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# KOL Knockout™: Cancer Pain Management Edition

**Announcer:**
Welcome to CME on ReachMD. This activity titled KOL Knockout: Cancer Pain Management Edition, is provided by Evolve Medical Education and IASLC. It is supported by an independent educational grant from the Opioid Analgesic REMS Program Companies. This replay of a live broadcast is a fun and exciting gameshow-style quiz competition that features key opinion leaders, KOLs, as contestants, hosted by program chair, Dr. Pranshu Mohindra, and features Drs. Melissa Teply, Judith Paice, and Fionnuala Crowley. There will be learning, laughter, and only one KOL left standing.

**Dr. Mohindra:**
All right, everyone, here's the moment. KOL Knockout: Cancer Pain Management Edition. We are very excited to get 3 good experts on pain management, specifically with cancer, fighting it out today to see who's the strongest of them all. And as they come out with their opinions, their recommendations, and cross question each other and hopefully beat them out so that we have one clear winner. This competition, an exciting learning opportunity, is brought to you by Evolve Medical Education and endorsed by the International Association for the Study of Lung Cancer, IASLC. We will get started as soon as all of you have completed your preregistration or pretest quiz, and hoping everyone is dialed in. Let's get started.

And so introducing myself, I'm Pranshu Mohindra, a radiation oncologist, vice chair of operations and quality in radiation oncology at UH Seidman Cancer Center in Cleveland, Ohio. I also chair the Education Committee of the IASLC and have been engaged with this committee here. Joining our contestants are 3 really important members. We'll have them introduce themselves.

We have Dr. Melissa Teply. Dr. Teply?

**Dr. Teply:**
Hi, everyone. I am a palliative care physician at the Buffett Cancer Center at the University of Nebraska Medical Center in Omaha, Nebraska. And I came in my unicorn outfit tonight. I am chasing that elusive dream of trying to treat patients' pain without any complications or side effects from what we're doing for them.

**Dr. Mohindra:**
That is so important. It's all about managing their cancer outcomes and maintaining their quality of life. Thank you, Dr. Teply.

All right, our next contestant is Dr. Paice.  Dr. Judy Paice, if you want to please introduce yourself.

**Dr. Paice:**
Sure. Thank you. So my name is Judy Paice. I am an advanced practice nurse in the Division of Hematology Oncology in the Feinberg School of Medicine at Northwestern in Chicago. But what I'm really called is the pain, poop, and pot nurse in our oncology clinic, and I decided that trying to dress up in that kind of costume would probably not be conducive to many of you who might be having your dinner at this time. Thanks for inviting me.

**Dr. Mohindra:**
That's exciting. Well, dinner or not, we need everyone excited.

So let's go on to our next contestant and that is Dr. Crowley. Dr. Crowley?

**Dr. Crowley:**
Hi, I'm Fionnuala Crowley. I am an integrated palliative care and hematology oncology fellow at Mount Sinai in New York. Obviously, the underdog in the contest today but looking forward to the contest.

**Dr. Mohindra:**
Underdogs are what make any competition alive. And so the competition is on, Dr. Paice, Dr. Teply, let's go for it.

With that exciting introduction, let's continue the disclosures. None of the faculty and staff involved have any financial relationships with ineligible companies. The Evolve Medical Education staff and planners also do not have any financial relationships with ineligible companies. This activity is supported by an independent educational grant from the Opioid Analgesics REMS Program Companies.

The learning objectives today are to address and resolve educational needs through the following objectives: Apply proper patient communication strategies; formulate a plan to wean cancer patients from various pain management strategies when appropriate; explain opioid dosing, titration, and adverse effects regarding the pain management options; outline pharmacological options and alternate therapies for treating cancer pain; and finally to illustrate how to effectively assess and screen cancer patients who require pain management.

With that, we are all set to get started. The boxing gloves are on and we are ready to box each one out. Fortunately, I'll be the referee, so I just have to make sure I stay safe and all 3 of them stay safe as well.

So let's get started. Again, we'll have a series of cases. Each case will start with a case presentation talking about the history and the cancer pain etiology. And then we'll move on to the treatment recommendation, which is when I will call on all the 3 contestants one by one, to get their answers. At the end of each case you will have to vote who you agree with. Of course with this format your engagement is really very important, so keep the polls on and keep voting through.

So case 1, we'll start off with a typical cancer pain presentation that many of us see in the clinic. And so this is a 47-year-old diagnosed with non-small cell lung cancer, adenocarcinoma in the right lower lobe with malignant diffusion, brain and bone metastasis, and stage IVB. She presented with a severe upper back pain during a postural change, basically bending forward activity. The pain was relatively subacute to acute in onset, was severe and throbbing character, and unbearable in nature. The visual analog score for her was 8 out of 10.

Let's get started on that screening tool itself. For our contestants, which is your preferred pain intensity rating screening tool and why? And how do you use that in your clinic?

And randomly, we will get started with the unicorn. Dr. Teply?

**Dr. Teply:**
I tend to use the visual analog scale. My rationale for that is that is what patients are hearing in most other settings and so it's not as confusing to them.

**Dr. Mohindra:**
All right. Dr. Paice?

**Dr. Paice:**
So I'm going to buck the answer here. I have used this numeric rating scale, 0 to 10, for such a long time, and yet, people struggle. So I wish the Joint Commission would get on board. But I really prefer mild, moderate, or severe, just to get a sense of how intense the pain is and then asking patients, "And so with this degree of intensity, is this keeping you from being active? And if so, what are the things you'd like to be able to do that you can't now?"

**Dr. Mohindra:**
That's important. I guess it's always about the ease for the patients and how effectively can they score it, especially when they are in a lot of pain. As you can imagine, these are not the questions that patients would want to keep hearing from every clinic member they go to. So a simple score is important.

Dr. Crowley, what's your favorite?

**Dr. Crowley:**
Yeah, I think we use the visual analog score probably the most, but I think what's important, really, about these scales is that the best use of them really is kind of as a control for the same patient the next time they come. So, you know, sometimes it's not the initial score

is the most important; it's more comparing how that progresses as you treat the pain. Because one person's 8 is different to another person's 8, etc. So it's more useful, I think, in comparing them to that patient when they come back later.

**Dr. Mohindra:**
And of course, important is the consistency in being able to score between that. I guess the question really is: Will patients truly use the same screening tool and be able to answer in a consistent manner when they are in stages of intense pain versus low pain, or would there be variability?

**Dr. Paice:**
I think that's why I enjoy the mild, moderate, and severe; it's just too difficult. And if anybody here has been in an emergency room or in a hospital setting and they've asked you your pain score, it is really a difficult thing to conceptualize this really sick, serious symptom as a number. So people struggle with that.

**Dr. Mohindra:**
All right, so we have Visual Analog Score, the numerical rating scale, and there's also the FACES pain rating scale. And all of these are important screening tools. The message there is that the screening tools are important for us to be able to assess how much pain is impacting the patient's day-to-day activities.

So this patient had a CT scan of the chest, which in addition to identifying the primary lung tumor mass, identified this paraspinal tumor that's shown in the CT scan image there in the red circle that's eroding into the neuroforamina and also eroding into the ribs, which clearly explains the pain. There are additional sites of metastatic disease within the chest and other areas. So with this imaging finding the patient was started on a strong opioid by the practitioner directly at oxycodone 10 mg every 8 hours along with a fentanyl patch 25 mcg q3 days. It was observed that only 60% of pain was relieved with this prescribed dose of oxycodone and fentanyl patch.

So that leads us to the questions. Let's start with Dr. Crowley. What are your thoughts about the combination of these drugs as first-line therapy for this unfortunate patient situation?

**Dr. Crowley:**
Yeah, so I think when we're thinking about what we're going to use first-line therapy, there's always a few things that we think about. One, which I didn't catch in the previous slide is, you know, does this patient have organ dysfunction or not? Because that usually puts us into kind of different categories in terms of what opioids we can use. So if someone has issues with kidneys or liver, then we can't use any morphine, which is our usual first line. And then you move to things like oxycodone. You can use it in renal failure, or renal dysfunction, but you need to monitor it more closely. And then hydromorphone is one that we would use most often. And then fentanyl is a good medication for anyone that has any sort of organ dysfunction. So I think, you know, that kind of is one of the big things that determines what we start first.

I think, usually in our practice, if they don't have organ dysfunction, we usually would start with morphine. For people that are not here in the US, are not joining from the US, you know, we have a big shortage of opioids at the moment. So it can be very difficult to get medications like oxycodone on a regular basis. So last week, I had to send oxycodone prescription to 8 pharmacies to try and get it filled. So we usually would start with morphine for that reason, just because it's easier. But I don't think there's anything wrong with starting with the oxycodone and fentanyl patch here.

The other thing to think about, then, in terms of what you're starting is what type of pain it is. And I think it is appropriate in this case. You know, I think considering where the lesion is, I think it is possible that he would also have neuropathic pain. But I know from the start of the case presentation it didn't seem like he was having burning or shooting pain; it was more of a kind of nociceptive somatic pain that they described in the first one.

**Dr. Mohindra:**
All right, so you touched multiple points. Obviously, knowing the patient's medical history, associated medical comorbidities are important and trying to characterize the pain itself is relevant. But you feel that this combination is an accepted option.

Dr. Teply, what are your thoughts about starting off with a combination of these 2 drugs as first-line therapy?

**Dr. Teply:**
One thing I didn't have clarity on is where this patient is being seen. So if they're in the inpatient setting, that has a big impact on what I am doing for treating their pain. If I were treating this person as an outpatient, I would be a little bit more hesitant to start both short-acting and long-acting opioid for them. Whereas in the inpatient setting, you can kind of sort of start with anything, just start somewhere, and then you're doing frequent reassessments that you could do, you know, every hour or every few hours. And specifically, you have the ability to do that multiple times a day. Whereas in the outpatient setting, that's going to be a little bit more difficult.

So I would be a little bit more reluctant. I would probably start them on a short-acting opioid in the outpatient setting and then be in touch with them by phone the following day to see how things are going. And if they're taking regular doses, which my threshold is usually at least 4 times a day, and/or if they're waking up in the middle of the night, then I start to consider a long-acting opioid. And that would also help kind of figure out the short-acting opioid dosing.

The other thing that I would have a very low threshold on for this person is to start steroids because of that cancer being near the spinal cord, because there's likely some inflammatory pain that's going on there. And then I am hoping that I am getting radiation oncology to take a look at this person's situation and see them as soon as possible to think about radiation starting for them as well.

**Dr. Mohindra:**
All right, so very important points. The setting of the patient, inpatient versus outpatient, does impact our treatment choices and allows us to balance between using a short-acting and long-acting version. So that was the message from Dr. Teply.

Dr. Paice, how do you look at this combination as your choice?

**Dr. Paice:**
You bet. So I would be really pretty reluctant to start a fentanyl patch. We look at a fentanyl patch 25 mcg; that's approximately equal to 50 mg of oral morphine in a 24-hour period. And I believe from this case, that she was opioid naïve; it's not exactly clear. But if she was indeed naïve, that's a really big jump. So like Dr. Teply mentioned, I would feel much more comfortable starting with the immediate-release opioid on a regular basis. And again, as we talked about, whether she's an outpatient or an inpatient might dictate the frequency for that short-acting. We wrote the ASCO guidelines on the use of opioids in people with cancer, and in fact, that was our recommendation, to start with a short-acting opioid until you get a sense of how well they tolerate this and an approximate dose at which they get pretty good comfort.

I'm jumping ahead, but one of the questions that you're asking about later –

**Dr. Mohindra:**
And that's where the referee blows the whistle and says, yes, we don't jump ahead and we follow the route there.

**Dr. Paice:**
Oh, darn!

**Dr. Mohindra:**
But I appreciate that enthusiasm and maybe some points for that as well.

But again, very important point that you noted there is a history of opioid use has a bearing on what treatment options would be better for patients in different settings. I think all of you agreed on recommending some kind of short-acting, whether that's oxycodone or morphine as a starting point, especially in outpatient setting.

So in this case, going with the story we have, if the patient reached this level – and presumably the medication doses were escalated gradually to reach to this point of 10 mg oxycodone and a fairly high dose of the fentanyl patch itself.

When you are using a combination therapy of a short-acting and a long-acting drug, what is your individual approach for gradually titrating the dose up? Is there a particular formula that you like to use in your clinic or a practical rule of thumb? Dr. Crowley?

**Dr. Crowley:**
So I think in this patient where you have a fentanyl patch, you know, titrating the fentanyl patch is a little bit different to titrating other opioids in that, you know, you can't kind of up-titrate it every day. So usually, you'll up-titrate it every 72 hours. And then, you know, longer, over a 6-day period, on subsequent up-titrations. So because of that, a lot of the time we will try and optimize the breakthrough first and figure out how much extra we need to add to the long-acting before we would increase the fentanyl patch. So I think how I would do that is, you know, we would try and optimize the oxycodone to see how much we need and how often to achieve the pain that we need. So in this case, if, you know, the patient has, you know, 60% pain, which would probably be classed as moderate, you would increase by 25% to 50% the dose, see how that does. In this case it's PO, so an hour later you should see the kind of maximal effect of that, and then you'd go from there. And then when you have data of a few days of how much you're needing to optimize their pain, then you can add that then – convert it and then add it to the fentanyl patch.

**Dr. Mohindra:**
All right. So again, trying to get an estimate using the short-acting and building up.

Dr. Paice, how would you approach a combination regimen like this?

**Dr. Paice:**
Yeah, so the 25% to 50% is a nice range. What I see often happening in the clinic is people will just readminister the same dose. And we all know that the definition of crazy is doing the same thing over and over again and expecting a different result. Right? So I would think about a range of 25% to 50%, but look at the patient who's in front of you. Is this patient sedated? Does this patient have a lot of comorbidities? Then err on the lower side. And if they're in really pretty excruciating pain and tolerating the opioids okay, then I would go with even maybe more than 50% increase.

**Dr. Mohindra:**
Got it. Dr. Teply?

**Dr. Teply:**
I would largely echo what Dr. Paice and Dr. Crowley are saying but put it in a slightly more simplified questions. What I tend to ask the patient is, "When you take the dose of the oxycodone, is it helping a ton, is it helping somewhat, or is it not helping at all?" And if it is not helping at all, then I will have them try double the dose of what I have given them. If it is helping some, then my next question is, "About how often are you taking it?" If it's helping some/enough and they're taking that every 4-plus hours, then I probably would stick with that dose, but maybe have them take it a little bit sooner as it's starting to wear off. Whereas if they're saying, "Yeah, it helps, but it only helps every 2 or 3 hours," then I am probably going to initially increase the dose of that oxycodone a little bit, such as like 15 mg instead of 20, but I'm also starting to think about adding up the total daily dose and calculating that into increasing the long-acting dose of the medicine.

**Dr. Mohindra:**
All right, so using the response as your measure to decide how much to escalate the dose and whether to 25% to 50% or really doubling at the low-dose ranges and definitely on how long the patient has been on those medications.

So very important points coming from our 3 contestants on this.

As this patient continued on the regimen that was chosen for this patient, the patient starts developing itching around the patch site. I guess I would make this as a more of a generic conversation as well. Patch is easy to remove and of course that can be addressed, but let's say a patient was on an extended-release morphine or some kind of a delayed-release formulation and starts having some side effects from it, how would you all approach that setting when the patient is on good control but is now starting to have side effects?

Dr. Teply, maybe if you want to continue the conversation?

**Dr. Teply:**
I will try an opioid rotation to some other long-acting medicine. I find that I'm pretty limited in my long-acting pain options with insurance coverage. So usually that is fentanyl patch or methadone in my experience. It's hard for me to get long-acting oxycodone covered anymore. And so opioid rotation is going to be the first thing that I will think about. And then sometimes I will consider adding Zofran for some of the antiserotonergic effects that that can have to try to see if that possibly helps with itching. And sometimes I'm getting a 2 for 1 out of that because people are otherwise taking it for nausea. Other antihistamines are an option, but they can be really sedating. So Zofran is the first thing I will try if opioid rotation is not helping.

**Dr. Mohindra:**
Dr. Paice?

**Dr. Paice:**
So I learned an amazing option from our hospice nurses, that when someone – and this only obviously works when it's an itching that has occurred around the patch site or underneath the patch. Obviously, if you apply a steroid cream, the patch won't stick. But if you take an inhaled steroid, like an over-the-counter nasal spray, something that is aqueous or one of the inhaled steroid sprays for people with asthma, let it sit and dry for a moment, spray the area where you're going to apply the patch, and then that seems to mitigate any potential erythema and generalized itching that would be occurring as a result of the patch itself. This also works really well with the Butrans, or buprenorphine patch, which is a 7-day patch, and I do tend to see a little bit more erythema, I think just because the skin is occluded for 7 days instead of 3.

**Dr. Mohindra:**
All right. So a nasal spray or the steroid to start off with. Antihistamines are covered.

Dr. Crowley, do you have any other third option that you really love?

**Dr. Crowley:**
Well, that was a really cool, fun fact that I didn't know, actually. So thank you for sharing that. I think usually we would try, like, a non-

drowsy antihistamine and if not, then, as Dr. Teply said, we would rotate probably to another opioid.

**Dr. Mohindra:**
All right, so opioid rotation is a common theme there. With that and moving the case along, as you all mentioned, the patient's background is very important as you come to a decision with regards to the best pain management strategy. This patient is young, educated, she's working as a caregiver in a nursing home, so sees patients around who are in different pain needs. She's married with a young son, lives in a joint family with excellent support. She's a nonsmoker herself. Of course, at this young age she is concerned about all the issues in her life, and she would wish to live long with her family as long as possible. All this is causing deep stress and depression.

So the question is, as you're working up your strategy for pain management for these patients, how do you look at the social history and other factors, and what other supporting referrals do you initiate while you work on the pain side? Dr. Crowley?

**Dr. Crowley:**
Yes, I think we're so, so lucky in in palliative care because, you know, in the clinic, I see patients and we have social work, and we have the spiritual care in that clinic. So a lot of the time we actually go in and see these patients together, which is really, really great. So while I'm doing the medical assessment, they're doing a social and they're doing a spiritual assessment. And I think, you know, it's great how we can work together in those situations. And I think I get a lot more out of the visits when I have the IDT [interdisciplinary team] members with me just because they're able to hone in on different aspects of care that are really important.

I think we all know that mood and social situations and everything else can affect your pain. So it's really, really important that patients are supported to have these extra stressors outside of just their cancer diagnosis addressed as well because I think in someone whose mood is lower, they're stressed, or they're anxious, it's going to be really, really difficult to get their pain under control in that environment. So I definitely need to make sure that they're on board.

We also then also have the option of referring patients for music therapy, massage therapy, all these other integrative therapies as well which patients find really, really beneficial. They are also a group of people that I would also get on board in certain scenarios.

**Dr. Mohindra:**
Getting palliative care involved is an important step that Dr. Crowley identifies, and we all agree on the importance of that and, of course, using other integrative treatment options.

Dr. Paice?

**Dr. Paice:**
So think about pain as a biopsychosocial spiritual phenomenon, and then think about who are the professionals who can help us? And Dr. Crowley's absolutely right; palliative care is a great place for this woman in particular. I would think about mental health counselors, again, not because she's crazy, because she's going through the normal stress of being diagnosed with a serious illness. Social work, if you have chaplains available, integrative therapy, as Dr. Crowley mentioned, all of the different team members that we can pull together. And even if you aren't working in a palliative care team, you can kind of use all the resources available to you. She probably would benefit at some point with physical therapy, occupational therapy, and maybe even some rehab. She's got a physical job; it’s going to be a very difficult thing.

And then there's another wrinkle that I want to just introduce, and that is we are talking about using opioids for this gal, and she has a 20-year-old son at home. And it says living in a joint family, so I don't know who all the members of the family are, but this would be a really important time to talk about safety with opioids.

**Dr. Mohindra:**
Such an important observation. That was a very, very sharp comment there, Dr. Paice. Yes, especially with the risk factors of opioid abuse, which we'll cover in a little bit, that would be important.

Dr. Teply, anything that you would counterargue or support?

**Dr. Teply:**
I support all of those referral resources. I recognize that not every cancer center has access to all of those resources that Dr. Crowley and Dr. Paice have mentioned. I think, for me, it's trying to think about being considerate about pacing the introduction of some of those resources, because it's very easy for people to be very overwhelmed by so many appointments and so many team members, and each referral comes with its own team. And so I think it's trying to prioritize what seems like the most pressing issue and trying to address that as possible and then gathering in other resources over time as it's warranted.

**Dr. Mohindra:**
All right. That's a pretty strong counterpunch there by Dr. Teply. I think recognizing the resources is important. Also, we all need to keep in mind this patient's just diagnosed with a metastatic cancer; there's going to be tons of cancer-related appointments that are also going to be adding to the plate.

With that, moving this along, I know, Dr. Crowley, in your prior description you talked about the type of pain, whether this is truly neuropathic or not, and that is very relevant. Looking at the location and on further history, let's say we see that this is a neuropathic type of pain.

What are the adjuvant analgesics that you all would consider in the management of cancer-related neuropathic pain? And maybe we'll start with Dr. Paice on that.

**Dr. Paice:**
So generally, I liked Dr. Teply's recommendation earlier about dexamethasone. That would be clearly warranted for this particular patient. The other neuropathic agents that we consider are the adjuvant analgesics, might be the gabapentinoids, either gabapentin or pregabalin. They're both working on the same alpha-2/delta subunit of the calcium channel. The benefit of pregabalin is it has a little bit better bioavailability. So it can be given twice a day, whereas gabapentin really, to be effective, needs to be TID. One does have to dose reduce if the individual has a low creatinine clearance. So that's something we need to consider.

And then the other major category of drugs that could be helpful, particularly if she's having some mood issues, might be the SNRI [serotonin-norepinephrine reuptake inhibitor], particularly duloxetine, which would be Cymbalta.

And if we couldn't get the pain under control using those agents, then one could consider NMDA [N-methyl-D-aspartate] antagonists like ketamine. I joke that most everybody who gets discharged from my hospital leaves with a lidocaine patch. I would have very low anticipation that that would be particularly helpful with a deep kind of pain as this likely is, but sometimes desperate times call for desperate measures.

**Dr. Mohindra:**
All right. Marshaling all the resources and starting with steroids and then escalating between gabapentin, pregabalin, and then other medications.

Dr. Teply?

**Dr. Teply:**
I'm going to say something that might possibly be very controversial because every guideline that I see out there seems to prefer pregabalin over gabapentin, and I can't tell you how many patients I have that cannot tolerate pregabalin and do so much better with gabapentin. And I know that gabapentin is considered a – I don't know – like a dirtier drug in terms of how it works on various receptors. But so if you're hemming and hawing about which one to do, in my practice, I tend to start with gabapentin first. The majority of the times when I've tried pregabalin, I'm inevitably switching back to gabapentin due to tolerance issues.

I have a very low threshold for patients who are presenting like this to switch their long-acting or to start with a long-acting of methadone because of that NMDA antagonism. And I would consider an SNRI, although I anecdotally really don't see those helping a ton for neuropathic pain in the setting of cancer. So I would be using it primarily more for the mood and then maybe crossing my fingers that it would help with the pain.

And then depending on how severe this pain seems, and if it is really, really horrific, I might start to think about an intrathecal pain pump. I don't know how far this case is moving along, but that's something in the back of my mind that I might start thinking about if the pain is not getting better with all the things we've been discussing.

**Dr. Mohindra:**
Right. So your preference of gabapentin as a starting point and then trying to explore other options.

Dr. Crowley?

**Dr. Crowley:**
Yeah. You know, I think it's working, I guess, in the theory that other than, like, chemo-induced peripheral neuropathy, there isn't any, you know, great evidence favoring one over the other in terms of the kind of main 3 agents that we mentioned. And then I think, as others had said, a lot of time it's looking at what else you want to, you know, treat at the same time. So in this case, if you want to use depression, then maybe you'd start with duloxetine. I think important to warn patients that ,you know, the GI [gastrointestinal] side effects, especially when you start that medication, can sometimes be quite tough. So sometimes a patient needs support in the first

while with that. And then in the trials that, you know, in other trials with duloxetine it's, you know, 60 mg, so a lot of time you're starting on 30, and then you up-titrate it after 2 weeks to the 60. So it's taking quite a while until you're getting to a point where you're going to see, you know, any sort of benefit.

And then as, you know, Dr. Teply was saying about the pregabalin, another thing about pregabalin is a lot of insurances won't cover it unless you try out gabapentin as well. So a lot of the time, I find we're not starting off with that, aside from the tolerance, just because we can't get that covered. So there are some other considerations.

Other things which, again, don't really have great evidence, but I think that some patients have come and said that, you know, they find it helpful, is like TENS [transcutaneous electrical nerve stimulation] therapy and other integrative therapies like that, you know, anecdotally patients have found them helpful for one reason or another, but there isn't great evidence to support them coming globally as treatment for neuropathic pain.

**Dr. Mohindra:**
All right. Dr. Crowley, clearly, your response was so exciting, Dr. Teply had to take a jump and get her bearings back.

With those answers, I think all of you touched a little bit on other treatment options beyond the medications. Intrathecal pump or any other, Dr. Paice, that comes to your mind that was beyond the medications?

**Dr. Paice:**
Well, I did like the idea of a TENS unit for some patients, as long as they don't have any implanted devices, it's worth a try, very low risk. And you can purchase these devices for less than $50 on Amazon. And then the other would be a referral to our anesthesia pain colleagues who may have some interventional techniques that could be of benefit. And as Dr. Teply was thinking about, an implanted device, those are often the folks who would be placing those kinds of equipment as well. But I'd favor trying less invasive, less expensive kinds of treatments first.

**Dr. Mohindra:**
All right. Dr. Teply?

**Dr. Teply:**
Agreed. You see the look on the patient's face, and if they're not having a significant response to the opioids that I'm trying, then I start to get nervous and I'm starting to think about the possibility of an intrathecal pain pump.

**Dr. Mohindra:**
All right. A great first case. I think we covered a lot of topics here from screening tools to trying to assess the situation, to assess the pain strategy using a combination of short- and long-acting pain medications, managing the side effects and intolerance with opioid rotations, and some cool techniques that people have used. And then, of course, integrative care, palliative care, biopsychosocial spiritual phenomena of pain and how's that addressed, as Dr. Paice pointed out, looking at all the resources available, and then using adjuvant analgesics and other treatment options.

So again, for this case, the fentanyl patch was increased due to difficulty in pain management; morphine was added for frequent breakthroughs. The pain medications were ultimately titrated between fentanyl, extended-release morphine, and breakthrough morphine. Patient did undergo local radiotherapy to target this area, as seen in the screenshots below, showing the radiation dose distributions, very targeted, very focused. And then, of course, extensive counseling was done for patient and family with referrals for pain clinic, palliative care, and radiation oncology.

So moving on to the second case, one of the factors that was brought up in the prior discussion is whether a patient is narcotic naïve or does have history before, in the previous, for other medical reasons. And so we're going to look at a narcotic-naïve patient. So a 74-year-old woman, pain in the lower sacral area, which is getting worse when she tries to sit and at night impacting her sleep. It's been increasing over a 3-month period, radiating down her right leg. The physician orders initially conservative measures and then an MRI which reveals a lytic lesion at the S2, extending and impinging on the nerve roots. PET scan shows a mass in the lung and many additional sites of bony metastatic disease. Unfortunately, the biopsy does confirm a metastatic lung cancer. The patient is 74, has history of hypertension, osteoarthritis, cholecystectomy when she was very young, has had problems with chronic constipation and acid reflux. She did try acetaminophen for her pain, but it has not been helpful. She did use narcotics for her cholecystectomy a few decades ago, and did not like the side effects but doesn't have specific details that she can remember.

So the focus of the conversation now is just looking at NSAIDs [nonsteroidal anti-inflammatory drugs] as a treatment option and how to build that up.

Dr. Teply, what is your strategy for initiating pain management just using NSAIDs, especially in the setting of elderly patients who are

narcotic naïve?

**Dr. Teply:**
It's just a back-and-forth discussion with people. It is always something that I consider as part of a step-up therapy. So my favorite medication of all time is acetaminophen, if that works for people, because that will have the least amount of side effects as long as they're staying under the maximum recommended daily dose, which is generally about 3,000 mg a day or 4,000 depending on how much you want to push it. So then I do tend to think about NSAIDs as the next step. If I could get away with using a topical NSAID like diclofenac, that's great, but that's often not enough for situations like this. I try to use longer-acting NSAIDs, so once-daily meloxicam or twice-daily celecoxib. There's maybe possibly something that those might not cause as much of a risk of GI bleeding. And those tend to be a little bit better tolerated, from my observation, without causing as much issues with reflux. That said, oftentimes, if people are concerned about that, I'm also talking with them about starting a proton pump inhibitor [PPI] at the same time and just balancing the risks of trying this for their pain compared to stepping up to opioids.

**Dr. Mohindra:**
All right, so a few different options that you talked about, including addressing side effects. You refer to gastritis management.

Dr. Crowley, what is your strategy for using NSAIDs and side effects that you worry about?

**Dr. Crowley:**
Yeah, you know, I think NSAIDs are kind of tricky in the population that I usually see, because a lot of them have CKD [chronic kidney disease], a lot of them have, you know, heart disease, a number of them are on, like, dual antiplatelets. And then a number of them are very frail, which is a number of comorbidities. So I find myself not using NSAIDs that often in the clinic for that reason, because it's a patient population that, you know, it's just contraindicated in.

You know, another thing to consider for patients that are, you know, undergoing chemotherapy is that a lot of the time they're going to be thrombocytopenic during periods of that. And that's another consideration that we need to think about when we're thinking of using NSAIDs. If we are going to use NSAIDs, we use naproxen quite often. Other times, if they have NSAIDs at home, we can try and optimize the NSAIDs that they have. But as I said, it's just because of the population we treat, most often we're probably going to the opioids fairly early on.

**Dr. Mohindra:**
All right, so the concomitant or the ongoing oncological treatments and how that gets impacted by use of NSAIDs is important. Thrombocytopenia has an effect Dr. Crowley highlighted.

Dr. Paice?

**Dr. Paice:**
So I agree with Dr. Crowley and with Dr. Teply. Frankly, the patients I see have generally already tried NSAIDs. This woman has likely musculoskeletal pain and neuropathic pain because of the radiculopathy that she's having. So the NSAID isn't going to be a great help for the radicular kind of pain, which is more neuropathic. Dr. Crowley very appropriately mentioned the cardiovascular effects, and I do see that a lot of healthcare professionals don't seem to be very aware of the increased risk of stroke and MI [myocardial infarction] associated with NSAIDs, particularly in people who are at risk. Now she doesn't have amazing risk factors, but she's not a young person, and so she may have some undiagnosed cardiovascular issues.

Piece that I would just like to point out that with all of our efforts to not use opioids, I am seeing more GI bleeds associated with NSAIDs. So I would definitely get this person on a PPI, even if she were on celecoxib or meloxicam, because we often have these folks, a baby aspirin or, you know, they get a PE [pulmonary embolism] and now they're on an anticoagulant, and boy, that really places them at increased risk.

**Dr. Mohindra:**
All right. Again, a highlighted emphasis on the GI side effects that come along.

Dr. Crowley?

**Dr. Crowley:**
I think I had spoken about the things that – do you want me to move on to the next one? Or you –

**Dr. Mohindra:**
All right, yeah, sorry I'm losing track of which contestant is fighting, how well. So for these patients, again recognizing that you would want to get to the opioids as quickly as possible, there are some side effects with opioids that also need to be managed. And so, I

guess, what is your strategy in patients like these who are presenting with chronic constipation, and how do you address that in your practice, Dr. Crowley?

**Dr. Crowley:**
Yes, I think in someone that has chronic constipation, I think firstly, you know, before you start any opioids, you do have to educate the patient in terms of the side effects they're going to see and how long we expect those side effects to last. So things like nausea, and, you know, the kind of somnolence associated when you start opioids, they tend to, you know, get better as time goes on. But constipation doesn't. So the constipation stays there throughout your treatment with opioids. So it's something that patients need to keep on top of.

For this patient, from the offset, I think we'd be starting her senna probably from the beginning. I don't see that she's on any laxatives currently. So she would be on senna, probably from the beginning, because that's a stimulant laxative, and then we would add in more medications as needed.

**Dr. Mohindra:**
All right. Starting on a stimulant laxative, like senna, up front and expecting the side effects.

Dr. Paice?

**Dr. Paice:**
So this is right up my alley as the pain and poop nurse. I agree with Dr. Crowley. We have to educate people; we have to set expectations too. So we want you to have a bowel movement every day or every other day. And I wish I had a dollar every time I heard, "But I'm not eating." Even if you're not eating, you need to have a bowel movement; you need to get rid of some of that bacteria and other things that are in the colon. And the way I model it for patients is it's mush and push. That when the opioids are taken, the peristalsis slows and all of the water in the feces get sucked back up into the lining of the gut. So to correct that, you need something to push; that's the senna. And most people need something that will mush, something to soften it. So it could be a docusate, it could be a Miralax. I prefer to have the senna and docusate together, even though I know that there are some studies that say docusate doesn't work and one or two studies have said that senna don't work. But if you really evaluate a lot of those studies, they're in really, really end-stage patients with a lot of other comorbid issues. So then I talk about the first phase is prevention, and then the second phase is dynamite. So hopefully if we do a good job with prevention, you won't need the dynamite. The dynamite is day 2. If you haven't pooped that night, we need something. So how's that for a start?

**Dr. Mohindra:**
I think that is a great start. So keep focusing on the poops are very important for patients who are an opioids.

Dr. Teply?

**Dr. Teply:**
I want to circle back that I agree with Dr. Paice and Dr. Crowley about care with NSAIDs. That said, I have some people who will absolutely refuse to take opioids because of the constipation on top of their constipation they already have. So I will oftentimes do a time-limited trial of an NSAID, if they don't have other medical contraindications, because they're so worried about this issue.

I would definitely want to know what other things have possibly helped with the constipation in the past so that we're already not trying things that this person has tried before. And so I tend to start with polyethylene glycol and senna, depending on, as Dr. Paice was saying, the mush or push issue. Some people do not have opioid-induced constipation. And so I give people anticipatory guidance that they will probably need to use one or the other or both of these agents, but I don't necessarily have people start right off the bat and then start to have issues with diarrhea on top of what's happening. And it's frustrating. I just tell them this is frustrating trying to figure this out because it's a lot of trial and error. And generally speaking, the overdose on this is just diarrhea. And so I'll have them start slow and then gradually increase as needed. And then if they can't take the volume of polyethylene glycol and they still need something to kind of soften things, I have a low threshold to jump to lactulose at very, very small volumes for them to use as needed.

**Dr. Mohindra:**
All right. Dr. Teply's favorites are polyethylene glycol and lactulose. With that, I think, again, these are important factors of recognizing the side effects for NSAIDs and opioids and having a strategy to address with those as you approach your pain management is very important.

So after addressing an elderly patient who was narcotic naïve and addressing the various side effect management, we're still continuing that theme, but this time focusing a little bit more on other general aspects.

So an 84-year-old who comes with a thigh mass had noticed 9 months ago abdominal pain. This led to workup, ultimately leading to a diagnosis of a lung nodule for which she underwent a wedge resection and a lobectomy to confirm a sarcomatoid carcinoma stage I. But

then 2 months ago, she started noticing swelling in her thigh, which became painful and started to grow, and had a biopsy that confirmed metastatic sarcomatoid carcinoma again. The pain has been constant in nature, throbbing 6 out of 10 on the visual analog score, she's using acetaminophen without any other relief.

So I think building up on the conversation we just did in the prior case, for these patients where NSAIDs may or may not be helpful and they're elderly and they're narcotic naïve, what is your first-line approach to get started?

Again, reminding everyone that this is an 84-year-old who has presented to the clinic with metastatic disease. So, Dr. Paice?

**Dr. Paice:**
So in the ASCO guidelines that we just published this past year related to the use of opioids, we conducted a very large systematic review of all of the randomized controlled trials related to opioids. And frankly, there isn't one opioid that's better than another. So that was the conclusion of our review. So what really leads one to choose an agent is first, you know, what has the patient tolerated well in the past? What are some of their comorbidities? Again, back to renal failure that both Dr. Crowley and Dr. Teply mentioned, you wouldn't want to think about morphine for that particular agent; morphine, codeine, hydrocodone, would not be great choices. And sometimes we choose an agent because it's available in a lower dose. So the smallest tablet of morphine, in terms of dosing, is 15 mg. And yes, one can use liquids, but they're kind of a pain for a lot of our patients to use. So sometimes we look at other agents like oxycodone, which comes in 5 mg. You can cut that tablet in half. Again, not optimal but it's possible. And then hydromorphone comes in 2 mg. So we look at comorbidities; we look at the bioavailability; we look at the route of administration. At this point, it looks like the patient likely can swallow a pill, so we'd want to think about the agents that have a low dose and which one will get approved by the insurance companies, because that has been a huge problem, and where we don't have a shortage. Right now, in the Chicago area, we have a horrible shortage on the hydrocodone 10 mg. Just about a month ago, we had a terrible shortage on oxycodone. And we also currently have a very significant problem of obtaining fentanyl patches.

**Dr. Mohindra:**
All right. So starting an option that starts with a low dose and then can be built up and, of course, limited by availability and insurance.

Dr. Teply?

**Dr. Teply:**
I agree with the different considerations that Dr. Paice was mentioning. I just ask people, you know, about starting the lowest doses. Do they prefer to take a pill or a liquid? And depending on what they say, my general starting dose is either hydrocodone 5 mg split in half or oxycodone 5 mg split in half as a pill or using oxycodone liquid or hydromorphone liquid. And I've started people at 0.25 or 0.50 an mL of hydromorphone, just so that they're not scared of the effect that it'll have on them.

There's also increasing recommendations about using buprenorphine first line for people who are elderly. So using the lowest dose buprenorphine patch of 5 mcg, it lasts for up to 7 days at a time. That's probably has the best safety profile in terms of not having respiratory depression. The biggest issue is insurance coverage for those patches.

**Dr. Mohindra:**
All right. So buprenorphine is a good option if insurance covers.

Dr. Crowley?

**Dr. Crowley:**
Yeah. Buprenorphine, I think, we use a lot in our palliative care clinics in our elderly patients, so that's what I was going to say. But obviously, it's not something I would recommend people probably in the oncology clinics to be starting at the beginning. It's probably something that you need to refer to palliative care to start, but we do use it a lot in our elderly patients.

And then, you know, I kind of agree with everything that's been said already. One thing is that, you know, these are patients that I probably follow up a little bit more frequently with about the medicines in the first few days after we start this just to see how they're doing and see can we try and get an effective dose that's not causing them too much in the way of side effects or somnolence. So, again, they are patients that I follow a little bit more closely in the first few weeks.

**Dr. Mohindra:**
And that sends us to the next slide, which is very important, is following these patients closely is relevant, especially in the elderly population.

So this patient lives with her husband, who is mobile but has his own health problems, didn't have much medical issues before other than irritable bowel disease. Her son lives close by. But she's anxious about the pain and the discomfort and the negative impact on

quality of life. She's really worried about getting addicted with any opioids. She was recommended oxycodone by her doctor.

So I guess for patients who are worried about addiction, especially at this age, not just the constipation issues, how do you approach that discussion and communication? Dr. Teply?

**Dr. Teply:**
I find that it's less helpful to present facts and data to people. What I tend to say is I am not worried about the risk of addiction for them, given the fact that they've gotten through life this far without that as an issue. But that said, this is a tool that we have. You have a choice to get through your day and to keep doing what you have – it is always a choice for you to keep doing what you're doing. And at the same time, we have this tool that we would start with the lowest possible dose and walk with you as you're taking it and how you're feeling with it. And we can always stop or adjust or change courses as needed. And so really trying as best as possible to say that this person is not taking this because they're an addict; this person is taking this because it is a tool to help them get through their day, the same way that we use any other types of tools and equipment to make life a little bit less distressing and a little bit more manageable.

**Dr. Mohindra:**
That's relevant. So focusing on using opioids or medications as a tool.

Dr. Paice, what is your take on this?

**Dr. Paice:**
So when I would first meet this patient, I would have, in addition to a complete pain history, I would have also done a screening for risk for misuse. And those questions, what some people use screening tools, I like to include it in my history. Simple questions about smoking and alcohol use and cannabis use, illicit compound use, either currently or in the past. I ask about family history. It's a proxy for genetics, but it also tells me who's living in the home. And then the last question that I ask, and I always give the patient that palliative care warning shot, “I have a very difficult question to ask you right now, and that is, have you ever been abused?” And most people are kind of surprised that I'm asking that question. And I'll ask, especially if they say, “No, I've never been,” I'll say, “You're wondering why I asked you that question. It's because that's one of the strongest predictors for addiction or substance use disorder. And do you know, all these questions I just asked you were about your risk, and I really saw no red flags.” So that would be the way I would approach this particular patient is to just let her know I’ve already screened her for her risk, and I saw no red flags.

**Dr. Mohindra:**
All right. So assessing a patient's history or risk factors for drug abuse is an important variable there.

Dr. Crowley?

**Dr. Crowley:**
Yeah, something else which I do a lot with these patients is I try to ask a lot of exploring questions and try and figure out where this, you know, fear has come from. And I think sometimes when you do that, sometimes patients will talk about things they saw on Netflix, but other patients, you know, have had addiction in their, I suppose, in friends or family who have been affected in some way. And, you know, for those patients, I think sometimes it's a bit of a longer discussion because they have kind of preconceived ideas on different things that need to be addressed. Because I think the worry about being addicted comes from a different place in different patients. So I think I do try and explore where that's come from or what the exact fears are. And then I, you know, reassure them that my job is to treat their pain but also to keep them safe, and that we're not going to recommend anything that's going to put them in harm's way. And that if we were concerned that she was going to become addicted to medications we, you know, might change how we follow her up, or we might change in terms of how we prescribe things. But if we've done a screening tool, which we do at the first encounter for all these patients, in addition to you talk, you know, I would reassure her that that's not something we're concerned about with her.

**Dr. Mohindra:**
All right. So 3 great communication strategies using exploring questions is what Dr. Crowley recommends in addition to reassurance.

Moving on, the patient was, initiated on oxycodone. The dose was titrated up, morphine extended release was added. She unfortunately did present to the ED with increasing confusion over 2-week period and was admitted with a diagnosis of delirium. Infection, lab workup, etc., was done to rule out other causes of delirium.

So let's quickly review the strategies for managing delirium in this setting from opioid use. It's not an overuse and an abuse; it's specific to this patient population. So what are your different takes? And which drugs do you prefer?

Dr. Crowley, let's start with you this time.

**Dr. Crowley:**

Yes, I guess you kind of start with managing delirium in any setting. I know you said that the infection and lab work doesn't reveal any other causes, but trying to figure out has any other medication been added recently? In elderly patients, are they sleeping? Are they constipated? Urinary retention? All of these things need to be looked at. And then, you know, if you do all that and nothing's coming up, I think you have to consider whether it's the opioids or not.

One thing I'm wondering about here is, you know, is her pain controlled on the opioids? Because if it is controlled and well controlled, we'd have to figure out how many PRNs she's needing. You could try and maybe come down on the opioids and see does that help with the confusion? Or else you might consider rotating.

And then in terms of drugs to be used when she's admitted with delirium, I don't know, that's for in terms of pain or –

**Dr. Mohindra:**
For delirium management.

**Dr. Crowley:**
Yeah, so I think in these patients, you know, we really try and avoid chemical restraints if possible. So I think usually the best thing is try to get family at bedside, try to reorientate them as best you can, try to preserve day and night. And then usually, if we have to use a medicine, it would be Haldol, low-dose Haldol, is what we would probably use. But again, we really don't use that unless the patient is a risk to themselves or a risk to those around them.

**Dr. Mohindra:**
All right. Dr. Paice?

**Dr. Paice:**
Agree with everything that Dr. Crowley said, and I would think about rotating to a different opioid. And we do find that for some patients, particularly closer to the end of life, a little bit of fluids can be helpful. So if that isn't contraindicated, that might be useful, whether it just helps the individual clear some of the metabolites of the agent, but that can reverse some of the delirium that we see particularly at the end of life.

**Dr. Mohindra:**
All right, another practical point from Dr. Paice. And Dr. Teply?

**Dr. Teply:**
I think everything else has been really well said. There's maybe possibly some thought that I've seen that people think that buprenorphine is possibly doesn't cause as much issues with confusion. So that is another case to make for that. And then I would be thinking about these already before that, but would any nerve blocks be helpful by interventional pain? Would any radiation be helpful, given the fact that this is generally one area? And then oftentimes just recognizing with opioid rotation, there's this idea of incomplete cross-tolerance. So you might possibly be able to utilize lower doses of the medication that you're switching to than you otherwise thought, because you're switching it up and kind of confusing the pain receptors. And then just with delirium, I know that we all talk about not using medications, but at the end of the day, sometimes you still just have to; that's just the reality of the situation. And so and the hospital system will oftentimes use atypical antipsychotics like risperidone or quetiapine, as well.

**Dr. Mohindra:**
All right. So again, opiate rotation and ultimately managing the delirium medically is relevant.

This case, again, was managed with all the factors that was mentioned in the discussion, constipation management, monitoring for confusion. And then when she did come with delirium, she was managed with dose reductions of opioids, haloperidol. And then, as Dr. Teply noted, patient was recommended palliative radiotherapy, which was very effective.

So we'll now move to two quick cases on acute pain on expected short-term duration. This is me coming in with my radiation oncology background to try to bring out these situations that we see in clinic.

So a 65-year-old, extensive smoking history, active antiretroviral therapy, past IV drug abuse history, who presents with cough. Workup leads to a diagnosis of a non-small cell lung cancer with PET/CT scan findings, as shown, a PET-avid mass and the right hilum subcarinal region, mediastinal invasion, negative metastatic disease is stage IIIB. So treated with concurrent chemoradiation. Patient's planned for 60 Gy 30 fractions of radiation with carboplatin paclitaxel. At week 3, starts developing esophagitis symptoms, which is commonly seen with radiation therapy.

So with that let's review the management for these acute issues that are more in the luminal types. So first-line management options, Dr. Crowley?

**Dr. Crowley:**
Yes, I think the first thing you said dietary modification, so that's always the first line. Then in terms of other things, you think about, I guess lidocaine liquid, morphine liquid is another one that we would use quite often. But you know, usually if people have very bad esophagitis from this where I'm actually seeing them is on the inpatient setting when they're admitted for reduced PO intake or failure to thrive. And, then a lot of those patients who are admitted in that case, and a lot of the times we put them on a PCA [patient-controlled analgesia].

I think one thing that's, you know, important to think about when you're doing this is that, you know, if a patient loses a lot of weight during this period, or loses a lot of weight during treatment for their cancer, we know that those patients have a lot worse outcomes. So I think a lot of the time people might be putting off starting opioids in this scenario, because they, you know, they're worried about the side effects or they're worried about opioid misuse. But really the, you know, if the patient isn't able to get through their treatment, or they have to be admitted, or on a PCA, or they lose a lot of weight, it can have a lot of impact on their cancer treatment as a whole. So that's something that has to be weighed up in this decision when you're thinking about starting opioids or not.

**Dr. Mohindra:**
Dr. Teply?

**Dr. Teply:**
At my training institution, when they anticipated radiation around the esophagus, they would start people on gabapentin and try to get as many people as possible up to a dose of 800 mg 3 times a day. And they essentially almost did that prophylactically. On the times when I've seen people that haven't already been on that, that's something that I consider; just all that irritation to it's almost like a burn injury. And so that's something that I consider as an adjunct.

And then trying that first and then using opioids as needed. And then forgive me, Dr. Crowley, if this is where sometimes palliative care will advocate for a feeding tube, that there's like more contact irritation by swallowing things by mouth like, well, let's just bypass that so that we're not irritating the area any further. So that's something I would potentially think about. And then, are we already at the question of factors when evaluating for opioid misuse?

**Dr. Mohindra:**
We'll come to that in a second as well. And so Dr. Paice what are your first-line options that you think about for these patients?

**Dr. Paice:**
I would consider the gabapentin. And that does come into liquid as well so if they haven't started the person on gabapentin already, that could be a little bit easier tolerated. And then liquid opioids. And the liquid opioids, as has already been mentioned, could be long, the short-acting liquid morphine, there's oxycodone, hydromorphone, and then hydrocodone, as well, comes in a liquid. The hydrocodone is a little bit more milky, and so some patients prefer that and others do not. You have to be cautious about how much acetaminophen the patient can tolerate. The general guidelines now are 2,000 to 3,000 mg per day.

**Dr. Mohindra:**
All right. And so with those options, and recognizing gabapentin as an option that's actually underutilized in the radiation community, but there is definitely data for head and neck mucositis as well.

And so coming to the second factor, Dr. Paice, I know you addressed that partially, but this patient has history of IV drug abuse, has been sober for 10 years, is an antiretrovirals for that management and is concerned about because of his prior abuse history. So let's say this patient is at a point where gabapentin is not working, other approaches has not been considered. How do you then discuss or evaluate these patients who have drug abuse history?

**Dr. Paice:**
So my experience has been that many people with a prior history of substance use disorder who has been sober for this long, it is almost more difficult to get them to consider using an opioid for pain control and yet, you know, helping them to discern the difference between when they might have been using the agents for recreation, for other purposes, and that now it is to help keep their nutrition so they can tolerate their therapy so that we can shrink the tumor, and describe for them all the potential benefits of taking the agent, sometimes this is a patient who had IV drug use, sometimes I'll bring in the family members to help with sort of monitoring and dispensing. Sometimes, unfortunately, with my patients who are currently still experiencing substance use disorder, they often have pretty fractured family relationships. But incorporating the family into the delivery of the medication so the patient maybe feels that there's a little bit more structure. And then I would only dispense small amounts at a time, so that in case they did become more compulsive about using the drug and taking more than what was ordered, they don't have a whole month supply to misuse. But I would have a low concern for someone who's been sober for such a long period of time.

**Dr. Mohindra:**
All right. So again in creating them, these are tougher patients to manage and starting with small amounts. Dr. Crowley?

**Dr. Crowley:**
Yeah, I think you know, echoing what's been said usually, for these patients, you know, we do the "you talks" on the initial visit, we do our opioid screen, and then we say that, you know, really, you know, our aim, as I said, is keeping them safe. And what that usually looks like is shorter prescriptions, we check the I-STOP every time they come in which is what we do for every patient, but we made sure to do for them. And then yeah, just more frequent follow-up.

What I would say is, you know, this is kind of a little bit of a different case, because, you know, it's a patient that is…we're thinking isn't going to…if they need opioids, it should only be for a few weeks, and I think it's really important to set that expectation from the beginning in these patients that are going to be on it for short-term to say, you know, look, we're starting this, but we're going to be tapering this pretty quickly when the symptoms start to get better. And I think that creates a sense that there's a little bit control in this situation and it's not a case that we're starting and they're going to be on it forever.

You know, in patients with cancer pain, generally, you know, I have a patient in our clinic who uses active heroin. But if we don't treat his pain, he uses more heroin. So sometimes in those cases, it becomes a little bit of a harm reduction setting where you're trying to minimize the heroin they're using by making sure that their pain is treated appropriately. But yeah, it's a little bit different in this case, when it's an acute thing that will hopefully be settled in a few weeks.

**Dr. Mohindra:**
Such an important point that ultimately, you're trying to reduce harm. And if avoiding opioids is only going to lead to increased risk for getting to the street drugs, that's a bigger problem. Dr. Teply?

**Dr. Teply:**
I'm going to be a broken record and say this is also where I would consider a buprenorphine product for someone. So there's the long-act – and I think why buprenorphine is really intimidating is because it comes in so many different formulations. And insurance coverage is a challenge with it. There's a long-acting buprenorphine patch, but there's also films that can be cut smaller. And so those can be dosed up to three times a day. And so that is potentially an option that I would talk about with them. And then depending on the situation, and especially in which state a person lives if it was specifically a concern about opioids, I might consider bringing up cannabis as an option for them to see if that might possibly help with their pain.

**Dr. Mohindra:**
All right, so buprenorphine is definitely a point Dr. Teply is highlighting definitely for all the audience and to try to focus on that and read about that a little bit more.

With that, again the patient did have worsening symptoms, was managed appropriately, and then grad tapered off. So very quickly in one or two lines, what is your typical taper approach for these patients with short-term pain management? Dr. Teply?

**Dr. Teply:**
I try to reduce by about 10% every 2 to 4 weeks, depending on how quickly we're going, of the total dose.

**Dr. Mohindra:**
All right. So a relatively slow gradual taper 10%. Dr. Paice?

**Dr. Paice:**
The same. If this person has only been on it for a few weeks, I might go a little bit more rapidly. But the general rule of thumb is 10 to 20% reduction per every few weeks.

**Dr. Mohindra:**
All right. Dr. Crowley?

**Dr. Paice:**
And providing a lot of coaching and support. And you know, helping them to see what the final game plan is and maybe even mapping it out for them so they can see where we're headed.

**Dr. Mohindra:**
Dr. Crowley?

**Dr. Crowley:**
Yeah, the same. I think usually it's around 10% every few weeks and just educate patients on - on if they're having symptoms of

withdrawal and how we manage those with kind of non-opioid medications usually and supportive medications to help them through.

**Dr. Mohindra:**
There's one point I would probably throw in a referee punch in here is for these patients who have been on these medications for about just 3 to 5 weeks, if we'd go as low as 10 to 20% over a few weeks, it lands up being fairly extensive there, but often happens as their symptoms resolved fairly quickly on their own and then they are ready to get done. So again, obviously these are complicating factors that you have to account for in the patient.

So moving on. Just along the lines, so this patient was managed with dietary modification. Sucralfate is what a lot of radiation oncologists use as a barrier protection a combination of what we call as magic mouthwash with diphenhydramine, Maalox, viscous lidocaine, and then of course going along the routes of oxycodones IV fluids, nutrition referrals, and then starting to taper as their symptoms improve.

Some patients, however, will have extended issues with radiation. This is a 62-year-old security guard, smoking history, presents with genital itching and it leads to a diagnosis of vulvar cancer which is treated with chemoradiation. Patient's had significant pain at baseline from the tumor itself and was started on oxycodone/acetaminophen combination by the GYN oncologist. The skin irritation progresses from radiation week 3, 4, 5, starts having diarrhea, and now suddenly the skin's even more irritated and exposed to infection. And so in scenarios like that patients then will develop moist desquamation. I'm showing an example of a neck just not showing a genital desquamation here.

But when pain starts reaching this level beyond opioids, what all would you typically consider in these settings. Dr. Paice, let's start with you.

**Dr. Paice:**
So this is where I would rely heavily upon the gabapentinoids, again because this tends to be very neuropathic in nature. I have a lot of patients that I care for with head and neck cancers. And when we get this kind of desquamation, that can be exquisitely helpful. Once the person is done with radiotherapy, I will sometimes, in really complicated cases, use a topical morphine solution. It can be mixed with DuoDerm or any other kind of base. Now, there was a time when people were trying to get away with not using fentanyl patches to save money. And they were applying topical morphine to the wrist for systemic uptake. That doesn't work. Morphine is hydrophilic. But here we have - the skin is excoriated, and it's open. And so morphine can then be exposed to those primary afferent nerve endings. So that's an option again, once the radiotherapy is complete. And then of course systemic treatment with opioids,

**Dr. Mohindra:**
All right. So systemic opioids and topical morphine another good practical point that I don't think a lot of practitioners have used. Dr. Teply?

**Dr. Teply:**
That's an awesome point about the topical morphine, using morphine solution. My only caveat is during the radiation treatment, I would again have a lower threshold for using methadone if a long-acting opioid was needed, because it might have some more impact on neuropathic pain in addition to – and I also agree with the gabapentin.

**Dr. Mohindra:**
All right. Gabapentin, long-acting methadone. Dr. Crowley?

**Dr. Crowley:**
Yeah, I agree with what's been said kind of combining your nerve agents or else using methadone. I think a lot of the time we end up using opioids for these patients because it takes a little bit of while for the gabapentinoids and those to work. And she's coming here currently with 9 out of 10 pain, so sometimes it can take a little while for them to get relief, so we probably would give an opioid just so that she has a bit of relief until the adjuvants kick in.

**Dr. Mohindra:**
All right, so you're already looking ahead, and that is exactly the point. A month postradiation, patient has had a very good response. But at the same time, there's still ongoing pain. And so the long-acting opioids that you've mentioned would all of you just continue that? Dr. Crowley?

**Dr. Crowley:**
Yes, I think methadone is a good one in this patient if they're on long-acting because of the nerve agents. The other thing is that I think this is a patient that we would think is probably going to, you know, not have - she doesn't have metastatic cancer from what I saw. So then this is a patient that may be you might use buprenorphine again, because it's someone that, you know, hopefully won't need

opioids forever, like metastatic patients.

**Dr. Mohindra:**
All right, we are finally having a contestant starting to get to the buprenorphine find. Dr. Paice?

**Dr. Paice:**
So hopefully in the beginning when we started the opioid, we were really clear with her why we were using it for pain control only, not to improve mood. It will cause you to feel a little less anxious, especially in the beginning, and not to help fall asleep at night unless it's pain that's keeping someone awake. So I'm trying to read between the lines: Why is she continuing going to have 6 to 8 pain and with the skin resolving? So it could still be the topical damage. But I'm a little bit nervous or worried is this also related to the mood changes that she's getting from opioids? That she's depressed, especially if the body image changes? These vulvar cancers are just not only is it a body image change, you think no one sees it except your partner, and it affects voiding and defecating, and sexual activity. So I would just have a real low threshold for investigating more about why the opioids seemed to be needed and why she's still experiencing pain.

**Dr. Mohindra:**
All right, so again, looking beyond the local cause of pain and the systemic effect that it has. Dr. Teply, did you already put a punch into this answer? I lost track.

**Dr. Teply:**
I agree with what's been said. And then this is when I would actually think about an SNRI, about trying to see if there's potentially some mood issues, and then also trying to treat some of the neuropathic pain with it.

**Dr. Mohindra:**
All right. So again using all these different options and then gradually continuing to taper it off these patients will often times, exactly like you mentioned, Dr. Paice, for even though the tumor response treat - radiation effects are gone they continue to have some low-grade pain from multiple local changes that potentially are compounded by systemic effects.

So at what point, 3, 4 months if these patients are still needing opioids at what point would you attempt a weaning or a transition off to a specialized clinic? Dr. Crowley?

**Dr. Crowley:**
I think this, you know, if it's still you know, weeks and months in she should probably be referred to palliative care just for more probably a holistic evaluation. And as I said, we have kind of more people in terms of interdisciplinary to assess what else might be going on. And then I guess usually the steps in those cases if we feel that we can't, if she still feels she is needing the opioids, and we've basically maxed ourselves out on the adjuvants and we've done the integrative therapies and all of that we, you know - buprenorphine, as I said, is the one that we probably would stick with if we're not able to taper further. But again, we do put a lot of effort into basically making sure we have no avenue left, we've gone down every avenue in terms of integrative therapies and her kind of assessing her total pain before we would feel that we keep on the opioids.

**Dr. Mohindra:**
Dr. Paice? We are in the last 2-3 minutes, so a quick answer.

**Dr. Paice:**
I would like to recommend to her a short pilot test, if you will, or a short trial of starting to wean just a tiny bit to see if there is any change in her pain. We may have a pain response that is not really opioid responsive. And it will help me to discern more, how much of this is mood versus how much of this is true pain?

**Dr. Mohindra:**
Dr. Teply?

**Dr. Teply:**
I agree with trying to see if possible to taper her, considering buprenorphine. The other thing that it's just not clear to me from the case how it's presented, is if there's a role for trying to mobilize that myofascial tissue that's painful, like if there's a role for pelvic physical therapy, if there's a role for vaginal dilators, things like that, that would potentially help with the pain as well.

**Dr. Mohindra:**
All right. So again, looking beyond the standard routes of management is very important.

With that, I think we'll conclude with recognizing the FDA-established opioids and risk evaluation and mitigation strategy programs to address the public health crisis of addiction, misuse, abuse, overdose, and deaths from opioids. Provider and patient education are key

components of the program, both for opioid naïve and those with history of abuse and misuse. Providers need to know how to effectively assess and screen patients that require pain management. Communication strategies are critical in developing a comprehensive pain management plan for the patients. And both non-opioid and opioid pharmacological treatment options need to be evaluated. Monitoring for side effects is critical. And then requires a multidisciplinary approach between palliative care, supportive oncology, radiation oncology, interventional pain management, radiology, intervention surgery or surgery, anesthesia, neurosurgery, and counselors.

With that, I think we are ready to wrap this up. To obtain the CE/CME credit as applies please click the next page at the conclusion of this session. To receive the credit, you have to complete the post-test and the evaluation to get the credits back. So again many thanks for our three experts for staying quite late into the evenings for this really educational discussion, I think we all learned a lot and some very good practical tips that came from this. And I think with that, we are right at the hour so we will complete this session. Thank you everyone for joining in.

**Announcer:**
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