

Pain and the Cancer Patient

Webcast

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Introduction

Andrew Schorr:

Hello and welcome once again to another edition of Patient Power. I'm Andrew Schorr. We do this every two weeks with M.D. Anderson. I am delighted. I learn so much. And of course it's often about specific cancers, specific treatments, and there's so much of that in the Patient Power section of the mdanderson.org website. But then there's some overriding issues, and we've talked about them, supporting caregivers and dealing with emotional issues, but there's one very real issue that cuts across a lot of people's cancer journey, and that is pain. And we're not always talking about just pain when somebody may be in an almost end-of-life situation. Happily, millions of us cancer survivors are not in that situation. We hope to live a long life, whether we're cured or whether the cancer has been knocked back and we can live with it chronically, like I do with leukemia that I was diagnosed with it now 12 years ago.

Well, some of us feel really good, but some people go along with pain, chronic pain. Well, I'm happy to tell you that M.D. Anderson, being a leader in the field, has a whole pain management program. And with us today is the professor and clinical medical director there in the department of anesthesiology and pain medicine, head of that department, Dr. Allen Burton.

Dr. Burton, thank you so much for being with us on Patient Power.

Dr. Burton:

It's a pleasure, Andrew. Nice to talk to you.

Types of Pain

Andrew Schorr:

Dr. Burton, so obviously there are people who may have pain, either because of the cancer and their intervention hopefully to treat the cancer and hopefully that can alleviate the pain, or sometimes it can come as a side effect of treatment, and there may be a recovery period, but for other people that can go on for a long time. So help us understand the different situations of pain, and then we will begin to learn how you can help.

Dr. Burton:

Right. Pain of course comes in many forms, and there's many ways to describe it, and one of the ways is by the time course of pain. Acute pain is a short lasting type of pain generally associated with a tumor that has just shown up or with an operation or some painful treatment. And acute pain typically can be fairly intense, but it's fairly straightforward to kind of treat it and then gradually as we heal up from the surgery or from the treatment that pain generally gets better.

Now, chronic pain typically is a much more long-lasting condition that may come and have many types of causes. And chronic pain is typically described as pain which far outlasts the injury and the typically expected healing or recovery time. In other words I had surgery to resect part of my lung eight years ago and my chest still feels like it's on fire. It still hurts as though my surgery was two weeks ago. Or I had an amputation ten years ago and I still have intense pain in my foot that's no longer there, sometimes we call that phantom pain, but it hurts as though the surgery was done two days ago as though the tumor is still there. Even though I can see with my eyes that it's been resected and that it's well healed up, I still have this intense long-lasting pain syndrome. And sometimes people have called it chronic pain or other people have called it persistent pain, where the nervous system has continued to fire off pain signals, and the brain continues to sense pain although the healing phase has in fact already happened.

If I might elaborate a little bit on the causes of that type of pain.

Andrew Schorr:

Sure.

Dr. Burton:

The cancer treatments, as you described, cancer treatments typically being either surgery, chemotherapy or radiation or many times a blend of those treatments, any of those alone can by themselves trigger chronic pain conditions, or certainly when they're combined then they can have some additive what we term toxicities, and these are well described. There are certain neuropathic pain conditions for example. After chemotherapy people have tingling or burning pain in their hands and feet that sometimes can be long, long lasting, long after the cancer has been eradicated. And similarly radiation can damage nerves or soft tissue with pain lasting far after the cancer has been cured. And post-surgical pain syndromes are also understood. And some of these that impact on cancer patients are post thoracotomy pain syndromes, post mastectomy pain syndromes, post amputation pain syndromes, sometimes termed phantom pain because sometimes the limb that is actually gone, or the phantom limb, continues to pursue. Sometimes post neck surgery, especially radical neck surgery, head and neck cancer pain, again long after the cure the patient still has ongoing persistent pain, so that's where those pain syndromes can stem from.

Available Treatments

Andrew Schorr:

Dr. Burton, now, it used to be that people were so delighted if they could to have their cancer cured or knocked back so that was good enough, but then they maybe had pain that was continuing, and many people didn't speak up about it, and many doctors didn't ask about it. All the discussion was on killing the cancer cells or cutting it out. Where are we now at M.D. Anderson with someone's right almost to try to limit or totally alleviate the pain?

Dr. Burton:

Well, thankfully scientists continue to move us in a very fruitful direction, and if I might borrow into other arenas, the don't ask don't tell policies of the old days perhaps stemmed out of the fact that physicians often were frustrated that they didn't have many effective treatments for chronic pain conditions particularly. Now, maybe starting back in the mid 90s and certainly today we have specialists, myself and my colleagues for example, that are board certified in chronic pain medicine. So we have a whole variety of treatments that are quite effective for chronic pain syndromes.

And this doesn't mean just pills, for example, or it doesn't mean just nerve blocks. It includes things like rehabilitation programs, psychological therapies and strategies, holistic treatments such as massage or relaxation strategies, acupuncture, acupressure, in addition to more traditional things like pharmacologic agents either in tablet form or in patches and then perhaps blended in with some nerve blocks or other types of interventional pain management strategies. And many times a blended strategy, as the diagnosis is sorted out the patient is walked through a program of using different treatments as appropriate in their case, and gradually the attempt is to reintegrate that patient into a more functional status where they can have a more full quality of life.

And as our oncology colleagues have gotten so much better at curing more and more patients I think we've continued to raise the bar on our expectations on the full quality of life following that cure. And I think in many if not most cases we certainly can attain a very, very good quality of life for our cancer survivors, and I think that should be our goal.

Andrew Schorr:

So you have a whole department devoted to that. So if someone is treated at M.D. Anderson or somewhere else how do they get you all involved? How does that happen? How do they bring it up? Because again for a long time people were told to be a good soldier, have the cancer treatment, if you were experiencing some discomfort or actual pain just live with it. I'm not saying that was said at M.D. Anderson, but going back over many years you were fighting the cancer or they weren't asked about it, as I said. How does it work now at M.D. Anderson?

Dr. Burton:

I think now there's a variety of pathways that people get into our pain clinic. The most common one is by referral from their oncologist. We certainly do take outside patients, although in many cases chronic pain therapies and pain medicine in general is available in many places throughout the country and has grown up in the last decade or so. Now, the awareness of it is just starting to filter out in all the nooks and crannies of the country and so on. And certainly there used to be a focus of cancer pain being predominantly focused, as you said earlier, on an end of life type of situation but now we're realizing that patients with chronic cancer pain really will benefit from many strategies that used to be held in the realm of post-traumatic care or rehabilitative care, care that was largely nononcologic. It was largely based in rehabilitation institutes or spine centers or these types of locations, and now what we're doing is blending in hopefully the best aspects or the most helpful aspects of these chronic pain treatment strategies into the cancer setting.

And this really starts at diagnosis and at the time certainly of painful interventions such as surgery, radiotherapy or chemotherapy. We have certainly educated our oncologists and practically really knocked them over the head with the concept of early and aggressive treatment of acute pain and many times helps us to avoid chronic pain. And I think that's a really important message to get out there, that people just hanging in there and suffering with acute pain in some cases may set you up to have chronic, long-lasting pain so that anything that can be done--the more expeditiously I think that you can effectively treat somebody's acute pain then the odds are much less likely that they're going to be set up with a long-term, chronic pain syndrome. So that's probably a very important message to get out to our listeners.

Andrew Schorr:

I've heard that one-third of cancer patients may experience pain, so I imagine now at M.D. Anderson you check somebody's blood pressure and you have a discussion about the latest in their cancer care, but as part of that you ask them about their pain. That's probably one of the things you're encouraging the whole team throughout the medical center to do.

Dr. Burton:

Oh, that's absolutely right. And in fact the American Pain Society has advocated and successfully pushed through a number of years ago pain as being the fifth vital sign, and we've adopted that readily. And every time a patient has their vital signs taken at M.D. Anderson they have a pain assessment done that's then recorded. And the importance of that of course is not just recording more numbers, but it's acting on the information. So I think we certainly utilize those numbers to guide our referral patterns, and we utilize those frequent assessments to direct patients over into our care. And our oncology colleagues as well as our nurses and physician assistants and nurse practitioners have really adopted these strategies, I

would say quite avidly, and they're really, really actively assessing patients and then acting on that information, which is really the closure of the deal.

Range of Treatments

Andrew Schorr:

Right. Dr. Burton, let's get a little more specific about the range of treatments. You have mentioned it. So somebody is living, let's say, with that chronic pain. It's not just immediately after surgery. Maybe it's gone on for a long time, but now we're trying to address it. So on one end the fear is, Well, I don't want to be a drug addict and take some heavy-duty pain medicine and create another problem beyond my cancer. Well, we're not really talking about that, are we? We're talking about a whole range of modalities you have. Start to take us through them, and let's understand a little more in detail.

Dr. Burton:

Sure. If a patient has a long-standing chronic pain syndrome frequently the nerves in that area are involved, and we have a terminology that we say the nerves are wound up or they're kind of on alert or they're hyperexcitable. So that any time the patient moves their normal sensation in that area is amplified by the patient's sensitive nerves that are in that damaged area. And the patient feels that as very intense, kind of usually burning or electrical type of pain. So when we start treating them we can either use sometimes physical therapy modalities in that area, such as either massage or some what they call desensitization techniques, to start getting the nerves used to being stimulated but in a normal fashion.

At the same time a nerve block sometimes to quiet down those amplified signals that are coming through the spinal cord and then being sensed in the brain will sometimes help to quiet that down. Sometimes taking an oral medication, and sometimes that will include an opiate or narcotic medicine, and sometimes it won't. It really depends on the severity and the nature of the pain, how severe it is and how long lasting it is and how you responsive it is to different treatments. We have a number of agents such as anticonvulsant medicines or antidepressants that help to quiet down some of these amplified signals. We also have some topical medicines that are sometimes applied in that area where that nerve is to help to kind of quiet down those pain signals.

Andrew Schorr:

Wow. Dr. Burton, I'm just going to interrupt for a second. We're going to take a quick break because we want to keep getting deeper into this discussion of pain, even bring up - you've talked about holistic approaches too. Want to understand what's your belief about acupuncture, and you mentioned massage earlier, as we get to that. We're going to continue our discussion on Patient Power.

We're talking about the management of pain, particularly chronic pain in cancer patients with a man who truly knows and helps lead the field nationally and at M.D. Anderson, Dr. Allen Burton, who is professor and he's clinical medical director in the department of anesthesiology and pain medicine. We'll be back with much more Patient Power sponsored by M.D. Anderson right after this.

Andrew Schorr:

Welcome back to Patient Power as we continue our discussion of pain and the cancer patient and understand what is offered at M.D. Anderson, what's really the philosophy of spinal management now. But I think the bottom line is if you're experiencing pain somebody should ask you about it, first of all, and second of all, you should be offered help, and that is available at M.D. Anderson as they have a department that deals with pain medicine. And the leader of that is Dr. Allen Burton, who is with us today.

Dr. Burton, you were talking about the different modalities, and I mentioned as I asked about it, you know, people worry about it, some people do or family members, drug addiction. If you start taking a pill or any kind of these pills, Oh, my goodness will you be addicted, and it will have side effects all its own that will be as bad or worse than the pain. Want to comment on that?

Dr. Burton:

Certainly. Well, Andrew, as you've outlined, drug treatments or pharmacologic agents are one of the treatments that we use in treating chronic pain, but by no means are they the only treatment modality that we utilize. So I think if we do focus on the medications for just a minute we have to realize that the addictive medications people are typically concerned about include the opioids or sometimes they've been called narcotic medications or sometimes muscle relaxants and/or antianxiety medicines. Sometimes these medications are the ones that are primarily feared or have addictive potential. And I think we're gaining insight - in some patients when these are used chronically they can be used quite safely and in many cases for years and years with no problems with addiction whatsoever.

But I will say that we are also gaining an insight that in some small percentage of patients they can become addicted to these medicines, and we do have to keep an awareness that these medicines alone are not a panacea for treatment of pain syndromes. So when medications are used frequently we blend them. In other words, we'll use anticonvulsants or antidepressants or topical type of medications first of all in an effort to if we can treat the patient with medications that have no addictive potential that really eases everybody's mind, and there's really no need to be concerned about anything. Lastly, if those medications are only partly effective then sometimes we blend in an opioid or what are called a narcotic medicine in a smaller amount or on an as needed basis or in maybe a less strong opioid or narcotic medicine so that again people's fears are allayed. That's only part of their treatment algorithm. It's only part of the treatment that they're on or taking.

And then I think, so if we're addressing the pain management aspect of this or just hitting the pain with some certain agents, then I think the other important aspect to focus on is that the patient needs to be utilizing that improved pain relief or lessened amount of pain that they're dealing with in terms of rehabilitation. In other words, if the patient has been immobilized because of pain or things that they haven't been able to do, such as walk or do their own activities of daily living or climb stairs or certain things that they couldn't accomplish, take a walk or get on at bicycle or do things, with their new improved pain control we want them to be rehabilitated, and with the use of careful physical therapy many of our patients begin setting goals and then we walk them through attaining, regaining their functionality and gaining their life back in steps. So that's a very, very important aspect of what we do.

And then the triad, the third part in addition to the pain control, the rehabilitative aspect, then there's also kind of a psychological and coping issue that many people with chronic pain have had an immense amount of loss and have depression and anxiety, and they've lost perhaps their job or many of their previous capabilities and perhaps they're having financial difficulties in addition to this ongoing persistent pain. So the third aspect of this triad of treatment is to work through some of those issues and to begin to help the patient with relaxation strategies, coping strategies, and really a new kind of outlook and a new focus instead on what they've lost on what they can achieve now and taking stock, and then making gains and making goal setting and realistic goal setting and pacing themselves so that they can day by day, month by month, year by year look at new achievements and look in a positive sense at what they're able to achieve and what they're getting back as part of their treatment strategies. So these three kind of work together.

And there's complicated little nuances in each of these three areas that we can delve into, and in some patients there certainly are need for more complex treatment in any one of the three areas depending on the exact nature of the problem and so forth, but we have a lot of different strategies to offer patients.

Acupuncture

Andrew Schorr:

Now, there's some things, I think you mentioned one of them earlier, and we've talked about the heavy-duty drugs and some that are in kind of the middle ground but also some adjunctive things like massage. And I often when we think of pain wonder about acupuncture as well. What's your thought about all that?

Dr. Burton:

Well, we actually are quite enthusiastic I would say about acupuncture. I think the current thinking in pain medicine today is that acupuncture can be extremely effective for certain pain syndromes. The problem with acupuncture in the past is I

don't think anybody has ever questioned that it worked, but there's a problem of how long-lasting is the relief that you get. People typically would get a significant amount of relief, but it wouldn't be very long-lasting, and I think this got into a little frustrating situation. People would have to go back repeatedly so often that they would become frustrated, or they weren't certain how to blend that into their other treatments.

One of my colleagues is leading an acupuncture study on cancer patients with different types, either acute or chronic pain syndromes, and we're hoping to clear the mist a little bit about acupuncture with some more study. But we certainly are open to acupuncture, and we view it as a viable option for many, many types of pain syndromes.

Massage

Andrew Schorr:

What about massage?

Dr. Burton:

I think massage is also probably underutilized. There are many types of pain that we see become musculoskeletal conditions. Patients have a focus of pain, and whether or not it starts in the muscles often, whether it's nerve damage or there was radiation or tumor damage that had to be resected with a surgery, the body is made up of a bony structure but then it's all covered with layers of muscle and tendons that interact with each other, and when people get a pain syndrome where either they become inactive or when they begin to do things in ways that they didn't do before, such as walking in an unusual way or holding their head in a funny posture or different things that they have to do just to survive, it throws things out of alignment a little bit. And frequently their muscles can go into spasm or muscle groups can go into spasm and it triggers other muscle spasms. And sometimes this whole phenomenon gets out of control, and the patient becomes just a tight ball of spasm in their muscles and it becomes quite uncomfortable.

And sometimes the application with a really good massage therapist just is tremendously relieving to many of our patients. So I think massage is really, really an excellent technique. Again, not for everybody. And many times not in the acute setting because the patient just had an injury, you don't necessarily want to be getting a deep tissue massage. But sometimes for chronic pain syndromes it's really, really helpful.

Post-Mastectomy

Andrew Schorr:

Let's ask about a more acute situation. It was actually Jerry from Houston who wanted to know about massage. So Jerry, there's your answer.

Linda from New York wrote in, and she said, "I'm wondering if anyone else has had experience with intense, unrelenting, burning pain after mastectomy in the armpit and on the incision. It's been about a month since my mastectomy, and I haven't been rid of this pain for one minute. It's only relieved to a certain degree by narcotics."

I know you can't comment on her specific situation, but I imagine that there are many women who find themselves in that situation. What do you do for it?

Dr. Burton:

Right. Well, first of all, I would reassure her that she has a lot of company. There's a whole literature on what we call post-mastectomy pain syndromes. And I would also say that she's a little early to start defining her as having chronic pain. A month after surgery is still in the healing phase. But I would encourage anybody, even two to four to six weeks after surgery, if the pain is still a major problem you really need to bring it up with your surgeon and/or your primary care doctor, your oncologist, somebody to help you get more attentive care. Because if she's able to find relief currently I think that will lessen her chance of having a long-term chronic pain syndrome in that area.

And her relief, although it's coming right now a little bit with her opioid or narcotic medicines, I think she's appropriately concerned that, Look, I should be healing up, and I need to be cutting back on these medicines, but this is the only thing I have that can give me relief. Her physicians can begin blending this, and they can begin adding some other types of medicines that are a little bit more well studied in chronic pain usage. Some of them that come up that are used very commonly are anticonvulsants like gabapentin or pregabalin are two that we use very commonly that really help with this kind of burning pain, which is very likely an irritation of the nerves that run under the arm that are easily angered, if I might get colloquial about it with surgery under the armpit. These nerves frequently get revved up or angry just by being brushed by when the surgeon's getting at the lymph nodes in there.

And then many times, most times in fact given a period of time, several months, they will begin to quiet down quite nicely, but in the meantime while she's having this discomfort we are really thinking that if she's able to get some other type of medication on board that will help that pain to quiet down, that will in fact improve

her long-term outcomes. She'll be able to use her arm better, she'll be able to become more mobilized, less worried about this pain and perhaps it will speed her healing up in that area.

Surgery as a Solution

Andrew Schorr:

Here's a question we got from Angie in El Paso, Texas, and she gets to the points of whether surgery can be an intervention. She says, "My name is Angie. I'm 30 years of age. I've had surgery two times for removal of tumor and lymph nodes in the small intestine." She says she has a rare type of cancer. And after her surgery she took chemo and now she's in radiation but here's the problem. She says, "The problem is I now have upper abdominal pain because the bowel is stuck to the wall of the stomach with adhesions. The doctor told me the only solution is surgery again. Is this my only option?"

So we know we can't speak too specifically about her situation, but it really speaks to when would surgery be part of the pain control approach.

Dr. Burton:

Right. Well, one of the fortunate things that we have at M.D. Anderson is we have surgical oncologists here, and I know that my surgical colleagues have become more sophisticated in their application of many different types the surgical techniques. And offhand I can think of easily five or ten different surgeries that are really primarily directed at relieving pain. This may be one of them. In other words, when patients develop painful adhesions or painful situations, sometimes a partial obstruction, the surgeon can go in and alleviate that.

Now, there is a bit of a problem with scarring that sometimes going back in repeatedly can develop more scarring. I'd have to state that I'm not a surgeon, but one of the really significant advances that our surgical colleagues have made are minimally invasive approaches, where they go in through scopes now, where the amount of trauma that they cause by going in repeatedly really can be minimized basically by using these endoscopic approaches to go in for instance alleviate adhesions and so on.

One of the other major areas that our surgical colleagues can help us with pain relief is in the case of bony tumors, that if a patient has either a fracture due to a tumor in a bone or a significant amount of involvement of a bone with a tumor, many times our orthopedic colleagues can go in and stabilize that bone, and the pain relief is quite dramatic and really rather quick following the surgery. So our surgeons and our surgical colleagues can certainly help us in many, many ways.

And I would say that her situation sounds quite complicated. Obviously, she's discussing it with her physicians, but if she has doubts about that treatment

approach I always encourage our patients to get second opinions. When they're in doubt about second or third opinions, when they're in doubt about their treatment approach that's being recommended.

Andrew Schorr:

Dr. Burton, let's see, as we draw to a close, if I've got it right. So first of all there's a significant percentage of patients, maybe a third, could be more, who suffer from pain, cancer patients, and they can get help. They deserve to get help. And now you you're field of pain management, you have more tools, some drug therapies, you mentioned about surgery, massage, acupuncture, biofeedback, a variety of different classes of medications all, as you said, blended can make a difference. And you have a whole department at M.D. Anderson that can help people evaluate their specific situation.

Dr. Burton:

I think you hit it pretty much right on the head, Andrew. If I might expand, there's a couple surgeries that are done very specifically for pain and there's even a thing called an implanted pain pump or an implanted neurostimulator, when we have the really most refractory cases, that there can even be a surgical implant that is done very specifically just to address the pain and to quiet down the nervous system. So even to that extent, rather than if there's a problem, people always think about fixing the problem, well, in some cases we don't quite understand why that pain persists, but we certainly have a variety of techniques to quiet down those painful signals.

Andrew Schorr:

Well, from where I sit as a leukemia survivor I think, well, I've been given a gift of life after cancer diagnosis, and it's wonderful that there are provider such as you we can work with to make the quality of time, whether we live to a ripe old age or not, to make that as best we can pain-free, high quality and we can go about being with the people we care about and do what we like to do. I like that idea of the bike riding. That sounds good to me.

Dr. Allen Burton, professor and clinical medical director department of anesthesiology and pain management, thanks for being with us and thanks for helping all of us have a high quality of life. I really hope that people who are listening, M.D. Anderson patients and maybe some outside if they're nearby, wherever they may be, or with clinics near them if they're far, far away but they seek experts in your field, and I'm happy to hear that your field is growing and that the tools you have are expanding.

Dr. Burton:

Well, thank you very much, Andrew. I greatly enjoyed talking to you.

Andrew Schorr:

Thank you, sir.

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