Royal United Hospitals Bath NHS
NHS Foundation Trust

Managing symptoms in advanced carcinoma of the prostate

Rachel Davis

Cancer of the prostate

- Second highest cancer mortality after lung cancer
- 20-30% will have advanced disease at diagnosis
- Metastatic spread will be most likely to the bones, other sites include lymph nodes, liver and lungs
- Patients experience a variety of symptoms which impact on their quality of life
- Palliative care aims to relieve pain and other symptoms. It also provides emotional, physical, practical and spiritual support.
- Palliative care can be provided at any stage of advanced prostate cancer.

Symptoms in advanced disease

Symptoms can be caused by the cancer itself, or metastases, or other co-morbidities

- Pain
- Fatigue
- Lower urinary tract symptoms
- Malignant spinal cord compression
- Lymphoedema
- Psychological

Pain

Pain is whatever the person says it is and exists whenever the person says it does

Pain- assessment

- Remember that not all pains are caused by cancer
- Consider the following

- The site of the pain
- The patients' description of the pain
- The severity of the pain
- What makes the pain better
- What exacerbates the pain
- Is sleep affected
- What effect does the pain have on the patients' quality of life
- What have they tried to help the pain
- How does the pain affect the patients' psychological state

Factors that lower pain threshold

- Insomnia
- Fatigue
- Anxiety
- Fear
- Anger
- Sadness/depression
- Boredom
- Social isolation

Factors that increase pain threshold

- Relief of symptoms- analgesics, anxiolytics, antidepressants
- Sleep
- Creative activity
- Relaxation
- Distraction
- Understanding
- Companionship
- Reduction in anxiety
- Elevation of mood

Patient related factors influencing pain

Ineffectual reporting of pain due to

- Desire to focus on treatment
- Stoicism
- Desire to please healthcare professional
- Use of pain to see whether the disease has progressed

Principles of managing pain

- Accurate assessment and continual reassessment
- Selection of the most appropriate analgesic
- Regular dosing and breakthrough management
- Give by the clock
- Selection of adjuvant therapies where relevant
- Management of side effects
- Optimise dose and timings of current analgesics before switching to an alternative
- Information and explanation with the patient and family

Bone pain (somatic)

How does the patient describe the pain	What is the pain responsive to	Examples
Continuous ache Tender to pressure	NSAIDs –naproxen ibuprofen Opioids can only be partly responsive	Metastases
Worse on movement Localised	radiotherapy	
Dull pain	Bisphosphonates	

Neuropathic (Nerve) pain

How does the patient describe the pain?	What relieves the pain	Examples
Burning, stabbing, shooting, stinging Intermittent Not movement related Allodynia Sensory deficit	Antidepressants Anticonvulsants TENS Nerve blocks Steroids	Nerve compression Spinal cord compression Peripheral neuropathy

Visceral (soft tissue) pain

How does the patient describe the pain	What relieves the pain	Examples
Dull, aching, cramping, deep, constant, sore Not usually related to movement	Analgesic ladder Weak opioids titrated to strong opioids	Tumor infiltration Localised disease and compression of surrounding structures

Total pain

Physical

Cancer

Side effects of treatment

Non cancer pathology

Insomnia and fatigue

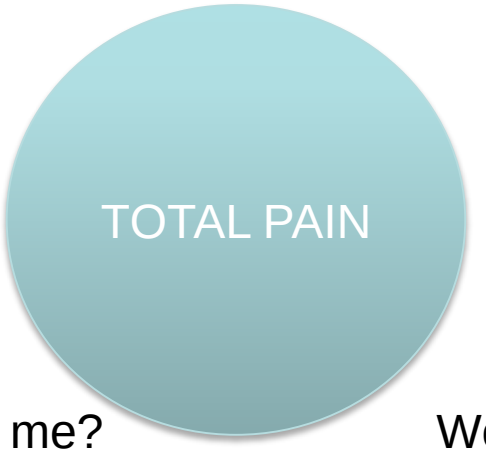
Psychological

Delays in diagnosis

Anger

Fear of pain or of death

Meaning of the pain



Spiritual

Why has this happened to me?

What is the point of it all?

Is there any purpose or meaning in life?

Why am I left to suffer like this?

Is this my fault?

Social

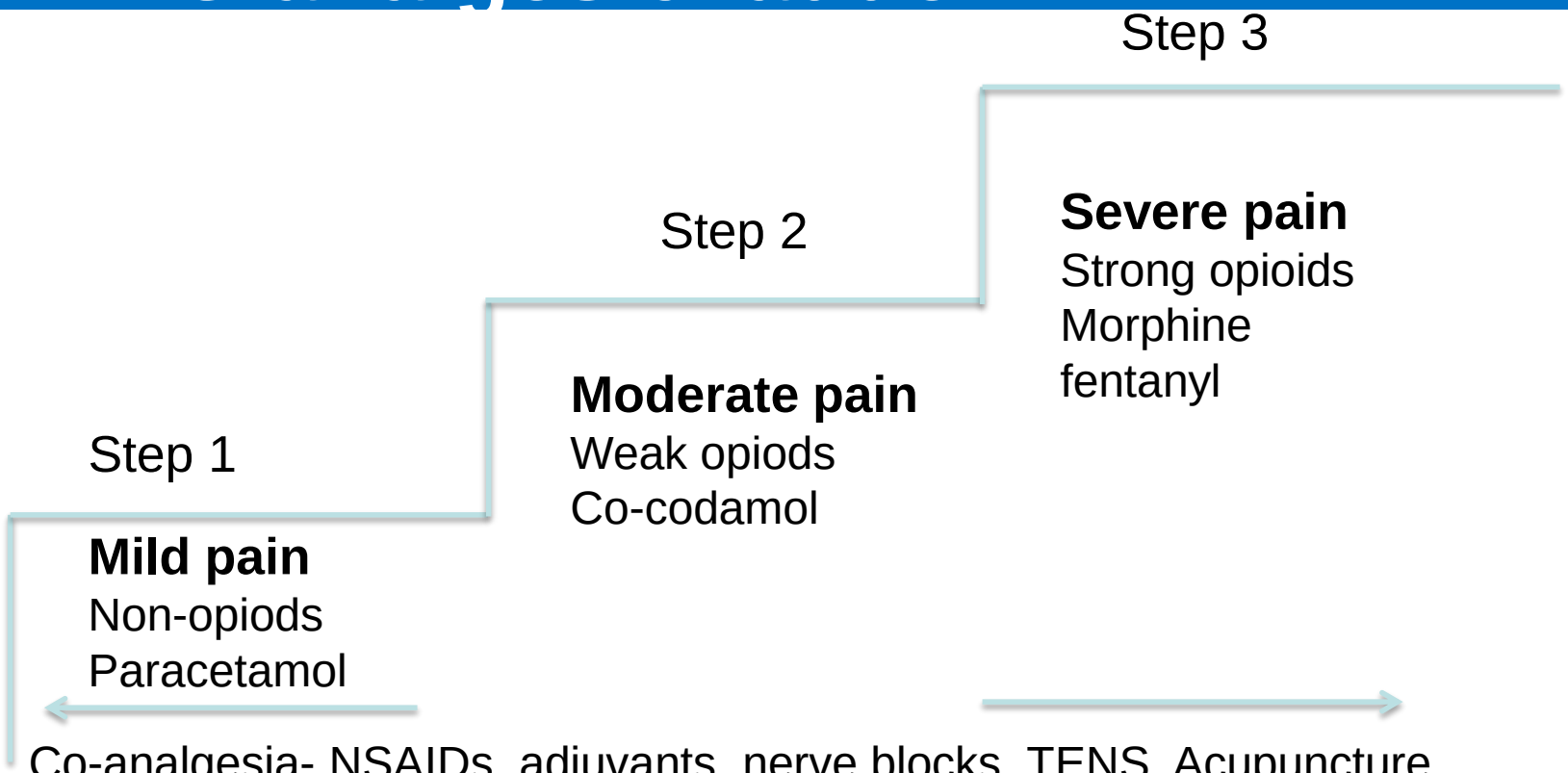
Worry about family and finances

Loss of job, role and income

Loss of social position

Feelings of abandonment and isolation

WHO analgesic ladder



Co-analgesia- NSAIDs, adjuvants, nerve blocks, TENS, Acupuncture

Specific therapies- Radiotherapy, Chemotherapy,

Address Psychological Issues

Adjuvant treatments

Bone pain

Radiotherapy

NSAIDs

Bisphosphonate

Heat

Give medication prior to movement

Muscle relaxant eg. diazepam

Nerve Pain

Gabapentin

TENs

Referral to pain clinic for nerve block

Visceral pain

Steroids

If liver capsule pain consider steroids

For all pains

Relaxation/distraction

Psychological support

Opiates

- If used appropriately for pain morphine is not addictive
- No maximum dose- it is what the patient requires
- But not all pains are relieved by opioid analgesics
- All analgesics are constipating
- May cause nausea or even vomiting when first commenced
- Stigma attached to taking morphine
- Tolerance to morphine does not exist
- Reduce dose in the frail elderly

Fatigue

A persistent feeling of physical, emotional or mental tiredness or exhaustion

Symptoms of fatigue

- Lack of energy
- Feeling unmotivated or lack of interest in aspects of life
- Insomnia
- Difficulty in getting up in the morning
- Feeling anxious or depressed
- Breathless on exertion
- Difficulty concentrating

Fatigue in cancer of the prostate

Surveys of patients with metastatic disease suggest that the prevalence of fatigue exceeds 75% (2015)

Potentially reversible causes of fatigue are

- Anaemia
- Depression
- Poor sleep patterns
- Early signs of hypercalcaemia
- Infection
- Medications
- Renal failure

Management of fatigue

- Assessment - is the fatigue acute or chronic
  - how much fatigue interferes with daily life
- Use of equipment to minimise everyday tasks
- Advice regarding modification of activity and rest patterns- exercise may be helpful
- Steroids may help with poor appetite
- Ensure adequate sleep
- Support for anxiety and low mood- eg. distraction
- Nutritional advice and support
- Blood transfusions- limited benefit in advanced disease

Lower urinary tract symptoms

- Incomplete emptying
- Frequency
- Intermittency
- Urgency
- Weak stream
- Straining
- Nocturia
- Sexual dysfunction

Management of symptoms

Key themes

- Holistic assessment
- Treatment of potential reversible cause

Malignant Spinal Cord compression

Symptoms that may indicate MSCC

- Known bone metastases, especially spinal mets
- Increased pain or persistent pain
- Altered or odd sensations in legs
- Altered gait
- Leg weakness
- Urinary hesitancy
- Altered bowel habit

Management of spinal cord compression

Diagnosis

- MRI
- Clinical history

Treatment- Oncological emergency

- Steroids
- Radiotherapy
- Pain management
- Rehabilitation
- Psychological adjustment

Lymphoedema

Poor drainage of lymph caused by

- Lymph node metastases
- Radiotherapy
- Contributing factors

  -Poor nutrition- low albumin

  -Advancing disease and immobility

Effects of lymphoedema

Effects on the skin

- Persistent swelling of all or part of the limb
- Genital and truncal oedema
- Distorted limb shape
- Lymphorrhoea
- Risk of infection- cellulitis

Other effects

- Pain or discomfort
- Effects on reducing mobility
- Psychological effect

Management of lymphoedema

In advanced disease it may not be possible to reduce the size of the limb

Consider the following to prevent deterioration and relieve discomfort

- Skin care- dressings if lymphorrhoea present
- Soft bandaging- possible massage if patient well enough and use of hosiery for lower limb oedema
- Compression garments for genital oedema
- Elevation and positioning
- Gentle exercise, aids for walking and dressing
- Diuretics- limited benefit
- Education of the patient and carer

Psychological distress

‘is a multi-factoral unpleasant emotional experience of a psychological, social and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment

Assessment of distress

Scale of distress from

- Sadness
- Anger
- Fear for the future
- Feelings of vulnerability
- Feeling out of control
- Experiencing symptoms of poor sleep, appetite or ability to concentrate

To

- Depression
- Anxiety
- Panic
- Spiritual crisis
- Social isolation
- Despair and hopelessness

Tools for measuring distress

- Hospital anxiety and distress scale
- Distress thermometer

Patients are asked to rate their global distress ranging from 0-10

Alternatively, explore their distress in relation to

- Physical problems eg. Housing, transport, work
- Family problems
- Emotional problems
- Spiritual/religious concerns
- Physical symptoms

Management of distress

- Support
- Help with practical problems
- Pastoral support
- Open communication-picking up cues and not avoiding issues eg. End of life care
- Relaxation techniques
- Distraction
- Symptom management
- Medication for panic eg. benzodiazepines

Case studies

A 76 year old gentleman with a diagnosis of cancer of the prostate, known to have bony metastases, admitted to hospital with in increasing pain. He also was experiencing persistent vomiting secondary to increasing MST dose which means that he cannot take his oral medication.

His medication is MST 100mg (increased over the last few days from 40mg), Lanzaprozole 15mg, Temazepam 10mg nocte and Gabapentin 300mg tds

On admission to hospital he was found to be in acute renal failure

MRI has shown disease progression

Key issues

- Rapid increase in opiates
- Increasing pain- need to establish if this is bone pain
- Check that the cause of vomiting is increase in opiates
- Not tolerating oral medication- vomiting
- Poor renal function

Management plan

- Regular anti-emetics
- Reduce morphine

- Consider alternative management of bone pain eg. Radiotherapy, paracetamol, fentanyl, heat, steroids, reduce activity that increases pain, ?NSAIDS

Opiates in renal impairment

Avoid

- codeine

Use in caution

- Tramadol
- Morphine and diamorphine- may be fairly safe in low doses
- Hydromorphine
- Oxycodone

Use

- Fentanyl- short acting synthetic morphine
- Alfentanil
- Buprenorphine eg. butrans

Case study

80 year old gentleman admitted to hospital with increasing frailty and reports that his wife has found it increasingly hard to manage his care at home. He is fatigued, with poor appetite and bilateral leg oedema.

He is found to have a low blood albumin level and Hb of 70

Key issues

- Anaemia
- Frailty
- Fatigue
- Lymphoedema
- Social issues
- Poor appetite

Management plan

- Consider blood transfusion
- Nutritional supplements
- Skin care and elevation of limbs
- Consider steroids for appetite
- Occupational therapy and physiotherapy assessment
- Review of care at home
- Support for patient and his wife

Case study

50 year old gentleman admitted with increasing back pain and an intermittent burning pain radiating down his left leg. He complains of insomnia, and family are very concerned that he seems low in mood. He has not had his bowels open for about a week. He was working up until 2 weeks ago.

Key issues

- Pain
- Changes in bowel habit
- Poor mood
- Insomnia
- Family distress

Management plan

- Neurological exam- consider MSCC
- If suspected MSCC- steroids and MRI
- Urgent Radiotherapy
- Pain relief- morphine, NSAIDs, gabapentin
- Laxatives for constipation
- Night sedation
- Support- Attention to loss of role and loss of control
- Family support

Thank you

Any questions