



# Not Just Cutting It, a Successful Interprofessional Cooperation for the Treatment of Intractable Cancer Pain

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## Short Communication

The modern era in oncology brought a major change in the composition of patients treated for cancer in the oncology divisions. New cutting-edge anticancer biological and immunological treatments provide long term survival even for advanced stage 4 cancer patients.

One of the major challenges in the care of advanced cancer patients is pain management. These patients often suffer from severe pain that is refractory to standard medical treatment according to the WHO guidelines and require out of the box solutions. The presence of pain influences greatly their quality of life and functional status.

The consideration of interventional pain procedures as a “fourth” step to the WHO ladder has been widely discussed in the literature [1]. The most commonly applied interventions are intrathecal or epidural drug delivery systems and/or peripheral nerve blocks and ablations. However, these neuromodulatory techniques although non-destructive and reversible, require ongoing maintenance, and also carry specific risks such as infection, especially in immunocompromised and cachectic patients. Patients, who suffer from refractory cancer pain, may benefit from targeted neurosurgical procedures that selectively intervene along the central pain pathways. The neurosurgical ablative armamentarium to treat pain includes a variety of procedures that can be tailored to the patient’s specific pain syndrome. Patients with localized unilateral pain can be treated by disconnection of the spinothalamic pain pathways using percutaneous cordotomy or stereotactic mesencephalotomy. Patients who suffer from diffuse pain can undergo stereotactic cingulotomy that decreases the overall suffering associated with the perception of pain. These procedures are minimally invasive, can be performed without general anesthesia and most importantly achieve immediate and long lasting pain relief.

Appropriate patient selection is essential for the success of these procedures and is not a one person’s job. In the last three years we have incorporated the use of these interventions in our oncology division. We have formed an interdisciplinary service comprised of a palliative care physician, a neurosurgeon and a pain specialist. The service evaluates advanced cancer patients who suffer from intractable pain, referred from their oncology or palliative care providers. Our patient selection process includes a thorough pain assessment, revision of the different modalities already attempted to alleviate pain and an honest and detailed discussion about the goals is done with the patients and their families. After this evaluation, the team is able to offer a neurosurgical intervention that is most appropriate to the patients’ medical status, their goals of care and in accordance to their oncological treatment plan.

In the course of our work we have managed to improve the pain and the quality of life of some of the most complex and advanced cancer patients, previously diagnosed with intractable pain. In many patients we have seen a marked reduction in opioids analgesics doses, improved function and even the ability to participate in oncology treatments that were previously intolerable due to pain [2,3]. With shared, wholistic, decisions making process, we have managed to offer the most complex patients a unique, “out of the box”, solution and exemplary palliation in accordance to the ethos of modern palliative care profession: “You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die.” - Dame Cicely Saunders, founder of the modern hospice movement.

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