TREATMENT GUIDANCE FOR CANCER PAIN

COMMON TYPES OF CANCER PAIN

Visceral / Soft Tissue Pain (nociceptive)
Constant dull pain; Poorly localised
Usually opioid responsive

Bone Pain (somatic nociceptive)
Usually well localised; Worse on movement; Localised tenderness
Partly opioid responsive; NSAID responsive
Radiotherapy iv Bisphosphonates may help

Nerve Pain (neuropathic)
Try opioids first, but may be less responsive
Consider co-analgesic neuropathic agents

WHO STEP ONE
Non-Opioids
Paracetamol 1g qds PO

WHO STEP TWO
Non-Opioid plus Weak Opioid
Codeine 30-60mg qds PO

WHO STEP THREE
Non-opioid plus Strong opioid
Morphine

PLUS CO-ANALGESICS AT ANY STAGE

NSAIDS
Ibuprofen
or Naproxen

Neuropathic Agents
Amitryptylline
or Gabapentin
or Pregabalin

Conventional Opioid Titration
IMMEDIATE RELEASE MORPHINE
(4hrly preparation)
Oramorph liquid 2.5-5mg 4hrly & 1hrlyPRN
Lower doses: elderly or renal impairment
Assess response of background pain to opioids
If necessary, increase dose by 30-50% every 24-48hrs to achieve pain control
Higher doses can use morphine IR tablets (Sevredol10 / 20 / 30mg strength)

When pain controlled on steady dose, convert to sustained release morphine

Add total daily dose of 4hrly immediate release morphine, and divide by two

SUSTAINED RELEASE MORPHINE
(12 hrly preparation)
Zomorph capsules bd MST tablets bd
Morphgesic SR bd Filnarine SR bd

Alternative Opioid Titration
SUSTAINED RELEASE MORPHINE
(12hrly preparation)
Zomorph capsules 10mg bd
MST tablets 10mg bd
Morphgesic SR 10mg bd
Filnarine SR 10mg bd
Assess response of background pain to opioids
If necessary, increase dose by 30-50% every 24-48hrs to achieve pain control
Consider co-analgesic use

PLUS
IMMEDIATE RELEASE MORPHINE
(4hrly preparation)
PRN FOR BREAKTHROUGH PAIN
Sevredol tablets or Oramorph liquid can be up to 1hrly PRN if needed

Add total daily dose of background morphine, and divide by six for PRN dose

PLUS ANTICIPATE OPIOID SIDE EFFECTS

Always co-prescribe regular laxatives
Senna or Docusate
or Co-danthramer
or Movicol
and consider PRN antiemetics
Levomepromazine or Haloperidol

Cancer pain can be improved for the majority of patients ***If not improving, seek specialist advice***

USE OF FENTANYL PATCHES

Consider if:

- **Pain is stable, and NOT rapidly changing**
- **Oral route not appropriate or poorly absorbed**
- **Unmanageable constipation with opioids**
- **Renal impairment**
  (seek specialist palliative care advice in renal failure)
- **Unacceptable side effects from other opioids**

Commencing Fentanyl Patches

- Titrate with 4hrly immediate release oral morphine, until pain is controlled
- Calculate patch size using table below
- Remember a fentanyl 25mcg/hr patch is equivalent to a 60-90mg total daily dose of oral morphine
- Stick patch to hairless skin; clip (not shave) hair
- Initial analgesic effect will take at least 12-24 hrs, and a steady state may not be achieved for 72 hrs
- Ensure immediate release oral morphine (or alternative) is available for breakthrough pain; calculate correct PRN dose from table below
- Change patch every 72 hrs; use a new area of skin
- A 12-24hr depot of drug remaining when patch removed; fold in on themselves and discard safely
- Opioid withdrawal may occur when switching from morphine to fentanyl; manage with PRN morphine

Buprenorphine & Fentanyl Patches at End of Life

- When a patient is dying, **LEAVE PATCH IN SITU**, and change as before (see frequency in table below)
- Use subcut opioid PRN for breakthrough pain; if PRN needed regularly, start CSCI in addition to patch
- Ensure PRN dose adequate for both patch & CSCI
- **Seek Specialist Palliative Care advice if unsure**

NAUSEA & VOMITING

General Measures

- **Correct reversible causes if possible**
  drugs; uraemia; hypercalcaemia; constipation; bowel obstruction; ascites; severe pain; cough; infection; raised intracranial pressure; anxiety
  (*may not be appropriate if patient is imminently dying*)
- **Review regular oral antiemetic medication: consider conversion to alternative route**
- **For any given cause, prescribe the first line antiemetic REGULARLY, and second line PRN**
- **Review efficacy of antiemetic medication every 24 hrs until control of symptoms is achieved**
- **1/3 of patients need more than one antiemetic**

Prokinetic antiemetics for gastric causes

- gastritis, gastric stasis
- other considerations: antacid, PPI, antifungal, laxatives

First line	
Metoclopramide	pro-kinetic antiemetic 10mg tds PO or 30mg CSCI/24hr (max 90mg/24hr under specialist guidance)
Domperidone	pro-kinetic antiemetic 10mg tds PO or 30mg PR use in patients with parkinsonism
Second line	
Levomepromazine	6.25-12.5mg = ½-¼ 25mg tablet nocte PO (or 6mg tablet nocte PO) or 6.25-12.5mg CSCI/24r

Centrally acting antiemetics

First line – for chemical causes

- morphine, drugs, chemo, hypercalcaemia, uraemia

Haloperidol	1.5-3mg nocte PO or 2.5-5mg CSCI/24hr

First line – for central cerebral causes

- brain primary or brain metastases, raised ICP, cranial radiotherapy

Cyclizine (constipating)	25- 50mg tds PO or 50-150mg CSCI/24hr
Second line – for chemical and central cerebral causes	
Levomepromazine	6.25-12.5mg = ½-¼ 25mg tablet nocte PO (or 6mg tablet nocte PO) or 6.25-12.5mg CSCI/24r

Review

- Switch to oral antiemetic after 72hrs of symptom control
- If little or no improvement after 24-48 hrs despite optimising antiemetic dose and route, review cause:
  if changed, substitute first line antiemetic
  if unchanged, add second line antiemetic

SPECIALIST PALLIATIVE CARE ADVICE
Trinity Hospice Advice Line (24 hours)
7 days a week 01253 359359
Trinity Community Palliative Care Team
Monday to Friday 09.00 -18.00 01253 359379
Hospice at Home 20.00- 08.00 overnight
7 days a week 01253 955750

A GUIDE TO EQUIVALENT DOSES FOR OPIOID DRUGS

This table of doses is a guide, not a set of definitive equivalences. Use the table to identify an appropriate starting point for your prescribing decision. ALL prescribing decisions must be based on a full clinical assessment. Ask if the pain is opioid responsive. Think about the role of adjuvant medication before rotating opioids, changing the dose or route. Consider reducing prescribed opioid dose by 30-50% if converting from one route to another route or there is concern about opioid toxicity (confusion, drowsiness, myoclonic jerks, slowed respiration, pin-point pupils.)
Be aware of drug interactions and remember individual patients may metabolise and absorb different drugs at varying rates.

Never increase an opioid dose by more than 50% of the previous 24 hour regular dose without SPECIALIST ADVICE

Oral Morphine		Oral Oxycodone		Transdermal Buprenorphine		Transdermal Fentanyl	Subcutaneous Morphine		Subcutaneous Oxycodone	
4-hr dose (mg)	12-hr SR dose (mg)	4-hr dose (mg)	12-hr SR dose (mg)	**BuTrans** (mcg/hr) *change every **seven** days*	**Transtec** (mcg/hr) *change every **four** days*	Patch strength (mcg/hr) *change every **three** days*	4-hr dose (mg)	**24-hr** CSCI dose (mg)	4-hr dose (mg)	**24-hr** CSCI dose (mg)
1.25	5	-	-	5	-	-	0.5	5		
2.5	10	1	5	10	-	-	1.25	10		
5	15	2.5	10	15	-	12	2.5	15	1.25	10
10	30	5	15	25	-	25	5	30	2.5	15
15	45	7.5	25	35	35	37	7.5	45	3.75	22.5
20	60	10	30	-	52.5	50	10	60	5	30
30	90	15	45	-	70	75	15	90	7.5	45
40	120	20	60	-	105	100	20	120	10	60
50	150	25	75	-	122.5	125	25	150	12.5	75
60	180	30	90	-	140	150	30	180	15	90
SEEK SPECIALIST ADVICE				**SEEK SPECIALIST ADVICE**			**SEEK SPECIALIST ADVICE**			