CME CREDIT

TAKE-HOME POINTS FROM LECTURES BY CLEVELAND CLINIC AND VISITING FACULTY

Palliative care: Clinical approach to chronic pain and intestinal obstruction

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ABSTRACT

Many patients with terminal cancer receive inadequate treatment for pain and other symptoms. Yet, using oral medications in a simple stepwise approach, we should be able to control pain in up to 80% of patients.

"The hospice movement is too good to be true and too small to be useful...Why should only the minority who die of malignancies—and precious few even of them—be singled out for de luxe dying?"[1]

COLIN DOUGLAS, physician and novelist, Edinburgh, Scotland

TOO OFTEN, terminally ill patients receive inadequate treatment for pain and other distressing symptoms. An estimated 80% of cancer patients could achieve pain relief with oral analgesics and adjuvant drugs.[2] Yet, a study from the United Kingdom[3] found that only 22% of patients who had died of cancer had been completely free of pain in their last year of life. Other studies also concluded that pain is often undertreated.[4–7]

Although the hospice movement is popular and has "irreversibly improved the standards of care for the dying,"[8] only a minority of patients have access to hospice programs. The challenge as I see it is to integrate palliative care more fully into mainstream medicine, so that all patients receive adequate treatment.

CONTROLLING PAIN ADEQUATELY

For pharmacologic pain management to be effective, it must be simple, individualized, and continuous, and it should make use of adjuvant analgesics. The World Health Organization[2] has outlined a stepwise approach (TABLE 1). The aim is to match the analgesic to the severity of the pain and to use oral drugs whenever possible.

Morphine by mouth: Safe, effective, underused

Morphine is remarkably effective and, when used correctly, quite safe. In patients with chronic pain, opioids are usually given by mouth, and oral morphine is now established worldwide as the strong opioid of choice for cancer pain management. In many developing countries, however, morphine and even codeine are not available at all.

Why the bias against oral morphine? Countries that ban opioids altogether do so out of fear of narcotic addiction, an irrational con-

TABLE 1

A stepwise approach to analgesia in palliative care

For mild pain: non-opioids ± adjuvants
- Aspirin
- Acetaminophen
- Nonsteroidal anti-inflammatory drugs

For mild or moderate pain: weak opioids + non-opioids ± adjuvants
- Codeine/hydrocodone
- Dextropropoxyphene
- Tramadol

For severe pain: strong opioids ± non-opioids ± adjuvants
- Morphine
- Diamorphine
- Hydromorphone
- Methadone
- Oxycodone
- Fentanyl

cern in terminal cancer patients. In other countries, physicians have learned in medical school that oral morphine is not effective. However, the studies on which this belief is based were of single doses in acute pain, whereas cancer patients take repeated doses for chronic pain. Although there are a number of alternatives to morphine, morphine remains the standard against which others are measured.

Higher doses must be used when morphine is given by mouth than by the parenteral route. Yet the higher oral doses necessary to be effective do not pose a problem in practice. The dose of morphine has to be tailored to the individual patient's requirements. There is no arbitrary ceiling. The most important factor is not body weight, but rather the severity of the pain. Age is also relevant: The elderly are more sensitive to morphine. The dose must be adjusted repeatedly until the pain is controlled. For cancer pain, oral morphine doses can vary 1,000-fold among patients (eg, from 15 mg/day to 15 g/day or more) to achieve the same pain relief. Some patients get very good relief with low doses, while others need very high doses.

In dosing oral morphine, the most important factor is the severity of the pain

Constipation is inevitable with regular morphine use and must be anticipated and treated prophylactically with laxatives, attention to diet, and adequate hydration. Sedation is usually only a problem when opioids are first administered or when the dose is adjusted. It usually resolves within a few days but may take longer in some patients.

MANAGING INTESTINAL OBSTRUCTION

Intestinal obstruction is common in terminal cancer (particularly ovarian cancer). Usually, surgery is out of the question. The target symptoms that worry the patient are pain, nausea, vomiting, inability to eat, and constipation. What can the palliative care team do?

When we see these patients in our hospital, invariably across the top of the bed is the sign "nil by mouth." Thus, these patients not only have terminal intestinal obstruction, but they are also being starved. These patients should eat and drink (obviously, sensible, small amounts), and the food should be as palatable as possible. They may still go on vomiting, but the psychological benefit of being able to eat is enormous.

Medical management of intestinal obstruction includes:

- Small meals (low-residue but palatable)
- Antimuscarinic drugs (eg, hyoscyamine) to reduce peristalsis and colic
- Adequate analgesia for continuous pain and colic
- Antiemetics by subcutaneous infusion
- Softening laxatives (eg, docusate sodium 100 mg three times a day) if there is large bowel obstruction
- Enemas or suppositories to empty the rectum
- Corticosteroids (eg, dexamethasone 16 mg/day intravenously) in some patients to reduce vomiting and intestinal edema
- Somatostatin analogues (eg, octreotide 300–900 µg/day subcutaneously). These agents can control the vomiting dramatically in some patients and may make the difference between remaining in the hospital and going home.

REHABILITATION

We usually do not think about rehabilitation in patients with end-stage cancer, but it helps in certain circumstances. For example, we had a patient who had a lytic bone lesion due to thyroid cancer. In a situation like that, we prophylactically pin a leg if it makes the difference between a patient lying in bed for the last 3 months of her life or being able to walk. This patient was fine when she was at rest, but whenever she stood up or tried to move about, she had intolerable pain. By supporting her leg with an intramedullary pin, we were able to mobilize her and discharge her back home.

Rehabilitation is an essential, concomitant part of effective symptom control and getting patients home, functioning as well as possible, and maximizing their potential.

CONTINUITY OF CARE

According to a recent study in the United Kingdom,[9] some cancer patients may see from 14 to 90 doctors over the course of their cancer care (ranging from 4 months to 26 years; median 2 years 4 months): a resident

one week, another resident the next week, and so on. Although there is sometimes very little continuity in our system, continuity is extremely important to the patient. One of the principles of palliative care is to provide continuity.

TOWARD BETTER PALLIATIVE CARE FOR ALL

The World Health Organization would like to see the philosophy and practice of palliative care integrated into routine cancer care, if necessary, from the time of diagnosis. Moreover, in Great Britain, we believe that the principles of palliative care should not be confined to cancer patients but should be applicable to all patients with chronic, difficult, terminal phases. Approximately 10% of the patients referred to the palliative care team our hospital have cardiac or respiratory disease, and others have renal or chronic neurological disease.

The priorities for the future are to take palliative care to where the patients are, to include palliative care in the core curriculum of every health care professional, and to establish the evidence base for palliative care with high-quality clinical and health services research.

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Evidence-based medicine in everyday practice

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ABSTRACT

The evidence-based medicine method of answering clinical questions involves searching the literature for relevant studies, assessing study quality, interpreting the findings, and applying them in light of patients' preferences and societal values. In this article, evidence-based methods are used to solve questions posed by two patients.

EVIDENCE-BASED MEDICINE should never be an impersonal "cookbook" approach to treating patients. Scientific evidence in and of itself never tells us how to treat a particular patient. Rather, our decisions are informed by the values and preferences of the patient, the physician, and society.

In the two cases below and the discussion that follows, I outline how evidence can guide a busy physician.[1]

CASE #1: MR. SMITH'S OPTIMAL TREATMENT

One day, Mr. Smith, a 70-year-old man, visits your office. He suffered an anterior myocardial infarction 2 years ago, complicated by heart failure. He is concerned because his shortness of breath seems to be getting worse, hampering his ability to take walks or do other activities he once took for granted. He takes an angiotensin-converting enzyme (ACE) inhibitor, digoxin, and a diuretic.

Despite the limitations imposed by his health, Mr. Smith enjoys life. He is worried about premature death and would like to live