Pain Management

Introduction
This guideline relates to the management of pain in adult patients with palliative care needs.

Assessment
- Assess pain fully before treatment (see Pain assessment guideline)
- Consider reversible causes.
- Ask the patient regularly about their pain.
- Record pain scores. Use a pain assessment tool.

Management

Step 1: mild pain
- **paracetamol** 1g four times daily
- or **non-steroidal anti-inflammatory drug (NSAID)**
- ± **other adjuvant**

(If not contraindicated - see section "Adjuvant therapies" below)

Consider reducing paracetamol dose to 500mg four times daily when poor nutritional status, low weight (< 50kg), hepatic impairment and/or chronic alcohol abuse (check local policy for paracetamol and NSAIDs if patient receiving chemotherapy).

Inadequate pain relief

Step 2: mild to moderate pain
- **weak opioid**
- Codeine 30 to 60mg four times daily or dihydrocodeine 30 to 60mg four times daily
- + **paracetamol** (Dose as above)
- (If no benefit stop after 3 to 4 days)
- or **NSAID**
- (if not contraindicated)
- ± **other adjuvant**

Alternative: use a combined preparation such as co-codamol 30/500, 2 tablets four times daily (see notes above regarding restrictions)

- Consider prescribing a laxative and anti-emetic
Inadequate pain relief

Step 3: moderate to severe pain

<table>
<thead>
<tr>
<th>strong opioid</th>
<th>+ paracetamol</th>
<th>or NSAID</th>
<th>±other adjuvant</th>
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<td></td>
<td>(Dose as above)</td>
<td>(if not contraindicated)</td>
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<td></td>
<td>(stop if no benefit)</td>
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Stop any step 2 opioid
Codeine or dihydrocodeine 60mg 4 times daily≈30mg oral morphine in 24 hours

If titrating with immediate release oral morphine prescribe 5mg, 4 hourly and as required for breakthrough pain.

If starting with modified release oral morphine prescribe 10 to 15mg, 12 hourly and immediate release morphine 5mg as required for breakthrough pain.

Seek advice:
- severe pain not responding to treatment
- unacceptable side effects or toxicity.

- Use lower doses and increase dose more slowly if patient is frail, elderly or has renal impairment.
- In severe renal impairment, an alternative opioid may be needed (see 'Choosing and changing opioids' guideline).

Dose titration for Step 3
- Increase regular oral morphine dose each day in steps of about 30% (or according to breakthrough doses used) until pain is controlled or side effects develop.
- Increase laxative dose as needed.
- Convert to modified release morphine when stable.
- Divide 24 hour dose of immediate release morphine by 2.
- Prescribe as modified release morphine, 12 hourly.
- Prescribe breakthrough analgesia at correct dose (1/10th to 1/6th of 24 hour morphine dose).
### Anti-emetic

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<tr>
<th>Metoclopramide 10mg up to three times a day</th>
<th>Senna 2 tablets at night or bisacodyl 5 to 10mg at night + docusate 100mg twice daily</th>
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<tr>
<td>Haloperidol 500 micrograms to 1.5mg daily. Prescribe as required for 5 to 10 days</td>
<td>Macrogol 1 to 3 sachets per day</td>
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### Subcutaneous (SC) analgesia

- Usually given in CME T34 syringe pump over 24 hours.
- Calculate the 24 hour dose of oral morphine.
- Convert this to SC morphine.
- Oral morphine 30mg=SC morphine 15mg.
- When large doses of breakthrough SC analgesia are required consider SC diamorphine.
- Prescribe 1/10th to 1/6th of the 24-hour SC opioid dose as required, SC for breakthrough pain.
- (See Subcutaneous infusion of medication in palliative care guideline).

### Breakthrough pain

Defined as a transient exacerbation of pain which occurs either spontaneously or in relation to a specific trigger (incident pain) in someone who has mainly stable or adequately relieved background pain.

- Prescribe immediate release morphine at 1/10th to 1/6th of the regular 24 hour dose, as required.
- Assess 30 to 60 minutes after a breakthrough dose.
- If pain persists give a second dose as required.
- If pain is still not controlled seek advice.
- Change breakthrough dose if regular dose altered.

### Movement or incident related predictable pain

Can be difficult to manage; a dose of short-acting opioid before moving or when pain occurs may help. If pain is short-lived and the patient develops excessive drowsiness seek specialist advice.

### Adjuvant therapies

- **NSAID**: for bone pain, liver pain, soft tissue infiltration, or inflammatory pain (side effects: gastrointestinal ulceration or bleeding [consider proton pump inhibitor (PPI)], renal impairment, fluid retention).
- **Antidepressant or anticonvulsant**: for nerve pain. Start at low dose: titrate slowly. (see Neuropathic pain guideline). No clear difference in efficacy between the two types of medicine for this indication.
  - amitriptyline (side effects: confusion, hypotension) caution in cardiovascular disease.
  - gabapentin (side effects: sedation, tremor, confusion; reduce dose if renal impairment).
- **Corticosteroids**: dexamethasone
- 16mg daily for raised intracranial pressure.
- 8mg daily for neuropathic pain; 4 to 8mg/day for liver capsule pain.
- Give in the morning; reduce to lowest effective dose. Consider PPI. Monitor blood glucose.

- **TENS, nerve block, radiotherapy, surgery, bisphosphonates, ketamine** (specialist use) and skeletal or smooth muscle relaxants.

### Opioid toxicity – seek advice

- Increasing drowsiness, sedation or **delirium**.
- Peripheral shadowing, vivid dreams or hallucinations.
- Muscle twitching, myoclonus or jerking.
- Abnormal skin sensitivity to touch.
- Rarely respiratory depression.
- If the patient’s pain is controlled reduce opioid dose by one third, ensure patient is well hydrated; consider checking renal function; review and re-titrate analgesia.
- Consider adjuvant therapies, alternative opioids or both (see Choosing and changing opioids guideline).
- Previous treatment that may reduce analgesic requirements such as radiotherapy.

### Resources

**Patient/carer information**

When prescribing regular analgesia for continuous pain, discuss and resolve any concerns about taking opioids, including:

- addiction
- tolerance
- side effects
- fears that treatment implies the final stages of life.

Provide information (verbal and written) to the patient:

- when and why strong opioids are used to treat pain
- how effective they are likely to be
- background and breakthrough pain management
- signs of toxicity
- strong pain killers and driving
- follow-up plans.

### Further reading

**SIGN 106 – Management of pain in adult patients with cancer**

**Use of opioid analgesics in the treatment of cancer pain: evidence-based recommendations from the EAPC.**
References

Bennett, M. I. 2011. Effectiveness of antiepileptic or antidepressant drugs when added to opioids for cancer pain: Systematic review. Palliative Medicine, 25(5), pp. 553-559.


† Indicates this use is off licence
QT Indicates this medication is associated with QT prolongation