Estado actual de las guías de dolor por cáncer

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Estado actual de las guías de dolor por cáncer

- Objetivos
  - Evaluar el estado actual de las guías
  - Evaluar si hay diferencia entre el manejo del anciano vs adulto joven
  - Adherencia a las recomendaciones

Estado actual de las guías de dolor por cáncer

Cancer-related Pain Management

A Report of Evidence-based Recommendations to Guide Practice

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- Canadá

- Resultados
  - 70 % respuesta adecuada
  - 30 % poco satisfactoria o nula

  - ¿ Que pasa con ese 30%?
    - Calidad de las Guías?

Clin J Pain 2010;26:449-462

Estado actual de las guías de dolor por cáncer

- Existen mas de 25 Guías
  - 8 cumplen criterios adecuados de evidencia
    - Una es especial para ancianos
      - 2009 JAGS

TABLE 1. Summary of Evidence

Recommendation Section	SIGN[4]	AGS[5]	RNAO[6]	NBCC-NCCI[7]	CANO[8]	APS[9]	CPS[10]	CCNS[11]
Final AGREE Score	Strongly Recommend	Strongly Recommend	Strongly Recommend	Strongly Recommend	Strongly Recommend	Strongly Recommend	Recommend	Strongly Recommend
Assessment of pain	✔						✔	
Assessors of pain							✔	✔
Time and frequency of assessment	✔					✔	✔	✔
Components of pain assessment	✔							✔
Assessment of pain in special populations		✔			✔	✔	✔	
Plan of care			✔			✔		
Pharmacologic intervention		✔	✔			✔	✔	✔
Nonpharmacologic intervention				✔		✔		✔
Documentation			✔		✔		✔	✔
Education	✔				✔	✔	✔	✔
Outcome measures								

✔ is used to indicate that consensus by the reviewers to include the elements (column 1) on the guidelines listed across the top of the table (horizontal).
AGS indicates American Geriatrics Society; APS, American Pain Society; CANO, Canadian Association of Nursing Oncology; CCNS, Cancer Care Nova Scotia; CPS, Canadian Pain Society; NBCC-NCCI, National Breast Cancer Centre and National Cancer Control Initiative; RNAO, Registered Nurses Association of Ontario; SIGN, Scottish Intercollegiate Guidelines Network.

Clin J Pain 2010;26:449-462

Estado actual de las guías de dolor por cáncer

- Se recomienda
  - Evaluación geriátrica multidimensional
  - Utilizar escalas para cuantificar el dolor
  - Diferenciar tipos de dolor
    - Crónico
    - Agudo
    - Dolor total

Quality Indicators for Pain Management in Vulnerable Elders

Cancer Pain

3. IF a VE presents for a cancer-related physician visit, including visits for chemotherapy or radiation, THEN pain should be assessed, BECAUSE pain is common and underreported in patients with cancer, and identification of pain will result in the initiation of treatment and improvement of patient outcomes.

4. IF an outpatient VE with cancer presents with severe pain (score > 5 on a 0–10 scale or similar quantifiable measurement), THEN an adjustment of pain treatment should occur, BECAUSE this will reduce pain.

Primero

Primero

Evaluación

Cuantificar

Table 1

Comprehensive Assessment of Pain in Older Cancer Patients

	Assessment Tools
History	Characteristics, intensity, location, aggravating factors of pain
	Stage of the cancer
	Recent chemotherapy and/or radiation therapy
	Self-rated pain scales: vertical, horizontal, and faces pain scales
Performance status	Karnofsky Performance Scale or Eastern Cooperative Oncology Group Scale
Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)	6-item ADL
	8-item IADL
Evaluation of comorbid conditions	
Evaluation of medications and possible interactions (polypharmacy)	
Physical examination	
Assessment of other physical symptoms related to pain (fatigue, anorexia, nausea, dyspnea, insomnia, drowsiness, constipation)	Edmonton Symptom Assessment System (ESAS)
	Abdominal x-ray to assess constipation
Assessment of psychosocial symptoms:	
Anxiety/depression	Anxiety/Depression (ESAS)
Family/caregiver's distress	Family/Caregiver Assessment
Assessment of delirium	Memorial Delirium Assessment Scale (MDAS)
	Mini-Mental State Examination (MMSE)
	Confusion Assessment Method (CAM)
Assessment of spiritual distress	Spiritual Assessment
Assessment for chemical coping	CAGE questionnaire (see text)



Management of Pain in the Older Person With Cancer

Part 1: Pathophysiology, Pharmacokinetics, and Assessment

JANUARY 2008 • ONCOLOGY

Original Article

Assessing and Treating Pain in Hospices: Current State of Evidence-Based Practices

Table 1
CPPI Practice Indicators: Abbreviated and Detailed Descriptions

Abbreviated Description	CPPI Indicator Detailed Description
1. Valid pain scale use at admission	Pain assessment completed using a valid culturally sensitive pain scale (numeric scale, verbal descriptor scale, Faces scale) for patients able to report pain *or* using a nonverbal pain scale *and/or* pain behaviors documented for patients with a cognitive impairment at hospice admission. (Culturally sensitive = translated pain scale and/or interpreter services used.)
2. Comprehensive assessment—primary	Patients with pain present at admission with *primary* components of comprehensive pain assessment completed within 24 hours of admission (pain intensity, pain location, pain quality, pain duration/pattern, impact of pain on function).
3. Comprehensive assessment—other	Patients with pain present at admission with *additional* components of comprehensive pain assessment completed within 48 hours of admission (detailed pain history, including description of previous and current pain episodes and treatment effectiveness; physical exam, including musculoskeletal and neurological assessment; presence or absence of delirium; things that make pain better; things that make pain worse; presence of anxiety and depression).
4. Pain intensity reassessment for moderate or severe pain (≥5)	Reports of moderate/severe (≥5) pain followed by pain intensity assessment within 24 hours.
5. Increases in pain medications for consecutive reports of pain intensity of ≥5	Consecutive pain intensity reports of 5 or greater that are followed by increases of opioid dose or additional analgesic added within 24 hours.
6. Order for pain medication with admission pain report	Patients with admission report of pain as mild (1—4) with order for nonopioid or combination of opioid-nonopioid analgesic within 24 hours of admission *or* patients with admission report of pain as moderate (5—6) or greater with order for opioid analgesic within 24 hours of admission *or* Patients unable to self report with pain behaviors documented with an order for a nonopioid or opioid analgesic within 24 hours of admission.
7. Bowel regimen initiated	Patients with an opioid order who have an existing bowel regimen (includes both laxative and stool softener) in place or a new order for a bowel regimen initiated within 24 hours of an opioid order.
8. Analgesic side effects monitored	For patients with opioids ordered, who are monitored each day, a focused assessment is completed for the 5 most concerning analgesic-induced side effects (respiratory depression, sedation, nausea and vomiting, constipation, and delirium).
9. Nonpharmacological therapies used	Patients with report of pain with any cognitive/behavioral nonpharmacological therapies documented in the following week (e.g., meditation, music, prayer, aromatherapy, imagery) OR any physical nonpharmacological therapies documented in the following week (e.g., massage, vibrations, medicated lotions, repositioning, use of hot, use of cold).
10. Review of the pain treatment plan	Focused pain assessments that include a review of the pain treatment plan. Review of the pain treatment plan is defined as documentation regarding the current treatment approaches and maintaining or changing orders, and others, if the patient is following the plan, and/or the degree of adherence to the pain treatment plan.
11. Written pain management plan	Patients with documentation of a written pain management plan that includes *all* the following components: the causes of their pain, the types of and rationale for their analgesic meds, specific instructions on how to dose and titrate their analgesic medications, instructions on how to manage analgesic side effects, instructions for storage and safe keeping of medications, whom to call if pain is not relieved or increases in intensity or if side effects occur, when and how to use nonpharmacological approaches to pain management.

1. Escalas de validación del dolor
2. Evaluación integral
3. Reevaluar la intensidad del dolor
4. Si dolor mayor de 5 incrementar medicación
5. Iniciar medidas para prevenir la constipación
6. Monitorizar efectos adversos de los opioides
7. Utilizar terapias no farmacológicas
8. Revisar el plan de tratamiento Farmacológico periódicamente
9. Dejar por escrito el plan de manejo del dolor

J Pain Symptom Manage 2010;39:803—819

SPECIAL ARTICLE

Pharmacological Management of Persistent Pain in Older Persons

American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons

JAGS 57:1331–1346, 2009

Table 2. Pharmacological Changes with Aging

Pharmacological Concern	Change with Normal Aging	Common Disease Effects
Gastrointestinal absorption or function	• Slowing of gastrointestinal transit time may prolong effects of continuous-release enteral drugs. • Opioid-related bowel dysmotility may be enhanced in older patients.	• Disorders that alter gastric pH may reduce absorption of some drugs. • Surgically altered anatomy may reduce absorption of some drugs.
Transdermal absorption	• Under most circumstances, there are few changes in absorption based on age but may relate more to different patch technology used.	• Temperature and other specific patch technology characteristics may affect absorption.
Distribution	• Increased fat to lean body weight ratio may increase volume of distribution for fat-soluble drugs.	• Aging and obesity may result in longer effective drug half-life

JAGS 57:1331–1346, 2009

Table 2. Pharmacological Changes with Aging

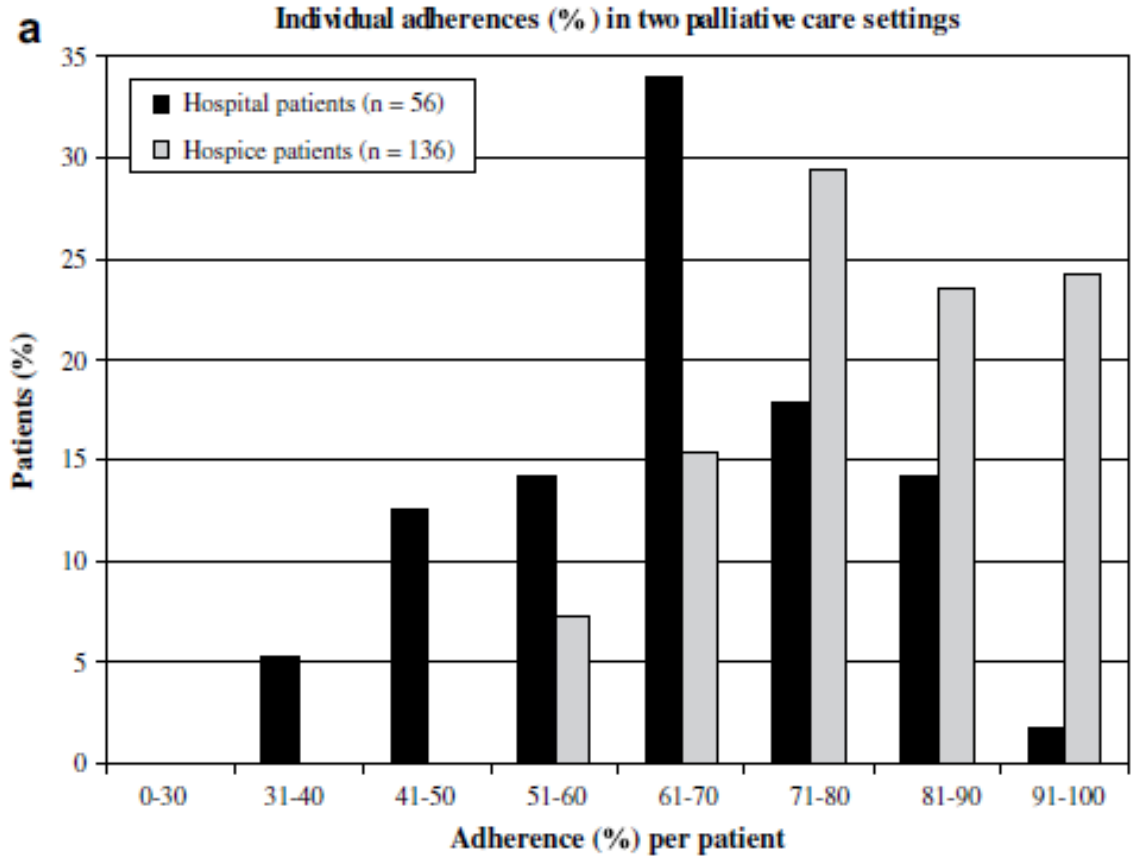
Liver metabolism	• Oxidation is variable and may decrease resulting in prolonged drug half-life. • Conjugation usually preserved. • First-pass effect usually unchanged. • Genetic enzyme polymorphisms may affect some cytochrome enzymes.	• Cirrhosis, hepatitis, tumors may disrupt oxidation but not usually conjugation.
Renal excretion	• Glomerular filtration rate decreases with advancing age in many patients, which results in decreased excretion.	• Chronic kidney disease may predispose further to renal toxicity.

Table 2. Pharmacological Changes with Aging

Active metabolites	• Reduced renal clearance will prolong effects of metabolites.	• Renal disease. • Increase in half-life.
Anticholinergic side effects	• Increased confusion, constipation, incontinence, movement disorders.	• Enhanced by neurological disease processes.

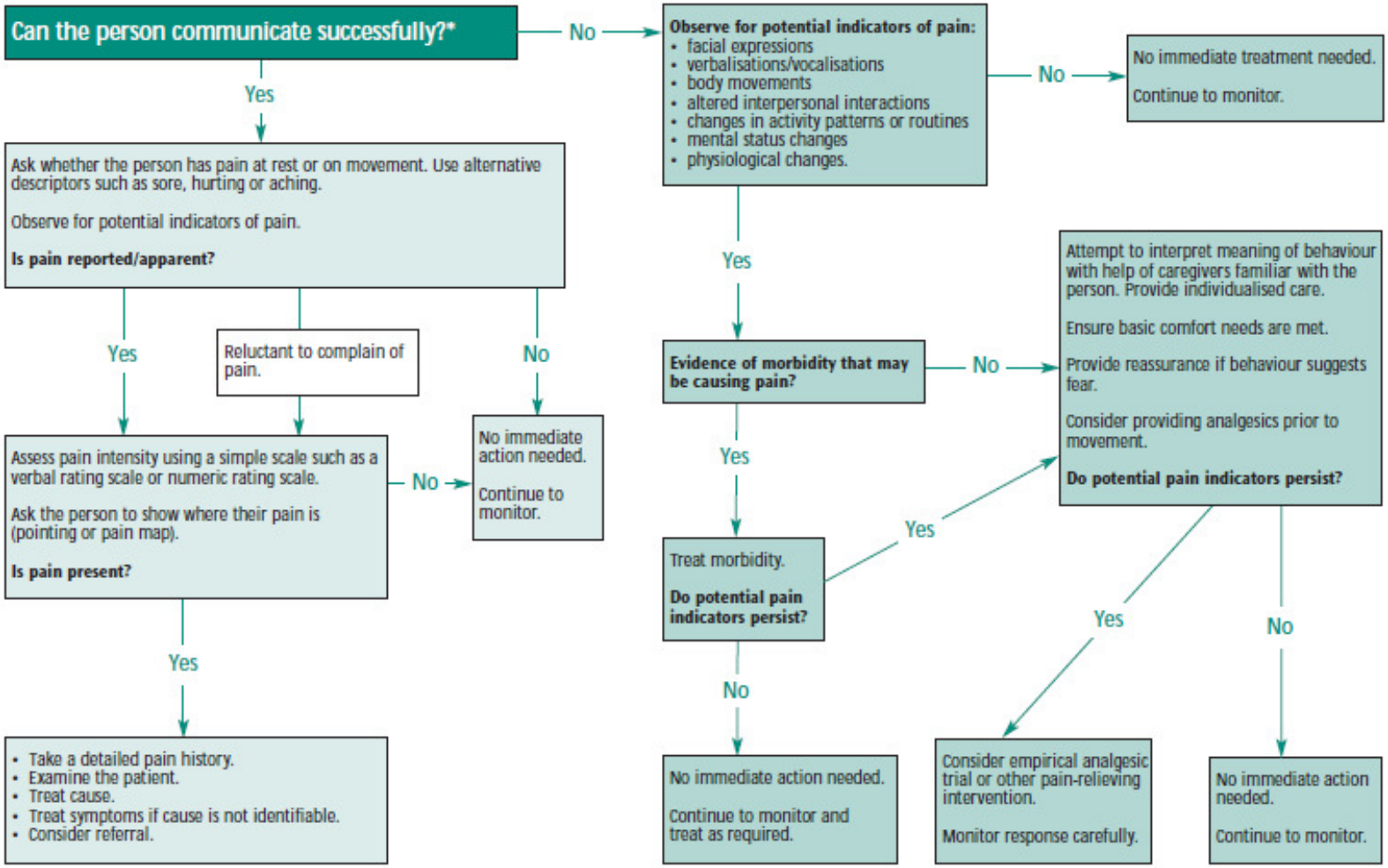
Original Article

Adherence to Medication Guideline Criteria in Cancer Pain Management



J Pain Symptom Manage 2009;37:1006–1018.

Appendix 2. Algorithm for the assessment of pain in older people



*If there is doubt about ability to communicate, assess and facilitate as indicated in Recommendations 4 and 5 of the Guidelines.

Conclusiones

- Pocas guías dirigidas a la atención del adulto mayor
- La calidad de las guías
  - No es Integral
- Considerar los cambios farmacológicos
  - Especiales en los ancianos
    - Ejem: farmacocinética y farmacodinámia
- Diferente apego de acuerdo al lugar de aplicación
- Algoritmos complejos
  - Que hacen adherencia de los médicos

Conclusiones