Centre for Palliative Care
Education & Research

The CENTRE*PIECE*

Newsletter of the Centre for Palliative Care Education and Research

Welcome to the first edition of The CENTRE*PIECE*, the newsletter of the Centre for Palliative Care Education and Research (the Centre). It is anticipated that a new edition of the newsletter will be circulated three times a year. The purpose of the newsletter is to promote evidence based practice. We welcome your feedback and contributions.

The Centre is part of St Vincent's Hospital, is affiliated with The University of Melbourne, and has a statewide role in palliative care education and research. For more information about the Centre, including staff, please visit our website: www.pallcare.unimelb.edu.au.

Peter Hudson,
Director, CPCER

Case Study – Pain Management and its Complexities

By Dr Jenny Philip

We encourage you to consider this case study and discuss amongst your team.

Joyce is a 54 year old woman, who lives alone in commission flat in metropolitan Melbourne. She has had a difficult life and is estranged from her husband and children. Following an episode of haemoptysis, Joyce underwent investigation culminating with a diagnosis of non small cell lung cancer. She underwent thoracotomy and lobectomy, but was found to have mediastinal lymphadenopathy. She is planned to have chemotherapy start next month.

Past medical history includes:

- chronic back pain – 2 × laminectomies
- history of opioid use for back pain, now on tramadol 50mg bd
- alcohol 3 + drinks/day

Despite having potentially curable disease, Joyce has been referred to the palliative care service because of problems with pain management. Since surgery, Joyce has had difficult to control pain. She has been prescribed oxycodone both slow release and prn, but she is reluctant to use this. She is now 3 weeks out from surgery and still having severe pain. She already has developed a productive cough due to inadequate expectoration. Her hospital doctors have expressed some exasperation with her and have referred her for pain management but stating clearly that she is continuing to be managed curatively.

The pain is felt over and distal to the thoracotomy scar. It is locally tender but has some more diffuse sensitivity over a broader area of skin. Apart from the redness of healing there are no other skin signs or swellings. There is no discharge from the wound which appears to be healing well.

Issues of Interest

- Diagnosis of pain – Differential diagnosis may include:
  - Post surgical 'healing' pain
  - Post thoracotomy pain
  - Pain due to malignant infiltration of pleura
  - Referred pain from vertebral column eg. nerve impingement/infiltration
- Opioid use in person with history of opioid use
- Any role for palliative care in people with curative treatment intent but high risk of recurrence

Possibilities of Pain Management

- Non-opioid pharmacological measures:
  - Use of NSAIDs or paracetamol if unable to tolerate anti-inflammatories (ie. GIT ulcers, renal failure, CCF).
  - Could consider addition of agent for neuropathic component of the pain, but in view of efficacy and tolerability, I would suggest not doing this 'up front'
- Non pharmacological measures:
  - Frequently overlooked but heat packs are often very useful and culturally comfortable for many people
  - If effective, then is a good indicator that TENS may be useful
  - Intercostal nerve block frequently very helpful to convert an unmanageable pain into one that is manageable. Often done very easily by thoracic surgeons or anaesthetists (even some palliative care doctors – but not this one!).
- Negotiated and carefully supervised opioid use with a plan to review regularly:
  - Exploration of views about opioids, previous experiences. She may be fearful of recurrence of tolerance or even addiction.
  - Consider a long acting opioid where the dose is not easily manipulated eg. Transdermal Fentanyl. If a breakthrough dose is required then it may be useful to put a limit on the number of doses to be used in the first instance to put some framework in place.
  - In view of previous opioid use, she will continue to have some tolerance and a higher dose is likely to be necessary than someone who is opioid naïve. While choosing a usual starting dose be prepared to escalate the dose (within agreed parameters) according to response.

According to the Edmonton Staging system for pain, Joyce has a number of parameters that suggest a more 'difficult' pain to manage.

Edmonton Classification System for Cancer Pain

1. Mechanism of pain
   - No – No pain syndrome
   - Nc – Any nociceptive combination of visceral and/or bone or soft tissue pain
   - Ne – Neuropathic pain syndrome with or without any combination of nociceptive pain
   - Nx – Insufficient information to classify
2. Incident pain
   - Io – No incident pain
   - Ii – Incident pain present
   - Ix – Insufficient information to classify
3. Psychological distress
   - Po – No psychological distress
   - Pp – Psychological distress present
   - Px – Insufficient information to classify
4. Addictive behavior
   - Ao – No addictive behavior
   - Aa – Addictive behavior present
   - Ax – Insufficient information to classify
5. Cognitive function
   - Co – No impairment. Patient able to provide accurate present and past pain history unimpaired
   - Ci – Partial impairment. Sufficient impairment to affect patient's ability to provide accurate present and/or past pain history
   - Cu – Total impairment. Patient unresponsive, delirious or demented to the stage of being unable to provide any present and past pain history
   - Cx – Insufficient information to classify

Reference: Fainsinger RL, Nekolaichuk CLA. A "TNM" classification system for cancer pain: The Edmonton Classification System for Cancer Pain (ECS-CP). *Support Care Cancer* 2008; 16:547–555.

Recent Publications to Inform Practice

By Associate Professor Peter Hudson

Each edition of the newsletter we will profile a few recent key publications of which we believe the palliative care community should be aware.

Title: Screening for psychological distress in palliative care: a systematic review.

Authors: Thekkumpurath, P. et al.

Publication: *Journal of Pain and Symptom Management* 2008; 36:5 p520–528

Summary: Psychological distress is common in the terminally ill. It is often underdetected and undertreated and has significant impact on the individual and family. Psychological screening programs play an important role in improving detection and management of distress. National and international guidelines recommend routine screening. This systematic review summarizes the evidence for screening for psychological distress in a palliative care setting. The review includes studies that compare screening questionnaires against a gold standard criterion of semistructured or structured psychiatric interview. Ten screening questionnaires were reviewed. Unidimensional scales appear to perform equally well compared to the longer versions. This review summarizes the evidence, the quality of this evidence, and future challenges to improve identification and management of distress in palliative care.

Title: Factors influencing death at home in terminally ill patients with cancer: systematic review.

Authors: Gomes, B. and Higginson, I.J.

Publication: *BMJ* 2006;332:p515–521 (4 March), doi:10.1136/bmj.38740.614954.55 (published 8 February 2006)

Summary: The aim of the article was to determine the relative influence of different factors on place of death (home or hospital) in patients with cancer. A review of 58 studies showed that here was high strength evidence for the effect of 17 factors on place of death. The risk factors examined related to illness, the individual, and the environment (healthcare input and social support), and the latter group was found to be the most important. Home death was strongly associated with patients' low functional status, patient and carer preferences for home death, more home care input and more frequent visits, the patient living with relatives, and more extended family support. Future policies and clinical practice should focus on ways of empowering families and public education, as well as intensifying home care, risk assessment, and training practitioners in end of life care.

Title: Sustaining hope when communicating with terminally ill patients and their families: a systematic review.

Authors: Clayton, J.M. et al.

Publication: *Psycho-oncology* 2008;17:7 p641–659

Summary: The aim of this systematic review was to examine studies that have investigated sustaining hope during prognostic and end-of-life issues discussions with terminally ill patients and their families. This review of 27 studies suggests that the issues surrounding hope in this context are complex. Findings suggest that balancing hope with honesty is an important skill for health professionals (HPs). Many patients seem to be able to maintain a sense of hope despite acknowledging the terminal nature of their illness. Patients and caregivers mostly preferred honest and accurate information, provided with empathy and understanding. Many different sources of hope were identified in this context in broad aspects of life, not just the medical situation. HPs need to recognize this spectrum of hope and appreciate that patients may simultaneously hope for cure while acknowledging the terminal nature of their illness. HPs may help patients to cope with their terminal prognosis by exploring and fostering realistic forms of hope that are meaningful for the particular patient and their family.

Congratulations to Nicola Atkin on winning the Order of Malta Award for the highest achieving student from the Specialist Certificate in Palliative Care 2008.
Left to right: Nicola Atkin; Associate Professor Peter Hudson.

Simplifying Research

By Dr Suzanne Robson

Qualitative and Quantitative Research

People are often confused as to what is the difference between qualitative and quantitative research. Here we attempt to demystify the differences between the two types of research. Put simply, quantitative research refers to counts and measures of things and the analysis of numerical data, while qualitative research involves collecting, analysing, and interpreting data by observing what people do and say.

Qualitative Research

- Is used to explore and understand people's beliefs, experiences, attitudes, behaviour and interactions.
- Is often exploratory in nature.
- Generates non-numerical data, for example a patient's description of their pain rather than a measure of pain.
- Some examples of qualitative research techniques are focus groups, in-depth interviews and direct observation.

Quantitative Research

- Refers to counts and measures of things.
- It generates numerical data or data that can be converted into numbers.
- Graphs, tables and statistics are often used to represent the results of quantitative research.
- Some examples of quantitative research techniques include surveys, questionnaires, scales and non-randomised and randomised trials (eg clinical trials).

Reference: Kuper, A., Reeves, S., & Levinson, W. An introduction to reading and appraising qualitative research. *BMJ* 2008; 337, pp404–409.

Centre News

Project Update – The Victorian Palliative Care Research Collaboration Project

The current ad hoc approach to palliative care research in Victoria is inadequate to ensure Victoria is able to provide for the needs of the community with regard to evidence based palliative care into the future. The Victorian Palliative Care Research Collaboration project was funded by the Victorian Cancer Agency and aimed to determine the feasibility, requirements and recommendations for establishing a statewide collaborative approach to enhance palliative care research outcomes. The project objectives were to:

1. Report on the current status of palliative care research in Victoria
2. Develop a proposed framework for a Victorian Palliative Care Research Collaboration

A literature review, a palliative care research questionnaire, semi-structured interviews with key informants and two workshops were held with the project's steering committee and key informants have been undertaken. The data has been collated in order to help inform collaboration options. While more work is required to progress a formal research collaboration, this project has been an important first step. We would like to take the opportunity to thank the many other individuals, academic institutions and clinical services who have been involved in this project.

Family Carer Resource Packs!

Recently, the Centre sent out a Family Carer Resource Pack to all palliative care services in Victoria. The pack consisted of the following two educational dvds and clinical guidelines:

- Family meetings in palliative care: multidisciplinary clinical practice guidelines (2008)
- Family Carer Group Education Program: A resource for health professionals working in palliative care (2008)
- Conducting a family meeting: A resource for health professionals working in cancer and palliative care (2009)

If you would like to access any of the above resources, please visit our website: www.pallcare.unimelb.edu.au

2009 Education

The Centre offers a Postgraduate Specialist Certificate in Palliative Care through the University of Melbourne. The Certificate is over one year and is targeted at health professionals (all disciplines) who are required to provide palliative care in their work setting.

Most components of the Specialist Certificate are also offered as individual short courses (non-award):

- Evidence Based Palliative Care (17 July)
- Symptom management in palliative care (13 Aug)
- Palliative care in non-cancer contexts (14 Aug)
- Psycho-social aspects of palliative care (10 Sep)
- Family centred palliative care (11 Sep)

For further information on courses please visit the CPCER website or contact Danielle Boardman:

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