

# Integrative Pain Management-Physical, Emotional and Spiritual, Issues

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# Objectives: Understand

- nature of palliative care services.
- nature of physical, emotional and spiritual pain
- assessment and management of various pain syndromes
- Complementary approaches to pain management

# The Myths and Facts About Palliative Care

## • Palliative Care **IS**:

- A philosophy of care
- The management of physical, emotional, social, and spiritual "suffering"
- Best utilized at the onset of diagnosis and throughout the disease course
- Symptoms related to a chronic, life-threatening, or terminal disease process
- A collaborative effort of the Interdisciplinary team, patient, family, caregiver, and research team.

## • Palliative Care **IS**

### **NOT**:

- A treatment modality
- Restricted to pain management
- Utilized during end-of-life care only
- Limited to cancer-related diagnosis
- Paternalistic/maternalistic

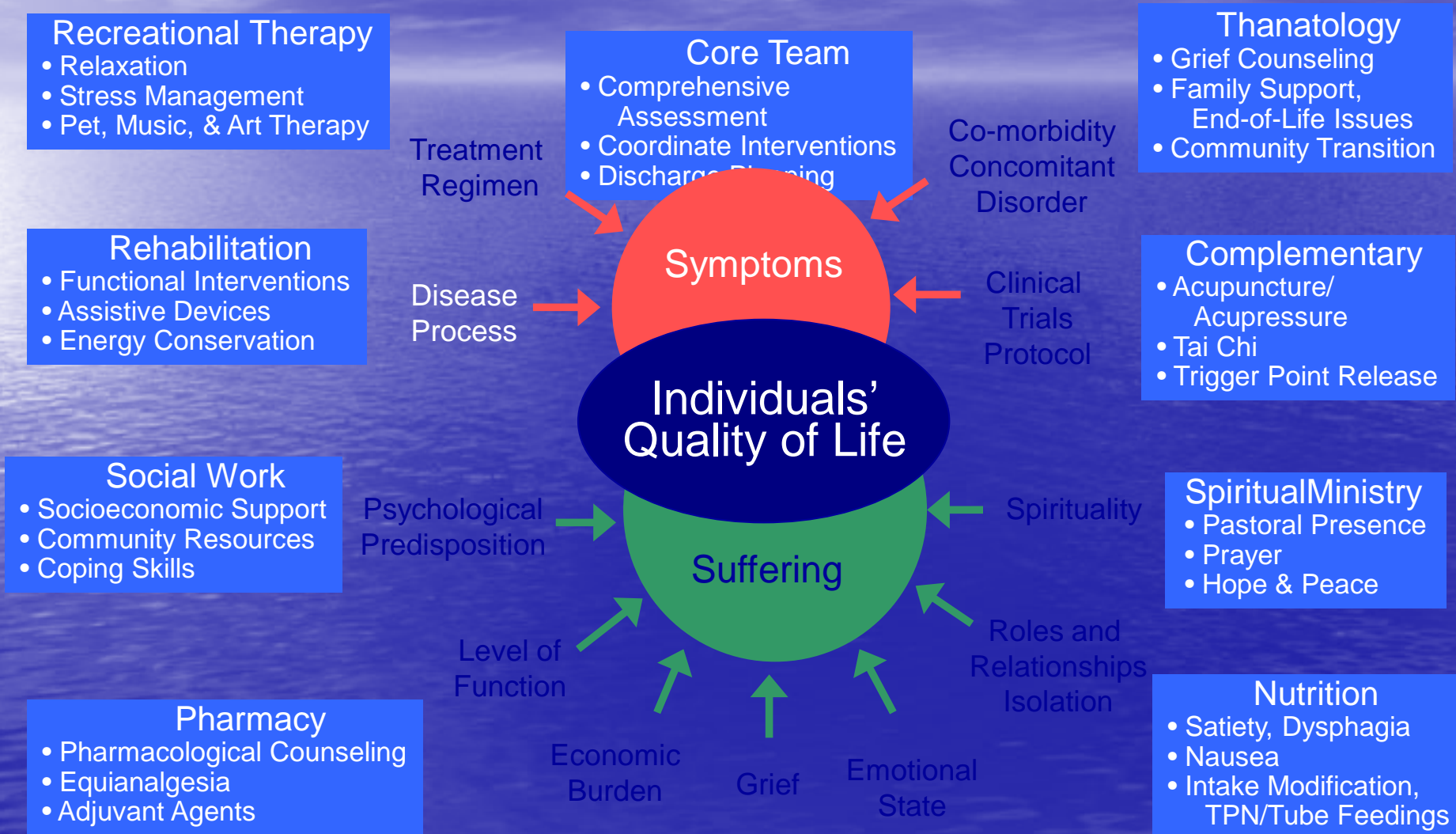
# Palliative Care Philosophy

- To cure sometimes, to relieve often, and to comfort always
- Bridge science and humanism to provide competent and compassionate care
- Enable the patient and family to become “empowered” through education and support
- Provide early intervention of symptom management and coping skills

# Palliative Care Philosophy

- Promote collaborative relationship-centered communication . . . “break down hierarchical relationships”
- Relieve suffering and improve quality of life
- Validate and disseminate information through research-based investigation and documentation
- Integrate palliative care services into mainstream of medical therapy

# It takes a nurturing interdisciplinary team to practice the nature of palliative care



# Essence of a Palliative Care Service

- Utilizing liaisons as integral interdisciplinary team members
- Providing palliative symptom management in conjunction with aggressive treatment modalities
- Ensuring continuity of symptom management /support throughout the stages of the disease process & across healthcare settings
- Implementing integrative medicine

# Quality of Life Palliative Care Symptoms

- Lack of energy (74.2%)
- Worrying (70.9%)
- Feeling sad (66.1%)
- Pain (62.7%)
- Feeling nervous (61.9%)
- Drowsiness (61.0%)
- Dry mouth (56.5%)
- Difficulty sleeping (53.7%)
- Feeling irritable (48.3%)



# Quality of Life Palliative Care Symptoms

- Nausea (45.5%)
- Dizziness (24.4%)
- Loss of appetite (45.5%)
- Diarrhea (24.3%)
- Sexual problems (23.9%)
- Shortness of breath (23.5%)
- Vomiting (21.0%)
- Hair loss (17.8%)
- Urination problems (15.7%)

# Acute vs. Chronic Pain

## Acute

time course-transient

features-fight or flight

pupillary dilatation

sweating



increased RR



increased HR



increased shunting of  
blood from  
viscera to muscles

## Chronic

vegetative

Sleep disturbances

anorexia

decreased libido



anhedonia

constipation

Somatic pre-occupation

Personality change

lethargy

# Pathophysiologic Mechanisms of Pain

<u>Type</u>	<u>Cause</u>	<u>Characteristics</u>
Somatic	Nociceptor activation	Aching or gnawing, localized
Visceral	Nociceptor activation	Aching, vaguely localized, often referred
Neuropathic	Destruction of a nerve	Severe or dull shooting pain on background of burning, aching sensations

# Somatic Nociceptive Pain

- Responsive to:
  - narcotics
  - chemical or surgical blockade of proximal innervation provides effective analgesia and anesthesia

# Key Points of Comprehensive Assessment

- Recognize pain and its location, subjective quality, and severity
- Assess not only the type and intensity of pain but how it impacts life of patient
- Use pain assessment to determine the pathophysiology and select treatment strategies
- Determine the best time(s) to assess and reassess the pain
- Establish comfort/function goals with the patient

Vallerand. *Semin Oncol Nurs* 1997;13:16.

McCaffery and Pasero. *Pain Clinical Manual*; 1999:67.

# Pain Management

- **Pharmacotherapy**
  - analgesic ladder
    - opioid analgesics
    - nonopioid analgesics
    - adjuvant analgesics
- **Adjuvant techniques**
  - noninvasive
    - psychosocial interventions
    - relaxation techniques
    - distraction techniques
  - invasive
    - nerve blocks
    - surgical or chemical ablation
    - spinal opioid infusions

# Extended Release and Long Half-Life Opioids

- Longer half-lives (12-24 hours)
- Release drugs over 8, 12, 24, 72 hours.
- Extended release tablets (do not crush)
- Extended release capsules (may open)
  - Extended release patches

# Opioids for Moderate to Severe Pain

## *Long Acting*

- Morphine (MS Contin, Oramorph SR, Kadian)
- Oxycodone (Oxycontin)
- Fentanyl (Duragesic)
- Methadone (Dolophine)
- Levorphanol (Levo-Dromoran)



# Opioids for Moderate to Severe Pain

## *Short Acting*

- Morphine (Roxanol, MSIR)
- Oxycodone (Roxicodone, Oxy IR)
- Fentanyl (Actiq)
- Hydromorphone (Dilaudid)

# Other Routes

- Continuous Subcutaneous Infusion (CSCI)
- Intravenous Infusion
- Intraspinal Infusion
  - Epidural
  - Intrathecal
  - Intraventricular
- Direct Neuro-Axial Dosing
  - Epidural
  - Intrathecal (spinal)

# Methadone

- Consider for high tolerance, hyperalgesia, and neuropathic pain, or when cost is significant barrier.
  - Lacks neuroactive metabolites
  - Has two nonopiate analgesic receptor activities:
    - Prevents MAO reuptake in periaqueductal gray
    - Prevents N-methyl-d-aspartate (NMDA) receptors
  - Negative: long half-life and association with addiction

# Transdermal System

- Fentanyl
  - 100 times more potent than Morphine.
  - Advantages of using fentanyl in transdermal system:
    - lipid solubility
    - capillary penetration
    - high analgesic potency

# WHO IS NOT APPROPRIATE FOR TRANSDERMAL FENTANYL?

- Patients who are:
  - Anorexic or Cachexic
  - Sweating profusely
  - Experiencing "Fluid in Funny Places"
    - Ascites
    - Pleural Effusion
    - Peripheral Edema
  - Currently taking less than 50 mg of Oral Morphine or the equivalent.

# Breakthrough Pain

A transitory exacerbation of pain that occurs on a background of otherwise stable pain in a patient receiving chronic opioid therapy

Portenoy, R (1990)

# BREAKTHROUGH DOSING

- Treatment of pain at rest or with movement.
- Immediate release preparation of same medication.
- Dosing: 10-20 % of 24 hour dose of opioid.
  - PO q 1-4 hours PRN
  - SQ q 15-30 minutes PRN
  - IV q 5-15 minutes PRN

# OT Fentanyl Use: Optimal Absorption Through Oral Mucosa

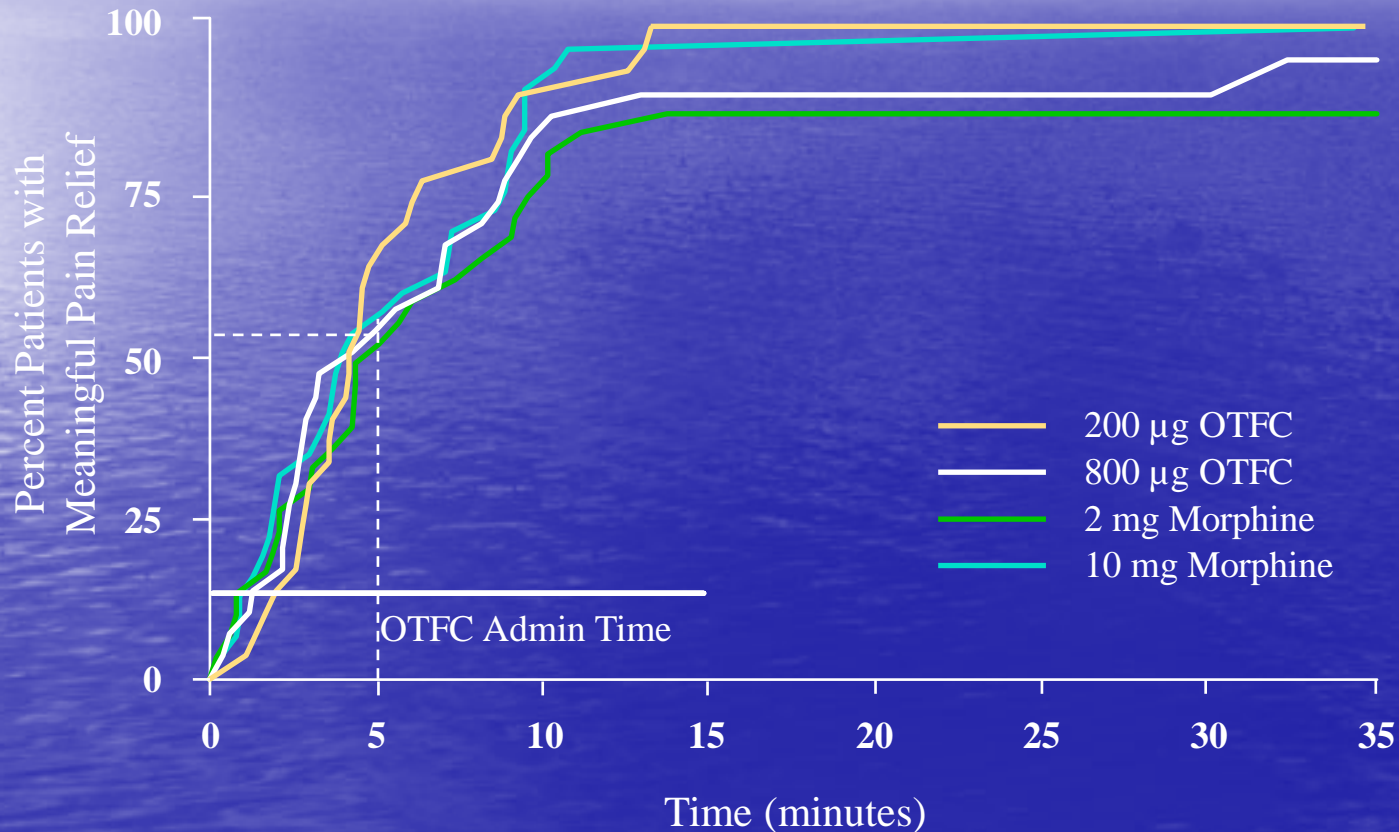
- Rate of consumption: 15 minutes.
- Saliva production: enough for dissolution.
- Swallowing of drug: minimize.
- Area of mucosa: buccal.
- pH of mouth: avoid low pH fluids i.e..  
OJ



# OT Fentanyl Bioavailability

- 50% Total Bioavailability
  - 25% Rapid OT absorption.
  - 25% Slow GI absorption.
  - 50% Lost to liver metabolism or not absorbed.

# Onset of Pain Relief: OTFC vs IV Morphine



Adapted from Sevarino FB, et al. *Anesth Analg* 1997;84:S330.

# Management of Common Opioid Side effects

- Constipation
  - prophylactic use of laxatives and stool softeners
- Nausea and vomiting
  - neuroleptics, metoclopramide, cisapride, antivertigenous drugs
- Sedation
  - discontinue other CNS depressants
  - add psychostimulants
- Respiratory depression
  - monitor if not severe; carefully titrate naloxone if severe

# Neuropathic Pain

- involves neuronal malfunction
- after insult to distal or proximal neural element
- marked by aberrant receptor function or sensory processing resulting in a sensation of pain

# Neuropathic Pain- common examples

Metabolic

- Diabetic neuropathy

Infectious

- Herpes zoster

Traumatic

- Post-surgical nerve impingement

- Brachial or lumbosacral plexopathy

- Post CVA neuropathy

- Phantom limb phenomena

- Post spinal cord injury pain

Chemotherapy induced

# Neuropathic Pain

- Less sensitive to standard analgesic regimens than somatic pain
  - NSAID's usually ineffective
  - opioids usually required in large doses
  - tolerance quickly develops
- Adjuvant analgesics may be helpful

# Neuropathic Pain- Adjuvant Analgesics

- Tricyclic antidepressants
- Anticonvulsants
- Clonidine
- Corticosteroids
- Local anesthetics
  - Mexilitine

# Procedures

Intractable, local pain syndromes

Regional neurolytic blocks

Ablative; Radiofrequency

Central analgesia

Intrathecal/epidural



# Complementary Approaches

Acupressure

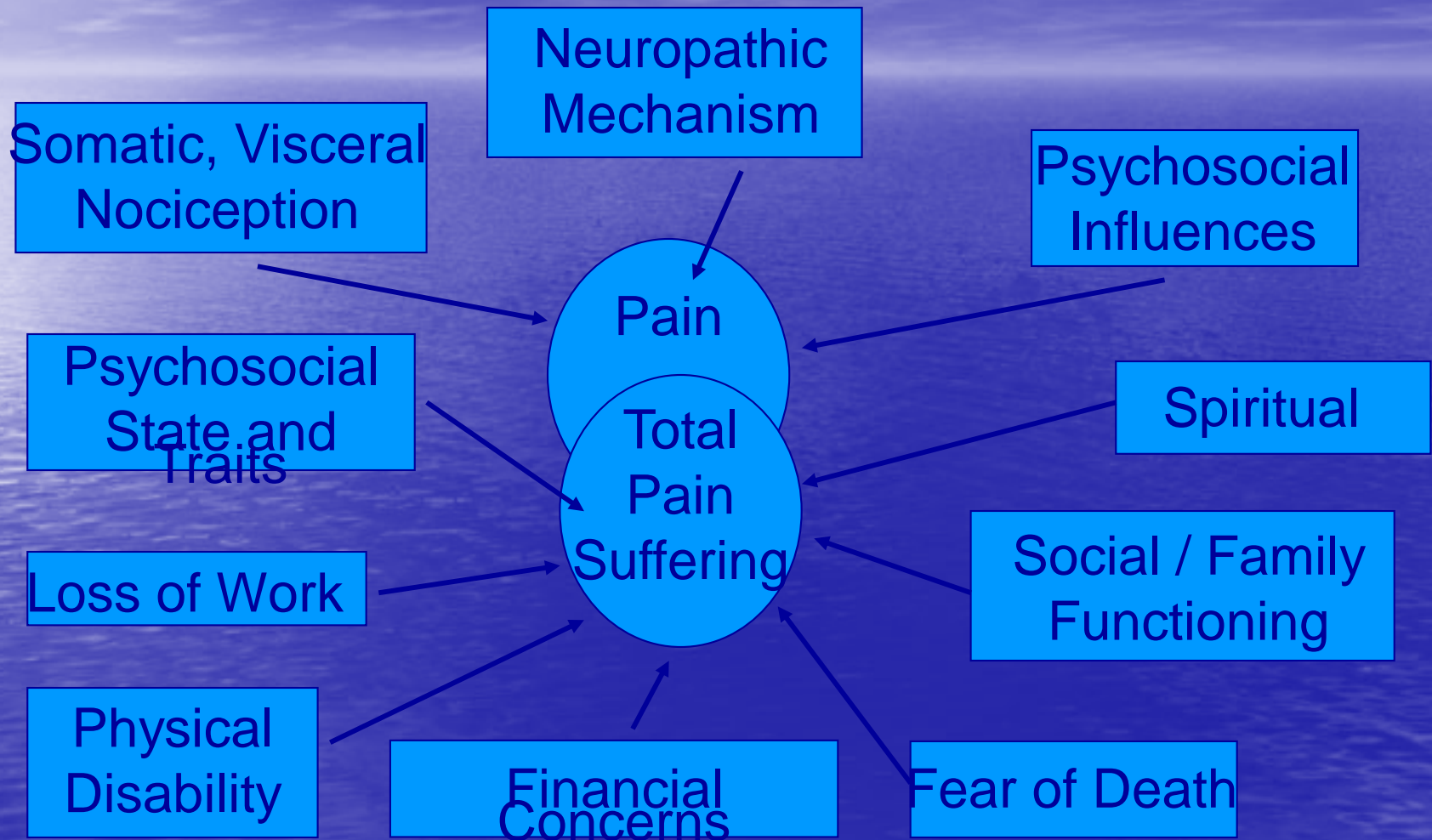
Acupuncture

Massage

Trigger Point

ProTens

# Nature of Pain



# Emotional Pain “hurts all over”

Most common palliative care symptoms

*Anxiety*; may present as sleeplessness,  
reluctant to be left alone or overt fright

*Anticipatory Anxiety*; previous negative  
experience becomes overwhelming

Treatment: relaxation & imagery,  
acupressure, massage, music therapy,  
hypnosis.... then maybe pharmacotherapy  
such as lorazepam, haloperidol

# Emotional Pain:

*Care Giver Burden "communication, communication, communication"*

Spirit of cooperation

Complex family dynamics emerge

Support to work through accumulated emotions

Can not take away all of the symptoms all the time

Imposing own expectations

Sense of presence is the very best medicine

# Spirituality

The part of self where search for meaning takes place.

Distinction between religion and spirituality

Intimate connection with life through family, home, friends, leisure and work

# Spirituality

## Spiritual Assessment

Spiritual History Developed for Physicians

F = Faith & Belief

or “Do you consider yourself spiritual  
religious?” or “Do you have spiritual  
beliefs that help you cope with  
stress?”

# Spiritual History

I = Importance

What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?

# Spiritual History

C = Community

Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?



# Spiritual History

A = Address in Care

How would you like me, your health care provider, to address these issues in your health care?

# Spiritual Pain

Disconnection threatened by or challenges the individuals ability to make meaning

Treatment plan may include:

- ❖ Chaplain interventions
- ❖ Labyrinth; prayerful reflection and focus following an octagonal/circular, interchanging pathway
- ❖ Mandalas'; a sacred circle of meditation

# Non Pharmacological Methods of Pain Management

- Distraction
- Hypnosis
- Relaxation Exercise
- Biofeedback
- Guided Imagery
- Acupuncture
- Meditation
- Pet Therapy
- Art Therapy
- Music Therapy
- Reiki
- Tea Party





# Biofeedback

- Training technique used for relaxation and self-regulation. First and foremost, it provides direct feedback to client of their bodily processes.
- Goals:
  - Self regulation
  - Decrease anxiety
  - Educational experience providing validation and guidance for self-regulation

# Guided Imagery

1. cognitive tool to achieve desired therapeutic outcome
2. method of deliberate use of imagery to modify behavior, perceptions, feelings, or internal psychological state
3. A process that uses thoughts to evoke and use the senses (thinking in pictures instead of in words)

# Guided Imagery- Benefits

- Decrease muscular tension
- 'Reinforces the message' to Relax
- Pain control
- Amelioration of other symptom
- Distracts the mind (from bothersome symptom or state to reduce suffering)
- Accesses feelings



# Hypnosis

- Purposeful altered state of consciousness
  - Focus of attention
  - Ability to accomplish psycho physiologic changes which are otherwise more difficult to accomplish
  - Often accompanied by relaxation

# Hypnosis Benefits/Uses

- Accrue from direct response to suggestion
- Pain, anxiety, sleep, nausea and physical symptoms
- Addiction, habits, phobias
- Coping with internal or external stressors or stimuli

# Reiki

Universal life force energy or spirit

Conveyed through touch and intention

It can do no harm

Follows 7 chakras; it is not given by the healer, but rather accepted by the healee

# The Secret to Success In Palliative Care

- "Back to the Basics" of bedside caring
- One success at a time, "actions speak louder than words"
- Teach by "recommendation rather than prescription"
- Palliate staff as well as patients/families











“You can’t die cured, but you can die healed. Healing is about a sense of wholeness as a person, and that wholeness includes understanding our mortality, our place in the world—death is not a betrayal of life, but a part of it.”

- Dan Frimmer M.D.
- *TIME* Magazine, 2000





“You matter because you are you. You matter to the last moment of your life, and we will do all that we can not only to help you die peacefully, but also to live”  
until you die.

- Dame Cicely Saunders