

Multidisciplinary treatment for pain control in Palliative Care

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Before spending time in a palliative care team, I highlighted my attention mostly about pharmacologic pain control to care for patients who were terminally ill. Actually, it is just one of the aspects which concerns dying patients and the medical education of doctors caring about them.

Palliative Care is the active total care of patients and their families at a time when the disease is no longer responsive to curative treatment. The goal of palliative care is the achievement of the best quality of life for patients and their families (WHO 1990). Of course, pain is one of the most important factors decreasing patients' quality of life compromising their self-sufficiency, social relationship, and making patients depressed. One of the doctor's goals should be to make the last weeks of life for patients who are terminally ill pain free.

During my placement with the palliative care team, I experienced various different environments (Marie Curie Hospice, Llandough Hospital, University Hospital of Wales and Velindre Cancer Center) observing the patients, starting from admission to discharge. I'd like to begin by talking about Velindre Cancer Center, where more often than not patients meet for the first time the palliative care team. Velindre Hospital is the Center where patients undergo specific anti-cancer therapies. This means that patients, even if informed about their pathology, feel they can still fight against their disease. We have to make the difference between patients needing pain therapy, having chemotherapy at the same time, than patients unable to receive any further anti-cancer therapies. In the first case the doctor's goal is to get symptoms under control allowing patient to go on, having specific therapies and maintaining a good quality of life. Symptom control can be achieved by various different ways depending of the cause of pain. Pharmacologic approach is largely used to make patient pain free. First the doctor has to identify what is causing the pain, evaluating if it is an acute or chronic problem. Moreover, he has to identify the kind of pain: nociceptive, neuropathic or both. It is very important to choose what kind of pain killers

need to be used. Depending of the type of pain, the doctors' plan will be varied, integrating different medical teams (e.g. radiotherapist) to sort out the problem. For example, in a patient with breast cancer and bone metastasis, referring to pain in her back due to a lytic lesion in the spine, analgesic drugs could be integrated with radiotherapy or intravenous bisphosphonates. Following the start of opiate therapy, it is very important to find the best drug dosage keeping maximum effect with minimum adverse side effects. It is important, as well, to choose the route of administration. In clinical practice, the most useful are oral and subcutaneous. For the oral route, the opiate titration can be obtained both by sharing out the total daily dose twice a day (every 12 hours) with a long-release formulation (starting with low dose for patients opiate naïve) and by rapid-release formulation (even four hours). Total daily dosage will be calculated from how many times a day the patient takes the drug. Subcutaneous route by syringe-driver, as well, is largely used for pain killer administration. Often using this route, because the total dose is shared out in 24 hours, opiate induced side effects (mostly nausea) are better controlled than by oral route. Continuous opiate infusion by syringe driver seems to be useful mostly in patients with oral route uncontrolled pain. Moreover, by the syringe driver it is possible to infuse, at the same time, opiate drugs and anti-emetics. When the patient becomes pain free and side effects are under control, it will then be possible to change the route of administration from subcutaneous to oral (if there aren't contraindications to shift to this route). The assessment of the pain should be driven by what the patient feels. There are different ways to measure the patient pain, for example giving a questionnaire asking the patient to comment about how his pain is and how it interferes in his daily life (Brief Pain Inventory, MCGILL pain questionnaire). Actually, in clinical practice, it is more common to use numeric or a verbal scale to assess the pain and to evaluate if pain killers prescribed are working. For a suffering patient it is easier and quicker to describe his pain in that way than answering a long questionnaire. The usefulness of a pain questionnaire is certain in controlled trials for pain evaluation, but in clinical practice, numeric or verbal scales are used more to assess the patient pain as quickly as possible.

Once the patient is settled from the pain, he can go on with his specific anti cancer therapies and maintain a good quality of life.

It is a different scenario for patients with advanced disease, not treatable any more with actives therapies, for which symptom control is the most important goal. In general, it is a very difficult moment, for patients, when they are informed that it isn't possible to go on

with chemotherapy because their disease is too advanced and their biological parameters do not allow them to have anti cancer therapies more and/or because of their performance status. In that case, as a part of pain control, patients need a strict medical and social support. Depending of what the patient needs and wishes are would it be possible to decide, to keep him in Hospital or send him to Hospice or home. In general, patients staying at home, under their GP, are cared for by the Community.

The Community is a home assistance organization, connected with the Hospice. There is a strict collaboration between the Community and the Hospice. A specialist nurse goes during the week to see patients and to check if they are comfortable, settled and pain free. If something isn't working well, the nurse can ask a palliative care consultant to go and visit the patient. Moreover, if they are not comfortable at home, or the family needs a respite, they can be admitted to the Hospice where a specialist palliative care team will care for them.

The University Hospital of Wales and Llandough Hospital are general hospitals where they have palliative care units. Patients admitted, if required are referred to the palliative care team which gives advice to the doctors on the wards and plans the following program. Among the palliative care workers there are the Occupational Therapists (OT). An OT uses specific activities to limit the effect of disability and promote independence in all aspects of daily life. OT promotes the well-being and independence of people with cancer in various settings: in their homes, in hospital (acute or community), in nursing and residential homes, in day care hospices and in in-patients hospices. OTs have a role to play at all stage of the cancer pathway, from diagnosis to palliative and terminal care; they see such grades of ability as changeable, working with patients to make them as able as possible.

The Hospice where I attended is part of the Marie Curie Hospices, called Holme Tower. There, everyone works to make patients feel safe, comfortable and settled. They have a weekly meeting where doctors, nurses, social workers, physiotherapists and OTs discuss about the patients, both medical and familiar problems. The Hospice isn't just a building where patients are admitted to die. There is also the possibility to receive actives and procedures to improve the patients' quality of life, including, if necessary, interventistic pain therapy like nerves blocks or cordotomy. Patients admitted into the hospice, aren't just terminal patients, but, as well, patients needing pain therapy assessment or related

symptom control. In that scenario they aim to get patients settled so that they can go back home to be cared for by a community nurse.

In the last days of life, patients can be attended in different settings: hospices, general hospitals, own homes. The patient assessments are noted in the Care Pathway. It is intended as a guide in providing care for the patient and their family during the last days of life. The goal to achieve, in that case, is to have the patient pain free, not nauseous or vomiting, not having rattling secretions and being in a safe environment. The patient is checked four hourly by ward nurses and by doctors, as well, if required. This all happens until the patient's death.

In conclusion, pain therapy is included in the most complex pathway of palliative care. It is possible to fight against pain with multiple procedures, including drug administration, interventional therapies, radiotherapy and physiotherapy. Because the pain interferes in multiple aspects of patient's life, pain therapy has to include, as well, the management of the patients distress related to their inability. In that contest, doctors, nurses, OTs, social workers, physiotherapists and priests, as well, have to work to make patients feel safe, helping them to face daily difficulties both with symptom control and making them as able as possible. In that way, the best goal, for patients and doctors will be to: **keep a good quality of life.**

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I have, as well, to thank ESMO Palliative Care Working Group which has allowed me to have my experience in Palliative Care. It has been both an occasion to learn and mostly an opportunity for improvement. I hope, now, to apply in the best possible way my improved knowledge for Sardinia's patients.