

PAIN

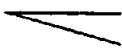
SECTION A: PRINCIPLES

- 1: Pain is a **total personal experience** with physical, psychological, social and spiritual dimensions. Optimal pain management will be compromised if any of these aspects is ignored or neglected.
- 2: Pain is common in cancer patients, has a sinister significance and a **remorseless depressing quality** which many patients find difficult to cope with.
- 3: Not all "cancer pain" is caused by the cancer itself. Often several pains coexist, and **accurate diagnosis** of each pain's cause or mechanism must precede effective treatment. Pain changes from day to day, and **regular review** is vital for good pain control.
- 4: **Successful relief of pain** in cancer requires:
 - (a) **Regular**, not prn, dosage.
 - (b) **Titration** of dose against effect with no rigid upper limit.
 - (c) **Appropriate time interval** between doses.
 - (d) **Sufficient dose** to prevent return of pain before next dose is due.
 - (e) Willingness to give strong opioids **early** when other analgesics fail.
- 5: **Morphine** (or diamorphine) is **still the mainstay** of pain control in advanced cancer, though other analgesics such as paracetamol or weak opioid may suffice. Follow a simple "analgesic ladder" (see B2).
- 6: Give morphine **orally** if the patient can swallow and absorb. Only consider other routes when dysphagia, gastric stasis, intractable vomiting or impaired consciousness dictate. Consider **syringe driver** administration as an alternative.
- 7: If **parenteral opioids** are required, either 4-hourly injections or a continuous subcutaneous infusion by portable syringe driver are best. Diamorphine is the preferred drug because its high solubility allows large doses to be given in small volumes.
- 8: **Opioid side-effects** include constipation (very common), nausea and vomiting (common but controllable), drowsiness (often dose-related and temporary) and respiratory depression (clinically not a problem). Always prescribe laxatives, and think about antiemetics. Neither tolerance nor addiction is a problem in palliative care.
- 9: Some pains are **not opioid-responsive**, and careful assessment helps to identify these. They include tension headache, post-herpetic pain, muscle spasms, and nerve damage producing stabbing or shooting pain, burning pain, or distressing paraesthesiae.
- 10: Certain other pains (such as bone pain, nerve compression, visceral distension or tenesmoid pain and activity-provoked pain) may be **partly relieved** by opioids, but also require other measures (including "co-analgesics").
- 11: **Co-analgesics** include corticosteroids, anti-depressants, benzodiazepines, non-steroidal anti-inflammatory drugs (NSAIDs) and anticonvulsants.

PAIN

SECTION B: PRACTICAL TIPS

1: What's the Pain due to?

Consider:  anatomy = site of origin
aetiology = cause of pain

Be inquisitive. Review and review again. Investigate appropriately. Think of x-ray for pathological fracture or bone metastases, bone scan for early bone metastases, ultrasound or CT scan for deep soft-tissue tumours. Remember common non-malignant causes, e.g. arthritis, tension headache, infections including oral thrush.

2: Which analgesic?

An "analgesic ladder" progresses logically from non-opioid (aspirin, paracetamol) via weak opioid (coproxamol, codeine preparations) to strong opioid (morphine, diamorphine, TTS fentanyl). Start at the bottom of the ladder and work up, depending on the patient's analgesic response on the lower "rungs". Don't use partial agonists such as pentazocine (Fortral) or buprenorphine (Temgesic), mixtures such as Diconal, short-acting drugs like pethidine or very long-acting ones like methadone.

3: What if opioids don't work?

(a) Is the dose high enough?

If partial response or inadequate duration (under 4 hours for oral morphine or 12 hours for MR morphine), increase dose rather than shorten interval between doses. Start at 10mg oral morphine 4-hourly if on step 2 of analgesic ladder (5mg if opioid naive, frail or elderly). Increase by increments of approximately 30%. Many patients need 30mg or less 4-hourly, few more than 60mg 4-hourly.

(b) Is drug being absorbed?

Uncontrollable vomiting or dysphagia may necessitate a change to transdermal or parenteral routes, but oral analgesia is the norm outside the last few days of life.

(c) Is pain breaking through with movement or painful procedures?

Consider additional 'prn' short-acting analgesia such as dextromoramide (Palfium) or Entonox, or extra doses of morphine. **Do not use MR morphine for breakthrough pain (too slow).** Minimise provoking factors.

(d) Is patient waking at night with pain?

Either give 4-hourly painkillers through the night, or a double dose at bedtime, or change to MR morphine (see C1). Treat mood disturbance if present.

(e) Is the pain opioid-unresponsive? (see A9-10).

Consider using co-analgesics as follows:-

NSAIDs	Metastatic bone pain, other musculoskeletal and soft-tissue pains.
Anticonvulsants	Nerve pain, especially stabbing and shooting pain.
Antidepressants	Nerve pain, especially burning pain or distressing paraesthesiae.
Benzodiazepines	Skeletal muscle spasm or anxiety.
Corticosteroids	Nerve or cord compression, symptomatic cerebral metastases, peri-tumour swelling.

See Section C.

4: Who might be able to help?

Don't be afraid to ask a more experienced colleague for help. Your local hospice or Macmillan nursing service will gladly offer advice. Don't forget palliative radiotherapy for bone secondaries, often given as a single treatment. In 5-10% of cases some kind of nerve block will help (e.g. coeliac plexus block in pancreatic pain) - ask your Pain Clinic for an opinion.

SECTION C: RECOMMENDED DRUGS

Details are given here of selected widely used drugs. See also the BNF sections on "Controlled Drugs" and "Prescribing in Terminal Care". Check BNF for formulations and dose recommendations.

1: OPIOID ANALGESICS

Diamorphine:

Preferred drug for parenteral use.
Highly soluble in small volume.

Can be give 4 hourly SC or by syringe driver as continuous infusion.

Start with 2.5-5mg SC 4 hourly if opioid naive otherwise $\frac{1}{3}$ of previous oral 4 hourly morphine dose.

Syringe Driver Total 24 hour SC dose =
Total 24 hour oral morphine dose/3

Morphine:

Readily available in various forms for oral use:

- Tablets 4 hourly, MR 12 hourly, or 24 hourly
- Elixirs - Oramorph 4 hourly
- Suspension MR 12 hourly
- Start with 5mg 4 hourly if opioid naive
- 10 mg 4 hourly if on full dose of regular step 2 analgesia
- Half these doses, ie. 2.5mg or 5mg if patient elderly frail or has renal impairment
- Titrate dose up to relieve pain without side effects or toxicity
- It may be appropriate to transfer to longer acting preparations 12 hourly or 24 hourly eg:
 - MR dose 12 hourly = Total 24 hour dose / 2
 - MR dose 24 hourly = Total 24 hour dose

TTS fentanyl (Durogesic):

Transdermal patch with 72 hour duration of action. Mainly suitable for patients with severe chronic pain already stabilised on other opioids.

25mcg/hour patch is approximately equivalent to 90 mg morphine per day.

2: NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

Naproxen 500mg 12 hourly
Diclofenac 150mg daily - in divided doses

3: CORTICOSTEROIDS

Dexamethasone 4-16mg/d
Agent of choice — high potency and low mineralocorticoid effect.

4: ANTIDEPRESSANTS*

Amitriptyline 10-150mg daily
Dothiepin 25-150mg daily
Start with low dose and gradually increase every 2 to 4 days to maximise pain control.

5: ANTICONVULSANTS*

Sodium Valproate 100-500mg 12 hourly
Carbamazepine 100-200mg 6-8 hourly

6: MUSCLE RELAXANTS

Diazepam 2-5mg 8-12 hourly
Baclofen 5-10mg 6 hourly
Dantrolene 25mg 6 hourly

7: ANXIOLYTICS*

Diazepam 2-5mg 8-12 hourly

*NB With most centrally acting drugs, gradually increased, and night weighted doses help to reduce side effects, especially in the elderly.