Symptom management in elderly cancer patients

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Assistant Professor University of Manitoba

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Case 1

• 80 yo female with an enlarging nasopharyngeal adenoma presents to clinic.
• She has 5/10 pain over her left face and skull. It is aching and has a burning component to it. It does not radiate. Swallowing makes it worse. It keeps her up at night.
• She has good family support apart from an estranged son
Suffering in cancer pts

Physical (49.5%)
- Fatigue
- Pain
- Nausea
- Weakness

Social-relational (18.8%)
- Isolation
- Communication
- Burden to others
- Leaving loved ones

Psychological (14%)
- Anxiety
- Depression
- Hopelessness
- Desire for death

Existential (17.7%)
- Loss of resilience
- Loss of dignity
- Loss of control
- Spiritual crisis
- Difficulty accepting

N = 381
Median age = 65

Wilson KG et al: J Clin Oncol. 2007; 5:1691-1697
Prevalence and severity of cancer pain

- 122 studies (2005 – 2014)
- N = 63,533

<table>
<thead>
<tr>
<th>Group</th>
<th>Pain (%)</th>
<th>Moderate-severe (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>After curative tx</td>
<td>39.3</td>
<td>27.6</td>
</tr>
<tr>
<td>During tx</td>
<td>55.0</td>
<td>32.4</td>
</tr>
<tr>
<td>Advanced-metastatic</td>
<td>66.4</td>
<td>51.9</td>
</tr>
</tbody>
</table>

Worst Pain:
- Head + Neck ca
- Lung ca
- Breast ca

Age not associated with pain prevalence

Opioid prescriptions in elderly cancer pts based on pain severity: N = 219,535

<table>
<thead>
<tr>
<th>Year</th>
<th>Moderate (%)</th>
<th>Severe (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>41.8</td>
<td>60.9</td>
</tr>
<tr>
<td>2008</td>
<td>38.0</td>
<td>52.8</td>
</tr>
<tr>
<td>2009</td>
<td>29.6</td>
<td>46.7</td>
</tr>
<tr>
<td>2010</td>
<td>27.6</td>
<td>45.4</td>
</tr>
<tr>
<td>2011</td>
<td>26.2</td>
<td>42.7</td>
</tr>
<tr>
<td>2012</td>
<td>25.4</td>
<td>42.6</td>
</tr>
<tr>
<td>2013</td>
<td>25.0</td>
<td>39.2</td>
</tr>
</tbody>
</table>

“a quality gap in the management of pain in [elderly] pts with cancer”

Classifying cancer pain

Nociceptive

Somatic
- Aching
- Stabbing
- Throbbing
- Pressure like
- Well localized

Visceral
- Gnawing
- Crampy
- Aching
- Stabbing
- Poorly localized

Mixed

Neuropathic
- Burning
- Shock-like
- Electrical
- Allodynia
- Hyperalgesia
- Neurologic defect
- Autonomic defect

Cancer (75%)
Cancer treatment (25%)

Elderly: Chronic non-cancer pain = 45-85%

Portenoy RK. Lancet. 2011;377:2236-2247
Classifying cancer pain: Edmonton Classification System of Cancer Pain

- Multinational validation study
- N = 1100, Mean age = 61 - 69

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
<th>Time to pain control</th>
<th>Adjuvant analgesics</th>
<th>Total opioid dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nociceptive</td>
<td>67</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
</tr>
<tr>
<td>Neuropathic</td>
<td>27</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Incident pain</td>
<td>48</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Psychological distress</td>
<td>44</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Addictive behavior</td>
<td>11</td>
<td>↔</td>
<td>↔</td>
<td>↑</td>
</tr>
<tr>
<td>Impaired Cognition</td>
<td>21</td>
<td>↔</td>
<td>↔</td>
<td>↔</td>
</tr>
</tbody>
</table>

↓ or ↑ = P < 0.05

Age > 60 ↓ time to pain control

World Health Organization Pain Ladder

- Non-opioids +/- adjuvant tx
- Weak opioids +/- adjuvant tx
- Strong opioids +/- adjuvant tx
- Interventional pain tx

Up to 90% of patients can get adequate pain control

Prommer EE: Cancer Control. 2015;22(4):412-425
Case 1 continued

• PMH: DM, HTN
• H/o falls, uses a walker
• Hard of hearing

• CrCl = 45
• Normal LFT’s

• Currently on Acetaminophen

• Realistic about treatment goals.
Acetaminophen

- 3 studies, N = 122
- Low quality of evidence
- No studies looked at acetaminophen alone
- No evidence of benefit when combined with opioids
- No clear evidence of harm

**Elderly:**
- well tolerated, 1\textsuperscript{st} line treatment, not habit forming, elimination not affected by age

Delgado-Guay MO, Bruera E. Oncology. 2008;22(2):148-152
NSAIDs

- 11 studies, N = 949
- Alone or in combination with opioids
- Significant improvement (within 1-2 weeks):
  - 26 – 51%

- Common side effects:
  - Thirst/dry mouth (15%), loss of appetite (14%), dyspepsia (11%), somnolence (11%)

- Treatment withdrawal:
  - Lack of benefit = 24%
  - Adverse event = 5%

NSAIDS: Elderly

• Toxicity ↑ in elderly
• Brief better than long term use
• Topical = ↓ toxicity
• Consider GI protection

• COX-2 inhibitors:
  – ↓ GI toxicity
  – ↑ CVD toxicity
• Naproxen = ↓ CVD risk

## Common opioids

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Opioid</th>
<th>Potency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pure agonist</td>
<td>Morphine</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Hydromorphone</td>
<td>5 x</td>
</tr>
<tr>
<td></td>
<td>Oxycodone</td>
<td>2 x</td>
</tr>
<tr>
<td></td>
<td>Fentanyl</td>
<td>100 x</td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td>4-12 x</td>
</tr>
<tr>
<td></td>
<td>Codeine</td>
<td>1/10 x</td>
</tr>
<tr>
<td>Agonist-antagonist</td>
<td>Buprenorphine</td>
<td></td>
</tr>
<tr>
<td>Mixed mechanism</td>
<td>Tramadol</td>
<td>1/10 x</td>
</tr>
<tr>
<td></td>
<td>Tapentadol</td>
<td>2.5 x</td>
</tr>
</tbody>
</table>

Similar efficacy

## Common opioid toxicities

<table>
<thead>
<tr>
<th>Adverse event</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>25</td>
</tr>
<tr>
<td>Nausea +/- vomiting</td>
<td>21</td>
</tr>
<tr>
<td>Somnolence</td>
<td>23</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>17</td>
</tr>
<tr>
<td>Decreased appetite</td>
<td>13</td>
</tr>
<tr>
<td>Dizziness</td>
<td>13</td>
</tr>
<tr>
<td>Fatigue</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Mood changes</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Insomnia</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

### Opioids have similar toxicity

### Toxicity: Elderly > Younger

### At least 1 significant adverse event = 11-77%

### Pts Stopped therapy = 6-19%

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Important considerations in the elderly

↑ comorbidities
↑ prescription meds
↓ organ perfusion
Δ in GI absorption (pH)
↑ adipose tissue
↓ body mass
Δ in volume of distribution
Implications for prescribing pain meds in the elderly

- ↓ 1\textsuperscript{st} + 2\textsuperscript{nd} pass metabolism
- ↓ renal excretion
- ↑ ½ life
- ↓ time to peak analgesia
- ↑ metabolites
- ↓ therapeutic window

Prescribing pain meds in the elderly

- Check for drug-drug interactions
- Introduce 1 agent at a time
- Start slow and go slow (i.e. 1/2 regular dose)
- Increase interval between medication titration
- Monitor for toxicity more frequently

Prescribing opioids in the elderly

• Start with short acting medication

• Weak evidence:
  – Oxycodone ↓ hallucinations
  – Fentanyl ↓ confusion + constipation

• Consider least invasive route
• Use long-acting formulations after adequate exposure
• Breakthrough dose ≈ 10% of 24 hour needs
• Have lower threshold for rotating opioids

Opioid-Induced Neurotoxicity (OIN)

Cognitive dysfunction
Hallucinations
Myoclonus/seizures
Hyperalgesia/allodynia

High/prolonged opioid use
Advanced age
Comorbidities/ Renal failure
Poly-pharmacy

Look for other causes
Rotate opioids
Hydrate

Daeninck PJ, Bruera E. Acta Anaesthesiol Scand. 43(9):924-38, 1999
Case 1 continued

• We started HM 0.5-1 mg po q2h prn pain.

• Over the next month the dose was titrated to HM C 6 mg po bid and HM 1-2 mg po q2h prn.

• She was worried about taking more and felt that it was making her fatigued.
## Common adjuvant therapies: Neuropathic pain

<table>
<thead>
<tr>
<th>Type</th>
<th>Studies</th>
<th>N</th>
<th>NNT</th>
<th>NNH</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCA’s</td>
<td>15</td>
<td>948</td>
<td>3.6</td>
<td>13.4</td>
</tr>
<tr>
<td>SNRI’s</td>
<td>10</td>
<td>2541</td>
<td>6.4</td>
<td>11.8</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>25</td>
<td>5940</td>
<td>7.7</td>
<td>13.9</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>14</td>
<td>3503</td>
<td>7.2</td>
<td>25.6</td>
</tr>
<tr>
<td>Tramadol</td>
<td>6</td>
<td>741</td>
<td>4.7</td>
<td>12.6</td>
</tr>
<tr>
<td>Strong opioids</td>
<td>7</td>
<td>838</td>
<td>4.3</td>
<td>11.7</td>
</tr>
</tbody>
</table>

NNT > 50% reduction in pain

Choosing adjuvant tx in the elderly

<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
<th>Clinical Pearls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>Nortriptyline</td>
<td>Preferred TCA Anticholinergic AE’s</td>
</tr>
<tr>
<td></td>
<td>Duloxetine</td>
<td>Preferred SNRI</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Gabapentin</td>
<td>Monitor renal function ↑ risk of falls</td>
</tr>
<tr>
<td></td>
<td>Pregabalin</td>
<td>Monitor renal function ↑ risk of falls</td>
</tr>
</tbody>
</table>

Other adjuvants in elderly

<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topical</td>
<td>Menthol 1.5-3%</td>
</tr>
<tr>
<td></td>
<td>Capsaicin 0.025-8%</td>
</tr>
<tr>
<td></td>
<td>Lidocaine 2-5%</td>
</tr>
<tr>
<td></td>
<td>Diclofenac 1-3%</td>
</tr>
<tr>
<td>Antispasticity agents</td>
<td>Baclofen</td>
</tr>
<tr>
<td></td>
<td>Dantrolene</td>
</tr>
<tr>
<td></td>
<td>Tizanidine</td>
</tr>
<tr>
<td>Antispasmodic agents</td>
<td>Carisoprodol</td>
</tr>
<tr>
<td></td>
<td>Cyclobenzaprine</td>
</tr>
<tr>
<td></td>
<td>Methocarbamol</td>
</tr>
<tr>
<td>Steroids</td>
<td>Dexamethasone</td>
</tr>
<tr>
<td>NMDA antagonist</td>
<td>Ketamine</td>
</tr>
</tbody>
</table>

Case 1 continued

• We started a topical lidocaine ointment

• Later we felt there was a component of depression and initiated venlafaxine
Case 2

- 72 female with h/o metastatic endometrial ca
- She has visceral-nociceptive 4/10 abdominal pain despite morphine 10 mg po q1h prn. She has great social support.

- She does not want to start a long acting opioid
- She cries frequently in clinic. Depression screening (+)

- We started duloxetine

- At follow-up visit her depression is better. She continues to have pain. She wants to try Marijuana
Medical Marijuana

• CB receptors
  – CB1 = neuro-modulatory
  – CB2 = immune-modulatory

<table>
<thead>
<tr>
<th>Type</th>
<th>Onset (min)</th>
<th>Duration (h)</th>
<th>Enzyme inhibition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoked</td>
<td>5</td>
<td>2-4</td>
<td>3A4</td>
</tr>
<tr>
<td>Vaporized</td>
<td>5</td>
<td>2-4</td>
<td>3A4</td>
</tr>
<tr>
<td>Oral</td>
<td>30-60</td>
<td>8-12</td>
<td>3A4</td>
</tr>
<tr>
<td>Nabilone</td>
<td>60-90</td>
<td>8-12</td>
<td></td>
</tr>
<tr>
<td>Dronabinol</td>
<td>30-60</td>
<td>4-6</td>
<td>3A4</td>
</tr>
<tr>
<td>Nabiximols</td>
<td>15-40</td>
<td>2-4</td>
<td>3A4</td>
</tr>
</tbody>
</table>

THC = psychoactive
CBD = non-psychoactive

Cannabinoids

- RCT
- THC:CBD extract vs. THC extract vs. placebo
- N = 177, all pts on baseline opioids
- Median age = 60

<table>
<thead>
<tr>
<th>Pain Outcome</th>
<th>THC:CBD</th>
<th>THC</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>↓ VAS (10 point)</td>
<td>-1.37*</td>
<td>-1.01</td>
<td>-0.69</td>
</tr>
<tr>
<td>≥ 30% ↓ Pain</td>
<td>43%*</td>
<td>23%</td>
<td>21%</td>
</tr>
</tbody>
</table>

* P < 0.05 (THC:CBD vs. Placebo)

Cannabinoids for medical use: A systematic review and meta-analysis- 2015

- Cancer and non-cancer patients (N = 6462)
- Moderate-quality evidence to support use in chronic pain
- > 30% improvement pain = 37% vs. 31%, OR 1.41 (0.99 – 2.00)
- ↓ VAS vs. control arm - 0.47

The effects of cannabis among adults with chronic pain and an overview of general harms- 2017

- Cancer (N = 596, 3 RCTs)
- Significant methodological limitations
- Insufficient evidence

Systematic review and meta-analysis of cannabinoids in palliative medicine- 2018

- Cancer patients (N = 758)
- No significant improvement in:
  Caloric intake, appetite, N/V, > 30% decrease in pain, sleep

## Cannabinoid toxicity

<table>
<thead>
<tr>
<th>Side effect</th>
<th>Odds ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorientation</td>
<td>5.41 (2.61 – 11.19)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>5.09 (4.10 – 6.32)</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>3.5 (2.58 – 4.75)</td>
</tr>
<tr>
<td>Nausea</td>
<td>2.08 (1.63 – 2.65)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>2.00 (1.54 – 2.62)</td>
</tr>
<tr>
<td>Somnolence</td>
<td>2.83 (2.05 – 3.91)</td>
</tr>
<tr>
<td>Euphoria</td>
<td>4.08 (2.18 – 7.64)</td>
</tr>
<tr>
<td>Confusion</td>
<td>4.03 (2.05 – 7.97)</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>2.19 (1.02 – 4.68)</td>
</tr>
<tr>
<td>Serious AE</td>
<td>1.41 (1.04 – 1.92)</td>
</tr>
<tr>
<td>Motor vehicle accident</td>
<td>1.35 (1.15 – 1.61)</td>
</tr>
</tbody>
</table>

Cannabis in the elderly

- Prospective study, out-pt cancer clinic
- Age ≥ 65, cannabis tx for 6+ months
- N = 2736

- 43% used for 6+ months
- Oil (37%), smoking (24%), vaporizing (6.4%), oil + vaporizing (48.6%)

- Median pain scores: 8 ➔ 4
- 93.7% = overall improvement
- 41.9% = significant improvement
- 58.6% = QoL good or very good

- Side effects mild
  - Dizziness (9.7%), dry mouth (7.1%), somnolence (3.9%)

Case 3

• 82 yo male with metastatic bladder ca on the palliative care program.

• He has cancer-related pain that is managed with Fentanyl and morphine breakthrough.

• He has significant constipation despite PEG, senna, glycerin supps.

• Abd XRT + stool. Rectal = clear.
Constipation in the elderly

• More common
• Females > males

• Delayed colonic transit
• Pelvic floor dysfunction
• Psychosocial and behavioral factors

## Causes of constipation

<table>
<thead>
<tr>
<th>Cause</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>Immobility, dehydration, weakness</td>
</tr>
<tr>
<td>Metabolic</td>
<td>↑ca, ↓K, ↓Na, ↓Mg</td>
</tr>
<tr>
<td>Cancer</td>
<td>Tumor, radiotherapy, chemotherapy</td>
</tr>
<tr>
<td>Medications</td>
<td>Analgesics (opioids, NSAIDs)</td>
</tr>
<tr>
<td></td>
<td>Anticholinergics</td>
</tr>
<tr>
<td></td>
<td>TCAs</td>
</tr>
<tr>
<td></td>
<td>Antihypertensives (CCB’s, BB’s)</td>
</tr>
<tr>
<td></td>
<td>Antiemetics (ondansetron)</td>
</tr>
<tr>
<td></td>
<td>Minerals (aluminum, ca, iron)</td>
</tr>
<tr>
<td></td>
<td>Antihistamines</td>
</tr>
<tr>
<td></td>
<td>Diuretics (HCTZ, furosemide)</td>
</tr>
<tr>
<td>Medical conditions</td>
<td>Renal disease, Dementia, DM, hypothyroidism, depression</td>
</tr>
</tbody>
</table>

# Treatment

<table>
<thead>
<tr>
<th>Category</th>
<th>Type</th>
<th>Route</th>
<th>Treatment line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osmotic</td>
<td>Polyethylene glycol</td>
<td>PO</td>
<td>1\textsuperscript{st}</td>
</tr>
<tr>
<td></td>
<td>Sorbitol</td>
<td>PO</td>
<td>1\textsuperscript{st}</td>
</tr>
<tr>
<td></td>
<td>Lactulose</td>
<td>PO</td>
<td>1\textsuperscript{st}</td>
</tr>
<tr>
<td></td>
<td>Mg hydroxide/sulfate/citrate*</td>
<td>PO</td>
<td>Caution</td>
</tr>
<tr>
<td></td>
<td>Glycerin</td>
<td>PR</td>
<td>3\textsuperscript{rd}</td>
</tr>
<tr>
<td></td>
<td>Phosphate*</td>
<td>PR</td>
<td>Caution</td>
</tr>
<tr>
<td>Stimulant</td>
<td>Senna</td>
<td>PO</td>
<td>2\textsuperscript{nd}</td>
</tr>
<tr>
<td></td>
<td>Bisacodyl</td>
<td>PO/PR</td>
<td>2\textsuperscript{nd}</td>
</tr>
<tr>
<td>Lubricant</td>
<td>Mineral oil</td>
<td>PR</td>
<td>3\textsuperscript{rd}</td>
</tr>
</tbody>
</table>

Difficult to control constipation

<table>
<thead>
<tr>
<th>Drug</th>
<th>Mechanism</th>
<th>RCT</th>
<th>RR</th>
<th>NNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methylnatrexone</td>
<td>PAMORA</td>
<td>6</td>
<td>0.62</td>
<td>3.4</td>
</tr>
<tr>
<td>Naloxone (oral)</td>
<td>Opioid antagonist</td>
<td>5</td>
<td>0.63</td>
<td>4</td>
</tr>
<tr>
<td>Naldemedine</td>
<td>PAMORA</td>
<td>4</td>
<td>0.65</td>
<td>5</td>
</tr>
<tr>
<td>Naloxegol</td>
<td>PAMORA</td>
<td>3</td>
<td>0.77</td>
<td>7</td>
</tr>
<tr>
<td>Lubiprostone</td>
<td>Type-2 chloride channel activator</td>
<td>3</td>
<td>0.90</td>
<td>15</td>
</tr>
<tr>
<td>Prucalopride</td>
<td>5-HT4 agonist</td>
<td>1</td>
<td>0.88</td>
<td>12</td>
</tr>
</tbody>
</table>

PAMORA = peripherally-acting Mu-opioid receptor antagonist

Case 4

• 67 yo female with metastatic pancreatic cancer on chemotherapy

• She has 9/10 visceral-neuropathic (mixed) pain despite Fentanyl 200 ug/h, morphine 80 mg po q1h prn, pregabalin and duloxetine.

• She has a friend who took methadone because she was a “drug addict” and does not want to take it.
## Interventional therapies

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Example</th>
<th>Level of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomic nerve blocks</td>
<td>Celiac plexus</td>
<td>IIB</td>
</tr>
<tr>
<td></td>
<td>Superior hypogastric plexus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ganglion impar</td>
<td></td>
</tr>
<tr>
<td>Neuroaxial infusion</td>
<td>Epidural/intrathecal</td>
<td>IIB</td>
</tr>
<tr>
<td>Vertebroplasty</td>
<td>Spine</td>
<td>IIIB</td>
</tr>
<tr>
<td>Peripheral nerve blocks</td>
<td>Paravertebral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intercostal</td>
<td></td>
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<tr>
<td></td>
<td>Brachial plexus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gassesian ganglion</td>
<td></td>
</tr>
</tbody>
</table>

Non-pharmacologic interventions

• RCT and meta-analysis benefits seen with:
  – Psycho-social interventions
  – Cognitive behavior therapy
  – Mindfulness-based therapy
  – Physiotherapy
  – Massage therapy
  – Yoga
  – Acupuncture

Electrical nerve stimulation

• Transcutaneous electrical nerve stimulation (TENS):
  – Cancer pts = 3 small RCT: no clear benefit
  – Chronic neuropathic pain
    • -1.58 (-2.08 to -1.09), p <0.01
    • Very low quality of evidence = benefit unclear

• Scrambler therapy:
  – Preliminary reports (20) suggest benefit

Benefit of radiotherapy

• Improves pain (bone):
  – 90% have some pain relief
  – 50% have complete pain relief

• Can also be used to improve symptoms associated with:
  – Brain metastasis
  – Spinal cord compression
  – Bronchial obstruction
  – Bleeding (i.e. Lung, bladder, rectum, stomach)
  – Lymphadenopathy
How are clinic works

• Holistic approach
• Nurse
• Pharmacist
• Physiotherapist (CCMF grant)

• Early psychosocial intervention
• Frequent f/u via telephone
• Utilize integrative medicine
Conclusion

• Cancer related symptoms are common in the elderly

• Understanding factors influencing cancer pain is important

• Elderly pts have unique needs

• Many treatment options are available

• A multifaceted approach is essential to minimize toxicity and maximize benefit
Symptom Management: Consider Geriatric Syndromes

- Cognitive impairment
- Falls
- Frailty
- Incontinence

Under-treatment of cancer pain

- 26 studies (1994 – 2013)
- N = 18,384

<table>
<thead>
<tr>
<th>Year</th>
<th>Undertreated (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994 – 2000</td>
<td>46.6</td>
</tr>
<tr>
<td>2001 – 2007</td>
<td>41.5</td>
</tr>
<tr>
<td>2008 - 2013</td>
<td>31.8</td>
</tr>
</tbody>
</table>

Economic level and cancer specific centers = Better pain control

Age not associated with under-treatment of cancer pain

Unique characteristics in elderly patients: Self reflection

• ↑ Life experiences

• Want to be listened too/respected

• ↑ Time to process

• Longer appointments