NBPA – Winter Meeting 2012

Part 2

**Cancer Pain Interventions**

**An Integrated Appraoch**

 **DrAlison Mitchell, Dr Gordon McGinn, Claire O’Neill**

**Summary**: Excellent presentation by 3 clinicians from the Greater Glasgow and Clyde Cancer Service. All 3 presenteres discussed different aspects of ITDD delivery including referral, assessment and education. The first 2 presentere were very informative but I particularly found the education session may be transferrable to education about chronic pain in Physio.

**Dr Alison Mitchell** Palliative Medicine Consultant kicked off the session with a quote form an Orthopaedic surgeon who tried to give her a bit of advice about her future career in palliative medicine:

‘it’s not a proper job and that all that was needed was a bottle of whisky and a river!’

Needless to say Dr Mitchell ignored the above advice and has been working in Palliative Medicine and has never looked back! She helped set up the Greater Glasgow and Clyde Cancer Service in 2007.

The main topic over talk was intrathecal drug delivery.

Again this is an area I am not familiar with but she went on to explain the criteria for considering an ITDD pump alongside potential benefits and complications.

ITDD is the 4th step on the WHO analgesia ladder i.e. when strong opiates plus adjuvants do not provide adequate pain relief.

ITDD deliver opioid and anaesthetic to the dorsal horn and cerebrospinal fluid. One of the benefits of intrathecal delivery is that the opioid dose is 1/300th that of an oral dose.

The internal intrathecal delivery via a pump is considered after oral meds and then external intrathecal delivery has been tried.

The risks of ITDD is:

* Loss of power
* Loss of bladder and bowel sensation
* Discrete areas of loss of skin sensation that can lead to pressure sores.

Referral for ITDD is from existing palliative care patients for whom pain is uncontrolled despite best practice and/or there is untolerabel side effects form current meds.

This is followed by multidisciplinary assessment where psychological assessment is important. The patient is then provided information and a further MDT discussion is held.

**Dr Gordon McGinn** – Chronic Pain Consultant to the GGC Cancer Service

Dr McGinn talked initially about the different types of pumps used in ITDD and reported that his service uses the Archimedes.

They have audited and evaluated the patients fitted with internal pumps since 2007.

The average number of internal ITTD pumps per year is 5. Since 2007 21 patients have had ITDD pumps.

3/21 patients were unable to continue with their pumps due to CSF leak, unable to refill the pumps (with opiate and anaesthetic) or unable to be supported in the community.

16/21 patients used their pumps until death.

Physio assessment is completed before and after insertion of pump. The assessment covers pain VAS for sitting, standing and walking, mobility, RoM and power, and the Brief Pain Inventory.

Before insertion of pump the average functional pain VAS is 5/10, after pump is fitted it is down to 1/10.

Brief Pain Inventory pre is 9/10 and post is 4/10.

Pre ITTD mean morphine intake is 1168 mg

Post ITTD mean morphine intake is down to 31mg!!

Mean length of time with ITTD ranges from 10 days to 292 days. Dr McGinn mentioned at this point that patients need to be fit enough to undergo the procedures required for fitting.

Place of death data: 6/16 at home and 3/16 in the cancer centre.

**Claire O’Neill** Specialist Nurse GGC Cancer Service

Claire’s presentation focussed on education and training of community staff in maintaining the safety of the person with an ITDD in the community.

Claire went onto present the structure of their training of community healthcare professionals.

I felt there was a lot form this that could be translated to Physio training.

Education and training of community staff consists of:

* Formal training
* Competency is measured and assessed on an annual basis.
* Including the development of a competency document.

The competency document contains the requirements of the competencye.g.

* Theoretical knowledge and practical experience
* Knowledge of policy
* Completion of an e-module which also includes a trouble shooting section

She has gone onto establish Nurse Champions who then go onto train other staff.

She then went to demonstrate the patient information they have produced including:

* Patient leaflets
* Patient experience DVD with interviews of patients

Some patient quotes from the DVD were from patients who’d had an ITDD implanted. Including:

* ‘I initially thought this was the end but found actually it was the beginning’
* ‘I had nothing to lose and everything to gain’
* Husband reports that ‘I have my wife back’

Mental Imagery in Chronic Pain

Dr David Gillanders and Natalie Rooney

**Summary**: Dr Gillanders presented Natalie Rooney’s work and others involved in similar research at Edinburgh University. This was a very interesting presentation and whilst I do not specifically ask patients if they have an image of their pain, if they raise I may see if they can manipulate it. If they can manipulate the image it seems this gives them a greater feeling of control and has benefits in reduction of withdrawal behaviour.

In 2011 Claire Phillips asked a group of patients if they had an image of their pain:

79% did! In 2012 she asked the question if they could could change the image could they reduce their pain.

Reports from patients. Some:

* Saw pictures of themselves in the future e.g. in a wheelchair
* Saw themselves as having pain inflicted upon them
* Images of inside themselves e.g a ‘crumbling spine’

Patients were then asked if they could imagine pain outside their body. Descriptions included:

‘like a black egg with electrical shocks across the surface’

In a further study at Edinburgh University 25 – 40% of patients with chronic pain had images of their pain. Having images of their pain was associated with **increased levels of distress and depression but not higher pain.**

Natalie Rooney interviewed patients using a qualitative study protocol based on Grounded Theory which allows themes and meanings to emerge from an interview. This allows a theory to be built from the data.

The interview may start with:

‘Tell me what kind of things come in to your mind when you imagine your pain?’

‘Do these images take a form?’

Responses included:

* Images of the pain itself
* Images of the self in pain
	+ ‘I am in a long hole and keep falling’
* Emotional and behavioural responses to images e.g. feeling hopeless and anxious and withdrawn

The patients were then asked about what meanings the images had for them:

* ‘Pain is controlling me’
* ‘Pain is defining me’
* The threatened self

Two patients used coping imagery:

e.g. ‘I had to box the pain’

 ‘I tried to cut the pain’

She found that being able to manipulate the images was associated with a reduction of withdrawing behaviour.

Conclusion: Dr Gillanders wondered if the comments from patients represents intrusive cognitions or metaphorical descriptions.