

XVIII CONGRESSO  
DI ONCOLOGIA TREVIGLIESE

# Un incidente di percorso

**28 SETTEMBRE 2017**

**ASST BERGAMO OVEST**

Sala Verde - Piazzale Ospedale, 1 - Treviglio (BG)



*Gli aiuti:  
il dolore*

*Giovanni Zaninetta*

*Hospice Domus Salutis*

*Fondazione Teresa Camplani, Brescia*

Brescia Italia Sanitale



Regione  
Lombardia

ASST Bergamo Ovest



# Total pain

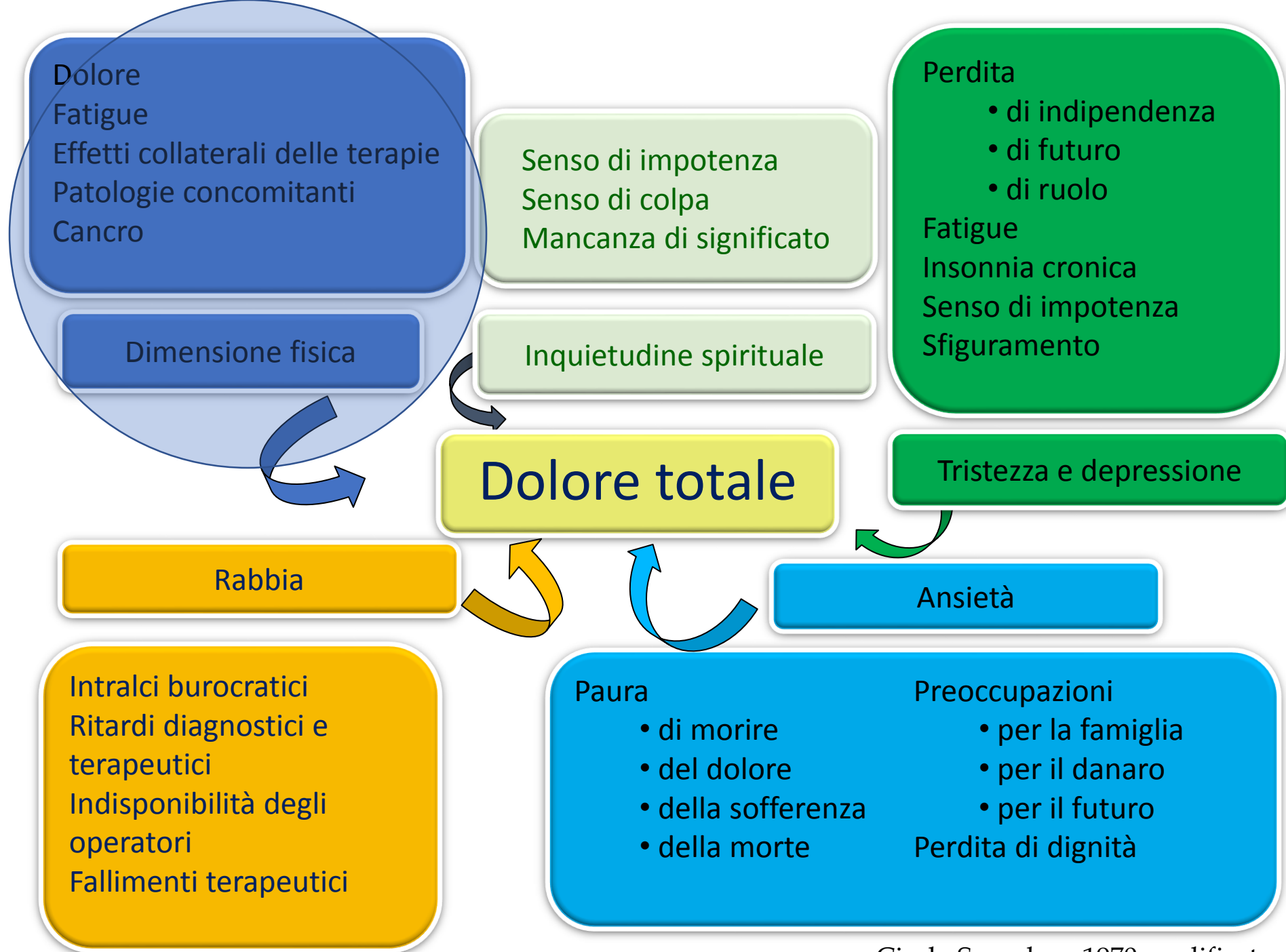
*I remember one patient who said, when asked to describe her pain: “Well, doctor, it began in my back but now it seems that all of me is wrong,” and she then described her other symptoms. She went on...”I could have cried for the pills and injections but knew that I must not. My husband and son were wonderful but they were having to stay off work and lose their money.” She was suffering a “total pain”....It is, in a way, somewhat artificial thus to divide a whole experience but it may give an internal checklist on meeting a new patient.*

***Cicely Saunders***

# Dolore totale

Mi ricordo di una paziente che mi disse, quando le fu chiesto di descrivere il suo dolore: "Beh, dottore, è iniziato nella mia schiena ma ora sembra che tutto di me sia sbagliato", e poi ha descritto i suoi altri sintomi. Ha continuato ... "Avrei potuto piangere per avere le pillole e le iniezioni, ma sapevo che non dovevo. Mio marito e mio figlio erano meravigliosi, ma dovevano rimanere a casa dal lavoro e perdere i loro soldi". Stava soffrendo un "dolore totale" ... È, in un certo senso, un po' artificiale suddividere un'intera esperienza ma può essere utile per fornire una check list interiore quando si incontra un nuovo paziente.

***Cicely Saunders***



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REVIEW ARTICLE

## Pain in Cancer Survivors

*Paul A. Glare, Pamela S. Davies, Esmé Finlay, Amitabh Gulati, Dawn Lemanne, Natalie Moryl, Kevin C. Oeffinger, Judith A. Paice, Michael D. Stubblefield, and Karen L. Syrjala*

# Long survivor: a che prezzo di dolore?

Il dolore è un problema comune nei sopravvissuti al cancro, soprattutto nei primi anni dopo il trattamento.

A lungo termine, circa dal 5% al 10% dei superstiti ha dolore cronico grave che interferisce con la funzionalità. La prevalenza è molto più alta in alcune sottopopolazioni, come le superstiti del cancro al seno.

Tutte le modalità di trattamento del cancro presentano inoltre il rischio di causare dolore. Attualmente, l'approccio alla gestione del dolore nei sopravvissuti al cancro è simile a quello per il dolore cronico correlato al cancro, e la farmacoterapia è la principale modalità di trattamento. Anche se può essere opportuno continuare ad impiegare oppioidi forti nei sopravvissuti con dolore da moderato a severo, la maggior parte dei pazienti con dolore non ne avrà bisogno.

# Long survivor: a che prezzo di dolore?

Inoltre, poiché più del 40% dei sopravvissuti al cancro vive più di 10 anni, cresce la preoccupazione per gli effetti avversi a lungo termine degli oppioidi e sui rischi di abuso, uso scorretto e sovradosaggio anche nella popolazione non ammalata. Come nel caso del dolore cronico non maligno, gli interventi multimodali che incorporano terapie non farmacologiche dovrebbero essere parte della strategia di trattamento del dolore nei sopravvissuti al cancro, prescritti allo scopo di ripristinare la funzionalità, non solo per fornire comfort. Per i pazienti con problemi di dolore complessi dovrebbero essere utilizzati programmi multidisciplinari, se disponibili. Un nuovo dolore o un peggioramento del dolore in un sopravvissuto al cancro deve essere valutato per determinare se la causa è una malattia ricorrente o una seconda malignità.

*Pain in cancer survivors J Clin Oncol. 2014 Jun 1;32(16):1739-47*



# Chronic Pain Syndromes Related to Cancer Treatment

## Surgery

- Intercostal neuralgia
- Lymphedema
- Neuroma pain
- Pain related to breast implants/reconstruction
- Phantom pain
- Postmastectomy pain
- Postsurgical neck dissection pain
- Post-thoracotomy pain

## Radiation

- Chest pain/tightness
- Cystitis
- Enteritis/proctitis
- Fibrosis of skin or myofascia
- Fistula formation
- Myelopathy
- Osteoradionecrosis
- Pelvic insufficiency fractures
- Peripheral nerve entrapment
- Plexopathies
- GI, abdominal, other adhesions in the radiation field

# Chronic Pain Syndromes Related to Cancer Treatment

## Hormonal therapy

- Arthralgia/myalgia

- Muscle cramps/spasms

- Carpal tunnel syndrome

- Trigger finger

## Chemotherapy

- Arthralgia/myalgia

- Osteoporosis

- Osteonecrosis

- Chemotherapy-induced peripheral neuropathy

- Muscle cramps

## Steroids

- Osteoporosis

- Osteonecrosis (avascular necrosis; typically femoral head, knee, humeral head)

## Bisphosphonates

- Osteonecrosis of jaw

# Chronic Pain Syndromes Related to Cancer Treatment

Hematopoietic stem-cell transplantation (chronic graft-versus-host disease)

Abdominal, GI adhesions, pain

Arthralgia/myalgia

Contractures with pain and decreased range of motion

Corneal ulcerations with pain, dryness, and burning in eyes

Cystitis

Erythema

Esophageal strictures and ulcers leading to retrosternal pain

Fibrosis/scleroderma with contractures, pain and decreased range of motion

Infection

Inflammation/edema

Mucous membrane inflammation, thinning, strictures, ulcers (mouth, GI tract, vagina)

Muscle cramps

Peripheral neuropathy

Osteonecrosis of joints

# Outpatient Chronic Pain Management in Cancer Survivors: A Framework for Evaluation and Management

1. Define who is responsible for comprehensive pain management program and prescribing.

Providers who may provide chronic pain management

Medical or radiation oncologist

Survivorship clinic provider

Primary care provider

Palliative or supportive oncology provider

Chronic pain specialist (anesthesia, neurology, rehabilitation medicine, internist)

If plan involves co-management, define and communicate to other providers who is responsible for prescription management.

Opioids should be prescribed by only one provider.

# Outpatient Chronic Pain Management in Cancer Survivors: A Framework for Evaluation and Management

## 2. Evaluation

Perform comprehensive history and physical examination with attention to functional and psychosocial issues related to pain.

If opioids are being considered, a standard opioid risk assessment tool may be useful, such as the Screener and Opioid Assessment for Patients with Pain (SOAPP-R) or Opioid Risk Tool (ORT).<sup>4,5</sup>

For new or changing pain syndromes, always evaluate for recurrence or second primary, as well as development of late effects of treatment.

For new or changing pain syndromes, consider imaging and referral back to oncology (if the oncologist is no longer involved).

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# Outpatient Chronic Pain Management in Cancer Survivors: A Framework for Evaluation and Management

## 3. Management

### Pharmacologic

Co-analgesics: antidepressants, anticonvulsants, nonsteroidal anti-inflammatory drugs, acetaminophen, others.

Opioids: prescribing should be undertaken within the following universal precautions framework:

- Assessment of risk for opioid misuse

- Stratification for location of pain care based on risk assessment (primary care, occasional specialty consultation, or specialist management)

- Structuring of therapy commensurate with assessment of risk (weekly versus monthly prescriptions; regular versus sporadic urine drug screens)

- Establishment of functional goals to guide dose titration

- Maintenance of ongoing monitoring for opioid misuse, abuse, or diversion

- Management of emerging problems consistent with medical best practices and existing laws and regulations

Nonpharmacologic: Refer for the following behavioral and therapeutic interventions:

- Exercise program

- Cognitive-behavioral therapy

- Physical medicine and rehabilitation, physical therapy, transcutaneous electrical nerve stimulation, scrambler therapy

- Integrative medicine approaches (acupuncture, massage)

- Interventional approaches

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# Chronic Pain Syndromes in Cancer Survivors, by System

System Affected	Pain Syndrome	Incidence
Neurologic	<p>Chemotherapy-induced peripheral neuropathy</p> <p>Postoperative pain syndromes</p> <p>Brachial or lumbar plexopathy, secondary to radiation, brachytherapy, or surgery</p> <p>Postherpetic neuralgia</p> <p>Complex regional pain syndrome after axillary node or neck dissection</p>	<p>Up to 100%</p> <p>Post-thoracotomy pain: 25%–60%</p> <p>Postmastectomy pain: 50%; lumpectomy with axillary node dissection: 39%</p> <p>Phantom-breast pain: 13%–24%</p> <p>Postamputation pain: 30%–80%</p> <p>Radical neck dissection: 40%–52%</p> <p>Brachial: 18% radiation-induced pain; onset may be delayed by decades</p> <p>Lumbar: radiation-induced is uncommon</p> <p>35%, after stem-cell transplantation (retrospective medical records review). May also develop at site of radiation therapy or surgery. More common in patients older than 50 years. Risk of postherpetic neuralgia developing is no greater than in general population.</p> <p>Rare (case reports)</p>
Rheumatic	Migratory noninflammatory myalgias and arthralgias from tamoxifen, aromatase inhibitors, radiation, deconditioning, steroids, and steroid taper	Common
Integumentary	Graft-versus-host disease with pain in skin, mucous membranes, and musculoskeleton	30%–80% of those who survive 6 months after transplantation with graft-versus-host disease

# Chronic Pain Syndromes in Cancer Survivors, by System

Lymphatic	Pain or discomfort from lymphedema, secondary to breast surgery, axillary or inguinal node dissection, or radiation	Upper extremity: 20%–56%; of those, 30%–60% have pain; lower extremity: 10%–15%
Skeletal	<p>Osteoporosis</p> <p>Osteonecrosis of femoral head, knee, humeral head</p> <p>Pelvic insufficiency fracture after whole pelvic radiation</p> <p>Osteonecrosis of the jaw from bisphosphonates, denosumab, or radiation to the head and neck</p>	<p>10%–38% (arthritis/osteoporosis)</p> <p>3.7% at 5 years; 5% at 10 years after hematopoietic cell transplantation</p> <p>8.5%–32%</p> <p>Bisphosphonates: 3%–11%. Radiation: small incidence. More common after prolonged exposure (36 months or more) to pamidronate and zoledronic acid, age &gt; 65 years and with pre-existing dental problems</p>
Myofascial	Rotator cuff tendonitis, adhesive capsulitis (frozen shoulder), neck and back pain	70% shoulder pain after radical neck dissection
GI/urinary/pelvic	<p>Chronic pelvic pain, chronic enteritis, proctitis, cystitis, tenesmus</p> <p>Associated urinary or fecal urgency/incontinence is common</p> <p>Radiation-related adhesions</p>	Cervical cancer: 38%
Genital	Dyspareunia: secondary to menopause, decreased vaginal lubrication from radiation, vaginal stricture/fibrosis from radiation	34%–58%; women experience more of an impact than men



# Concludendo ...

Guarire o prolungare significativamente la vita di una persona malata di cancro non può significare di per sé un grande successo se non è accompagnato da un follow up che renda il prolungamento della vita un tempo di valore, tempo in cui il dolore deve essere allontanato il più possibile