

Transcript of PRF Podcast with Judith Paice

(Questions by PRF Correspondent Sarasa Tohyama in bold, answers by NAPS visiting faculty member Judith Paice in plain text).

Thank you so much, Dr. Paice, for sitting with me today. We are incredibly lucky to have you here at NAPS, and you gave an incredible talk this morning. I wanted to start off by asking you about how you came into your career and specifically working with cancer pain patients.

Thank you, Sarasa, it has been so nice meeting you and all of the other NAPSters at the conference here. I began as a staff nurse in oncology. I knew I loved oncology from the very beginning, and it was clear when I was a brand-new clinician that we did not do a good job with pain control at that time. So, I wanted to learn more about how we could address that.

Eventually, I got my master's degree and cared for patients. I got involved in some research with a neurosurgical colleague of mine, where we were using intraspinal drugs. We had an amazing team. We had the neurosurgeon [and] myself. We had a basic scientist, and we had other trainees coming. We tested new compounds, which was really exciting, but I often felt that I wanted more information, and so I went back and got my PhD. I did my dissertation work in an animal model, looking at descending pathways associated with pain and that was really exciting. I learned so much about the mechanisms of pain but also about some of the techniques that are used to study pain. Although I no longer work in the laboratory, it helps me to digest and consume the literature.

In terms of your current practice right now, my understanding is that you do mostly clinical work and you have a lot of interaction with cancer patients with pain. How do you assess pain in patients currently?

Yes, my practice is about 90 to 95% cancer patients at any given time. We are a hematology/oncology department, so the remaining 5 to 10% would be people with sickle cell disease or with hemophilia. The assessment of pain in people with cancer and other disorders has evolved over time. We still need to do a very thorough history and include all the different components like the locations and the quality and the sensations that patients feel and aggravating factors, etc., but there is so much less emphasis on the pain intensity score, if you will, that 0 to 10. Many people still include that in the assessment. You would certainly want a sense of how intense the pain may be, but, in my experience, a lot of patients really struggle with asserting a number for their pain, or ascribing a number for their pain. So, if someone says it is mild or it is moderate or it is severe, that is enough, I think, to give a sense, to categorize it. I also always ask patients – do you ever have a time of day when your pain is 0? That also gives me a sense of the periodicity of the pain and whether there are times when the pain is completely gone.

What's really changed in the past few years is the exploration of function – talking to folks about what their goals are – if we can do a better job with pain management, what will you be able to do that you can't now? For some patients who are very highly functioning, some of our cancer survivors, it might be return to work, so that would be great. When we do devise some kind of analgesic plan, whether it is pharmacology, physiology, physiotherapy, psychology, all of the

above in the best of all possible worlds, then we can evaluate whether we were successful – whether they were successful – by being able to return to work. For some patients, that is not a realistic goal. So, we set alternative goals. Maybe it is being able to walk around the block. For some patients, it might be being able to sit in the hard chair at a restaurant and enjoy a meal with friends or family. For some of my patients, it may be being able to hold their grandchild. Again, we keep checking in. Are you able to meet that goal? Is it time to revise the goals? Are you ready to do something a little bit more aggressive? You start with walking around the block, and then later you may be able to cut the grass or maybe return to work.

I think you bring up a very interesting perspective from the clinical side of things in terms of how you assess pain because, on the research end, we really primarily focus on the numerical rating scale, the 0 to 10 scale, to assess patients' pain intensity, in terms of their pain management, how their outcome is after treatment, for example. Really, in the clinic, what you seem to focus more on is actually the function and the goals of the patient, which I think is a little bit disconnected from research. Am I understanding that right?

Yes. It is so much more than a number.

Right. I want to move on to a topic that you are very much involved in, which is the use of opioids in cancer pain patients. What are the difficulties of managing pain in cancer patients in the midst of this opioid epidemic in North America?

Sure. To really address the problem of pain, we, of course, would prefer to use a multimodal approach, right? We would prefer to have physical therapy, occupational therapy, and cognitive-behavioral therapy, addressing all aspects of the person's pain. For some of our patients, that may not be feasible. It may not be paid for, unfortunately, in the U.S. It may not be feasible for patients to be involved in very aggressive physical therapy, for example, if they are very ill.

When it comes to pharmacology, we prefer, again, to use a multimodal approach – nonopioids, opioids, adjuvant analgesics – and, yet again, for some patients, those are not all options. The population I think of are the people with multiple myeloma. They have really significant bony-type pain. We can't use NSAIDs. We can't use agents like ibuprofen, for example, because they are at very high risk for kidney dysfunction. These drugs can cause significant problems with kidney functions. So, opioids are a mainstay in oncology.

The challenges that we're facing now in the face of an opioid epidemic is access to the medicines. There is also a lot of stigma right now. Patients hear through the media that opioids are associated with death, that they are associated with addiction, so we need to do a lot of education about the positive role of opioids and disabuse them of some of the myths and attitudes that they may have gotten from the media.

Has there been any sort of significant shift in terms of the therapeutic strategy with regards to managing pain in your patient population because of the opioid epidemic?

We certainly are looking at the long-term use of opioids, for example, in our cancer survivors. We now have a better understanding that there are long-term negative consequences of using

opioids. When people were actively dying or in the very final weeks to months of life, it made very good sense to use opioids. It may not always make sense in someone who has a very long lifespan ahead of them. The challenge is that we need more science to know who would benefit and who would be at great risk if we were to provide opioids, both from a physiologic perspective – things like the endocrine changes that we see associated with opioids – but also what about misuse? Who is at risk for misuse of these agents?

Going on this topic of the media, the media coverage of the opioid crisis in the U.S., specifically for chronic pain patients, what are your thoughts on this? Has the media gotten things wrong that you may want to address, and what is your personal experience talking about these really important issues with the media?

Some reporters want to provide the simplest cause for the opioid epidemic. We'll hear some of their biases, quite frankly, and we often hear that the pain is the fifth vital sign as the entire cause of the opioid epidemic, or it is bad prescribers who cause the opioid epidemic, the insurance companies because they wouldn't pay for physical therapy and mental health counseling. It is such a complicated phenomenon. What's often missed is the historic change or the evolution that has gone on with the opioid epidemic. It started with the misuse of prescription drugs. When one really looks at the data and those people who were misusing prescription drugs, many of them never had a prescription for prescription drugs. They bought them, they stole them, they borrowed them from other people. So, they were using them inappropriately from the very beginning.

But unfortunately, the story that often gets presented in the media is that there is a poor child who has their wisdom teeth extracted, and they're given some amount of opioid, and they are now starting to inject heroin. It is true that some people are at great risk for misuse, and we need to do a better job in the healthcare system assessing who's at risk and finding alternatives as much as possible and being very cautious about the amount of medication that we distribute to people, and to educate people about safe storage and safe disposal, so it isn't sitting in the medicine cabinet.

But that initial aspect of the opioid epidemic has now evolved. It then became more common for people to be misusing heroin because it was cheaper than the prescription opioids. It got very difficult to obtain those prescription opioids, and, in the last few years, the drug that is really contributing to the large number of opioid deaths is synthetic fentanyl. Many of my patients, when they heard about the death of a celebrity from fentanyl, came and asked about their fentanyl patch. Should they be taken off that patch? So, you can see there is so much misunderstanding. That's not what killed some of these prominent people. People were using synthetic fentanyl and either snorting it or injecting it. It didn't come from appropriate use of pain medicines.

In addition to the use of opioids in the cancer pain patients, what are some of the non-pharmacological approaches to managing cancer pain currently?

There are many different therapies, and that's the great opportunity we have in this current era. So, we do have, yes, physical therapy, occupational therapy, recreational therapy, and, in the best

possible world, all of this would be done in a multimodal, multidisciplinary kind of clinic, if you will, or center. Unfortunately, it is kind of siloed in most settings. We've got all of these physical therapies including other kinds of exercise routines, we can use braces and orthotics, and more and more people are understanding that movement really is medicine and that patients who have gone through pretty extensive cancer treatments have become deconditioned, and they've lost muscle mass, and they've been on steroids, for example, which can cause myalgia, so it is hard to get moving again. But, under the training and the watchful eye of a great therapist, they can get back in most cases to pre-morbid levels. So, we've got all of these physical measures. We've got integrative therapies, things like acupuncture and massage and yoga and tai chi, which again are all very restorative and many have a component of mindfulness to them.

There is also psychological counseling. As we know in the pain world, anxiety and depression certainly interface with reports of pain, but then imagine the person who may or may not have pre-existing mental health issues such as anxiety. Now, they're given the diagnosis of a serious illness. They have gone through some pretty difficult anticancer therapies. Of course, they are going to need some reframing, some support, some cognitive-behavioral therapies. That's really hard to convince folks. Not only is there an access problem, again, in terms of insurance paying, but there is a stigma, especially amongst older individuals, that psychology and psychological counseling somehow means you're weak, you shouldn't talk to people about this. I am frequently saying to patients – I'd love for you to see our psychologist. She is not for crazy people. She is here to help normal people who are going through crazy, difficult times. What she's going to help you do is to find the inner strength that you already have but is hidden right now because of this difficult time. Psychological counseling is a wonderful asset, and, yet, some patients are somewhat reluctant.

To finalize the question you asked, we also have neurostimulatory kinds of procedures, and some of them are getting a little bit more attention and studied a little bit more, some of the transcranial kinds of nerve energies and even TENS units are being used by patients, and then interventional procedures – nerve blocks, epidural steroid injections, different radioablative kinds of techniques, and others. So, it behooves all of us working in oncology to know who those appropriate referrals would be if we don't have all of those folks, and most of us don't, in our clinic.

Right, because you mentioned that this multimodal assessment is important, but, then, the practicality of it is that you need to be in contact or know who to go to and come together with to provide this multimodal assessment. In Canada, we have multidisciplinary pain clinics and people that basically do this for a living and know to provide it through their means of their clinic. What are the challenges in the States with that because it seems like there are challenges to having an actual clinic in place for multimodal assessments?

There are few multidisciplinary clinics. Many have closed in the United States, and much of it is related to the cost of providing care and the insufficient reimbursement for providing this kind of optimal, evidence-based care, right? So, it's very discouraging. One would hope that that might change in the future as we become more aware of the need for more than just pharmacologic interventions. This is one way the electronic medical record may be of benefit. If we can build in some of those kinds of standing orders so that the person who maybe doesn't always work with

people who have cancer pain would see who their resources might be within the institution, because you have to build your own matrix if you do not have the nice clinic sitting right next to you.

Thank you so much for discussing all of the important things that happen and go on in your clinical work. Is there anything else you would like to speak on that we haven't covered already?

One of the messages that I would like basic scientists to be aware, social scientists, clinician scientists, all of our scientists who are interested in the world of pain, is to think about cancer and the various cancer syndromes and mechanisms as an opportunity for investigation. We, in the cancer world, desperately need your knowledge and expertise. There are so few individuals who are currently studying either the effects of the tumor, itself, in relationship to pain, or the treatments and how they cause pain. So, we'd love to have more science and you folks are the individuals who will provide that insight.

I have one last question. Any tips or words of wisdom for a trainee that wants to pursue your area of career?

I would encourage all trainees to spend a day or a week in the clinic and actually see and meet patients. That will put a human face on some of these syndromes, and you, by having a new way of looking at things, certainly very different than what a clinician might see, you will be able to think of new questions and new opportunities for investigation. So first and foremost, meet the patients. Secondly, do interact with clinicians. I know it's challenging because our vocabulary can be very different. We often feel intimidated by the knowledge base that you, as basic scientists, have. It is really a challenge for us in the clinical world to keep up with your knowledge base, so you may have to summarize some your findings. But it's really well worth it because you will then learn, again, about potential opportunities for investigation, and you'll meet collaborators, and you will be able to then give back to the patients. Being able to describe your research to the public, in particular a patient group of individuals who have cancer, will finetune your speaking skills and it will also bring you that sense of meaning that you have made a difference in the lives of individuals.

Thank you so much for sitting down with me.

My pleasure. Thank you for asking these wonderful questions, Sarasa. Thanks.