Cancer Pain Care in 2025 – Tales of Turtles and Rabbits

Larry C Driver, MD
Department of Pain Medicine

THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

Centers of Excellence
AMERICAN PAIN SOCIETY

TPS 10/25/2025

Disclosures

- No relevant conflicts of interest to disclose
- No off-label Rx will be discussed – N/A
- Acknowledgement and appreciation to colleagues for permission to adopt and adapt parts of some slides
- "..knowledge belongs to humanity..." *Louis Pasteur*

Learning Objectives

- Discuss interdisciplinary, multimodal cancer pain care
- Review pearls and pitfalls of various strategies for managing cancer pain

Samuel J. Hassenbusch III, MD PhD (1954-2008)

Dr. Hassenbusch, a tenured professor in the Department of Neurosurgery at The University of Texas MD Anderson Cancer Center, was a well known international expert in pain medicine who was credited with developing novel techniques, therapies and methods for infusing drugs to block pain. He was certified by the American Board of Pain Medicine and the American Board of Neurological Surgery.

In 1987, he was one of four Johns Hopkins neurosurgeons to perform the first successful separation of twins joined at the back of the head. In addition to his neurosurgical expertise and accomplishments, he received widespread recognition for his contributions to pain medicine and research, including computer-guided stereotactic techniques for brain tumor biopsies, focused radiation therapy and direct injection of chemotherapy agents into brain tumors, defining the role of new non-opioid drug development for long-term spinal infusions, cingulotomy for severe cancer pain, and expanding the roles for long-term electrical stimulation, both at peripheral nerve and spinal levels. He also created a set of treatment algorithms for the use of different agents in long-term spinal infusions. And, he headed a consensus group to provide information and guidelines for the detection and treatment of possible granuloma formation at a spinal infusion catheter tip. The guidelines were among more than 80 publications and 30 book chapters authored by Dr. Hassenbusch.

In addition, Dr. Hassenbusch was one of 12 distinguished physicians on the AMA's CPT Editorial Panel for coding & reimbursements, where he was instrumental in implementing a number of new billing codes for pain medicine.

His leadership legacy includes serving as President of the Texas Pain Society, American Academy of Pain Medicine, American Neuromodulation Society, Texas Society of Neurological Surgeons, North American Neurological Surgery Society. He received Distinguished Service Awards and other honors from numerous Pain Medicine and Neurosurgery organizations.

He was diagnosed with glioblastoma multiforme in May 2005 and spent most of his remaining days using his unique situation to advocate and inspire others through the media and other public forums.

We continue to draw inspiration from his enduring works and legacy.

The University of Texas MD Anderson Cancer Center

Places and People

- > 11 M square feet of clinical, research, education, administrative space across > 30 buildings in TMC, greater Houston, central Texas
- > 26,000 employees, including > 1,900 faculty
- National and Global network of affiliated institutions
- 1 Nobel Laureate
- 9 National Academy of Medicine members
- 8 National Academy of Sciences members
- 6 Academy of Arts and Sciences members
- 53 American Association for the Advancement of Science fellows
- 17 Association of American Physicians members
- 34 American Society of Clinical Investigation members
- 1 faculty member who became head of FDA
- 1 faculty member who became head of NCI and then FDA
- 2 faculty physicians who are former NASA astronauts

•Clinical Care - FY24 Patient Care Facts

- 777 bed acute care hospital
- 187K patients
- 1.7M patient visits
- 9M pathology/laboratory medicine procedures
- 684K diagnostic imaging procedures
- 22K surgeries
- 43K+ patient visits for cancer prevention services
- Tele-video Pain Mgt visits > 6300
- Follow-up Pain Mgt Ctr visits > 4400
- Pain Mgt Ctr Consult visits > 1600

Research

- FY24 Research Facts
- $1.3B invested in research
- 1556 clinical trials
- 10K patients in trials
- 188 patents awarded
- 27 drugs tested received FDA approval

Education

- 5,609 trainees participated in MD Anderson educational programs
- 1,775 clinical residents and fellows
- 974 nursing trainees
- 368 School of Health Professions students
- 1,414 research trainees
- 1,292 student program participants
- 59 interns and fellows participated in special programs

1999 Cancer pain management was easy!

Just give more opioids until the pain is relieved or the side effects become a problem.

The opioid recipe is:

0.75 SR + 0.25 RR = MEDD
(+/- ROF, AED, NSAID, SSRI, SNRI, TCA, etc)
(Remember the TMB, DEA, FDA, CMS, etc)

Do a nerve block! Put in a pain pump!
Call Psych/Clergy/SocialWork!
Call Palliative Care!
Call Hospice!

Cancer / Pain Care 2025

- Evolution of Cancer Care: Prevention + Early Dx + Personalized Treatment → Improved Survival and QoL
- Evolution of Cancer Pain Care: WHO 3-step Ladder → 21st Century Integrative Strategies
- Multidisciplinary Multimodal Management
- Consilience and cancer / pain care
- 2+ / 0.6+ / 18+ / 69%↑@5y / $200+B

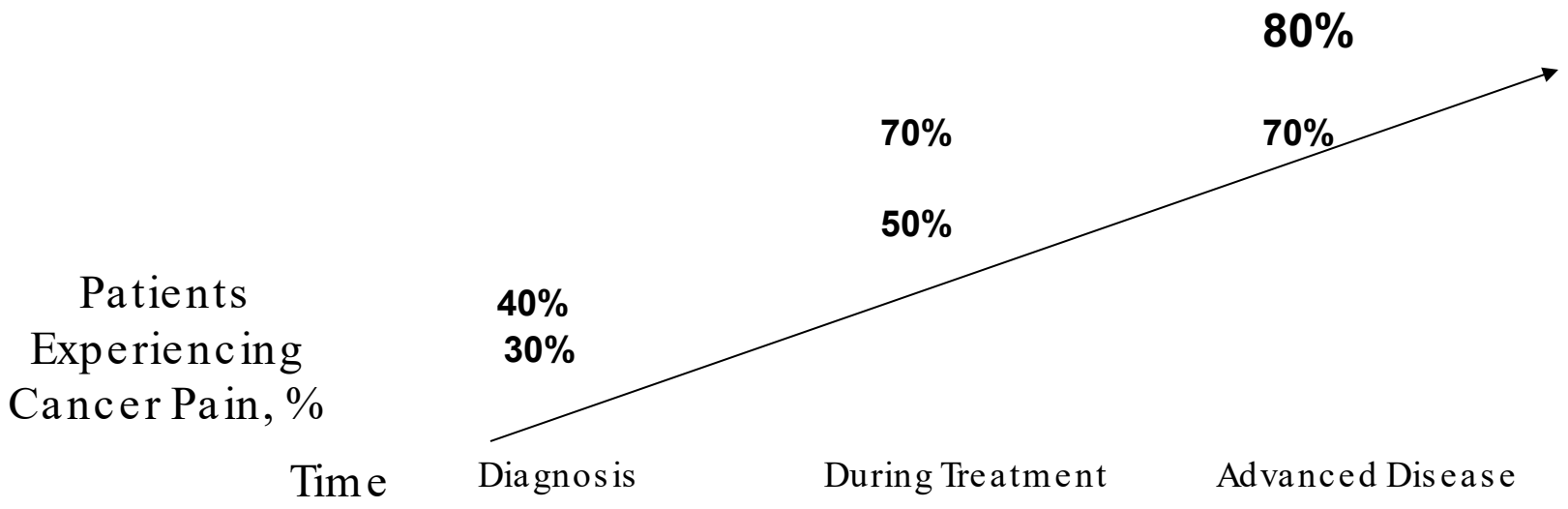
(NCI, ACS)

Cancer Pain Type Descriptors

- Acute / Chronic / Persistent / Episodic
- Basal / Breakthrough
- Nociceptive/Neuropathic/Nociplastic/Inflammatory/Mixed
- Pain throughout the cancer experience:
  - Pain at diagnosis
  - Painful diagnostic bx and/or resective surgery
  - Pain due to chemo/radiation
  - Pain due to disease progression/metastasis
  - Pain due to noncancer reasons
  - Painful survivorship
  - Painful end-of-life

Pain Affects Patients Throughout the Disease Experience

Most patients with cancer experience cancer-related pain. Significant pain can be present at any stage of disease, and may be present for long periods of time, even for the duration of disease.



1. Svendsen KB et al. *Eur J Pain*. 2005;9(2):195-206.

Complexity of the Cancer Patient and Their Pain

- Prior/current comorbidities
- Organ failure (liver, kidney…)
- Inability to use the oral route
- Abnormal laboratory values
- Polypharmacy
- Anxiety and psychiatric disorders
- Addiction
- Allergies and side effects
- Clinical trials
- Insurance coverage

- Tumor related pain (60+%)
  (bone, soft tissue, nerve)
- Treatment related (20+%)
  (chemo, surgery, radiation)
- Aggressive Rx → patients live longer → "chronic cancer" → chronic pain
- Non-cancer-related pain (10%)

Christo and Mazloomdoost, ANYAC 2008

Social Influencers of Health (Pain)

- Income and income distribution
- Education
- Unemployment / Job security
- Employment / Work conditions
- Early child development
- Food insecurity
- Housing
- Social exclusion
- Social safety net
- Health services
- Geography
- Disability
- Indigenous ancestry
- Gender
- Race
- Immigration
- Globalization
- ???

Symptom Prevalence Summary from the Symptom Grid

Symptoms	Cancer	AIDS	Heart disease	COPD	Renal Disease
Pain	35–96%	63–80%	41–77%	34–77%	47–50%
Depression	3–77%	10–82%	9–36%	37–71%	5–60%
Anxiety	13–79%	8–34%	49%	51–75%	39–70%
Confusion	6–93%	30–65%	18–32%	18–33%	—
Fatigue	32–90%	54–85%	69–82%	68–80%	73–87%
Breathlessness	10–70%	11–62%	60–88%	90–95%	11–62%
Insomnia	9–69%	74%	36–48%	55–65%	31–71%
Nausea	6–68%	43–49%	17–48%	—	30–43%
Constipation	23–65%	34–35%	38–42%	27–44%	29–70%
Diarrhea	3–29%	30–90%	12%	—	21%
Anorexia	30–92%	51%	21–41%	35–67%	25–64%

Minimum-maximum range of prevalence (%) is shown

- **Joao Paulo Solano, et al**

Journal of Pain and Symptom Management,2006

"Total Pain" (Dame Cicely Saunders)

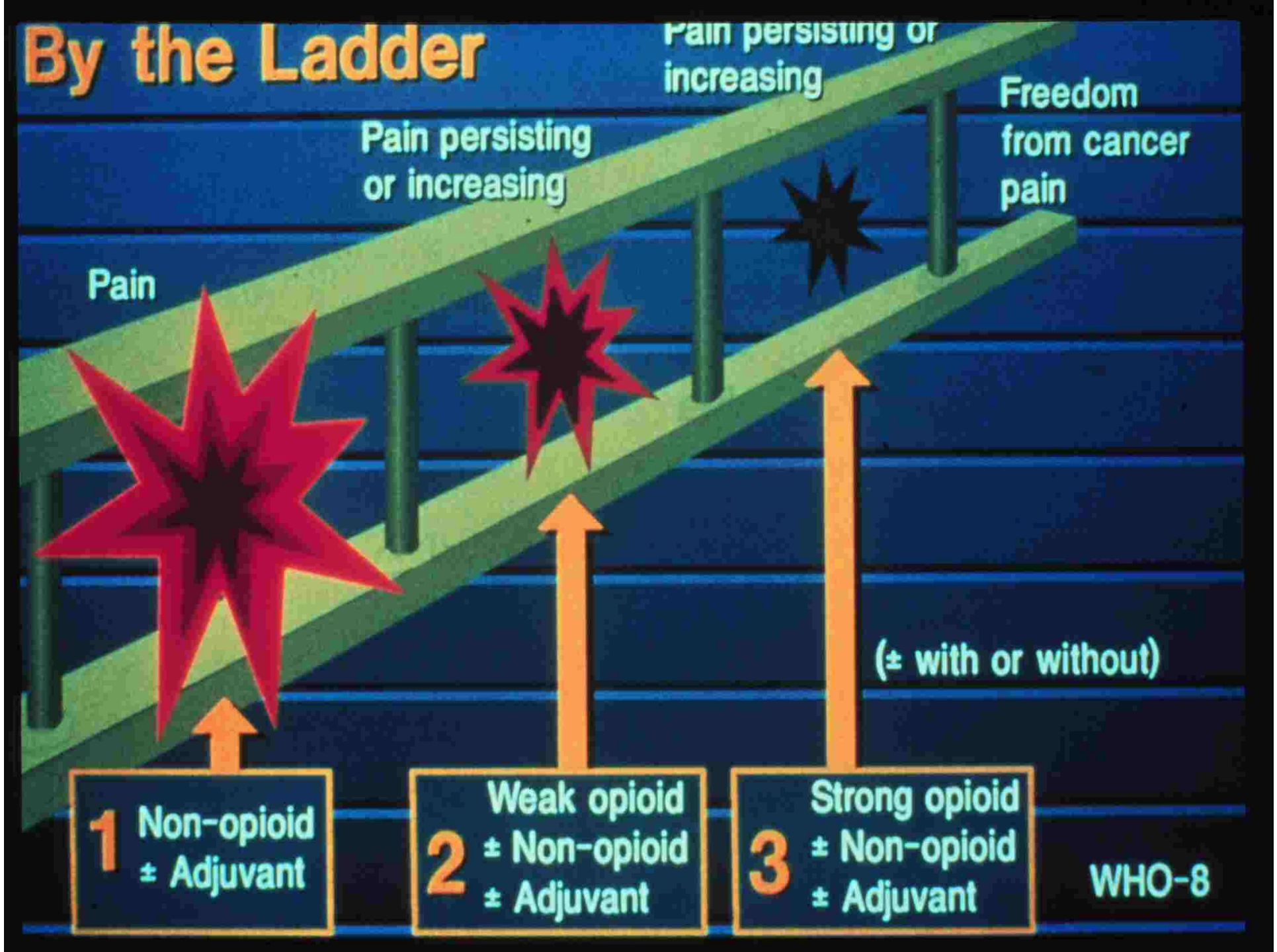
- What the patient really has, a sum of
  - Physical pains (often multiple)
  - Psychological issues (e.g., depression, anxiety, anger, personality, etc)
  - Social problems (e.g., isolation/connections, financial distress, housing, etc)
  - Spiritual (e.g., absence of meaning and hope, other existential angst)
- This complexity means
  - There are multiple ways to intervene.
  - Effective interdisciplinary teamwork is essential!

Pain and Suffering

- Suffering more likely when:
  - Pain intensity is overwhelming
  - Pain source is unknown
  - Pain is chronic
  - Meaning of pain is dire (influences amount of medication needed to control pain)

- In these circumstances, suffering occurs when pain is perceived as a threat to the individual's continued existence:
  - integrity as a person (QoL)
  - survival

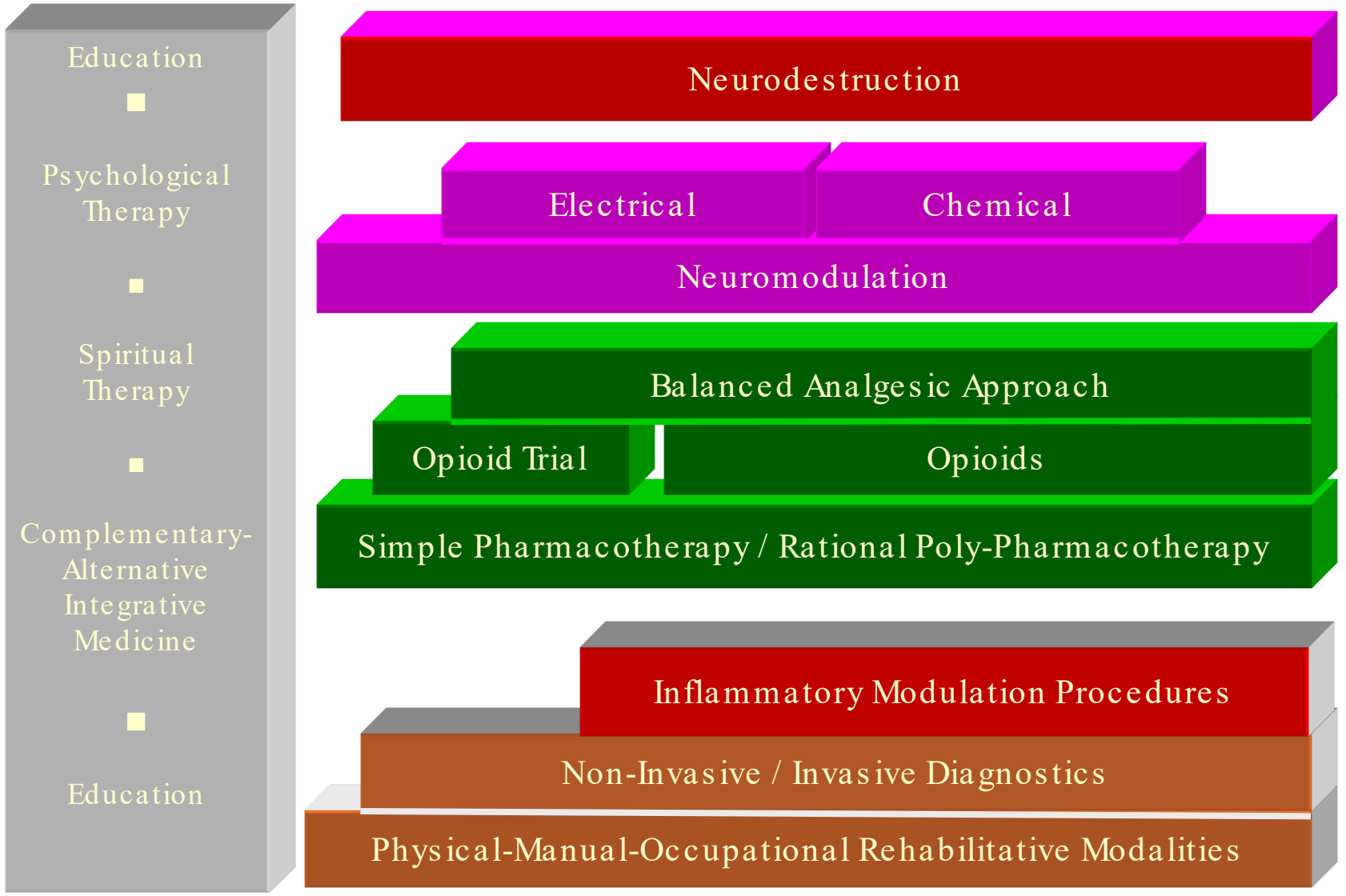
The Nature of Suffering and the Goals of Medicine Eric J. Cassel, M.D.
N ENGL J MED 1982; 306:639-645


By the Ladder
Pain persisting or increasing
Pain persisting or increasing
Freedom from cancer pain
Pain
(± with or without)
1 Non-opioid ± Adjuvant
2 Weak opioid ± Non-opioid ± Adjuvant
3 Strong opioid ± Non-opioid ± Adjuvant
WHO-8

Role of Interventional Procedures

- 4th step in WHO ladder approach?
- Earlier use if risk/benefit is favorable
- Understand limitations and contraindications
- Sometimes, interventional procedures helpful for chronic ongoing pain; sometimes beneficial in very end stage situations …No absolute rules

21st Century Holotherapeutic© Paradigm



LCDriver adaptation from Daniel Bennett MD

Dimensions of Quality Pain Care

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Patient-centered

- Safe
- Timely
- Ethical
- Efficient
- Effective
- Equitable
- Expert
- Patient-centered
- Professional

- Competent
- Compassionate
- Committed
- Communicated

- Consistent
- Coordinated
- Continuity-assured

- Cost-effective
- Value-driven

Institute of Medicine's (IOM) 2001 report *Crossing the Quality Chasm*

Cancer Pain Treatment: Mechanism Based / Personalized

- Medical Assessment (Tumor pain? Therapy side effect? Noncancer pain?)
- Physical exam / Indicated studies / Differential Dx
- PsychoSocialSpiritual assessment/therapy
- Global Impact Assessment
- Oral analgesic regimen appropriately dosed for balance
- Functionality optimization
- Chemo-/radio-/surgical therapy as indicated
- “Nerve blocks”/RFA/Neurolytic techniques
- Intraspinal pharmaco/electro Neuromodulation
- Frequent reassessment for optimal ongoing outcomes
- Palliative approaches to collateral symptom burden
- Balanced Integrative Treatment Strategies

Commonly Prescribed Opioids

- "IR"
- Regular-Release
  - Morphine
  - Tramadol
  - Tapentadol
  - Oxycodone
  - Oxymorphone
  - Hydromorphone
  - Fentanyl
  - Hydrocodone
  - Codeine
  - Buprenorphine

- "ER" (SR, CR, LA)
- Extended-Release
  - Morphine
  - Tramadol
  - Tapentadol
  - Oxycodone
  - Oxymorphone
  - Hydromorphone
  - Fentanyl
  - Buprenorphine
  - Hydrocodone
  - Methadone

Collateral Opioid Issues and Caveats

- Physiologic / Psychologic dependence
- Tolerance / Pseudotolerance
- Addiction / Pseudoaddiction
- Realistic expectations / Hope
  - Cure / Comfort / Care
- Risk Evaluation and Mitigation Strategies
- Legislative and Regulatory Policies

??????????????

Adjuvant Medications / Co-analgesics

- Topicals (lidocaine, capsaicin, ketamine, etc)
- Antidepressants (TCAs, SNRIs, SSRIs)
- Anticonvulsants (AEDs)
- NSAIDs, Steroids, Bisphosphonates
- Ion channel agents / Toxins
- Psychotropics: anxiolytics, stimulants
- Cannabinoids: CBD, THC
- Psychedelics: LSD, psilocybin
- Through the looking glass…

Procedural Interventions for Pain: When/Which Procedure?

- When?
  - Pain refractory to usual management
  - Unacceptable side effects from analgesics
- Which?
  - Focal pain: Nerve blocks, neurolytic, radiofrequency, vertebral augmentation, neuromodulation, etc
  - Widespread pain: Neuraxial infusion, neuromodulation

Indications / Limitations / Contra-indications.

Risk/Benefit analysis. Disease status.

Patient-Centric – always.

Neurodestructive procedures for localized pain

- Head and Neck: Stellate Ganglion/Peripheral nerve
- Extremity: DRG/Plexus
- Chest wall: Epidural/DRG/Intercostal
- Upper Abdominal: Celiac/ Splanchnic
- Lower Abdomen/Pelvic: Superior Hypogastric
- Rectal: Intrathecal/Superior Hypogastric/ Ganglion Impar
- Lower extremity: LSB/Subarachnoid

NCCN Pain Guidelines

Procedural Interventional Pain Management

- Trigger point needling/injections – myofascial pain
- Head&Neck – sphenopalatine, occipital, Trigeminal V1-V2-V3, Botulinum toxin injections for migraines or trismus/fibrosis, glossopharyngeal
- Joint injections – joint pain
- Epidural steroid injections – C-T-L spine
- Nerve root blocks and transforaminal injections (neck, back pain, migraines)
- Spinal facet joint and nerve injections (HA, neck and back pain)
- Sacroiliac joint injections (back, hip pain)
- Peripheral nerve injections (migraines, trigeminal neuralgia, shingles pain, localized pain, postsurgical incisional pain, post surgical neuropathic pain, localized neuropathic pain, muscle spasms)
- Discography (diagnostic)
- Radio-frequency lesioning (Rhizotomy) (neck, back pain)
- Kyphoplasty/Vertebroplasty (pathologic vertebral fractures: MM, mets,)
- Neuromodulation (SCS, DRG, PNS, Scrambler, qEEG, et al)
- Spinal infusion/Intrathecal pumps (opioids et al)
- Sympathetic blocks (SMP, shingles, et al)
- Neurolytics of celiac plexus, superior hypogastric plexus, ganglion impar (abdominopelvic pain)
- Surgery: Joints. Spine. Cordotomy, Myelotomy, MCS, DBS

Therapies for Chemoneuropathy (CIPN)

- Pharmacotherapy: AED, SNRI, TCA, Micronutrients, et al
- Alpha-stim
- Capsaicin topical
- Closed-loop brain-computer interface (clBCI) neurofeedback
- High-Intensity Light Therapy (HILT)
- Quantitative EEG (qEEG)
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Scrambler Therapy
- Dorsal Root Ganglion Stimulation (DRGs)
- Spinal Cord Stimulation (SCS)
- Peripheral Nerve Stimulation (PNS)

Creative and Innovative Advances

- The Long-Term Impact of Neurofeedback on Symptom Burden and Interference in Patients With Chronic Chemotherapy-Induced Neuropathy: Analysis of a Randomized Controlled Trial. Prinsloo S, Novy D, Driver LC, Lyle R, Ramondetta L, Eng C, Lopez G, Li Y, Cohen L. J Pain Symptom Manage. 2018 May;55(5):1276-1285. doi: 10.1016/j.jpainsymman.2018.01.010. Epub 2018 Feb 5. PMID: 29421164

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- Methylene blue for intractable pain from oral mucositis related to cancer treatment: a randomized phase 2 clinical trial. Roldan CJ, Huh B, Song J, Nieto Y, Osei J, Chai T, Nouri K, Koyyalagunta L, Bruera E. BMC Med. 2022 Nov 3;20(1):377. doi: 10.1186/s12916-022-02579-8. PMID: 36324139 PMCID: PMC9632023 DOI: 10.1186/s12916-022-02579-8

Creative and Innovative Advances

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- The impact of scrambler therapy on pain and quality of life for chemotherapy-induced peripheral neuropathy: A pilot study Chung M, Chen TH, Wang XS, Kim KH, Abdi S. Pain Practice. 2024 June; 24(5): 749-59. https://doi.org/10.1111/papr.13355

- Peripheral nerve stimulation: recent advances and future directions. Ganji-Angirekula S, Javed S. Pain Management 2025 Apr; 15(4): 173-175. https://doi.org/10.1080/17581869.2025.2488244

Nanomedicine and Pain Management – Overpromised and Underdelivered?

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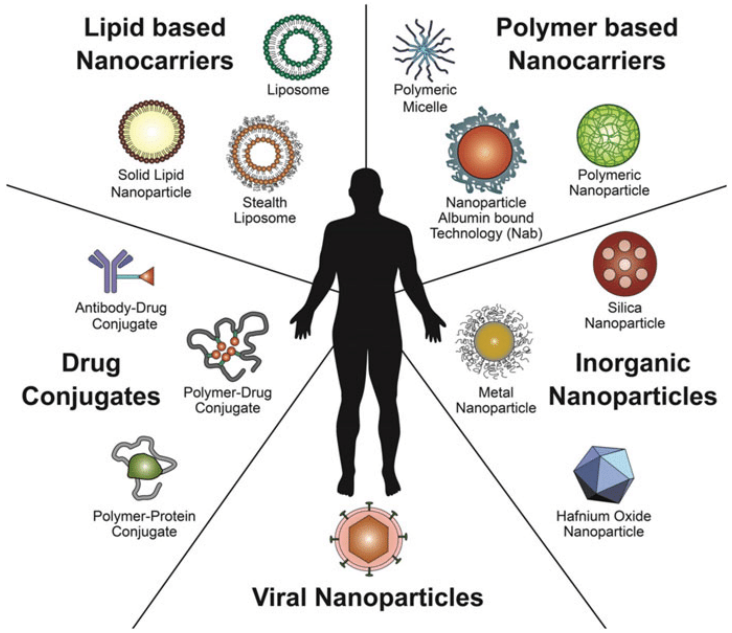
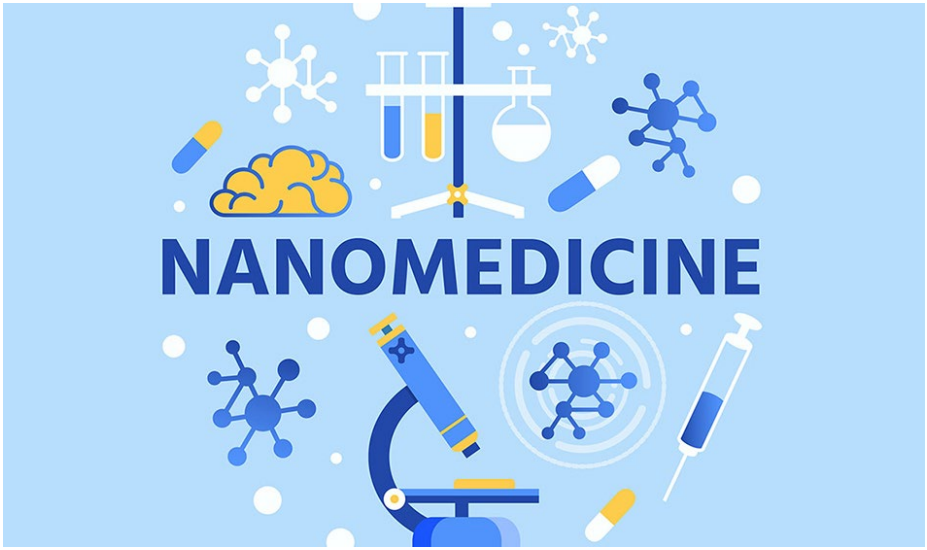
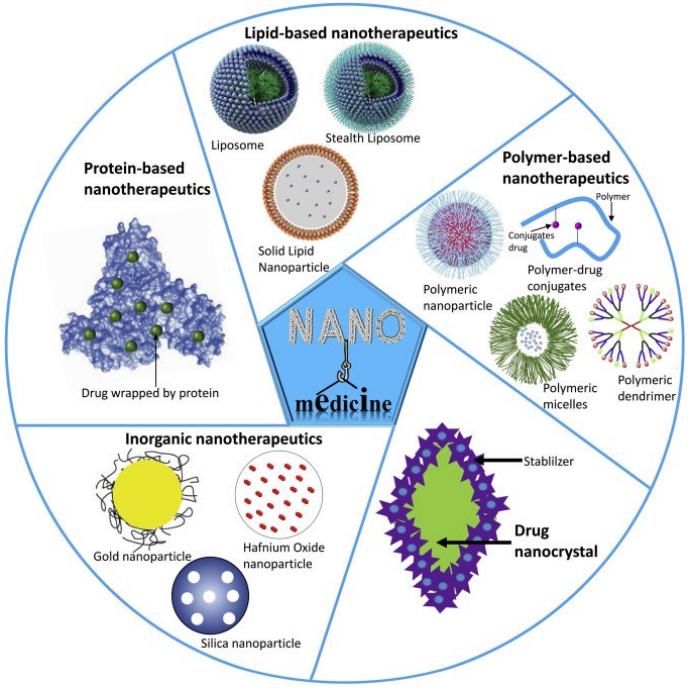
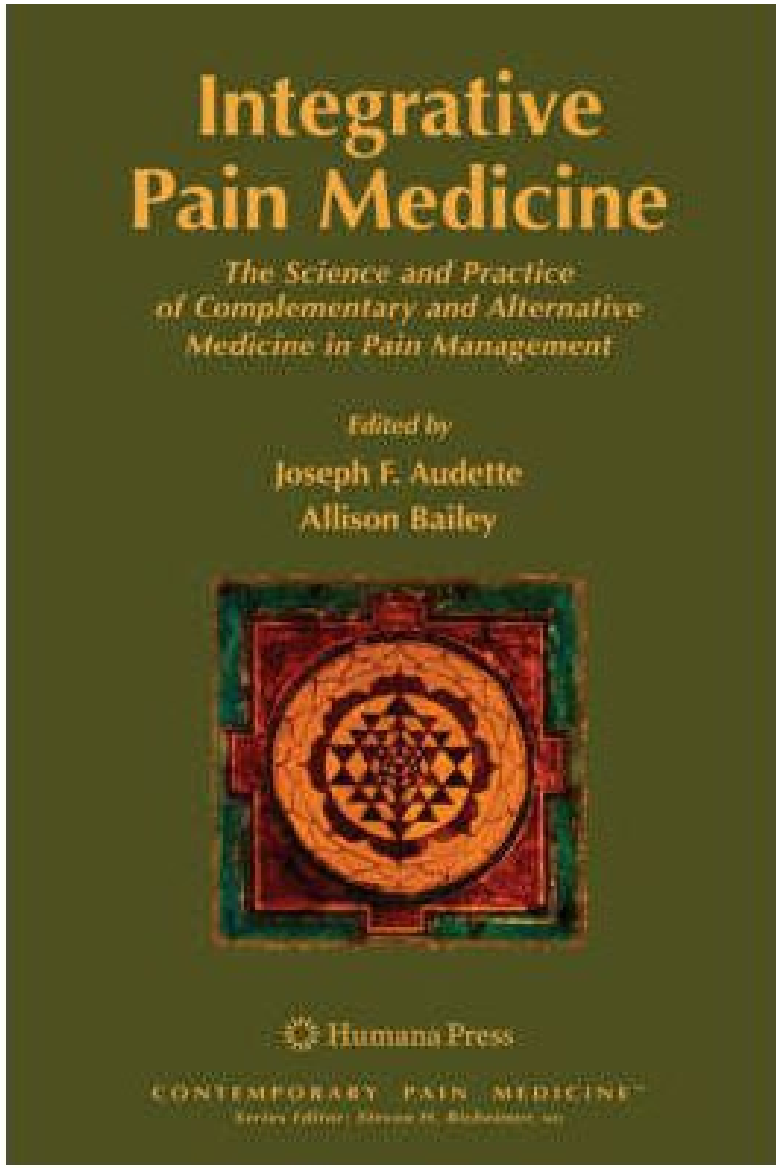
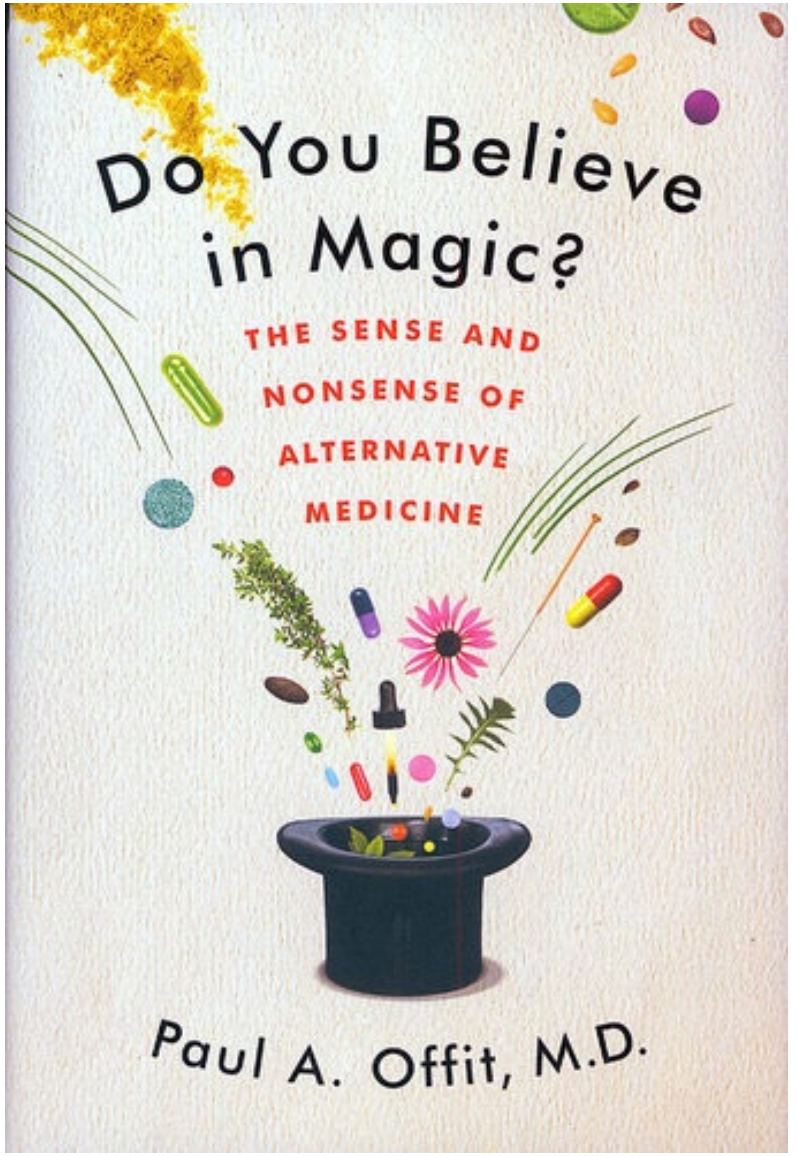






- Nanomedicine for chronic pain management: From pathophysiology to engineered drug delivery systems. Li Li, Ting Li, Hanxi Wang, Lihan Luo, Yuqi Cheng, Yang Li, Shanjun Huang, Xueou Zhang, Jiannan He, Jian Guo, Cao Zhang, Fengjiang Zhang, Longguang Tang, Jianhong Xu. Mater Today Bio. 2025 Jun 10;33:101976. doi: 10.1016/j.mtbio.2025.101976


Integrative
Pain Medicine
The Science and Practice
of Complementary and Alternative
Medicine in Pain Management
Edited by
Joseph F. Audette
Allison Bailey
Humana Press
CONTEMPORARY PAIN MEDICINE


Do You Believe
in Magic?
THE SENSE AND
NONSENSE OF
ALTERNATIVE
MEDICINE
Paul A. Offit, M.D.

NIH 5 Domains of Complementay-Alternative Medicine

Alternative Medical Systems	**Ayurveda, Chinese, Native American, Aboriginal, African, Middle Eastern, Tibetan, Central and South American cultures, Homeopathy, Naturopathy**
Mind-Body Interventions	**cognitive-behavioral approaches, meditation, hypnosis, dance, music, art therapy, prayer, mental healing**
Biological Based Therapies	**dietary supplements, herbs, orthomolecular (varying concentrations of chemicals, such as, magnesium, melatonin, and mega-doses of vitamins), individual biological therapies (use of laetrile, shark cartilage, bee pollen).**
Manipulative And Body-Based Methods	**chiropractic, osteopathic manipulation, massage**
Energy Therapies	**Qi gong, Reiki, therapeutic touch, bioelectromagnetic-based therapies (pulsed fields, magnetic fields, or alternating current or direct current fields)**

Integrative medicine in oncology: redefining the standard of care

Gabriel Lopez, Santhosshi Narayanan & Lorenzo Cohen

Table 1 | Recommendations for integrative oncology in cancer care

	Acupuncture/ Acupressure	Massage/ reflexology	Yoga/ meditation/ MBSR	Tai Chi/ Qigong	Hypnosis	Music Therapy	Nutrition	Exercise
Pain	X	X	X		X	X	X	X
Arthralgia	X		X					X
Fatigue	X	X	X	X			X	X
Anxiety/ depression			X	X	X	X		X
Sleep dysfunction			X	X				X
Nausea	X		X		X	X		
Cognitive dysfunction			X					
Hot flashes/ night sweats	X		X		X			X

Combination of NCCN and ASCO–SIO guidelines that have: moderate/intermediate or higher evidence; moderate to strong recommendation; and/or NCCN category 2A or higher. MBSR, mindfulness-based stress reduction. The table is adapted with permission from ref. 5, Wiley.

nature reviews cancer 2024


Rx
PATIENTS
NAME
ADDRESS

Factors Influencing Pain and Its Relief

- Specific medication issues
- Receptor affinity
- Drug interactions
- Metabolite effects and interactions
- CNS Neuroplasticity
- Pharmacogenetics: polymorphisms (opioid receptors, metabolizing enzymes, etc)
- Epigenetics / Transposons
- Tolerance / Hyperalgesia
- Rx misuse, abuse, diversion, addiction

Factors Influencing Pain and Its Relief

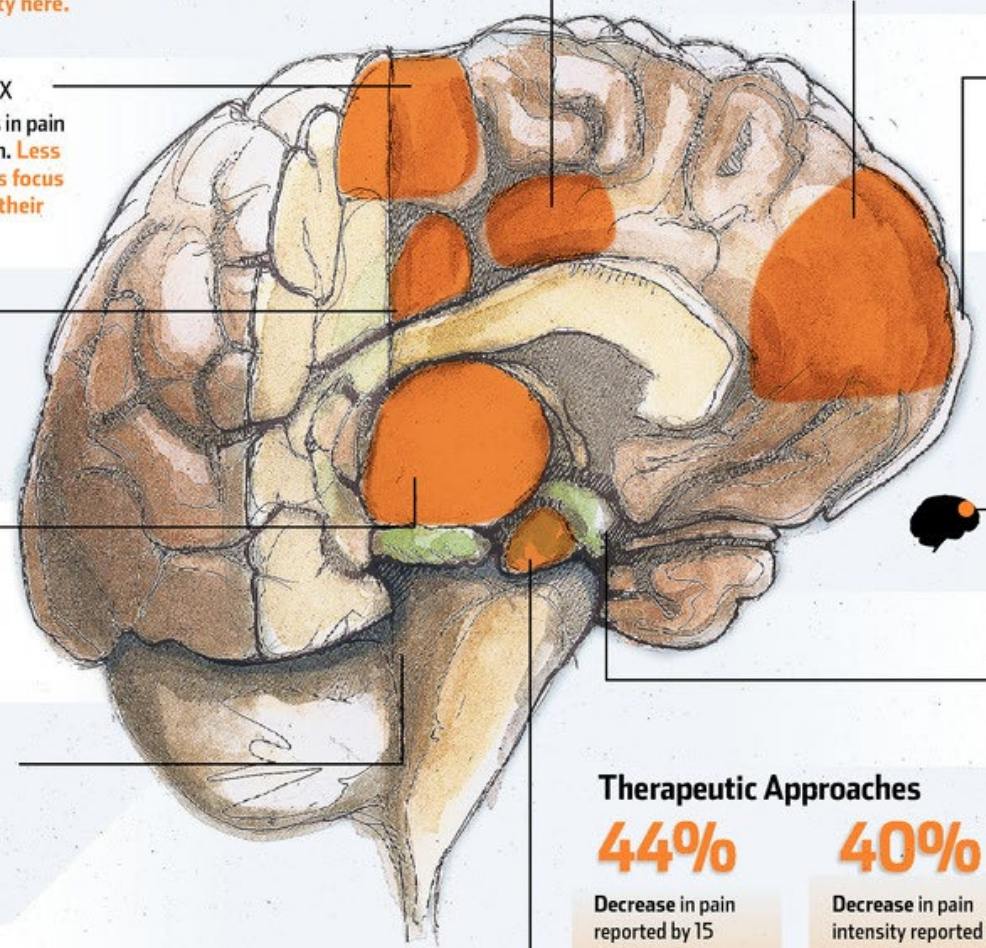
- Dynamic Patient/Disease-related factors
- Evolving clinical scenarios
- Disease progression / humoral factors
- Pain type/mechanism
- Concurrent collateral symptoms
- Personality et al Psychological influences
- Socio-Cultural factors
- Spiritual issues / Karma / Yin-Yang
- Mind-Body dynamism
- Higgs Boson / Dark matter effects
- And others that we have not yet observed or thought of

Molecules participating in transduction - nociception

- AMPA GRIA2 , GRIA4 , GRM3
- BDNF
- CACN (voltage-dependent calcium channel) CACNA2D1 , CACNA2D2 , CACNA2D3 , CACNA2D4
- CalmK CAMK1 , CAMK1G , CAMK2A , CAMK2B , CAMK2D , CAMK2G , CAMK4
- COX2
- CREB1 / CREB2 ATF2 , ATF4 , CREB1
- ERK1 / ERK2 / ERK3 MAPK1 , MAPK3 , MAPK6
- GRM (glutamate receptor, metabotropic) GRM1 , GRM2 , GRM3 , GRM4 , ... GRM7 , GRM8
- NK1R
- NMDAR (GRIN, ionotropic glutamate receptor) GRIN2A , GRIN2B , GRIN2C , GRIN2D
- PIK (Phosphatidylinositol 3-Kinase, PI3K) PIK3C2A , PIK3C2B , PIK3C3 , PIK3CA , ... PIK3R2 , PIK3R3
- PKA (Protein Kinase A) PRKACB , PRKAR1B , PRKAR2A , PRKAR2B
- PKC (Protein Kinase C) PRKCA , PRKCD , PRKCE , PRKCG , PRKCH , ... PRKCN , PRKCQ , PRKCZ
- PLC (Phospholipase C) PLCB1 , PLCB2 , PLCB3 , PLCB4 , PLCD1 , PLCG1 , PLCG2 , PLCZ1
- Potassium Channel Proteins KCMF1 , KCNK1 , KCNK10 , KCNK12 ,..... KCNK16 , KCNK17 , ..
- Sodium Channel SCN10A , SCN11A , SCN1A , SCN2A1 , ... , SCN9A , SCNN1A , SCNN1B , ...
- Src
- TRKB

Q's: Which molecules initiate nociception? Maintain it? Are most important?

How the Mind Processes Pain



ANTERIOR CINGULATE CORTEX
Registers unpleasant feelings when things go wrong, either physically or emotionally. **People who are highly sensitive to pain have greater activity here.**

SOMATOSENSORY CORTEX
Registers which body part is in pain and the intensity of that pain. **Less activity here when patients focus their attention away from their pain.**

INSULAR CORTEX
Integrates sensory, emotional and cognitive states; **feels empathy for others' pain.**

THALAMUS
Receives **pain signals** from spinal cord and relays them to higher brain regions.

PERIAQUEDUCTAL GRAY
An area rich in natural opioids that act as a **pain reliever.**

AMYGDALA
Anticipates pain and reacts to perceived threats.

PREFRONTAL CORTEX
Processes pain signals rationally and plans action. **Active when trying to consciously reduce pain.**

MEDIAL PREFRONTAL GYRUS
Focuses on negative personal implications of pain. **Heightened activity seen in anxious people.**

RIGHT LATERAL ORBITOFRONTAL CORTEX
Evaluates sensory stimuli and **decides on response,** particularly if fear is involved. Mindfulness meditation calms down this response.

NUCLEUS ACCUMBENS
Releases **dopamine and serotonin** during pleasure or pain.

Therapeutic Approaches

44%

Decrease in pain reported by 15 undergraduates when they focused on a loved one's photo while exposed to a heated probe.

40%

Decrease in pain intensity reported by 15 people who learned mindfulness meditation and used it while exposed to a heated probe.

30%

Percentage of people in a study of 422 fibromyalgia patients who reported less pain after receiving cognitive behavioral therapy.

Sources: Sean Mackey, Stanford; PLoS One; Journal of Neuroscience; Archives of Internal Medicine

21st Century Integrative Cancer Pain Management Paradigm "Onco-Holo-Analgesia"

- Edutherapy – Psychotherapy – Sociotherapy – Spiritutherapy
- Complementary and Alternative Therapies = Integrative Therapy
- Rehabilitation Therapy: Physical/Occupational
- Simple Pharmacotherapy / Rational Balanced Poly-pharmacotherapy
  Non-opioids / Opioid trial / Chronic opioid therapy + Adjuvant Co-analgesics
- Neuromodulation Therapy: Pharmaco / Electro (central, peripheral)
- Neurodestructive Therapy: EtOH, Phenol, RFA, pRFA, Cryo, …
- Balanced Multimodal Analgesia, Personalized Tailored Strategy
- Patient-centered and personalized, context-driven and coordinated, evidence-informed, clinically indicated, appropriate balanced multimodal strategies, at the right times, for the duration needed, value-based with attention to maximal benefit and minimal adverse effects, always sharply focused on achieving optimal outcomes yielding the best possible QoL.

The Biopsychosocial Model of Pain

Interactive dimensions of pain:

Biomedical

- Physical sensation, location, and biomedical causes of pain
- Sleep disturbance
- Activity limitations
- Medication issues, including risks and benefits of opioids

Psychological

- Negative emotions & stress
- Strained coping resources
- Negative thinking
- Vulnerability (prior psych problems; substance abuse)

Social

- Strained support systems (family, work, healthcare)

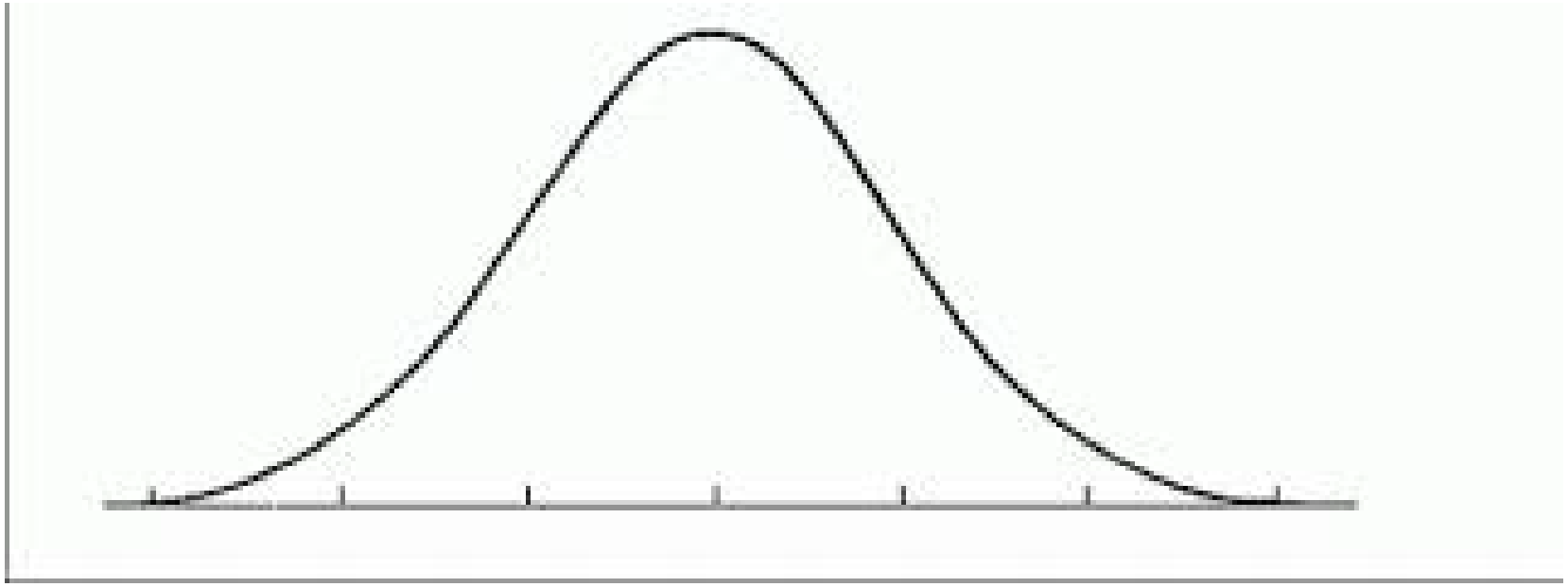
Psychological Treatments for Pain

- Supportive Counseling
- Behavioral Therapy
- Cognitive Behavioral Therapy
- Acceptance Commitment Therapy
- Motivational Interviewing
- Biofeedback
- Neurofeedback
- Presence

Remember the patients at the tails of the curve…

- Not everything that can be counted counts…
  and not everything that counts can be counted.

  - Albert Einstein



Palliative Care = Patient-Centered Care for People Facing Serious & Chronic Illness

Palliative care…

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August 18, 2010

Palliative Care Extends Life, Study Finds

By DONALD G. McNEIL Jr.

In a study that sheds new light on the effects of end-of-life care, doctors have found that patients with terminal lung cancer who began receiving palliative care immediately upon diagnosis not only were happier, more mobile and in less pain as the end neared — but they lived nearly three months longer.

The findings, published online Wednesday by The New England Journal of Medicine, confirmed what palliative care specialists had long suspected. The study also, experts said, cast doubt on the decision to strike end-of-life provisions from the health care overhaul passed year.

- Focuses on relief from symptoms, pain, and stress.
- Improves QOL for both patient and family.
- Teams include physicians, nurses and other specialists who work with patient's doctor to provide an extra layer of support
- Appropriate at any age and any stage in a serious illness and can be provided concurrent with curative treatment
- Delivers value to people, providers, and systems by improving care quality and efficiency and reducing costs

How We Define Palliative Care Matters

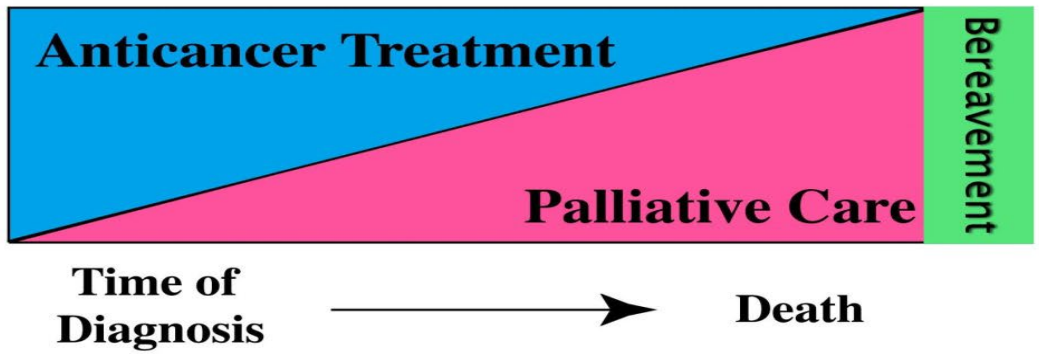
- Palliative care is about improving quality of life, providing an extra layer of support, and having a team focus to patient care.

- Palliative care is about helping both the family as well as the patient with serious illness.

- Differentiate from hospice or EOL care.

  (Avoid defining palliative care by what it is NOT.)

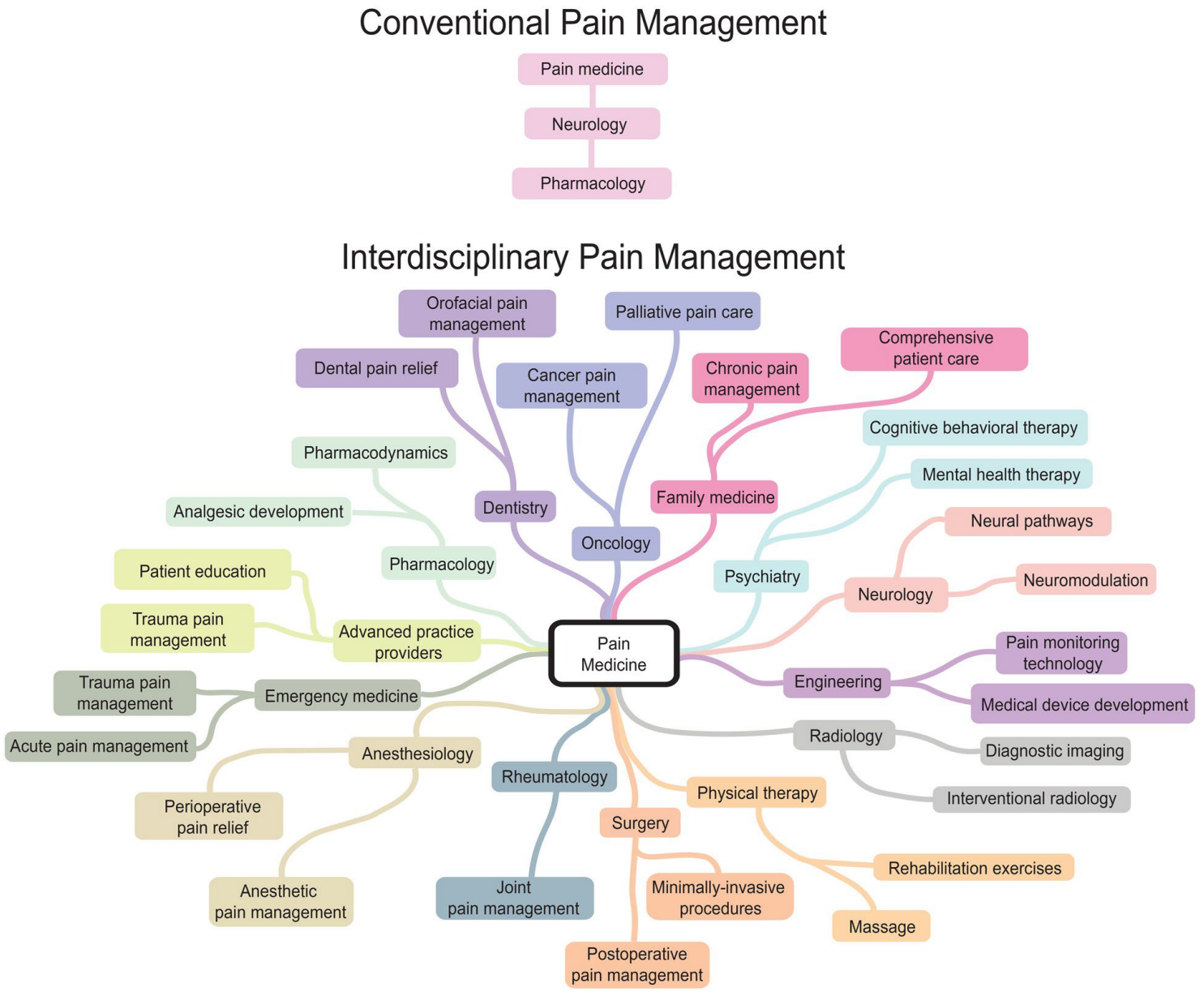

Anticancer Treatment
Palliative Care
Time of Diagnosis
Death


Anticancer Treatment
Palliative Care
Bereavement
Time of Diagnosis
Death


Anticancer Treatment
Good Clinical Care
Palliative Care
Bereavement
Time of Diagnosis
Death

Interdisciplinary
Multimodality
Pain/Symptom
Care

Patient-centered
Individualized
Targeted
Timely
Safe



Pain Med, pnae130, https://doi.org/10.1093/pm/pnae130

Palliative Sedation

Palliative sedation refers to

- Use of non-opioid medications, including benzodiazepines, barbiturates, et al
- Control of refractory symptoms (e.g., agitated delirium, pain, dyspnea) that have not responded to conventional symptom management

Assessment and treatment by an interdisciplinary PC team (palliative physician, psychosocial counselor, chaplain, pharmacist, nurse)

Decision-making with clear communication between physician/IDT and patient or family members

Care in a closely monitored Palliative Care setting (e.g. PSCU)

Not associated with hastening of death

Slide adapted from Azhar A

Medical Aid in Dying - MAID

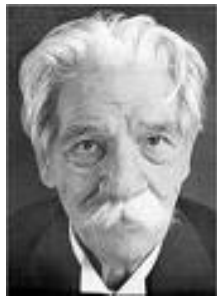
- MAID is an option for patients with a terminal condition
- MAID is legal in OR, WA, MT, VT, CA,CO, DC, HI, NJ, ME, NM
- MAID is not suicide
- MAID provides patients control over the timing of their death
- MAID potentially minimalizes patient suffering
- MAID requires: 18+yo, state resident, 6-months prognosis by 2 providers, capacity for own decision-making, act voluntarily, capable of self-admin of Rx
- Role and status of a healthcare provider
  - Have patient-centered discussions around MAID with patients and their family
    - What are their fears about dying?
    - What are their concerns?
      - Being a burden to loved ones?
      - Suffering/Pain?
      - Have control over their death?
  - Consult Social Work, Supportive Care, Spiritual Care, and/or Clinical Ethics

Slide adapted from Enck G and Bitter A

AI / QC

“Pain is a more terrible lord of mankind than even death itself.”

Albert Schweitzer



Cure sometimes –

Comfort and Care always

同情

Saturday, 11/1/2025, 8AM–3:30PM

https://mdanderson.cloud-cme.com/course/courseoverview?P=5&EID=48761

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