



# Early Hospice Consultation Team Engagement for Cancer Pain Relief: A Case Report

Jisoo Jeong, M.D.

Department of Hemato-Oncology, Soonchunhyang University Hospital, Cheonan, Korea

This case report explores the challenges and complexities associated with opioid management of cancer pain, emphasizing the importance of early involvement of a hospice consultation team and the adoption of a multidisciplinary approach to care. A 56-year-old man with advanced pancreatic cancer experienced escalating pain and inappropriate opioid prescriptions, highlighting the shortcomings of traditional pain management approaches. Despite procedural intervention by the attending physician and increased opioid dosages, the patient's condition deteriorated. Subsequently, the involvement of a hospice consultation team, in conjunction with collaborative psychiatric care, led to an overall improvement. The case underscores the necessity of early hospice engagement, psychosocial assessments, and collaborative approaches in the optimization of patient-centered palliative care.

**Key Words:** Hospice care, Opiate overdose, Pain management

**Received** April 11, 2024  
**Revised** May 16, 2024  
**Accepted** May 17, 2024

## Correspondence to

Jisoo Jeong  
ORCID:  
<https://orcid.org/0000-0003-3084-6456>  
E-mail: 112746@schmc.ac.kr

## INTRODUCTION

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage [1]. The prevalence of pain among patients with cancer ranges from 20% to 50%, and approximately 80% of those with advanced cancer experience moderate to severe pain related to their condition [2,3].

In the context of cancer pain management, opioid escalation is frequently viewed as a straightforward option. However, due to the patient's medical condition, adhering to standard protocols for opioid titration can present challenges [4]. The National Comprehensive Cancer Network guidelines recommend considering injectable opioids when initiating therapy for severe cancer pain or during pain crises [5,6]. However, opioid misuse is a particular risk among hospice patients, emphasizing the need for appropriate pain assessment in opioid administration [7].

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/4.0/>) which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

Copyright © 2024 by Korean Society for Hospice and Palliative Care

Comprehensive evaluation in patients at the end of life aims to alleviate their overall physical and psychological suffering, a practice known as hospice palliative care [8]. In South Korea, this care is delivered in three forms: inpatient, consultation-based, and home-based. Consultation-based hospice palliative care is provided by a multidisciplinary team of doctors, nurses, and social workers, who offer relief services through counseling rather than direct treatment or prescribing medications [9].

We present a case in which the involvement of a consultation-based hospice palliative care team corrected inappropriate opioid prescriptions in a patient with terminal cancer. The Soonchunhyang University Institutional Review Board (IRB No. 2024-03-017) approved the description of this case report.

## CASE PRESENTATION

A 56-year-old man had exhibited a history of chronic pan-

creatitis for the past few years. He had been receiving outpatient treatment for persistent abdominal pain that began 4 months before his hospitalization at our institution. The patient was diagnosed with advanced pancreatic cancer at another hospital 40 days prior to admission, with metastases to the liver and thoracic spine noted at the time of diagnosis. Due to the advanced stage of cancer, the patient was not a candidate for curative surgery or chemotherapy, and he was transferred to our hospital for palliative care.

The patient reported persistent abdominal and back pain, which prompted the attending physician to conduct a personal assessment to address his discomfort. The patient described an atypical dull pain that did not improve over time, and he could not identify any specific aggravating or alleviating factors. However, the patient was assessed based solely on the intensity of pain as measured by the numeric rating scale, resulting in a progressive increase in the prescription of opioid analgesics.

Throughout his hospitalization, the patient was administered oral codeine at a dosage of 10 mg three times daily and experienced a series of dose escalations with a transdermal fentanyl patch. The dosage began at 50  $\mu$ g on day 1 and had been increased to 600  $\mu$ g by day 38. Starting on day 8, intravenous morphine was also provided at a rate of 0.5 to 0.75 mg per hour. Additional medications included 300 mg of pregabalin twice daily, along with escitalopram (5 mg) and quetiapine (25 mg). Despite these pharmacological measures, the patient's pain remained uncontrolled.

In terms of procedural interventions, a psoas compartment block was performed on day 8, a paravertebral block at the T10 level on day 22, and a celiac plexus block on day 35. Radiation therapy for pain control commenced on day 14; however, the patient exhibited no improvement.

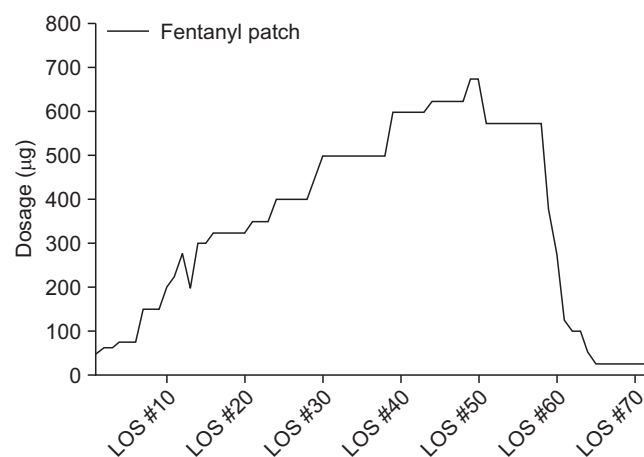
Despite the rapid increase in opioid administration, the patient's pain intensified, accompanied by side effects including local discomfort and constipation. As his symptoms worsened, the patient sought consultation with a hospice care team on day 38.

The hospice consultation team is composed of radiation oncologists, psychiatrists, oncologists, medical social workers, and nurses who are committed to providing hospice care. Following the patient's initial consultation, a second appointment took place 2 days later, with a third consultation occurring 1

week after that.

The initial assessment by the hospice care team revealed that the patient had been administered excessive doses of opioids. Concurrent interventions, such as radiation therapy and nerve blocks, were further complicating the clinical picture. In this context, the patient's symptoms had worsened.

On day 48, a change in the attending physician prompted a reevaluation by the hospice consultation team. This reassessment included a thorough examination of the patient's psychological state, which uncovered underlying issues that required attention. The examination revealed that the patient was dissatisfied with the medical staff regarding the delayed diagnosis of pancreatic cancer. Consequently, he projected his feelings onto the attending physician and reported pain that was unresponsive to treatment. Following the evaluation by the hospice consultation team, a collaborative consultation with the psychiatric department was initiated, based on the assumption that dissatisfaction, projection, and somatization were being directed toward the attending physician. After joint consultations between the psychiatric department and hospice care, the patient recognized his feelings of projection and psychological discomfort toward the medical team. He attributed these feelings to his belief that the delayed diagnosis by the attending physician had contributed to a delay in treatment. Subsequently, at the patient's request, a gradual reduction of the fentanyl patch was initiated. On day 72 of hospitalization, the patient was discharged with effective pain management,



**Figure 1.** A rapid decrease in fentanyl patch dosage ( $\mu$ g) is evident following the intervention of the hospice consultation team and the psychiatry department on day 50. LOS: length of stay (days).

which included a 25- $\mu$ g fentanyl patch and olanzapine (5 mg). This regimen alleviated the side effects caused by the opioid analgesics and achieved pain control (Figure 1).

## DISCUSSION

The prevalence of cancer pain has been reported to be 33% among patients who have undergone curative treatment, 59% in those currently receiving cancer therapy, and as high as 64% in patients with metastatic or advanced cancer [10]. Over 50% of patients with terminal cancer who are admitted to hospice palliative care facilities report moderate to severe pain [1]. Uncontrolled cancer pain not only exacerbates patient suffering but also results in a diminished quality of life, impaired social interactions, reduced compliance with cancer treatment, and adverse prognostic outcomes [11,12]. However, given the frequent occurrence of side effects from opioid medications, healthcare professionals must be proficient in preventing and managing complications such as constipation, nausea, sedation, and neurotoxicity [13]. Since most cancer pain can be adequately managed with appropriate pharmacological interventions that adhere to pain management principles, drug therapy for pain in patients with cancer is critically important.

An increasingly emphasized challenge in the safe and effective management of cancer pain is the potential for overtreatment with opioids over extended periods, in which cases the drugs may do more harm than good [13]. Barriers including limited knowledge, time constraints, and inadequate compensation have contributed to the exacerbation of opioid misuse, which in turn has led to undertreatment [13–16]. Undertreatment and its contributing factors then fuel the misuse of opioids. These barriers tend to result in the neglect of comprehensive pain assessments in routine practice. Additionally, some healthcare providers view opioid analgesics as the sole treatment option for pain, failing to offer patients alternative therapies such as mental health counseling or physical therapy.

The World Health Organization recommends morphine for treating cancer-related pain [17,18]. Despite the fairly stable consumption of morphine in numerous countries since 2000, reports demonstrate increases in the use of other opioid analgesics, such as fentanyl and oxycodone [19–23]. In Korea, nationwide data on opioid prescriptions are scarce. Neverthe-

less, a recent study assessed the trend of opioid prescriptions both nationwide and by administrative region from 2009 to 2019 [24]. The findings revealed significant upward trends in the prescriptions of overall, potent, and long-acting opioids. Prescription rates for all types of opioids nearly doubled across administrative regions, with a marked increase in the quantities of opioids prescribed during the study period [24].

Upon admission, the patient experienced intensified pain due to a pancreatic cancer diagnosis received at an external hospital. The attending physician, primarily considering the numeric rating scale for pain, rapidly escalated the fentanyl patch dosage without conducting a thorough personal assessment. This rapid increase in narcotic analgesics may have led to opioid-induced hyperalgesia. Furthermore, due to inadequate evaluation of side effects, particularly constipation, it is possible that the associated pain was not differentiated from other cancer-related pain. The patient's psychological distress necessitated a multidisciplinary approach for effective intervention. A comprehensive psychosocial assessment, conducted during initial and follow-up hospice care evaluations, uncovered a deep-seated ambivalence towards the attending physician and a reluctance to express grievances. Addressing these psychosocial concerns, along with the use of psychiatric medications and a gradual reduction in opioid dosage, contributed to a marked improvement in the patient's overall condition. Early involvement of the hospice consultation team could be beneficial in addressing similar concerns.

Hospice palliative care is designed to provide holistic assessment and treatment across physical, psychological, social, and spiritual domains. This care includes pain and symptom relief for patients in the terminal stages of illness and those approaching the end of life, as well as support for their families. Cancer pain is a highly personal experience, with patients exhibiting a wide range of discomfort levels, often exacerbated by psychological factors such as anxiety and depression [25]. Studies have shown that among those with advanced or metastatic cancer, anxiety is present in approximately 13% to 79% of patients, while depression is found in 3% to 77% [26,27]. Hospice consultation teams are uniquely equipped to address the complex causes of pain in patients with terminal cancer. These teams are composed not only of doctors but also of professionals from various fields who are trained in making

multidisciplinary decisions, making them more adept at intervention than general medical staff.

In South Korea, hospice care was initially introduced as a pilot project for patients with terminal cancer in 2003. Recently, the nation has seen an expansion to include inpatient, home-based, and hospice consultation services [9]. Still, the rigid framework of the Korean healthcare system has traditionally emphasized inpatient hospice care for terminally ill patients with cancer, leading to limited hospice care options for patients with other conditions and those who cannot be admitted to hospice wards in general hospitals. Recognizing this disparity, awareness has grown regarding the importance of consultative hospice services. These services aim to broaden access to hospice care, improve the quality of end-of-life care, and promote the efficient use of healthcare resources by integrating hospice care earlier in the course of terminal illness. Consequently, the recent emphasis on consultative hospice services has emerged as a core initiative in this field.

This case highlights the importance of early hospice involvement, comprehensive psychosocial assessments, and a collaborative, multidisciplinary approach in palliative care. Improved communication between patients and physicians is essential for

building trust and addressing underlying psychological distress, particularly when managing conventional opioid therapy. Timely intervention can avert complications associated with rapid opioid titration and optimize patient-centered care.

## FUNDING

None.

## CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

## ORCID

Jisoo Jeong, <https://orcid.org/0000-0003-3084-6456>

## SUPPLEMENTARY MATERIALS

Supplementary materials can be found via <https://doi.org/10.14475/jhpc.2024.27.2.77>.

## REFERENCES

- Kim J, Shin SJ, Yoon J, Kim HS, Lee JW, Kim YS, et al. Recent trends in opioid prescriptions in Korea from 2002 to 2015 based on the Korean NHIS-NSC cohort. *Epidemiol Health* 2022;44:e2022029.
- Ho KY, Ahn JS, Calimag MM, Chao TC, Kim YC, Moon H, et al. Inadequate treatment practices for pain relief and adverse event management in cancer patients across 10 countries/regions in Asia: a call for greater efforts to improve standards for patient care. *Asia Pac J Clin Oncol* 2018;14:159-66.
- van den Beuken-van Everdingen MH, Hochstenbach LM, Joosten EA, Tjan-Heijnen VC, Janssen DJ. Update on prevalence of pain in patients with cancer: Systematic review and meta-analysis. *J Pain Symptom Manage* 2016;51:1070-90.e9.
- Huh SJ, Oh SY, Kang JH, Go SI, Lee S, Kim HR. 2096P Morphine titration with intravenous patient-controlled analgesia for severe cancer pain (Mr. TIPS). *Ann Oncol* 2023;34(Supple 2):S1100.
- Levy MH, Back A, Benedetti C, Billings JA, Block S, Boston B, et al. NCCN clinical practice guidelines in oncology: palliative care. *J Natl Compr Canc Netw* 2009;7:436-73.
- Ripamonti CI, Santini D, Maranzano E, Berti M, Roila F; ESMO Guidelines Working Group. Management of cancer pain: ESMO Clinical Practice Guidelines. *Ann Oncol* 2012; 23 Suppl 7:vii139-vii154.
- Langmann GA, Childers J, Merlin JS. Caring for patients with opioid misuse or substance use disorders in hospice: a national survey. *J Palliat Med* 2024;27:209-15.
- Jaiswal R, Alici Y, Breitbart W. A comprehensive review of palliative care in patients with cancer. *Int Rev Psychiatry* 2014;26:87-101.
- Lee SW, Lee YS, Ko CA. Development of a team-oriented advisory hospice palliative care provision model [Internet]. Wonju: National Health Insurance Service; 2018 [cited 2024 Feb 11]. Available from: <https://repository.hira.or.kr/handle/2019.oak/1533>.
- Treede RD. The international association for the study of pain definition of pain: as valid in 2018 as in 1979, but in need of regularly updated footnotes. *Pain Rep* 2018;3:e643.
- Te Boveldt N, Vermooij-Dassen M, Burger N, Ijsseldijk M, Vissers K, Engels Y. Pain and its interference with daily activities in medical oncol-

- ogy outpatients. *Pain Physician* 2013;16:379-89.
12. Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med* 2010;363:733-42.
  13. Bruera E, Paice JA. Cancer pain management: safe and effective use of opioids. *Am Soc Clin Oncol Educ Book* 2015:e593-9.
  14. Breuer B, Chang VT, Von Roenn JH, von Gunten C, Neugut AI, Kaplan R, et al. How well do medical oncologists manage chronic cancer pain? A national survey. *Oncologist* 2015;20:202-9.
  15. Fisch MJ, Lee JW, Weiss M, Wagner LI, Chang VT, Cella D, et al. Prospective, observational study of pain and analgesic prescribing in medical oncology outpatients with breast, colorectal, lung, or prostate cancer. *J Clin Oncol* 2012;30:1980-8.
  16. Greco MT, Roberto A, Corli O, Deandrea S, Bandieri E, Cavuto S, et al. Quality of cancer pain management: an update of a systematic review of undertreatment of patients with cancer. *J Clin Oncol* 2014;32:4149-54.
  17. World Health Organization. Cancer pain relief: with a guide to opioid availability [Internet]. 2nd ed. Geneva: World Health Organization: 1996 [cited 2024 Feb 11]. Available from: <https://iris.who.int/handle/10665/37896>.
  18. Zin CS, Chen LC, Knaggs RD. Changes in trends and pattern of strong opioid prescribing in primary care. *Eur J Pain* 2014;18:1343-51.
  19. Hamunen K, Paakkari P, Kalso E. Trends in opioid consumption in the Nordic countries 2002 - 2006. *Eur J Pain* 2009;13:954-62.
  20. Hider-Mlynarz K, Cavalie P, Maison P. Trends in analgesic consumption in France over the last 10 years and comparison of patterns across Europe. *Br J Clin Pharmacol* 2018;84:1324-34.
  21. Kalkman GA, Kramers C, van Dongen RT, van den Brink W, Schellekens A. Trends in use and misuse of opioids in the Netherlands: a retrospective, multi-source database study. *Lancet Public Health* 2019;4:e498-e505.
  22. Nissen SK, Pottgard A, Ryg J. Trends of opioid utilisation in Denmark: a nationwide study. *Drugs Real World Outcomes* 2019;6:155-64.
  23. Ruscitto A, Smith BH, Guthrie B. Changes in opioid and other analgesic use 1995-2010: repeated cross-sectional analysis of dispensed prescribing for a large geographical population in Scotland. *Eur J Pain* 2015;19:59-66.
  24. Cho NR, Chang YJ, Lee D, Kim JR, Ko DS, Choi JJ. Trends in opioid prescribing practices in South Korea, 2009-2019: are we safe from an opioid epidemic? *PLoS One* 2021;16:e0250972.
  25. Kata V, Novitch MB, Jones MR, Anyama BO, Helander EM, Kaye AD. Opioid addiction, diversion, and abuse in chronic and cancer pain. *Curr Opin Support Palliat Care* 2018;12:124-30.
  26. Delgado-Guay M, Parsons HA, Li Z, Palmer JL, Bruera E. Symptom distress in advanced cancer patients with anxiety and depression in the palliative care setting. *Support Care Cancer* 2009;17:573-9.
  27. Utne I, Miaskowski C, Bjordal K, Paul SM, Rustoen T. The relationships between mood disturbances and pain, hope, and quality of life in hospitalized cancer patients with pain on regularly scheduled opioid analgesic. *J Palliat Med* 2010;13:311-8.