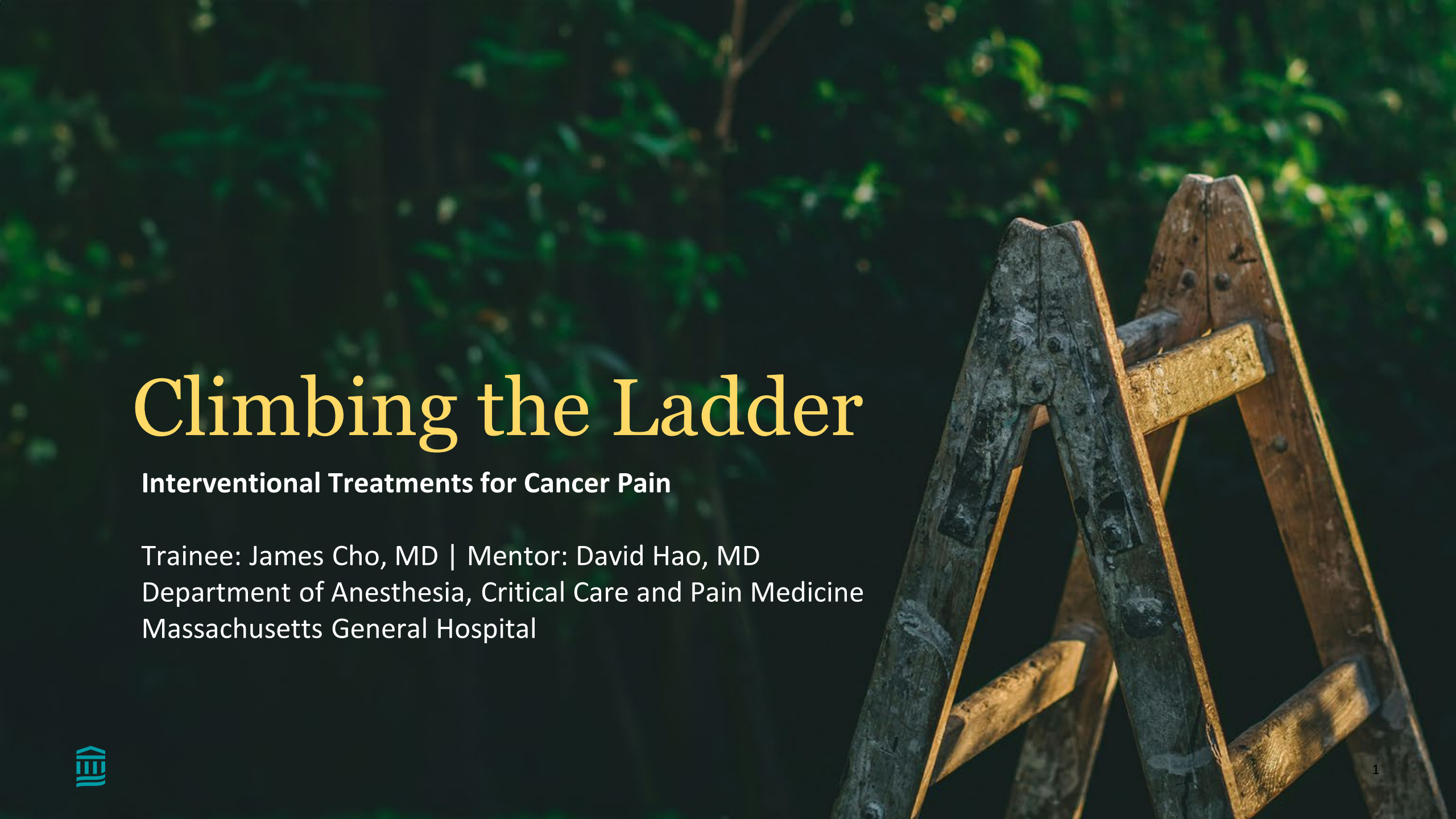

Climbing the Ladder

Interventional Treatments for Cancer Pain

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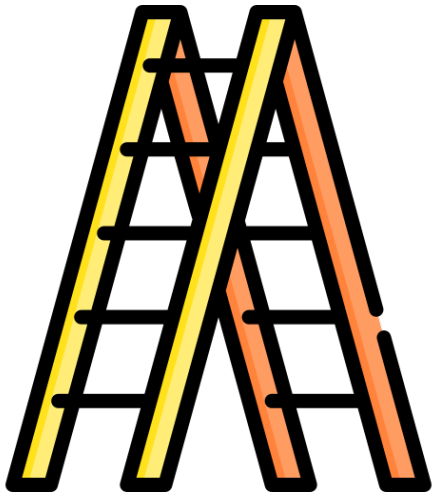
Objectives

1



Review the World Health Organization (WHO)'s analgesic ladder and the role of interventional therapies in the treatment of cancer pain

2

Discuss a case of a patient with metastatic rectal cancer presenting with uncontrolled pain

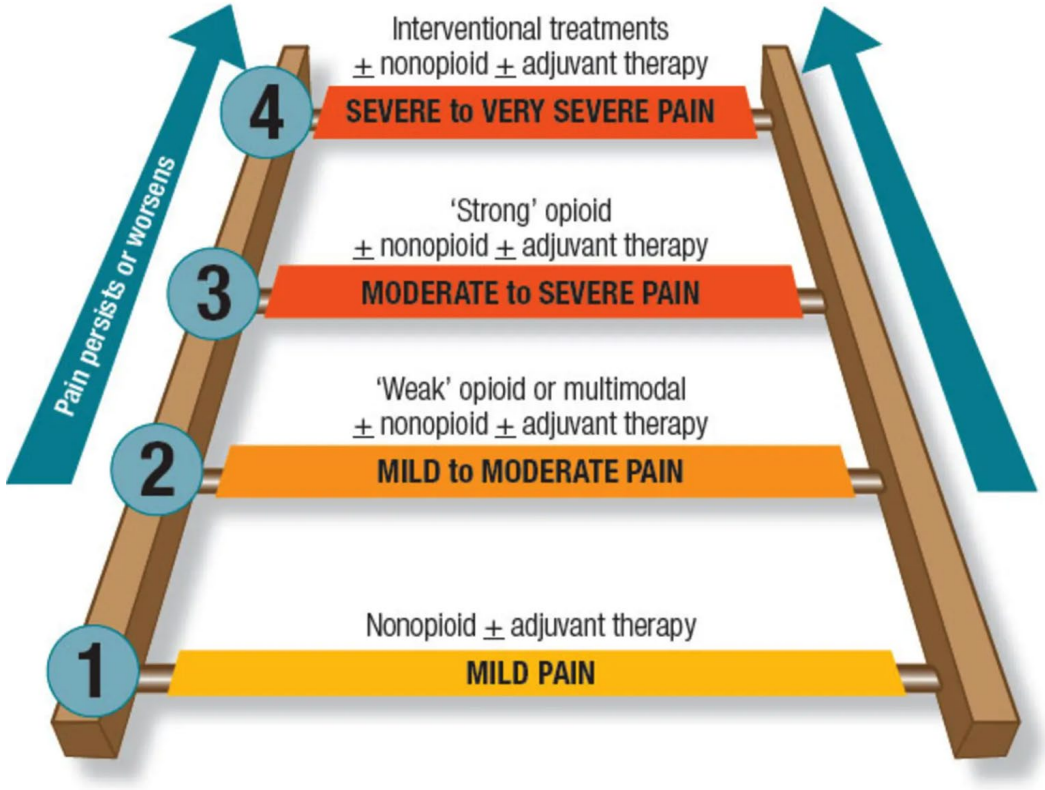
3

Explore interventional treatment options available for cancer pain

The authors have no relevant disclosures

Cancer Pain and the Role of Interventional Therapies

- Cancer pain can result from direct, structural effects of tumors; from paraneoplastic syndromes; or from anticancer therapy.
- Determining the source(s) of cancer pain is essential to selecting the proper therapy.
- The WHO analgesic ladder was developed to guide treatment of cancer pain.
- A fourth step encompassing interventional treatments has been suggested.



Pergolizzi J, Raffa R. The WHO Pain Ladder: Do We Need Another Step?. Pract Pain Manag. 2014;14(1).

Case Presentation

Patient Summary

58-year-old woman with metastatic rectal cancer presents with local recurrence after surgery and chemotherapy

Hospital Problems

- Admitted for hydronephrosis and severe pelvic pain
- MRI shows mass infiltrating pelvic organs, presacral venous plexus, and the sacral plexus
- Although pain control improved with escalation of analgesic regimen, patient now experiencing concerning level of sedation, leading to a pain consult

Inpatient Pain Regimen

Methadone **15 mg** PO TID **(up from 5 mg)**
Hydromorphone 8-12 mg PO Q4H PRN
Hydromorphone 1.5 mg - 2 mg IV Q3H PRN (new)
Acetaminophen + NSAIDs ATC
Duloxetine 60 mg PO QD

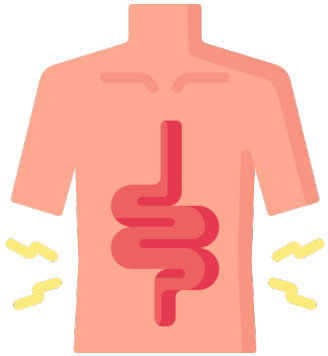
Assessment

Neuropathic pain (sacral plexus involvement), somatic pain (soft tissue involvement), as well as visceral pain (pelvic organs).

Interventional Therapies for Cancer Pain

Somatic Pain

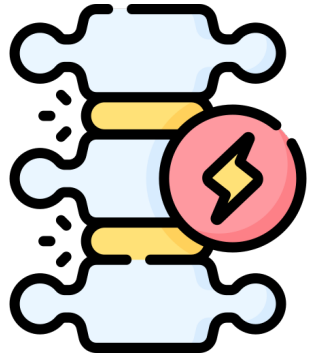
- Truncal blocks (e.g. paravertebral)
- Kyphoplasty/vertebroplasty for pathologic fractures
- Intrathecal drug delivery
- Steroid injections



Visceral Pain

Often treated with sympathetic blocks, such as:

- Stellate ganglion blocks
- Lumbar sympathetic blocks
- Celiac plexus blocks
- Superior hypogastric plexus blocks
- Ganglion impar blocks

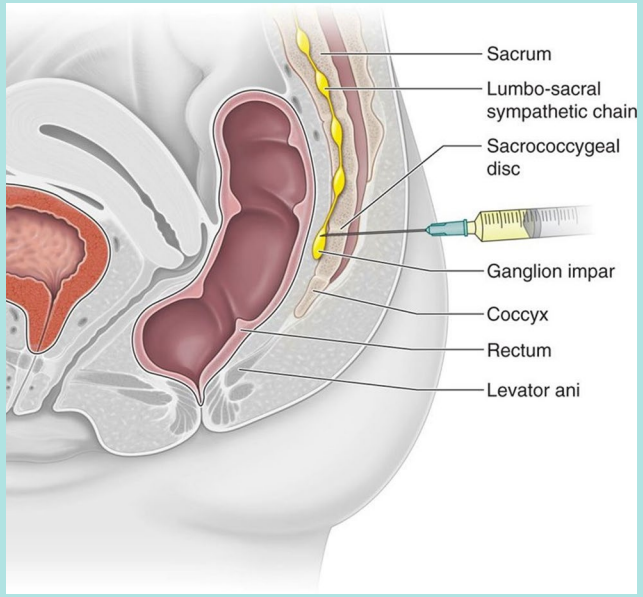


Neuropathic Pain

- Steroid injections
- Spinal cord / peripheral nerve stimulators

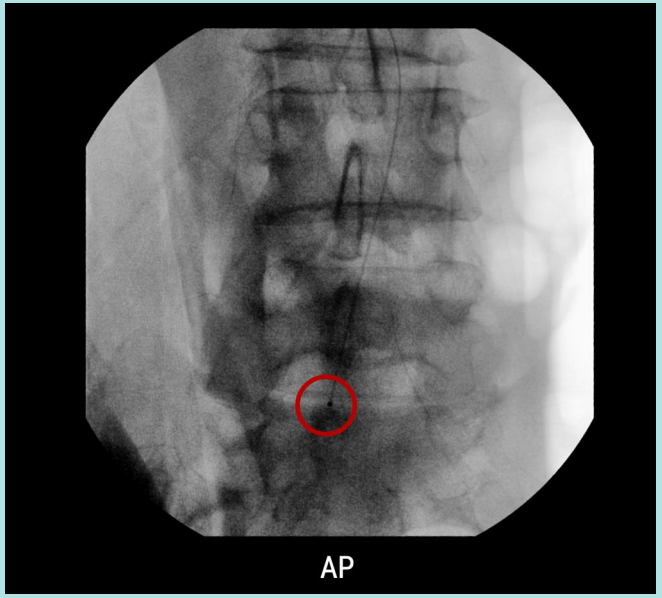
Case Presentation (Continued)

Ganglion Impar Sympathetic block



No response to prognostic ganglion impar sympathetic block

Intrathecal Pump



- POD#1, patient's pain significantly improved.
- By POD#6 (three days after discharge), weaned off of methadone and systemic regimen de-escalated to **Hydromorphone 2 mg Q6H PRN** and **Duloxetine 60 mg PO QD**.

Conclusion

- The pain physician has a large armamentarium to choose from when treating cancer pain.
- A thoughtful consideration of the etiology of each patient's pain may improve success.
- In some scenarios, climbing the ladder to an interventional procedure may lead to a de-escalation of treatment while improving patient comfort.