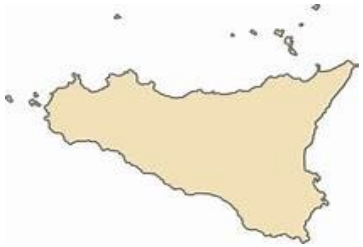
Refractory cancer pain



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THE UNIVERSITY OF TEXAS
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Making Cancer History®

Adjunct Professor,
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Stearns LM, Abd-Elsayed A, Perruchoud C, et al. Intrathecal drug delivery systems for cancer pain: an analysis of prospective, multicenter product surveillance registry. *Anesth Analg*. 2020;130:289–297.

Devices or Care for Cancer Pain Management?

To the Editor

The analysis of a prospective, multicenter product surveillance registry of intrathecal drug delivery systems (IDDSs)[1] raises concerns about the underlying assumptions of need and the interpretation of data. The fact that cancer pain remains undertreated due to lack of adherence to guidelines does not imply such guidelines do not work; rather it is necessary to spread the knowledge regarding the use of opioids. The 3-step approach, improved by optimal use of opioids and tailored treatment, resolves most cancer pain issues, even in difficult cases. Thus, the bad examples should be not used to promote something other. The increased scrutiny of long-term systemic opioids used triggered by the opioid epidemic in the United States does not support the use of implantable techniques. Appropriate use by skilled professionals is a warranty for minimizing this risk.

Is the statistically significant reduction in pain intensity from 6.6 to 5.5 clinically relevant? To most clinicians and patients, this would be considered a failure corresponding to evitable and prolonged suffering. The minimal clinically important difference should be of at least 2 points or <33%.[2] Regarding data on quality of life on 41 available patients in a population with a median survival of 3 months, an incalculable number of reasons, other than pain, profoundly influence the quality of life.

In very conservative settings, as deduced by the low opioid dose escalation after 1 month of treatment (mean dose of 32 mg of oral morphine equivalents), pain intensity decreased from 6.1 to 2.6.[3] The outcome obtained with such low level intensity of care raises the question of why or when an IDDS would be considered in a treatment plan.

Finally, what is intractable pain? Is it just a state of pain intensity, regardless the level of analgesic treatment, or after "optimization" of opioid therapy according to the "best" palliative care (pain does not live alone!)? I published a case of a patient treated with an intrathecal pump unsuccessfully that was resolved with simple therapeutic measures … by telephone.[4]

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Duarte R, Copley S, Nevitt S, Maden M, Al-Ali AM, Dupoiron D, Eldabe S. Effectiveness and safety of intrathecal drug delivery systems for the management of cancer pain: a systematic review and metaanalysis. Neuromodulation. 2022;S1094–7159(22): 00563–73.

Our findings suggest that IDDS is effective in reducing pain intensity for patients with cancer pain when compared with pretreatment.

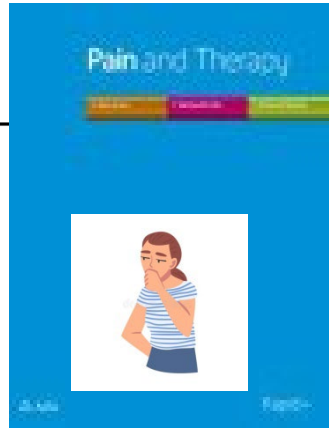

THE DANGER OF ...
BMF
... A ONE SIDED STORY

Pain Ther
https://doi.org/10.1007/s40122-023-00507-z

REVIEW

Refractory Cancer Pain and Intrathecal Therapy: Critical Review of a Systematic Review

Sebastiano Mercadante



21 studies selected. Analysis of these studies showed evident **lack of proper assessment because of optimistic interpretation regarding the outcomes, poor consideration of complications, and inclusion of patients with short survival.** Indication of **intrathecal therapy as a condition in which a patient has failed to respond to multiple therapies provided by a pain or palliative care physician or at sufficient doses for adequate durations**, as suggested by the same research group, has been disregarded.

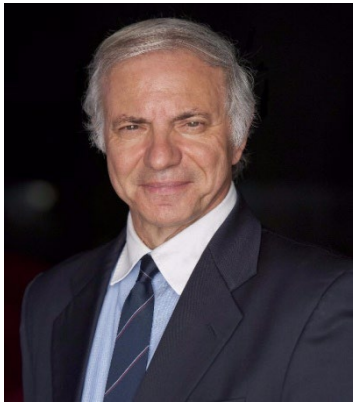
This can **discourage to use intrathecal therapy in patients who are really unresponsive to multiple opioid strategies**

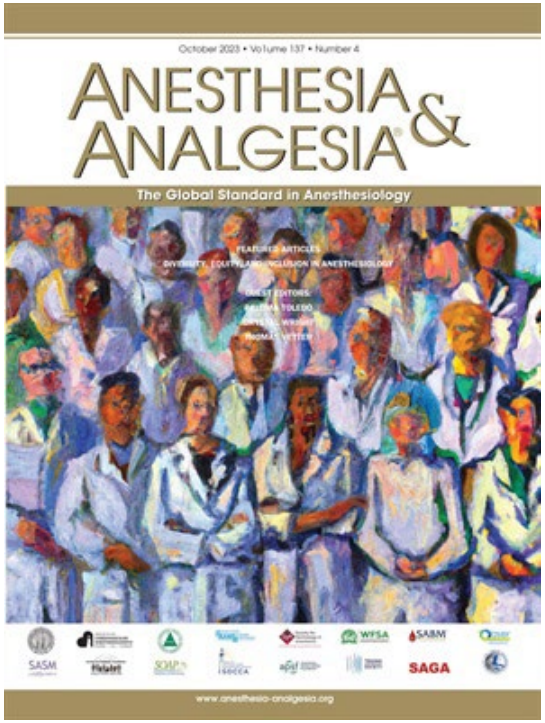
subtrahend a potent means to be used in a very selected population.

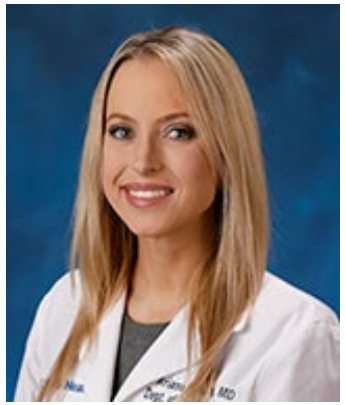
A&A Open mind article

Sebastiano Mercadante, Palermo, Italy
Ariana Nelson, Irvine CA, USA

Complementary role for palliative care in intractable cancer pain







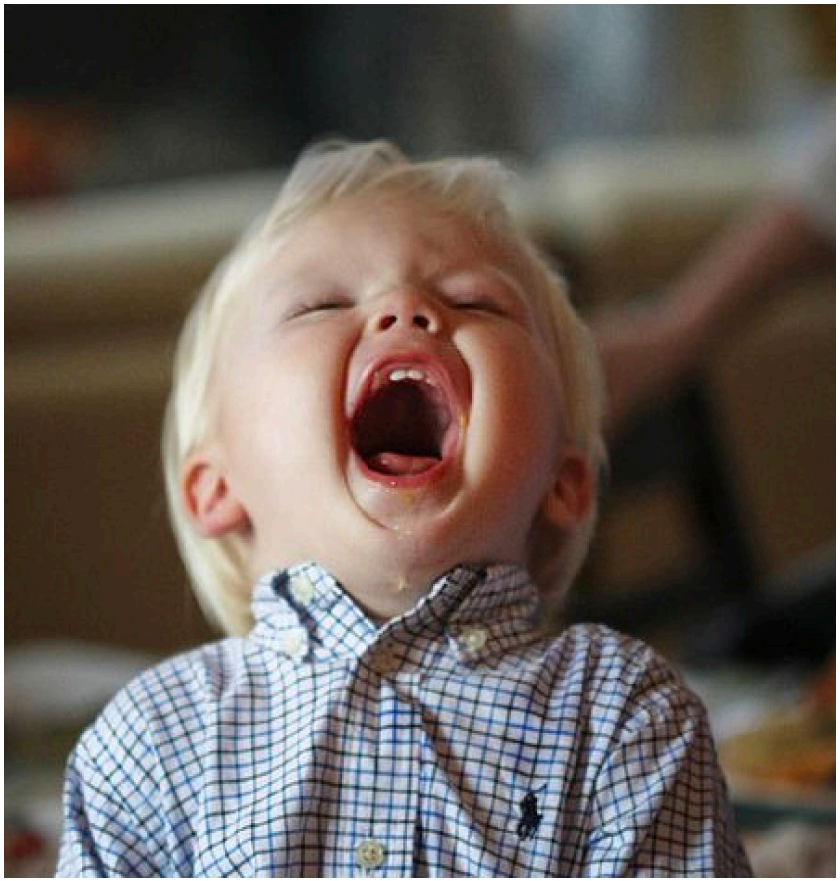
RCT of an implantable drug delivery system compared with comprehensive medical management.
Smith et al, J Clin Oncol 2002

- 202 pts with uncontrolled pain by opioid doses >200 mg/day or presenting toxicity
  CMM v CMM plus IDDS

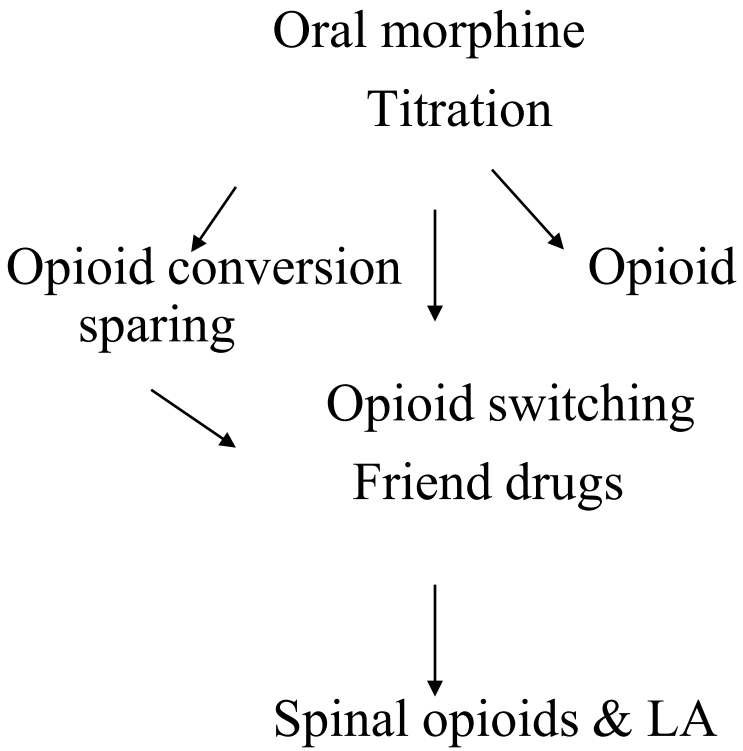
RESULTS

- Less pain
- Less toxicity
- Lower systemic opioid doses
- Longer survival
- QoL

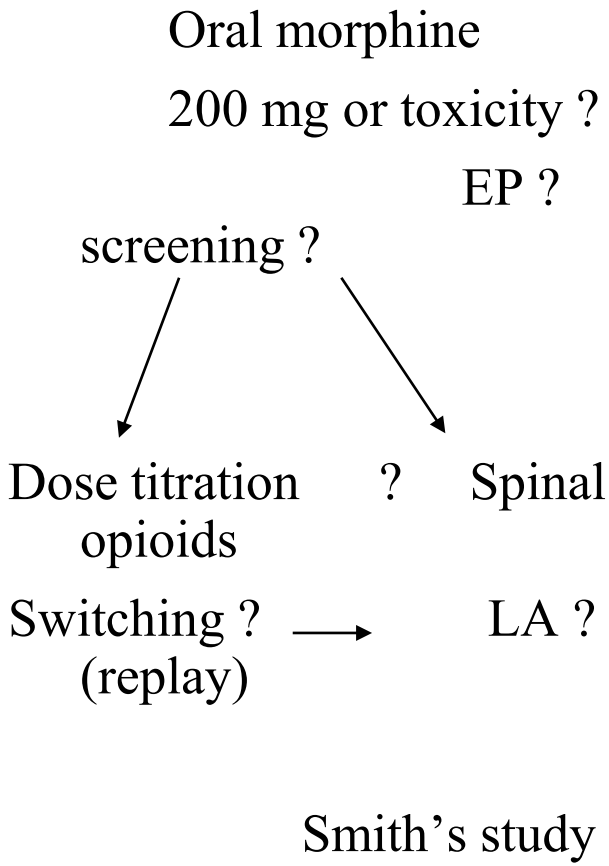
Thus…….
There is strong evidence that patients receiving 200 mg/day of oral morphine are candidates for an implantable pump for delivering IT morphine



Concerns



Current practice



Smith's study

Implantable pumps in cancer pain Concerns…

- No previous optimization therapy
- Intractable pain???
- The use of implantable pumps also depends on the amount of volume to administer (maximum 60 mls).
- Refilling
- Problems in changing the doses
- It is unlikely to be used in pts requiring adjuvant drugs to opioids, such as local anesthetics (2.5-5 mls/day, equivalent to 12.5-25 mg of bupivacaine 0.50%)

Long-term effects of IDDS… (6 mos follow-up)Smith et al, Ann Oncol 2005

Costs: 22718 $ (CMM) 52745 $ (IDDS)

Pts randomized to IDDS but never receiving it because their pain and toxicity were controlled,

had survival equal to those who received IDDS……

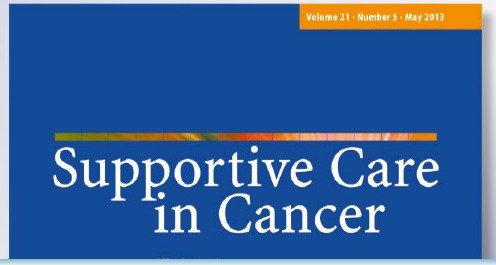
Can a phone call be more effective than an intrathecal implanted pump?

Sebastiano Mercadante & Patrizia Giardina

Supportive Care in Cancer

ISSN 0941-4355
Volume 21
Number 5

Support Care Cancer (2013)
21:1213-1215
DOI 10.1007/s00520-012-1665-7



7

- 40 yrs, lung cancer, bone metastases
- Admitted to hospice after being managed in an acute hospital with a pain clinic (national hub….)

Previous treatment:

Oxycodone/naloxone 20/10 mg → inefficacy

?

Phone call from Hospice in Messina to the Unit in Palermo:

Bla bla, bla…

Dont' care of the pump and restart with IV morphine titration, and call again in 15 minutes

Effective dose 10 mg !!!

OK, start an IV infusion of 60 mg/day of IV Morphine and the same dose 10 mg for BTP. Call again tomorrow morning

The day after

Prof?

Hi, how is going there?

Perfectly, just two calls for BTP. The patient is really happy.

That's good. Give oral morphine 60 mg three times a day and 30 mg as needed.

I look forward to have news in the next days

Three days after

Ohhh, anything is under control and the patient is ready to go home. No BTP episodes anymore, what about?

Hi Patricia, let's discharge home. Good job.

I'm creditor for a dinner…

Cognome e Nome [redacted] Nato il ______ Età ______

Residente a ______ Via ______ Tel. ______

Anamnesi - Esame obiettivo

Port 14-6-2011 catetere medtronic INDURA-PORT (perfuss 4000)

pompa deltec dd 5800 , infus. continua

formula ziconotide - morfina

07/09/2011 dolore T dx nelle ultime settimane. Alvo stitico, riposo ...

... box dx ore - pompa ...

Diagnosi NPM EPITELIOIDE Tr 4 brune (Kg 61) VINORELBINA ...

dolore toracico dx

POMPA
Co ...
~~Morfina fl. ogni 3 = 1 ... S.C. - 4-5 fiale~~

Terapia
PALEXIA 150 mg x 2
MEGACE 160 x 1
DECTACORTENE 25 x 1
TRANSTEC 52 ogni 3 giorni
EFFENTORA 600 ...
ONDANSETRON ... 25 ...
~~DEPALGOS~~ 20 1 al mattino ... 1 ... 1 ...

Comunicazioni particolari: ______

Da conservare per le visite successive

Per il Dott. ______

Lo Specialista

TLM mod 46/03

67 yrs, Ka colon

Surgery - pelvic RT

No disease, motor deficit from RT, on wheel chair

Three years of suffering…

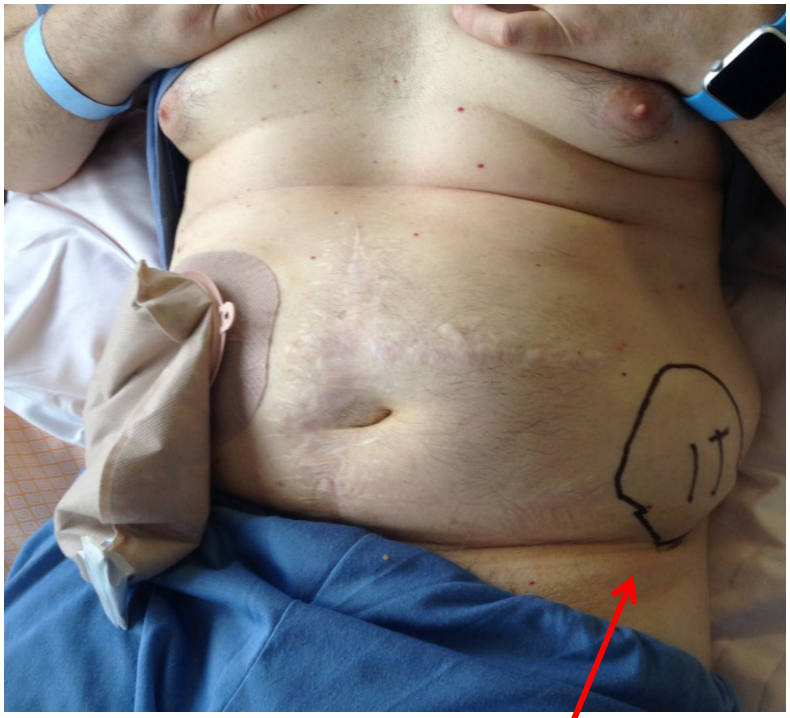
Maximum opioid dose TD fentanyl 100µg/h

Myoclonus, hiccup

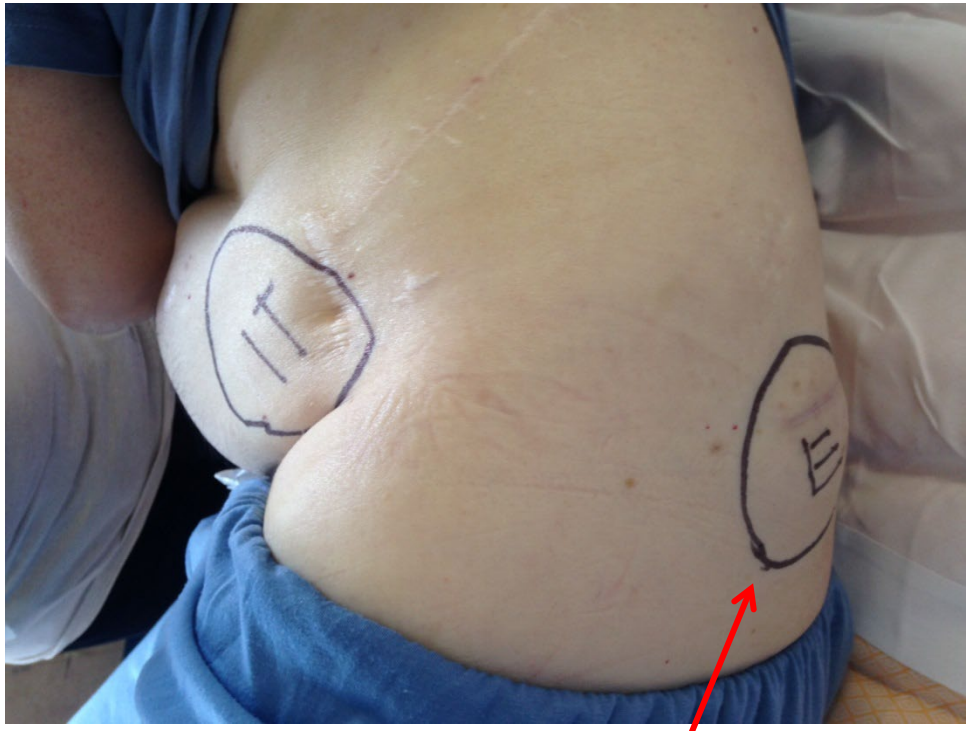
Addicted: OTFC 400 mcg (> 10 pieces a day), with a pain control for 1 h).

and…..

Device ladder !



IT pump



Spinal cord stimulation

Treatment

Switch-off SCS
Defilling IT pump
Rapid titration IV fentanyl 0.6 mg
IV infusion fentanyl 3 mg/24 hrs

Disappearance of myclonus & hyccup
Happy with pain control
Transdermal fentanyl 150 µg/h
Sublingual fentanyl 600 µg as needed

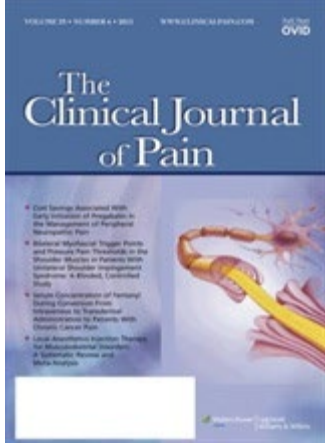
Discharge

- Pain optimally controlled
- On Methadone 18 mg x 3

- Long survivor
- After 7 yrs….
- pain controlled with multiple switching in time

Intrathecal Treatment in Cancer Patients Unresponsive to Multiple Trials of Systemic Opioids

Sebastiano Mercadante, MD,† Giuseppe Intravaia, RN,* Patrizia Villari, MD,* Patrizia Ferrera, MD,* Salvatore Riina, BS,* Fabrizio David, MD,* and Salvatore Mangione, MD†*



This study first, provided further information on the outcome of an intrathecal treatment in highly opioid tolerant patients. Given the complexity of this kind of
patients and the need to provide individually the best outcome, controlled studies are really difficult to perform and often provide information, which may be inferred by protocol limitation, not always ethically acceptable.

In patients who had received multiple trial of opioids and routes of administration, the intrathecal treatment started with an oral-intrathecal morphine conversion ratio of 100:1, and local anesthetics at the most convenient clinical doses, provided a rapid and long-term improvement of analgesia, with a decrease in adverse effects and opioid consumption until death.

Research Paper

PAIN®

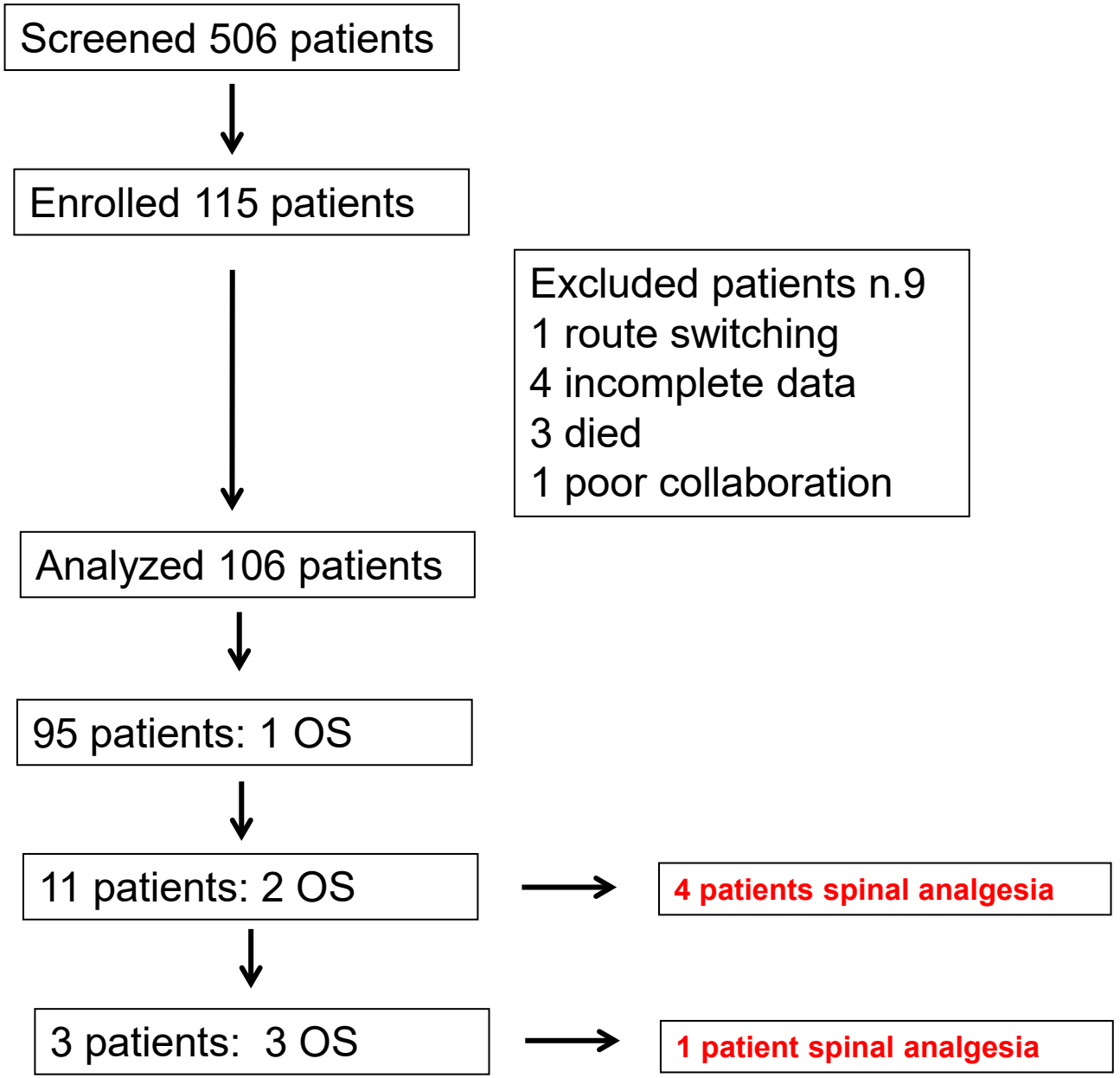
Maddalena Opioid Switching Score in patients with cancer pain

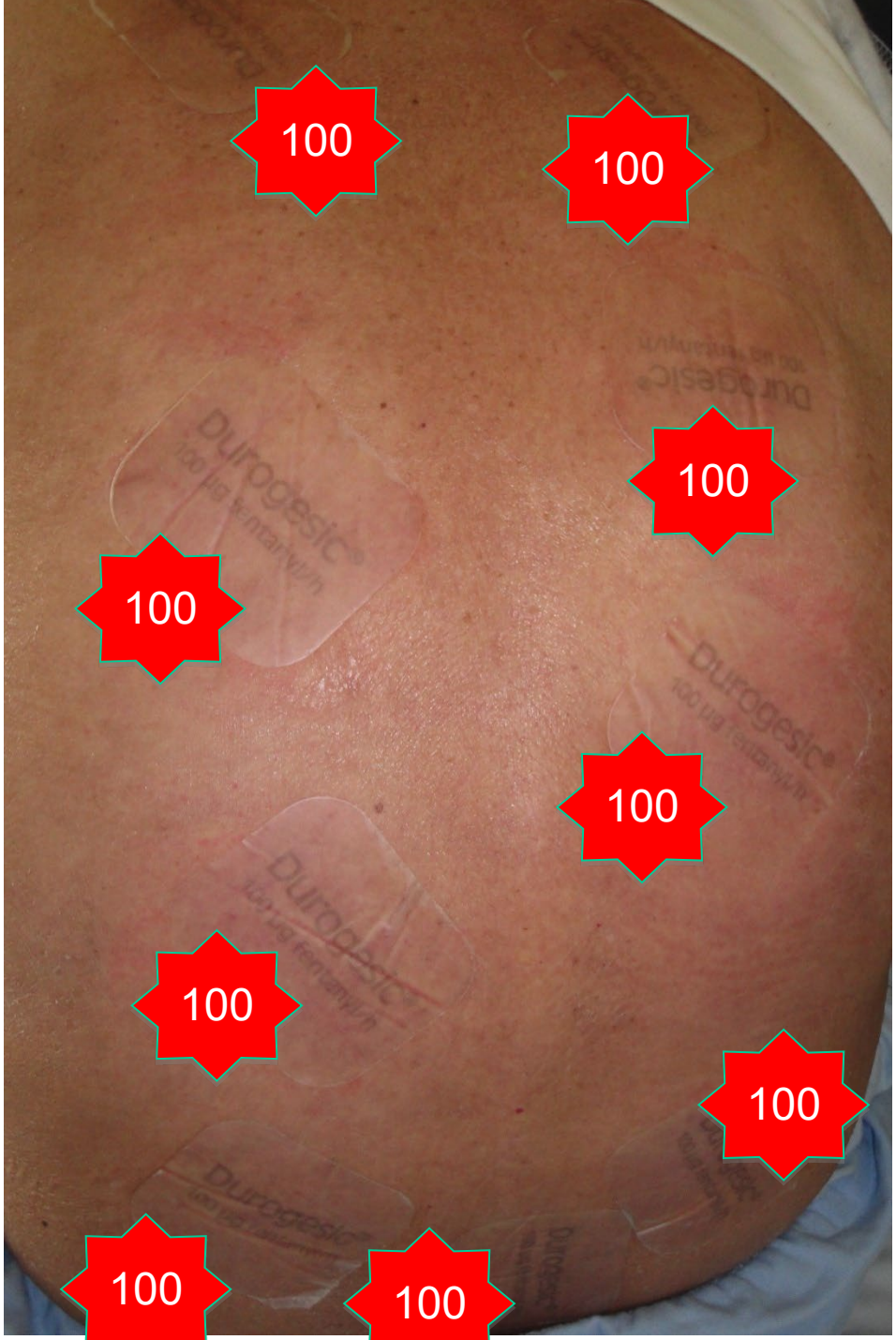
Sebastiano Mercadante[a,*], Alessio Lo Cascio[a], Claudio Adile[a], Patrizia Ferrera[a], Alessandra Casuccio[b]

Abstract

Evaluation of opioid switching (OS) for cancer pain has not been properly assessed. The aim of this study was to assess an integrated score (Maddalena Opioid Switching Score) as a simple and repeatable tool to evaluate the outcomes of OS, facilitating the interpretation and comparison of studies, and information exchange among researchers. The integrated score took into account pain intensity, intensity of opioid-related symptoms, and cognitive function by using an author's formula. Physical and psychological symptoms were evaluated by the Edmonton Symptom Assessment Scale and Patient Global Impression (PGI) by the minimal clinically important difference. One hundred six patients were analyzed. Ninety-five patients were switched successfully, and 11 patients underwent a further OS and/or an alternative procedure. The Maddalena Opioid Switching Score significantly decreased after OS and was highly correlated to PGI of improvement ($P < 0.0005$). In patients with unsuccessful OS, no significant changes in the Maddalena Opioid Switching Score and PGI were observed. A significant reduction in Edmonton Symptom Assessment Scale items intensity was observed after OS. The Maddalena Opioid Switching Score resulted to be a sensitive instrument for measuring the clinical improvement produced by OS.

Keywords: Cancer pain, Opioid switching, Pain intensity, Chronic pain, Adverse effects, Palliative care


Screened 506 patients
Enrolled 115 patients
Excluded patients n.9
1 route switching
4 incomplete data
3 died
1 poor collaboration
Analyzed 106 patients
95 patients: 1 OS
11 patients: 2 OS
4 patients spinal analgesia
3 patients: 3 OS
1 patient spinal analgesia



High doses of Fentanyl

900 mcg/h
Transdermal
fentanyl

Pain **20?/10**

Crying and complaining

confused

Titration with 300 mg of IV morphine unsuccessfully, bolus of methadone 40 mg was unsuccessful

Ketamine-midazolam infusion for 24 hours, progressively tapering the doses, while starting an infusion of 100mg of methadone

Two days after when the patient was awake, he was smiling and collaborating. Methadone doses were progressively increased with the patient responding to each step.
He was discharged 4 days after on optimal pain control with oral methadone 225 mg/day and
40 mg as needed

More common than in the past…
Patients receive more aggressive treatments
and are exposed to more risks of difficult pain problems

Pain due to local and diffuse pain metastases

Multiple courses of chemotherapy and radiotherapy

Multiple opioid-route switching (morphine-fentanyl-methadone-morphine and Oral-IV-IT- IV+IT, local anesthetic switching)

Treatment required to control pain at the last admission:

INTRATHECALLY

morphine 100 mg, fentanyl 0.5 mg,

lidocaine 400 mg

Intrathecal lidocaine for breakthrough pain

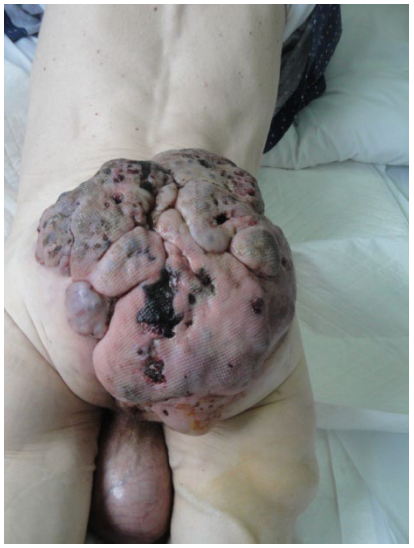
INTRAVENOUSLY

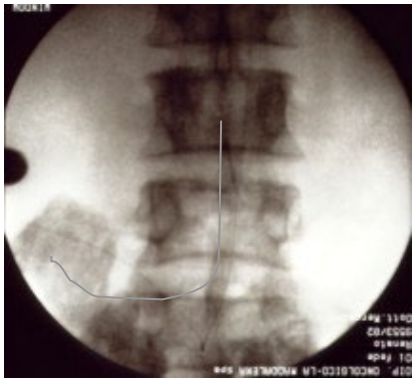
Ketamine 600 mg

methadone 160 mg,

ketorolac 90 mg

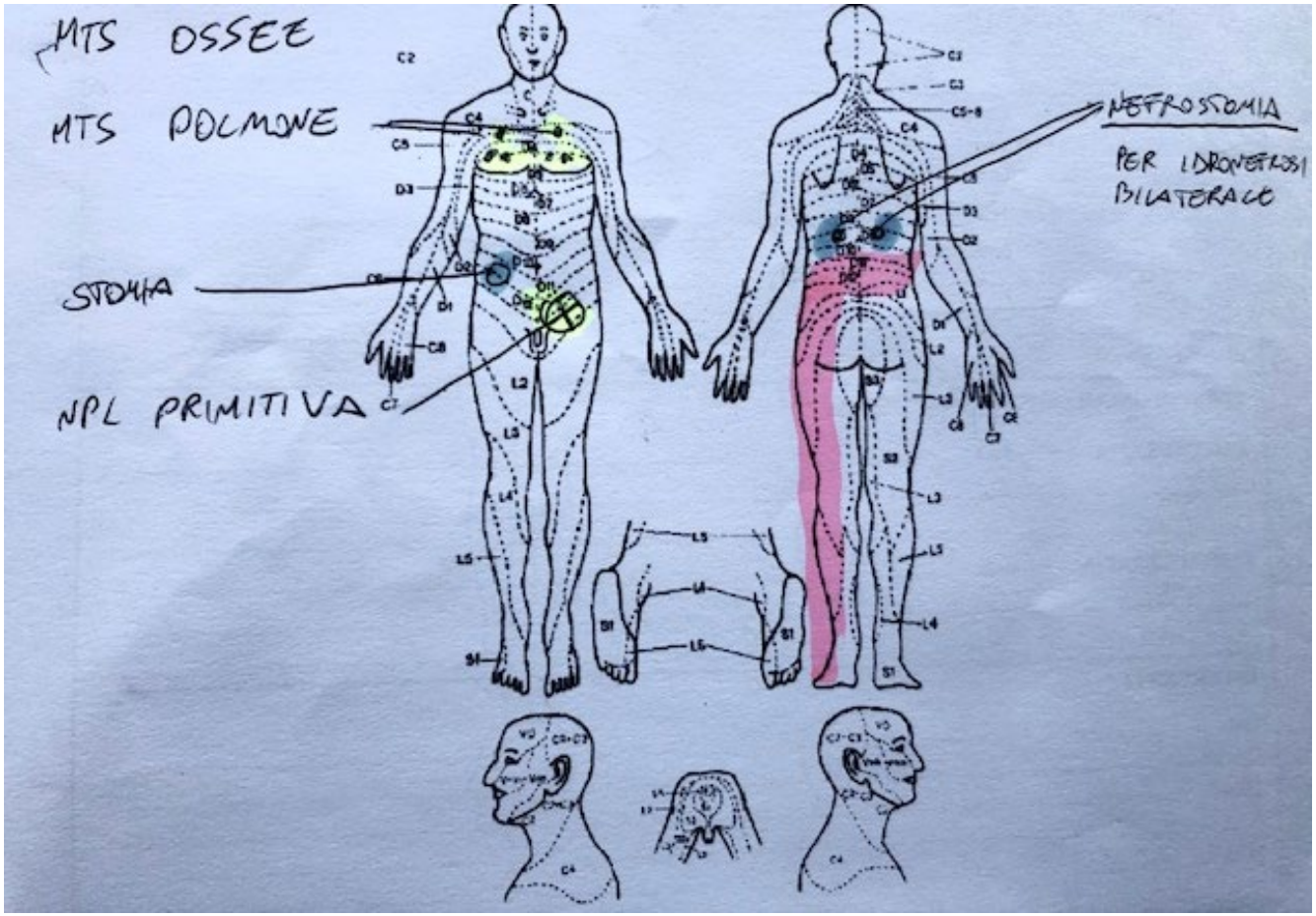
Intermittent infusion of midazolam





M 49 yrs, colon-rectum, MTS lung, bones bilateral nephrosomies, ileostomy

Neuropathic component and bone pain
biochemistry: bilirubin 2.8 mg/dl



Fentanyl 175 mcg/dday

Eptadone iv 60 90

methadone 120

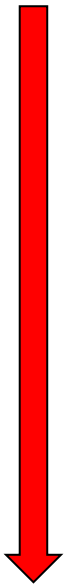
methadone 90

hydromorphone 36

pregabalin 100

duloxetine 60

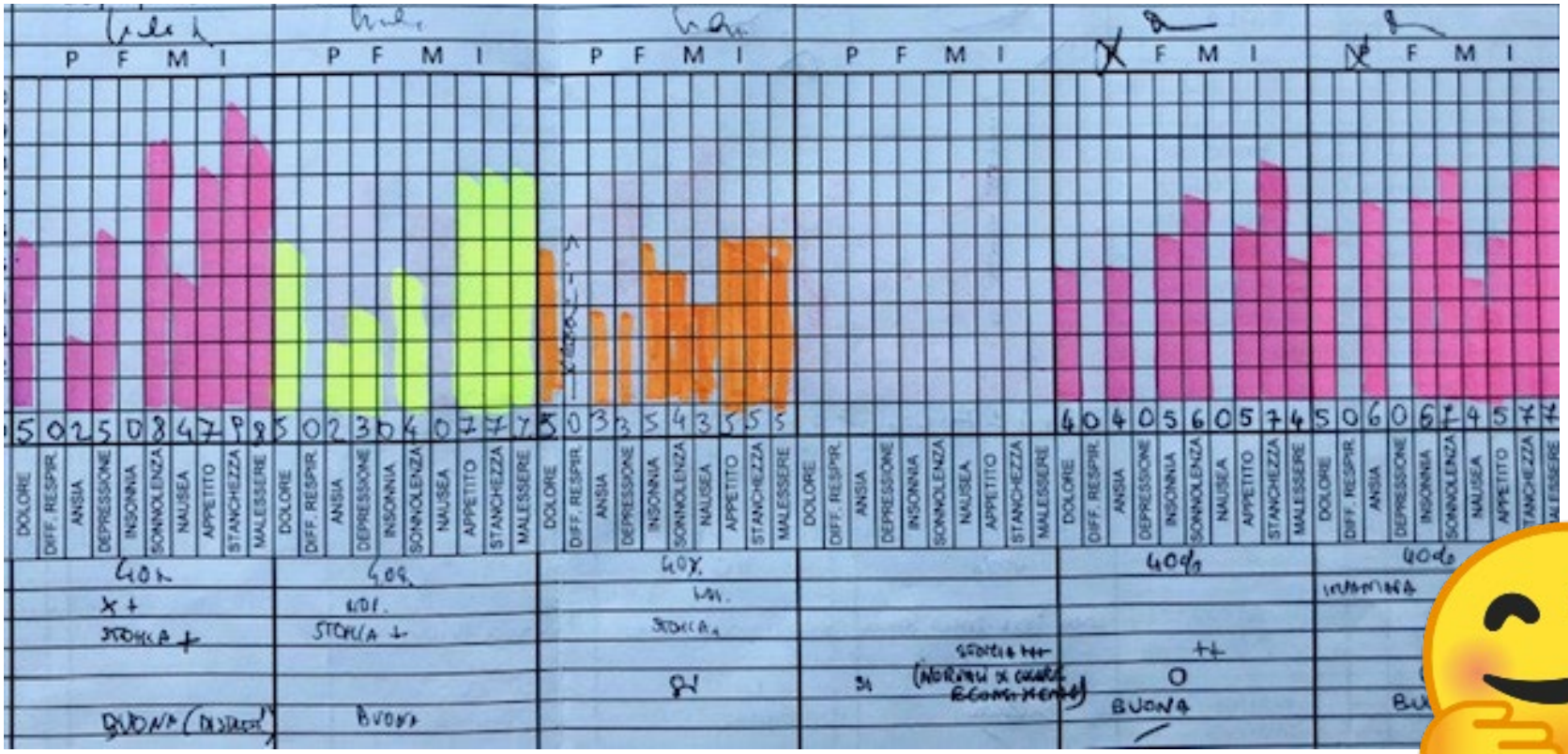
Adverse effects, poor analgesia



Spinal analgesia

Oral Methadone	36	45
IT bupivacaine	30	
IT morphine	10	

Complex treatment
Planned hospice admission



After the journey in acute palliative/supportive care unit

Patient was considered non trasferable at home due to the complex treatment

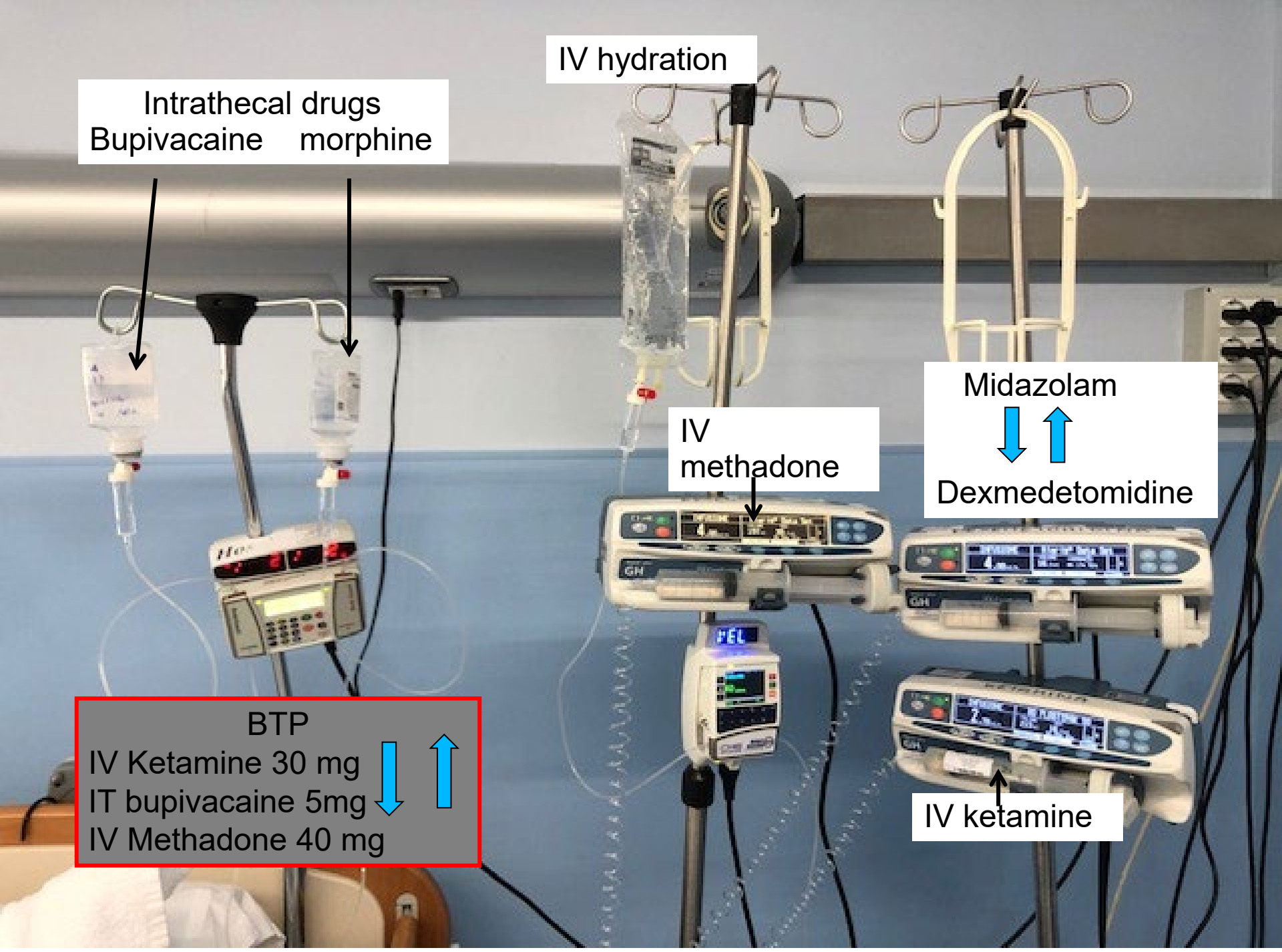
Discharged hospice with:

IT bupivacaine-morphine mixture

Methadone

Well controlled pain

- During hospice admission:
- Aggraviation of pain with hyperexpression with existential distress (feeling of imminent death)
- Spouse allowed to stay in hospice
- Allowed visit of sons
- Well control, conscious sedation
- Staying 20 days..
- Died without palliative sedation
- Aggressive pain management……


IV hydration
Intrathecal drugs
Bupivacaine morphine
IV methadone
Midazolam
Dexmedetomidine
BTP
IV Ketamine 30 mg
IT bupivacaine 5mg
IV Methadone 40 mg
IV ketamine

Short report

When the game is hard, more complex weapons are needed

Sebastiano Mercadante [1,2] Claudio Adile,[1] Patrizia Ferrera,[1] Fausto Giuliana[2]

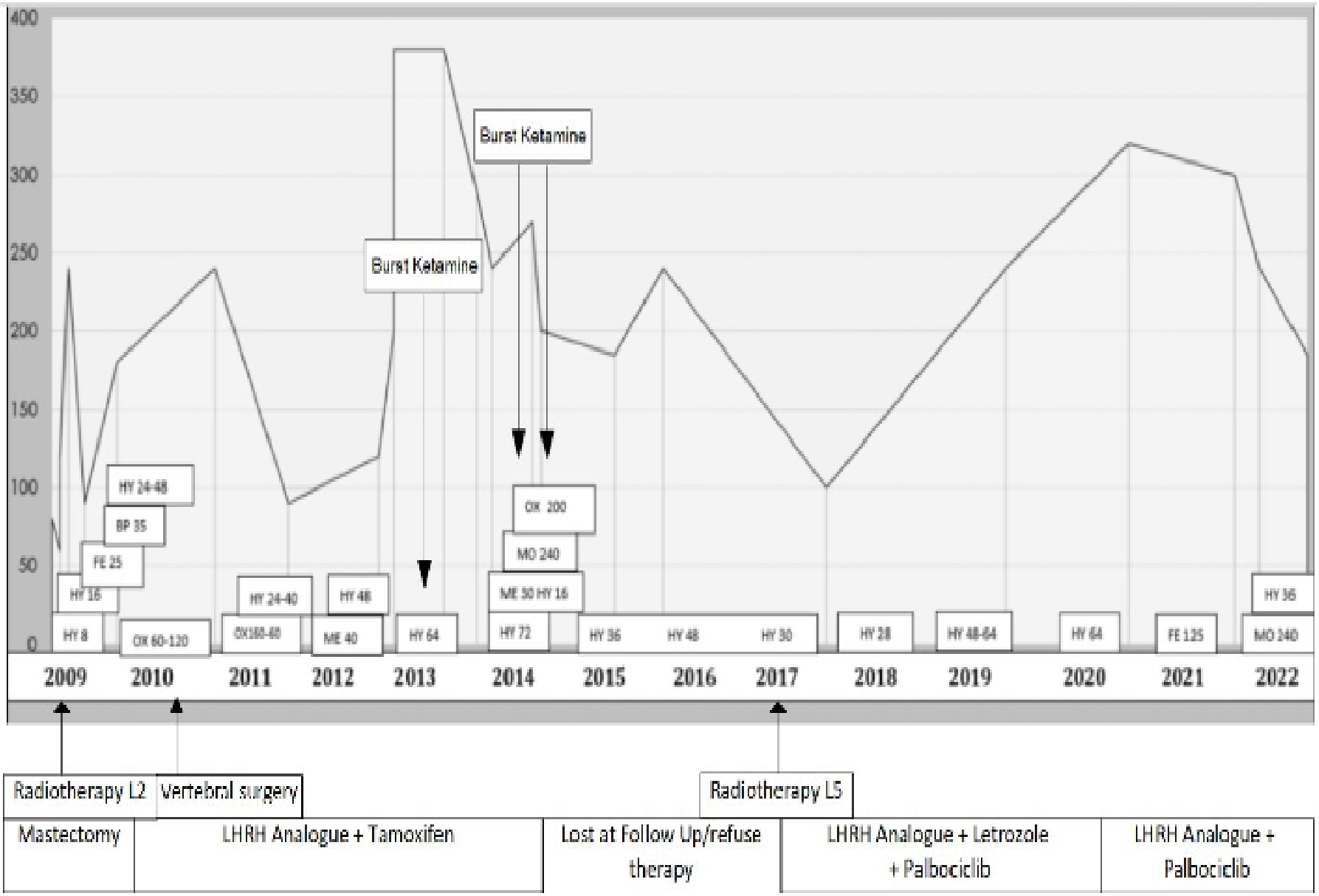
M, 60 yrs with liver tumor who had previously received radiotherapy to the pelvis and vertebral sites. Receiving buprenorphine 70 µg/hour and pectin fentanyl nasal spray 400 µg as needed for pain graded as 8/10 with frequent peaks of 10/10. Intravenous titration up to 15 mg oxycodone, continuous infusion of oxycodone at 80 mg/ day, progressively increased to 200 mg/day, then converted to oral oxycodone 400 mg/day.

Six months later worsening pain (9/10), despite increasing oxycodone to 600 mg/ day with pregabalin 100 mg/day. RMN = diffuse bone metastases. Titration with IV methadone 10 mg, followed by 60 mg/day, then converted to oral methadone 90 mg/day, progressively increased to 330 mg/day, unsuccessfully, despite a burst of ketamine–midazolam given for 2 consecutive days (100 mg and 15 mg/day, respectively).

Cancer survivors: - long-term opioid therapy – the challenge. BMJ Support Palliat Care, 2022

She received multiple opioid rotations or some more complex treatments, including burst of ketamine and midazolam, which allowed to maintain an acceptable pain control for 12 yrs, despite her poor compliance. With opioid rotations the oral morphine equivalents (OME) doses changed from 40 mg/day (8 mg of hydromorphone) to 180 mg/day (36 mg of hydroxymorphine), (OEI 0.021 mg/day, 0.074%/day) in 4670 days.

A high level of knowledge, experience, and assessment is mandatory to implement of pain management among survivors.

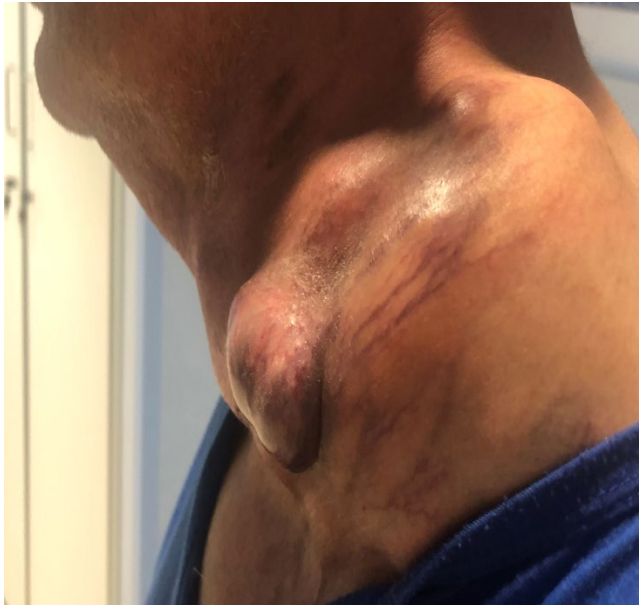

400
350
300
250
200
150
100
50
0
Burst Ketamine
Burst Ketamine
HY 24-48
BP 35
FE 25
HY 16
HY 8
OX 60-120
HY 24-40
OX160-60
HY 48
ME 40
HY 64
OX 200
MO 240
ME 30 HY 16
HY 72
HY 36
HY 48
HY 30
HY 28
HY 48-64
HY 64
FE 125
HY 36
MO 240
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
Radiotherapy L2
Vertebral surgery
Radiotherapy L5
Mastectomy
LHRH Analogue + Tamoxifen
Lost at Follow Up/refuse therapy
LHRH Analogue + Letrozole + Palbociclib
LHRH Analogue + Palbociclib

Cancer pain management and maintenance therapy

A 65-year-old male progressively developed neck pain and dysphagia. A diagnosis of epiglottis cancer was made in October 2021. He underwent a partial exeresis of a supraglottic mass, followed by carboplatin-taxol, cetuximab, then changed to carboplatin and cetuximab.

In June 2022 nivolumab was prescribed but due to the progression of disease he was then prescribed paclitaxel, and put on the waiting list for local radiotherapy.

Due to increasing levels of pain and clinical deterioration, he was referred to a home care program. The attending home palliative care physician referred him to an acute supportive palliative care unit (ASPCU) for a difficult pain syndrome, unmanageable at home.



On admission, physical examination finding showed a large supra-clavicular neck mass with tendency to ulceration and a mixed somatic-neuropathic pain

Syndrome of severe intensity (8/10 with frequent peaks of 10/10). Imaging studies showed a progression of disease, involving muscles and vessels of the neck.

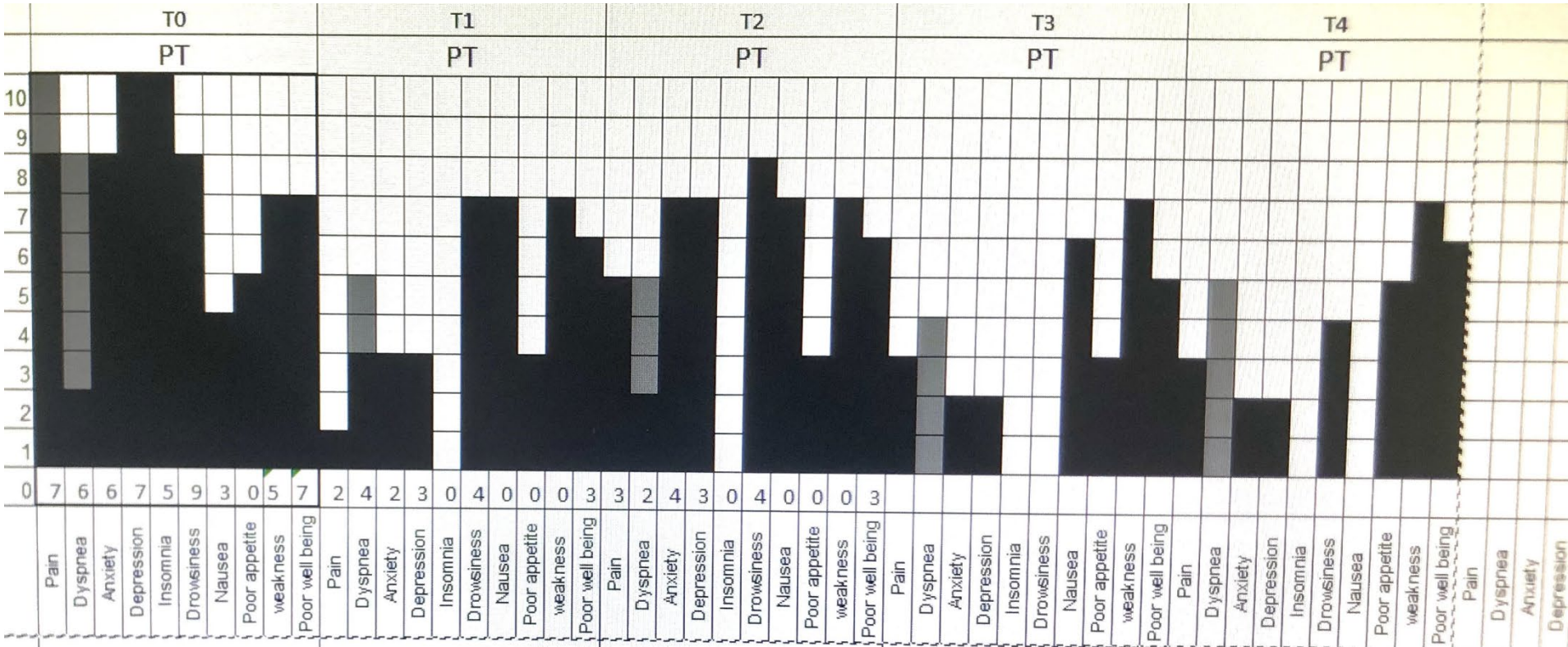
The **CAGE** (cut, annoyed, guilty, eye opener) test for drugs was positive (4/4). The Karnofsky status was 50 and the Memorial Delirium Assessment scale (MDAS) was 5. He also manifested high levels of anxiety, depression, and poor sleep.

Former addict on MTT for 30 years. The last methadone dose prescribed was 100 mg daily, although he was also taking an extra dose of 50 mg from his weekly prescribed reserve (total 150 mg/day).

A decision was made to split the patient's total home methadone dose into 60 mg three times a day (180 mg/day) with intravenous morphine 50 mg as needed for breakthrough pain.

The day after optimal pain relief with significant reduction in other symptoms.

He was discharged home on the 4th day. In follow-up phone contacts with the home care physician, the patient reported very good pain control, with no use of breakthrough medications, and no relevant problems, unless an abscess of the neck mass, requiring antibiotic therapy and frequent medications.



BA, 74 yrs, Small cell lung cancer

LN and pleural effusion, MTs liver, bone
MTs c6, C9, T3, ribs: 6-7 dx,2,5,7,8 sn,
pelvis, femurs
RT on T12

On Oxycodone 40 mg/day

A complex visceral pain

F 47 yrs, ovarium cancer, pelvic involvement, lower abdominal and perineal pain

On:

TD fentanyl 150 mcg/h

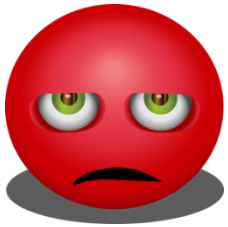
morphine sc 20 mg x 6

SL fentanyl 300 mcg as needed

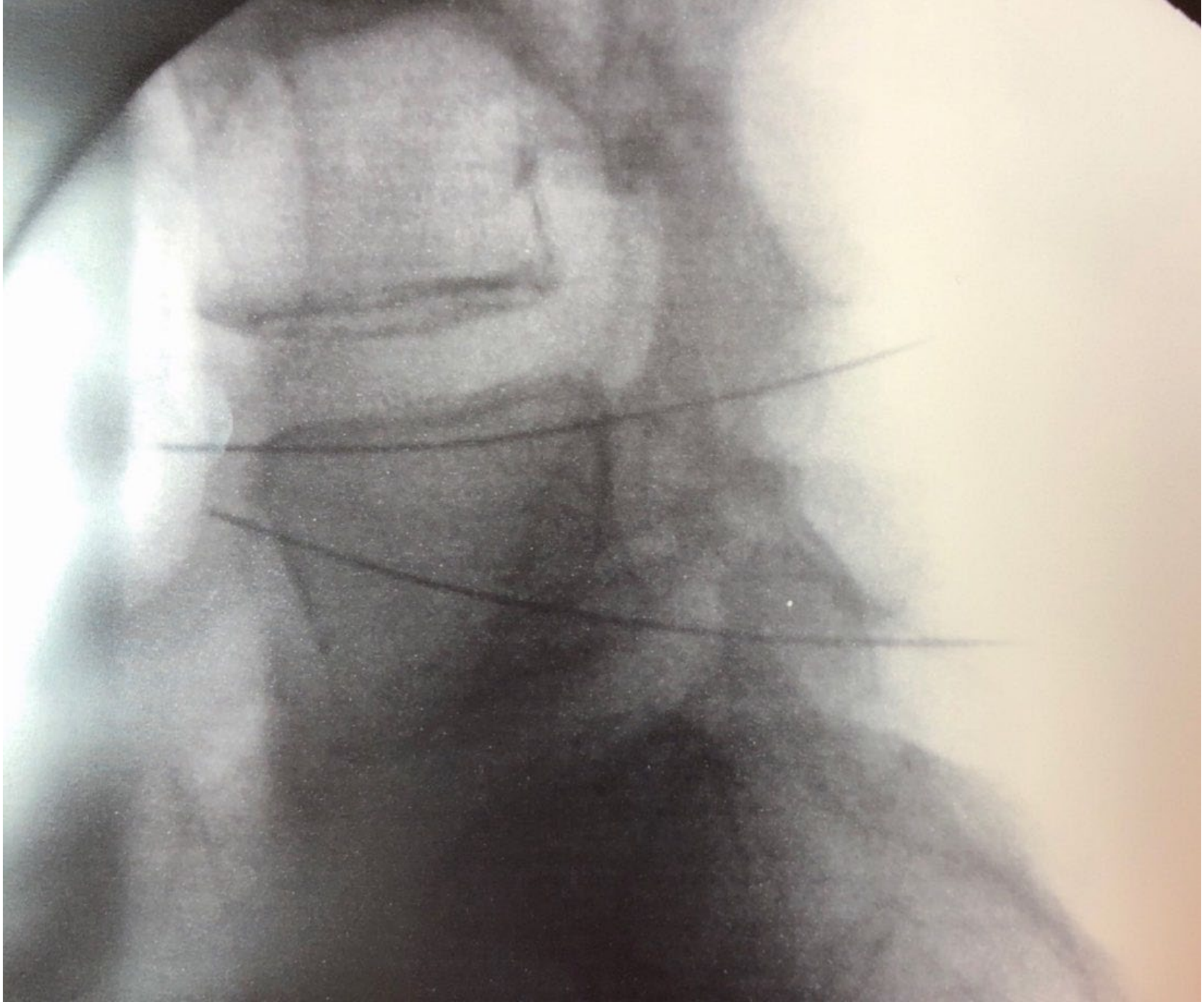
Paracetamol 500 x 3

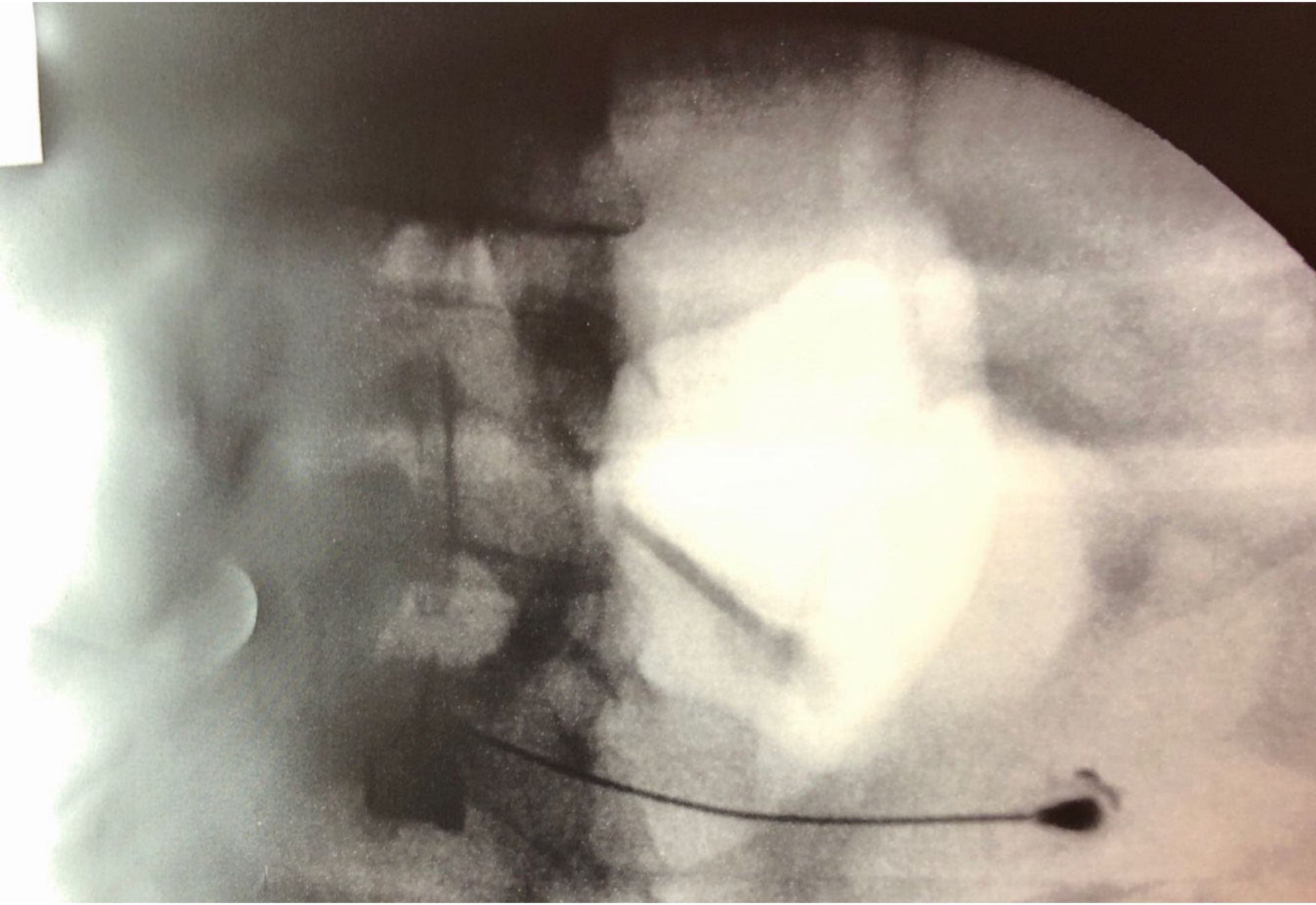
Pain 10/10, no signs of overexpression

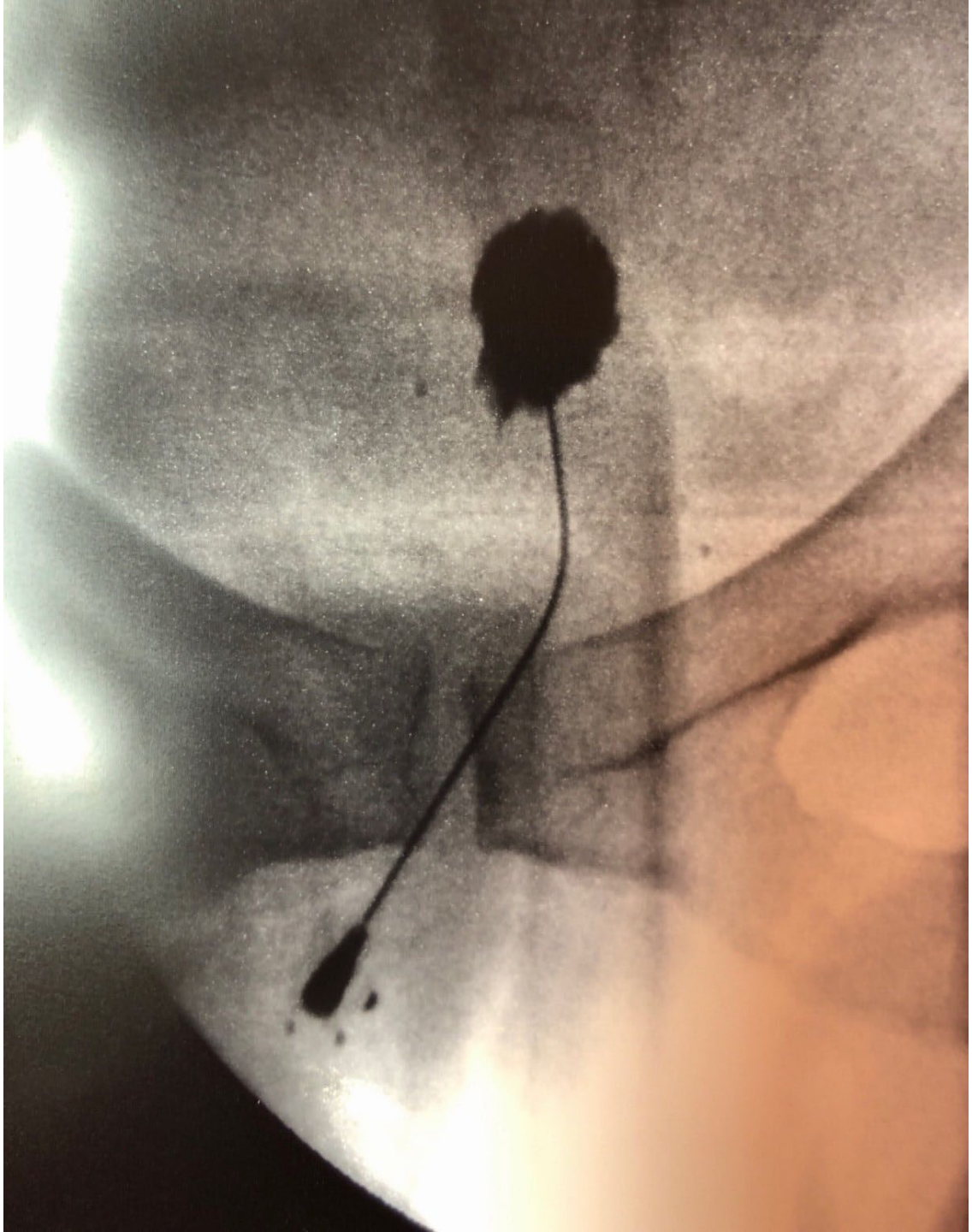
- Switched to intravenous methadone 45 mg and increasing the doses unsuccessfully
- Amitryptiline 25 mg
- Ketamine-midazolam burst for two days
- Methadone 75 mg/day
- uncontrolled pain



- Proposal for hypogastric plexus block and Walther ganglium block







The Combination of Superior Hypogastric Plexus Block and the Block of the Ganglium Impair in a Patient With Abdominal and Perineal Pain Poorly Responsive to Opioids

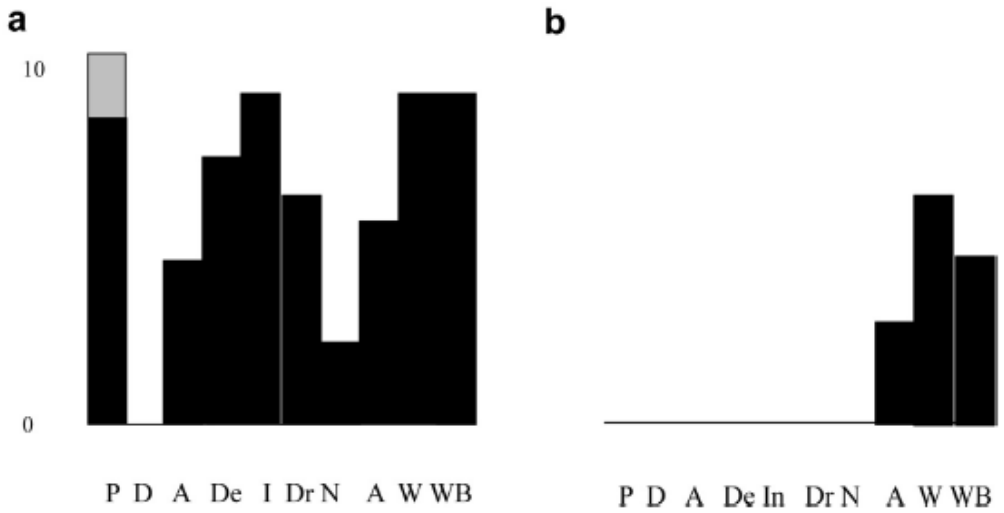
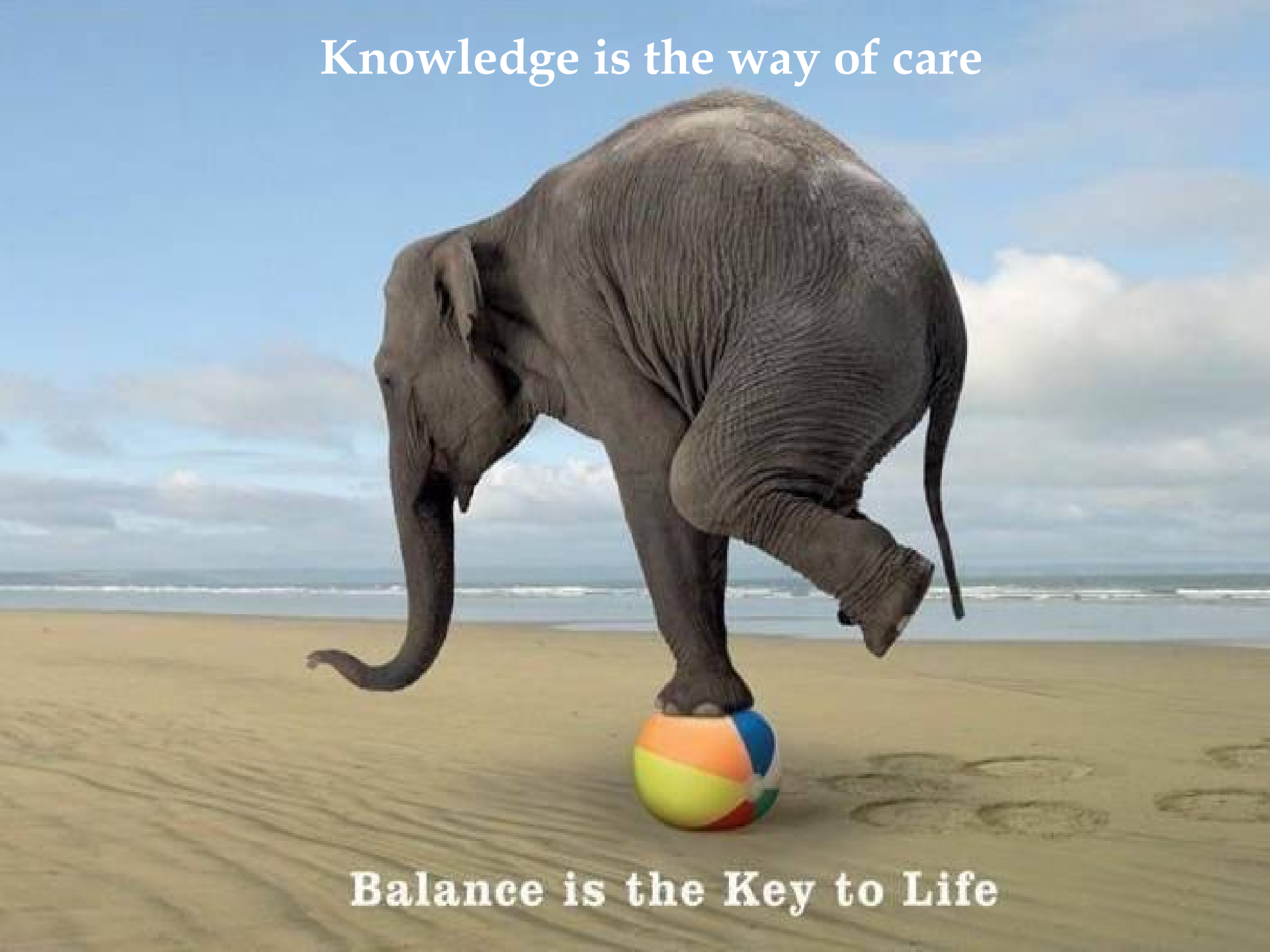


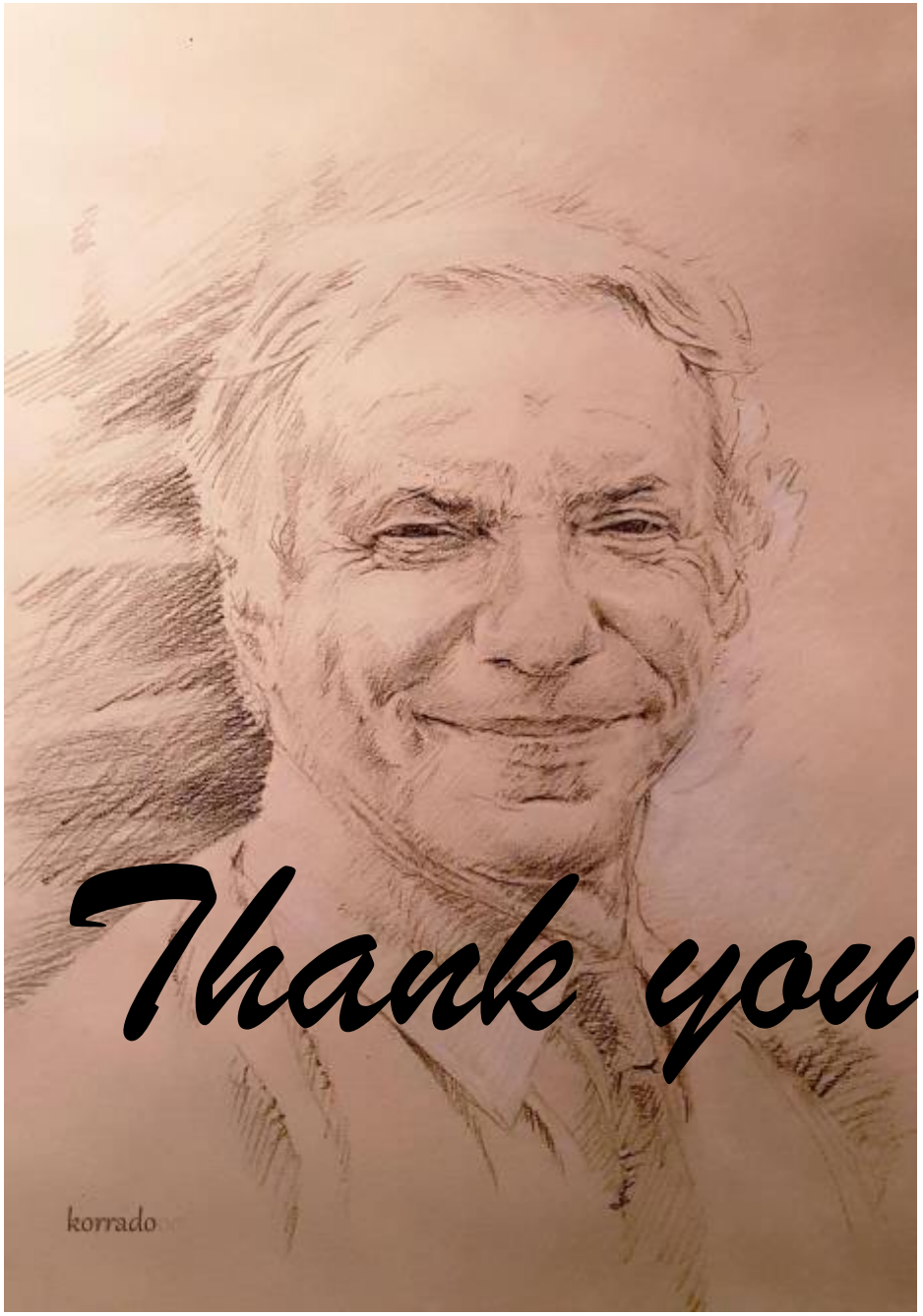
Fig. 1. a) ESAS before performing the blocks (see text); b) ESAS on the day after the blocks. P = pain; D = dyspnea; A = anxiety; De = depression; I = insomnia; D = drowsiness; N = nausea; A = appetite; W = weakness; WB = well-being; ESAS = Edmonton Symptom Assessment Scale. The gray area is the breakthrough pain intensity.

The management of difficult pain requires high level of competence and knowledge…

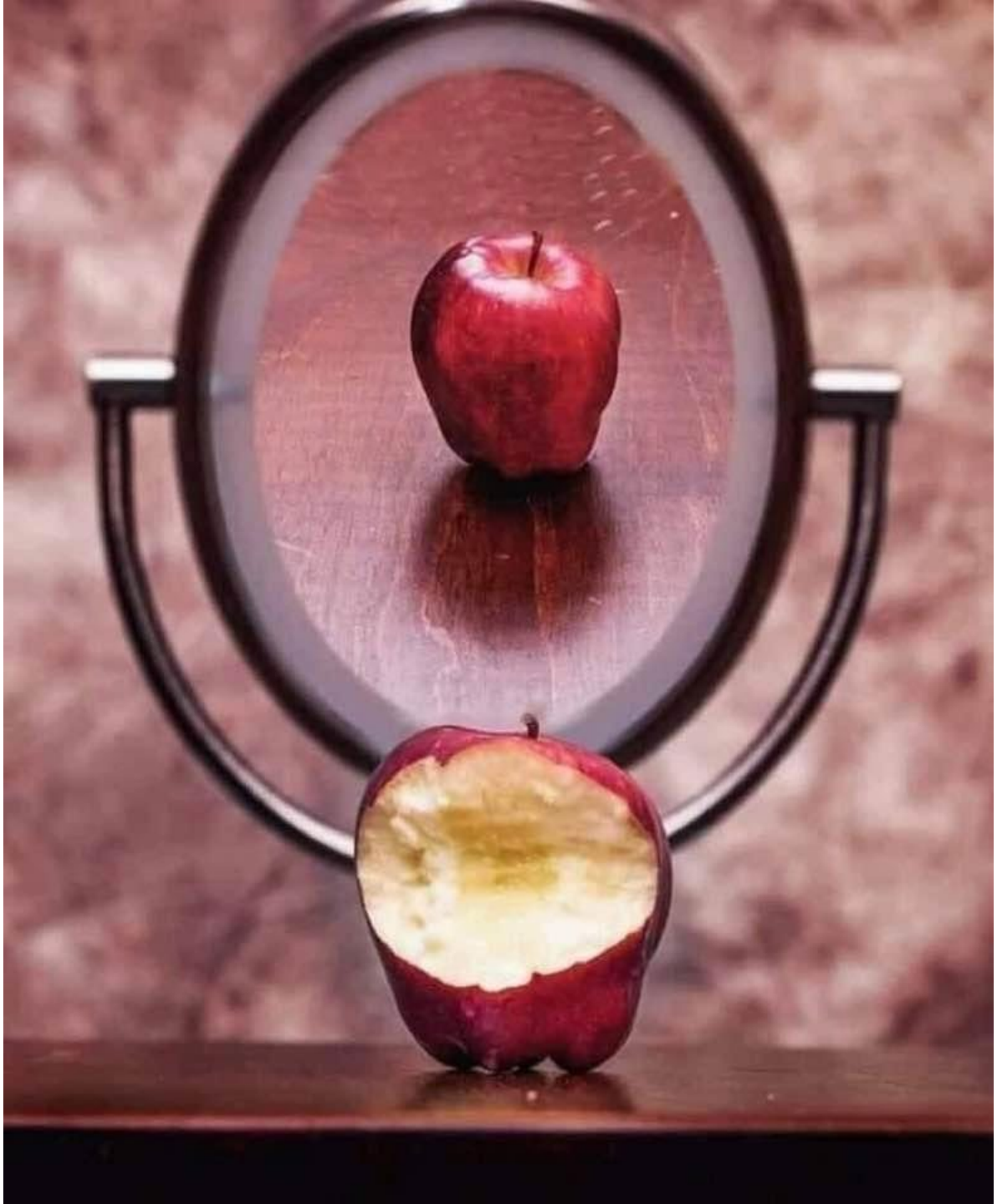
…as extreme conditions do not fit usual recommentadions which should be reserved to primary care


Quando non sei
sicuro del tuo
stile ...
ricordati che
Superman porta
le mutande
sopra i pantaloni.


Knowledge is the way of care
Balance is the Key to Life


Thank you
korrado


STUPOR
MUNDI
PALERMO
18-20
APRIL 2024



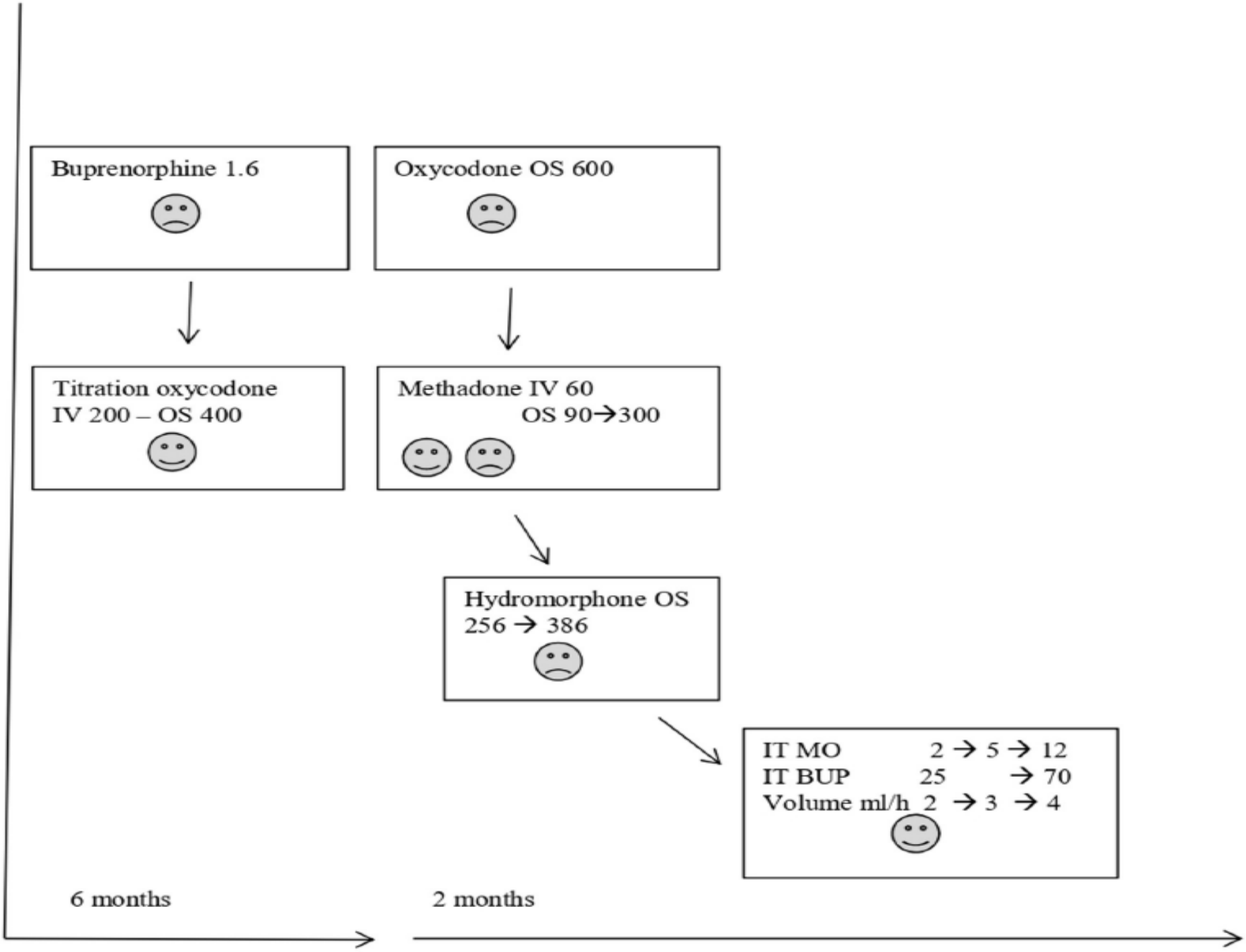
Due to progressive deterioration and the high level of distress, the patient was transferred to the adjacent **hospice**, also to allow the ongoing presence of his wife, which was prohibited in ASPCU, due to COVID-19 restrictions.
Switched to **oral hydromorphone 256-384** mg7day with no improvement. The addition of **lidocaine 400 mg/day** intravenously

IT catheter at T10 level, IT continuous infusion of morphine 2 mg/day and bupivacaine 25 mg/ day (in a volume 2 mL/hour). **Morphine 120 mg intravenously and midazolam 2 mg were given for breakthrough pain**.
Hydromorphone dose was progressively tapered down.
In the subsequent days, the daily dose of **IT morphine dose** was increased up to **4 mg/day,** as well as the infusion volume (3 mL/hour). Intravenous dexamethasone 4 mg and oral duloxetine 30 mg were added.
Pain control was achieved with no specific adverse effects.

Procedural pain for hygiene-dressing manoeuvres was prevented by **midazolam 3 mg.**

The patient and his wife were happy with symptom control and the warm atmosphere of the hospice provided by the staff.

The level of communication was optimal.
In the subsequent 2 months, IT doses of the drug combination were progressively changed, each time successfully. Breakthrough pain was treated with intravenous morphine 200 mg or with IT boluses of bupivacaine
5 mg, successfully. The IT morphine–bupivacaine
ratio was changed (12 mg/day and 70 mg/day, respectively),
while adding IT methadone 10 mg and an
intravenous oxycodone infusion of 200 mg/day. The
global volume rate was set at 4 mL/hour.
The patient and his wife were grateful to the entire staff who did their utmost care for them.
70 days after hospice transfer, the patient developed delirium and existential distress; he was not responsive to neuroleptic drugs and required palliative
sedation that was performed with midazolam 45 mg/
day. The patient died peacefully the day after.


Buprenorphine 1.6
Oxycodone OS 600
Titration oxycodone
IV 200 – OS 400
Methadone IV 60
OS 90→300
Hydromorphone OS
256 → 386
IT MO 2 → 5 → 12
IT BUP 25 → 70
Volume ml/h 2 → 3 → 4
6 months
2 months

D. Antonino, 42 anni
Ka sigma non operato avanzato, infiltrante di entrambe le ali sacrali (maggiore a dx) dal mese di marzo 2022, dolore a carico di anca destra.
15/06/2022 TC rachide lombosacrale: osteolisi a livello di emisacro di destra.
30/06/2022 visita oncologica: adeguamento terapia antalgica c/o ospedale di Trapani.
28/06/2022 TC total body: destrutturazione ossea a livello di entrambe le ali sacrali.
biopsia TC guidata del suddetto tessuto con esito negativo.
25/07-22/08/2022 Ricovero presso Oncologia Maddalena. E' stata adeguata la terapia antalgica inizialmente con morfina infusionale e successivo passaggio a fentanyl TD e morfina al bisogno. E' stata effettuata una agobiopsia TC guidata della lesione ossea sacrale con diagnosi istologica di adenocarcinoma con aree di necrosi e differenziazione immunoistochimica di tipo intestinale. E' stata effettuata una colonscopia con riscontro di eteroplasia del sigma con diagnosi istologica definitiva di adenocarcinoma infiltrante tessuto fibroso.
In data 05-06/08 e in data 18-19/08 sono stati somministrati i primi due cicli di chemioterapia con schema **FOLFOX**-4.02/09-03/09/22 è stato somministrato il III ciclo di chemioterapia sec.schema FOLFOX-4.16-17/09/2022: IV ciclo di chemioterapia sec.schema FOLFOX-4.
30/09-01/10/22 V ciclo di chemioterapia sec.schema FOLFOX-4.
19-28/10/2022 **RT** ad intento palliativo sintomatico su sacro con tecnica 3DCRT fotoni X da 18 MV dose 4 Gyfr>20Gy

Paziente in stato avanzato/terminale di malattia, con difficoltà di gestione domiciliare (sindrome dolorosa complessa), attualmente in terapia infusionale/al bisogno con eptadone, per il quale è stata avviata la procedura di dimissione complessa per ricovero in hospice.

Transferred from ASPCU to hospice on **Nov 25 :**
IV methadone 110 mg
Duloxetine 30 mg
Ibuprofene 400 mg x 2
Iv methadone 15-18 mg as needed (7 BTPs)

Increasing doses of IV Methadone
Adding midazolam and dexmedetomidine 600 mcg, ketamine 200 mg
IV morphine 400-600 mg
Octreotide-metoclopramide-dexamethasone for GI subostruction symptoms

IV morphine 2000 mg
BTP: IV morphine 480 mg + midazolam 2 mg

Dec 16
Intrathecal therapy with morphine 15 mg + bupivacaine 25 mg
IV morphine 480 mg + IV ketamine 200 mg + midazolam 25-30 mg
BTP: IV morphine 200 mg + midazolam 2,5 mg

14- may- 2023

IT Morphine 25 mg + bupivacaine 25 mg
IV methadone 430 mg (ketamine unavailable)
Hydromorphone 112 mg
Haloperidol 6 mg
Duloxetine 60 mg
Olanzapine 5 mg
Octreotide 0.6 mg + Dexametasone 16 mg

BTP: IV morphine 420 mg+ Midazolam 2,5 mg

In 6 months:
Normal intake
Good quality of life

15-may Dysphagia

Stop duloxepine olanzapine hydromorphone

IT Morphine 25 mg + bupivacaine 25 mg

IV methadone 430 mg

IVOxycodone 420 mg

Haloperidol 6 mg

Octreotide 0.6 mg + Dexametasone 16 mg

20 may

No pain, high distress, Start PS

midazolam 225 mg/day, Chlorpromazine 300 mg/day