

MULTIDISCIPLINARY TREATMENT FOR PAIN CONTROL: REPORT ON FIVE-WEEK PLACEMENT IN PALLIATIVE CARE TEAMS.

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Before I spent time in a palliative care team, I focused my attention mostly on pharmacologic pain control to care for terminally ill patients. Actually, it is just one of the aspects which concerns dying patients and the medical education of doctors caring for 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 achievement of the best quality of life for patients and their families (WHO 1990). Of course, pain is one of the most significant factors which decreases patients quality of life, compromising their self-sufficiency, social relationships, and making patients depressed. One of the goals of doctors should be to make the last weeks of life for patients with terminal illness pain free.

During my placement in the palliative care team, I was in different institutes (Marie Curie Hospice, Llandough Hospital, University Hospital of Wales and Velindre Cancer Center) observing which is the patient protocol, from admission to discharge. I'd like to start by talking about Velindre Cancer Center, where patients meet the palliative care team for the first time. Velindre Hospital is the Center where patients have specific anti-cancer therapies. It means that patients, even if informed about their pathology, feel they can still fight their disease. We have to differentiate between patients needing pain therapy, having chemotherapy at the same time, and patients no longer able to receive anti-cancer therapies. In the first case the doctor's goal is to get symptom control to allow patients to continue receiving specific therapies and maintain a good quality of life. Symptom control can be obtained in different ways depending of the cause of pain. The pharmacologic approach is widely used for pain relief. First, the doctor has to identify what is causing pain, evaluating if it is an acute or chronic problem. Then he has to identify the kind of pain: nociceptive, neuropathic or both. It is very important to choose what kind of pain killers have to be used. Depending on the pain, the doctors plan will be different, integrating different medical team (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 of 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 with maximum effect and minimum adverse events. 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 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 (every four hours). Total daily dose will be calculated from how many times a day patients take the drug. Subcutaneous route by syringe-driver is largely used to administer pain killers. Often using this route, because the total dose is divided out in 24 hours, opiate induced side effects, are better controlled than by oral route (most nausea). Continuous opiate infusion by syringe driver seems to be useful mostly in patients with oral route uncontrolled pain. Moreover, by syringe driver it is possible to infuse, at the same time, opiate drugs and anti-emetics. When the patient becomes pain free and the side effects are well controlled, it is possible to change the route of administration from subcutaneous to oral (if there aren't contraindications to a shift in this route). The

assessment of pain should be driven by what the patient feels. There are different ways to measure the pain, like giving a questionnaire asking the patient to describe the pain and how it interferes with his daily life (Brief Pain Inventory, MCGILL pain questionnaire). Actually, in clinical practice, is more common to use a numeric or verbal scale to assess the pain and to evaluate if the pain killers prescribed are working. For a suffering patient it is easier and quicker to describe his pain in that way rather 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 more frequently used to assess patients pain as quickly as possible.

Once the patients pain is alleviated, he can go on with his specific anti cancer therapies, maintaining a good quality of life.

It is quite different for patients with advanced disease, not treatable with active 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 isn't possible to go on with chemotherapy because their disease is too advanced and their biological parameters don't allow them to have anti cancer therapies anymore and/or because of their performance status. In that case, as a part of pain control, patients also need strict medical and social support. Depending on patients needs and wishes it is possible to decide, whether to leave him in th hospital or transfer him to a hospice or home. In general, patients who decide to stay at home are cared from the Community.

The Community is a home-assistance organization, connected with the hospice. There is close collaboration between the Community and the hospice. During the week a specialist nurse goes to see patients and check if they are comfortable, settled and pain free. If something isn't working well, nurses can ask palliative care consultant to see patients at home. Moreover, if they are not comfortable at home, or the family needs 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 with palliative care units. If needed, admitted patients are referred to the palliative care team that gives advice to the doctors in the wards and plans their programs. 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. The OT promotes the well-being and independence of people with cancer in various settings: in their homes, in the 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 stages of the cancer, 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 I visited is part of the Marie Curie Hospices, called Holme Tower, where everyone works to make patients feel safe, comfortable and settled. They have a weekly meeting where doctors, nurses, social workers, physiotherapists and OTs discuss patients, both about medical and family problems. The hospice isn't just a building where patients are admitted to die. There are also activities and procedures to improve patients quality of life, including, if necessary, interventistic pain therapy like nerve blocks or cordotomy. Patients admitted into the hospice, aren't just terminal patients, but patients needing pain therapy assessment or related symptom control. In that case, once patients are settled, they are ble to go back home and cared for by a community nurse.

In the last day of life, patients can be seen in different settings: hospices, general hospitals and their own homes. The patient assessments are noted in the Care Pathway, which is intended as a guide to providing care for the patient and their families during the last days of life. The goal is to achieve pain free existence for the patient, no nausea, vomiting, rattling secretions and finally, creating a safe environment. Patients are frequently checked by ward nurses and doctors, if required, up to 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 the management of the patients distress related to their inability. In that context, doctors, nurses, OTs, social workers, physiotherapists and priests have to work to make patients feel safe, helping them face daily difficulties both with symptom control and making them as independent as possible. The ultimate goal for patients and doctors is to maintain quality of life.

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I have, as well, to thank ESMO Palliative Care Working Group that has allowed me to part in this experience in Palliative Care. It has was both an occasion to learn and most of all to improve. My next step is to apply what I've learned to help patients in Sardinia.