

FAST FACTS AND CONCEPTS #471
ANALGESIC STRATEGIES FOR SURVIVORS OF CANCER
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Background With improvements in detection and treatment, more cancer patients are surviving their disease (1). Cancer survivorship, remission, or being cured of cancer can be defined as living cancer free for many years or even the remainder of one's life but while often still experiencing late complications of treatment (2). Around 1 in 4 of survivors of cancer (one meta-analysis suggests more than half of survivors of solid malignancy) still experience pain 3 months after completing curative treatments (3,4). This is likely because: a) many patients have preexisting non-cancer-related pain; b) many patients experience a period of significant cancer-related tissue injury that requires the use of opioid analgesics and can eventually evolve into a complex chronic pain scenario (3-6). Ambiguity may arise when cancer goes into remission about the ongoing role of opioid analgesics. Some survivors of cancer may wish to be tapered off opioids, while others are not able to be successfully tapered off opioids despite the utilization of analgesic adjuncts and other multimodal approaches (3,6). Clinicians may feel discomfort prescribing opioids for chronic non cancer related pain or even feel discomfort in determining who the right clinician would be to transition the patient's analgesic management to. Management guidelines and protocols are sparse. Depending on the resources of the clinical practice and community, finding a healthcare team who is willing to accept the patient for long term pain management can be challenging. This *Fast Fact* will offer tips on analgesic management for chronic pain in survivors of cancer.

Care coordination considerations

- Examine the pain management resources within your healthcare system. In some systems, the primary care provider may assume the ongoing analgesic management of a survivor of cancer, other patients may be referred to a pain management team, survivorship clinic, or palliative care specialist.
- Not all survivors of cancer are the same when it comes to pain etiology and management. The choice of which specialist overtakes the analgesic management therefore will also depend upon specific care considerations (e.g., a patient with severe degenerative disc disease of the spine may benefit from a pain management specialist that has a multimodal spine clinic team).
- Engage in a conversation with the new specialist to provide a warm hand-off. Inquire and be specific about what the accepting service will be willing to do (e.g., "*Will you be comfortable managing the opioids?*"). Negotiate a clear analgesic plan that anticipates common scenarios (e.g., what if the patient does not show up for the appointment). Each team should know what their specific role will be moving forward in the patient's analgesic plan.
- If there is not an available and accepting chronic pain team for survivors of cancer in your community and the treating clinicians needs clinical advice, consider collaborating with colleagues via an established pain management forum. For example, some health care systems have implemented multi-specialty "*Pain Boards*" that is much akin to a tumor board to deliberate cases in which survivors of cancer experience pervasive pain and offer best care guidance to the prescribing clinician.
- Palliative care teams also may not have the capacity to manage chronic pain in individuals whose cancer has been cured or stabilized to such a significant degree that the patient no longer has a life-limiting illness. In these cases, transition of analgesic management to a chronic pain team or primary care physician is quite common. For patients with who are not cured of cancer and continue to have a life-threatening cancer, extra consideration should be given for having them remain under palliative care for continued analgesic management and advanced care planning.

Patient care considerations

- Some survivors of cancer may be hesitant to transfer opioid management to a new clinician for various reasons. Explore these reasons, try to move at the patient's preferred pace, and always reinforce non-abandonment.
- Once the decision to transition the patient to a different service for chronic opioid management has been communicated to the patient, be clear about expectations as far as a timeline is concerned.
- Consider bridging the patient's opioid or other analgesic prescriptions while the patient is in process of reestablishing care with another medical team. This should reinforce non-abandonment.
- See *Fast Facts* #413 and 414 for tips on who and how to taper opioids.

- Recognize that not all patients will be successfully tapered off opioids. In these cases, the focus should be on finding an analgesic plan that minimizes long-term health risks and best aligns with the patient's longer-term prognosis. For example, rotating to an opioid with less long-term detrimental side effects such as buprenorphine or buprenorphine/naltrexone (Suboxone®) could be considered. See *Fast Facts* 268, 441, and 457.
- Review prior screening for opioid use disorder (OUD, see *Fast Fact* #244) and review other current markers of ongoing opioid safety (e.g., state PDMP, urine screening, unsafe opioid behaviors such as lost pills). Identify patients at higher risk for OUD and opioid misuse, especially if they are unable to be tapered off opioids. If appropriate, consider referral options to an OUD specialist.
- Consider multimodal analgesic approaches such as physical therapy, psychology, acupuncture, corticosteroid injections, nerve blocks, etc., with careful attention to evidence-based approaches that effectively address pain and help patients learn to cope with a residual amount of pain. Be mindful of insurance coverage and whether these therapies are covered or an out-of-pocket expense.
- Involve an interdisciplinary team that includes mental health specialists to help the patient reset expectations for pain control and perhaps learn to adapt to living with chronic pain.

References

1. Miller KD, Nogueira L, Devasia T, et al. Cancer treatment and survivorship statistics, 2022. *CA Cancer J Clin.* 2022;72(5):409-436. doi:10.3322/caac.21731
2. Mayer DK, Nasso SF, Earp JA. Defining cancer survivors, their needs, and perspectives on survivorship health care in the USA. *Lancet Oncol.* 2017;18(1):e11-e18. doi:10.1016/S1470-2045(16)30573-3
3. Poço Gonçalves J, Veiga D, Araújo A. Chronic pain, functionality, and quality of life in cancer survivors. *Br J Pain.* 2021;15(4):401-410. doi:10.1177/2049463720972730
4. Haenen V, Evenepoel M, De Baerdemaeker T, et al. Pain prevalence and characteristics in survivors of solid cancers: a systematic review and meta-analysis. *Support Care Cancer.* 2022;31(1):85. Published 2022 Dec 27. doi:10.1007/s00520-022-07491-8
5. Evenepoel M, Haenen V, De Baerdemaeker T, et al. Pain Prevalence During Cancer Treatment: A Systematic Review and Meta-Analysis. *J Pain Symptom Manage.* 2022;63(3):e317-e335. doi:10.1016/j.jpainsymman.2021.09.011
6. Gallaway MS, Townsend JS, Shelby D, Puckett MC. Pain Among Cancer Survivors. *Prev Chronic Dis.* 2020;17:E54. Published 2020 Jul 9. doi:10.5888/pcd17.190367

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Conflicts of Interest: The author does not have any conflicts of interest to report.

Version History: Originally edited by Sean Marks MD; first electronically published in October 2023

Fast Facts and Concepts are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-review editorial board, and are made available online by the [Palliative Care Network of Wisconsin](#) (PCNOW); the authors of each individual *Fast Fact* are solely responsible for that *Fast Fact's* content. The full set of *Fast Facts* are available at [Palliative Care Network of Wisconsin](#) with contact information, and how to reference *Fast Facts*.

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