CARESEARCH®
Updated Evidence Summary

Pain: Best practice and emerging approaches

Keep up to date with new Australian palliative care research evidence caresearch.com.au

November 2019

C Phelan

ABSTRACT

Pain is a common symptom across the life span and is frequently a major issue for those with palliative care needs. Clinical evidence in pain management in palliative care is often derived from non-palliative care areas. Our recent review and update of the CareSearch Clinical Evidence Patient Management pages has highlighted new areas of clinical practice, evolving and novel approaches to managing pain and gaps in the research.

Reviewing the evidence

Pain is a common symptom for many people with palliative care needs and is one of the most common symptoms experienced by people in the terminal phase. [1] It occurs in most life limiting illnesses, such as cancer, lung disease, HIV, renal and heart failure. Pain that is not well controlled causes significant distress and disability to the person experiencing it.

With the increasing complexity life-limiting illness treatments, and the longer survival of patients who have painful conditions, approaches which are holistic, multimodal, mechanism-based, and which start at diagnosis, are needed.

The evidence for best practice pain management in palliative care is evolving. Much of the evidence comes from studies in populations potentially different from palliative care patients. Studies of acute pain, single dose studies of particular analgesics, and studies in chronic non-malignant pain contribute to the evidence that practice is based on. For clinicians there is emerging evidence that may help guide current and future best practice.

Assessing pain

The assessment of pain is widely recognised as a key component of care and the first step in the development of an effective pain management plan and in guiding decision making. Self-report is the gold standard and indicates intensity or severity. Some pain is complex and requires a multidimensional assessment tool. The Brief Pain Inventory (BPI) and the Brief Pain Inventory-Short Form (BPI-SF) have been widely used in chronic pain and shown to be valid and reliable in advanced cancer, patients with COPD, end stage renal failure and in both older people and children.

As a person deteriorates they may lose the ability to speak and self-report will not be possible. Behavioural observation tools are important in assessing pain in people who are dying and not able to respond to questions. While there are no specific tools which have been validated in the non-verbal dying patient a recent review highlighted some tools which may be useful. Both the PAINAD and the Abbey pain scale were developed for people with advanced dementia. The Critical Care Pain Observation Tool (CPOT) was developed for use in non-verbal critically ill patients. [2]

Managing pain

Pain management will include a multimodal approach, which means using a number of treatment options at the same time. Improving a person and their carer's understanding of pain and the treatment options available to them

CareSearch is funded by the Australian Government Department of Health.

Flinders UNIVERSITY

has been shown to improve pain outcomes and improve patient satisfaction. [3] Music therapy has also been shown to improve pain in people with cancer. Both of these therapies are useful to consider in all palliative patients, as well as relaxation and cognitive behavioural therapy. [4]

The role of simple analgesics in pain management in palliative care is controversial. There is limited evidence to support the use of paracetamol but there may be a use for NSAIDs in some conditions for a short period of time. [5] Recommendations about the management of neuropathic pain include Duloxetine and Amitriptyline (both antidepressants) and Gabapentin (an anticonvulsant). [6]

Opioids continue to be the mainstay of severe pain management. Choice of specific opioid should be guided by patient preference, previous history and clinical assessment. All opioids should be titrated to effect. Methadone and transdermal preparations are not recommended as first-line opioids. Methadone has complex pharmacokinetics and a long and unpredictable half-life and should be prescribed by experienced clinicians. [7]

Novel approaches to pain

When the oral route is no longer available or no longer effective patients are commonly transitioned to subcutaneous infusions. Research into the use of Patient Controlled Analgesia is evolving for this group. More analgesics are now available via the sublingual or intranasal route. Sublingual Buprenorphine is available in Australia and development of sublingual fentanyl (as opposed to buccal) and ketamine is underway. The alpha-2 agonist dexmedetomidine has been tested via the intranasal route with promising results. [8] Intranasal fentanyl has also been proven to be effective in paediatric palliative care. [9]

There remains limited evidence to support the use of cannabis or cannabinoids in pain management in palliative care. [10] While there remains considerable community interest in this medication based on available evidence its best indication is as an anxiolytic.

Conclusion

The evidence to support pain management approaches in palliative care is evolving. There continues to be a strong need to include people with palliative needs in research on assessment and management of pain. A person-centred approach involves educating people about their options, monitoring people for pain and reassessing their response to treatment.

REFERENCES

1. Clark, K., et al., Physical Symptoms at the Time of Dying Was Diagnosed: A Consecutive Cohort Study To Describe the Prevalence and Intensity of Problems Experienced byImminently Dying Palliative Care Patients by Diagnosis and Place of Care. J Palliat Med, 2016. 19(12): p. 1288-1295.
2. Tapp, D., et al., Observational Pain Assessment Instruments for Use With Nonverbal Patients at the End-of-life: A Systematic Review. J Palliat Care, 2019: p. 825859718816073.
3. Mayahara, M., et al., Behavioral Pain Intervention for Hospice and Palliative Care Patients: An Integrative Review. Am J Hosp Palliat Care, 2018. 35(9): p. 1245-1255.
4. Zeng, Y.S., et al., Complementary and Alternative Medicine in Hospice and Palliative Care: A Systematic Review. J Pain Symptom Manage, 2018. 56(5): p. 781-794 e4.
5. Schuchen, R.H., et al., Systematic review and meta-analysis on non-opioid analgesics in palliative medicine. J Cachexia Sarcopenia Muscle, 2018. 9(7): p. 1235-1254.
6. Finnerup, N.B., et al., Pharmacotherapy for neuropathic pain in adults: a systematic review and meta-analysis. Lancet Neurol, 2015. 14(2): p. 162-73.
7. Mercadante, S. and E. Bruera, Methadone as a First-Line Opioid in Cancer Pain Management: A Systematic Review. J Pain Symptom Manage, 2018. 55(3): p. 998-1003.
8. Splinter, W., Novel Approaches for Treating Pain in Children. Curr Oncol Rep, 2019. 21(2): p. 11.
9. Harlos, M.S., et al., Intranasal fentanyl in the palliative care of newborns and infants. J Pain Symptom Manage, 2013. 46(2): p. 265-74.
10. Hauser, W., et al., Cannabinoids in Pain Management and Palliative Medicine. Dtsch Arztebl Int, 2017. 114(38): p. 627-63