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## FAST FACTS AND CONCEPTS #215

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**Background** Relief of cancer pain from opioids is rarely all or nothing; most patients experience some degree of analgesia alongside opioid toxicities. When the balance of analgesia versus toxicity tips away from analgesia, the term 'opioid poorly-responsive pain' is invoked. While opioid poorly-responsive pain is not a discreet syndrome, it is a commonly encountered clinical scenario. This Fast Fact reviews key points in its assessment and management.

### Differential Diagnosis of Opioid Poorly-Responsive Pain

1. Cancer-related pain
  - a. Cancer progression (new fracture at site of known bone metastases).
  - b. Causes of pain (eg. neuropathic pain, skin ulceration, rectal tenesmus, muscle pain) that are known to be less responsive to systemic opioids or opioid monotherapy.
  - c. Psychological/spiritual pain related to the cancer experience (existential pain of impending death).
2. Opioid pharmacology/technical problems
  - a. Opioid tolerance (rapid dose escalation with no analgesic effect).
  - b. Dose-limiting opioid toxicity (sedation, delirium, hyperalgesia, nausea – see *Fast Facts* #25, 142).
  - c. Poor oral absorption (for PO meds) or skin absorption (e.g. transdermal patch adhesive failure).
  - d. Pump, needle, or catheter problems (IV, subcutaneous, or spinal opioids).
3. Non-cancer pain
  - a. Worsening of a known non-cancer pain syndrome (diabetic neuropathy).
  - b. New non-cancer pain syndrome (dental abscess).
4. Other psychological problems
  - a. Depression, anxiety, somatization, hypochondria, factitious disorders.
  - b. Dementia and delirium both can effect a patient's report of and experience of pain.
  - c. Opioid substance use disorders or opioid diversion.

### Management Strategy

1. Initial Steps
  - a. Complete a thorough pain assessment including questions exploring psychological and spiritual concerns. If substance abuse or diversion is suspected, complete a substance abuse history (see *Fast Facts* #68, 69).
  - b. Complete a physical examination and order diagnostic studies as indicated.
  - c. Escalate a single opioid until acceptable analgesia or unacceptable toxicity develop, or it is clear that additional analgesic benefit is not being derived from dose escalation. If this fails, consider:
    - i. Rotating to a different opioid (e.g. morphine to methadone).
    - ii. Changing the route of administration (e.g. oral to subcutaneous).
  - d. Treat opioid toxicities aggressively.
  - e. Use (start or up-titrate) adjuvant analgesics, especially for neuropathic pain syndromes.
  - f. Integrate non-pharmacological treatments such as behavioral therapies, physical modalities like heat and

cold, and music and other relaxation-based therapies – see *Fast Fact #211*.

2. Additional steps – Pain refractory to the initial steps requires multi-disciplinary input and care coordination.
  - a. Hospice/Palliative Medicine consultation to optimize pain assessment, drug management, and assessment of overall care goals.
  - b. Mental health consultation for help in diagnosis and management of suspected psychological factors contributing to pain.
  - c. Chaplain/Clergy assistance for suspected spiritual factors contributing to pain.
  - d. Interventional Pain and/or Radiation Oncology consultation.
  - e. Rehabilitation consultations (Physiatry, Physical and Occupational Therapy) to maximize physical analgesic modalities.
  - f. Pharmacist assistance with drug/route information.

## References

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**Version History:** Originally published May 2009.

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**ACGME Competencies:** Medical Knowledge, Patient Care

**Keywords:** Communication, Pain – Evaluation, Pain – Opioids, Prognosis

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