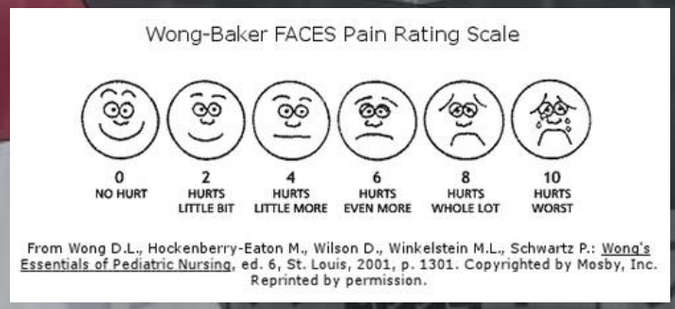
Adapted from the book “Palliative Care and Me” written by Greg Clements 2014

Pain Workshop

A masterclass with Dr Gregory Clements MBChB



You conduct a home visit to see a 32 yr old with advanced breast cancer with liver mets (expected prognosis short months).

She explains that the pain in her RUQ that was previously responding well to MST and dexamethasone has now spread to involve her LUQ. “its so painful I can’t do anything doctor, even taking a deep breath catches me”.

You calculate her PRN oramorph usage and increase her MST and aim to review her in a few days.

Failure to distinguish between pains caused by cancer and pain related to other causes.

An elderly gentleman in the hospice with a locally advanced fungating oral cancer complains of painful cramping in his neck.

On examination there is a fungating mass centred around the left masseter protruding well into the oral cavity and extending into the left super-anterior aspect of the neck with some degree of torticollis. He explains that although his inner mouth tenderness is still an issue actually his main trouble is with pain and stiffness in his neck.

You decide to initiate NSAID given that the pain is musculoskeletal and increase his morphine syringe driver.

Failure to use non-drug treatments particularly for muscle spasm pain.

Failure to use different modalities of drug administration.

Mildred is an 86 yr old with an advanced ovarian cancer with widespread bony mets.

Previous scans show significant infiltration of her pelvis and left hip with mets. She complains of left hip pain.

You decide to switch her paracetamol and codeine to paracetamol and regular Zomorph.

Was this appropriate?

What else should you have considered?

Consider pathological fracture

Failure to use a NSAID and an opioid in combination

Consider bone pain treatments

Mohammed is a 76 yr old with prostate ca with extensive lumbar and sacral bony mets.

An oncologist has previously remarked that the cauda equina area is so distorted with tumour that “theres no proper anatomical structures there any more, its just cheese”.

He has been off his feet for some time with little to no movement in his legs. This is well known about and no treatment can be offered.

You see him at his home due to a complaint of leg pain which he describes as burning and often stabbing.

You inspect his legs and when questioned about the longstanding brown discolouration distally you delight in explaining the various sequelae of venous insufficiency. “Cetraben is your answer here my good man!! these legs are too dry!”

What should you have considered?

Ignorance about adjuvant analgesics, notably antidepressants and anti-epileptics.

Rudge is a stoic gentleman you recognise from the local bowling greens. You are well aware that he has palliatively managed bowel cancer.

He is still passing stool well with the aid of laxatives and has no signs of obstruction but his wife explains to you that his pain is becoming uncontrollable with his current dose of oramorph 10mg 4hrly (of which yesterday he had 3 doses of) and oxycodone M/r 30mg BD.

You decide to switch to a twice daily modified release morphine.

What dose do you prescribe?

Peter is in the last few weeks of life at home. With the help of the macmillan nurse you increase this gentleman’s opiates:

He was taking morphine via CSCI 50mg and needed 2 doses of 7.5mg sc morphine sulphate.

What should you increase the driver morphine dose to and what should you prescribe PRN?

You are called to see a man with metastatic prostate cancer who after increasing his morphine m/r 30mg BD is now reported to be confused by the carers at his home. However his pain is now well controlled.

You carefully assess him and he complains of seeing rats under the curtains and shadowy figures in the corners of the room. His AMT is surprisingly 9/10 and he actually doesn't appear too confused to you.

What should you do about his opiates?

What else should you consider?

- William is a 76 yr old with advanced cancer involving small and large bowel. The primary cancer is not obvious and further investigation into this was deemed inappropriate. His prognosis is weeks.

- He begins to develop vomiting which is now bilious and in large quantities. Despite this he has very little colic and is still passing flatus. You suspect bowel obstruction. What do you do next?

A. NG tube insertion on free drainage with iv fluids

B. Prescribe an osmotic and stimulant laxative in combination

C. Prescribe a prokinetic regularly with a stool softener

D. Prescribe dexamethasone 10mg sc followed by further oral doses if not settling

E. Prescribe an anti-secretory and antispasmodic e.g. hyoscine butylbromide

- The same gentleman after a course of metoclopramide and dexamethasone then starts to develop intense colic with his vomiting. What do you do?

A. NG tube insertion on free drainage with iv fluids

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C. Prescribe a prokinetic regularly with a stool softener

D. Prescribe dexamethasone 10mg sc followed by further oral doses if not settling

E. Prescribe an anti-secretory and antispasmodic e.g. hyoscine butylbromide