Pain management in palliative care

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Concept of total pain

Steps in pain management

- Identify physical cause of pain
  - Disease effects-inflammatory/pressure effects/ obstruction/. Nerve destruction
  - Treatment effects- radiotherapy burns/ chemo neuropathy
- Identify type of pain
  - Bone
  - Nociceptive (somatic or visceral)
  - neuropathic

Steps in pain management

- Identify any factors affecting pain (total pain)
  - Psychological/ spiritual/ social issues
- Use of pain scales to assess severity
- Treat underlying cause where possible
  - Palliative anticancer treatment
  - Modify effects of the disease (Rx hypercalcaemia/ manage lymphoedema)

Steps in pain management

- Start with simple analgesics
    - Increase dose according to response
    - Add in drugs as necessary (WHO ladder)

Recognising neuropathic pain

- Electric shock/ burning/ toothache
- Paraesthesia/ numbness
- Allodynia (pain caused by an innocuous stimulus)
- Hyperalgesia (increased sensitivity to pain)

Who analgesic ladder

- Stage 1- paracetamol +/- NSAID (+/- adjuvants)
- Stage 2- stage 1 + codeine/ tramadol (+/- adjuvants)
- Stage 3- stage 1 + opiates (+/- adjuvants)

Paracetamol

- Under used and underrated (by professionals and patients)
- Used in liquid form for post radiation oesophageal irritation
- Can potentiate the effects of other analgesics
- Can help with bone pain

NSAIDs

- Used where inflammation is suspected in the cause of the pain
  - Tissue inflammation/ bone metastases/ nerve involvement
- PPI cover
- NICE guidelines re choice (cardiac vs bleed risk factors)
- Naproxen can be useful for sweats

Codeine

- 1/10th the potency of morphine
- 60mg QDS =240mg over 24 hours = 24mg morphine (important when stepping up the analgesic ladder)

Tramadol

- 1/5th the potency of morphine
- Less constipating than codeine
- Some evidence to suggest benefit in neuropathic pains
- Rarely used in the hospice-? Why
  - Never initiated it at hospice
  - ? Related to reduced fit threshold
  - ? Related to patients already reaching step 3 of analgesic ladder by the time we see them.

opiates

- Stop codeine
- Commencing opiates
  - Advise 5-10mg immediate release (IR) morphine 4 hourly + PRN (Inform patients to use as often as required to relieve pain)
  - Can take 30 mins to reach max effect therefore advise to repeat dose if pain not settling after 30 mins.
  - Ask to keep a diary of usage-review 1/52 to convert to long acting opiates(MR)- total IR dose/2 = 12 hourly dose.
  - NB patients take prescribing advise literally-care re printed advice on bottle)

Opiates

- Breakthrough dose of IR morphine = 1/6th of total MR dose
- Important to remember to advise increases in IR dose with increased MR dosing- needed to keep effectiveness.

Which opiate to chose?

- Morphine = cheapest and 1st line
- Oxycodone
  - More expensive
  - Useful if side effects of morphine not tolerated
  - Better renal profile than morphine but still not recommended in end stage renal failure
  - 1.5-2 x as potent as morphine (some anecdotal evidence suggests equal potency)
  - Oxycontin = MR prep
  - Oxynorm = IR prep
  - ? Better for bone pain- evidence not convincing

Which opiate to chose?

- Fentanyl
  - Topical-useful in patients with swallowing issues
  - Less constipating than other opiates (more lipid soluble therefore crosses BBB easier-means lower doses required to give same effect of other opiates)
  - Overcomes some compliance issues
  - Sometimes accepted by patients reluctant to take anything with ‘morphine’ in the name.
  - 12-48 hours to reach max effect-only suitable for stable pain as titrating up the dose not easy
  - 17 hours to clear drug after removal of the patch-drug reservoir.
  - Better renal profile than morphine/oxycodone

NeuropathicAdjuvant agents

- Amitriptyline
- Gabapentin (other antiepileptic agents)
- Pregabalin(some anecdotal evidence to suggest better than gabapentin)
- Clonazepam
- Venlafaxine (possible benefit for sweats as well)
- Steroids
- Lidocaine patch
- Ketamine
- Others-Baclofen/Clonidine/Tramadol

Bone pain

- NSAIDs
- Paracetamol
- Steroids
- Bisphosphonates (renal function/ calcium checks and replacement/ dentist review/ hydration)
- Radiotherapy
- Opiates

Syringe driver issues

- Useful in certain circumstances
    - Vomiting patients
    - Patient no longer swallowing
    - For quick symptom control and dose titration
- Dose = total 24 hour oral opiate dose/2 (+ any subcut doses).
- Usually stick with same opiate as oral prep but changing to diamorphine can save volume in syringe driver

Syringe driver issues

- Keep fentanyl patch on and replace every 72 hours as normal-keep dose the same.
- Breakthrough doses need to take fentanyl patch into account as well as driver drugs
    - 1/6 driver dose
    - 1/5 fentanyl dose
    - Add both together to get total breakthrough dose

Things to remember

- Prescribe a laxative and antisickness meds as routine when commencing opiates
- Increase breakthrough dose of IR opiate when MR/ syringe driver dose increases
- Consider psychological/spiritual/social issues when pain difficult to control

Things to remember

- Adjuvant drugs may be opiate sparing- may need to decrease opiate dose
- If need advice with symptom control issues you can contact hospice for advice/ OPD review.
- Anticipatory drug supplies/prescribing need to take into account current opiate dose

Thank you

- Any questions?