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FAST FACTS AND CONCEPTS #215

Author(s): Tamara Sacks MD, David E Weissman MD, and Robert Arnold MD

Background Relief of cancer pain from opioids is rarely all or nothing; most patients experience some degree of analgesia alongside opioid toxicities. When the balance of analgesia versus toxicity tips away from analgesia, the term 'opioid poorly-responsive pain' is invoked. While opioid poorly-responsive pain is not a discreet syndrome, it is a commonly encountered clinical scenario. This Fast Fact reviews key points in its assessment and management.

Differential Diagnosis of Opioid Poorly-Responsive Pain

1. Cancer-related pain
   a. Cancer progression (new fracture at site of known bone metastases).
   b. Causes of pain (eg. neuropathic pain, skin ulceration, rectal tenesmus, muscle pain) that are known to be less responsive to systemic opioids or opioid monotherapy.
   c. Psychological/spiritual pain related to the cancer experience (existential pain of impending death).

2. Opioid pharmacology/technical problems
   a. Opioid tolerance (rapid dose escalation with no analgesic effect).
   b. Dose-limiting opioid toxicity (sedation, delirium, hyperalgesia, nausea – see *Fast Facts* #25, 142).
   c. Poor oral absorption (for PO meds) or skin absorption (e.g. transdermal patch adhesive failure).
   d. Pump, needle, or catheter problems (IV, subcutaneous, or spinal opioids).

3. Non-cancer pain
   a. Worsening of a known non-cancer pain syndrome (diabetic neuropathy).
   b. New non-cancer pain syndrome (dental abscess).

4. Other psychological problems
   a. Depression, anxiety, somatization, hypochondria, factitious disorders.
   b. Dementia and delirium both can effect a patient's report of and experience of pain.
   c. Opioid substance use disorders or opioid diversion.

Management Strategy

1. Initial Steps
   a. Complete a thorough pain assessment including questions exploring psychological and spiritual concerns. If substance abuse or diversion is suspected, complete a substance abuse history (see *Fast Facts* #68, 69).
   b. Complete a physical examination and order diagnostic studies as indicated.
   c. Escalate a single opioid until acceptable analgesia or unacceptable toxicity develop, or it is clear that additional analgesic benefit is not being derived from dose escalation. If this fails, consider:
      i. Rotating to a different opioid (e.g. morphine to methadone).
      ii. Changing the route of administration (e.g. oral to subcutaneous).
   d. Treat opioid toxicities aggressively.
   e. Use (start or up-titrate) adjuvant analgesics, especially for neuropathic pain syndromes.
   f. Integrate non-pharmacological treatments such as behavioral therapies, physical modalities like heat and

cold, and music and other relaxation-based therapies – see *Fast Fact* #211.

2. Additional steps – Pain refractory to the initial steps requires multi-disciplinary input and care coordination.
   a. Hospice/Palliative Medicine consultation to optimize pain assessment, drug management, and assessment of overall care goals.
   b. Mental health consultation for help in diagnosis and management of suspected psychological factors contributing to pain.
   c. Chaplain/Clergy assistance for suspected spiritual factors contributing to pain.
   d. Interventional Pain and/or Radiation Oncology consultation.
   e. Rehabilitation consultations (Physiatry, Physical and Occupational Therapy) to maximize physical analgesic modalities.
   f. Pharmacist assistance with drug/route information.

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Author Affiliations: University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania (TS, RA), and Medical College of Wisconsin, Milwaukee, Wisconsin (DEW).

Fast Facts and Concepts are edited by Drew A. Rosielle MD, Palliative Care Center, Medical College of Wisconsin. For more information write to: drosiell@mcw.edu. More information, as well as the complete set of Fast Facts, are available at EPERC: www.eperc.mcw.edu. Readers can comment on this publication at the Fast Facts and Concepts Discussion Blog (http://epercfastfacts.blogspot.com).

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