Specialist Certification in Health Coaching for Cancer Patients

# Pain Management and Symptom Control

Pain management and symptom control are core competencies for health coaches working with cancer patients. Mastery of the terminology used by oncologists, palliative-care teams, and pharmacists enables the coach to translate clinical language into understandable guidance, to advocate effectively for the patient, and to coordinate care across disciplines. Below is an extensive glossary of essential terms, organized by category, with definitions, examples of use in conversation, practical applications for coaching, and common challenges that may arise in the clinical setting.

Analgesic – Any medication that relieves pain. Analgesics are classified by mechanism of action and potency. A health coach should be able to identify whether a patient's prescription is a non-opioid analgesic such as acetaminophen, a weak opioid such as codeine, or a strong opioid such as morphine. Understanding this helps the coach to set realistic expectations about onset of relief, duration of action, and potential side-effects.

Non-opioid – Analgesics that do not act on opioid receptors. Common examples include acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen, and selective COX-2 inhibitors. When a patient reports mild to moderate pain, a coach can suggest trialing scheduled non-opioid dosing before turning to stronger agents, while also discussing contraindications such as renal insufficiency or gastrointestinal ulcer risk.

Opioid – Medications that bind to mu-opioid receptors to produce analgesia, sedation, and euphoria. Opioids range from weak (e.G., Tramadol) to strong (e.G., Fentanyl). A coach should be familiar with concepts of tolerance, dependence, and physical addiction, and be prepared to address patient fears about "getting addicted." Practical coaching includes reinforcing proper storage, disposal, and the importance of reporting side-effects like constipation early.

Adjuvant – Drugs that are not primarily analgesics but have pain-relieving properties in certain contexts. Antidepressants (e.G., Duloxetine), anticonvulsants (e.G., Gabapentin), and corticosteroids fall into this category. For patients with neuropathic pain, a coach can explain why a medication originally prescribed for depression may actually help control burning or shooting sensations, and can encourage adherence despite the off-label indication.

Breakthrough pain – A transient exacerbation of pain that occurs despite stable baseline analgesia. These episodes often last minutes to hours and may be triggered by movement, coughing, or procedures. Coaches can work with patients to develop a rapid-acting rescue plan, such as an oral morphine dose every 1–2 hours as needed, and to track the frequency of breakthrough episodes to inform dose adjustments.

Nociceptive pain – Pain arising from tissue injury or inflammation, typically described as throbbing, aching, or pressure-like. In cancer, surgical wounds, bone metastases, and tumor infiltration can generate nociceptive pain. A coach should ask patients to describe the quality of their pain, because this information

guides the selection of non-opioid versus opioid therapy and the use of adjuvant anti-inflammatory agents.

Neuropathic pain – Pain caused by damage to nerves, often described as burning, electric-shock, or tingling sensations. Common in patients receiving chemotherapy (e.G., Paclitaxel-induced peripheral neuropathy) or after radiation therapy. Coaching strategies include recommending protective footwear, temperature modulation, and the use of specific adjuvant medications such as gabapentin or duloxetine, while monitoring for sedation.

Visceral pain – Pain originating from internal organs, often poorly localized and described as deep, cramping, or pressure. Examples include pain from pancreatic tumors or peritoneal carcinomatosis. Because visceral pain can be associated with autonomic symptoms (nausea, sweating), a coach may suggest integrating antispasmodics (e.G., Hyoscine) and relaxation techniques into the management plan.

Somatic pain – Pain arising from skin, muscle, or bone, usually well localized. Bone metastasis pain is a classic example. Somatic pain often responds well to NSAIDs and scheduled opioid dosing, and coaches can emphasize the importance of maintaining mobility and gentle stretching to prevent stiffness that can exacerbate discomfort.

WHO analgesic ladder – A stepwise approach to cancer pain management originally proposed by the World Health Organization. Step 1 recommends non-opioids for mild pain, Step 2 adds weak opioids for moderate pain, and Step 3 introduces strong opioids for severe pain, with adjuvants at any step. Coaches should be comfortable explaining this framework to patients, illustrating how escalation is based on pain intensity scores rather than arbitrary “failure” of a medication.

Pain intensity scale – Tools used to quantify pain severity. Common scales include the Numeric Rating Scale (0-10), the Visual Analogue Scale (0-100 mm), and the Wong-Baker Faces Scale for pediatric or low-literacy populations. A coach can help a patient practice using the chosen scale during clinic visits, ensuring consistent communication with the care team.

Brief pain inventory – A questionnaire that assesses pain severity, interference with daily activities, and analgesic use. It is often used in research but also in clinical practice to monitor changes over time. Coaches can guide patients in completing the inventory before each appointment, making it a reliable source for medication adjustments.

Side-effect management – The proactive identification and treatment of adverse effects from analgesics. Opioid-related side-effects include constipation, nausea, sedation, pruritus, and respiratory depression. A coach should have a checklist of non-pharmacologic and pharmacologic strategies: For constipation, recommend a high-fiber diet, adequate hydration, and scheduled laxatives; for nausea, consider antiemetics and ginger tea; for pruritus, antihistamines or low-dose naloxone may be useful.

Opioid rotation – Switching from one opioid to another to improve pain control or reduce side-effects. This process requires calculation of equianalgesic doses and a “washout” period to avoid cumulative toxicity. Coaches can support patients by clarifying why a rotation is recommended, helping them understand the expected timeline for pain relief after the switch, and reinforcing the need for close follow-up.

Equianalgesic conversion – The calculation of an equivalent dose of a different opioid based on standardized tables. This is essential when rotating opioids or when converting from oral to transdermal formulations. A coach should caution patients against self-adjusting doses and encourage communication with the prescribing clinician for accurate conversion.

Transdermal patch – A skin-applied system that delivers medication continuously over several days (e.G., Fentanyl patch). Benefits include steady plasma levels and reduced dosing frequency, but challenges involve proper site rotation, temperature sensitivity, and delayed onset. Coaches can teach patients how to apply the patch, monitor for skin irritation, and keep a log of patch change dates.

Patient-controlled analgesia (PCA) – A device that allows patients to self-administer a predetermined dose of opioid, typically via an intravenous line. PCA is commonly used in inpatient settings but may also be available in home hospice. Coaching points include explaining lockout intervals, ensuring patients understand the limits of the device, and monitoring for signs of over-sedation.

Rapid-onset opioid – Formulations designed to provide quick pain relief, such as oral transmucosal fentanyl or sublingual lozenges. These are usually reserved for breakthrough pain in patients already on a stable opioid regimen. The coach must emphasize that rapid-onset opioids should never be used as primary therapy and that they require strict adherence to dosing guidelines.

Non-pharmacologic therapy – Interventions that do not involve medication. Examples include physical therapy, acupuncture, massage, heat/cold application, guided imagery, and mindfulness meditation. Coaches can help patients integrate these modalities into a daily routine, tailor them to individual preferences, and assess effectiveness by using pain intensity scales before and after each session.

Physical therapy – A discipline focusing on movement, strength, and functional restoration. In cancer pain, PT may address muscle weakness due to deconditioning, joint stiffness from immobility, or lymphedema after surgery. Coaches can coordinate with PT providers to schedule sessions, encourage adherence to home-exercise programs, and track improvements in range of motion.

Acupuncture – Insertion of fine needles at specific points to modulate pain pathways. Evidence suggests benefit for chemotherapy-induced neuropathy and postoperative pain. When recommending acupuncture, coaches should verify that the practitioner is licensed, discuss insurance coverage, and monitor for any adverse sensations such as bruising.

Massage therapy – Manipulation of soft tissue to reduce muscle tension and promote relaxation. Massage can alleviate pain, anxiety, and improve sleep quality. Coaches should assess contraindications (e.G., Open wounds, thrombocytopenia) and select appropriate pressure levels based on the patient's comfort.

Heat therapy – Application of warmth (e.G., Heating pads, warm baths) to increase blood flow and relax muscles. Heat is useful for musculoskeletal pain but should be avoided over areas with impaired sensation or active infection. Coaches can teach safe temperature limits (no hotter than 40 °C) and duration (typically 15-20 minutes).

Cold therapy – Use of ice packs or cool compresses to reduce inflammation and numb painful areas. Cold is

especially helpful for acute inflammatory pain after radiation or surgery. Coaches should advise patients to wrap ice packs in a cloth, limit application to 10-15 minutes, and avoid direct contact with skin.

Mindfulness-based stress reduction (MBSR) – A program that combines meditation, body scanning, and yoga to cultivate present-moment awareness. Studies show MBSR can lower pain intensity scores and improve emotional coping. Coaches can guide patients through short mindfulness exercises (5-10 minutes) and encourage regular practice.

Cognitive-behavioral therapy (CBT) – A psychotherapeutic approach that identifies maladaptive thoughts and replaces them with healthier coping strategies. CBT for pain includes activity pacing, cognitive restructuring, and relaxation training. Coaches can collaborate with mental-health professionals to reinforce CBT skills during coaching sessions.

Activity pacing – The deliberate planning of activity and rest periods to prevent pain flare-ups. For example, a patient may break a 30-minute walk into three 10-minute intervals with short rests. Coaches can help patients create pacing schedules, track energy levels, and adjust as needed.

Sleep hygiene – Practices that promote restorative sleep, such as maintaining a consistent bedtime, limiting caffeine, and creating a dark, quiet environment. Poor sleep can amplify pain perception. Coaches can assess sleep patterns, suggest relaxation techniques before bed, and refer to sleep specialists when insomnia persists.

Nutrition support – Dietary interventions that address malnutrition, cachexia, or medication-related side-effects. Certain foods may aggravate gastrointestinal upset from opioids, while adequate protein intake supports wound healing. Coaches can collaborate with dietitians to develop individualized meal plans that consider taste changes, appetite loss, and drug-food interactions.

Opioid-induced constipation (OIC) – A common side-effect characterized by hard stools, straining, and incomplete evacuation. Management requires a prophylactic approach: Initiating a bowel regimen (stool softener, stimulant laxative) at the start of opioid therapy, encouraging fiber intake, and monitoring bowel movements. Coaches should educate patients on the importance of reporting OIC early, as untreated constipation can lead to fecal impaction.

Opioid-induced nausea and vomiting (OINV) – Nausea often occurs during opioid initiation or dose escalation. Strategies include taking the opioid with food (if appropriate), using antiemetics such as ondansetron, and employing ginger or peppermint tea. Coaches can ask patients to keep a symptom diary to identify patterns and trigger points.

Opioid-induced sedation – Drowsiness that may impair cognition and increase fall risk. Sedation is dose-dependent and can be exacerbated by concurrent CNS depressants (e.G., Benzodiazepines). Coaches should counsel patients on timing doses to avoid daytime drowsiness, encourage regular activity, and discuss dose reduction if sedation interferes with daily functioning.

Opioid-induced pruritus – Itching that can be localized or generalized. Antihistamines (e.G., Diphenhydramine) or low-dose naloxone can alleviate pruritus without affecting analgesia. Coaches can

suggest applying moisturizers, avoiding hot showers, and reporting severe itching promptly.

Respiratory depression – A life-threatening reduction in breathing rate and depth. While rare at therapeutic doses, it becomes a concern with high opioid doses, sleep-disordered breathing, or concurrent sedatives. Coaches should reinforce safe dosing, educate patients on signs (e.G., Shallow breathing, confusion), and stress the importance of emergency contact numbers.

Tolerance – A physiological adaptation whereby higher doses are required to achieve the same analgesic effect. Tolerance develops gradually and does not imply addiction. Coaches can explain that dose escalation may be necessary over time and that it should be guided by the prescriber, not self-adjusted.

Physical dependence – The body's adaptation to a drug, resulting in withdrawal symptoms if the medication is abruptly stopped. Dependence is expected with long-term opioid use and differs from addiction. Coaches must reassure patients that dependence is a normal response and that tapering plans can minimize withdrawal.

Addiction – A disorder characterized by compulsive drug-seeking behavior despite harmful consequences. Cancer patients on opioids have a low risk of addiction when used as prescribed. Coaches should address stigma, provide education on safe use, and differentiate addiction from dependence.

Opioid stewardship – The systematic approach to prescribing opioids responsibly, balancing pain relief with risk mitigation. This includes thorough assessment, clear documentation, regular re-evaluation, and patient education. Coaches can support stewardship by encouraging patients to keep medication lists, report side-effects, and attend scheduled follow-ups.

Controlled substance – Medications regulated by federal and state laws due to potential for abuse. Opioids, certain benzodiazepines, and stimulants fall into this category. Coaches should be aware of prescription-monitoring programs, the need for secure storage, and proper disposal methods (e.G., Drug-take-back programs).

Prescription-monitoring program (PMP) – A state-run database that tracks controlled-substance prescriptions. PMPs help identify potential misuse and facilitate communication among prescribers. Coaches can explain to patients why a clinician may review PMP data and how it contributes to safe pain management.

Medication reconciliation – The process of creating an accurate list of all medications a patient is taking, including over-the-counter drugs and supplements. Errors in reconciliation can lead to drug interactions, duplicated therapy, or missed doses. Coaches can assist patients by maintaining a medication notebook, reviewing it at each visit, and alerting clinicians to any changes.

Drug–drug interaction – An alteration in the effect of one medication caused by another. For example, concurrent use of an opioid and a CYP3A4 inhibitor (e.G., Ketoconazole) may increase opioid plasma levels, raising overdose risk. Coaches should encourage patients to disclose all medications, including herbal products, and to ask clinicians about potential interactions.

Adherence – The extent to which a patient follows the prescribed medication regimen. Non-adherence can be intentional (e.G., Fear of side-effects) or unintentional (e.G., Forgetfulness). Coaches can employ reminder tools (phone alarms, pillboxes), educate on the importance of regular dosing, and explore barriers to adherence.

Rescue medication – A short-acting analgesic taken for breakthrough pain. Rescue doses are typically 10-20 % of the total daily opioid dose. Coaches should verify that patients understand the timing (e.G., Take at the first sign of pain) and limit the number of doses per day to avoid over-medication.

Scheduled dosing – Regularly timed medication administration, regardless of pain level, to maintain steady analgesic coverage. Scheduled dosing reduces peaks and troughs, improving overall pain control. Coaches can help patients set dosing schedules that align with daily routines (e.G., Morning, noon, evening, bedtime).

PRN (pro re nata) – "As needed" medication orders. PRN dosing allows flexibility for intermittent symptoms but can lead to inconsistent pain control if patients wait until pain is severe. Coaches can discuss the advantages of combining scheduled dosing with PRN rescue medication to achieve optimal relief.

Multimodal analgesia – The use of multiple agents and techniques targeting different pain pathways. Combining an NSAID, an opioid, and an adjuvant can provide synergistic pain relief while minimizing individual drug doses. Coaches should explain this concept to patients, emphasizing that each component plays a specific role and that the overall plan is tailored to their pain profile.

Escalation protocol – A predefined set of steps for increasing medication dose or adding therapies when pain remains uncontrolled. Protocols often specify criteria such as pain score ≥ 7 for three consecutive days despite optimal dosing. Coaches can assist patients in recognizing when escalation criteria are met and in communicating promptly with the care team.

De-escalation – The systematic reduction of opioid dose when pain improves or side-effects become intolerable. De-escalation should be gradual (e.G., 10-20 % Dose reduction per week) and accompanied by close monitoring for withdrawal. Coaches can support patients by tracking pain scores, mood, and sleep during tapering.

Opioid taper – A structured plan to lower opioid dose over time. Tapers may be linear (same reduction each week) or exponential (larger reductions as dose decreases). Coaches should discuss realistic timelines, set expectations for potential transient increase in pain, and coordinate with prescribers to adjust the plan as needed.

Clinical pathway – A standardized care plan that outlines recommended interventions for a specific condition, such as cancer-related bone pain. Pathways streamline decision-making and ensure evidence-based practice. Coaches can familiarize themselves with relevant pathways to anticipate upcoming steps in a patient's treatment.

Quality-of-life (QoL) – A multidimensional concept encompassing physical, emotional, social, and functional well-being. Pain control directly influences QoL, as uncontrolled pain can limit activity, cause depression,

and diminish enjoyment. Coaches should regularly assess QoL using validated tools (e.G., EORTC QLQ-C30) and incorporate findings into care planning.

Functional assessment – Evaluation of a patient's ability to perform daily activities such as bathing, dressing, and walking. Pain may limit function even if intensity is moderate. Coaches can use simple functional questionnaires (e.G., Barthel Index) to track changes and to identify when additional support (occupational therapy, home aides) is needed.

Symptom burden – The cumulative impact of multiple symptoms (pain, nausea, fatigue, dyspnea) on a patient's overall experience. High symptom burden often correlates with poorer outcomes. Coaches can employ comprehensive symptom inventories (e.G., MD Anderson Symptom Inventory) to prioritize interventions and to guide discussions with the multidisciplinary team.

Dyspnea – Shortness of breath, frequently experienced in advanced lung or pleural disease. Though not a pain term, dyspnea often co-exists with chest pain and requires integrated management. Non-pharmacologic strategies include positioning, fan therapy, and breathing exercises; pharmacologic options may involve low-dose opioids. Coaches should validate the patient's experience and coordinate with respiratory specialists.

Fatigue – Persistent tiredness that is not relieved by rest. Cancer-related fatigue can be worsened by pain, sleep disruption, and depression. Coaches can suggest energy-conservation techniques, moderate aerobic activity, and evaluation for anemia or thyroid dysfunction.

Depression – A mood disorder that frequently accompanies chronic pain. Depression can amplify pain perception and reduce motivation for self-care. Coaches should screen for depressive symptoms using brief tools (e.G., PHQ-2) and refer to mental-health professionals when scores indicate moderate to severe depression.

Anxiety – Excessive worry that may arise from fear of disease progression, medication side-effects, or loss of independence. Anxiety can heighten pain sensitivity. Coaching interventions include deep-breathing exercises, guided imagery, and reassurance about the pain management plan.

Spiritual distress – A sense of loss of meaning, purpose, or connection that can occur in serious illness. Spiritual pain may manifest as existential dread or feelings of abandonment. Coaches should approach this domain with sensitivity, offering a listening ear, facilitating connection with chaplaincy services, and respecting patients' belief systems.

Cultural competence – The ability to understand and respect cultural differences that influence pain perception, expression, and treatment preferences. Some cultures may view pain as a test of endurance, while others expect aggressive pain relief. Coaches should ask open-ended questions (e.G., "How do you feel about using medication for pain?") And adapt communication style accordingly.

Health literacy – The capacity to obtain, process, and understand basic health information. Low health literacy can impede medication adherence and symptom reporting. Coaches can use plain language, visual aids, and teach-back methods to ensure comprehension of dosing schedules and side-effect management.

Shared decision-making – A collaborative process where clinicians and patients exchange information, discuss preferences, and agree on a treatment plan. In pain management, shared decision-making empowers patients to voice concerns about opioid use, choose among non-pharmacologic options, and set realistic goals. Coaches can facilitate this process by summarizing options and clarifying values.

Goal-setting – Establishing specific, measurable, attainable, relevant, and time-bound (SMART) objectives for pain control. Example goals: "Reduce average pain score from 7 to ≤ 3 within two weeks," or "Walk 15 minutes without severe pain three times per week by next month." Coaches can help patients track progress and celebrate achievements.

Documentation – Accurate recording of pain assessments, medication changes, side-effects, and patient-reported outcomes. Documentation supports continuity of care, legal compliance, and quality improvement. Coaches should encourage patients to keep a pain journal that includes date, time, pain score, triggers, interventions used, and effectiveness.

Telehealth – Delivery of health services via video, phone, or messaging platforms. Telehealth visits allow timely pain assessments and medication adjustments, especially for patients with limited mobility. Coaches can prepare patients for virtual visits by ensuring stable internet connection, having medication lists ready, and testing device functionality.

Electronic health record (EHR) – Digital system that stores patient health information. EHRs often contain pain assessment tools, medication orders, and laboratory results. Coaches can request that key pain-related data be entered into the EHR to facilitate communication among the care team.

Clinical trial – Research study evaluating new interventions. Some trials focus on novel analgesics, nerve blocks, or integrative therapies. Coaches can discuss trial eligibility with patients, explain the potential benefits and risks, and assist with the consent process if the patient expresses interest.

Interventional pain management – Procedures that target pain sources directly, such as nerve blocks, epidural infusions, or radiofrequency ablation. These techniques can provide substantial relief for refractory pain. Coaches should be aware of indications, potential complications, and the need for post-procedure monitoring.

Neuraxial analgesia – Delivery of medication into the spinal canal (e.G., Intrathecal morphine) for severe cancer pain. This approach offers potent relief with lower systemic opioid doses but carries risks such as infection and catheter malfunction. Coaches can discuss the logistics of pump management, refill schedules, and signs of catheter-related complications.

Peripheral nerve block – Injection of local anesthetic near a specific nerve to block pain signals. Useful for localized bone metastasis pain. Coaches may coordinate with anesthesiology to arrange the procedure, ensure the patient understands post-procedure activity restrictions, and monitor for return of pain.

Psychosocial assessment – Evaluation of the emotional, social, and environmental factors that influence health. A comprehensive assessment includes family dynamics, financial stressors, and caregiver support. Coaches can use this information to tailor interventions, such as connecting patients with financial

counseling or caregiver respite services.

Caregiver burden – The stress experienced by those providing unpaid care. High caregiver burden can affect the patient's pain management, as caregivers may be responsible for medication administration and monitoring. Coaches should assess caregiver strain, provide education, and refer to support groups when needed.

Advance care planning – The process of discussing and documenting preferences for future medical care, including pain management goals at the end of life. Early conversations about comfort-focused care can prevent crises and ensure that pain control aligns with the patient's values. Coaches can facilitate these discussions by providing resources and prompting reflection.

Do-not-resuscitate (DNR) order – A directive indicating that cardiopulmonary resuscitation should not be performed in the event of cardiac arrest. While separate from pain control, DNR status can influence opioid prescribing decisions, especially regarding the use of high-dose opioids for comfort. Coaches should clarify that adequate pain relief is appropriate regardless of DNR status.

Palliative care – Specialized medical care focused on relief of symptoms, pain, and stress of serious illness. Palliative care teams work alongside oncology to optimize comfort. Coaches should understand the scope of palliative care, know how to refer patients, and recognize that palliative care is compatible with curative treatment.

Hospice – End-of-life care provided to patients with a life expectancy of six months or less, emphasizing comfort over curative interventions. Pain management in hospice often involves higher opioid doses, subcutaneous administration, and continuous infusion pumps. Coaches can assist families in navigating hospice enrollment, medication management, and bereavement resources.

Opioid stewardship program – Institutional initiatives designed to monitor opioid prescribing, promote safe practices, and reduce misuse. Components may include prescribing guidelines, audit-feedback loops, and education modules. Coaches can align their practice with stewardship principles by adhering to prescribing recommendations and participating in quality-improvement activities.

Risk assessment tool – Instruments that evaluate the probability of opioid misuse, such as the Opioid Risk Tool (ORT) or SOAPP-R. These tools are used by prescribers to inform monitoring frequency. Coaches should be aware of the purpose of these tools, reassure patients that assessment is for safety, and help them understand any resulting monitoring plan.

Urine drug screen – Laboratory test that detects the presence of prescribed and non-prescribed substances. In some cancer settings, urine screens are used to verify adherence and detect illicit drug use. Coaches can explain the rationale for testing, address privacy concerns, and support patients through the process.

Medication-assisted treatment (MAT) – Use of medications such as buprenorphine or methadone to treat opioid dependence. While MAT is primarily for substance-use disorders, some cancer patients with pre-existing opioid use disorder may require coordinated care. Coaches should be prepared to refer patients to addiction specialists when appropriate.

Regulatory compliance – Adherence to laws governing controlled substances, including proper prescribing, record-keeping, and disposal. Non-compliance can result in legal consequences and interruptions in medication supply. Coaches can reinforce compliance by reminding patients to keep prescription bottles, avoid sharing medication, and use approved take-back programs.

Take-back program – Community initiatives that allow safe disposal of unused medications. These programs reduce the risk of diversion and accidental ingestion. Coaches can provide information on local take-back events, pharmacy drop-boxes, and mail-back envelopes.

Electronic prescribing (e-prescribing) – Transmission of prescription information via secure electronic systems. E-prescribing reduces errors, improves tracking, and facilitates refill requests. Coaches should encourage patients to use e-prescribing when available and to verify that the prescription appears correctly in the pharmacy system.

Drug formulation – The physical form of a medication (e.G., Immediate-release tablet, extended-release capsule, liquid, transdermal patch). Different formulations affect absorption rate, peak concentration, and dosing frequency. Coaches should verify that patients understand the correct formulation and avoid substituting one form for another without clinician approval.

Extended-release (ER) formulation – A dosage form designed to release the active ingredient slowly over time, providing prolonged analgesia. ER opioids are typically used for baseline pain control, while a short-acting agent is reserved for breakthrough pain. Coaches must emphasize that ER tablets should not be crushed or chewed, as this can lead to rapid release and overdose.

Immediate-release (IR) formulation – A dosage form that releases the drug quickly, producing a rapid onset of effect. IR opioids are often used for rescue dosing. Coaches can help patients differentiate between IR and ER prescriptions, preventing accidental double-dosing.

Liquid formulation – Oral solutions or suspensions, useful for patients with dysphagia or difficulty swallowing tablets. Dosage accuracy is critical; a calibrated syringe or dosing cup should be employed. Coaches can demonstrate proper measurement techniques and verify that the concentration matches the prescribed dose.

Compounded medication – Custom-prepared drugs tailored to specific patient needs (e.G., A flavored oral solution for a child). Compounding may be necessary when standard formulations are unavailable. Coaches should verify that compounding pharmacies follow USP standards and that the patient receives clear labeling.

Pharmacokinetics – The study of how the body absorbs, distributes, metabolizes, and excretes a drug. Factors such as liver function, renal clearance, and genetic polymorphisms affect opioid levels. Coaches can explain to patients why dose adjustments may be needed after a change in kidney function, for example.

Pharmacodynamics – The study of drug effects on the body, including receptor binding and therapeutic outcomes. Understanding pharmacodynamics helps explain why two patients on the same dose may experience different pain relief or side-effects. Coaches can use this knowledge to set realistic expectations

and to encourage open reporting of individual responses.

Cross-tolerance – A phenomenon where tolerance to one opioid reduces sensitivity to another opioid. When rotating opioids, cross-tolerance is considered by applying a reduction factor (often 25-30%) to the calculated equianalgesic dose. Coaches should caution patients that dose reduction is essential to avoid overdose during rotation.

Renal dosing – Adjusting medication dose based on kidney function. Certain opioids (e.G., Morphine) have active metabolites that accumulate in renal impairment, increasing toxicity risk. Coaches can remind patients to have regular renal function tests and to discuss dosing changes with their prescriber if creatinine clearance declines.

Hepatic dosing – Adjusting medication dose based on liver function. Opioids metabolized heavily by the liver (e.G., Fentanyl) may require dose reduction in hepatic failure. Coaches should encourage patients to report signs of liver decompensation (jaundice, ascites) promptly.

Genetic polymorphism – Variations in genes that affect drug metabolism, such as CYP2D6 variants influencing codeine conversion to morphine. Some patients are “ultra-rapid metabolizers,” experiencing heightened effects, while others are “poor metabolizers,” gaining little analgesia. Coaches can suggest genetic testing if atypical responses are observed.

Opioid-induced hyperalgesia (OIH) – A paradoxical increase in pain sensitivity caused by high opioid doses. OIH may manifest as diffuse, worsening pain despite dose escalation. Coaches should recognize OIH as a possible cause of uncontrolled pain, discuss dose reduction or opioid rotation, and incorporate non-opioid modalities to break the cycle.

Medication adherence tools – Devices or strategies that support consistent medication use. Examples include weekly pill organizers, smartphone reminder apps, and automated dispensing machines. Coaches can assess which tool fits the patient’s lifestyle and cognitive abilities, and can periodically review its effectiveness.

Sleep-disordered breathing – Conditions such as obstructive sleep apnea that can be worsened by opioids. Screening for sleep apnea is recommended before initiating high-dose opioids. Coaches can advise patients to avoid sedating alcohol, to use CPAP devices if prescribed, and to monitor for morning headaches or daytime sleepiness.

Psychosocial support groups – Peer-led or professionally facilitated gatherings where patients share experiences, coping strategies, and emotional support. Participation can reduce isolation, improve pain coping, and provide practical tips for medication management. Coaches can provide referrals to local or virtual groups.

Family education – Instruction for family members on safe medication handling, side-effect monitoring, and supportive caregiving techniques. Coaches should involve families in discussions, offer written handouts, and ensure that caregivers understand the importance of maintaining the patient’s comfort regimen.

Medication reconciliation interview – A structured conversation where the coach reviews all medications with the patient, confirming names, dosages, frequencies, and indications. This interview helps identify discrepancies such as duplicate therapy or omitted doses. Coaches should document any changes and communicate them to the prescribing clinician.

Clinical outcome measures – Standardized tools that quantify changes in health status, such as the Brief Pain Inventory, the Edmonton Symptom Assessment System, or the Karnofsky Performance Status. Regular use of outcome measures provides objective data for treatment adjustments. Coaches can administer these tools during each coaching session and track trends over time.

Electronic symptom monitoring – Use of mobile applications or web portals for patients to log pain scores, medication use, and side-effects in real time. Data can be transmitted to the care team for rapid response. Coaches can assist patients in selecting a user-friendly platform, setting up daily reminders, and interpreting trends.

Quality improvement (QI) initiatives – Systematic efforts to enhance care processes, such as reducing time to pain-control medication or improving documentation completeness. Coaches can participate in QI projects by providing frontline feedback, collecting data, and implementing practice changes based on findings.

Continuing education (CE) – Ongoing learning activities that maintain competence in pain management. CE may include webinars on opioid stewardship, workshops on integrative therapies, or certification programs. Coaches should seek CE opportunities to stay current with evolving guidelines and emerging evidence.

Guideline adherence – Following evidence-based recommendations from professional bodies such as the American Society of Clinical Oncology (ASCO) or the National Comprehensive Cancer Network (NCCN). Coaches can reference these guidelines when discussing treatment options with patients, ensuring that recommendations are aligned with best practice.

Patient-reported outcome (PRO) – Direct reports from patients about their health status without clinician interpretation. PROs are valuable for capturing subjective experiences like pain intensity, interference with daily life, and emotional distress. Coaches should encourage patients to complete PRO questionnaires and to share results with the care team.

Risk-benefit analysis – The systematic evaluation of potential advantages versus potential harms of a therapeutic option. In opioid prescribing, this analysis weighs pain relief against risks of side-effects, dependence, and overdose. Coaches can facilitate this discussion by presenting balanced information and eliciting patient values.

Clinical decision support (CDS) – Integrated tools within the EHR that provide alerts, dosing calculators, and guideline reminders at the point of care.