



S I G N

Control of pain in patients with cancer



Quick Reference Guide

PRINCIPLES OF MANAGEMENT OF PAIN IN PATIENTS WITH CANCER

- A** Patients should be given information and instruction about pain and pain management and be encouraged to take an active role in their pain management.
- B** The principles of treatment outlined in the WHO Cancer Pain Relief programme should be followed when treating pain in patients with cancer.
- B** For appropriate use of the WHO analgesic ladder, analgesics should be selected depending upon initial assessment and the dose titrated as a result of ongoing regular reassessment of response.
- B** A patient's treatment should start at the step of the WHO analgesic ladder appropriate for the severity of the pain.
- B** If the pain severity increases and is not controlled on a given step, move upwards to the next step of the analgesic ladder. Do not prescribe another analgesic of the same potency.
- B** All patients with moderate to severe cancer pain, regardless of aetiology, should receive a trial of opioid analgesia.
- B** Analgesia for continuous pain should be prescribed on a regular basis, not 'as required'.

EDUCATION

- B** Pre-registration curricula for health care professionals should place greater emphasis on pain management education.
- B** Continuing pain management education programmes should be available to all health care professionals caring for patients with cancer.

ASSESSMENT

- B** Prior to treatment an accurate assessment should be performed to determine the type and severity of pain, and its effect on the patient.
- B** The patient should be the prime assessor of his or her pain.
- C** For effective pain control the physical, functional, psychosocial, and spiritual dimensions should be assessed.
- B** A simple formal assessment tool should be used in the ongoing assessment of pain.
- B** All health care professionals involved in cancer care should be educated and trained in assessing pain as well as in the principles of its control.
- C** Sudden severe pain should be recognised as a medical emergency and patients should be seen and assessed without delay.

Types of pain:

- Somatic
- Visceral
- Neuropathic
- Sympathetically mediated
- Mixed
- Anguish

PSYCHOSOCIAL ISSUES

- B** A thorough assessment of the patient's psychological and social state should be carried out. This should include assessment of anxiety and, in particular, depression, as well as the patient's beliefs about pain.

KEY

A

B

C

indicates grade of recommendation



Good practice point

CHOICE OF ANALGESIA FOR CANCER PAIN

THE WHO ANALGESIC LADDER

STEP 3: MODERATE TO SEVERE PAIN

(opioid for moderate to severe pain plus a non-opioid ± adjuvant)

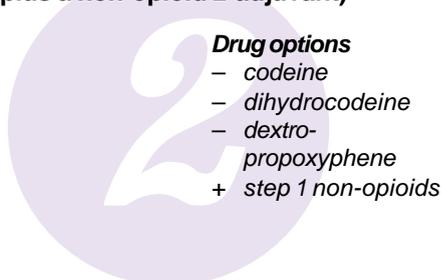
- 
- Drug options first line**
- morphine
 - diamorphine
 - + step 1 non-opioids
- alternative**
- fentanyl
 - hydromorphone
 - methadone
 - oxycodone
 - phenazocine
 - + step 1 non-opioids

Freedom from cancer pain

- B** Morphine or diamorphine should be used to treat moderate to severe pain in patients with cancer.
- C** The oral route is the recommended route of administration and should be used where possible.
- B** A trial of alternative opioids should be considered for moderate to severe pain where dose titration is limited by side effects of morphine/diamorphine.

STEP 2: MILD TO MODERATE PAIN

(opioid for mild to moderate pain plus a non-opioid ± adjuvant)

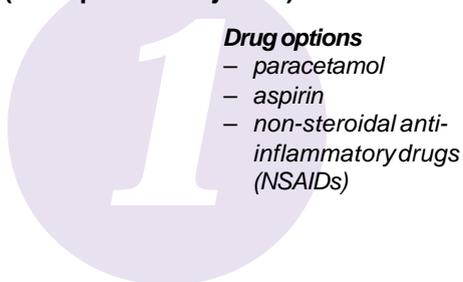
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- Drug options**
- codeine
 - dihydrocodeine
 - dextro-propoxyphene
 - + step 1 non-opioids

Pain persisting or increasing

- B** Patients with mild to moderate pain should receive codeine, dihydrocodeine or dextropropoxyphene plus paracetamol or a NSAID.
- C** If the effect of an opioid for mild to moderate pain at optimum dose is not adequate, do not change to another opioid for mild to moderate pain. Move to step 3 of the analgesic ladder.
- C** Compound analgesics containing subtherapeutic doses of opioids for mild to moderate pain should not be used for pain control in patients with cancer.

STEP 1: MILD PAIN

(non-opioids ± adjuvant)

- 
- Drug options**
- paracetamol
 - aspirin
 - non-steroidal anti-inflammatory drugs (NSAIDs)

Pain persisting or increasing

- A** Patients with mild pain should receive either a NSAID or paracetamol at licensed doses. The choice should be based on a risk/benefit analysis for each individual patient.
- A** Patients receiving a NSAID who are at risk of gastrointestinal side effects* should be prescribed misoprostol 200 µg two or three times a day or omeprazole 20 mg once a day.

Pain

* includes patients aged >60 years, smokers, previous peptic ulcer, those on steroids or anticoagulants, patients with existing renal or hepatic disease, or cardiac failure

USE OF OPIOIDS IN TREATMENT OF MODERATE TO SEVERE CANCER PAIN

INITIATING AND TITRATING ORAL MORPHINE

- C When initiating normal release morphine, start with 5-10 mg orally at four hourly intervals, unless there are contraindications.
- B The opioid dose for each patient should be titrated to achieve maximum analgesia and minimum side effects for that patient.
- C Where possible, titration should be carried out with a normal release morphine preparation.
- A Once suitable pain control is achieved by the use of normal release morphine conversion to the same total daily dose of controlled release morphine should be considered.

BREAKTHROUGH ANALGESIA

- C Every patient on opioids for moderate to severe pain should have access to breakthrough analgesia, usually in the form of normal release morphine.
- C Breakthrough analgesia should be one sixth of the total regular daily dose of oral morphine.
- Following the delivery of oral breakthrough analgesia wait 30 minutes to assess the response. If pain persists, repeat analgesia and reassess in a further 30 minutes. If pain still persists, full reassessment of the patient is required.
- Careful explanation of the correct use of breakthrough analgesia to carers and patients is necessary.

PREDICTABLE SIDE EFFECTS

- B **Constipation:** Patients receiving an opioid must have access to regular prophylactic laxatives. A combination of stimulant and softening laxative will be required.
- Nausea and vomiting:** Patients commencing an opioid for moderate to severe pain should have access to a prophylactic antiemetic to be taken if required.
- Sedation:** Patients receiving opioids for moderate to severe pain for the first time should be warned that sedation may occur and be advised of the risks of driving or using machinery. The use of other sedative drugs or drugs with sedative side effects should be rationalised.
- Dry mouth:** All patients should be educated on the need for, and methods to achieve, good oral hygiene.
- B Alternative opioids can be tried in patients with opioid sensitive pain who are unable to tolerate morphine side effects.

OPIOID TOXICITY, TOLERANCE, AND DEPENDENCE

- C Opioid toxicity should be managed by reducing the dose of opioid, ensuring adequate hydration and treating the agitation/confusion with haloperidol 1.5-3 mg orally or subcutaneously. This dose can be repeated hourly in the acute situation.
- B Initiation of opioid analgesia should not be delayed by anxiety over pharmacological tolerance as in clinical practice this does not occur.
- C Initiation of opioids should not be delayed due to unfounded fears concerning psychological dependence.
- B Patients should be reassured that they will not become psychologically dependent on their opioid analgesia.

PARENTERAL ADMINISTRATION

- B Patients requiring parenteral opioids should receive the appropriate dose of diamorphine via the subcutaneous route.
- C To calculate the 24 hour dose of subcutaneous diamorphine divide the total 24 hour oral dose of morphine by 3. Administer this dose of diamorphine subcutaneously over 24 hours.
- C Safe systems for use and management of syringe drivers must be in place as detailed in guidance issued by the Scottish Executive Department of Health.

ADJUVANT ANALGESICS

- A Patients with neuropathic pain should have a trial of a tricyclic antidepressant and/or an anticonvulsant.
- C A therapeutic trial of oral high dose dexamethasone should be considered for raised intracranial pressure, severe bone pain, nerve infiltration or compression, pressure due to soft tissue swelling or infiltration, spinal cord compression, or hepatic capsular pain (unless there are contraindications). In some clinical situations (e.g. if the patient is vomiting) it may be necessary to use the intravenous route.
- A Mexiletine should not be used routinely as an adjuvant analgesic.

SYSTEMIC ANTI-CANCER THERAPY

- A In patients with metastatic breast cancer who have progressive disease despite prior tamoxifen, the use of specific aromatase inhibitors such as anastrozole and letrozole should be considered.
- C Primary endocrine therapy should be considered for all patients presenting with prostatic carcinoma and painful bone metastases.
- C Maximum androgen blockade should be considered for management of patients with prostate cancer with worsening bone pain or progression on current single agent endocrine therapy.

RADIOTHERAPY

- C Radiotherapy should be considered for painful bone metastases.
- C The management of mechanical bone pain is more complex and if the patient is fit enough should involve consultation with an orthopaedic surgeon.
- B Radioactive strontium should be considered for the management of pain due to widespread bone metastases from prostatic carcinoma.
- Urgent treatment should be given for all patients with spinal cord compression.

BISPHOSPHONATES

- A Bisphosphonate treatment should be considered for all patients with multiple myeloma.
- A Bisphosphonates should be considered in the management of breast cancer patients who have pain due to metastatic bone disease.

INTERVENTIONAL TECHNIQUES

- A In patients with upper abdominal pain, especially secondary to pancreatic cancer, coeliac plexus block should be considered.
- C All professionals looking after patients with pain from cancer should have access to a specialist pain relief service.

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Derived from the national clinical guideline recommended for use in Scotland by the Scottish Intercollegiate Guidelines Network (SIGN)

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