Sociedad Médica Cuidados Paliativos Chile

¿Qué debemos saber sobre Dolor Irruptivo?

Dra. Angela Malebran
Unidad de Cuidados paliativos
Hospital Base Valdivia

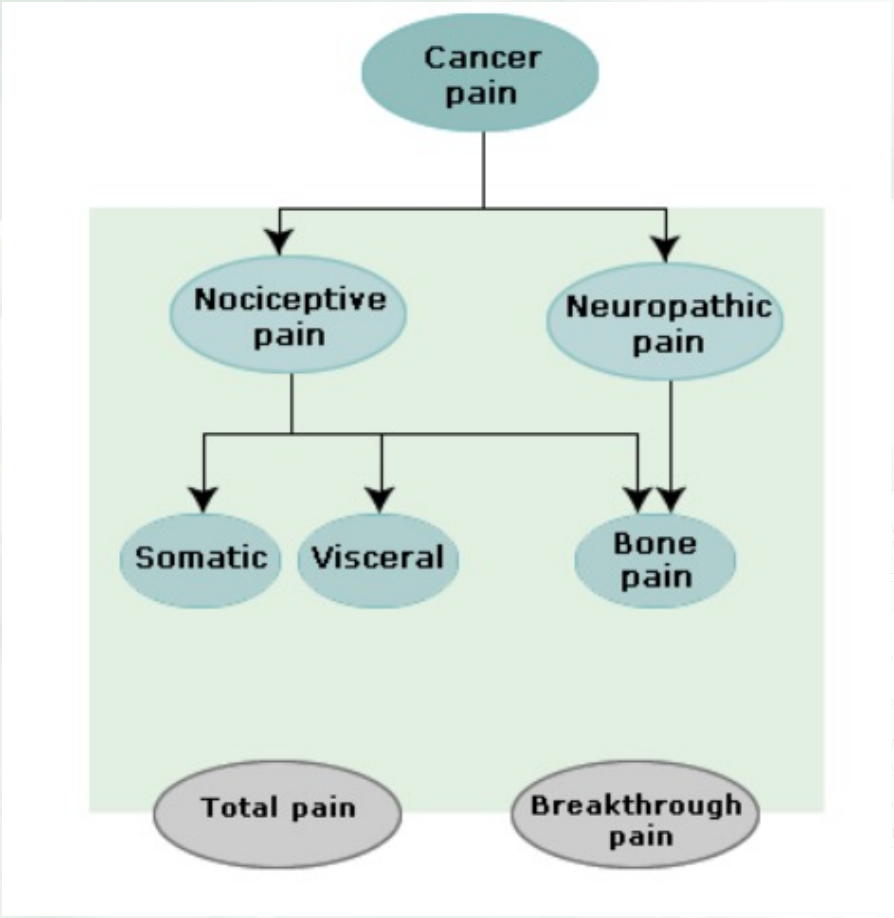


Hoja de Ruta

- Definición y Características
- Diagnóstico y Evaluación
- Tratamiento
- Caso Clínico
- Conclusiones



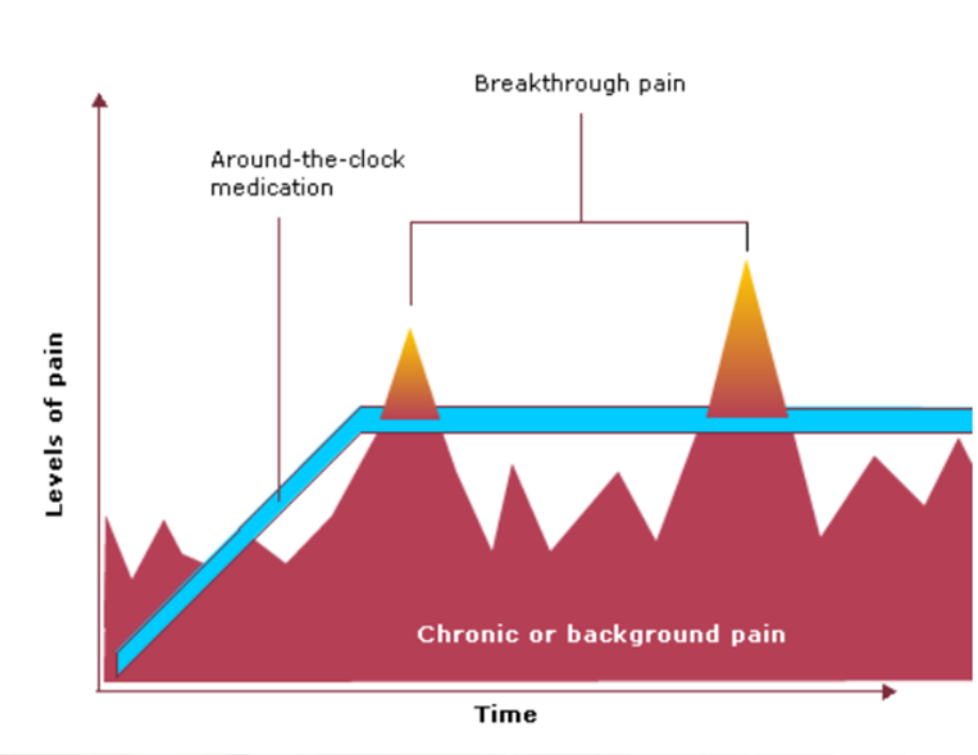
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Hjermstad MJ, Fainsinger R, Kaasa S. European Palliative Care Research Collaborative (EPCRC). Assessment and classification of cancer pain. Curr Opin Support Palliat Care. 2009 Mar;3(1):24-30.

Definición y Características



Portenoy RK, Payne D, Jacobsen P. Breakthrough pain: characteristics and impact in patients with cancer pain. Pain. 1999

Dolor transitorio de alta intensidad en pacientes oncológicos, con dolor basal controlado con opioides.

- Intensidad: EVA mayor a 7
- Duración: menos de 30 min
- Frecuencia: < de 4 episodios al día

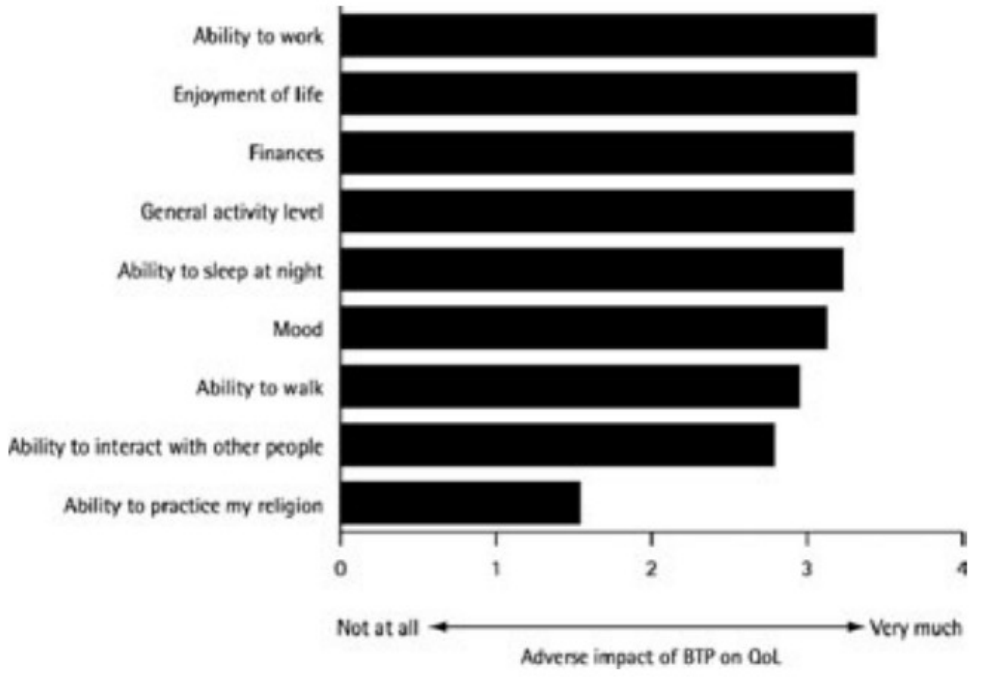
Definición y Características

Sociedad Médica Cuidados Paliativos Chile

Clinical Trial > Pain Med. 2007 Apr;8(3):281-8. doi: 10.1111/j.1526-4637.2007.00298.x.

Impact of breakthrough pain on quality of life in patients with chronic, noncancer pain: patient perceptions and effect of treatment with oral transmucosal fentanyl citrate (OTFC, ACTIQ)

Donald R Taylor [1], Lynn R Webster, Steven Y Chun, Jeffrey Reinking, Mary Stegman, Steven Shoemaker, Barry Fortner



Definición y Características

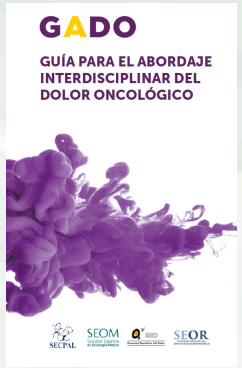
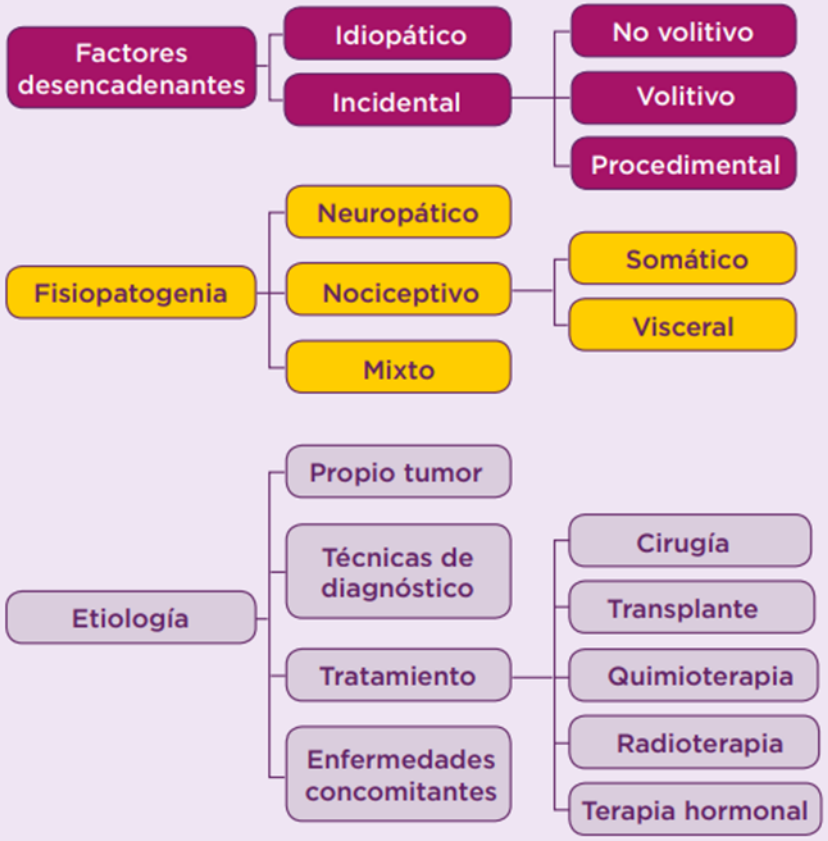


Figura 2. Criterios de clasificación.

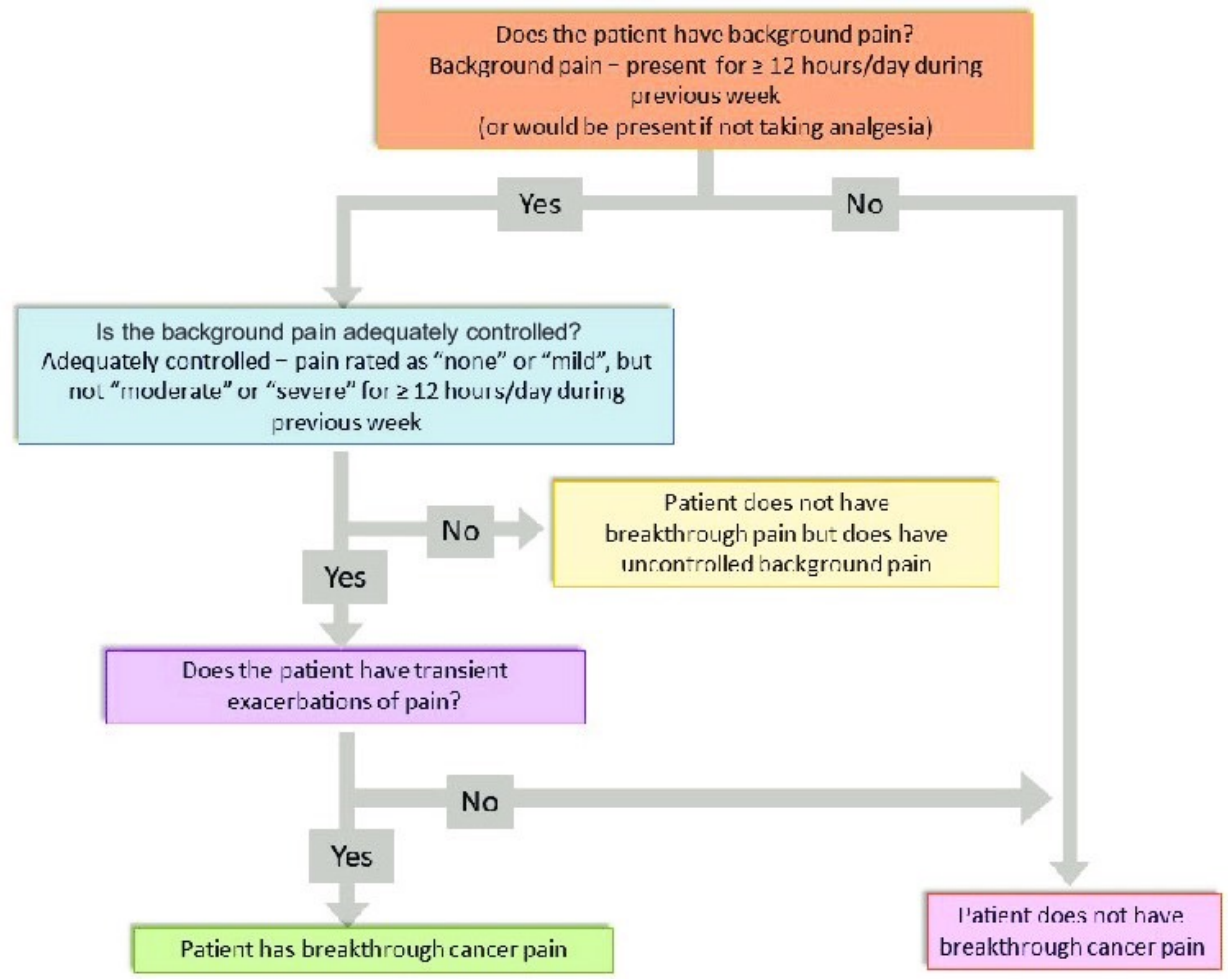


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La mayoría de las veces es multifactorial y con distintas etiologías, así como cambiante en el tiempo.

Pérez Hernández C, Alonso Babarro A, Ramos Aguerri A, Villegas Estévez F, Virizuela Echaburu JA, coords. GADO. Guía para el abordaje del dolor oncológico. 2018.

Definición y Características



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Davies AN, Dickman A, Reid C, Stevens AM, Zeppetella G. The management of cancer-related breakthrough pain: recommendations of a task group of the Science Committee of the Association for Palliative Medicine of Great Britain and Ireland. Eur J Pain 2009;13(4):331-8. DOI: 10.1016/j.ejpain.2008.06.014. [Links]

Diagnóstico y Evaluación

Review

Breakthrough cancer pain (BTcP) management: a review of international and national guidelines

Received 13 November 2017
Revised 10 April 2018

Andrew Neil Davies,[1] Frank Elsner,[2] Marilène Jeanne Filbet,[3]
Josep Porta-Sales,[4] Carla Ripamonti,[5] Daniele Santini,[6] Kath Webber[1]



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Etiología

Fisiopatología

Características clínicas del dolor.

Etapa de enfermedad

PS

Factores personales, familiares y del entorno

Diagnóstico y Evaluación

Mercadante *J Anesth Analg Crit Care* (2023) 3:23
https://doi.org/10.1186/s44158-023-00101-x

Journal of Anesthesia, Analgesia and Critical Care

REVIEW Open Access

Once again... breakthrough cancer pain: an updated overview

Sebastiano Mercadante[1*]

Abstract

Breakthrough cancer pain (BTcP) is a complex and variegate phenomenon that may change its presentation during the course of patients' disease in the same individual. An appropriate assessment is fundamental for depicting the pattern of BTcP. This information is determinant for a personalized management of BTcP. The use of opioids as needed is recommended for the management of BTcP. There are several options which should be chosen according to the individual pattern of BTcP. In general, a drug with a short onset and offset should be preferred. Although oral opioids may still have specific indications, fentanyl products have been found to be more rapid and effective. The most controversial point regards the opioid dose to be used. The presence of opioid tolerance suggests to use a dose proportional to the dose used for background analgesia. In contrast, regulatory studies have suggested to use the minimal available dose to be titrated until the effective dose. Further large studies should definitely settle this never ended question.

- Prevalencia que fluctúa entre 40 -80%
- Fenómeno multivariado
- Peak de BTCP de intensidad moderada a severa.
- Peak alcanzable en 10 min, duración 45 min.
- BTCP espontaneo o incidental.
- 3-4 episodios diarios.
- > frecuencia tu Ca cabeza y cuello y Ca páncreas.
- > crisis de BTCP relación con pobre analgesia.
- Plan de cuidados centrado en el paciente

Diagnóstico y Evaluación

Mercadante *J Anesth Analg Crit Care* (2023) 3:23
https://doi.org/10.1186/s44158-023-00101-x

SIAARTI
PRO VITA CONTRA DOLOREM SEMPER

Journal of Anesthesia, Analgesia and Critical Care

REVIEW Open Access

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Breakthrough cancer pain (BTcP) is a complex and variegate phenomenon that may change its presentation during the course of patients' disease in the same individual. An appropriate assessment is fundamental for depicting the pattern of BTcP. This information is determinant for a personalized management of BTcP. The use of opioids as needed is recommended for the management of BTcP. There are several options which should be chosen according to the individual pattern of BTcP. In general, a drug with a short onset and offset should be preferred. Although oral opioids may still have specific indications, fentanyl products have been found to be more rapid and effective. The most controversial point regards the opioid dose to be used. The presence of opioid tolerance suggests to use a dose proportional to the dose used for background analgesia. In contrast, regulatory studies have suggested to use the minimal available dose to be titrated until the effective dose. Further large studies should definitely settle this never ended question.

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- Pobre evidencia en el rol de medidas no farmacológicas
- Perfil del fco: Lipofílico, débil metabolismo de primer paso hepático, fácil administración.

Diagnóstico y Evaluación

Journal of Pain Research

Dovepress
open access to scientific and medical research

Open Access Full Text Article

REVIEW

Assessment and treatment of breakthrough cancer pain: from theory to clinical practice

This article was published in the following Dove Press journal:
Journal of Pain Research
12 September 2017
Number of times this article has been viewed

Renato Vellucci[1]
Rocco Domenico Mediati[1]
Silvia Gasperoni[1]
Massimo Mammucari[2]
Franco Marinangeli[3]
Patrizia Romualdi[4]

[1]Palliative Care and Pain Therapy Unit, University Hospital of Careggi, Florence, [2]Primary Care Unit, ASL RM 1, Rome, [3]Department of Life, Health and Environmental Sciences, University of L'Aquila, l'Aquila, [4]Department of Pharmacy and Biotechnology, University of Bologna, Bologna, Italy

Abstract: Breakthrough cancer pain (BTcP) is a common condition in oncological patients. However, its management is still suboptimal. Improved knowledge of BTcP and its management in clinical practice may have immediate importance for all physicians involved in the supportive care of cancer patients. This review critically discusses the most important concepts for the correct diagnosis of BTcP and presents some intriguing cases of the management of this condition in clinical practice. Overall, the most appropriate therapeutic choice appears to be a rapid-onset opioid (ROO), and in particular, the nasal route of administration is the quickest and most convenient mode of administration for the management of BTcP, especially when the patient needs rapid resolution of pain. To this end, intranasal fentanyl spray may have a particular relevance in clinical practice. Future research should focus on accepted definitions of BTcP to investigate the optimal management of this highly heterogeneous pain condition. Therapeutic decision-making of patients, clinicians, and payers will likely be driven from results of well-designed clinical trials of ROOs.

Keywords: breakthrough cancer pain, rapid-onset opioid, intranasal fentanyl spray

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Table 1 Characteristics of IR opioids

Hydrophilic ↕ Lipophilic	IR opioid	Onset of analgesia (minutes)	Duration of effect (hours)	Advantages (A)/disadvantages (D)
	Morphine (oral)	30–40	4	A – available in multiple dosage forms, liquid concentrate D – slow onset of analgesia for idiopathic BTcP
	Oxycodone (oral)	30	4	Same as morphine
	Hydromorphone (oral)	30	4	D – no liquid concentrate, slow onset of analgesia far idiopathic BTcP
	Methadone (oral)	~10–15	4–6	A – faster onset of analgesia in one small study D – complex pharmacology, pharmacokinetics
	Fetanyl (transmucosal)	~5–10	1–2	A – fastest onset of analgesia D – requires ongoing patient cooperation in use

ROO

Note: Copyright © MediMedia. Reproduced with permission from Bennett D, Burton AW, Fishman S, et al. Consensus panel recommendations for the assessment and management of breakthrough pain: Part 2 management. *P and T*. 2005;30(6):354-361.[31]

Abbreviations: BTcP, breakthrough cancer pain; IR, immediate release.





CONGRESO PRESEN

La Universalidad de los Cuidados Paliativos:

una realidad y un desafío

Annals of Oncology 29 (Supplement 4): iv166–iv191, 2018
doi:10.1093/annonc/mdy152
Published online 24 July 2018

CLINICAL PRACTICE GUIDELINES

Management of cancer pain in adult patients: ESMO Clinical Practice Guidelines†

M. Fallon[1], R. Giusti[2], F. Aielli[3], P. Hoskin[4], R. Rolke[5], M. Sharma[6] & C. I. Ripamonti[7], on behalf of the ESMO Guidelines Committee*

- Recomienda uso de opioides de liberación rápida solo en pacientes con uso basal de morfina equivalente a 60 mg.
- Formulaciones de fentanilo transmucoso tienen un rol en el DIO de rápida presentación y corta duración
- Se sugiere uso de morfina oral en DIO de presentación lenta o como administración 30 min antes de un desencadenante conocido.

Tratamiento

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Use of Opioids for Adults With Pain From Cancer or Cancer Treatment: ASCO Guideline

Judith A. Paice, PhD, RN[1]; Kari Bohlke, ScD[2]; Debra Barton, PhD, RN[3]; David S. Craig, PharmD[4]; Areej El-Jawahri, MD[5]; Dawn L. Hershman, MD, MS[6]; Lynn R. Kong, MD[7]; Geana P. Kurita, PhD, MNSc[8]; Thomas W. LeBlanc, MD[9]; Sebastiano Mercadante, MD[10]; Kristina L. M. Novick, MD, MS[11]; Ramy Sedhom, MD[12]; Carole Seigel, MBA[13]; Joanna Stimmel, PhD[14]; and Eduardo Bruera, MD[15]

PURPOSE To provide guidance on the use of opioids to manage pain from cancer or cancer treatment in adults.

METHODS A systematic review of the literature identified systematic reviews and randomized controlled trials of the efficacy and safety of opioid analgesics in people with cancer, approaches to opioid initiation and titration, and the prevention and management of opioid adverse events. PubMed and the Cochrane Library were searched from January 1, 2010, to February 17, 2022. American Society of Clinical Oncology convened an Expert Panel to review the evidence and formulate recommendations.

RESULTS The evidence base consisted of 31 systematic reviews and 16 randomized controlled trials. Opioids have primarily been evaluated in patients with moderate-to-severe cancer pain, and they effectively reduce pain in this population, with well-characterized adverse effects. Evidence was limited for several of the questions of interest, and the Expert Panel relied on consensus for these recommendations or noted that no recommendation could be made at this time.

RECOMMENDATIONS Opioids should be offered to patients with moderate-to-severe pain related to cancer or active cancer treatment unless contraindicated. Opioids should be initiated PRN (as needed) at the lowest possible dose to achieve acceptable analgesia and patient goals, with early assessment and frequent titration. For patients with a substance use disorder, clinicians should collaborate with a palliative care, pain, and/or substance use disorder specialist to determine the optimal approach to pain management. Opioid adverse effects should be monitored, and strategies are provided for prevention and management.

Additional information is available at www.asco.org/supportive-care-guidelines.

J Clin Oncol 41:914-930. © 2022 by American Society of Clinical Oncology

- Uso de opioides de liberación rápida dosis del 5 al 20% equivalentes a dosis de morfina/día.
- Insuficiente evidencia para recomendar un opioide específico de corta duración.

Tratamiento

NICE National Institute for Health and Care Excellence

Search NICE... Menu

Home > NICE Guidance > Health and social care delivery > End of life care

Palliative care for adults: strong opioids for pain relief

Clinical guideline [CG140]
Published:
23 May 2012
Last updated:
03 August 2016

First-line treatment for breakthrough pain in patients who can take oral opioids

1.1.14 Offer oral immediate-release morphine for the first-line rescue medication of breakthrough pain in patients on maintenance oral morphine treatment.

1.1.15 Do not offer fast-acting fentanyl as first-line rescue medication.

1.1.16 If pain remains inadequately controlled despite optimising treatment, consider seeking specialist advice.

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CURRENT ONCOLOGY
A Canadian Cancer Research Journal

PRACTICE GUIDELINE

Canadian recommendations for the management of breakthrough cancer pain

P. Daeninck MD,* B. Gagnon MD,† R. Gallagher MD,‡ J.D. Henderson MD,§ Y. Shir MD,‖
C. Zimmermann MD PhD,# and B. Lapointe MD**

ABSTRACT

Breakthrough cancer pain (BTCP) represents an important element in the spectrum of cancer pain management. Because most BTCP episodes peak in intensity within a few minutes, speed of medication onset is crucial for proper control. In Canada, several current provincial guidelines for the management of cancer pain include a brief discussion about the treatment of BTCP; however, there are no uniform national recommendations for the management of BTCP. That lack, accompanied by unequal access to pain medication across the country, contributes to both regional and provincial variability in the management of BTCP.

Currently, immediate-release oral opioids are the treatment of choice for BTCP. This approach might not always offer optimal speed for onset of action and duration to match the rapid nature of an episode of BTCP. Novel transmucosal fentanyl formulations might be more appropriate for some types of BTCP, but limited access to such drugs hinders their use. In addition, the recognition of BTCP and its proper assessment, which are crucial steps toward appropriate treatment selection, remain challenging for many health care professionals.

To facilitate appropriate management of BTCP, a group of prominent Canadian specialists in palliative care, oncology, and anesthesiology convened to develop a set of recommendations and suggestions to assist Canadian health care providers in the treatment of BTCP and the alleviation of the suffering and discomfort experienced by adult cancer patients.

Key Words Breakthrough cancer pain

Curr Oncol. 2016 Apr;23(2):96-108 www.current-oncology.com

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- Uso de algoritmo de Davis en diagnostico
- Tratar la causa del dolor cuando sea posible.
- Tratamiento con opioides de liberación rápida o preparaciones de fentanilo transmucoso.
- En ciertos tipos de DIO el fentanilo transmucoso es preferible. El costo de este fármaco no debiese ser un impedimento para su uso.
- Acceso desigual a nivel nacional, variabilidad regional en el manejo del BTCP.



Medicina Paliativa

www.elsevier.es/medicinapaliativa

ARTÍCULO ESPECIAL

Diagnóstico y tratamiento del dolor irruptivo oncológico: recomendaciones de consenso

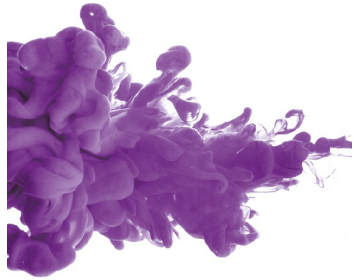
Yolanda Escobar Álvarez[a,*], Albert Biete i Solà[b], Manuel Camba Rodríguez[c], Rafael Gálvez Mateos[d], Ana Mañas Rueda[e], César A. Rodríguez Sánchez[f], Dulce Rodríguez Mesa[g] y Albert Tuca i Rodríguez[h]

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Recibido el 1 de febrero de 2013; aceptado el 27 de marzo de 2013
Disponible en Internet el 9 de agosto de 2013

GADO

GUÍA PARA EL ABORDAJE INTERDISCIPLINAR DEL DOLOR ONCOLÓGICO



SECPAL SEOM SEOR

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- La morfina de acción rápida no es el medicamento óptimo para el tratamiento del DIO.
- Los ROO son los fármacos de elección para el tratamiento del DIO debido a sus características farmacocinéticas y al rápido inicio de acción



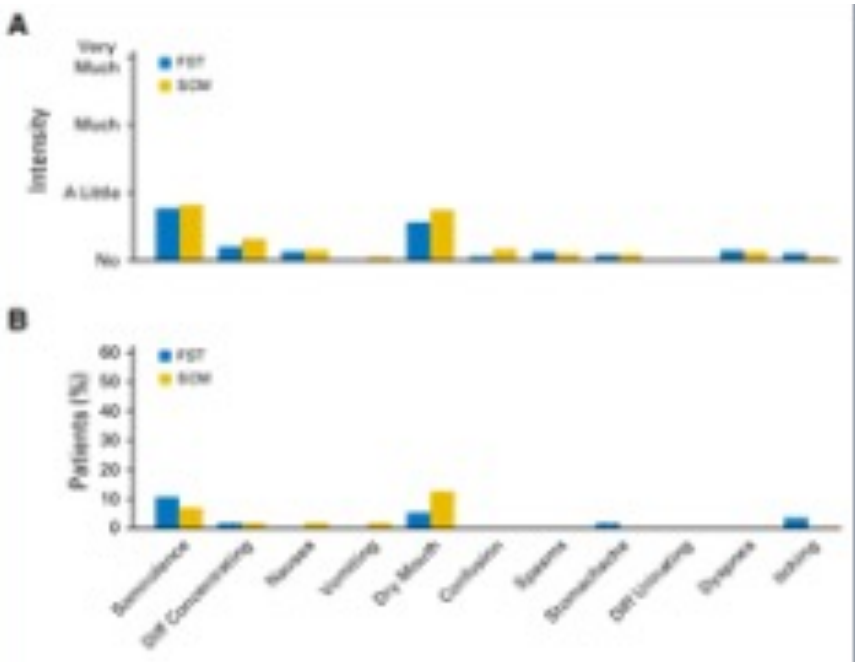
Randomized Controlled Trial > J Clin Oncol. 2017 Mar;35(7):759-765.
doi: 10.1200/JCO.2016.69.9504. Epub 2017 Jan 23.

Fentanyl Sublingual Tablets Versus Subcutaneous Morphine for the Management of Severe Cancer Pain Episodes in Patients Receiving Opioid Treatment: A Double-Blind, Randomized, Noninferiority Trial

Ernesto Zecca [1], Cinzia Brunelli [1], Fabio Centurioni [1], Andrea Manzoni [1], Alessandra Pigni [1], Augusto Caraceni [1]

Affiliations + expand

PMID: 28113021 DOI: 10.1200/JCO.2016.69.9504



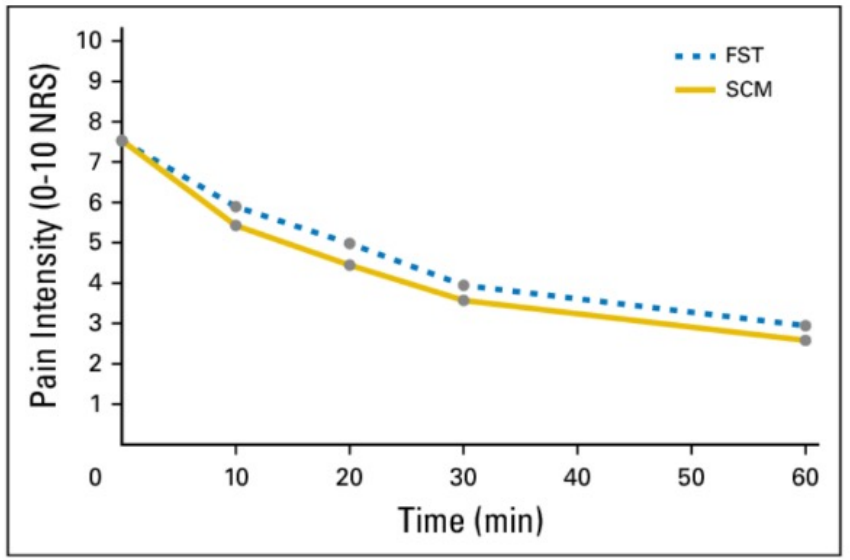


Fig 3. Profile of pain reduction in the first 60 min post-treatment by study druc

Pacientes prefirieron administración de FSL

Tratamiento

Caso Clínico

Mujer, 27 años, vive en Panguipulli con su madre, 2 hermanos menores y un hijo de 4 años. Nódulo mamario derecho de un año de evolución. Eco mamaria dic 2021: nódulo de 60 mm BIRADS IV. Bp CORE mama y axila: Carcinoma ductal invasivo, IHQ HER 2 (-) RE 3%, RP < 5%. PDL1 no expresado. KI67 5%.

PET CT marzo 2022: Adenopatías hipermetabólicas axilares y retropectorales derecha. Nódulo pulmonar solido hipermetabólico, lesión lítica en condilo mandiubular izq.

QMT paliativa 1era línea Doxurrubicina, Ciclofosfamida 4 ciclos más Paclitaxel 4 ciclos. Presenta progresión ósea L5 y lesiones en columna y pelvis. Por progresión recibe RDT paliativa sobre segmento vertebral T9-T11 8 Gy/1 Fx y 2da línea de QMT con capecitabina oral.



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Caso Clínico

PET CT marzo/23: Progresión de enfermedad, aumento de tamaño de adenopatías hiliares, adenopatías mediastínicas y retroperitoneales, aumento en número y tamaño de nódulos pulmonares bilaterales, lesión secundaria renal bilateral y aumento de localizaciones óseas multifocales en esqueleto axial y apendicular proximal.

Se deriva a C Paliativos con seguimiento en domicilio, ECOG 2, dolor lumbar controlado con buprenorfina.

24/03/23, Con aumento de requerimiento de analgesia hasta llegar a 70 ucg/h TD, inicia dolor en EII y en hombro derecho asociado a la movilización, EVA 8/10, de inicio súbito y de 30 min de duración aprox.



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Caso Clínico

Se inicia rescate de morfina 5 mg sc SOS.

01/04, Con dolor mal controlado, requiere al menos 5 rescates al día.

Se rota a morfina sc 80 mg/día x infusor elastómero, más rescates de 10 mg morfina sc.

Después de 2 semanas, comienza con dolor en crisis EVA 9/10 en cadera izquierda y hombro derecho, en forma espontánea, con aumento progresivo de morfina, con 120 mg /día más rescates de 10 mg que utiliza hasta 9 veces al día. Al ex destaca mayor CEG, hiperalgesia y alodinia, animo bajo, crisis de ansiedad e insomnio.



Caso Clínico

Se decide rotar a metadona, más uso de midazolam intermitente durante 5 días, con buen control del dolor.

Con deterioro progresivo, síntomas controlados, fallece en 2 semanas.



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- DIO presenta alta prevalencia en pacientes con cáncer avanzado, que afecta de forma importante la Calidad de vida.

- Es un fenómeno multivariado y cambiante en el tiempo.

- Requiere un abordaje multidimensional e integral centrado en el paciente, para un plan de tratamiento individualizado.

- Se recomienda el uso de opioides de liberación rápida o inmediata, según características del dolor, disponibilidad y preferencias del paciente.



Conclusiones


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Médica
Cuidados
Paliativos
Chile
CONGRESO PRESENCIAL
La Universalidad de los Cuidados Paliativos:
una realidad y un desafío

GRACIAS