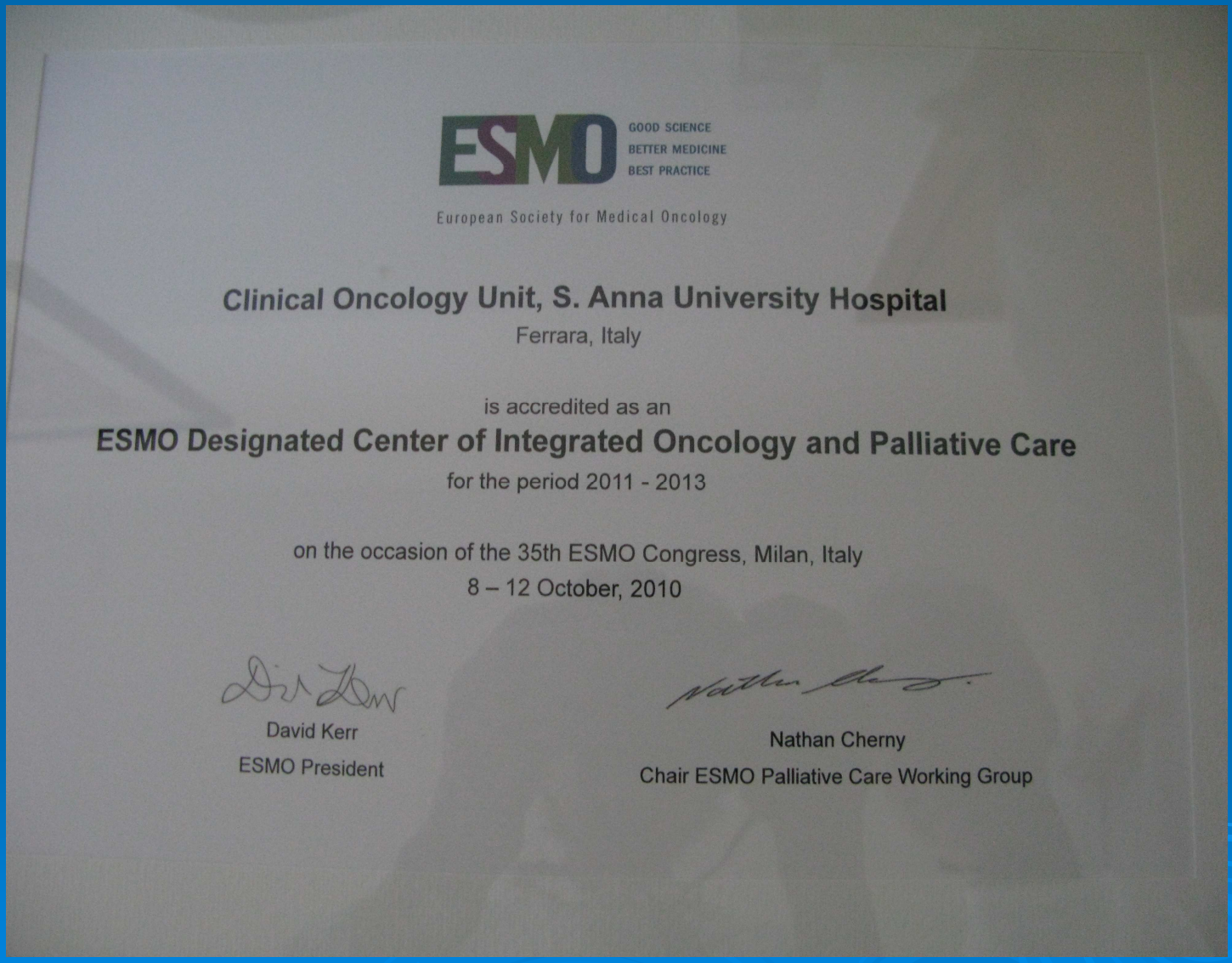
TRATTAMENTO DEL DOLORE PELVICO CRONICO

Dott. E. Piva
Oncologia Clinica Ferrara

Ferrara, 15 Dicembre 2012



ESMO
GOOD SCIENCE
BETTER MEDICINE
BEST PRACTICE

European Society for Medical Oncology

Clinical Oncology Unit, S. Anna University Hospital

Ferrara, Italy

is accredited as an

ESMO Designated Center of Integrated Oncology and Palliative Care

for the period 2011 - 2013

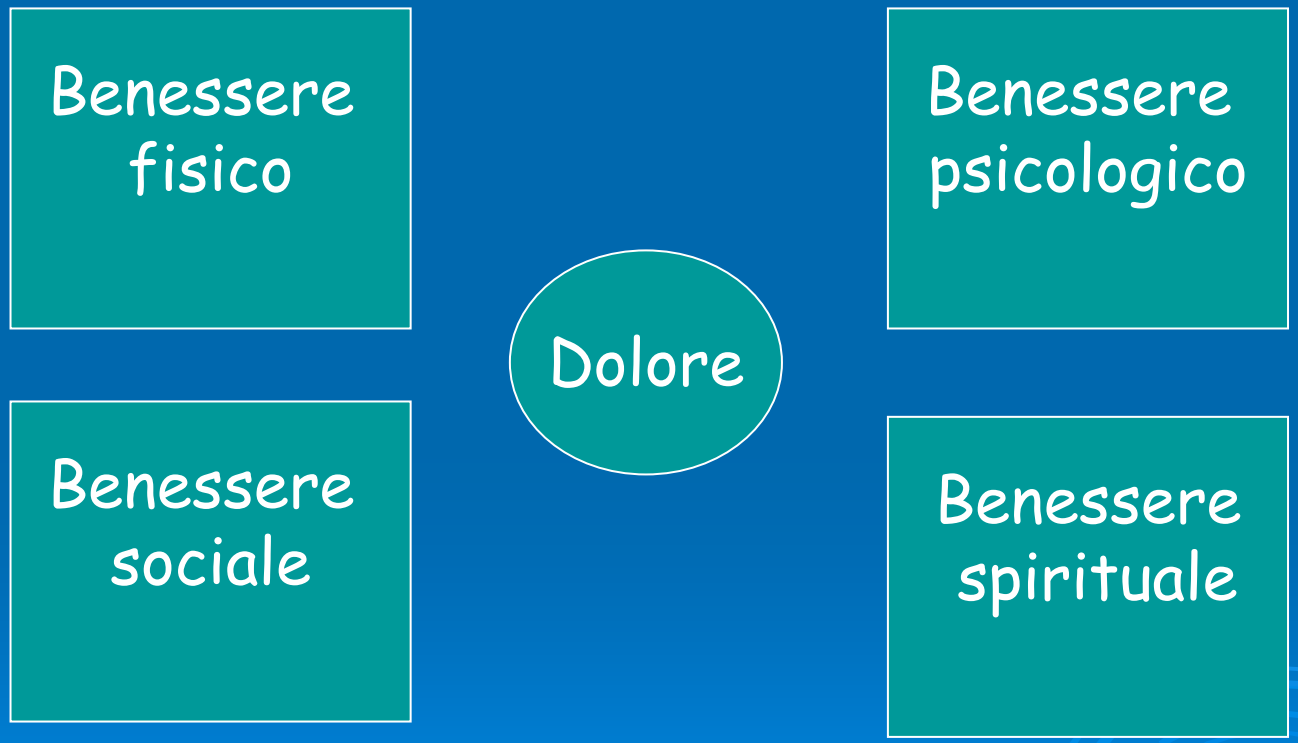
on the occasion of the 35th ESMO Congress, Milan, Italy

8 – 12 October, 2010

David Kerr
ESMO President

Nathan Cherny
Chair ESMO Palliative Care Working Group

Il concetto di dolore totale



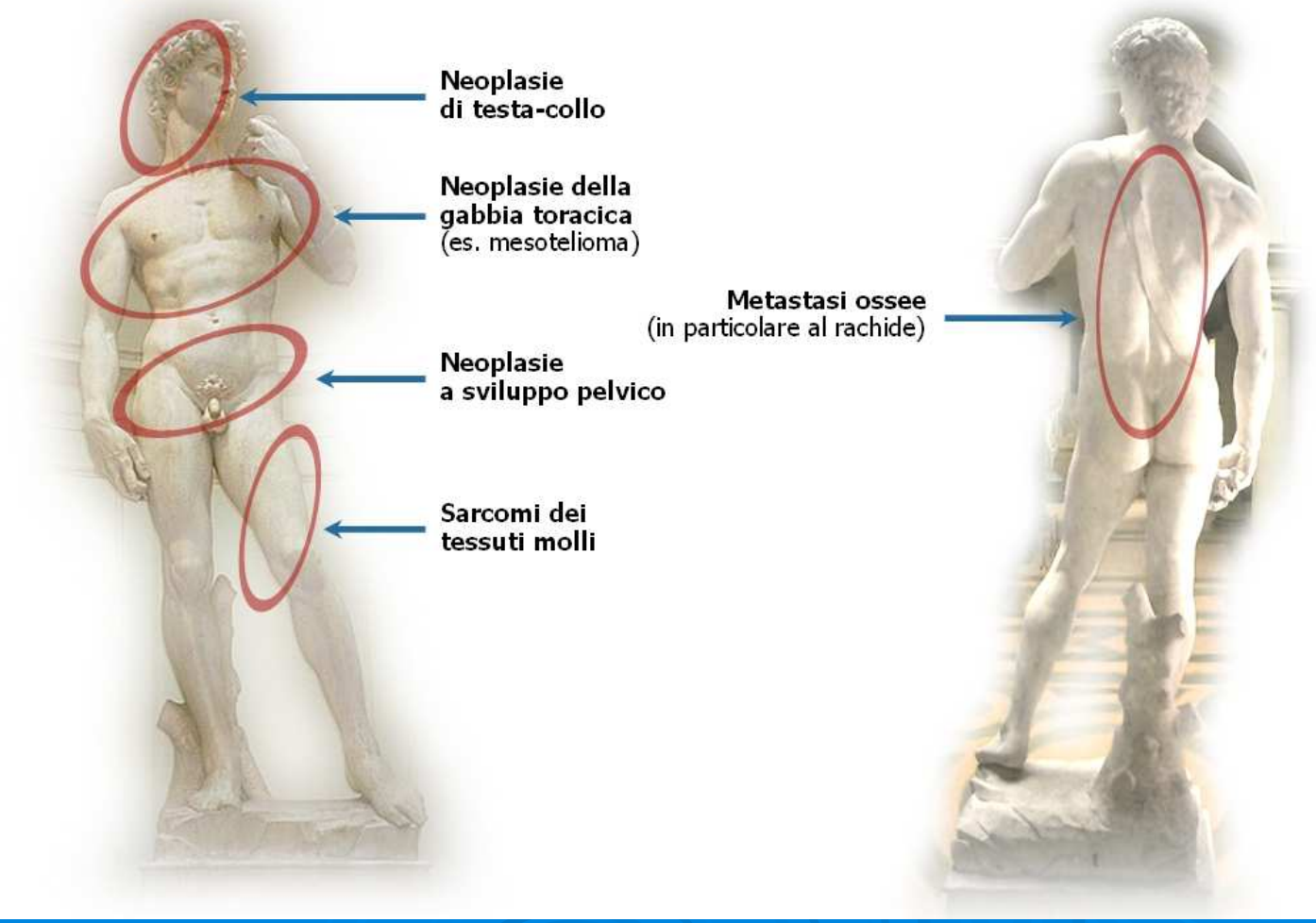
da Ferrel B. Oxford Textbook of Palliative Medicine

Il dolore pelvico è spesso una caratteristica delle neoplasie addominali ed è determinato dall'interessamento delle molte strutture pelviche che risultano essere innervate in modo assai complesso

QUADRI ALGICI DI DIFFICILE GESTIONE !!

Neuropatia da infiltrazione/compressione neoplastica di nervi, radici nervose o plessi

Principali localizzazioni tumorali che si associano a neuropatia dolorosa periferica



VALUTAZIONE DOLORE

- Intensità del dolore (NRS; VAS)
- Aspetti temporali (BTcP)
- Aspetti qualitativi (sede, caratteristiche, aree irradiazione)
- Interferenza con attività quotidiane e con il sonno
- Fattori scatenanti
- Eventuali precedenti terapie

SCALA ANALGESICA OMS [23]

SCALA DEL DOLORE OMS

1	2	3	4	5	6	7	8	9	10
lieve (I GRADO)				moderato (II GRADO)		severo (III GRADO)			

SCALA ANALGESICA OMS

I GRADINO

Paracetamolo o FANS ± adiuvanti

II GRADINO

codeina
tramadolo

OPPIOIDI DEBOLI ± paracetamolo o FANS ± adiuvanti

III GRADINO

morfina, metadone, fentanil, buprenorfina, ossicodone, idromorfone

OPPIOIDI FORTI ± paracetamolo o FANS ± adiuvanti

Approccio polimodale terapia dolore

- L'approccio a tre gradini andrebbe inserito in una strategia complessiva che comprenda anche terapie non farmacologiche (anestesiologiche, oncologiche, radioterapiche, fisiatriche, psico-sociali e spirituali).

OBIETTIVI DA RAGGIUNGERE

- Alleviare il dolore a riposo
- Alleviare il dolore in posizione eretta e durante le attività
- Aumentare le ore di sonno
- Migliorare la qualità di vita

Perché buone abilità comunicative sono importanti per la cura?

Per il clinico le abilità comunicative possono:

- Aumentare la soddisfazione del paziente
- Assicurare il consenso informato
- Favorire il reclutamento agli studi clinici
- Aumentare la "compliance"
- Ridurre le controversie medico-legali
- Rendere il paziente un partner nelle decisioni
- Ridurre il burnout in situazioni di ristrettezze delle risorse
- Aumentare la competenza del medico nel discutere argomenti difficili, come quelli sulla fine della vita

Terapia dolore
Principi generali (1)

- Il trattamento deve essere proporzionato alla situazione del malato
- Il malato deve condividere il trattamento ed essere informato dei potenziali effetti collaterali
- Il trattamento deve essere il più semplice possibile ed adeguato al setting di cura

Terapia dolore
Principi generali (2)

- Il trattamento deve essere prescelto in base al proprio livello di conoscenza ed esperienza professionale
- La posologia, gli orari, le vie di somministrazione devono essere chiaramente indicate
- Consigliare sempre eventuale terapia al bisogno !
- Approcci invasivi solo se necessari

DOLORE DI BASE APPROCCIO FARMACOLOGICO

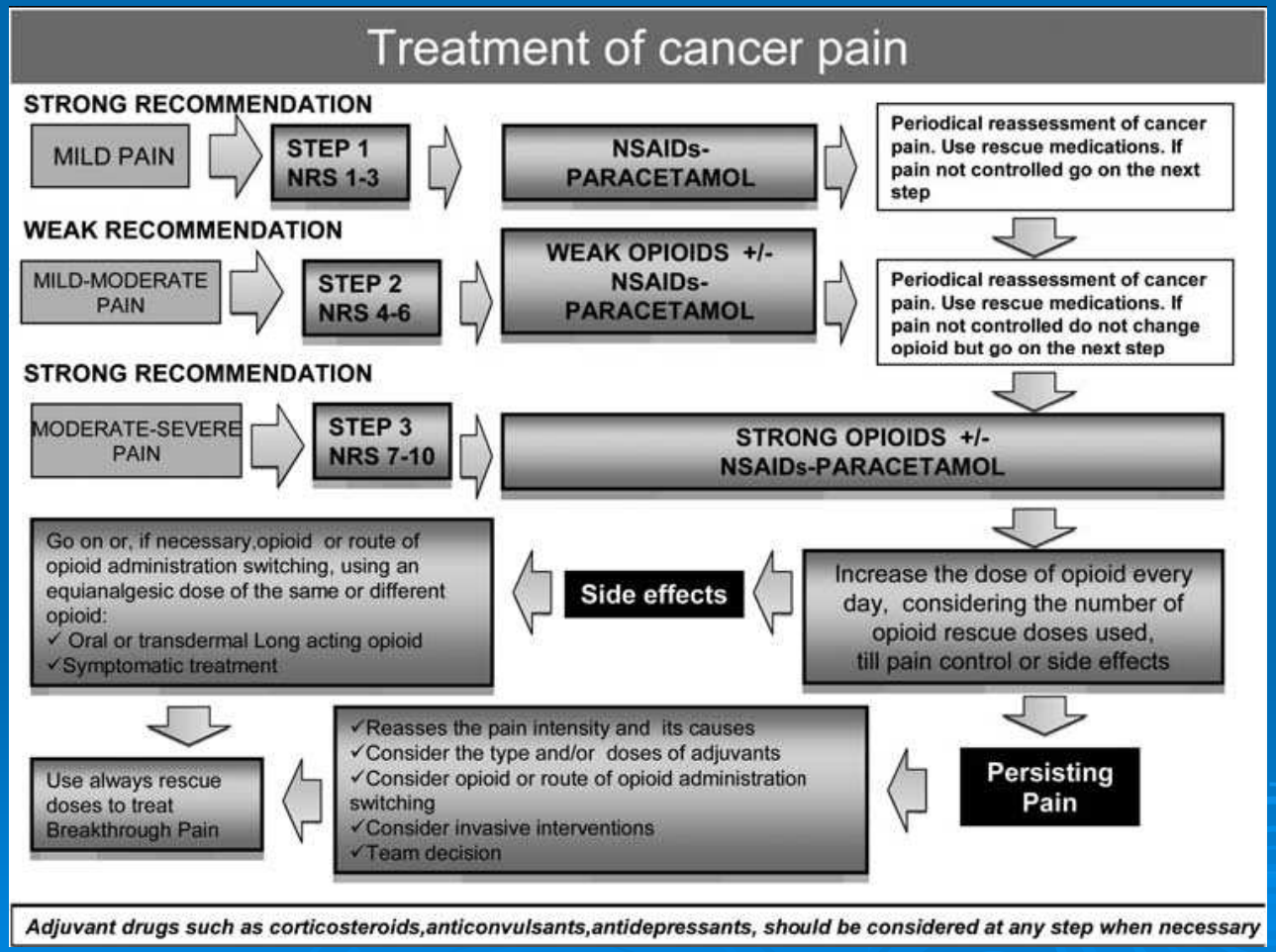
- Somministrazione di dosi fisse ad orari fissi (around-the-clock schedule)
- Farmaci per via orale se possibile
- Personalizzazione e ottimizzazione delle dosi (aumentare gradualmente le dosi fino al massimo effetto analgesico con tollerabilità accettabile)
- Associazione con analgesici ed adiuvanti
- Prevenzione effetti secondari analgesici

LA GIUSTA DOSE AL GIUSTO INTERVALLO

OPPIOIDI MAGGIORI

- MORFINA (MS Contin® Twice® Oramorph®)
- OSSICODONE (OxyContin® Targin®)
- FENTANYL (Durogesic® Matrifen® Actiq® Effentora® Instanyl ® PecFent®)
- IDROMORFONE (Jurnista®)
- BUPRENORFINA (Transtec®)
- METADONE
- TAPENTADOLO (Palexia®)

Management of cancer pain: ESMO Clinical Practice Guidelines 2012



- Clinical practice guidelines

- Management of cancer pain: ESMO Clinical Practice Guidelines

- C. I. Ripamonti1, E. Bandieri2 & F. Roila3
- On behalf of the ESMO Guidelines Working Group*
- 1Supportive Care in Cancer Unit, IRCCS Foundation, National Cancer Institute of Milano, Milan; 2Palliative Care Unit, Azienda Usl Modena (CeVEAS), Modena;

  3Department of Medical Oncology, S. Maria Hospital, Terni, Italy

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Use of opioid analgesics in the treatment of cancer pain: evidence-based recommendations from the EAPC

Prof Augusto Caraceni MD a c _ †, Prof Geoffrey Hanks DSc (Med) b †, Prof Stein Kaasa MD c f †, Prof Michael I Bennett MD h, Cinzia Brunelli ScD a, Prof Nathan Cherny MD i, Prof Ola Dale MD d, Franco De Conno MD j, Prof Marie Fallon MD k, Magdi Hanna FCA l, Dagny Faksvåg Haugen PhD e m, Gitte Juhl MD n, Samuel King MRCP b, Pål Klepstad MD d g, Eivor A Laugsand MD c, Marco Maltoni MD o, Sebastiano Mercadante MD p q, Maria Nabal MD r, Alessandra Pigni MD a, Prof Lukas Radbruch MD s, Colette Reid MD b, Prof Per Sjogren MD t, Patrick C Stone MD u, Davide Tassinari MD v, Giovambattista Zeppetella FRCP w, for the European Palliative Care Research Collaborative (EPCRC)on behalf of the European Association for Palliative Care (EAPC)

Summary

Here we provide the updated version of the guidelines of the European Association for Palliative Care (EAPC) on the use of opioids for the treatment of cancer pain. The update was undertaken by the European Palliative Care Research Collaborative. Previous EAPC guidelines were reviewed and compared with other currently available guidelines, and consensus recommendations were created by formal international expert panel. The content of the guidelines was defined according to several topics, each of which was assigned to collaborators who developed systematic literature reviews with a common methodology. The recommendations were developed by a writing committee that combined the evidence derived from the systematic reviews with the panellists' evaluations in a co-authored process, and were endorsed by the EAPC Board of Directors. The guidelines are presented as a list of 16 evidence-based recommendations developed according to the Grading of Recommendations Assessment, Development and Evaluation system.

RECOMMENDATION FOR WHO STEP II OPIOIDS

- For patients with mild to moderate pain or whose pain is not adequately controlled by paracetamol or a non-steroidal anti-inflammatory drug (NSAID) given regularly by mouth, the addition of a step II opioid (eg, codeine or tramadol) given orally might achieve good pain relief without troublesome adverse effects. Alternatively, low doses of a step III opioid (eg, morphine or oxycodone) may be used instead of codeine or tramadol. The data permit a weak recommendation to start a step II opioid in these circumstances.

The Lancet Oncology, February 2012

- **RECOMMENDATION FOR WHO STEP III OPIOID OF FIRST CHOICE**

- **The data show no important differences between morphine, oxycodone, and hydromorphone given by the oral route and permit a weak recommendation that any one of these three drugs can be used as the first choice step III opioid for moderate to severe cancer pain.**

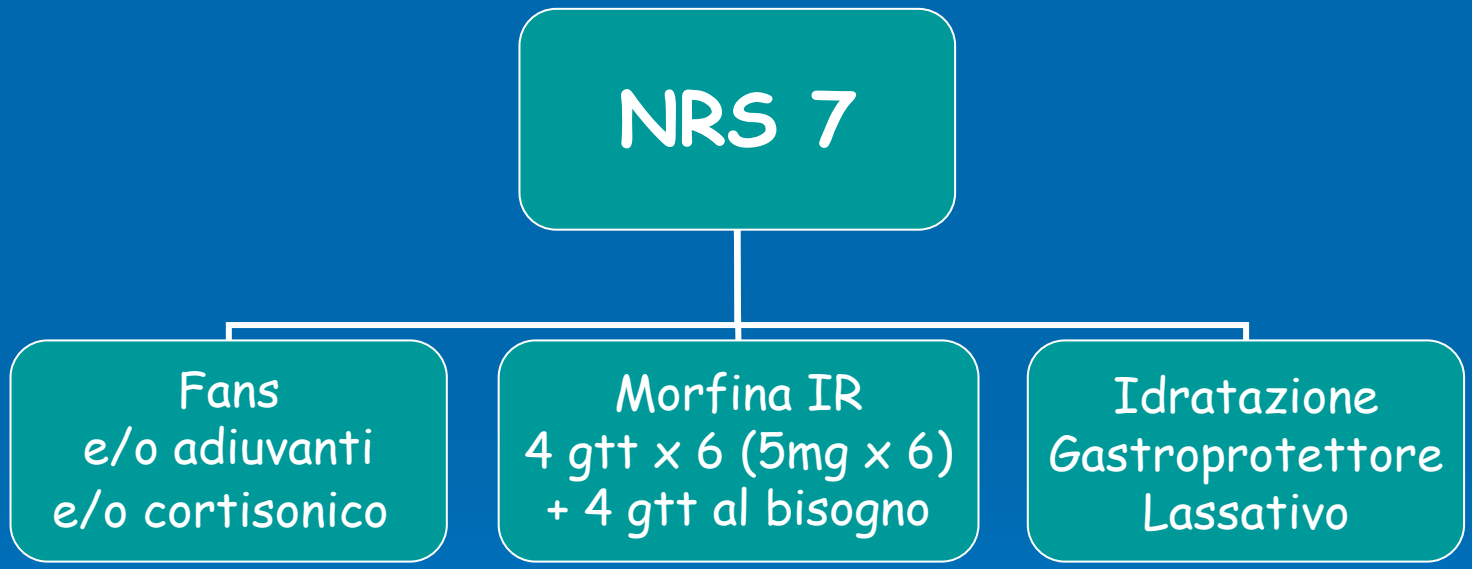
The Lancet Oncology, February 2012

RECOMMENDATION FOR OPIOID TITRATION

- The data permit a weak recommendation that immediate-release and slow-release oral formulations of morphine, oxycodone, and hydromorphone can be used for dose titration. The titration schedules for both types of formulation should be supplemented with oral immediate-release opioids given as needed.

The Lancet Oncology, February 2012

Titolazione degli oppioidi



- **RECOMMENDATION FOR THE USE OF TRANSDERMAL OPIOIDS**

- **Transdermal fentanyl and buprenorphine are alternatives to oral opioids. The data permit a weak recommendation that either drug may be the preferred step III opioid for some patients. For patients unable to swallow they are an effective, non-invasive means of opioid delivery.**

The Lancet Oncology, February 2012

- **RECOMMENDATION FOR OPIOID SWITCHING**

- **The data permit a weak recommendation that patients receiving step III opioids who do not achieve adequate analgesia and have side-effects that are severe, unmanageable, or both, might benefit from switching to an alternative opioid.**

The Lancet Oncology, February 2012

- **RECOMMENDATION FOR RELATIVE OPIOID ANALGESIC POTENCIES**

- **When switching from one opioid drug to another, dose conversion ratios can be recommended with different levels of confidence. These conversion ratios are specific for patients in whom analgesia from the first opioid is satisfactory. Therefore, when the opioid is switched because of unsatisfactory analgesia, excessive side-effects, or both, clinical experience suggests that the starting dose should be lower than that calculated from published equianalgesic ratios. In all cases the dose needs to be titrated in accordance with clinical response.**

The Lancet Oncology, February 2012

Equipotenza antalgica (equianalgesia):

DOSAGGI TERAPEUTICI EQUIVALENTI DEGLI OPPIACEI COMUNEMENTE USATI [4-7]

Idromorfone mg/die	4mg	8mg	12mg	16mg	20mg	24mg	28mg	32mg	36mg	40mg	44mg	48mg
Morfina Orale mg/die	20	40	60	80	100	120	140	160	180	200	220	240
Ossicodone mg/die	10	20	30	40	50	60	70	80	90	100	110	120
Fentanyl mcg/ora			25			50			75			100
Buprenorfina mcg/ora			35		52,5	70		87,5	105		122,5	140
Tramadolo (+Paracetamolo) mg/die	80	160	240	320	400							
Codeina (+Paracetamolo) mg/die	120	240										

NOTA: I dosaggi delle formulazioni orali sono espressi in mg/die; quelli delle formulazioni transdermiche sono espressi in mcg/ora.

4. **RCP Jurnista.**
5. A. Ordóñez Gallego et al. **Oxycodone: a pharmacological and clinical review**, *Clinical translational oncology,* 2007, vol. 9 (5), pp. 298-307.
6. S. Mercadante, **Il dolore**, *Valutazione, diagnosi e trattamento,* Ed. Masson 2005, pag. 434.
7. CH Wilder-Smith et al. **Oral tramadol, a mu-opioid agonist and monoamine reuptake-blocker, and morphine for strong cancer-related pain**, *Annals of Oncology,* 1994 Feb, vol. 5(2), pp. 41-46.

RECOMMENDATION FOR ALTERNATIVE SYSTEMIC ROUTES OF OPIOID ADMINISTRATION

- The data permit three strong recommendations: the subcutaneous route is simple and effective for the administration of morphine, diamorphine, and hydromorphone, and it should be the first choice alternative route for patients unable to receive opioids by oral or transdermal routes; intravenous infusion should be considered when subcutaneous administration is contraindicated (eg, because of peripheral oedema, coagulation disorders, poor peripheral circulation, and need for high volumes and doses); and intravenous administration should be used for opioid titration when rapid pain control is needed.
- The data permit four weak recommendations: intravenous and subcutaneous infusions can be used to achieve optimum pain control in patients unable to achieve adequate analgesia with oral and transdermal administration; techniques for patient-controlled analgesia can be adopted for subcutaneous and intravenous opioid infusions in patients who are able and willing to be in control of rescue doses; when switching from oral to subcutaneous and intravenous morphine administration, the relative analgesic potency is the same for both routes and is between 3:1 and 2:1; and, although rectal opioids are effective, appropriate formulations are often not readily available and for many patients are not acceptable, and this route of administration should be used only as a second choice.

The Lancet Oncology, February 2012

RECOMMENDATION FOR OPIOIDS FOR BREAKTHROUGH PAIN

- The data permit a strong recommendation that pain exacerbations resulting from uncontrolled background pain should be treated with additional doses of immediate-release oral opioids, and that an appropriate titration of around-the-clock opioid therapy should always precede the recourse to potent rescue opioid analgesics. Breakthrough pain (eg, incident pain) can be effectively managed with oral, immediate-release opioids or with buccal or intranasal fentanyl preparations. In some cases the buccal or intranasal fentanyl preparations are preferable to immediate-release oral opioids because of more-rapid onset of action and shorter duration of effect.
- Additionally, the data permit a weak recommendation that immediate-release formulations of opioids with short half-lives should be used to treat pre-emptively predictable episodes of breakthrough pain in the 20–30 min preceding the provoking manoeuvre.

The Lancet Oncology, February 2012

- **RECOMMENDATION FOR THE ROLE OF ADJUVANT DRUGS FOR NEUROPATHIC PAIN**

- **The data permit a strong recommendation that amitriptyline or gabapentin should be considered for patients with neuropathic cancer pain that is only partially responsive to opioid analgesia. The combination of an opioid with these drugs is likely to cause more CNS adverse events unless careful titration of both drugs is undertaken.**

The Lancet Oncology, February 2012

- **RECOMMENDATION FOR SPINAL ROUTE OF OPIOID ADMINISTRATION**

- The data permit a weak recommendation that spinal (epidural or intrathecal) administration of opioid analgesics in combination with local anaesthetics or clonidine should be considered for patients in whom analgesia is inadequate or who have intolerable adverse effects despite the optimal use of oral and parenteral opioids and non-opioid agents.

The Lancet Oncology, February 2012

Grazie per l'attenzione