

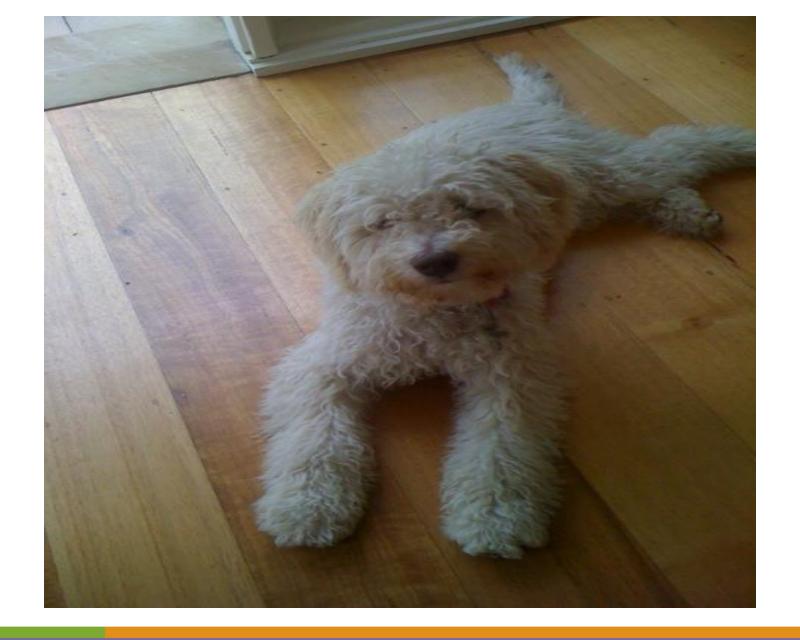
HammondCare

An independent Christian charity

Cancer Pain: closing the evidence-practice gap

Hospice New Zealand
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FAChPM







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Cancer Pain

Lech's story







Overview

- About cancer pain
- Principles of cancer pain management
- Evidence in cancer pain management
- One more person's story



Adult cancer pain

- Pain experienced by 30-75% people with cancer
 - Moderate to severe in 40-50%
 - Severe in 25-30%
 - 53% at any stage of disease
- Guidelines available internationally (e.g. NCCN)
- But undertreated, inadequate analgesia in 42%
 » Deandrea 2008

Causes

- Directly caused by the cancer
- Indirectly related to the cancer or debility consequent to the cancer
- Cancer treatment acute and chronic
- Comorbidities
- 24% multiple pains (Caraceni and Portenoy, 1999)

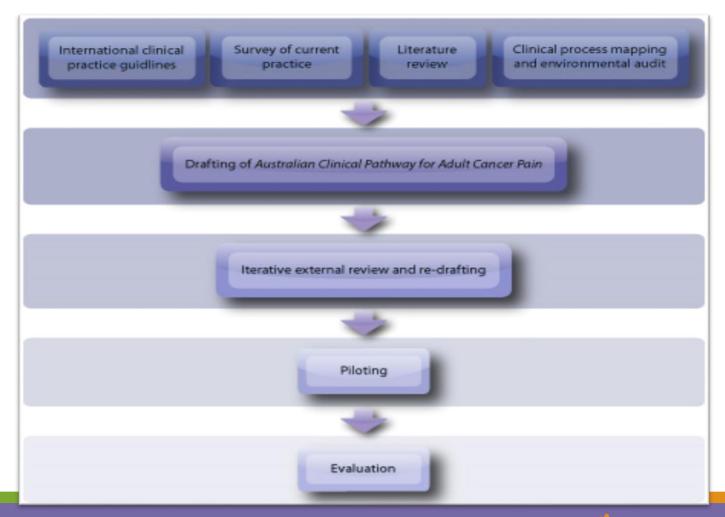
Principles of cancer pain management

- Screen for pain
- Comprehensive assessment for each pain- cause and mechanism
- Treat the cancer
- Regular analgesia
- Strength of analgesia proportional to severity of pain
- Breakthrough analgesia
- Titrate
- Use simplest regimen by most convenient route
- Prevent side effects laxatives, antiemetics



Evidence in cancer pain managment

Pathway development plan





Lit review: Qualitative synthesis

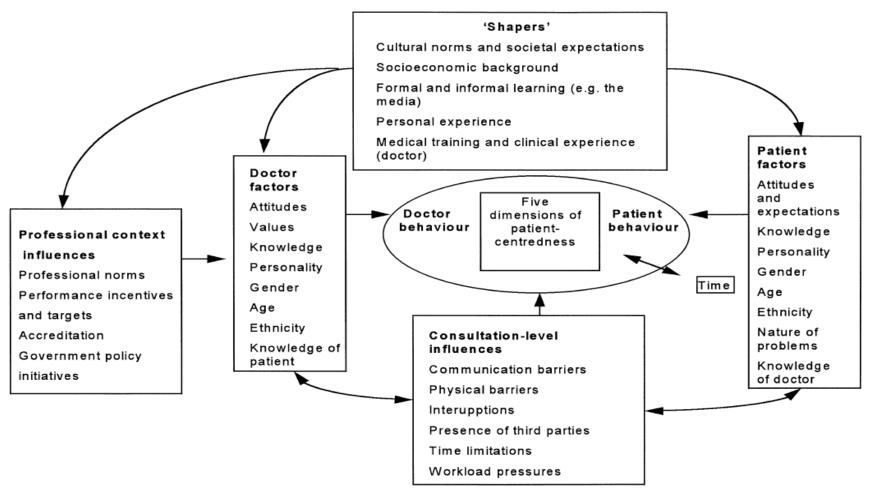
Aims:

- To comprehensively catalogue barriers & facilitators to adult cancer pain assessments & management based on reports of patients, caregivers/families & health professionals
- To contextualise barriers & facilitators within a comprehensive framework of patient care
- To integrate information at levels of patient, provider & system to inform practical recommendations for increasing implementation of evidence-based practice





Factors affecting person-centred care



Ref: Mead & Bower, Soc Sci Med 2000; 51(7): 1087-110

Results: Themes illustrative of 5 dimensions of person-centred care

- 1) Pain as a synonym for suffering:
- "Pain is more than a physical symptom; it is spiritual & social as well" (Patient - Pelusi, 2005)
- 2) Seeing the whole person:
- "I think that they are working very much with isolated parts of the It's as if they weren't connected" (Patient Bostrom, 2004) body.
- 3) Patients as experts on management of their own pain:
- "Sometimes, patients know better than doctors what they need to their pain under control" (Patient - Pantelli, 2005)
- 4) Being believed:
- "They don't know what I'm saying, they don't understand my pain at all. And therefore it's made me feel...that I'm lying...that I have been making a fuss about nothing" (Patient - Reid, et al., 2008)
- 5) Health Professional-as-person:
- "I think that [when] nurses go into nursing they already have had own idea of what pain is because of their own experiences with pain" (Health Professional - Lasch, 2002)





Lit review: Patient Education

Aims:

- To conduct a systematic review and metasynthesis of randomised controlled trials of patient education interventions
- To identify the effective elements of patient education
- To integrate information at levels of patient, provider & system to inform practical recommnedations for increasing implementation of evidence- based practice





Lit review: Patient education

Results – Enabling elements most helpful
 These include patient diaries, goal setting, scripts, individualised pain management plan.







National Survey of Current Practice

- Aims: 1) Inform understanding of barriers & facilitators to adult cancer pain assessment & management in various Australian clinical practice settings from the perspectives of health professionals from different disciplines
 - 2) Find out which (if any) guidelines for adult cancer pain are being used
 - 3) Establish the level of support for new Australian guidelines & implementation strategy
 - 4) Inform understanding of barriers & facilitators to guideline use







National Survey Results

- 598 respondents
- Strong support for implementation strategy for guidelines (over 90%)
- 47% used an existing guideline routinely
- 18% used Therapeutic Guidelines palliative care
- Major barriers: lack of access to nonpharmacological treatment strategies, lack of coordination across multiple providers







STOP Pain Project



Aim:

- To develop and test methods to tailor implementation of a national clinical pathway for cancer pain to the local setting
- Case study design
- Study site:
 - Greenwich Hospital is the 'case boundary'
 - Also track transitions to/from other services as these occur









Methods: environmental scanning



- Institutional and systems levels
- Assessment of internal and external environment to identify opportunities and threats
- Review of the local and external policy, workforce, funding and clinical practice complexity
- Toolkit to be validated as part of this project which uses the method of a 'problem-solution gap analysis'







Methods: Process Mapping



- Provides a 'patient-eye' view of systems and processes on the shop floor
- Ensures person-centred focus
- Separates management into a series of consecutive events or steps (e.g. activities, interventions) = 'process of care'
- Informs improvements by identifying ineffective or redundant steps for replacement or removal
- Creates culture of ownership, responsibility and accountability among local staff







Process mapping



Data collection

- Focus groups / interviews clinicians - all relevant disciplines
- Mapping processes underlying assessment and management of cancer pain for 10 patients over 8 weeks
 - Interviews with patients / caregivers
 - Medical record review
 - Observation

Working Group

- Role: Reviews data to develop:
 - Clinical process map
 - Recommendations for improvement
 - Stakeholders
 - 'clinical champions' from each discipline
 - senior management
 - consumers (patients and caregivers)











STOP Pain - Outputs



Dual patient & clinician cancer pain pathways

- Patient
 - Promotes self-management
 - Helps identifies the who, how, what & when

Development & testing of an implementation strategy

Validation Environmental Scanning Toolkit











Guideline development

Follows 3 phase ADAPTE approach to adapting existing guidelines:

1) Set-up phase

- Organising Committee & Working Group established

2) Adaptation

- Existing guidelines identified & screened (English language; adult; chronic pain; relevant across tumour types, disciplines & settings; recent; national/international; rates as 'recommended' or 'strongly recommended' on AGREE)
- Resulted in 6 guidelines for adaptation (NCCN, EAPC, ESMO, NHS, SIGN, NICE)
- Synthesis via matrix of recommendations for each clinical question
- -Recommendations with inconsistencies &/or low application to Australian service settings sent to Expert Panel for adjudication
- Drafting of pathway

3) Finalization

- External review of iterative drafts



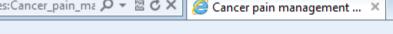


Australian Cancer Pain Guideline

- http://wiki.cancer.org.au/australia/Guidelines:Ca ncer_pain_management
- New platform
- Readily updated
- Widely accessible
- Available at point of care









Cancer Council Australia's Main Website



Search

References

Go



Cancer Council

Guidelines

Early stage endometrial cancer Surveillance

Colonoscopy Lung cancer treatment

Guideline Development Methodology

Australian Adult Cancer Pain Management Group

Cancer Pain Management

Clinical Oncological Society of Australia (COSA)

National Cancer Prevention Policy

Technical issues
 Report technical issues



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Self-management

Public comments

Overview Patient-centred care Screening Assessment

Opioid formulations

Cancer pain management in adults

Introduction

Pharmacological Mx

Evidence-based clinical practice guidelines adapted for use in Australia

Recommendations

Non-pharmacological Mx

Read

Resources

Practice improvement

Introduction

Summary of recommendations (Printable version @)

Cancer pain assessment and management overview

- 1. Patient-centred care
- 2. Screening
- 3. Assessment
- 4. Patient awareness & self-management
- 5. Pharmacological management
- 6. Non-pharmacological management
- 7. Practice improvement & quality control
- 8. Resources
- 9. Opioid formulations
- 10. References

Public consultation

Overview

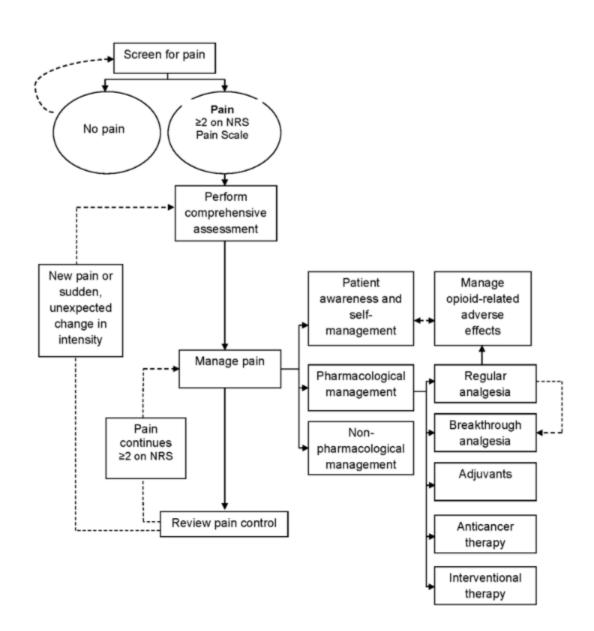
Australian Adult

Cancer Pain
Management Group
Cancer Pain
Management

Methodology

Clinical Oncological Society of Australia (COSA)

- National Cancer Prevention Policy
- Technical issues
 Report technical issues
- ▼ Toolbox
 What links here
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Screening and Assessment

- P- precipitating and relieving factors
- Q- quality of pain and quality of life
- R- radiation
- S- site
- T- time course
- Are you worried about something in particular?
- What is it important for me to know to care for you in the best possible way? (Chochinov)

Evidence – pharmacological management

- Mild pain –NSAIDS and paracetamol Level 1A
- Moderate pain low dose strong opioids or weak opioids like codeine
- Severe pain opioids morphine, oxycodone, and hydromorphone (fentanyl when stable)
- Titrate with long or short acting opioid

Neuropathic pain

- Optimise opioids
- Level 1 evidence for antidepressants and anticonvulsants but NNT is higher and NNH lower than in non-malignant pain
- Best evidence for gabapentin, pregabalin
- Note significant toxicity start low dose



Bone Pain

Addition of bisphosphonate

(Zometa – beware renal function and ONJ)

 Denosumab available for breast and prostate ca



Patient education

- As effective in clinical trials as analgesics
- Self management strategies: pain diary, script – how to explain your pain, management plan
- Explode the myths
 - people with pain and cancer do not become addicted to morphine
 - Starting morphine does not mean you are dying
 - You don't get used to it such that it does not work if the pain gets worse
 - Side effects do exist but can be managed



Non-pharmacological strategies

- CBT
- Hypnosis
- Relaxation
- Imagery
- Distraction
- Physical strategies eg exercise (Evidence level 3-4)
- Prayer

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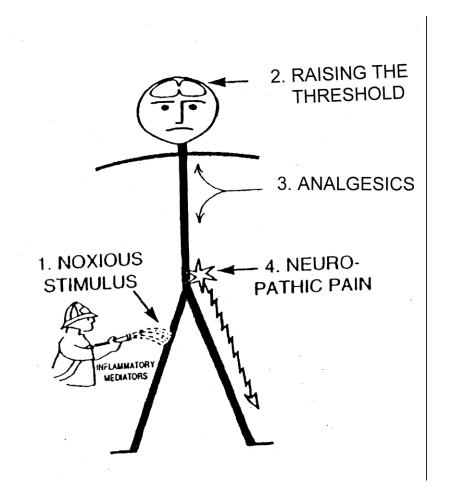
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Prof Lickiss Stickman





Meet Stewart



Symptom Burden

Please discom		above	the n	umber	that	best n	natche	s your	exper			h kind of	
not at all										worst possible			
Difficu	lty sleeping	0	_ 1	2	3	4	5	6	7	8	9	10	
Appeti	te problems	0	_ 1	2	3	4	□ 5	6	7	8	9	10	
Nausea	(fulluwing	0	□ 1	2	3	4	5	6	□ 7	8	9	10	
Bowel	problems	0	_ 1	2	3	4	□ 5	6	7	8	9	10	
Breath	ing problems	0		2	3	4	5	6	□ 7	8	9	10	
Fatigu	e	0	1	2	3	4	5	6	7	8	9	□ 10	
Pain		0	1	2	3	4	□ 5	6	7	8	9	10	
	symptoms WE SWEAD	_ 0	 1	□ 2	3	4	□ 5	6	7	8	9	10	
	symptoms	_ 0		2	3		□ 5	6	7	8	9	□ 10	
Blood	Blood Pressure (15/7)		175	/			Pulse Rate			_	103		

THE SYMPTOM ASSESSMENT SCALE

Stewart
Addressograph

SPO2%

(To be completed by patients)

Date April Time 12-50

Please tick the box above the number that best matches your experience of each kind of discomfort.

 $\theta = not$ at all 10 = worst possible not worst at all possible Difficulty sleeping П 9 0 10 Appetite problems 0 10 Q' Nausea 0 10 Bowel problems Breathing problems Fatigue l'ain Other symptoms Other symptoms Blood Pressure Pulse Rate

Temperature

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Our mission Our passion is improving quality of life for people in need

