen
- Oxycodone with acetaminophen: uses 1 or 2 daily “to take the edge off”
- Sennosides, docusate

Social Context

- Lives alone
- Adult son lives close by
- Isolated, suburban apartment
- Worked with special needs children

- 2 sisters, one being treated for a GI cancer
- Father died at age 52 of a head and neck cancer

The meaning of pain

- She is convinced the cancer has returned
- Multiple sources of loss because of pain, social isolation and disability associated with disease and treatment



Recurrence or CTRP?

If disease recurrence is likely,
do we alter our approach to
management?

What are the **Red Flags** that
should raise suspicion for
recurrence?

Responsible Therapy	Examples
Post-surgical Pain	<ul style="list-style-type: none"> ➤ Post breast surgery (especially after axillary exploration) ➤ Post thoracotomy ➤ Post neck Dissection ➤ Many other procedures
Systemic therapy associated pain: <ul style="list-style-type: none"> ➤ Peripheral neuropathy ➤ Myalgias/Neuralgias ➤ Osteonecrosis of the jaw 	<ul style="list-style-type: none"> ➤ Paclitaxel, docetaxel, vinorelbine, carboplatin, cisplatin, oxaliplatin, ixabepilone, vincristine, vinblastine, thalidomide, bortezomib ➤ Aromatase inhibitor induced ➤ Bisphosphonates
Radiation therapy-associated pain	Plexopathies / myelopathies

Post-surgical pain

- Usually begins 1-2 mo. following the procedure but may be hard to distinguish from the acute postoperative pain
- Although typically neuropathic, sometimes described as aching rather than burning or electric shock

Post-surgical pain

- Common concern is whether the pain is merely a postoperative phenomenon or represents disease recurrence
- Should be concerned that there is tumor recurrence late onset of pain e.g. 6 mo. post procedure & steadily increasing intensity over a period of months

Assessment

- Major assessment tools as with any pain is the comprehensive history

Comprehensive history includes:

- Takes in to account physiological, behavioural and cognitive-affective factors
- **Pain Characteristics**
- **Effect on Usual Routines**
- **Cognitive - Affective Responses**

Comprehensive history includes:

- Disease treatment, especially chemotherapy regimens, surgical interventions including reading operative notes & radiation therapy
- Time course of the pain in relation to treatment
 - Most post-surgical pains start either immediately post-operatively or within 4-8 wk after surgery
 - Pain occurring much later may be due to recurrence
 - Post-radiation neuritis may occur years after radiation

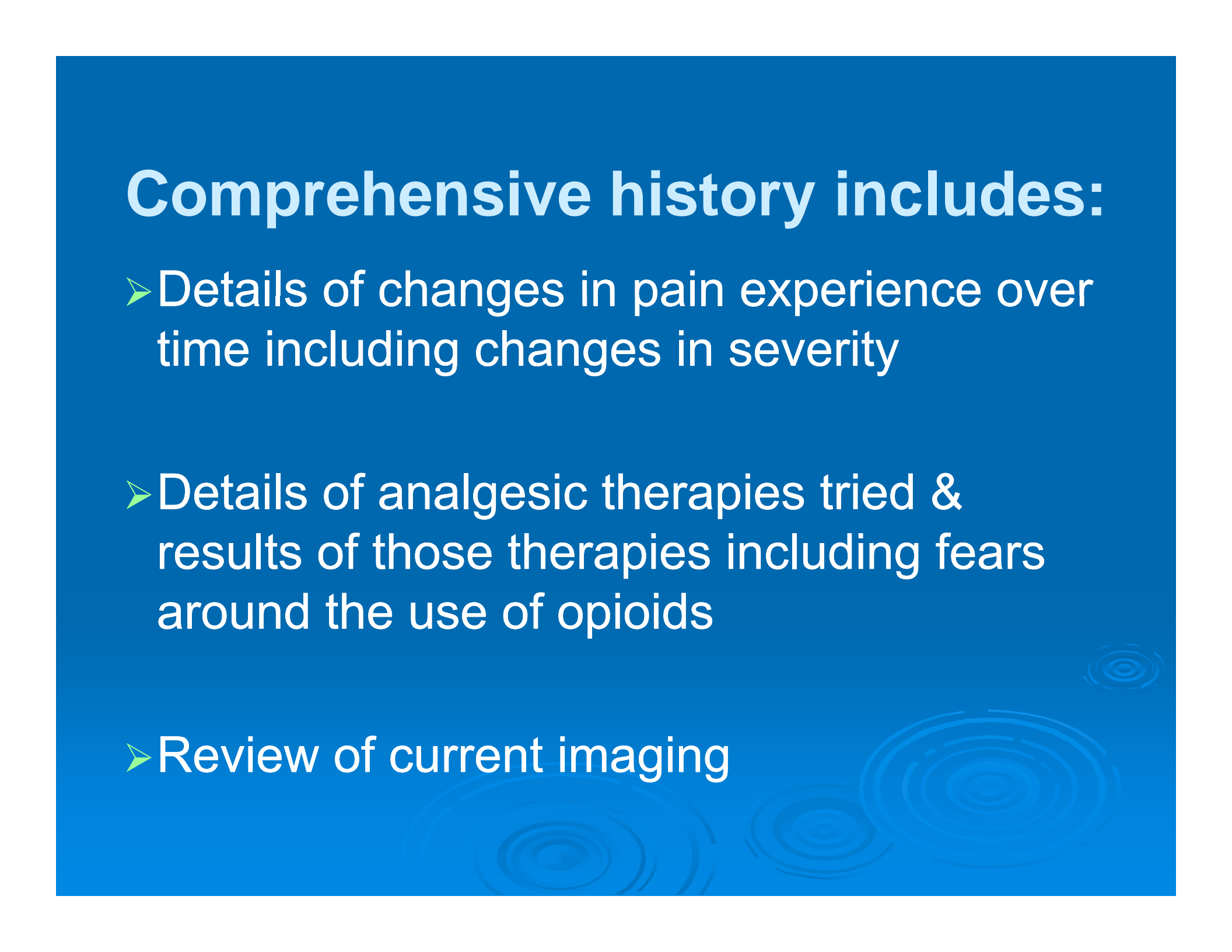
Comprehensive history includes:

➤ Site & quality of pain:


- typical features of neuropathic pain: radiating, lancinating pain, a burning quality, areas of dysesthesia or skin hyposensitivity / hypersensitivity

➤ Pain related to abdominal or pelvic surgery is often described as a deep aching, twisting & pulling sensation

Comprehensive history includes:

- Details of changes in pain experience over time including changes in severity
 - Details of analgesic therapies tried & results of those therapies including fears around the use of opioids
 - Review of current imaging
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Comprehensive history includes:

- Identification of co-factors such as diabetes or medications with potential for nerve damage
 - Past experiences with chronic pain
 - History of mental disorders & drug or alcohol use
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Physical examination

- Limited physical examination should be done to look for neurological changes & evidence of recurrence of cancer if any
- With peripheral nerve injuries, hypo- or hypersensitivity in areas of pain may be found

Investigations

- Few will aid in diagnosis or management of CTRP
- Nerve conduction studies may be inconclusive since isolating small peripheral nerves may not be possible especially in areas of surgery
- New imaging & other investigations should generally be done in patients whose pain begins well after the cancer treatment intervention to rule out disease recurrence

Sheila

- CTRP responded well to a combination of SR opioids and gabapentin
- One year later, she developed progressive systemic symptoms: fatigue, SOB
- New dental pain to left mandible
- Imaging and dental consult: lesion under molar and lung metastases

Red Flags for Disease Recurrence

1. Progressive pain over a defined period of time
 - Onset more than 6 months after treatment
 - Changes in pain experience over time including severity or intensity of pain and location
2. Changes in global functioning, constitutional factors

