Breakthrough cancer pain guidelines 2013 Pocket guide

This guide is intended to help oncology professionals to understand, recognise and improve the management of breakthrough cancer pain (BTCP) for their patients. Oncology nurses have a key role to play in identifying, assessing, and managing BTCP. Regular contact with patients enables observation and dialogue that can contribute to a more accurate diagnosis, better BTCP management and improved patient satisfaction with treatment. Good collaboration between healthcare professionals, patients, and carers represents an essential component for the provision of optimal care for cancer patients.

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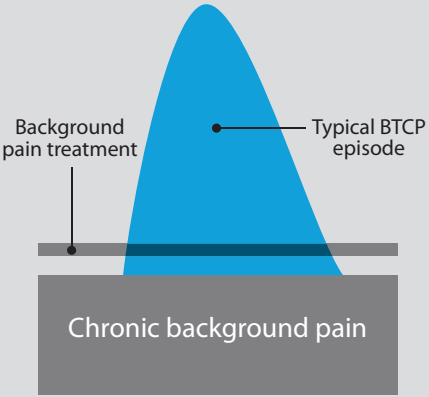
Introduction

Breakthrough cancer pain (BTCP) has been recognised as a burdensome symptom that is inadequately treated and often unresolved in many cancer patients.[1,2] Despite its self-limiting nature, the presence of BTCP can have a significant, negative impact on the quality of life of patients and caregivers.[3,4]

Definition of BTCP

A transient exacerbation of pain that occurs either spontaneously, or in relation to a specific predictable or unpredictable trigger, despite relatively stable and adequately controlled background pain.[5]

Figure 1. A 'typical' episode of BTCP



Characteristics of BTCP

BTCP is a heterogeneous pain symptom.[5] The two widely identified and accepted categories of BTCP are spontaneous pain and incident pain:[5]

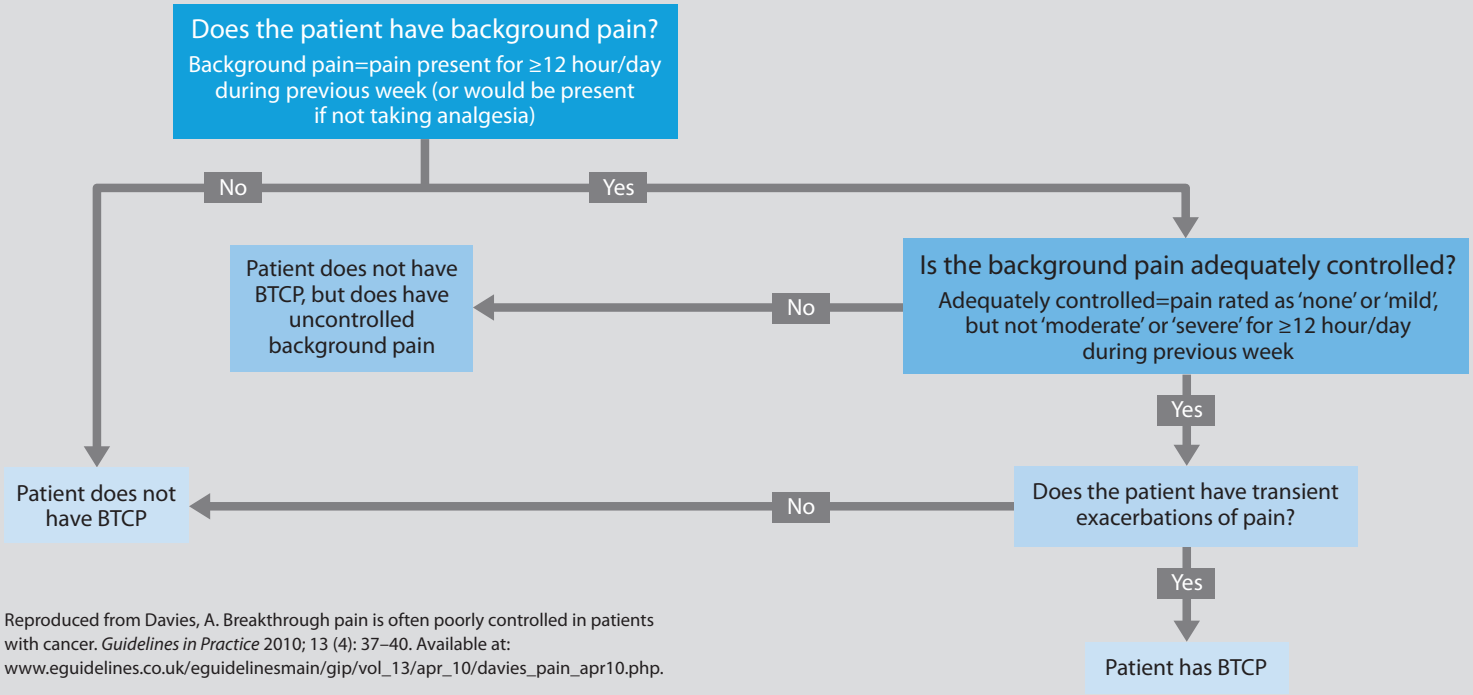
- Spontaneous pain ('idiopathic pain') – these episodes are not related to an identifiable precipitant and so, are unpredictable in nature.
- Incident pain ('precipitated pain') – these episodes are related to an identifiable precipitant, and can be generally predictable in nature. Incident pain is usually sub-classified into one of three categories:
  - Volitional incident pain – brought on by a voluntary act (e.g., walking)
  - Non-volitional incident pain – brought on by an involuntary act (e.g., coughing)
  - Procedural pain – related to a therapeutic intervention (e.g., wound dressing).

NB: BTCP is not to be mistaken for episodes of pain that occur during initiation or titration of opioid analgesics for the treatment of background pain, or for episodes of pain that occur before the administration of opioid analgesics (end-of-dose failure), as the patient does not have controlled background pain in either of these situations.[5]

BTCP versus uncontrolled background pain

It is vital to clearly identify that the patient has BTCP and not poorly controlled background pain.

Figure 2. Algorithm for diagnosing patients with BTCP[6-8]



Reproduced from Davies, A. Breakthrough pain is often poorly controlled in patients with cancer. *Guidelines in Practice* 2010; 13 (4): 37–40. Available at: www.eguidelines.co.uk/eguidelinesmain/gip/vol_13/apr_10/davies_pain_apr10.php.

Assessment of BTCP

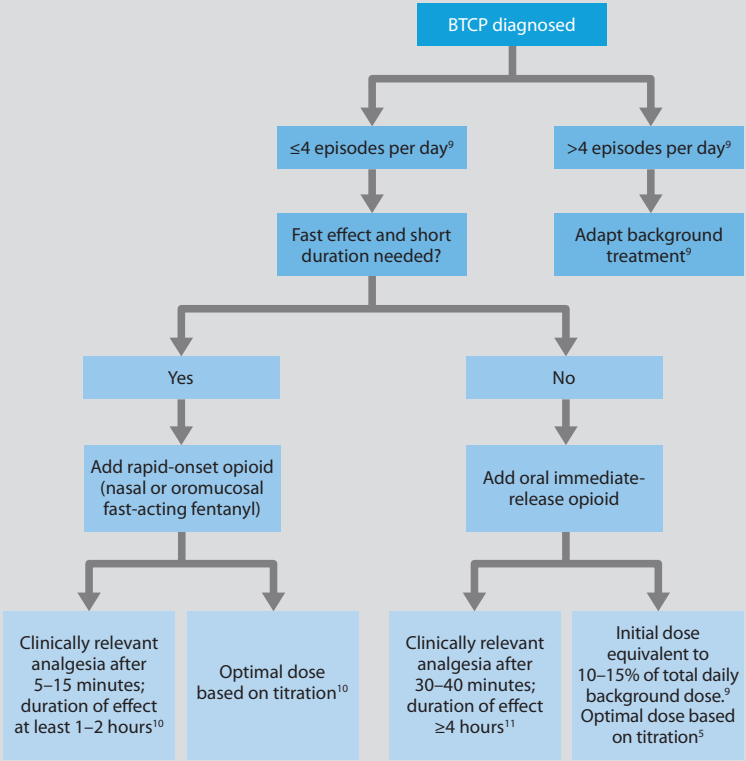
To assess BTCP, it is recommended that the patient is asked the following standard pain questions:[5]

- What is the onset of pain (e.g., spontaneous or incident)?
- What is the frequency of pain episodes?
- What is the site of pain (e.g., is it the same place as the background pain)?
- Is there radiation of pain (e.g., is there some neuropathic pain in the BTCP)?
- What is the quality (character) of pain?
- What is the intensity (severity) of pain (assessed using the numeric rating scale or verbal assessment scale)?
- What is the duration of pain?
- Are there exacerbating factors?
- Are there relieving factors?
- What is the response to analgesics?
- What is the response to other interventions (e.g., heat, massage, relaxation)?
- Are there associated symptoms (e.g., nausea, anxiety)?
- What is the interference with activities of daily living?

Management of BTCP

- **Lifestyle changes:** For example, pacing techniques to reduce activities that precipitate BTCP; the use of specific aides for activities of daily living (e.g., washing, dressing, and cooking); performing specific exercises; or utilising the assistance provided by family, to maximum benefit.[4]
- **Management of reversible causes:** For example, treating a cough with an antitussive, or constipation with a laxative.[4]
- **Modification of pathological processes:** For example, treating the cause of the pain – mostly cancer – with systemic therapies (e.g., chemotherapy), radiation therapy, and/or surgery.[3,4]
- **Non-pharmacological management:** For example, application of heat or cold, massage, and/or relaxation techniques.[3,4]
- **Pharmacological management:**
  - Rescue medication – traditionally, the most common form of rescue medication has been the oral normal-release ('immediate-release') formulations of morphine and other relevant opioid analgesics.[5]
  - Rapid-onset medications – specifically developed for the treatment of BTCP, these are all preparations of the potent opioid, fentanyl, which has been the opioid of choice for BTCP medications that use the oral transmucosal and intranasal routes of administration.

Figure 3. Management of BTCP



Reassessment of the management of BTCP

The objectives of reassessment are to determine the efficacy and tolerability of the BTCP treatment and whether or not there has been any change in the nature of the BTCP.[5] Inadequate reassessment of BTCP may lead to the continuation of ineffective and/or inappropriate treatment.[5]

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