**Multidisciplinary Approaches to Cancer Symposium**

# Opioid Sparing Pain Management Strategies for Cancer Patients

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# Disclosures

- I do not have any relevant financial relationships.

*This presentation and/or comments will provide a balanced, non-promotional, and evidence-based approach to all diagnostic, therapeutic and/or research related content.*

**The off-label/investigational use of Buprenorphine sublingual films/tablets will be addressed.**

# To prescribe opioids or not to prescribe……

Quality of life linked to length of life

Guidelines have opioids as mainstay of management

75-90% of patients with advanced disease experience cancer pain

Undertreatment prevalent in 40% of cancer patients and significantly higher in underrepresented populations

Chronic cancer pain is experienced by 30-50% of patients under active antineoplastic therapy

Prescribing responsibility

Risk for harm

Regulations and guidelines

**Opioid epidemic**


van den Beuken-van Everdingen MH, de Rijke JM, Kessels AG, Schouten HC, van Kleef M, Patijn J. High prevalence of pain in patients with cancer in a large population-based study in The Netherlands. Pain. 2007;132(3):312. Epub 2007 Oct 3.

Teunissen SC, Wesker W, Kruitwagen C, de Haes HC, Voest EE, de Graeff A. Symptom prevalence in patients with incurable cancer: a systematic review. J Pain Symptom Manage. 2007;34(1):94.

# Goal

Integrate an opioid sparing approach to effectively treat cancer pain.

# Framework for Approach
# 2023 NCCN Guidelines- General Principles of Cancer Pain Management

| |
|---|
| Optimal use of disease-specific therapies |
| Survival is linked to symptom control and pain management |
| Analgesic therapy is done in conjunction with management of multiple symptoms and symptom clusters (sleep, nausea, anxiety, etc.) |
| Engage a multidisciplinary team (Palliative/supportive care, pain anesthesia, radiation oncology, interventional radiology) |
| Provide accessible education material to improve pain assessment, pain management and the safe use of analgesics |
| Shared decision making |
| Address the multidimensional impact of “suffering” on patients and caregivers in a culturally respectful manner |

***GOALS OF CARE***

NCCN Guidelines Version 1.2023. Adult Cancer Pain. Assessed 8/1/2023. https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf

# Pain

Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.

Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.

Through their life experiences, individuals learn the concept of pain.

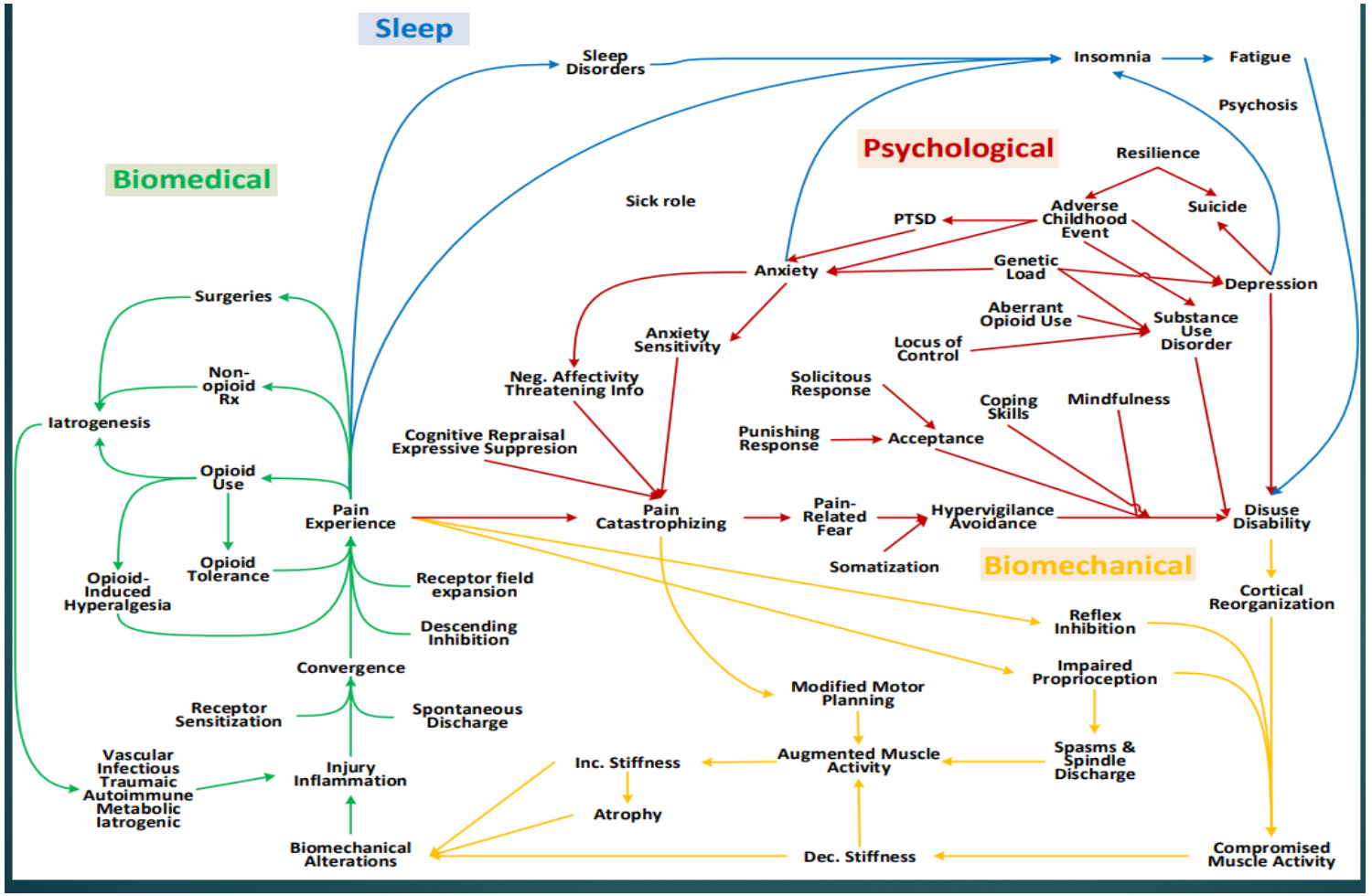
A person's report of an experience as pain should be respected.

Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.

Verbal description is only one of several behaviors to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.

Bennett MI, Kaasa S, Barke A, et al. The IASP classification of chronic pain for ICD-11: chronic cancer-related pain. Pain 2019;160:38-44.

# Complexity of Pain (BioPsychosocial Model)




https://choir.stanford.edu/research/

# Types of pain

**Nociceptive pain (purposeful pain):** caused by stimulation of nociceptors (pain receptors for a tissue injury) * pure mu agonist opioids often indicated for management of **severe** pain

- Visceral: internal organs

(pressure/aching/squeezing/cramping)

- Somatic: skin, joints, connective tissues, bones

(aching/gnawing sensation/ deep or superficial)

**Inflammatory pain:** caused by inflammatory factors *pure mu agonist opioids not indicated

**Neuropathic pain (nonpurposeful pain):** damage to or dysfunction of the nervous symptom *pure mu agonist opioids not indicated

- Burning/freezing/numbness/tingling/shooting/stabbing/electrical shocks

**Functional pain (dysfunctional pain):** often ill defined- non-neuropathic/non-inflammatory *pure mu agonist opioids not indicated

Vadivelu, N. et al. Pain pathways and acute pain processing. In Sinatra RS, et al, eds. Acute Pain Management. New York, NY: Cambridge University Press, 2009 3-20.

# Pain

**Acute pain:** < 3 months, typically a cause/injury
Assessment: Physical exam, diagnostics, comprehensive pain assessment if new or worsening pain, appropriate **pain scale,** caregiver perspective
Management: Often includes a pure mu agonist opioid as tool for severe pain management

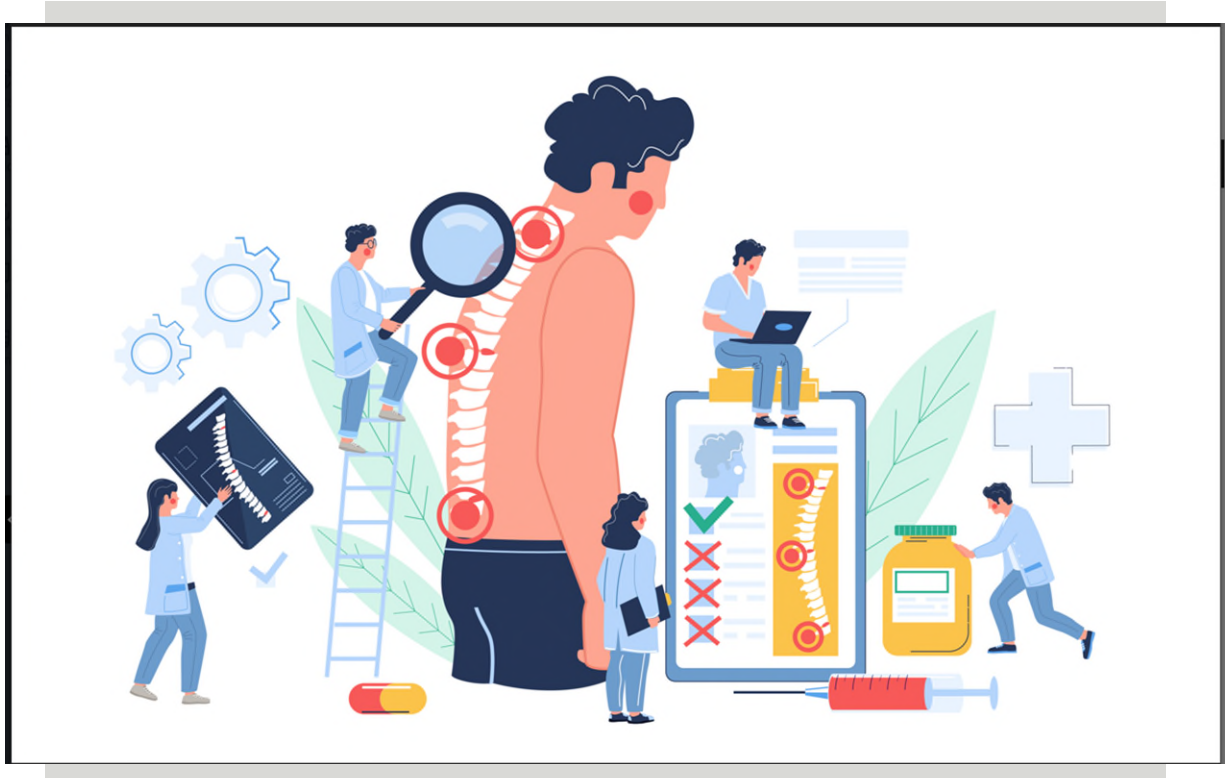

Gap in the cancer pain guidelines!

**Chronic pain:** > 3 months, persists after original injury heals
Assessment: Physical exam, +/- diagnostics, **functional pain scale,** caregiver perspective
Management: Less focus on opioid as the primary tool for pain management


Hicks CL, von Baeyer CL, Spafford P, et al. The Faces Pain Scale - Revised: Toward a common metric in pediatric pain measurement. Pain 2001;93:173-183. FPS-R © 2001, International Association for the Study of Pain. All rights reserved.
Ware LJ, Epps CD, Herr K, Packard A. Evaluation of the Revised Faces Pain Scale, Verbal Descriptor Scale, Numeric Rating Scale, and Iowa Pain Thermometer in older minority adults. Pain Manag Nurs 2006;7:117-125.

# Assessing Beyond PQRST- the pain experience

- Meaning and consequences of pain for patient/family/caregiver
- Patient and family/caregiver knowledge and beliefs about pain and pain medications
- Cultural beliefs toward pain, pain expression, and treatment
- Spiritual, religious considerations, and **existential suffering**
- Psychiatric history
- Family and other support
- Goals and expectations towards pain management
- Assess for integrative therapies
- Assess risk of opioid misuse/diversion
- Providing education on pain and coping
- Providing education on medications used to treat pain



# Multimodal Pain Management

## Medications or interventions

**Non-opioid analgesics**

Acetaminophen

Oral NSAIDS (with caution)

Topical NSAID (diclofenac gel or patch)

**Adjuncts**

Glucocorticoids

Antidepressants

Muscle relaxants*

Anti-seizure medications

Osteoclast inhibitors

**Interventions**

Celiac plexus block/neurolysis

Intrathecal pump

Palliative radiation

TPIs/Blocks

NCCN Guidelines Version 1.2023. Adult Cancer Pain. Assessed 8/1/2023. https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf

# Multimodal Pain Management

## Integrative interventions

### Cognitive modalities

CBT

MSBR

Imagery

Hypnosis

Biofeedback

Acceptance-based training

Distraction training

Relaxation training

Active coping training

### Nutritional modalities

Nutrition consult

Dietary recommendations

### Physical modalities

Bed, bath, and walking supports

Positioning instruction

Energy conservation, pacing of activities

Massage

Heat and/or ice

TENS

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# Integrative Medicine for Pain Management
# Society for Integrative Oncology-ASCO Guidelines

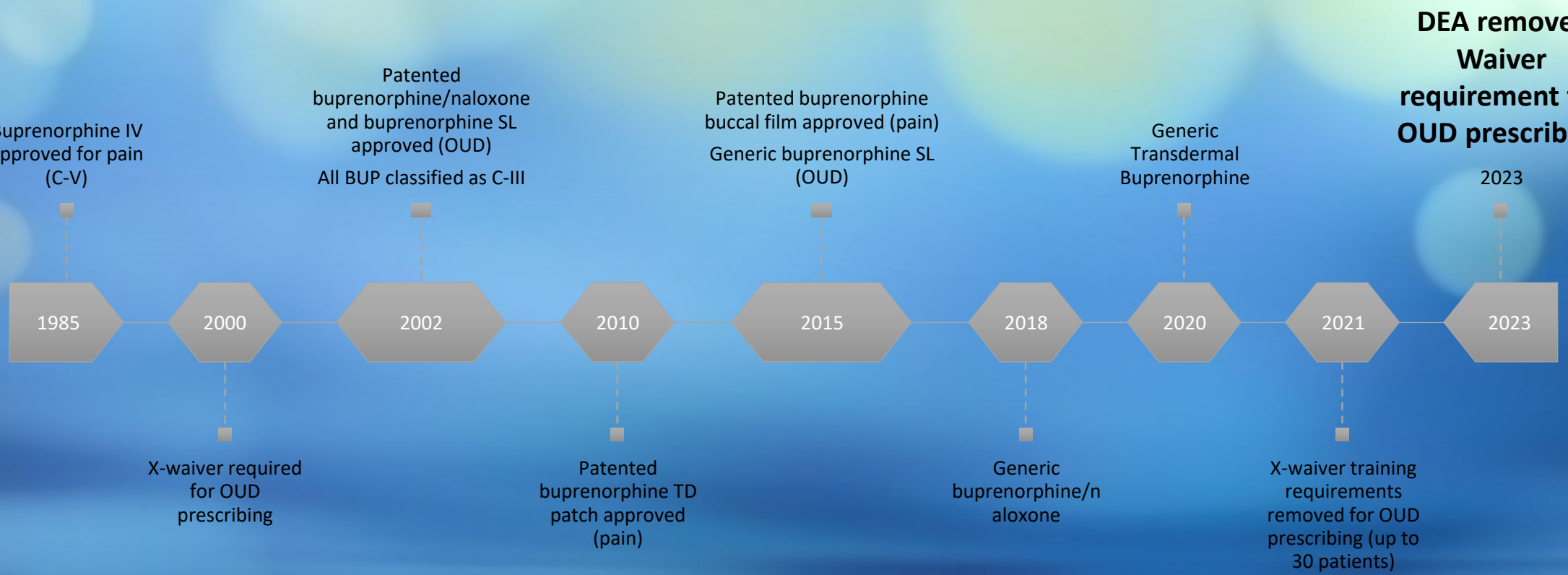
- **Acupuncture** and **yoga** should be offered to patients experiencing Aromatase inhibitor-related joint pain in breast cancer
- **Acupuncture** may be offered to patients experiencing general pain or musculoskeletal pain from cancer
- **Reflexology** or **acupressure** may be offered to patients experiencing pain during systemic therapy for cancer treatment
- **Massage** may be offered to patients experiencing chronic pain following breast cancer treatment
- **Hatha yoga** may be offered to patients experiencing pain after treatment for breast or head and neck cancers
- **Guided imagery** with progressive muscle relaxation may be offered to patients experiencing general pain from cancer treatment
- **Acupuncture, acupressure, or reflexology** may be offered to patients experiencing chemotherapy-induced peripheral neuropathy from cancer treatment
- **Hypnosis** may be offered to patients experiencing procedural pain in cancer treatment or diagnostic workups
- **Acupuncture or acupressure** may be offered to patients undergoing cancer surgery or other cancer-related procedures such as bone marrow biopsy
- **Music therapy** may be offered to patients experiencing surgical pain from cancer surgery

**Integrative Medicine for Pain Management in Oncology: Society for Integrative Oncology–ASCO Guideline** Jun J. Mao, Nofisat Ismaila, Ting Bao, Debra Barton, Eran Ben-Arye, Eric L. Garland, Heather Greenlee, Thomas Leblanc, Richard T. Lee, Ana Maria Lopez, Charles Loprinzi, Gary H. Lyman, Jodi MacLeod, Viraj A. Master, Kavitha Ramchandran, Lynne I. Wagner, Eleanor M. Walker, Deborah Watkins Bruner, Claudia M. Witt, and Eduardo Bruera. Journal of Clinical Oncology 2022 40:34, 3998-4024

# When it is time for an opioid……consider Bup

Bupra What?

# Bup over time



# When it is time for an opioid……

- Consider buprenorphine as a tool for stable cancer associated pain and/or those with history or high risk of OUD or AUD.
- Buprenorphine is a partial mu agonist opioid; thus, you get the benefits for pain relief with less opioid side effects.
  - **LESS** sedation, risk of hyperalgesia, risk of addiction, respiratory depression, constipation, effects on hormones, immunosuppression, impact on Sphincter of Oddi, withdrawal symptoms
  - No dose adjustment needed for patients with renal failure/renal insufficiency
  - Safer for older adults
  - Buprenorphine transdermal has been suggested to be safe and effect in patients with cancer pain and can be started in opioid-naïve patients
  - Schedule III drug (due to safety profile)
  - Can still use a short- acting pure mu agonist opioid (morphine, oxycodone, hydromorphone) for breakthrough pain
  - Can effectively treat breakthrough pain on standard doses of buprenorphine for pain management (and on higher doses for OUD- but leave that to the specialists)

NCCN Guidelines Version 1.2023. Adult Cancer Pain. Assessed 8/1/2023. https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf

# Common formulations

| | Drug | Formulation | Doses | Indication | Administration |
|---|---|---|---|---|---|
| Pain Management (mcg dosing) | Buprenorphine patch | Weekly patch | 5/7.5/10/15/20 **mcg**/hr | Pain<br>Chronic pain at high risk of an unintentional OD and < 80 mg/d of oral morphine | • Rotate patch sites<br>• Apply to fatty location<br>• Can titrate Q 72 hours, but usually Q 7 days<br>• Max dose is 20 mcg |
| | Buprenorphine | Buccal film | 75/150/300/600/750/900 **mcg** | Pain | Dissolves inside of mouth in 30 mins (no chewing/swallowing) |
| Treatment of OUD/Off-label for pain (mg dosing) | Buprenorphine/naloxone | Buccal film<br>SL tablet | <u>Film:</u><br>2/0.5 mg<br>4/1 mg<br>8/2 mg<br>12/3 mg<br><u>SL Tablet:</u><br>2/0.5 mg<br>8/2 mg | OUD<br>Off-label for pain | Dissolves under tongue in 5-7 mins |
| | Buprenorphine | SL tablet | 2 mg<br>8 mg | OUD<br>Off-label for pain | Dissolves under tongue in 5-7 mins |

# Additional tips for opioid sparing

- 2023 NCCN Guidelines on Adult Cancer Pain management provide the most robust guidance on pain management for the cancer specialist
- Assess for opioid risks when prescribe in any setting but also ensure pain management regardless of history
- Engage in opioid stewardship practices: PDMP monitoring, risk stratification, UDS, etc.
- Opioid exit strategy: When indicated, co-create an opioid taper plan with the patient and write it out explicitly
- Incorporate pain education and multimodal pain management strategies into your communication with patient regarding expectations for pain and guidance for management.  Equip the multi-disciplinary team with tools and training as well.
- Integrate non-opioid pain medications into the multimodal pain plan to reduce amount of opioid required (however, be cautious about polypharmacy)
- Taper opioids as appropriate
- Consider buprenorphine for chronic and/or stable cancer associated pain
- Engage a multidisciplinary team early

# THANK YOU!

# Cultural Linguistic Competency (CLC) & Implicit Bias (IB)

**STATE LAW:**

The California legislature has passed Assembly Bill (AB) 1195, which states that as of July 1, 2006, all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component. It has also passed AB 241, which states that as of January 1, 2022, all continuing education courses for a physician and surgeon **must** contain curriculum that includes specified instruction in the understanding of implicit bias in medical treatment.

*The cultural and linguistic competency (CLC) and implicit bias (IB) definitions reiterate how patients' diverse backgrounds may impact their access to care.*

***EXEMPTION:***

Business and Professions Code 2190.1 exempts activities which are dedicated solely to research or other issues that do not contain a direct patient care component.

***The following CLC & IB components will be addressed in this presentation:***

- *Minimizing bias in assessment and treatment of pain.*
- *Evidence based ways to minimize implicit bias in assessment and treatment of pain.*