Multidisciplinary approach, continuous care and opioid management in cancer pain: case series and review of the literature

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Abstract

Underlying cancer pain has heterogenous aetiologies and mechanisms. It requires detailed and comprehensive pain assessment, combined with personalized treatment. A multidisciplinary team is essential to providing the best management of cancer pain at every disease stage, improving the quality of life and outcomes in patients with cancer. This narrative literature review emphasizes the value of providing all patients with multidisciplinary pain management in their preferred care setting. Real-life experiences are also reported to witness the efforts of physicians to properly manage cancer pain.

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Keywords: cancer pain, multidisciplinary management, opioid.

Citation


Introduction

A systematic review and meta-analysis by van den Beukzen-van et al. in 2016 found that pain affected 50.7% of patients at all cancer stages and 70–90% of patients with advanced disease. Cancer pain is therefore a common symptom that has a notable impact on both health-related quality of life (QoL) and adherence to antitumoural treatment.2–5 A modern, multidisciplinary approach to cancer-related pain would ensure better health outcomes and an improved QoL for patients with cancer.6–9

Methods

With the aim of highlighting the importance of a multidisciplinary approach to cancer pain management, we performed a literature search in the databases PubMed, Scopus, ISI-Web of Science and Google Scholar for article titles containing the keywords “cancer pain”, “opioids” and “multidisciplinary”. The search was restricted to human, adult, English language and published in the period 2012–2022. Additional studies were manually included from the reference lists of identified articles. Four clinical cases were then described, with a focus on emphasizing the value of multidisciplinary teams in the management of complex cases of cancer pain. In accordance with the World Medical Association Declaration of Helsinki, all patient data were anonymized, excluding any details that would enable patient reidentification.

Review

Cancer-related pain may be due to the disease itself or to treatments such as surgery, radiotherapy,
Individualized, detailed and comprehensive pain assessment is essential to providing the best management approach for patients with cancer. Pain assessment must be repeated regularly to guide treatment strategies at each stage of illness. The description of the quality of pain, location, daily pattern and extent of relief after receiving medication are all fundamental attributes when investigating pain; however, pain intensity (mild, moderate, severe) is recognized as the most relevant clinical dimension of pain experience.

Amongst standardized unidimensional pain intensity scales, the visual analogue scale, verbal rating scale and numeric rating scale (NRS) are the most widely used worldwide. Specialized scales are also available for sub-populations (e.g. older adults with comorbidities and polypharmacy, non-verbal patients, and patients with substance use disorders). Clinicians should identify the most suitable scale for an individual patient, using that same scale at each subsequent assessment to track changes in pain intensity over time. Long-term historical pain must also be evaluated through verbal history or pain diaries, which can promote patient empowerment and involvement in pain management. The average pain score from the past months or weeks, the highest and lowest pain scores, any precipitating factors, and response to analgesic regimen are key factors to be defined as a part of pain history. This information allows for better differentiation between background pain, defined as the underlying persistent pain usually controlled by long-term analgesic treatment and episodes of breakthrough cancer pain (BTcP).

As defined in 2009 by the task group of the Science Committee of the Association for Palliative Medicine of Great Britain and Ireland, BTcP is an acute, transient exacerbation of severe pain occurring spontaneously or due to a specific trigger (walking, changes in position, coughing), in a patient whose background pain is stable and controlled for a greater part of the time. BTcP is associated with greater distress and poorer QoL, therefore, its assessment should be included in routine cancer pain evaluation.

Decisions regarding cancer pain treatments are based on compliance with guideline recommendations as well as on patient perspectives and expectations. Tailored treatment is required, whilst increasing the patient’s capacity for self-management. Alongside empowering patients to communicate their pain effectively with physicians, pain diaries are tools that progressively involve both parties in pain assessment, decision-making, therapeutic relationships and treatment evaluation.

In accordance with the World Health Organization (WHO) three-step analgesic ladder and guidelines for chronic cancer-related pain management, non-opioid analgesics (e.g. paracetamol and non-steroidal anti-inflammatory drugs) are first-line agents for the treatment of mild pain, whilst opioids are indicated for the treatment of persistent, moderate-to-severe cancer pain. Where background pain is controlled by strong opioids, BTcP should be treated with transmucosal immediate-release fentanyl (TIRF), following proper titration.

Currently, the benefits of modern drug formulation technologies, drug delivery systems, and digital care options facilitate the management of cancer pain. Furthermore, current evidence suggests that the most severe BTcP phenotypes are correlated with specific cancer characteristics or background pain types. In these instances, more severe phenotypes could be monitored using telemedicine programmes.

As an essential component of the multidisciplinary cancer team, responsibilities of the oncology pharmacist include optimizing the benefits of drug therapies, minimizing their toxicity, and working with patients and carers on supportive care issues. Several studies have shown that incorporation of pharmacists into the cancer pain team leads to observable reductions in drug-related issues, with a statistically significant reduction in pain intensity and adverse analgesic reactions.

The optimal route of drug administration (oral, parenteral, transdermal, transmucosal), the patient’s preferred formulation (tablet, capsules, liquids) and the type of release (immediate or controlled) should be carefully determined according to the pain assessment and may be modified over time. Interventional strategies, such as neurolytic blocks, intrathecal drug delivery systems, vertebral augmentation and neuro-modulation for neuropathic pain provide options for managing cancer pain that is refractory to pharmacological therapy. Furthermore, rehabilitative medicine (including preventative, restorative, supportive...
and palliative rehabilitation) can be combined with other analgesic strategies used to control cancer-related pain, whilst a range of adjuvant drugs (co-analgesics) can be combined with analgesic therapies to enhance their effects. Distress, anxiety and depression are prevalent in patients with cancer and can exacerbate pain expression, requiring appropriate and tailored healthcare interventions. A multidimensional approach, combining drugs with psychological and cognitive behavioural treatments, can reduce pain severity and interference with function.

The management of adverse effects induced by drugs used for cancer pain requires meticulous understanding of side-effect profiles linked to specific medications; consequently, it is essential to assess the patient's characteristics and comorbidities and to anticipate potential drug–drug interactions.

A cancer pain management plan should be reviewed regularly to assess outcomes, rescheduling treatments and gradually discontinuing drugs when no longer required. The active care of patients can be provided by a variety of healthcare professionals simultaneously (e.g. oncologists, surgeons, pharmacists, primary care physicians, nurses, psychologists, physiotherapists and occupational therapists). It is therefore essential to set up a dedicated multidisciplinary team with the knowledge, commitment, communication skills and capacities to manage cancer pain. Cancer care services require adequate resources to provide education to patients, caregivers and staff, whilst pathways for reviewing and improving the quality of pain care must be continually implemented.

Finally, inpatients and outpatients with advanced cancer should receive dedicated and early palliative care services to improve QoL, similarly managed by a multidisciplinary team, with equal consideration of the factors outlined in this discussion.

Case reports

We report four real-world clinical cases of managing complex cancer-related pain using a multidisciplinary and comprehensive approach.

All the data referring to the patients were published anonymously without any details allowing re-identification of the patient and in accordance with the World Medical Association Declaration of Helsinki.

Case report #1

A 75-year-old male with a functional status compatible with an Eastern Cooperative Oncology Group Performance Status (ECOG PS) of 0 and no relevant comorbidities underwent routine endoscopy and was diagnosed with a circumferential lesion of the stomach pylorus. The biopsy was compatible with adenocarcinoma stage cT3N0M0. The multidisciplinary tumour board proposed perioperative chemotherapy with 5-fluorouracil (5-FU), leucovorin, oxaliplatin and docetaxel. Four cycles pre-surgery and post-surgery were scheduled and primary neutropenic prophylaxis with filgrastim for 4 days was also prescribed. The first cycle was performed at 50% 5-FU, pending the detection of genetic variants of dihydropyrimidine dehydrogenase (DPYD). The second and third cycles were performed on 100% 5-FU.

Ten days after the third cycle, the patient was admitted at outpatients and complained of abdominal cramping (NRS 4–5) lasting 3–5 days. He reported oropharyngeal pain, nausea and anorexia that limited oral intake and diarrhoea grade 2 on CTCAE (Common Terminology Criteria for Adverse Events V 5.0) with liquid stool seven times a day and then twice or three times daily. No blood, mucus or purulent appearance were observed.

On clinical examination, the patient was dehydrated and debilitated with an ECOG PS scale of 1. Oropharyngeal candidiasis was observed, and the abdomen was plain and smooth with diffuse tender to deep palpation but no irritable signs. Blood tests revealed decreased albumin and elevated C-reactive protein levels with no other significant alterations. Gastroenteritis was suspected and the patient was started on hydration and intravenous bolus morphine. After 4–6 h with no pain exacerbation, the patient was discharged with ciprofloxacin (500 mg, twice daily), tapentadol (50 mg, twice daily), fluconazole (100 mg, once daily) and a suitable diet.

At the next clinical evaluation, scheduled 2 days later, the patient complained of excruciating irritative abdominal cramps, was unable to ingest due to oropharyngeal pain exacerbation and had no stool passage in the last 48 h. The patient had lost 3 kg since the beginning of treatment and appeared dehydrated, with evidence of oropharyngeal candidiasis. An abdominal X-ray and ultrasound showed small bowel distension. The patient was admitted for supportive measures with hydration and intravenous morphine for pain control. He was discharged a few hours later with hypercaloric and hyperproteic enteral supplements, TIRF (25 μg/h) and rescue sublingual fentanyl (133 μg up to four times, daily). The fourth cycle was postponed for 1 week to facilitate recovery.
The evaluation before treatment showed CTCAE V 5.0 Grade 2 asthenia, recovered appetite, abdominal discomfort without pain or need for rescue medication in the last 48 h, regular intestinal transit, mild bilateral ankle swelling and 2-kg weight gain. The dose of 5-FU in the fourth cycle was reduced by 20% and the transdermal fentanyl dose was decreased to 12.5 μg/h. The treatment was well tolerated and the patient recovered his activities with an ECOG PS of 0, regular food intake, regular intestinal functioning, no abdominal pain and no need for rescue medication. Two weeks after treatment, transdermal fentanyl was suspended and surgical intervention was planned 4–6 weeks after the last cycle.

Comment

Patients receiving chemotherapy often experience mucosal damage throughout the digestive tract; mucositis reflects a short-term, self-limited adverse effect of cancer treatments, especially in those treated with 5-FU, methotrexate, capecitabine and irinotecan.\(^{97–102}\) Symptoms include painful oral ulcerations, dysphagia, odynophagia, oesophagitis, gastritis, diarrhoea, electrolyte imbalance, dehydration, malabsorption and malnutrition. In some cases, life-threatening infections and sepsis can occur.\(^{99}\) Mild oral mucositis can also be very painful and worsen patients’ QoL. Basic physiological needs, such as swallowing and eating, can be limited, directly influencing the success of anticancer therapies and greatly impacting clinical outcomes.\(^{103–106}\)

The onset of chemotherapy-associated enteritis is acute (usually within 24–48 h after treatment) and may present with increased frequency of bowel movements, excessive gas, intestinal cramping and loosening of stool consistency. This can become severe with frequent watery stools. Nausea, vomiting, anorexia and intense abdominal pain can also occur.\(^{99,107,108}\) Patients with severe intestinal mucositis frequently require hospital admission for adequate supportive care.

The National Cancer Institute Common Terminology Criteria for Adverse Events\(^{96}\) grades the severity of mucositis on a scale of 0–5, based primarily on symptom severity, functional alteration and intervention requirements. Integration with patient-reported outcomes, such as the Oral Mucositis Daily Questionnaire\(^{109}\) or the Patient-Reported Oral Mucositis Symptom Scale,\(^{105}\) becomes critical for improving the accuracy of clinical evaluation.\(^{5}\) The Multinational Association of Supportive Care in Cancer and the International Society of Oral Oncology offer specific guidelines for the treatment of oral mucositis.\(^{110}\) Primarily, oral administration of systemic opioids is recommended to treat pain, whilst intravenous morphine is the preferred parental route for patients who cannot swallow. Transdermal fentanyl is another suitable option in this instance.\(^{31}\)

This case illustrates the need for regular examination in patients undergoing chemotherapy and highlights that monitoring of symptom evolution is mandatory to prevent toxicity. Optimization of a patient’s physical condition during perioperative treatment is essential to ensure the best possible outcomes and to support surgical aggressiveness. All approaches to iatrogenic symptom control should therefore be undertaken, including opioid therapy, even in the early stages of cancer.

Aligning the action of clinical resources and recruiting a multidisciplinary team are fundamental to addressing supportive care measures, accomplishing proposed plans and maintaining the best patient-centred care.

Case report #2

A 54-year-old man was diagnosed with bladder cancer (stage T3N2M0) in October 2021. Histological examination revealed high-grade invasive urethelial carcinoma (ypT4a, ypN3). Adjuvant chemotherapy (gemcitabine and carboplatin for three cycles) before radical cystectomy was performed and a cutaneous uretero-ileostomy ad modum Bricker was created.

In April 2022, the patient had persistent abdominal pain (NRS 3–4). Computed tomography (CT) revealed a large, capsulated fluid collection in the pelvis. Bilateral percutaneous drainage was performed but, at the next CT scan, fluid collection (7.8 × 5.5 cm) did not decrease and malignant ascites due to peritoneal carcinomatosis was found.

In May 2022, the patient complained of abdominal pain (NRS 6–7), nausea, vomiting and constipation and was treated at home with intramuscular ketorolac (30 mg) as needed. A clinical and radiological diagnosis of sub- obstruction was made; a nasogastric tube was placed and hydration was provided.

Rapid opioid titration with intravenous morphine (1.5 mg/10 min) was initiated to control pain, followed by continuous intravenous morphine (40 mg/24 h), dexamethasone (8 mg/24 h) and metoclopramide (10 mg/24 h). To manage transient exacerbations of pain, intramuscular butylscopolamine (20 mg, daily) and subcutaneous morphine (10 mg as needed) were provided.

In the subsequent days, the symptoms and pain remained well controlled; however, on hospital day 10, the patient complained of unrelenting severe abdominal pain (NRS 10). After swallowing of the oral water-soluble...
Pain was the paramount symptom in this patient; intravenous morphine was prescribed according to the European Society of Palliative Care and WHO guidelines. Notably, morphine is two to three times more potent when administered parenterally and is physically compatible with other drugs commonly used in syringe drivers.

When MBO is diagnosed in advanced cancer, a multidisciplinary team is required to inform medical decisions, directed at minimizing symptom burden and maximizing QoL. For improved medical decision-making, patients and their families must be informed about available treatment options and their respective likely outcomes. Patients must be encouraged to communicate their needs so that effective symptom and pain control can be delivered in their preferred setting.

Case report #3

A 78-year-old man, with a diagnosis of prostatic adenocarcinoma with pulmonary and vertebral metastases had recently discontinued active therapies on his own due to collateral effects and knowledge of disease progression at the last diagnostic investigation. Furthermore, the worsening of vision due to bilateral maculopathy and the need for urinary catheter had greatly reduced his independence.

Pain was poorly controlled with oxycodone (20 mg, twice daily), such that he avoided movement, spending most days alone in bed, lasting a period of approximately 2 months. The patient’s family consulted the oncologist, who reported the case to a multidisciplinary team. The team agreed on immediate referral to home palliative care service.

At the first home visit, the patient showed a discrete performance status (Karnofsky performance score of 60) and lumbar pain (NRS 4–5) radiating to the left leg, with several episodes of BTPC. BTPC episodes (NRS 8–9) were spontaneous and mainly exacerbated by movement or walking. Additionally, the patient was especially frightened by the upcoming catheter change, which he reported to be very painful. The patient reported taking oxycodone irregularly. The Palliative Prognostic score (PaP; 2.5 points and 30-day survival probability >70%), Hospital Anxiety Scale (9 points, borderline) and Hospital Depression Scale (16 points, abnormal) were used to assess the patient.

To improve adherence to opioid treatment, transdermal fentanyl (25 μg/h) was applied and sublingual fentanyl (133 μg, up to four times daily) was prescribed for BTPC, volitional or spontaneous. Sublingual fentanyl was also recommended shortly before catheter replacement to

After a 2-week inpatient stay, the patient wanted to return home to be with his family. He was referred to a home palliative care team, with a subcutaneous portable pump for prolonged subcutaneous administration of morphine (80 mg, daily), dexamethasone (8 mg, daily), hyoscine butylbromide (60 mg, daily) and octreotide (0.5 mg, daily). Oral transmucosal fentanyl (133 μg, up to four times daily) was prescribed for visceral BTPC. The patient died at home 20 days later.

Comment

Peritoneal carcinomatosis and MBO are common in the progression of many cancer types and demand a multidisciplinary approach for successful palliation. Medical management for inoperable symptomatic MBO includes antimotility, antisecretory and antiemetic drugs, which aid spontaneous occlusion resolution in 30–40% of cases.

Due to its anti-inflammatory effect, dexamethasone (4–12 mg, daily) provides central antiemetic effects and minimizes distension of the bowel wall. Whilst intravenous metoclopramide (10 mg/4 h) is the first-line treatment option for partial bowel obstruction, it should be avoided in cases of complete obstruction. Somatostatin analogues (e.g. octreotide) reduce peristalsis and gastroenteric secretions and may be administered by subcutaneous bolus or continuous subcutaneous infusion. It is also important to note that peripheral μ-opioid receptor antagonists, prescribed for the management of opioid-induced constipation, are contraindicated for MBO. Finally, for patients with intractable symptoms, immediate placement of a nasogastric tube for decompression provides relief.

Routine parenteral nutrition for patients with end-stage cancer and MBO is generally discouraged, and nutrition interventions should only be initiated when the benefits to QoL and survival outweigh the risks. Multidisciplinary teams should therefore identify patients that will survive long enough to benefit from tailored parenteral nutrition and hydration.

Pain was poorly controlled with oxycodone (20 mg, twice daily), such that he avoided movement, spending most days alone in bed, lasting a period of approximately 2 months. The patient’s family consulted the oncologist, who reported the case to a multidisciplinary team. The team agreed on immediate referral to home palliative care service.

At the first home visit, the patient showed a discrete performance status (Karnofsky performance score of 60) and lumbar pain (NRS 4–5) radiating to the left leg, with several episodes of BTPC. BTPC episodes (NRS 8–9) were spontaneous and mainly exacerbated by movement or walking. Additionally, the patient was especially frightened by the upcoming catheter change, which he reported to be very painful. The patient reported taking oxycodone irregularly. The Palliative Prognostic score (PaP; 2.5 points and 30-day survival probability >70%), Hospital Anxiety Scale (9 points, borderline) and Hospital Depression Scale (16 points, abnormal) were used to assess the patient.

To improve adherence to opioid treatment, transdermal fentanyl (25 μg/h) was applied and sublingual fentanyl (133 μg, up to four times daily) was prescribed for BTPC, volitional or spontaneous. Sublingual fentanyl was also recommended shortly before catheter replacement to
reduce procedural pain. Duloxetine (30 mg, once daily) was prescribed for the co-occurrence of neuropathic pain and depression in the patient, measured by the Hospital Depression Scale.

After approximately 3 weeks, the patient presented with baseline-controlled pain (NRS 1–2) and was receiving two daily intakes of TIRF on average for volitional BTcP; mood was markedly improved. Following recommendation from the palliative care physician, the patient underwent a new oncology consultation. The multidisciplinary team proposed single-shot spinal radiotherapy (D12–L1).

Comment
Sharing verified scales for the comprehensive and all-inclusive assessment of patients with cancer is essential for multidisciplinary teams. Greater interprofessional dissemination of scales validated by scientific societies, available on digital platforms, could enhance the management of patients with cancer. Consequently, training programmes for the use of validated scales and their implementation in clinical practice are critical in the future.\textsuperscript{129,130}

In this case, an overall PaP score, derived from the Karwowski Performance score combined with five other criteria, was used to generate prognostic information. The PaP was reported in the form of a 0–17.5 numerical scale, with higher scores predicting shorter survival.\textsuperscript{129}

The biopsychosocial model of pain emphasizes the interactions between chronic pain, anxiety and depression, which are often difficult to diagnose in patients with cancer despite their high prevalence and associated all-cause mortality.\textsuperscript{80–83}

The Hospital Anxiety Scale and Depression Scale are unidimensional measures recommended to assess psychological distress amongst populations aged 65–80 years. They yield consistent results and show invariance regarding sex.\textsuperscript{132} In this case, these scales simplified the assessment of depression in outpatient cancer care settings and guided treatment with duloxetine, which is also useful as an adjuvant for neuropathic pain.

Finally, regular and thorough assessment of pain, monitoring baseline and daily fluctuations, is crucial.\textsuperscript{133} Often, greater intensity breakthrough pain episodes in the advanced stages of cancer are due to bone pain, caused by metastasis. This is responsible for both incident and movement-induced BTcP.\textsuperscript{134} Correct management of BTcP allows for significant improvement in the QoL of these patients.\textsuperscript{135–137}

TIRF is the treatment of choice for BTcP due to its pharmacological properties, including rapid onset, increased potency and short half-life.\textsuperscript{126,138} Conversely, oral immediate-release opioids can be used to treat slow-onset or predictable BTcP.\textsuperscript{34,35,139} Furthermore, both TIRF and oral morphine can be prescribed to manage procedural pain, administered according to their onset of action (10–15 and 30 min, respectively).\textsuperscript{138,140}

In support of this, a Delphi expert management consensus recommended transmucosal fentanyl and oral morphine as the most appropriate drugs for procedural pain,\textsuperscript{138} suitable for both outpatients and inpatients, whilst intravenous and subcutaneous morphine was deemed most appropriate for inpatients.\textsuperscript{138}

Case report #4
A 44-year-old woman was diagnosed, in 2009, with epithelioid sarcoma, located primarily in the fifth left metacarpal bone. In 2012, the surgery was radicalized by amputating fifth metacarpal bones and fifth left finger. Due to a local recurrence in 2014, preoperative radiotherapy was provided prior to surgical treatment. The fourth finger and four left metacarpal bones were then amputated.

The patient received analgesic treatment with long-acting morphine (30 mg/12 h), short-acting morphine (as needed) and paracetamol (2 g, daily). However, due to the increased intensity of phantom pain (NRS 7), the treatment was modified by including oxycodone (40 mg/12 h) and short-acting morphine temporarily withdrawing from the long-acting form. Pregabalin was added and gradually increased to a dose (150 mg/8 h). Rehabilitation began with special focus on the mirror method.

Following complete resolution of phantom pain, pain medications (including pregabalin) were withdrawn 12 months after the initiation of analgesic treatment. The patient did not experience any episodes of pain and fully returned to social and professional activities. She assessed her QoL as high throughout periodic control performed by the care team (palliative care physician and oncologist).

In June 2016, the patient-reported pain in the left arm-pit area and the previous pain treatment schedule was gradually reinstated, achieving good pain control. No abnormalities were found in the imaging studies of the left armpit and chest.

At the end of December 2016, during a routine inspection at the palliative clinic, a painless mass approximately 5 mm in diameter was detected in the patient's left
armpit, and an urgent excision of the lesion with the surrounding tissue margin was performed. Histopathology confirmed epithelioid sarcoma and two lymph nodes 10 mm in diameter were identified upon re-examination of the thoracic CT. This prompted the multidisciplinary team to perform preoperative radiotherapy and subsequent axillary lymphadenectomies.

Due to local recurrence, the patient began to experience anxiety states and required psychological support; alprazolam (0.5 mg/8 h) was initiated, reducing their frequency and severity.

After radiotherapy and lymphadenectomy, the pain in the armpit and shoulder areas worsened (NRS 4–5), coupled by a significant reduction in shoulder joint mobility. Phantom pain worsened and BTcP appeared, often concurrent with physical activity. BTcP showed moderate-to-severe intensity (NRS 6–8), appearing suddenly, typically lasting approximately 30 min.

After increasing the dose of oxycodone (80 mg, twice daily) and pregabalin (300 mg, 150 mg and 300 mg, daily), complete control of phantom pain and good control of background pain was achieved (NRS <3). Initially, 133 μg of sublingual fentanyl was administered to treat breakthrough pain episodes. Following titration, the optimal dose was 267 μg for a maximum of 2–4 BTcP episodes throughout the day. The patient also underwent comprehensive rehabilitation, achieving significant improvement in functionality. In the following months, the patient experienced controlled pain and assessed QoL as good, with improved professional, social and family life.

In October 2020, 267 μg of sublingual fentanyl did not provide the patient with satisfactory relief from BTcP (reduction of NRS from 7–8 to 5–6) and the dose was increased to 533 μg, achieving fast and effective reduction of breakthrough pain.

In January 2021, local radiotherapy was initiated to treat a new recurrence. This resulted in dermatological complications (such as skin wounds and oozing) and tissue restrictions, which significantly limited mobility in the shoulder joint and caused severe pain. QoL deteriorated significantly, owing to the acknowledgement of disease progression and the patient became increasingly concerned about death. The multidisciplinary team requested a psychiatric consultation for depressive symptoms and the patient was referred to palliative care staff. After acceptance of disease progression and the inevitability of death, the patient tried to enjoy each subsequent day without pain. At present, despite the lack of recovery, the patient still participates in family life, is self-reliant, and her greatest joys are the graduation and independence of her daughters and her loving and supportive husband.

**Comment**

Epithelioid sarcoma is a rare, slow-growing soft tissue malignancy associated with a high rate of local recurrence, metastases and mortality.\(^{143,142}\) The classic variant typically occurs in young adults and tends to arise in the distal extremities.

Missed or delayed diagnosis is commonplace.\(^{143}\) In high-volume, comprehensive cancer centres, patient-centric oncological pathways should be established to address this, thereby lowering morbidity and mortality rates.\(^{144}\)

Limb-sparing surgery, with early reconstructive procedures and preservation of function is foundational in the treatment of most sarcomas of the forearm, hand and wrist.\(^{145}\)

In the described case, progressive neoplastic disease and iatrogenic consequences of treatment manifested in various types of pain and other ailments. The appropriate selection of painkillers allowed for complete pain control, relieving it almost completely with relatively few side-effects. Although the expected durations of opioid therapies, adjuvants and non-opioid analgesics can vary and range from infrequent to long-term, the present case demonstrates that the implementation of opioid drugs is not synonymous with lifelong use. This is supported by evidence that patients with cancer are not primarily affected by opioid misuse and appropriate pain management supports avoidance of addiction, whilst maintaining full symptom control.\(^{24,25}\) Even higher doses of opioid analgesics used across several months can be safely discontinued in the event of pain relief, provided that the treatment is properly administered and withdrawal is accompanied by strong clinician support.

Early and dedicated palliative care delivered by interdisciplinary teams, parallel to oncological therapies, improves health-related QoL and ameliorates symptom burden. Partnering with patients and their families is paramount to promote physical, spiritual and psychosocial well-being throughout their journey with the disease.\(^{93,146–148}\)

**Key highlights of cancer pain management**\(^{93,149}\)

- Always assess the presence of pain in patients with cancer.
- Identify the underlying mechanism of pain and intervene on modifiable causes.
- Assess psychological and emotional distress.
✓ Quantify pain periodically using validated scales.
✓ Select specific scales for cognitive impairment.
✓ Evaluate the most appropriate choice of treatment as part of the multidisciplinary team and propose it to the patient.
✓ Frequently reassess pain and encourage patients to use pain diaries.
✓ Consider the benefits of adjuvants to improve pain control.
✓ Assess for the presence of BTcP in patients on stable doses of opioids and offer appropriate tailored therapy, as needed.
✓ Change the route of opioid administration and use opioid rotation (or switching) to improve clinical outcomes.
✓ Assess addictive behaviour in patients using opioids.
✓ Gradually taper therapy when unnecessary.

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