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Dealing with metastatic bone disease in lung cancer and prevention of SREs and pain

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Metastatic bone disease occurs in patients with lung cancer, in 30-40% of patients at the time of diagnosis and as the patients live longer, incidence of bone metastases increases. Bone metastases have debilitating consequences called skeletal related events (SREs), i.e. fractures, surgery and radiation to bone, spinal cord compression and hypercalcemia, which then result in significant comorbidities, pain, loss of autonomy, reduced quality of life and increased healthcare costs. In randomized phase III trials in patients with solid tumors, 40-50% of patients developed SREs, 2.71 SREs per patient per year. Mechanism of action of nitrogen containing bisphosphonates and RANKL inhibitor and their efficacy in patients with lung cancer will be discussed. Trial of zoledronic acid (ZA) in patients with bone metastases from non-small cell lung cancer (NSCLC) and other solid tumors versus placebo will be described, including the impact of the reduction of SREs on survival pain and cost of managing lung cancer patients. A phase III trial of denosumab vs. ZA in the treatment of bone metastases in patients with advanced cancers (excluding breast and prostate cancer) or multiple myeloma, SREs and pain outcomes, analgesic use will be described. The proportion of patients with no or mild pain at baseline reporting moderate or severe pain by visit, pointing out that denosumab delayed the moderate or severe pain more effectively than ZA and how many patients in each arm shifted to strong opioid use. The conclusion of this trial was that a better pain control was achieved with denosumab compared to ZA. New bone targeted agents, i.e. dasatinib, sotatercept, cabozantinib and RAD 223 are under investigation.

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Nurse led fascia iliaca compartment block service for fractured neck of femur

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This was a service set up to be run by the pain nurses for the initial administration of pain relief to elderly patients with fractured neck of femur. This service was the first of its kind in the UK and Europe. In fact, we are not aware of the existence of a similar service anywhere else in the world as of the time. However, it has to be said that since then various modifications of the service have been reported. It is noteworthy that fascia iliaca compartment block (FICB) is not in itself new but it is a rather underused technique of pain relief. However, nurse administered FICB was a pioneering service. Our team was made up of 2 anesthetists and 2 pain nurses. After obtaining the Hospital Guidelines Committee approval which rigorously scrutinized the service proposal, the 2 pain nurses were trained by the 2 anesthetists. The training consisted of ensuring the appropriate patient selection, the performance and management of possible complications of fascia iliaca compartment block. Prior to rolling out the service and an initial audit was carried out. Patients were recruited into audit following the designed protocol. The outcome of the audit has been presented and published. My talk will cover how the service was set up, the initial challenges faced and how they overcame and the recent developments.

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