



PALLIATIVE CARE CASE OF THE MONTH

“Management of Odynophagia”

by

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Case: Ms. B was a 46-year-old female undergoing work up for potential lymphoproliferative disorder and management of disseminated MAC infection in the setting of immunodeficiency. She was experiencing severe odynophagia which was precluding tolerance of her MAC treatment. Outpatient imaging revealed new hepatic and splenic lesions along with inflammation of her small bowel and esophagus and she was admitted for expedited work up. She underwent EGD which revealed diffuse ulcerations and scattered white exudates throughout most of the mid-distal esophagus which were biopsied. Pathology was pending at the time of palliative care consultation for symptom management of severe odynophagia.

Discussion:

What causes odynophagia?

Odynophagia is defined as pain with swallowing and can often be associated with dysphagia, or difficulty swallowing. Etiologies can include:

- Infections of oropharynx or esophagus (candidiasis, HSV, CMV, viral/bacterial pharyngitis)
- Medications causing direct mucosal injury (antibiotics, anti-inflammatories, bisphosphonates)
- Inflammatory (reflux esophagitis, Crohn’s disease)
- Structural abnormalities (strictures, malignancy)
- Esophageal disorders

Odynophagia in palliative care

Odynophagia with or without dysphagia is commonly seen in seriously ill and/or dying patients. It can occur in the setting of malignancy (due to mechanical obstruction or primary disease involvement, as a direct effect of cytotoxic chemotherapy or radiation therapy, or as a result of other treatment-related complications such as xerostomia), inflammatory conditions, or infections (especially in the setting of acquired or drug-induced immunodeficiency). Other risk factors commonly seen in these populations include advanced age, frailty, and poor nutritional status. Odynophagia can have significant impact on quality of life and contribute to other distressing symptoms including anorexia and weight loss.

What are treatment options for odynophagia?

Odynophagia can be difficult to treat and present a barrier to adequate treatment of other symptoms given patients’ difficulty tolerating oral medications. Treatment should be directed at the underlying etiology and when possible, contributing medications or therapies should be stopped. Given the wide range of etiologies of odynophagia, evidence supporting specific pharmacologic therapies is limited. Although a different pathologic process, review of the literature for treatment of mucositis is likely a reasonable approach given similar clinical presentations and etiologies, particularly in palliative care populations.

Pharmacologic treatment options described in the literature include topical anesthetics, antihistamine rinses, coating agents (sucralfate), topical NSAIDs (benzydamine), topical and systemic opioids, and combination mouthwashes of varied components depending on the prescriber.¹ A systematic review of interventions for treating oral mucositis in cancer patients revealed no difference between benzydamine or sucralfate versus placebo. Less systemic opioid was used in patient-controlled analgesia when compared to continuous infusion.² The MASCC (Multinational Association of Supportive Care in Cancer) clinical practice guidelines for mucositis in the setting of cancer therapy suggest topical morphine and recommend against sucralfate for treatment of oral mucositis.³ Of note, topical opioid mouthwashes must be prepared by a compounding pharmacist. Many are made with an alcohol base, which can cause burning or irritation and therefore sometimes do more harm than good. To avoid systemic effects of the opioid, the mouthwash should not be swallowed and is therefore used primarily for oral (not esophageal) analgesia.⁵

A randomized-control trial in post-tonsillectomy patients did suggest a benefit to sucralfate therapy in relieving odynophagia compared to placebo. However, the small sample size and specific population makes it difficult to generalize.⁴

Doxepin is a tricyclic antidepressant with anesthetic and analgesic properties when administered topically. In a randomized controlled trial, doxepin mouth rinse for treatment of oral mucositis pain from head and neck radiotherapy resulted in modest but significant mouth and throat pain score reductions, while also causing more side effects (burning, stinging, change in taste, and drowsiness).⁶

Further well-designed studies are needed to assess the treatment options discussed above and novel interventions for treatment of odynophagia would be beneficial.

Return to Case: The patient was initially treated with a multimodal approach including twice daily proton pump inhibitor (in the event that reflux was exacerbating symptoms), sucralfate four times daily, and systemic opioids. Her esophageal candidiasis was treated with fluconazole. She had mild improvement in her symptoms but due to inability to tolerate oral intake consistently, she underwent PEG tube placement prior to discharge. Pathology returned with EBV positive DLBCL and her symptoms ultimately resolved with treatment of her underlying lymphoma.

Personal details in the case published have been altered to protect patient privacy.

For palliative care consultations please contact the Supportive and Palliative Care programs at PUH/MUH, 412-647-7243, pager # 8511, Shadyside, 412-647-7243, pager # 8513, Perioperative/ Trauma Pain, 412-647-7243, pager # 7246, UPCI Cancer Pain Service, pager 412-644-1724, Magee Women’s Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 412-688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children’s pager 412-456-1518

With comments about “Case of the Month” call Dr. Robert Arnold at (412) 692-4834.



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