PALLIATIVE CARE

PAIN AND POSSIBLE CAUSES IN PALLIATIVE CARE

Keywords: Palliative care, palliative pain aetiology

AIM

• The identification of the cause of pain in palliative care women.

BACKGROUND

Pain syndromes associated with gynaecological malignancy are related to the characteristics and progression of the underlying disease which vary with each primary site. The most common causes of pain in women with advanced gynaecological cancer are direct nerve infiltration, compression of structures by tumour masses, treatment neuropathies, bony or muscular infiltration, peri tumour oedema, infection or necrosis and hollow viscus obstruction.

PELVIC PAIN

Acute Onset

1. Acute onset of pelvic pain that is severe, difficult to localise and is worse with palpation and coughing may be caused by:
   • Peritonitis
   • Colitis secondary to radiotherapy or chemotherapy
   • Pelvic abscess
   • Pelvic thrombophlebitis
   • Ovarian vein thrombosis
   • Bleed into pelvic mass or cyst.

2. Abrupt onset of pelvic pain associated with flank pain, fever, nausea and vomiting with dysuria and haematuria may be caused by:
   • Pylonephritis
   • Other urinary tract infection
   • Urinary tract fistula
   • Renal infarct
   • Renal vein thrombosis
   • Papillary necrosis

3. Distressing, midline suprapubic pain with an associated palpable mass may be caused by:
   • Acute urinary retention
   • Ovarian mass
   • Pelvic abscess

Gradual Onset

1. Women with advanced cancer who develop pain that is dull, aching and poorly localised at rest, but more defined with movement may have:
   • Bone metastases
   • Other soft tissue injury

2. Visceral pelvic pain is characterised by dull aching pain associated with a dragging sensation when standing
   • Distinguishing pain of lower gastrointestinal (GI) and gynaecological origin is difficult because the uterus, cervix and ovaries share the same visceral innervation as the lower ileum, sigmoid colon and rectum.
   • Infiltration of the uterus (cancer, adenoma, endometriosis) and stretching of the broad ligament tends to lead to pain that is felt in the midline of the hypogastrium.
• Cervical pain (cancer, infection) is usually perceived in the lower back, sacrum and hypogastrium.
• Ovarian pain tends to be the most poorly localised due to interconnection of the ovarian and pelvic nerve plexus. It is usually perceived towards either edge of the pelvis.

3. Severe and difficult pain that is worse with hip flexion may be caused by:
• Lumbosacral plexopathy.
• Psoas muscle syndrome.

4. Midline or flank pain associated with dysuria, urgency, polyuria, fever, nausea may represent a number of different disorders of the renal tract and may be caused by:
• Cystitis
• Nephrolithiasis
• Perinephric abscess
• Urethritis

ABDOMINAL PAIN

Acute Onset
1. Associated with guarding, worse with palpation or coughing suggests inflammation which may be caused by:
• Ruptured viscus leading to peritonitis where there is associated fever, confusion, nausea and vomiting.
• Gut ischaemia.
• Other problems to exclude
  ➢ Lower lobe pneumonia
  ➢ Cholecystitis or cholangitis.
  ➢ Pancreatitis
  ➢ Appendicitis.

2. Left lower quadrant pain associated with loose bowel actions, low grade fever and rectal blood loss may be caused by:
• Colitis / mucositis – ischaemia / infection / post treatment (radiotherapy, chemotherapy).
• Metastases
• Diverticulitis
• Angiodysplasia

3. Few physical findings, but escalating pain may be caused by:
• Mesenteric angina or ischaemia.
• Gut ischaemia

4. Cramping abdominal pain associated with altered bowel habit may be caused by:
• Constipation
• Disordered motility of the gastro-intestinal tract
• Early bowel obstruction

5. Severe right upper quadrant pain may be caused by:
• Subcapsular hepatic bleed
• Subphrenic abscess
• Renal infarction

6. Sudden onset, left upper quadrant pain that is associated with fever, nausea and vomiting may be caused by:
• Renal infarction
• Splenic infarction
Gradual Onset
1. Generalised abdominal discomfort associated with increased abdominal girth, early satiety, altered bowel habits and increasing shortness of breath particularly when lying flat may be caused by:
   - Ascites
   - Infiltration of the abdominal wall
2. Epigastric pain may be caused by:
   - Compression of the stomach by a large liver
   - Metastatic infiltration of the stomach or upper GI
   - Peptic ulcer disease or gastritis secondary to \(H. pylori\), NSAIDs (inc Aspirin), corticosteroids, delayed gastric emptying, prolonged hospitalisation.
   - Upper GI lymphadenopathy.
3. Right upper quadrant pain or discomfort that may radiate to the back or epigastrum may be caused by:
   - Hepatic metastases
4. Focal epigastric pain may be caused by:
   - Peptic ulcer
   - Metastases

BACK PAIN

Acute Onset
1. May be caused by osteoporosis, metastatic bone disease or prolonged corticosteroids, exclude:
   - Vertebral crush fractures
   - Spinal cord compression or cauda equina compression
2. If associated with fever, neutropenia or epidural or intrathecal lines, possible causes include:
   - Epidural abscess
   - Meningitis
3. If associated with coagulopathy or thrombocytopenia, exclude:
   - Local epidural bleed.
4. In the presence of malignant disease, with or without neurological changes or changes in continence, exclude:
   - Cord compression from direct tumour effects
   - Cord compression with vertebral collapse.

Gradual Onset
1. In women who are bedbound, consider:
   - Pressure areas
   - Women may experience pain simply from the fact that they are bed bound.
2. Aching discomfort, worse with pressure in the paravertebral area, consider:
   - Para – aortic lymphadenopathy
   - Malignant bone disease.
3. Unilateral lower back pain radiating to the flank that is severe, intermittent and dull (sometimes exacerbated by oral fluids) and can be associated with haematuria and / or fever, consider:
   - Hydronephrosis or hydrourerter
   - Pyelonephritis
4. Dull, poorly localised, non colicky pain in the flank, back or lower abdomen, sometimes with fever, lower extremity oedema, phlebitis and deep vein thrombosis consider:
   - Retroperitoneal fibrosis
5. Cachexia:
   - Wasting of paravertebral muscles

CHEST PAIN

Acute Onset
Sharp, pleuritic pain, associated with breathlessness may be caused by:
- Pulmonary embolus (PE)
- Pneumonia
- Fractured rib
- Oesophageal disorders
- Pericarditis
- Myocardial ischaemia.

Gradual Onset
Gradual onset of chest pain associated with increasing shortness of breath and a non productive cough may be caused by:
- Pleural effusion
- Herpes zoster infection
- Bone metastases or fracture(pathological or traumatic)
- Chest wall invasion
- Oesophageal disease
- Pericardial disease.

VULVAL PAIN
Vulval burning and discomfort may be caused by:
- Vulvovaginitis:
  - Contact vulvitis or vaginitis secondary to an allergic reaction.
  - Infection eg bacterial, parasitic, fungal
  - Dysuria
  - Cutaneous ulceration of vulval tumour
  - Vulval / vaginal mucositis secondary to chemotherapy or radiotherapy.

- Vulvodynia
  - Hyperaesthesia of vulvovaginal skin from tumour infiltration of local nerves or surgery.
  - There may be no identifiable cause.
- Genital oedema

LOWER LIMB PAIN
1. Pain tenderness and leg swelling may be caused by:
   - Deep vein thrombosis may occur unilaterally or bilaterally
   - Lymphoedema
   - Dependant oedema
   - Inferior vena caval obstruction
   - Fibrosis secondary to treatment

2. Neuropathic pain radiating to the lower limbs may be caused by
   - Spinal cord compression
• Nerve roots compression
• Lumbosacral plexopathy

PAIN ASSOCIATED WITH TREATMENT

Neuropathic pain
• Post surgical
• Radiation induced plexopathy.
• Neurotoxic chemotherapy

Post Surgical
• Wound infection or abscess
• Peritonitis may occur as a consequence of undetected bowel perforations
• Bowel obstruction
• Enterocutaneous fistula
• Intra abdominal adhesions
• Thermal injury to the bladder or ureter
  ➢ Manifests up to 14 days postoperatively with abdominal or flank pain, fever and peritonitis.
  ➢ Findings from an intravenous pyelogram demonstrate extravasation of urine or urinoma
  ➢ Women with mechanical obstruction of urine may present with a similar clinical picture.
• Incisional hernias may become incarcerated, although this is rare.
• Thermal bowel injury
  ➢ Occurs infrequently, but may have serious consequences
  ➢ Symptoms may not occur for days or weeks post surgery and women are likely to present with bilateral lower quadrant pain, tenderness, fever, elevated white cell count and may develop peritonitis.
  ➢ Changes consistent with a paralytic ileus or free gas under the diaphragm may be noted on a plain abdominal x ray.

HEADACHE
Dull aching discomfort that is worse in the morning associated with nausea and vomiting may be caused by cerebral or leptomeningeal metastases.

REFERENCES / STANDARDS
National Standards – 1- Care provided by the clinical workforce is guided by current best practice
Legislation - Nil
Related Policies - Nil
Other related documents – KEMH Clinical Guidelines Palliative Care

RESPONSIBILITY
Policy Sponsor Nursing & Midwifery Director OGCCU
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Do not keep printed versions of guidelines as currency of information cannot be guaranteed.
Access the current version from the WNHS website.