[NM-256] Pain Management in a Pediatric Cancer Patient: Seeing the Whole Picture

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Management of terminal cancer pain has persistently been a challenge; we must account for physical pain and the psychological well-being of children. The WHO analgesic ladder provides guidance for pain relief in cancer patients yet there is no mention of psychological and spiritual support; which are just as important near the end of life. We were presented with a patient with refractory abdominal pain secondary to terminal cancer who failed above paradigm due to psychosocial barriers, supporting the need for an integrated approach to pediatric cancer patients.

20 y/o male with leiomyosarcoma presented for palliative chemo and management of his pain. His tumor filled the abdomen measuring 27 cm x 17 cm x 33 cm. On admission he was on fentanyl (10 mcg/kg/hr), Midazolam (1mcg/kg/min), Dilaudid (8mg Q1h), and oral Methadone (80mg TID). He still complained of unremitting pain (10/10) and severe opioid induced constipation and drowsiness. A tunneled L1-L2 epidural was placed to provide analgesia, facilitate opioid wean, and minimize the opioid induced side effects. His pain score went to 2/10 and was weaned off the fentanyl and midazolam drips and was able to get out of bed. However, he had never been told during his illness that his disease was terminal. His family and physicians finally decided to disclose the nature of the disease to the patient 10 days after epidural placement. After having learned of his real medical conditions, he became increasingly anxious, depressed and his pain severely worsened despite anxiolytics, opiates, antidepressants, and a functioning epidural. Palliative care, social work and psychology were all enlisted in managing his care. He ultimately required reinstating infusions of Dilaudid, Midazolam, and Ketamine to provide sedation before his death.

Pharmacologic and invasive methods failed to relieve our patient from terminal pain and suffering. While we are effective at managing physical pain, we often fail children by neglecting to treat depression, anxiety and excluding them regarding end-of-life decision-making. Cultural and attitudinal barriers can reduce communication amongst the medical team, family and patients. Palliative care begins with diagnosis of cancer and continues regardless of treatment (3). Pain management in terminal children is a complicated entity involving physical pain as well as psychological and spiritual angst. The onus is on us as healthcare providers to identify potential barriers and relieve psychological and social distress early on, placing as much emphasis on the psychosocial aspect of pain as we do the physical aspect.

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