### Synthesis Table: Integrative Modalities

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<td>Acupuncture reduce anxiety, mood disturbance, depression, fatigue, pain, QOL (C)</td>
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<td>Mustian, et al., 2012, Ex Recom, Oncol Hematol Rev, 8(2):81-8</td>
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<td>Peppone, et al., 2015, Breast Cancer Res Treat, 150, 597-604,(YOCAS®) BrstCA AI(95) TAM(72) R StdCare vs Std Care w 4wk yoga2x/wk/75m (207-2010)</td>
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<td>(breathing, 18 gentle Hatha &amp; restorative postures, meditation) reduce general pain, muscle aches &amp; physical discomfort (measure URCC SI, FACIT-F, MFSI-FS) 410 brst ca survivors; improved sleep quality, (measure PSQI)</td>
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Opioid Risk Stratification and Adherence Monitoring

**Low Risk**
- no history of alcohol abuse or drug abuse, no family history of alcohol or drug abuse
- no history of a major psychiatric disorder
- older age
- no smoking
- stable social support.

**Moderate Risk**
- remote history of alcohol or drug abuse;
- a history of addiction with a sustained period of recovery and a strong system to help sustain recovery;
- a questionable family history of alcohol or drug abuse;
- a past or current history of major psychiatric disorder that has been effectively managed
- younger age
- smoking
- history of physical or sexual abuse
- lack of social support
- involvement with others engaging in drug abuse.

**High Risk**
- a recent history, or multiple episodes, of alcohol or drug abuse
- history of addiction with limited or no system to sustain recovery
- strong family history of alcohol or drug abuse
- past or current history of major psychiatric disorder

**Risk Stratification**

**Adherence Monitoring and Mitigation**

- At least annual adherence monitoring
  - Monitoring usually should include:
    - detailed interviewing about drug-related behavior
    - questioning of family member and record review from other treating physicians,
    - check of prescription monitoring program
    - urine drug screen

- At least semi-annual adherence monitoring (more frequent at higher levels of assessed risk);
  - Monitoring usually should include:
    - detailed interviewing about drug-related behavior
    - questioning of family member and record review from other treating physicians,
    - check of prescription monitoring program
    - urine drug screen

- At least every 2-3 months adherence monitoring and more frequent visits
  - Monitoring usually should include:
    - detailed interviewing about drug-related behavior
    - questioning of family member and record review from other treating physicians,
    - check of prescription monitoring program
    - urine drug screen
    - pill counts

**Respond to Aberrant Behaviors**

- re-consideration of treatment to determine whether non-opioid therapies can be better
- re-consideration of treatment to determine whether non-opioid therapies can be better
- re-consideration of treatment to determine whether non-opioid therapies can be better

- Refills limited or not permitted
- Small frequent prescriptions
- No concurrent use of more than one opioid (e.g., no prescription of a second short-acting drug for breakthrough pain in those prescribed a long-acting drug for daily use)
- Mandated consultation with addiction specialists/psychiatrist

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Integrative Non-Pharmacologic Modalities for Chronic Cancer Patients

The James OP Palliative Medicine Clinic

- Conversion in 2005 to Palliative
- Primarily Pain and Symptom management
- Advance Directives and Goals of Care
- 2 Physicians, 2 NPs, 1SW, 1PharmD, 3 RNs, 1PCA, 1Psychologist

Objectives

- Brief review of The James OP Palliative Clinic as it dovetailed with the opioid epidemic.
- Review of ASCO Clinical Practice Guidelines Management of Chronic Pain in Adult Survivors of Cancer
- Discuss Non-Pharmacologic Modalities for chronic pain management with cancer survivors.
**Addiction**

- Chronic neurobiologic disease characterized by behaviors of compulsive use, impaired control over use, continued use despite harm, & cravings.
- Impaired function
- Goal to obtain medication to relieve physical effects of craving

**Dependence**

- State of adaptation; class specific withdrawal symptoms from abrupt discontinuation or reduction in dose or drug blood level
- Wean doses over time
- Physical Dependence does not equate to addiction.
Tolerance

- State of adaptation in which long exposure results in diminution of one or more of the drug’s effects
- More common with chronic pain
- Consider opioid induced hyperalgesia (an exaggerated sense of pain)
- Treat:
  - lower opioid doses
  - NMDA receptor trial

ASCO Chronic Pain in Survivors of Adult Cancers
Opioid Risk Assessment

ASCO Chronic Pain in Survivors of Adult Cancers
Opioid Risk Assessment

Risk Assessment for Opioid Initiation

- Consider non-pharmacologic therapies alone or in combination with opioids
- Consider non-opioid therapies such as NSAIDS or Acetaminophen or other adjuvant analgesics such as antidepressants, anticonvulsants for neuropathic pain, or topical analgesic compounds
- Consider an Opioid Abuse Risk Screening Tool (ORT)

Universal Precautions for Opioid Use

- Review state prescription drug monitoring program (OARRS) for controlled substance use
- Baseline Urine Drug Testing followed by minimally annually and PRN
- Avoid opioids and benzodiazepines concurrently when possible.
- Consider a controlled medication management agreement.

Risk of Opioid Abuse Assessment

- Consider validated screening tool
  - SOAPP-R
  - COMM
  - PDUQ
- Determine Risk Level—Low, Moderate, High
- Decision to prescribe opioids

Minimize Risk

- Optimize adjuvants, non-pharmacologic and interventional modalities, & psychosocial support
- Monitor 5 A’s
  - Analgesia
  - Adverse Effects
  - ADLs
  - Affect
  - Aberrant Behavior
- Respond to aberrant behavior

ASCO Chronic Pain in Survivors of Adult Cancers
Non-Pharmacologic Interventions

- Conversion in 2005 to Palliative
- Primarily Pain and Symptom management
- Advance Directives and Goals of Care
- 3 Physicians, 4 NPs, 1SW, 1PharmD, 5 RNs, 1PCA, 1 PharmTech
- Survivorship Clinic-Oncology PT/OT; PMR; Psychosocial-Oncology; Massage; Acupuncture; Music & Art Therapy
- Integrative Medicine
- FY 2017 4,044 visits
- FY 2018 July-April 4,290 visits

The James OP Palliative Medicine Clinic

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Non-Pharmacologic Modality-PMR/Interventional

- Physical/Occupational Therapy
- Individual Exercise Program
- Nerve blocks
- Neuraxial Infusions (epidural/intrathecal)

Non-Pharmacologic Modality-Psychological

- Cognitive Behavioral Therapy
- Mindfulness
- Relaxation/Guided Imagery

Non-Pharmacological Modality-Integrative

- Massage
- Acupuncture
- Music
- Yoga

Yoga

Synthesis Table

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Lyman, et al., 2018: (A) high certainty net benefit substantial; (B) high to moderate certainty net benefit moderate to substantial; (C) selectively offer or provide based on clinical judgment or patient preference.

Paice, et al., 2016: (MA = meta-analysis, SR = systematic review)

Exercise & PT improved pain small significant; improve physical function, no (A) moderate; benefits outweigh harms, no weak.

Acupuncture improved pain (2MA, 3SR), benefits outweigh harm, no weak.

Massage improved pain (2MA, 3SR), benefits outweigh harm, no weak

Music, pain improve weak, benefit outweigh harm, no weak.
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### Stretch Break

**Yoga**

![Yoga Image](image)

### Questions and Answers


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| Screening and   | Clinicians should screen for pain at each encounter. Screening should be performed and documented using a quantitative or semi-quantitative tool.                                                                     | Type: Informal consensus; benefits outweigh harms  
Evidence quality: Insufficient  
Strength of Recommendation: Strong                                                                 |
| Comprehensive   |                                                                                                                                                                                                                 |------------------------------------------------------------------------------------------------------|
| Assessment      | Clinicians should conduct an initial comprehensive pain assessment. This assessment should include an in-depth interview, which explores the multidimensional nature of pain (pain descriptors, associated distress, functional impact and related physical, psychological, social and spiritual factors) and captures information about cancer treatment history and co-morbid conditions, psychosocial and psychiatric history (including substance use), and prior treatments for the pain. The assessment should characterize the pain, clarify its etiology and make inferences about pathophysiology. A physical examination should accompany the history and diagnostic testing should be done when warranted. | Type: Informal consensus; benefits outweigh harms  
Evidence quality: Insufficient  
Strength of Recommendation: Moderate                                                                 |
|                 | Clinicians should be aware of chronic pain syndromes resulting from cancer treatments, their prevalence, risk factors for individual patients, and appropriate treatment options.                                      | Type: Informal consensus; benefits outweigh harms  
Evidence quality: Insufficient  
Strength of Recommendation: Moderate                                                                 |
MANAGEMENT OF CHRONIC PAIN IN SURVIVORS OF ADULT CANCERS: AMERICAN SOCIETY OF CLINICAL ONCOLOGY CLINICAL PRACTICE GUIDELINE

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<td>Clinicians should evaluate and monitor for recurrent disease, second malignancy or late onset treatment effects in any patient who reports new onset pain.</td>
<td>Type: Informal consensus; benefits outweigh harms E Evidence quality: Insufficient Strength of Recommendation: Moderate</td>
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<td>Clinicians should aim to enhance comfort, improve function, limit adverse events and ensure safety in the management of pain in cancer survivors.</td>
<td>Type: Informal consensus; benefits outweigh harms E Evidence quality: Insufficient Strength of Recommendation: Moderate</td>
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<td>Clinicians should engage patient and family/caregivers in all aspects of pain assessment and management.</td>
<td>Type: Informal consensus; benefits outweigh harms E Evidence quality: Insufficient Strength of Recommendation: Moderate</td>
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<td>Clinicians should determine the need for other health professionals to provide comprehensive pain management care in patients with complex needs. If deemed necessary, the clinician should define who is responsible for each aspect of care and refer patients accordingly.</td>
<td>Type: Informal consensus; benefits outweigh harms E Evidence quality: Insufficient Strength of Recommendation: Moderate</td>
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**Non-Pharmacologic Interventions**

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<td>Clinicians may prescribe directly or refer to other professionals to provide interventions, in disciplines such as physical medicine and rehabilitation, integrative therapies, interventional therapies, psychological approaches, and neurostimulatory, to mitigate chronic pain or improve pain-related outcomes in cancer survivors. The use of these interventions must consider pre-existing diagnoses and comorbidities and should include an assessment for adverse events.</td>
<td>Type: Evidence-based; benefits outweigh harms E Evidence quality: Intermediate Strength of Recommendation: Moderate</td>
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### Pharmacologic Interventions

**Clinical Domain**

**Recommendation**

**Evidence Rating**

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| **Pharmacologic Interventions** | Clinicians may prescribe the following systemic non-opioid analgesics, and adjuvant analgesics to relieve chronic pain and/or improve function in cancer survivors where no contraindications exist including serious drug-drug interactions:  
- NSAIDS  
- Acetaminophen (Paracetamol)  
- Adjuvant analgesics, including selected antidepressants and selected anticonvulsants with evidence of analgesic efficacy (such as the antidepressant duloxetine and the anticonvulsants gabapentin and pregabalin) for neuropathic pain conditions or chronic widespread pain | Type: Evidence-based; benefits outweigh harms  
Evidence quality: Intermediate  
Strength of Recommendation: Moderate                                                                 |
|                 | Clinicians may prescribe topical analgesics (such as commercially available NSAIDS, local anesthetics, or compounded creams/gels containing baclofen, amitriptyline and ketamine), for the management of chronic pain. | Type: Evidence-based; benefits outweigh harms  
Evidence quality: Intermediate  
Strength of Recommendation: Moderate                                                                 |
|                 | Corticosteroids are not recommended for long term use in cancer survivors solely to relieve chronic pain.                                                                                                      | Type: Evidence-based; harms outweigh benefits  
Evidence quality: intermediate  
Strength of Recommendation: Moderate                                                                 |
|                 | Clinicians should assess risks for adverse effects of pharmacologic therapies used for pain management, including non-opioids, adjuvant analgesics and other agents.                                             | Type: Evidence-based and Informal consensus; benefits outweigh harms  
Evidence quality: Intermediate  
Strength of Recommendation: Moderate                                                                 |
|                 | Clinicians may follow specific state regulations that allow access to medical cannabis or cannabinoids for patients with chronic pain after a consideration of the potential benefits and risks of the available formulations. | Type: Evidence-based; benefits outweigh harms  
Evidence quality: Intermediate  
Strength of Recommendation: Moderate                                                                 |
### MANAGEMENT OF CHRONIC PAIN IN SURVIVORS OF ADULT CANCERS:
**AMERICAN SOCIETY OF CLINICAL ONCOLOGY CLINICAL PRACTICE GUIDELINE**

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|                                                                                | Clinicians may prescribe a trial of opioids in carefully selected cancer survivors with chronic pain who do not respond to more conservative management and who continue to experience pain-related distress or functional impairment. Non-opioid analgesics and/or adjuvants can be added as clinically necessary. | Type: Evidence-based; benefits outweigh harms  
Evidence quality: Intermediate  
Strength of Recommendation: Moderate |
|                                                                                | Clinicians should assess risks for adverse effects of opioids used for pain management.                                         | Type: Evidence-based and Informal consensus; benefits outweigh harms  
Evidence quality: Intermediate  
Strength of Recommendation: Moderate |
| **Risk Assessment, Mitigation and Universal Precautions with Opioid Use**       | Clinicians should assess the potential risks and benefits when initiating treatment that will incorporate long term use of opioids. | Type: Informal consensus; benefits outweigh harms  
Evidence quality: Insufficient  
Strength of Recommendation: Moderate |
|                                                                                | Clinicians should clearly understand terminology such as tolerance, dependence, abuse and addiction as it relates to the use of opioids for pain control. | Type: Informal consensus; benefits outweigh harms  
Evidence quality: Insufficient  
Strength of Recommendation: Moderate |
|                                                                                | Clinicians should incorporate a “universal precautions” approach to minimize abuse, addiction and adverse consequences of opioid use such as opioid-related deaths. Clinicians should be cautious in co-prescribing other centrally-acting drugs, particularly benzodiazepines. | Type: Evidence-based and Informal consensus; benefits outweigh harms  
Evidence quality: Intermediate  
Strength of Recommendation: Moderate |
|                                                                                | Clinicians should understand pertinent laws and regulations regarding prescribing controlled substances.                       | Type: Informal consensus; benefits outweigh harms  
Evidence quality: Insufficient  
Strength of Recommendation: Moderate |
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|                 | Clinicians should educate patients and family members regarding the risks and benefits of long-term opioid therapy, safe storage, use and disposal of controlled substances. Clinicians are encouraged to address possible myths and misconceptions about medication use and should educate patients about the need to be cautious when using alcohol or sedating over-the-counter medications, or in taking centrally-acting medications from other physicians. | Type: Informal consensus; benefits outweigh harms  
Evidence quality: Insufficient  
Strength of Recommendation: Moderate                                                                                                                   |
|                 | If opioids are no longer warranted, clinicians should taper the dose to avoid abstinence syndrome. The rate of tapering and use of co-therapies to reduce adverse effects should be individualized for each patient.                                    | Type: Evidence-based and Informal consensus; benefits outweigh harms  
Evidence quality: Intermediate  
Strength of Recommendation: Moderate                                                                                                                     |
Universal Precautions in Chronic Cancer Pain Management

1. Assess and stratify risk of opioid misuse
   - Review of medical records including diagnosis
   - Interview (consider risk factors such as age, personal or family history of alcohol or drug abuse, major psychiatric disorder, history of sexual abuse)
   - Examination
   - Screening questionnaires
   - Review of Prescription Drug Monitoring Program data
   - Urine drug screening
   - Risk of diversion:
     - Low \(\rightarrow\) prescribe
     - High \(\rightarrow\) do not prescribe

2. Decide whether to prescribe or not
   - Risk of drug abuse:
     - Low \(\rightarrow\) prescribe
     - Moderate or High \(\rightarrow\) decision to prescribe requires a critical analysis of:
       - Whether the severity of the pain is meaningful to the patient, and physical or mental well-being,
       - Whether there are reasonable alternatives that may ameliorate pain with manageable risk, and
       - Whether the nature of the drug abuse risk is more (e.g., relapse of heroin abuse) or less (e.g., pattern of early refills) serious

3. Minimize Risk
   - Structure treatment in a manner that:
     - Establishes an appropriate level of adherence monitoring and
     - Helps patients avoid non-adherence
   - Always optimize adjuvant analgesics, nonpharmacologic and interventional approaches; psychological support for treatment of psychiatric illness, anxiety, depression, sleep disorders
   - Effectiveness (pain is described as less intense, with a relationship to dose and dosing that is expected, and the pain reduction is associated with the ability to sustain or improve physical or psychological functioning
   - Adverse effects
   - Adherence monitoring, including compliance with current analgesic and non-opioid analgesic treatments, based on risk assessment

4. Monitor drug-related behaviors
   - Effectiveness (pain is described as less intense, with a relationship to dose and dosing that is expected, and the pain reduction is associated with the ability to sustain or improve physical or psychological functioning
   - Adverse effects
   - Adherence monitoring, including compliance with current analgesic and non-opioid analgesic treatments, based on risk assessment

5. Respond to aberrant behaviors
   - Reassess and diagnose
     - Realize that aberrant drug-related behaviors have a differential diagnosis and that an assessment must be done to clarify whether behavior indicates addiction, other psychiatric condition associated with impulsive drug use, family issues, desperation or impulsivity driven by uncontrolled pain, or some combination of these factors. Also recognize that diversion is possible and assess for this behavior.
   - Consider whether to continue prescribing
     - If diversion is occurring or risks now exceed benefit, taper and discontinue
   - If diversion is not occurring and the assessment suggests that the benefits of therapy will continue to outweigh the risk if the aberrant behaviors are stopped, restructure prescribing to increase control and adherence monitoring
     - Avoid agents with higher abuse liability
     - Prescribe small amounts at short intervals
     - Review prescription drug monitoring data routinely
     - Employ pill counts
     - Monitor use of substances through urine/other toxicology screening
     - Require use of one pharmacy
     - Use written agreement
     - Obtain consultation from psychiatry/addiction specialists


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