Breakthrough pain, the horrible time bomb of cancer patients

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Outline

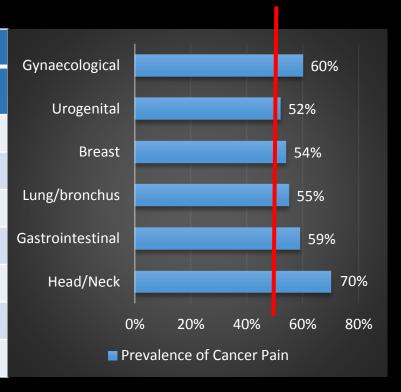
- What can we know more about breakthrough pain?
- Why do we need ROO treatments?
- What benefits could ROO bring?

More than half of the patients suffered from cancer pain

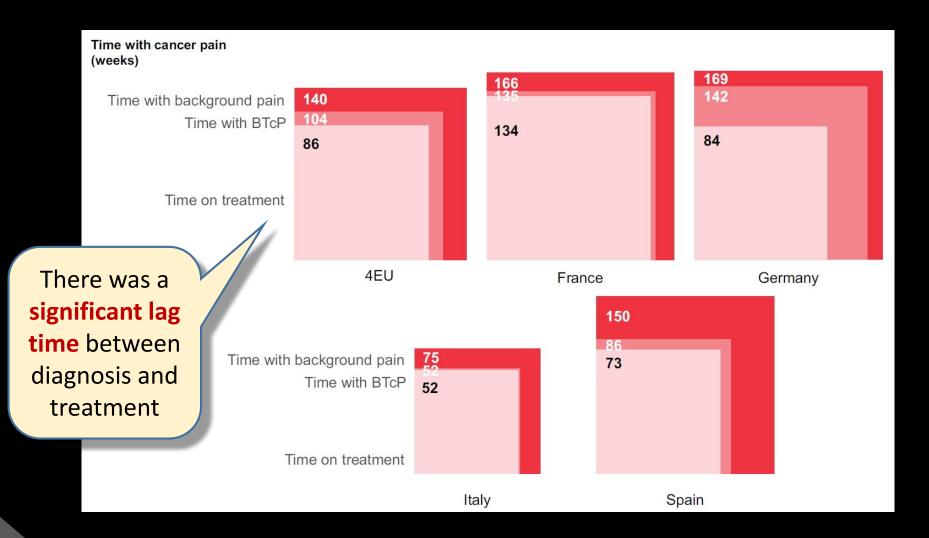
• Results of the meta-analyses:

>50%

Type of cancer	Groups 2-4			
	% Pain (95%CI)	No. of reports	No. of patients	
Head/Neck	70% (51%to 88%)	3	95	
Gastrointestinal	59% (44%to 74%)	9	564	
Lung/bronchus	55% (44%to 67%)	7	1546	
Breast	54% (44%to 64%)	7	420	
Urogenital	52% (40%to 60%)	4	336	
Gynaecological	60% (50%to 71%)	6	372	
CI, confidence interval				

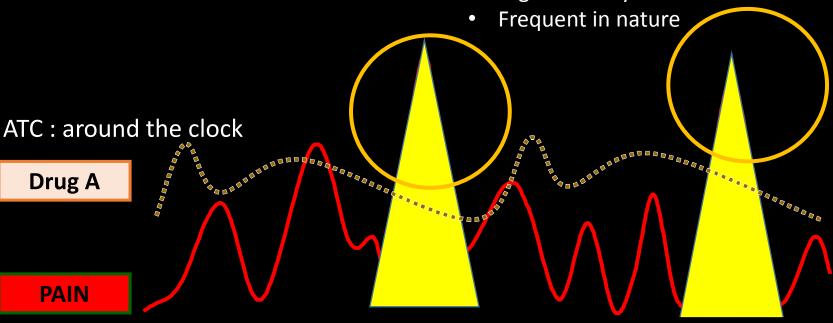


'Time Lag' between BTcP suffering and treatment exists





Breakthrough pain -High intensity



Time-





Oxycodone hydromorphone (Oxycontin) (Jurnista)



Buprenorphine (Transtec)





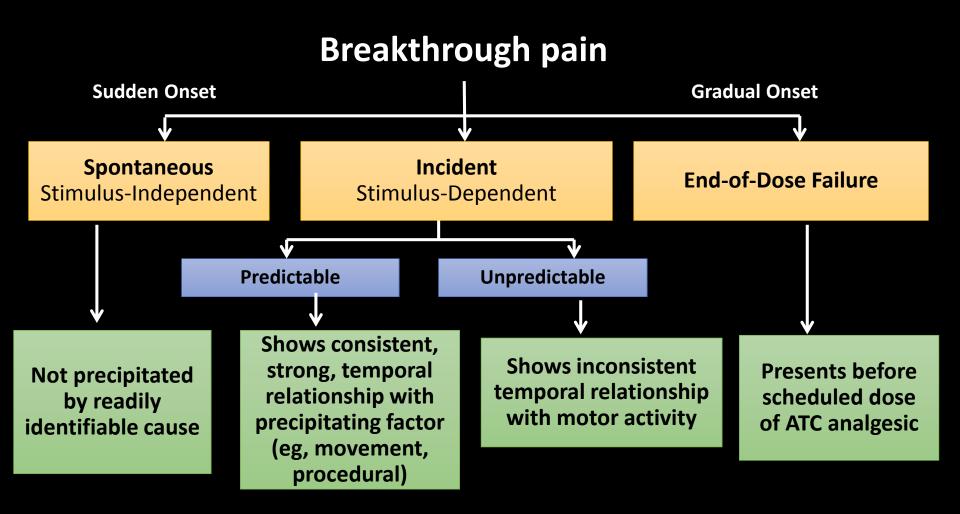




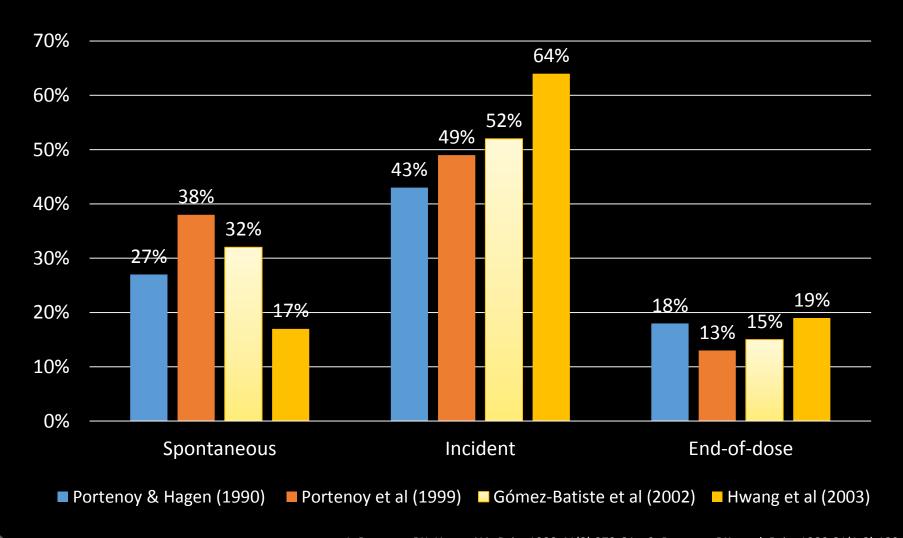
MXL, morphine cont

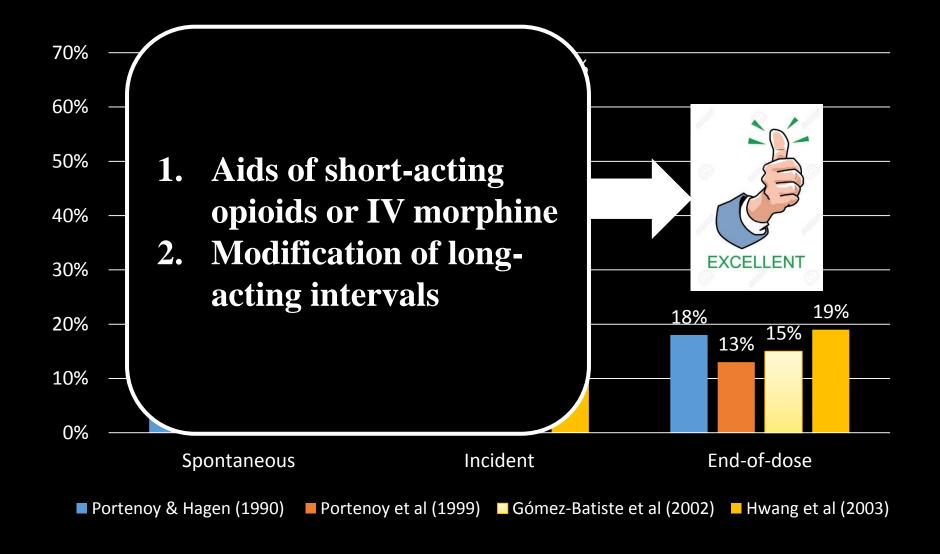
Fentanyl Patch

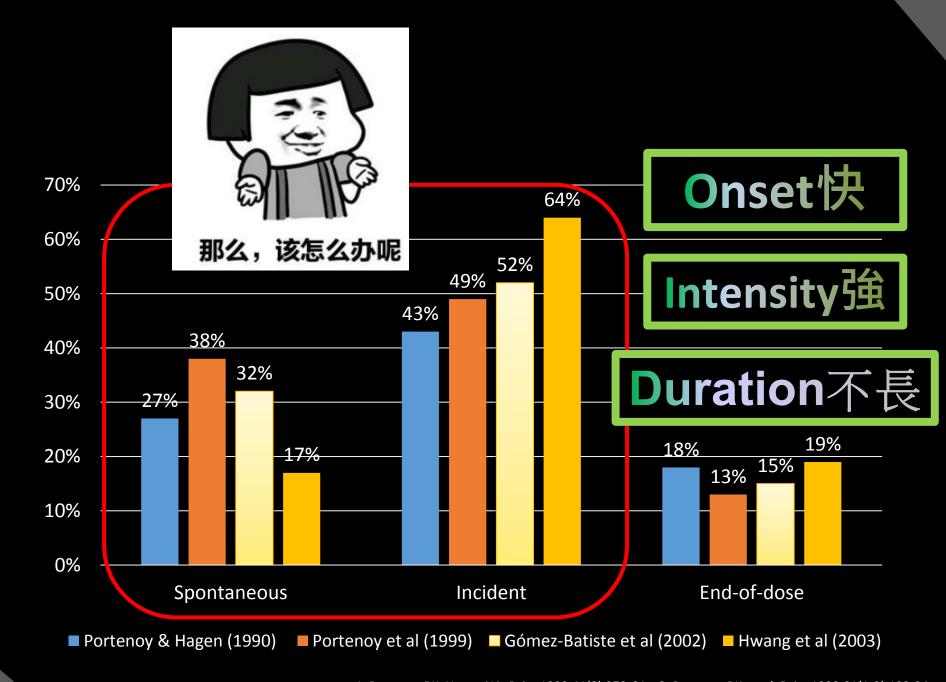
Subtypes of breakthrough cancer pain

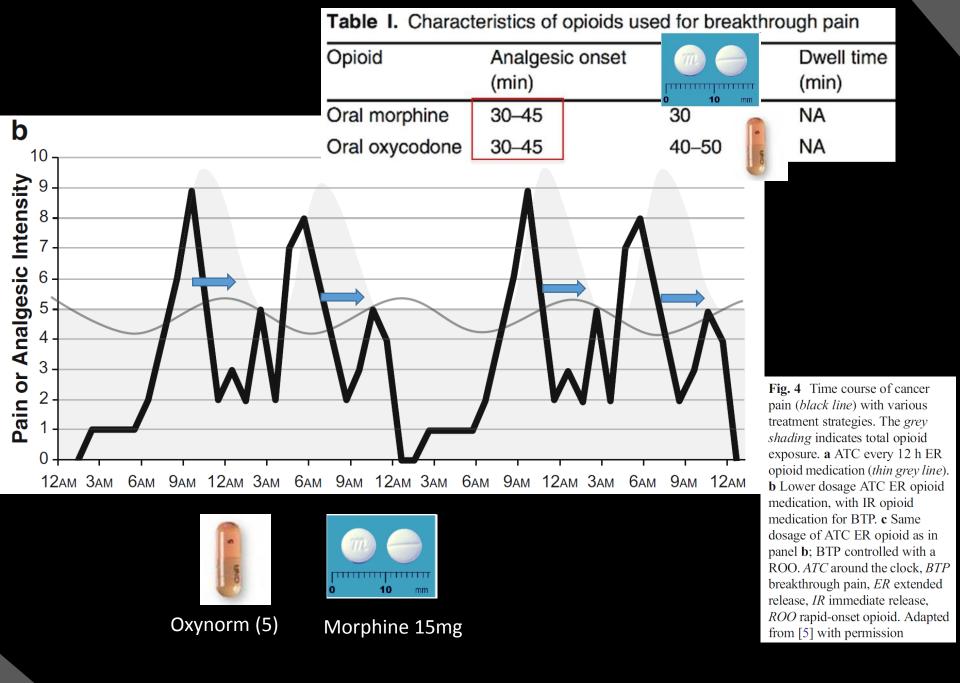


Prevalence of different types of BTcP

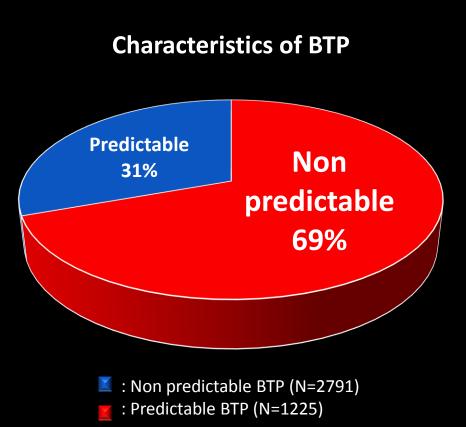


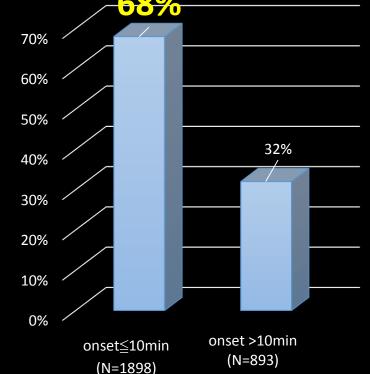


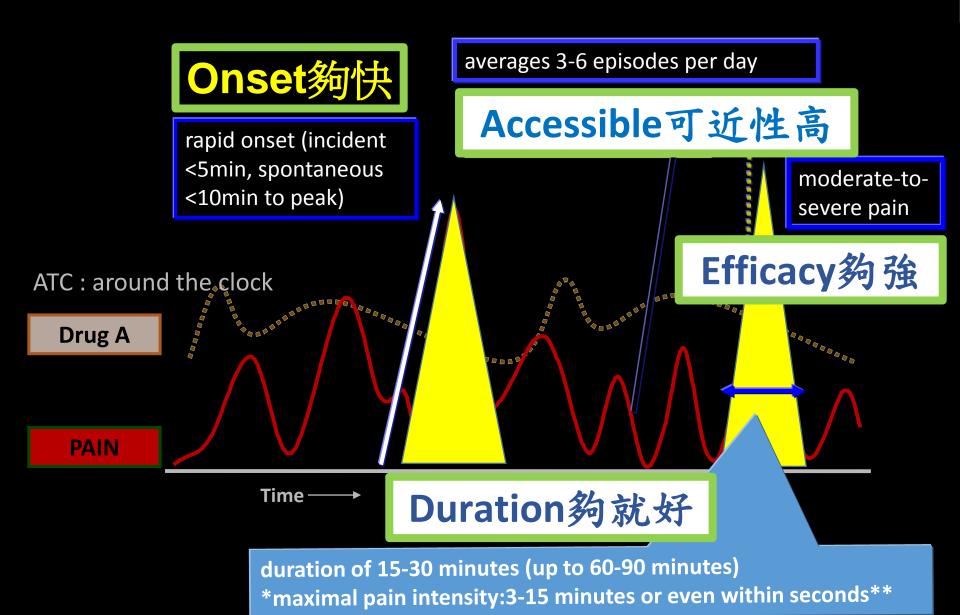




BTP is usually unpredictable and onset less than 10 minutes







Vicious Cycle of Breakthrough Cancer Pain









Abandon treatment

Tumor progression

Treatment procedures





Breakthrough pain

Depression











- 1. Nathaniel P. Katz, Kavita L. Gajria, Alicia C. Shillington, Judith J. Stephenson & Qing Harshaw (2017), Postgraduate Medicine, 129:1, 32-39
- 2. Clin Oncol 2011; 23: 393-398
- 3. American Pain Foundation. Breakthrough Cancer Pain Survey Fact Sheet. American Pain Foundation; 2012

Different opioids for standing & rescue is OK



NCCN Guidelines Version 3.2019 Adult Cancer Pain

NCCN Guidelines Index
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Discussion

OPIOID PRINCIPLES, PRESCRIBING, TITRATION, MAINTENANCE, AND SAFETY

Principles of Maintenace Opioid Therapy

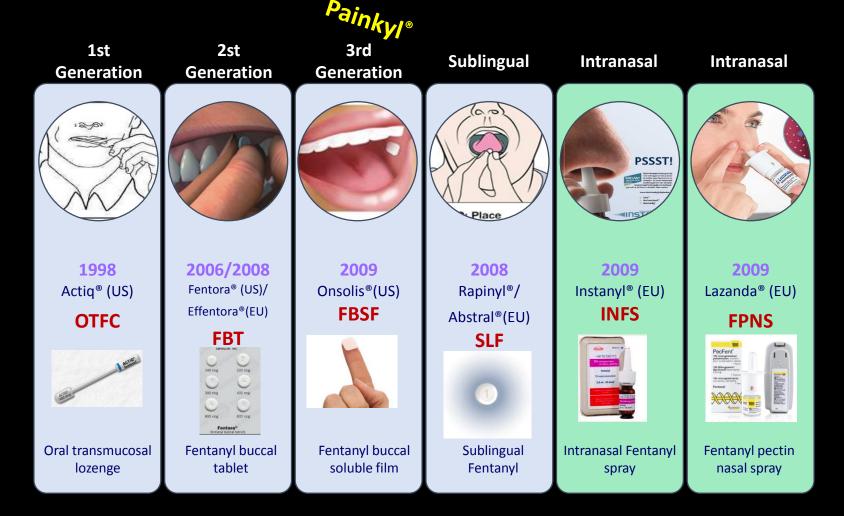
- For continuous pain, it is appropriate to give pain medication on a regular schedule with supplemental doses for breakthrough pain.
- Add extended-release or long-acting formulation to provide background analgesia for control of chronic persistent pain controlled on stable doses of short-acting opioids.
- ▶ Initial range for converting to long-acting opioid would be 50% to 100% of the daily requirement, depending on expected pain natural history.
- When using methadone as a long-acting opioid, consider supplementing with doses of short-acting opioid.
- · Increase dose of extended-release opioid if patient persistently needs doses of as-needed opioids or when dose of around-the-clock opioid
- fails to relieve pain at peak effect or at e
- Breakthrough pain (pain that fails to be doses of opioid for pain not relieved by evaluated into the following categories,
- Incident pain: pain associated with or

PAIN-E 4 of 13

- Bullet 3 was revised: "When possible, use the same opioid for shortacting and extended-release forms. When using methadone as a longacting opioid, consider..."
- anticipation of those events (eg, physicar merapy, exercise, or routine procedures that may induce pain;

 End-of-dose failure pain: pain recurring towards the end of dosing interval for regularly scheduled opioid, potentially managed by increasing the dose or frequency of regularly scheduled opioid
- Uncontrolled persistent pain: pain routinely uncontrolled by existing regularly scheduled opioid, potentially managed by adjusting dose of regularly scheduled opioid
- Allow rescue doses of short-acting opioids of 10% to 20% of the 24-hour total of long-acting or regularly scheduled oral opioid dose up to every 1 hour as needed.
- Consider rapidly acting transmucosal fentanyl (various formulations and delivery systems are available) in opioid-tolerant patients for brief
 episodes of incident pain not relieved by traditional immediate-release opioids and not attributed to inadequate dosing of around-the-clock
 opioid.
- Data do not support a specific transmucosal fentanyl dose equianalgesic to other opioids or between different transmucosal formulations. Always initiate transmucosal fentanyl with lowest dose in chosen formulation and titrate to effect. (See specific transmucosal prescribing information for appropriate dosing intervals.)
- Continue to monitor patients/family for abnormal patterns of opioid use that may suggest misuse or abuse. (See PAIN-E 6 of 13)

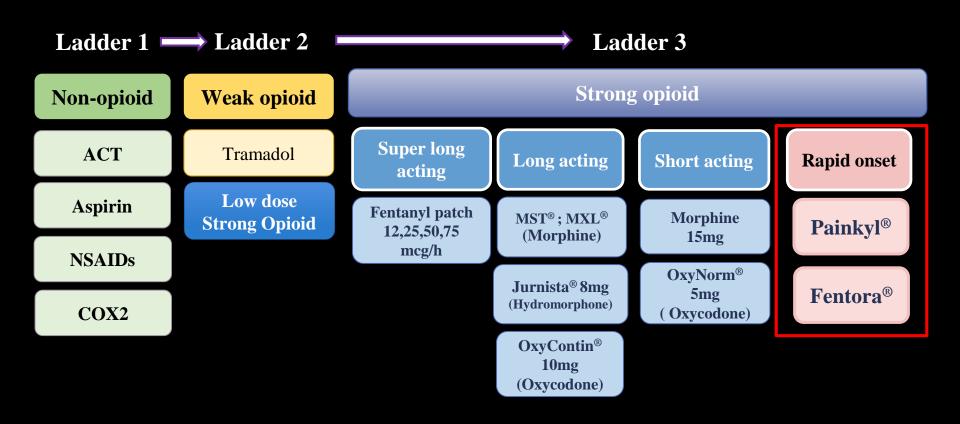
Different formulation of Rapid-onset-opioids



BTcP=breakthrough cancer pain; ROO=rapid-onset opioid; FBSF=fentanyl buccal soluble film; FBT=fentanyl buccal tablet; FPNS=fentanyl pectin nasal spray; INFS=intranasal fentanyl spray; OTFC=oral transmucosal fentanyl citrate; SLF=sublingual fentanyl.

Smith, H. S. (2013). Journal of Pain Research 6, 189-200

A new category of strong opioids: Rapid-onset opioids

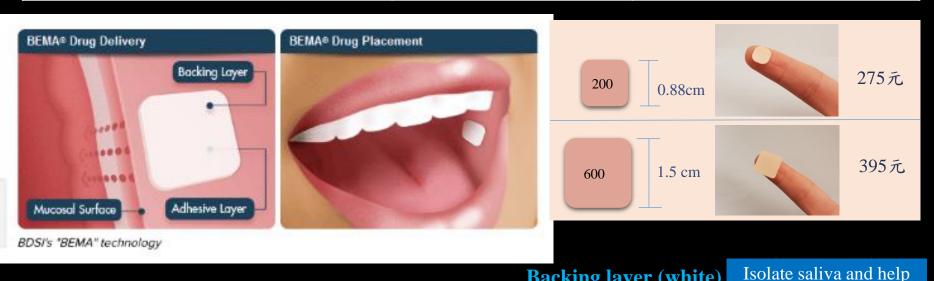


Adjuvant analgesics:

Antidepressants; Anticonvulsants; Corticosteroids; Bisphosphonate; GABAergic adjuvant analgesics.....

The newest ROO in Taiwan: Painkyl® Fentanyl buccal soluble film (FBSF)

Transmucosal fentanyl	Onset of analgesia	Duration
Buccal soluble film (FBSF)	9–15 min	1-2 hrs



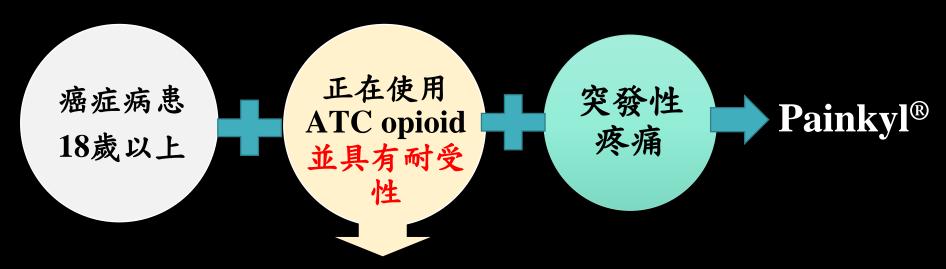
BEMA technology Bio Erodible Muco Adhesion 生物可溶性黏膜黏附雙層釋放技術

Backing layer (white) Painkyl® Adhesive layer (pink)

fentanyl-containing layer

absorption

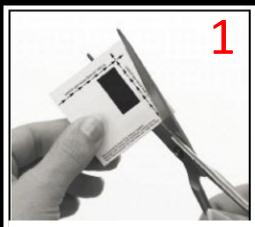
Painkyl® indication (健保)



- Patients considered opioid tolerant:
 - 60 mg oral morphine/day
 - 25 mcg transdermal fentanyl/ hour
 - 8 mg oral hydromorphone/day
 - 30 mg oral oxycodone/day
 - 25 mg oral oxymorphone/day, or an equi-analgesic dose of another opioid for one week or longer.

Patients must remain on around-the-clock opioids while taking Painkyl®

How to use Painkyl® correctly?



先用剪刀將鋁箔包裝剪開



使用前用舌頭潤濕您的口腔 黏膜或以清水漱口





粉紅面貼附到口腔黏膜,並按壓貼片5秒。



五分鐘後可以喝水或果 汁,30分鐘內會溶散。溶散 前避免進食



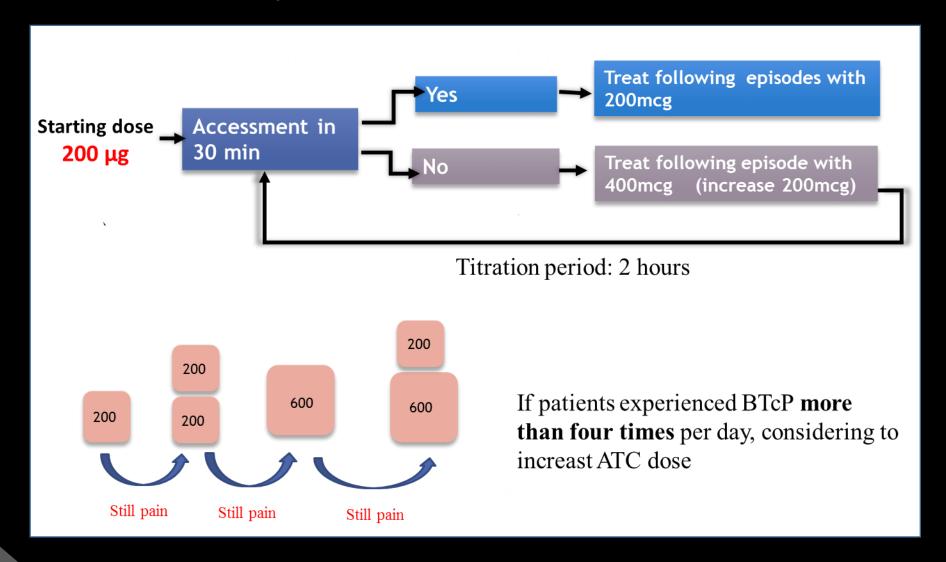
口頰給藥



唇內給藥

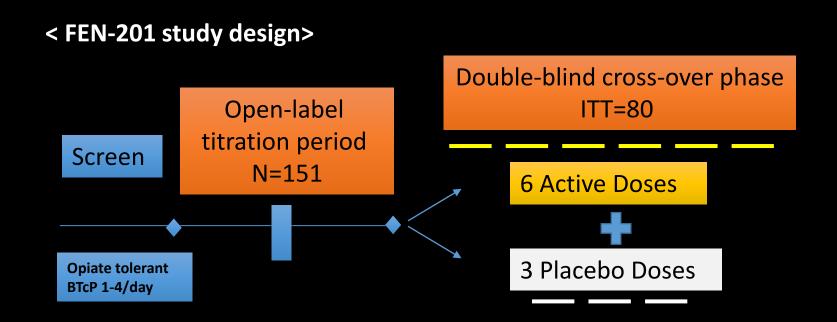
口訣:手乾,口濕,粉紅對粉紅,按壓5秒鐘

Painkyl® titration to effective dose



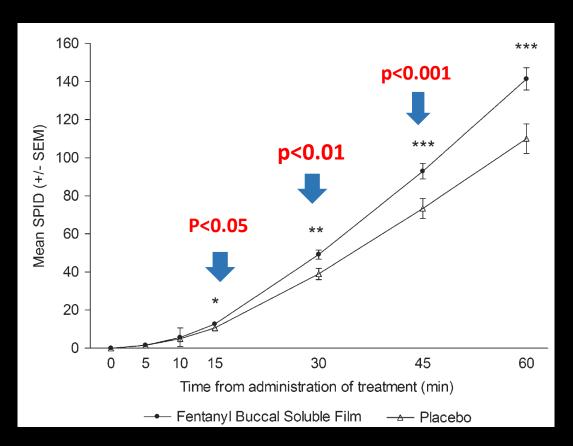
Fentanyl buccal soluble film for breakthrough pain in patients with cancer

-A randomized, double-blinded, placebo-controlled study



Primary outcome measure: SPID30 (the weighted Sum of Pain Intensity Difference over the first 30 min postdose)

Pain was relieved in 15 minutes with FBSF



The least squares mean (LSM \pm SEM) of the SPID30 was significantly greater for FBSF-treated episodes of breakthrough pain than for placebo-treated episodes (47.9 6 3.9 versus 38.1 6 4.3; P = 0.004).

.*P < 0.05; **P < 0.01; ***P < 0.001. SEM, standard error of the mean

Adverse effects were $\leq 6\%$ in FEN-201

Adverse events: Painkyl® (n = 151)

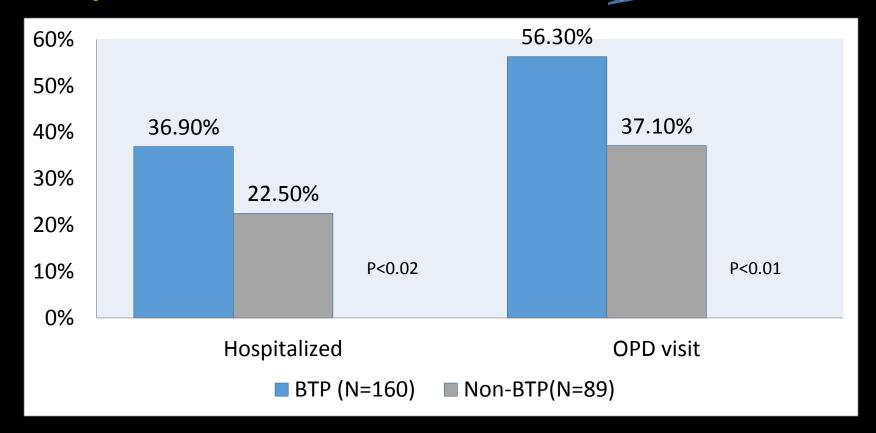
Adverse even	Incidence,n(%)
Somnolence	9(6.0)
Nausea	8(5.3)
Dizziness	7(4.6)
Vomiting	6(4.0)
Headache	4(2.6)
Constipation	3(2.0)
Dry month	2(1.3)
Dysgeusia	2(1.3)
Pruritus	2(1.3)
Confessional state	2(1.3)

There was no respiratory depression event in this study!

BTcP in Hospitalization and OPD Visit

Patients with BTcP have higher hospitalization and OPD visit rate

Well control of BTcP
→不須一直住院



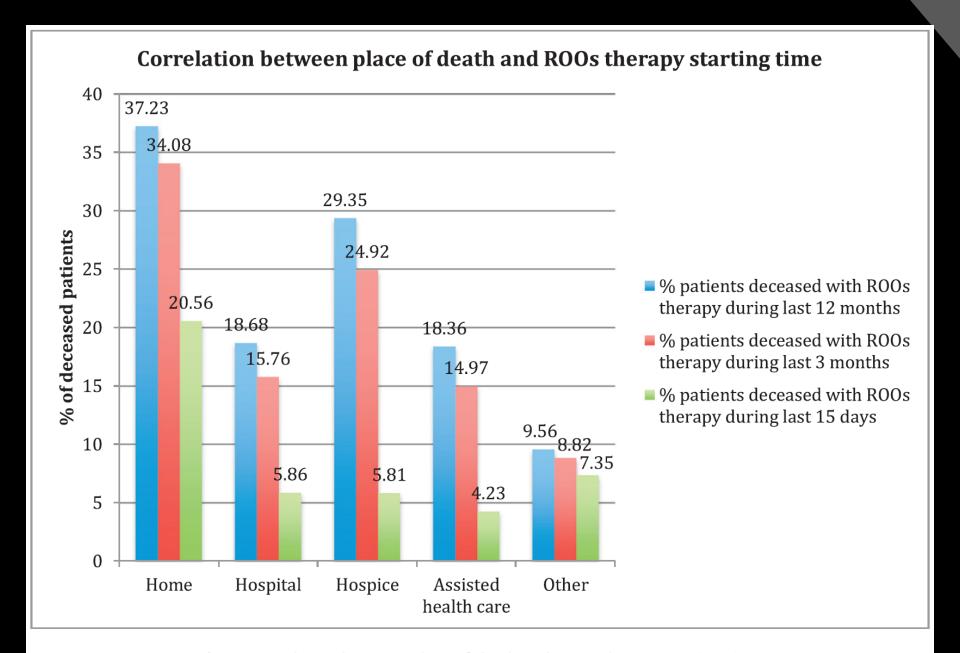
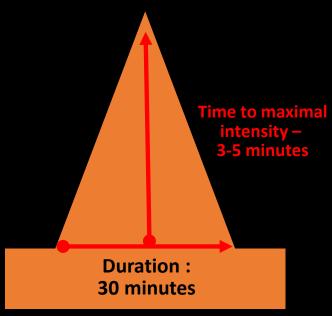


Fig. 1. Correlation between place of death and ROOs therapy starting time.

Onset

Duration

We need fast onset and short duration to avoid cumulated toxicity





- 1. Pharmacokinetic Optimisation of Opioid Treatment in Acute Pain Therapy Clin. Pharmocol inet. 1997 Sep; 33 (3); 225-244
- 2. Formulation Selection and Pharmacokinetic Comparison of FBSF with OTFC. Drug Investig 2009; 29 (10): 647-654
- 3. Pharmacotherapy for Breakthrough Cancer Pain. Drugs 2012; 72 (2): 181-190

