

ESMO Clinical Practice Guidelines

Discussion

Cancer Pain and Breathlessness Clinical Case Presentation

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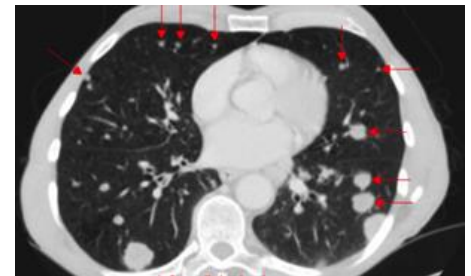
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Review: Case Situation

- Patient 39 year-old, lives alone, housekeeper
- Comorbidities:
 - Alcohol consumption (3l/d) ,Tobacco consumption (> 60 P/y)
 - Peripheral neuropathy (alcohol)
- Squamous cell carcinoma of the tongue with pulmonary metastasis
- Treatment: Cisplatin + Cetuximab
- Pain Severity:
 - Visual Numeric Scale (8/10)
 - Uncontrolled with 500 µg/h Transcutaneous Fentanyl
- Pain Location: Tongue, Chest
- Dyspnoea:
 - Limited for short efforts
 - Difficulties to speak: orthopnea
 - 2 – 3 weeks evolution
- Hospitalised in Supportive Care Unit for Assessment

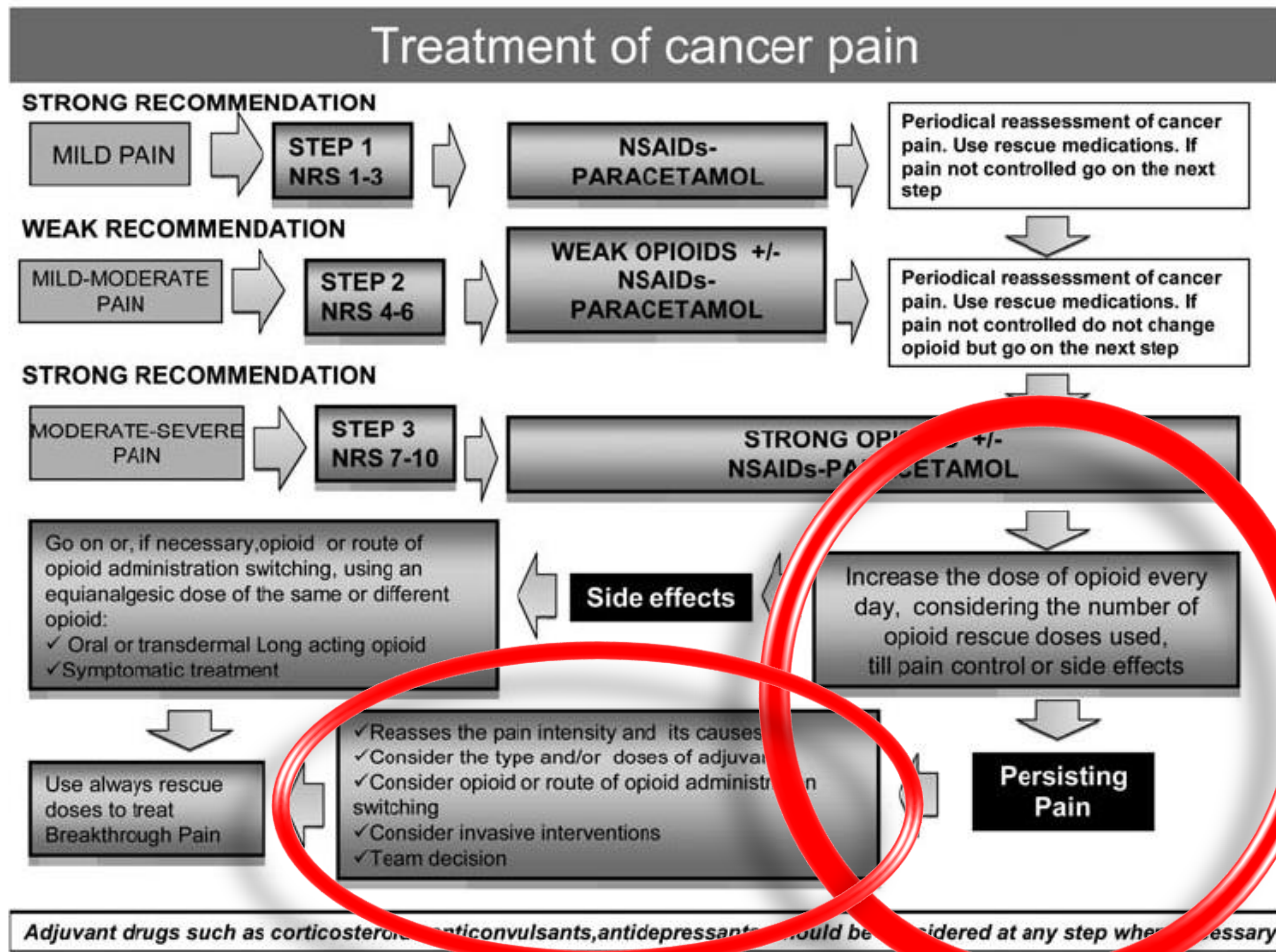


Q2: Pain Management?

1. No change: transcutaneous fentanyl 500 µg/h
2. transcutaneous fentanyl 500 µg/h + PCA bolus
3. Rotation to PCA
4. Rotation to oral Oxycodone + PCA bolus
5. Rotation to Oral Oxycodone + short acting oxycodone
6. Rotation to long acting opioid + transmucosal fentanyl



From ESMO guideline



From ESMO guideline

- Reassess the pain intensity and its causes
- Consider the type and/or doses of adjuvants
- Consider opioid or route of opioid administration switching
- Consider invasive interventions
- Team decision

In this case....

- Squamous cell carcinoma of the tongue
- Patient is on transdermal fentanyl 500 µg/hr
- NRS is 8/10, uncontrolled
- Dyspnea

- ~~1.~~ No change: transcutaneous fentanyl 500 µg/h
2. transcutaneous fentanyl 500 µg/h + PCA bolus
3. Rotation to PCA
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Switching opioid: relative potency

Transdermal fentanyl 500 µg/hr

- Equianalgesic dose
 - Morphine PO: 1200mg/day
 - SC: 600mg/day, IV 400mg/day
 - Oxycodone PO: 800mg/day
 - SC: 600mg/day, IV 600mg/day
 - Hydromorphone PO: 300mg/day
 - SC: 60mg/day, IV: 60mg/day
 - Methadone PO:
 - Morphine dose equivalence not reliably established

R3: Possible Aetiologies for Breathlessness ?


1. Cancer (metastasis, effusion)
2. Cancer Treatment (pulmonary toxicity)
3. Supportive Treatment (overdose)
4. Comorbidities (pulmonary embolism)
5. Dust allergy
6. Psychiatric disorders

R3: Possible Aetiologies for Breathlessness ?

1. Cancer (metastasis, effusion)
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 - Respiratory depression d/t opioid overdosing is not mentioned in ESMO clinical practice guideline
 - Breathlessness? or Respiratory depression?
 - “...opioids cause respiration to **slow and become irregular**, leading to hypercapnia and hypoxia. ”
4. Comorbidities (pulmonary embolism)
5. Dust allergy
6. Psychiatric disorders

R4: Management?

1. Drug dose adaptation: switch to Methadone 
 - Although evidence has been provided only for oral and parenteral morphine, diamorphine and dihydrocodeine, larger series, retrospective studies and case reports suggest that no opioid is superior to another and that hydromorphone, fentanyl and oxycodone may also be used.
 - ESMO Clinical Practice Guidelines
2. Bronchodilators inhaled (small airways)
3. Diuretics (lymphangitis).
4. Steroid drugs
5. AntiCancer Specific Treatment
6. Other...

R5: Dyspnoea Management ?

In advanced

cancer

1. Sedation
2. ICU
3. Palliative Care Team call
4. Antidote (Naloxone)
 - In this case, it may not be applicable...
 - For dyspnea? Use and Myths
 - When you see severe respiratory depression,
 - Close monitoring, oxygen, secure IV access, prepare for resuscitation
 - Use Naloxone to reverse opioid, only if necessary
 - ◆ 80µg IV and add 20µg every 1-2minutes

Using this slide only if it fits the image of discussion.
I don't know the detailed history of this patient, so I just imagined as what would I have done in a similar situation.

Alternatives,

- Switch to other opioids
 - Add IV morphine 240mg/day (with PCA) or methadone 30mg/day
 - Remove 100 μ g/hr patch every 24hrs
 - Increase IV morphine or methadone only if pain increases
 - Add IV acetaminophen 4000mg/day
 - Add any analgesic that may help to reduce opioid dose
- For dyspnea,
 - IV PCA hourly dose x1.5 to x2.0 q10min
- May use naloxone if,
 - Cause of respiratory depression d/t opioid overdose