Restoring Quality of Life: Managing Side Effects/Pain Control

Pain Control

Biren Saraiya, MD

A study was done looking at patients with advanced cancer indicated that patients did not want to spend time talking with the doctor about their pain because it would take time away from treating the cancer itself. Many patients felt pain was inevitable as part of the cancer and the dying process. Also, many patients fear taking medications due to side effects, and fear taking pain medication because of the connotation associated with pain medications.

As a medical oncologist, I focus on pain and how to help my patients live their lives. It can be considered palliative care. Pain control is desirable by most patients, and it is achievable. The discussion with the patient regarding what they desire in terms of the function and the pain control is often a balancing act; there are many choices for achieving pain control, including medications. Pain control requires frequent reassessment, adapting to needs and management of side effects. Two goals of cancer treatment are to cure the cancer, and where the cancer cannot be cure, to palliate the symptoms, thus prolonging quality of life. In either setting, optimal pain control is desired and probably achievable. How is this done? Pain medicines such as aspirin, ibuprofen, Tylenol are used; opioid medications may be used such as morphine, oxycodone, Percocet, Vicodin. Other medications which work as pain medications include antidepressants and anti-seizure medication. It is important for the clinician to evaluate the pain first and understand its etiology, then appropriately treat the patient.

We give medications by mouth, and also by IV for quick onset especially in someone with severe pain. Patches are another way to deliver pain, such as with fentanyl and lidocaine. Nonpharmacological therapeutics include radiation and surgery. Radiation is very effective in reaching the etiology of the pain, which is the cancer. For some patients, simple things such as exercise and heat and cold help reduce inflammation and thus ease pain. Quadramet, a radioisotope, can also be used.

While pain may be inevitable, it is still controllable. Patients may hold the belief that use of opioids such as morphine means that he/she is dying; the patient must be told this is not true. Patients may be reluctant to take pain medication fearing addiction; the patient must be told that it is a concern in patients with addiction, but it is still manageable such that symptoms and pain control are still treated. Most side effects are manageable and are usually not long-lasting. When a prescription change is required, the change should be in percentages rather than in absolute number. When additional need arises for pain control, breakthrough medication should be used; plans should be made for long-acting medication, short-acting medication, and how to treat side effects. A feedback loop allowing conversation between clinician and patient should be put in place to achieve optimal control as far as possible. Lastly, dosing should be based on desired and achieved pain control. If a physician is not comfortable treating pain, a pain management specialist, MD, anesthesiologist, or palliative care specialist whose focus is symptom management and quality of life should be located.

In response to an audience question, I want to find out the extent of cancer, whether it has spread to other parts of the body, and whether or not it is curable. I can then discuss what the expected course may be. Pain is often the first symptom of a catastrophic problem, such as something like spinal cord compression, and it is important for me as well as for the patient that the patient contact me when any pain arises; close communication among doctors should also take place.