From Perspective to Practice
Advanced Pain Management in the Terminally Ill

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ROSE OF TEXAS HOSPICE

Objectives

- The learner will be able to identify 3 types of pain
- The learner will be able to identify 3 types of pain management
- The learner will recognize myths of morphine use, appropriate use of methadone and appropriate adjuvant medications

What is Pain?

- Unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (IASP)

  or is it....

- Whatever the person says it is, experienced whenever they say they are experiencing it (McCaffery and Pasero)
Developing a new perspective

- “Pain, the Gift Nobody Wants”, Dr. Paul Brand
  - The Alarm Center
  - Awareness of “something wrong”
  - Medical Intervention and treatment
  - From Curative to Palliative

From Perspective to Practice
The Barriers

- Myths
- Cultural
- Financial
- Language
- Only for the “Last hours”
- Pain perceived as punishment

ASK and then LISTEN

- Where is the pain?
- What kind of pain is experienced?
- How does the patient describe the pain?
- When does it start? What makes it worse?
- What has helped in the past?
- What level of pain is acceptable?
World Health Organization Ladder

- Start low and go slow
- Consistency – load the receptor sites
- The type of pain identifies the treatment
  - Visceral
  - Somatic
  - Neuropathic
  - Skeletal

Opioids/Adjuvant Medications

Moderate Pain: ASA/APAP + Codeine, Hydrocodone, etc.

Mild Pain: ASA, APAP, NSAID’s

Morphine: the Gold Standard

- The measure by which other narcotics are weighed
- Multiple uses in terminal care
- Flexible dosing
- Allergies are extremely rare
- No ceiling dose
- Produces an overall sense of well-being

Side Effects and Precautions

- Narcotic induced nausea/vomiting
- Constipation
- Myoclonus in high doses
- Itching
- Tolerance
- Opioid effect on respirations
Adjuvant Medications and Indications

- Dexamethasone
- Antidepressants and anticonvulsants
- NSAIDS
- Tincture of Belladona
- Levsin/Scopolamine/Atropine

Methadone

- Overcoming the stigma
- Potentials for use
- Receptor site affinity

"Methadone is the opioid of choice for patients with poorly responsive neuropathic pain" Robert Tycross, DM, FRCP, FRCP – past Director of World Health Organization Collaborating Center of Palliative Cancer
Author of Cancer Pain Management

- Flexible dosing
- Long half-life (8-75 hours)
- Can reduce the dose of morphine by as much as 50% with only a very small dose of methadone
- Decreased effective laxative dose
- Low incidence of side effects
- Well tolerated in renal and hepatic impaired patients
Methadone

So...

If methadone is so great, why not use it for everyone?

“...Methadone is considered a good alternative when patients are no longer responsive to morphine, hydromorphone and fentanyl”

Carla Ripamonti, MD, Deputy Director, Division of Pain Therapy and Palliative Care Instituto in Milan, Italy

Methadone Conversion Ratios

<table>
<thead>
<tr>
<th>Morphine Equivalent (mg/day)</th>
<th>Initial Dose Ratio (Morphine:Methadone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 mg</td>
<td>2:1</td>
</tr>
<tr>
<td>30-99 mg</td>
<td>4:1</td>
</tr>
<tr>
<td>100-299 mg</td>
<td>8:1</td>
</tr>
<tr>
<td>300-499 mg</td>
<td>12:1</td>
</tr>
<tr>
<td>500-999 mg</td>
<td>15:1</td>
</tr>
<tr>
<td>≥ 1000 mg</td>
<td>20:1</td>
</tr>
</tbody>
</table>

Non-Pharmacologic Interventions

- Massage
- Relaxation
- Distraction
- Visualization
- Life Review
- Touch
- Prayer
- Music
There is no magic, but sometimes, there are Miracles