## Pain Management

### Introduction

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

### Assessment

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

### Management

#### Step 1: mild intensity pain

<table>
<thead>
<tr>
<th>paracetamol</th>
<th>or non-steroidal anti-inflammatory drug (NSAID) (if not contra-indicated – refer to &quot;Adjuvant therapies&quot; section below)</th>
<th>± other adjuvant</th>
</tr>
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<tbody>
<tr>
<td>1g four times daily</td>
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</tbody>
</table>

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

#### Step 2: mild to moderate intensity pain

- **Weak opioid**
  - Codeine 30mg to 60mg four times daily or dihydrocodeine 30mg to 60mg four times daily
  - Alternative: use a combined paracetamol codeine preparation such as co-codamol 30/500, 2 tablets four times daily (refer to notes above about restrictions)

<table>
<thead>
<tr>
<th>+ paracetamol (Dose as above) (If no benefit stop after 3 to 4 days)</th>
<th>or NSAID (If not contra-indicated)</th>
<th>± other adjuvant</th>
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</table>

- Prescribe a laxative and consider anti-emetic
Step 3: moderate to severe intensity pain

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

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 10mg to 15mg, 12 hourly and immediate release morphine 5mg as required for breakthrough pain.

- Consider prescribing a laxative and anti-emetic.
- 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 (refer to Choosing and Changing Opioids guideline).

**Dose titration for Step 3** (using morphine as an example)

- 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 (1/6th to 1/10th of 24 hour morphine dose up to a maximum of 6 doses in 24 hours).

**Anti-emetic**

<table>
<thead>
<tr>
<th>Metoclopramide 10mg up to three times a day</th>
<th>Senna 2 tablets at night or bisacodyl 5mg to 10mg at night + docusate 100mg twice daily</th>
</tr>
</thead>
<tbody>
<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>
</tr>
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</table>

**Regular laxative** (refer to Constipation guideline)

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Seek advice:
- severe pain not responding to treatment
- unacceptable side effects or toxicity.
**Subcutaneous (SC) analgesia**

- Usually given via a 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 1/6th to 1/10th of the 24 hour SC opioid dose as required, via SC route for breakthrough pain.
- Refer to [Syringe Pumps](#) 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 1/6th to 1/10th of the regular 24 hour dose, as required up to a maximum of 6 doses in 24 hours. If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review. If more than 6 doses are required in 24 hours seek advice or review.
- 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.

**Opioid toxicity – seek advice**

- Can be precipitated by several factors including rapid dose escalation, renal impairment, sepsis, electrolyte abnormalities, drug interactions.
- Wide variation in the dose of opioid can cause symptoms of toxicity.
- Prompt recognition and treatment are needed. Symptoms include:
  - persistent sedation (exclude other causes)
  - vivid dreams, hallucinations, shadows at the edge of visual field
  - delirium
- muscle twitching/myoclonus/jerking
- abnormal skin sensitivity to touch.

- If the pain is controlled reduce the opioid dose by a third. Ensure the patient is well hydrated. Seek advice.
- If patient still in pain consider reducing opioid dose by a third. Consider adjuvant analgesics, alternative opioids or both (refer to Choosing and Changing Opioids guideline). Seek advice.

Naloxone (in small titrated doses) is only needed for life-threatening respiratory depression (refer to Naloxone guideline).

**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, adverse cardiac events).
- **Antidepressant or anticonvulsant**: for nerve pain. Start at low dose: titrate slowly (refer to 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†
  - 8mg to 16mg daily for raised intracranial pressure.
  - 4mg to 8mg daily for neuropathic pain; 4mg to 8mg daily 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.

**Practice points**

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

- addiction
- tolerance
- short and long term 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, refer to NHS Inform page on driving: https://www.nhsinform.scot/care-support-and-rights/palliative-care/practical-help/driving
• follow-up plans.

Resources
• Guidance for healthcare professionals on drug driving.

References


