More Living, Less Pain: Comprehensive Approaches to Chronic Pain Management for Patients with Cancer

Dr. Michael Huber, Sylvester Comprehensive Cancer Center

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Bonnie Beckoff:

All right. I think we're going to get started. Welcome everybody to an exclusive webinar for the Sharsheret Embrace Community. This event is open to everyone. At the end of the webinar, we will have a special question and answer session for those with advanced metastatic or advanced ovarian cancer.

My name is Bonnie Beckoff. I am the Director of Support Services at Sharsheret, and tonight's webinar is on “More Living, Less Pain, Comprehensive Approaches to Chronic Pain Management for Patients with Cancer” with Dr. Michael Huber. So welcome everybody to this wonderful, wonderful webinar.

Before we begin, I wanted to let everybody know that the Embrace Community is for those diagnosed with metastatic breast and advanced ovarian cancer. We have specific materials on metastatic and advanced ovarian cancer, as well as a closed Embrace Facebook group. And I will put that link in the chat in a little bit to join and connect with others who are in similar situations as you, to ask your questions to get support and to be there for others.

Of course, you can always email me and I'll put my email in the chat box as well in a couple of minutes at Bbeckoff@sharsheret.org. Or you can call me at (866) 474-2774 and I'm here to answer any questions, get resources and support out to you.

Bonnie Beckoff:

Before we begin, I wanted to thank our summit sponsors, Eisai, GSK, Seagen, Pfizer, Merck, Daiichi Sankyo, Lilly Oncology and Exact Sciences, as well as Sylvester Comprehensive Cancer Center. Our Embrace sponsors are Daiichi Sankyo, Lilly Oncology, Novartis Oncology, and Seagen.

At this time I wanted to introduce Dr. Michael Huber. He is a palliative medicine physician and a clinical ethicist. He completed his medical school on internal medicine residency, a master's in public health sciences and fellowships in clinical ethics and in hospices and palliative medicines all at the University of Chicago. Dr. Huber assists patients with serious illness and performs comprehensive assessments to determine the best interdisciplinary plans to improve patients quality of life. He manages pain and non-pain symptoms and helps patients and their families with complex medical decisions.

So at this time, I would like to introduce Dr. Michael Huber. Thank you so much for taking the time to address the Sharsheret Community. So we'll hear your presentation, we'll have some question and answer and then we'll open it up to those with advanced cancer. Thank you so much.

Dr. Michael Huber:

Thank you so much for that introduction and please feel free to put any questions in the chat. I'll address them after my brief talk.

So I have no financial disclosures. I do want to say that every situation is unique. I'm going to speak in general about ways to treat pain, but there are a lot of specific questions that may come up and it's important that you consult your own physicians or providers about any pain or treatment plan.

So the International Association for the Study of Pain defines pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. That's a useful scientific definition and we need to come around on some unified definition for research and other purposes. But in reality, pain is what you say it is. It's your own unique experience. It's a subjective feeling. If you are feeling what your body defines as pain, then that's what pain is.

And this gets at the idea of total or whole pain, which is a concept that has long existed but was characterized beginning in the 1970s. And this is the idea that pain is more than just a physical. It includes a physical, but is also a psychological, a social, a spiritual or existential, and even a practical

experience. And to assess and understand and treat pain, we really need to be getting at all of these aspects that go into full or total pain.

Dr. Michael Huber:

Pain is also, unfortunately, a common experience for patients with cancer. Ranges vary, but many studies have shown that up to 30% of patients experience pain at some point in facing cancer. And other studies report that as many as 55% of patients on active cancer treatment will experience pain. And 65% of patients with advanced or metastatic disease will report pain at some point in their cancer journey. So unfortunately, it's a very common experience for patients who face cancer.

Assessing pain begins with understanding someone's medical condition and thorough understanding of their medical history, medications and all of those medical aspects. Assessing the pain itself, we as physicians try to get a sense of when it began, where it's located, and whether that moves around, how often it occurs, the quality or what it feels like. Is it sharp, dull, the severity, how severe it is, what makes it better, and what makes it worse? Generally, when we're assessing pain, we're trying to ask all of these characteristics. And when you're experiencing pain, it can be helpful if you start to think through and try to characterize for yourself some of these components to help get an assessment of pain and begin to think about what the best treatments are.

Because I'm only speaking for a short time, I won't spend much time on assessment. And I want to move into talking about treatments. In general, just like pain is a unique experience, the goals for treating pain are unique to you and what matters is what your goals are and what you're hoping for in treatment for your pain. In general though, as providers when we're treating pain, we're looking to reduce the severity of the pain experience or provide analgesia or relief. We're also very much looking to improve function to decrease how much pain is limiting you. And this could be physical function, this could be social function, especially those basic activities of daily living. And you know how pain is affecting your function as a person.

Like any treatment, treatment of pain will have benefits and will have potential risks. And as in treating pain, we aim to maximize the benefits and reduce the potential risks as one of the goals of pain treatment. And then finally, pain and mood such as anxiety and depression are intimately linked. And in a goal we aim to reduce the effects of pain on mood when we want to treat pain.

Dr. Michael Huber:

So I'm going to move into talking about specific treatment modalities. All of the modalities that I'm listing have evidence in the Western allopathic medical tradition, meaning there've either been experimental studies done that show benefits or that there has been careful observation in the real world of patients using treatment modalities and having beneficial outcomes. The list of treatment modalities I'm going to give are not at all exhaustive. I am attempting to list a somewhat comprehensive approach with different modalities, but there are tons of ways to treat pain. If one of the modes I'm listing is not one, you're taking something that's different than that, that doesn't mean that that's not appropriate. And just because I'm listing something doesn't mean it's appropriate for your pain. But everything I am listing does have research evidence to support it.

So the first thing we think about when we're treating pain that comes from cancer is getting at the source of the pain, the cancer itself. Any treatment for cancer may help pain. This includes surgery, chemotherapy, radiotherapy, hormonal therapy, immunotherapy, targeted therapy, all of these things can improve pain by improving the cancer. And in cases, a cancer directed treatment may be used exclusively for the purpose of reducing pain. In general, cancer treatments are hoping to help people live longer and better, and reducing pain is one of the ways that they can do that. On the flip side, many cancer therapies have the potential to either induce pain or worsen pain through their side effects. And

so it's always a discussion with your cancer team about what's going on with your pain. And the hope is that cancer treatments can help. Sometimes they can cause their own pains and that can be dealt with in different ways.

Dr. Michael Huber:

Moving beyond directly treating the cancer itself, there are many different modalities that can be used to treat pain. This is the World Health Organization pain staircase or ladder. This was developed in 1986 as part of a comprehensive, massive global effort to better treat cancer pain. It's been validated through research settings for many different types of cancer and populations across many decades, and it's one of the most commonly used approaches for pain. That being said, it has changed over the years, the four decades it's been in existence and is not without controversy, but it is a good approach to think through different modalities for how you treat pain. And what this ladder gets at is, you evaluate the pain severity and choose a modality. And then if the pain is more severe or if it's not getting better, then you escalate your modalities.

And so for mild or initial pain, you may choose a non-opioid medicine or adjuvant, which is broadly defined. If you're having moderate pain or it doesn't respond, then you may add additional treatments including opioids. And particularly for severe pain, you begin to think about using opioids in addition to the non-opioids and the adjuvants for all different types of pain. And so this is the World Health Organization ladder.

We're going to move through some of these possible treatments. We'll start with adjuvants, which is really broadly defined and particularly focuses on non-opioid ways to treat pain. And I'll start by talking about non-pharmacologic or non-medication ways that we can treat pain. A couple of those include physical therapy or exercise therapy, exercise physiology, rehab therapy, an umbrella look at therapies that work on physical function and physical ability. And so physical therapy can help assess pain, and get a better evaluation of exactly where the pain is coming from or what's triggering it. It can also directly help reduce pain and it can really help that part about improving function by giving exercise, strengthening muscles, building functional approaches to stop pain from limiting movement and ability to function. In physical therapy, there's a wide evidence base can help pain that comes from cancer.

While we're working on the body, we're also working on the mind. Going back to that idea of whole pain or total pain, a thorough psychological assessment to get at psychological components of pain is important. And then psychological therapies can be used directly to reduce the pain experience, including cognitive behavioral therapy, which has a very wide evidence base and many, many other psychological modalities. So psychotherapy or psychological therapy can be an important way to treat and reduce pain.

Dr. Michael Huber:

Additional non-pharmacologic ways include integrative approaches. Integrative is the term that is generally preferred. Other terms that may be used for some approaches are alternative or complimentary, but I prefer integrative. It gets at the idea that we work to include what previously was viewed as non-western or allopathic medical tradition approaches with the Western or allopathic medical approaches to have integrative and total approaches to care. Again, rooted in scientific evidence. I will say, throughout, this is not at all meant to be a total list of integrative approaches and scratches the surface of all the different approaches for pain.

I chose to single out here non-pharmacologic approaches that have an evidence base and were recently endorsed by the Integrative Society for Oncology and the American Society for Clinical Oncology in a joint statement looking at the evidence and putting guidelines for cancer pain.

So modalities such as acupuncture, reflexology, massage, yoga and music therapy, all have evidence for the ability to reduce particular types of cancer pain. For example, acupuncture has been found in evidence to reduce the joint pain associated with aromatase inhibitors or hormonal therapy, which is a common treatment for many patients. But all of these modalities have had evidence for reducing pain in different populations.

Unfortunately, access to these modalities is variable and limited in some communities and insurance coverage and payment for a lot of these treatments is also variable. So it's something to talk about with your cancer team and with organizations like Sharsheret because they sometimes have resources or are knowledgeable about resources in your individual community. The other thing I would say is, it's important to talk with your cancer team to get recommendations for practitioners because there is variability in the practice of these modalities and you want practitioners that are experienced if you can, with taking care of patients with cancer.

Dr. Michael Huber:

So again, this is going to be a fast talk and I'm just briefly covering some of the non-pharmacologic or medical approaches. And now I'm moving into medication meaning, or pharmacologics. Thinking back to that World Health Organization ladder, we always try to start with non-opioid medications and these include topical medications which can be delivered via patches, sprays, creams, lotions. Some of the advantages of topical medications are that they have less systemic total body absorption and therefore may have less side effects. They can be really helpful for localized pain. And some of the topical medications that have evidence for pain that comes from cancer include lidocaine, capsaicin, menthol and topical NSAID. So topical treatments can be very helpful with low side effects.

Moving into systemic treatments, we begin with acetaminophen. This has been studied widely for cancer pain with variability in the outcome seen in those studies, but generally has demonstrated some effectiveness for pain with cancer or pain from cancer, particularly mild pain. Acetaminophen is very safe to use. The only thing to think about is that there's a maximum daily dose you can take in a day that's individualized to your medical condition and something to discuss with your doctors, but no one should take more than four grams total in a day. And the other thing to remember is that acetaminophen is in a lot of different over-the-counter medications and prescription medications. So you always want to look carefully at all the medicines you're taking and notice if there's acetaminophen in it and count it towards your daily total. But acetaminophen is a very safe drug that can be effective for pain from cancer.

Nonsteroidal anti-inflammatory drugs or NSAIDs are another type of very effective treatment. Some like aspirin, ibuprofen and naproxen are available over-the-counter and some like celecoxib need prescriptions. NSAIDs have a large research base and a lot of efficacy for the pain that comes from cancer, particularly inflammatory components of that pain because they work to reduce inflammation. However, they do have a lot of adverse effects and side effects, including effects on bleeding, stomach ulcers, affecting blood pressure and affecting the kidneys. So these are medicines that can be very effective, but goes back to the idea that it needs to be an individualized discussion with your physician or provider to weigh their risks and benefits. But oftentimes there are benefits and it can be an effective treatment for the pain.

Dr. Michael Huber:

Serotonin norepinephrine reuptake inhibitors or SNRIs are drugs that were developed initially as antidepressants but found particularly through the N part, the norepinephrine component to act through complex pain pathways and reduce many different kinds of pain. They're especially effective for

reducing the pain that comes from nerve pain or neuropathy and in particular, the neuropathy that can be a side effect of many chemotherapy treatments.

Unfortunately, that neuropathy has two components, a numbness component and a painful component which can be difficult to distinguish and take some nuance to work out with your cancer team. And medications like SNRIs can be really effective for the painful numbness, but you do not restore sensation or get better, reduce the numbness itself, but they can really help with the pain part of it.

Similarly, gabapentinoids which were developed initially as anti-seizure drugs such as gabapentin and pregabalin also can be effective for many different types of pain and work in complex and somewhat poorly understood pain pathways, but particularly again, for neuropathic neuropathy pain can be very effective treatments.

Tricyclic antidepressants or TCAs such as amitriptyline or nortriptyline, again were developed for depression but were found to be effective in controlling pain pathways and particularly neuropathic pain. So what you're seeing is a pattern where many different drugs were developed for one purpose and then found to have another purpose and that gets at that term adjuvant that we're using on the World Health Organization pyramid.

Dr. Michael Huber:

I would point out that both SNRIs and TCAs, while they were indicated and developed initially for mood disorders such as depression, have been found to have efficacy for pain even in patients with no evidence of mood disorder or depression. So they can be pain medicines in and of themselves. But like we said at the beginning, pain is a complex experience that often involves mood and depression can often co-occur with pain and these types of medicines can be a useful way to treat both of those issues.

Returning to the World Health Organization table, we've thought through a few, again not at all in exhaustive, but many of the common evidence based approaches for adjuvant and non-opioid therapies. But for many patients experiencing cancer pain including especially moderate and especially severe pain, there is a role for opioid medications. I'm sure that many of you have heard many of the concerns about opioids and the concern for an opioid epidemic, which many practitioners including myself would rather frame as an overdose epidemic than an opioid epidemic because opioids themselves aren't the problem. There is a real problem and I think we need to hold two thoughts in our mind at the same time.

One is that opioids can cause overdose and that there is way too many overdoses happening in our country. At the same time, we need to recognize that there are centuries of experience and research evidence that supports the use of opioids for pain, particularly the type of pain that comes from cancer, and opioids can be and have been used for a very long time safely and very effectively to treat pain. If you are using opioids after a careful evaluation from a physician to treat your cancer pain and you are using it as prescribed though, we know that the risks of any misuses, addiction or overdose are exceedingly low and these medicines are exceedingly effective at making people's lives better and treating pain. And so while we have to use them safely and we have to recognize that there are risks and manage those risks, opioids can be a key component to treating pain and particularly pain that is severe from cancer and has not responded to other modalities.

Many practitioners may describe tramadol as a non-opioid medicine. It is actually a partial opioid and acts as the opioid receptor but not as strongly as full opioid medicines. It can be a good next step for patients who don't respond to non-opioid medicines. And there's a lot of evidence that it has efficacy for cancer pain. It's metabolized very differently by different people and it interacts with different medicines that combined with recent evidence that shows that pain may be more quickly controlled if patients are started on a full opioid rather than tramadol has led many practitioners to rely more again

on other opioids than tramadol. But there is evidence that tramadol can be very effective and it is very commonly used by many practitioners and that is totally appropriate as an initial step for patients who haven't responded to non-opioid treatment for pain.

Dr. Michael Huber:

Then there are the full opioid agonists, the commonly referred to opioid medicines, and these include codeine, morphine, hydromorphone, oxycodone, hydrocodone, fentanyl and methadone. There are many others, but these are the ones that are by far the most commonly prescribed. Opioid medicines work at the opioid receptors in the pain pathways to reduce pain. And as I've made the case, they have centuries of experience of being very effective pain medicine and can be used safely. As people's pain changes or they've been on opioid for chronic pain for a period of time, the body can develop tolerance, meaning it requires higher doses. This is very different than addiction and is a normal and natural occurrence and can be managed by providers. Oftentimes we start with a shorter lasting opioid that's taken as needed.

And the goal of the prescriber and the patient I'm sure is to take the lowest dose at the least frequency that is needed, but whatever is needed is what we aim to meet those treatment goals. And if a patient needs a short lasting opioid frequently throughout the day, there are long lasting formulations that can provide steady release of the opioid on a schedule and we often use those medicines in combination with short lasting opioids that can be taken as needed when pain adds in or breaks through the other medicines. We call that breakthrough pain. And so working with your provider, you can come up with a safe regimen that can be very effective to using opioids for cancer pain, particularly when it's severe.

Dr. Michael Huber:

I want to also mention buprenorphine, which we're gaining more and more experience with. It's an old drug that's becoming much more in use. It's a complex drug, but it acts strongly at the opioid receptor in the pain pathways. It acts in many other receptors so it can act through multiple pain pathways and for that reason have some advantages. Also for complex medication reasons, it's less likely to be able to cause an overdose than the other full opioid agonist, and for that reason can be safer than those medicines. Though I'll say, again, those medicines are all and can be used very safely with very low risk of overdose.

Buprenorphine has what's called a ceiling effect that limits its maximum dosing and that makes it a safe drug, particularly for patients with chronic pain including chronic long term, months or years pain, that comes from active cancer or cancer that has been treated. Buprenorphine can be a safe and effective alternative to being on other opioids for a very long period of time, though that may be indicated as well. And so there are many ongoing studies and very active interest in buprenorphine and I think it will see more use in the coming years.

I know there are many questions about cannabinoids, marijuana or cannabis products. So federally at the United States level, cannabinoids remain illegal, but it's a very complicated regulatory environment. Because of that status and because of bans on research in the United States, most of the evidence that we have for cannabinoids comes from other countries. But there is a body of evidence that shows that cannabinoids can be effective and safe for pain that comes from cancer. At the state level, cannabinoid regulation varies widely from state to state, from recreational availability to medicinal or both. And for medicinal it varies widely how that is regulated across states. So you need to know your own state regulations and providers in your state need to know those regulations too.

Many states providers simply certify that patients have a condition and cancer is almost universally recognized as one of the conditions that qualifies for medicinal permissions for cannabinoid products, but some states are different and generally providers are not intimately involved in giving specific

recommendations around ways to take it, the combination of the different molecules in the product or the doses of any of those aspects.

And so unfortunately, a lot of it is left to trial and error for patients working with marijuana, cannabis dispensaries. This is an area that's a gap for research and for clinical care. And my hope is that as things are deregulated more and more and there is ongoing and rapidly growing research evidence, providers will be able to give more specific recommendations regarding evidence based clear guidance on the use of cannabinoids. But what we can say is, in general, they may have a role for reducing pain that comes from cancer in general. They can be safe. The main side effects are generally cognitive or gastrointestinal. But again, this is very widely different in regulation across states. So it's important that you know your own state regulations and hopefully providers in your state and have more specific discussions.

Dr. Michael Huber:

So in addition to medication and non-pharmacologic approaches, your cancer team may involve other medical teams and specialists in the treatment of the pain. This includes pain specialists. There is additional medical training that providers can do to get certification and become specialists in evaluating and managing pain. And particularly pain specialists are often doing procedures. In addition to another group, I'll use the term interventionalists. This can be anybody ranging from rheumatologists, gastroenterologists, surgeons, radiologists. There are many, many different specialists that may be able to do procedures that can intervene upon cancer pain such as injections, nerve blocks, and other procedures that act directly, interventionally, through procedures to act on pain and pain pathways.

There is evidence for many different procedures for many different types of cancer pain and syndromes too much to talk about here, but it's something to talk about with your cancer team. And this pain, the interventions can reduce pain in and of themselves and they can reduce the amount of medicines you need and the possible risks or side effects of taking a lot of medicine. So it's definitely something to think about.

And then finally, there's what I do, which is palliative care. Palliative care is specialized medical care that's focused on relieving the symptoms, particularly pain and stress of a serious illness. It is appropriate at any age and at any stage. You can have palliative care alongside any treatment including curative treatments throughout your entire illness journey. And I always say, "The earlier, the better." The goal of palliative care is to improve your quality of life. And we do that by taking an interdisciplinary approach that really works to understand you as a whole person and that helps get at that whole idea of pain to treat pain if it's there, but really understand and help with anything going on with your illness and do anything we can and that improves your quality of life. So it's a very comprehensive and holistic approach to care.

That being said, part of that training is very specific, advanced training in pain management and the use of medications. So palliative care providers are expert in that and by practice, particularly in pain that comes from cancer. And I'm sure any palliative care provider would be happy to see you, to talk just about pain if you wanted to do that. But generally that involves a comprehensive understanding of who you are to try to get at pain and anything else affecting your quality of life.

Dr. Michael Huber:

If you are interested, the best place to go is getpalliativecare.org. It provides additional information about what palliative care is. There's many different kinds of handouts and then it gives a directory that's pretty comprehensive. Generally, all palliative care providers are in this directory, so it's a good way to find providers that are in your community if you're interested in seeing a palliative care doctor.

So I had to plug my own specialty as one of the fundamental ways to treat pain, but I know I went through a lot quickly and I want to open it up to more specific questions. And thank you again for the opportunity to speak tonight.

Bonnie Beckoff:

Thank you so much Dr. Huber. That was super, super informative. We really, really appreciate it. A bunch of questions did come in the chat and also a bunch of questions had come in prior to this webinar in the registration. One question that I have is, this individual had neuropathy numbness in her toes with chemo for at least five years or more. What can somebody do for neuropathy and numbness in their extremities?

Dr. Michael Huber:

Great, and I'll take this opportunity to say one more time, everybody's experience is unique and a lot that goes into understanding pain involves really understanding the medical history, other medications. So I'm not going to be able to give specific medical advice, I can speak in generalities, but any treatment plan should be discussed with your own personal provider and physician.

That being said, neuropathy is unfortunately a very common side effect of chemotherapy. As I mentioned in the talk, there's two components. There's the numbness itself and then the painful part of the numbness that can be really hard to tease out. And sometimes we try to just treat the numbness itself. Unfortunately, none of the treatments we have will restore the sensation, take away the numbness. The only thing that can do that is time if it can happen and it can take a really long time.

For the painful component, there's many different modalities including things like the SNRI, gabapentin, TCAs. Many times those have been tried. By the time someone who asked the question had this for a really long time. If those things have failed, you can ask to see either a palliative care or a pain specialist because there are other modalities that go beyond what I talked about in this talk, including interventional and different medication modalities. So again, some of the medicines I talked about, hard to really get into various specifics without knowing the answers. So hopefully that was general if not fully satisfactory.

Bonnie Beckoff:

Thank you. One question that just came in the chat was, how does CBD hurt gastro? I always take CBD, should I be worried?

Dr. Michael Huber:

So again, it's hard to cover all of these things so fast. When I mentioned gastrointestinal side effects of CBD, well, of cannabinoid products in general, which include CBD and THC, this can include things like nausea or upset stomach. But like any side effect, just because it's a potential doesn't mean you're going to experience it. If you are taking something and tolerating it fine, then you're probably not going to have side effects from it. And I do not mean to scare anybody from things that they are taking.

Bonnie Beckoff:

Thank you. While on pain medications, is it okay to also take a sleeping pill at night?

Dr. Michael Huber:

That has to be discussed with your provider. It depends very much on what pain medications you're taking and what sleeping medicine you're talking about. There are dangerous interactions between some pain medicines and some sleeping medicines. So I would absolutely consult your individual provider before you start any new medicine, including over-the-counter medicines for sleep. But there are safe combinations of pain medicines and sleep medicines that we use all the time. And so really wonderful questions. I encourage everybody to write these down and bring them to their primary care, their cancer team or if necessary, refer to a pain or psychiatry or especially palliative care to really get into the specifics of your own medicines.

Bonnie Beckoff:

How does one get ahead of pain from aromatase inhibitors?

Dr. Michael Huber:

Aromatase inhibitors, again, many people tolerate without any pain but many people do experience pain from them, particularly musculoskeletal or joint pain. There's growing body of evidence about how we treat it and actually much of that evidence aligns with really everything that I talked about and tracks along the World Health Organization ladder. There is recognition that it is probably a lot of inflammation that is causing this pain. And so some things that I didn't mention like fish oil has some evidence through purported anti-inflammatory effects, but other anti-inflammatories like NSAIDs and then if pain gets severe, moving up the ladder and sometimes patients even need opioids. But again, I can't say enough, it has to be a discussion with your individual physician or provider.

Bonnie Beckoff:

Of course. And I thank you so much for repeating that because it is so individualized. So thank you for saying that. One other question that came in, and I know that you spoke about medical marijuana and CBD, but one person asked, "Is medical marijuana accepted as a pain reliever by the medical community?"

Dr. Michael Huber:

That's a really interesting question and it gets at the idea as what does accepted by the medical community mean? Especially in light of still being illegal at the federal level. I think professional societies would be very hesitant to fully endorse cannabinoids or medical marijuana products, and providers generally, are not in a position to prescribe these things and therefore endorse or accept them. That being said, since there has been the ability to medically certify patients for years now in many states a very large number of medical providers are providing those certifications. I certainly provide medical certifications for marijuana. And so in that way I would say that there is increasing adoption and uptake of marijuana and cannabinoid products by practitioners in the medical community.

Bonnie Beckoff:

Thank you. Is there a way of non-narcotic options to treat chronic nerve pain without narcotics, without any form of medication? Is there a way to treat chronic nerve pain?

Dr. Michael Huber:

You can begin by trying a lot of those modalities I talked about. Physical therapy has some efficacy. Psychological therapy always may play a role and is worth trying if there's a strong motivation not to use medications and particularly opioids. Opioids is the medical term for the medications, narcotics is a legal term. And so in terms of non-opioid options, there are those, the SNRS, CCRA, TCAs, gabapentins. In terms of avoiding medications altogether, there are some interventional procedures you can discuss, and then physical therapy, psychological therapy, and the integrative approaches, massage, acupuncture, have some data for neuropathic pain.

Bonnie Beckoff:

Thank you. So we have time for one more question before we break off for our section for the advanced community. So this last question that I see is, what if chronic pain was already a problem years before diagnosis, then cancer comes and makes it worse or differently compounded and then there is nothing to do. What can one do to help themselves?

Dr. Michael Huber:

It's a very, very tough situation to be in and actually one of my own unique interests. I think it needs to be a careful assessment to understand where the chronic pain fits in, where the cancer pain fits in if it's there. Oftentimes the cancer pain comes on more acutely and there's efforts to treat that. And as that subsides the chronic pain rears itself as the bigger issue and honestly, and there's evidence of this, oncologists, cancer providers struggle to take care of chronic pain that's not coming directly from the cancer and patients often have trouble finding access to providers who can help with that. It's complicated. We still approach it in much the same way, trying to avoid opioids if we can. But if it comes to it, there may be a role for opioids and particularly the buprenorphine is gaining more and more evidence for management of chronic pain and particularly non-cancer related chronic pain. But you really approach it in the way you approach pain in general, trying to understand the whole components of pain and trying to meet those treatment goals as best you can.

Bonnie Beckoff:

Thank you so much for that really comprehensive explanation. Before we allow those with advanced cancer to stay on, everybody if they want, can leave the Zoom at that point. But in the meantime, I wanted to put in a brief survey link into the chat box while we thank our sponsors one more time for our summit, which is Eisai, GSK, Seagen, Pfizer, Merck, Daiichi Sankyo, Lilly Oncology and Exact Sciences, and of course Sylvester Comprehensive Cancer Center.

At this time, if anybody would like to stay on who has an advanced ovarian cancer diagnosis or metastatic breast cancer diagnosis, please feel free to stay on for a more intimate conversation with Dr. Huber to ask your questions specific to an advanced cancer diagnosis. I wanted to thank everybody for joining this really informative, wonderful evening on pain management and chronic pain management. So thank you. So I'll give everybody a couple of seconds to log off if they choose to. If not, please stay on for those with advanced cancer.

Okay, so we'll just give everybody a couple of seconds if they want to log off. I do see that there was one question from somebody who was talking about metastatic breast cancer. And Dr. Huber, before I begin that, I'm not sure if you saw on the chat, everybody was so thankful for your really great presentation. So for anybody that had to log off, I just wanted for you to see that. So one person wrote, "I have metastatic breast cancer in my spine. I get odd aches and pains in different places that last days and

weeks then disappear. What should I take and when do I mention it to my doctor? I've been put through scans and MRIs only to find nothing is wrong, however, I am in severe pain."

Dr. Michael Huber:

If you're in severe pain, mention it to your doctor even if you've had scans and nothing's wrong. If it's ongoing, bring it up. Message your doctor, let him know each time you see him or her. It can be very difficult. Pain is a really complex experience and you can be experiencing severe, severe pain that just doesn't seem to have something that gives you a clear reason for it being there on a scan. When we get MRIs and scans and there isn't evidence of cancer in an area directly causing the pain, that's good because we never want cancer to be there. But it leaves people wondering, "Why am I experiencing the severe pain?"

And doctors too, it can be difficult for us to understand, but bring it up to your doctors and make sure that they're doing that comprehensive evaluation to really understand all the components that are going into your pain and trying to address all the ways that they can treat it. Particularly if you have advanced cancer and you're not seeing a palliative care specialist, I would recommend it to really try and get at why this is happening and they can be the resource that you reach out to as you're experiencing these different pains.

Bonnie Beckoff:

Thank you. I want to give everybody a minute if they want to post a question in the chat box for Dr. Huber, this is your opportunity, a special question and answer session for the Embrace Community. So if there is a specific question you have, please feel free to post it in the chat box. So I'll give everybody a couple of minutes or a second or two.

Dr. Michael Huber:

I'm just going through some of the chat because [inaudible 00:46:09]-

Bonnie Beckoff:

Yeah. If there's anything you want to comment.

Dr. Michael Huber:

"What about a TENS unit, can that be used if someone has a pacemaker defibrillator?" I'm going to be a broken record because every answer is too complicated and requires too much medical information that can be given directly in a chat, but it would theoretically be possible to use a TENS unit. You would absolutely have to get permission from your cardiologist and your general doctor.

"How can one reduce pain enough to be able to sleep. Once I wake up within three to six hours, I can't go back to sleep even with medication, melatonin, et cetera. I've tried everything." I'm sorry you're going through that. That sounds like a really difficult experience. Again, we'll need to get into more specifics, but many medications can be dosed frequently, and if somebody is waking up frequently during the night, then they may need a longer lasting medicine. So that's something to talk about with your doctors. Maybe there's a longer lasting pain medicine you can take before bed.

CBD as an alternative is commonly discussed, but how about combining complementing with THC to simply be high as part of the patient's physical and psychological quality of life? Pain is a total experience, treatment goals are your own. If you are getting cognitive effects, meaning the high of a THC or CBD component, and that is reducing your pain experience or improving your quality of life. If

you are in a state where that can be legal through the regulatory requirements, that's a key caveat. If you can do it legally and it's improving your quality of life, then that would be something that if you were my patient I would support, but you would have to talk with your own doctor. Thank you for all the thank yous.

Dr. Michael Huber:

"Do you know of any treatment for a frozen shoulder?" That again, is really complex. There are interventional procedures, so ask your doctor for the possibility of a referral for interventionalists and then physical therapy can be really key to fully evaluating it. So I had mentioned those two things.

I just heard about aggressive insomnia and I think I have that. "So I can fall asleep, wake up, can't sleep when the pain is so bad." And you've tried all the medicines that I've went through and it doesn't help when you're in your thirties. Yeah, that sounds really, really miserable. Again, there are other things to try, in some ways there's always something else to try is what I tell patients when they're seeing me in my palliative care clinic. We do want to make sure that we're getting at a whole comprehensive understanding of what you're going through, including all of those components. The physical, the psychological, there are complex infusions and complex drugs.

Certainly, I think if you have not had the chance to see a palliative care doctor, that might be worth exploring so you can talk about specifics, especially, like I said, I did not do an exhaustive list. There are many other things that we have in our medicine bag that I did not go over, and if you've been through everything I went over, then definitely I think it's time to talk to a specialist.

"So hard with advanced ovarian cancer to have quality of life and yet the palliative team, and my onc said, I have six months to one year at every top of month finding new tumors. I'm just trying to plan three months at a time." There's so much in that and there's so much to facing an advanced cancer and the effect that it has on your life, your identity, everything you're going through. I'm glad that you're seeing a palliative team, bringing these concerns up with them. Hopefully, your palliative care team has an interdisciplinary component and if you haven't met with everyone, including social workers, chaplains, it might be helpful to do that. Taking things day by day, if not month by month, can be helpful. Planning out your morning through your afternoon, recognizing that there may be barriers that come up even with that, but keep bringing it up with your palliative care team.

Dr. Michael Huber:

So opioids carry a heavy stigma, unfortunately, and patients with cancer face that, they face that with their physicians, their providers, they face that at the check-in desk, they face that at the pharmacy when they're trying to pick up medicines. There is absolutely a problem with opioid misuse in this country and we need to monitor and be vigilant, but we also need to recognize the indications for opioids and that uncontrolled pain or uncontrolled symptoms doesn't necessarily mean that someone is just trying to get opioids. That's a balance that I wish all providers were able to do. It's something that I work to change the system on by training providers. It's something that patients with cancer face and have to deal with and a stigma I wish didn't exist, but it's there.

Regarding one side of the skull hurting terribly just for a short period of time, that is an experience that is not unique. Other people are experiencing that same symptom. Again, I appreciate everyone's symptoms and really their suffering with those symptoms, it's going to be too complex for me to be able to get into the details and understand and answer, in the format of this webinar.

Bonnie Beckoff:

Someone wrote, "Is treating the vagus nerve in the neck helpful?"

Dr. Michael Huber:

There are treatment modalities that work specifically on the vagus nerve, including interventional modalities that can be helpful for certain types of pain, particularly neuropathic pain. It's worth talking about. It is something that exists. I think we missed, "Mastectomy and reconstruction has left me with pain around the side and back. We tried acupuncture, myofascial massage, and you cannot tolerate medications." I think that's a really difficult situation. There sometimes are medications that can be better tolerated. My guess is, your team has tried many medicines just implied in your message. I'm sorry you're going through that. You can always ask for a referral to pain specialist, gastroenterologist.

I appreciate the endorsement for palliative care.

Bonnie Beckoff:

Yeah, I was hoping you would see that. It was a lovely, lovely note. I think we have answered all the questions in the chat. I think. Oh, one more came. Oh, I am too glad, I recommend. Yep.

Dr. Michael Huber:

I know the onc and the palliative folks at Duke, so I'm glad you're seeing them.

Bonnie Beckoff:

Wow. Well, thank you so much. I know that we have a couple of minutes left and I just wanted to thank you once again for really taking the time out of your busy schedule and sharing this wonderful, wonderful information, not only for the greater Sharsheret Community, but also for the Embrace Community.

Once again, there is a survey in the chat, so if you could please take a moment and fill out the survey. I also wanted to remind everybody to please join the Embrace Facebook group. It's a really great way to connect with everybody. That link is in the chat also, you can also email me or call me. I'm happy to schedule a time to talk with anybody, talk things through. I know it can be an up and down rollercoaster physically and emotionally, so please feel free to reach out. I am in the office Monday through Friday, so don't hesitate to reach out. I know we thanked our summit sponsors. I want to thank our Embrace sponsors one more time; Daiichi Sankyo, Lilly Oncology, Novartis and Seagen. Thank you so much everybody, thank you Dr. Huber, again, and I hope everyone has a really wonderful evening. Have a good night.

Dr. Michael Huber:

Nice to meet you all. I hope you continue to get relief however you can.