Synthesis Table Integrative Modalities

Article	Exercise	Acupuncture	Massage	Yoga	Music
Lyman, et al., 2018, SICO CPG, JCO, 36(25), 2647-2655 (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		Acupuncture reduce anxiety, mood disturbanc, depression, fatigue, pain, QOL (C)	Massage reduce anxiety (C), mood disturbanc (B)	Yoga reduce anxiety, mood disturbance, depression, QOL (B), fatigue, sleep (C)	Music Therapy reduce anxiety, mood disturbanc (B), pain (C)
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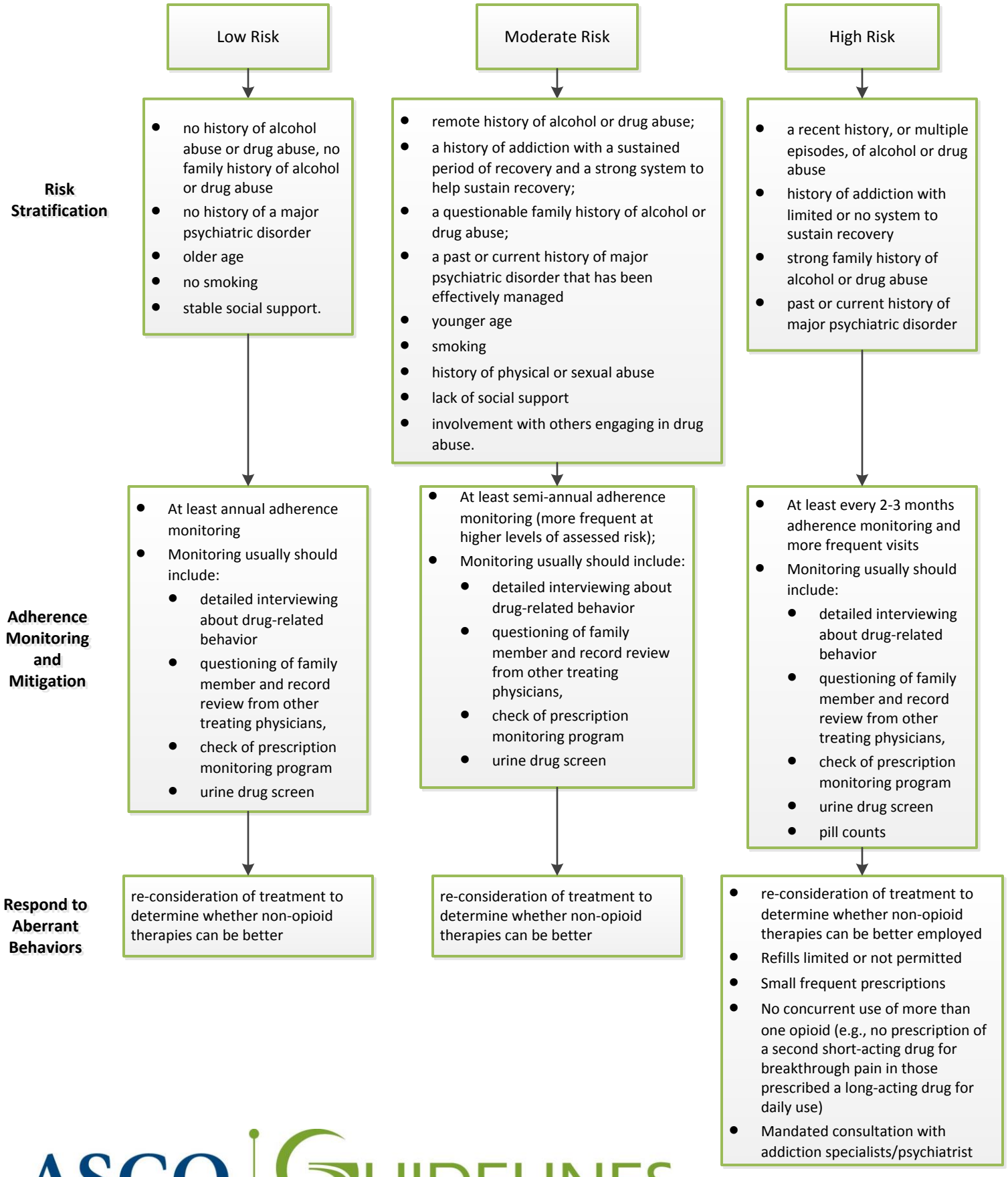
Paice, et al., 2016, ASCO CPG, JCO, 34(27), 3325-3347 (MA=meta-analysis,SR=systematic review)	Ex & PT improved pain small significant; improve physical function; rec moderate	Acupuncture improved pain (2MA, 3SR) benefits outweigh harm; rec weak	Massage improved pain (2MA, 3SR); benefits outweigh harm; rec weak		Music pain improve weak; benefit outweighs harm, rec weak
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)				(breathing, 18 gentle Hatha & restorative postures, meditation) reduce general pain, muscle aches & physical discomfort (measure URCC SI, FACIT-F, MFSI-FS)	
Mustian, et al., 2013, J Clin Oncol 31:3233-3241(YOCAS®)				410 brst ca survivors; improved sleep quality, (measure PSQI)	
Hershman, et al., 2018, JAMA, 320(2), 167-176 (11 acad centers, R true acupuncture-110; Sham Acup-59; waitlist control-57)		Post-men women, early Brest Ca, AI arthralgias; 6 & 12 wk BPI-WP score reduced 2 points (av pain) true acupuncture; 1.07 points sham; .99 points waitlist; true vs sham (95%CI, 0.20-1.65; P = .01); True vs waitlist (95% CI, 0.24-1.67; P = .01)			
Shin, et al., 2016, Cochrane			Massage with or without aromatherapy 19 studies, total 1274 participants, very low quality evidence reduce pain, anxiety, improve QOL; uncertain to high risk of bias		

Opioid Risk Stratification and Adherence Monitoring

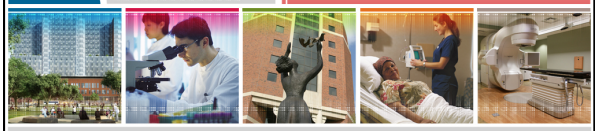


ASCO GUIDELINES

The James

The Ohio State University Comprehensive Cancer Center

Integrative Non-Pharmacologic Modalities for Chronic Cancer Patients



Creating a cancer-free world. *One person, one discovery at a time.*

Kimberly A Frier, MSN, APRN, FNP-BC, ACHPN, Palliative Medicine NP

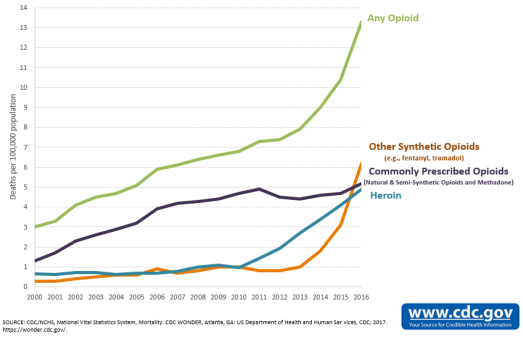
Objectives

- 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.

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

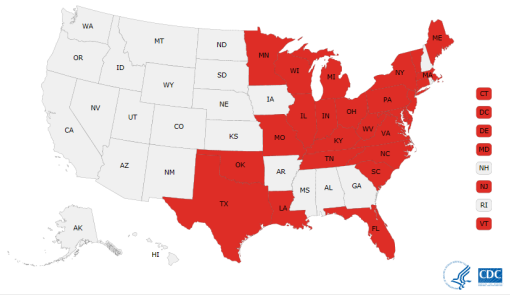
Overdose Deaths Involving Opioids, United States, 2000-2016



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Ser vices, CDC; 2017. https://wonder.cdc.gov/.

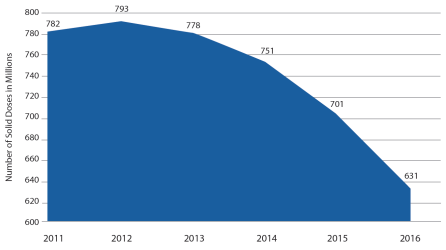
www.cdc.gov
Your Source for Credible Health Information

Statistically significant drug overdose death rate increase from 2015 to 2016, US states



OHIO Opioid Prescribing, 2011-2016

Figure 6. Opioid Solid Doses Dispensed to Ohio Patients, by Year, 2011-2016



Source: State of Ohio Board of Pharmacy, Ohio Automated Rx Reporting System.

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

The James
The Ohio State University Comprehensive Cancer Center

Paice, J. A., et al., (2016). Management of chronic pain in survivors of adult cancer: American society of clinical oncology clinical practice guideline. *Journal of Clinical Oncology*, 34(27), 3325-3347.

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

The James
The Ohio State University Comprehensive Cancer Center

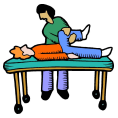
Paice, J. A., et al., (2016). Management of chronic pain in survivors of adult cancer: American society of clinical oncology clinical practice guideline. *Journal of Clinical Oncology*, 34(27), 3325-3347.

The James OP Palliative Medicine Clinic

- 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

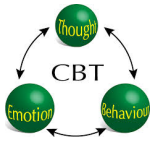
Non-Pharmacologic Modality-PMR/Interventional

- 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

Synthesis Table

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Stretch Break

Yoga

Questions and Answers

References

Integrative Non-Pharmacologic Modalities for Chronic Cancer Patients

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Eccleston C, Fisher E, Thomas KH, Hearn L, Derry S, Stannard C, Knaggs R, Moore RA. (2017). Interventions for the reduction of prescribed opioid use in chronic non-cancer pain. ***Cochrane*** *Database of Systematic Reviews*, Issue 11. Art. No.: CD010323. DOI: 10.1002/14651858.CD010323.pub3.

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Mustian KM, Sprod L, Janelsins M, Peppone LJ, Palesh OG, …Murrow GR. (2013). Multicenter, randomized controlled trial of yoga for sleep quality

among cancer survivors. *Journal of Clinical Oncology*, 31(26), 3233-3241. DOI: 10.1200/JCO.2012.43.7707.

Mustian KM, Sprod L, Janelsins M, Peppone LJ, & Mohile MD. (2012). Exercise recommendations for cancer-related fatigue, cognitive impairment, sleep problems, depression, pain, anxiety, and physical dysfunction: A review. Oncology & Hematology Review, 8(2), 81-88. DOI: 10.17925/OHR.2012.08.2.81.

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ASCO GUIDELINES

MANAGEMENT OF CHRONIC PAIN IN SURVIVORS OF ADULT CANCERS: AMERICAN SOCIETY OF CLINICAL ONCOLOGY CLINICAL PRACTICE GUIDELINE		
Clinical Domain	**Recommendation**	**Evidence Rating**
Screening and Comprehensive Assessment	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
	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		
Clinical Domain	**Recommendation**	**Evidence Rating**
	Clinicians should evaluate and monitor for recurrent disease, second malignancy or late onset treatment effects in any patient who reports new onset pain.	Type: Informal consensus; benefits outweigh harms Evidence quality: Insufficient Strength of Recommendation: Moderate
Treatment and Care Options	Clinicians should aim to enhance comfort, improve function, limit adverse events and ensure safety in the management of pain in cancer survivors.	Type: Informal consensus; benefits outweigh harms Evidence quality: Insufficient Strength of Recommendation: Moderate
	Clinicians should engage patient and family/caregivers in all aspects of pain assessment and management.	Type: Informal consensus; benefits outweigh harms Evidence quality: Insufficient Strength of Recommendation: Moderate
	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.	Type: Informal consensus; benefits outweigh harms Evidence quality: Insufficient Strength of Recommendation: Moderate
	Non-Pharmacologic Interventions	
	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.	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		
Clinical Domain	**Recommendation**	**Evidence Rating**
	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		
Clinical Domain	**Recommendation**	**Evidence Rating**
	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

MANAGEMENT OF CHRONIC PAIN IN SURVIVORS OF ADULT CANCERS: AMERICAN SOCIETY OF CLINICAL ONCOLOGY CLINICAL PRACTICE GUIDELINE		
Clinical Domain	**Recommendation**	**Evidence Rating**
	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

Assess

-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

2. Decide whether to prescribe or not

Risk of diversion:
Low → prescribe

High - and the controlled drug is preferred but not a standard of care → **do not prescribe**

High - and the controlled drug is the standard of care and no reasonable alternatives exist → **proceed only if controls and adherence monitoring** can be established to ensure that diversion is not occurring

Risk of drug abuse:
Low → prescribe
Moderate or High - decision to prescribe requires a critical analysis of:
-whether the severity of the pain is meaningfully compromising 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

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

A. 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.

B. Consider whether to continue prescribing,
-If diversion is occurring **or** risks now exceed benefit, taper and discontinue

C. 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

ASCO GUIDELINES

Adapted from Portenoy RK and Ahmed E, Principles of Opioid use in cancer pain. 2014; 32(16):1662-1670 and Portenoy et al 2011 Lancet 377:2236-2247.