



The British Pain Society's

Cancer Pain Management

A perspective from the British Pain Society, supported by the Association for Palliative Medicine and the Royal College of General Practitioners

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Chapter 14 Cancer pain: recommendations for service design and training

Summary

The management of cancer pain can and should be improved by better collaboration between the disciplines of oncology, pain medicine and palliative medicine. This must start in the training programmes of doctors, but also in established teams in terms of funding and time for joint working, and in the education of all healthcare professionals involved in the treatment of cancer pain.

14.1 Surveys of working with Pain Management and Palliative Care

- Despite the recognised need for improved pain management in palliative care, there is currently inconsistent partnership between the specialities of pain medicine and palliative medicine.
- A national survey of pain management services in palliative care was conducted in 2002 by Linklater, who sent a postal questionnaire to all consultant members of the Association for Palliative Medicine, asking whether they had contact with a pain management specialist. Most respondents had access to “as-required” anaesthetic pain consultations, with 72% feeling that the frequency of consultation was adequate, but 20% desiring more frequent input. 15% had access to regular weekly sessions; trainee anaesthetists featured in only 7% of sessions. Half the respondents used pain management advice less than four times a year. All respondents felt that the anaesthetist’s input involved advice on performing practical procedures, but only 25% felt that a joint consultation about analgesic therapy would be useful. The authors advocated the establishment of a regular weekly session with a pain specialist, and their experience showed that this rapidly increased the number of referrals to 11% of in-patients, with procedures performed on 8% and advice given on 3% of cases.
- A survey of anaesthetists in UK clinics was conducted in 2007 by Kay using a postal questionnaire and they found that referrals rates from palliative medicine to pain clinics were low; only 31% of respondents received more than 12 referrals per year. Only 25% of anaesthetists’ job plans had time allocated for palliative medicine referrals, and joint consultations were rare.
- A 2007 survey of hospices and palliative care units in England (Petrovic, personal correspondence) has shown that, while 92% of palliative care units have access to specialist pain management advice, only 16% have regular sessions; the situation has not changed over the past 5 years, despite the increasing complexity of illness. Only 41% of pain services provided a comprehensive range of pain treatments, including non-invasive therapies such as TENS and minimally invasive therapies such as acupuncture and trigger point injections, and in about 50% of palliative care units, neuraxial infusions are not available. There are distinct barriers to sending patients home with invasive therapies related to multiple factors, but particularly to a lack of training and the experience of the home care team and drug supply issues.

14.2 Barriers to links between specialist pain management and palliative medicine

These can be summarised as follows:

- Short survival of patients following referral to palliative care services.

- Funding of the service.
- Time on the part of the pain specialist for proper assessment and discussion.
- Facilities for performing interventions may not be easily accessible.
- Complexity/lack of real understanding.
- Staff training in the management of pumps and catheters.
- Pharmacy issues; procurement of solutions/ availability of preservative free opioids/ lack of sterile facilities for making up infusions.
- Cost of implanted devices.
- Who is going to manage neuraxial infusions at home?
- Lack of availability of pain specialists out of hours.
- The palliative care doctor may be unaware of potential benefits/ unsure how to access expertise.
- The pain doctor may not be adequately trained in the management of cancer pain/ selection of an appropriate technique.

There are examples in the literature of improved treatment outcomes from a multidisciplinary cancer pain clinic. A Danish study in 1991 showed an improvement in pain scores in over 50% of patients using medical pain treatment supplemented by analgesic tailoring, epidural opioid therapy, non-neurolytic blockades and combinations of these (Banning, 1991).

14.3 What can specialist pain management offer in palliative care?

- Assessment of complex cases.
- Detailed knowledge of the neurophysiology of pain.
- Specialist knowledge of treating different types of pain (e.g. neuropathic pain, complex regional pain syndrome).
- Interventional techniques.
- TENS, acupuncture.
- Psychological aspects of pain management.
- Provision of sedation.
- Management of non malignant pain.
- Recognition and advice about dependency and addiction.
- Withdrawal from opioids.

14.4 What can palliative medicine offer to specialist pain management?

- Detailed knowledge of using opioids.
- Management of opioid toxicity.
- Understanding of cancer pain and all cancer treatments.
- Excellent communication skills.
- Team working.
- Family therapy.
- Holistic medicine.
- Home care.
- End of life care.

14.5 Improving collaboration

Palliative medicine has been a recognised speciality since 1987, when speciality training programmes were established by the Royal College of Physicians. Funding of the speciality was further enhanced as a result of the Calman-Hine report in 1995, when palliative care was integrated with cancer services. Pain medicine is not yet a recognised speciality, although a Faculty of Pain Medicine of the Royal College of Anaesthetists was established in April 2007 to set and uphold standards in the training of doctors practising pain medicine in the future. Cancer pain management will be an essential part of this training. Interventional pain control is also a vital part of the training of palliative medicine doctors, thus providing hope for enhanced collaboration in the future. The training requirements detailed in 14.6 will enhance the knowledge of doctors in the future about pain management and palliative care. It is hoped that similar provision will be made in the training programme of medical oncologists.

It is important that nurses, physiotherapists, pharmacists and other healthcare professionals will also introduce the principles of multimodal pain management into their curricula.

14.5.1 Other ways in which collaboration can be improved

- Regular funded sessions for the pain specialist to work in palliative care, whether in hospital, the community or a hospice.
- Regular discussion about individual cases.
- Timetabled attendance of all types of healthcare professionals on joint ward rounds and at multidisciplinary meetings.
- Joint educational seminars, local and national.
- Joint national and international meetings (e.g. British Pain Society Annual Scientific Meeting, World Congress on Pain).
- Joint research projects and publications.



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