

## 1. Diagnosing and treating pain

Help the patient to manage any anxiety, fear, anger or low mood

Is the pain related to movement?

- **Slightest passive movement?** *Exclude a fracture- see Part 2*
- **Pain on stressing bone on examination?** *Consider bone metastases:*  
Arrange bone scan- if metastases confirmed arrange radiotherapy. Start a weak opioid, but a strong opioid is often needed. Consider an infusion of pamidronate.
- **Active movement only?** *Exclude muscle spasm or strain:*  
If trigger point present- refer to pain or palliative care team for TENS or local injection  
Muscle strain: local cooling or refer for TENS
- **Related to joints, infiltration or distension?** NSAID or corticosteroids (not both) + PPI.
- **During a procedure or during transfer?** Change technique or method of moving.  
Consider: 4-hourly dose of usual analgesic or Entonox.

Is the pain present at rest?

- **Inspiration?** *Exclude pleurisy or rib metastases.* Treat infection if present.  
Consider a NSAID. If pain persists refer to pain or palliative care team.
- **Periodic (regular pain every few minutes)?**  
*Colic from bowel, bladder, or ureter:*  
Hyoscine butylbromide (Buscopan) 10-20mg SC<sup>△</sup> or IV (ineffective orally)  
*Persisting bladder colic:* consider instilling 20mls 0.5% bupivacaine for 30 mins. 8-12 hourly
- **Related to eating?** *Exclude oral, pharyngeal, gastric or duodenal problems*  
*Mucosal pain:* treat infection if present. Consider benzydamine (Difflam) mouthwash, or try benzocaine lozenges. If this is chemotherapy mucositis: see local policy.  
*Gastritis:* use H<sub>2</sub> blocker (cimetidine, ranitidine), or proton pump inhibitor (lansoprazole or omeprazole). For NSAID-induced damage use a PPI (not a H<sub>2</sub> blocker).
- **Skin changes?** *Exclude pressure damage or ulcer.* If ulcer present: contact local wound viability nurse for advice. Contact pain or palliative care team if pain persists.
- **Unpleasant sensory changes at rest?** *Consider neuropathic pain:*  
Start and titrate a strong opioid. If no better, add gabapentin 100mg 8 hourly<sup>1<sup>st</sup></sup> day, 200mg 8-hourly<sup>2<sup>nd</sup></sup> day, 300mg 8-hourly<sup>3<sup>rd</sup></sup> day, then titrate (caution in renal impairment). If still no improvement, add amitriptyline 10mg at night, titrated up to 50mg if tolerated.
- **In an area supplied by a peripheral nerve?** *Consider nerve compression:*  
Start and titrate an opioid. Exclude skeletal instability (eg. vertebral collapse).  
Consider dexamethasone 6mg daily, reducing to lowest dose that will control pain.

Is the pain very severe? See Part 2

## 2. Severe pain in palliative care

Immediate

Exclude acute crisis eg. myocardial infarction, pulmonary embolus, cord compression  
 For fracture: immobilise.  
 For colic: hyoscine butylbromide 20mg SC<sup>Δ</sup>, IV or IM.  
 For agitation that prevents assessment: ask for specialist help.  
 For severe pain at rest: diamorphine or morphine IV or IM (5mg or equivalent of 4-hourly dose). Repeat every 20mins SC if needed up to 3 doses

Within 1 hr

If pathological fracture: decide if patient is able to travel for X-ray.  
 If still in pain: repeat above dose of diamorphine. Check Part 1 on previous page

Within 4 hrs

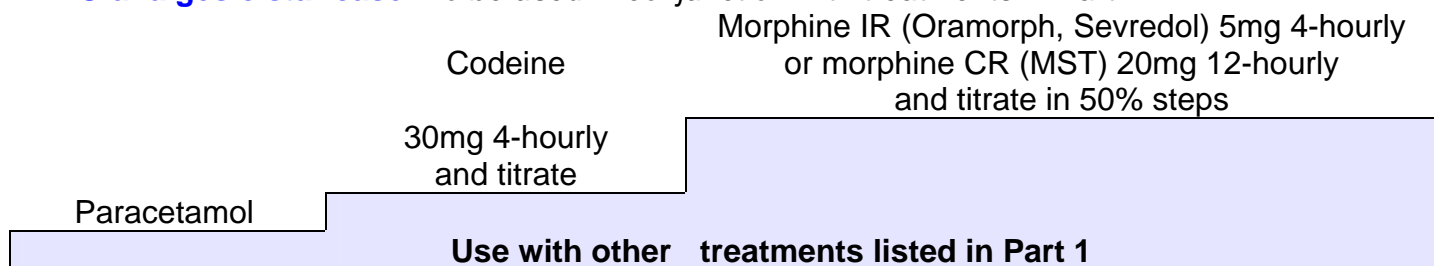
If still in pain: convert to morphine PO or diamorphine SC and increase dose by 50%.  
 Review in 2 hours: if still in pain contact pain or palliative care specialist  
 If treatment is to be delayed for 6 hours or more: ask advice.  
 Consider diamorphine equivalent (see Part 3),  
 plus lorazepam 500microg. sublingual<sup>Δ</sup> or PO.

Within 24 hrs

Ensure a good night's sleep with sedatives if necessary  
 If pain is localised (eg. fracture): consider referral for spinal analgesia or nerve block.

## 3. Using opioids in palliative care

**WHO analgesic staircase** To be used in conjunction with treatments in Part 1



### Choice of opioid

**Poor renal function:** ask pain/PC specialist for help. *Do not use morphine, diamorphine, oxycodone.*

**If poor hepatic function:** continue on codeine, morphine or diamorphine.

**If non-oral route needed:** use diamorphine SC, morphine SC, oxycodone SC or fentanyl TD  
 (NB. Transdermal fentanyl is not suitable for titration or in unstable pain).

**Breakthrough pain:** use IR preparations.

### Doses

See conversion table in Part 4 opposite for equivalents.

Typical starting dose: *if previously on non-opioid* = 2.5mg oral IR morphine 4-hourly

*if previously on weak opioid* = 5 – 10mg oral IR morphine 4-hourly

Typical oral morphine median dose = 120mg/24 hours (15mg 4 hourly)

### Titration

Either IR or CR preparations can be used in titration.

Increase dose by 50% every other day (can be increased daily if urgent control is needed)

NB. Adjust transdermal fentanyl more slowly, under specialist advice

### For breakthrough pain ('as required' or 'PRN')

- Divide 24 hour dose by 6 to give the required breakthrough dose  
 NB. for breakthrough pain whilst on fentanyl call pain or palliative care specialist
- Use IR opioid 1-hourly PRN- ask for help if pain is no better after 3 consecutive doses

**If pain is still >50% of starting level (or you are unsure), ask for help**

## 4. Opioid conversions in palliative care

	Conversion ratio from oral morphine	Approximate 24 hour dose equivalent	Approximate 12 hourly dose equivalent	Approximate 4 hourly dose equivalent	Approximate breakthrough dose equivalent
PO codeine	x 10	600mg	n/a	100mg	100mg
PO pethidine	x 10	600mg	n/a	100mg	100mg
PO dihydrocodeine	x 5	300mg	150mg	50mg	50mg
PO tramadol	x 5	300mg	150mg	50mg	50mg
<b>PO morphine</b>	<b>X 1</b>	<b>60mg</b>	<b>30mg</b>	<b>10mg</b>	<b>10mg</b>
PO oxycodone	÷ 1.5 - 2	30 - 40mg	15 - 20mg	5 - 7.5mg	5 - 7.5mg
SC oxycodone	÷ 2	30mg	15mg	5mg	5mg
SC morphine	÷ 2 - 3	20 - 30mg	10 - 15mg	2.5 - 5mg	2.5 - 5mg
SC diamorphine	÷ 3	20mg	10mg	2.5mg	2.5mg
PO hydromorphone	÷ 5	12mg	6mg	2.4mg	2.4mg
SC hydromorphone	÷ 10	6mg	3mg	1mg	1mg
fentanyl	÷ 3 (mg/24hr to microg/hr)	25 microg/hr patch	n/a	n/a	25microg

### Important:

These conversions are approximations and the dose of the new opioid may have to be adjusted.

**Example:** Oral morphine to diamorphine infusion: conversion factor of morphine is ( ÷ 3)  
So, 60mg/24 hours oral morphine = 20mg /24 hours SC diamorphine

- **Alternative opioids are available-** contact the palliative care specialist team.
- **The following are not recommended** for routine use in palliative care: dextromoramide, buprenorphine, pethidine, and methadone.
- **For fentanyl** use manufacturer's tables. As quick check use these conversions:  
oral morphine in mg/24hrs ÷ 3 ≈ TD fentanyl in microg/hour  
[ie. oral morphine 75mg/24hrs ≈ TD fentanyl 25microg/hour]  
  
TD fentanyl in microg/hour ≈ SC infusion diamorphine in mg/24hrs  
≈ SC infusion morphine in mg/24hrs  
≈ SC infusion oxycodone in mg/24hrs  
[eg. TD fentanyl 25microg/hour ≈ SC infusion diamorphine 25mg/24 hours]

### Caution with fentanyl:

- 1) This is an opioid whose potency is easily underestimated
- 2) It is preferable to use TD fentanyl only in patients with stable pain
- 3) The effects of TD fentanyl can continue for 30 hours after removing patch

- **These conversions are approximations, and the patient must be observed for:**  
-opioid toxicity if moving to a more potent opioid or a different strong opioid.  
-opioid withdrawal on stopping, moving to a weaker opioid or changing to a different strong opioid.
- **More potent opioids or routes DO NOT provide greater efficacy.** eg. a pain that is not responsive to titrated oral morphine, will not respond to injectable diamorphine either, even though this route and drug are 3 times as potent. An alternative route may be needed to ensure adequate absorption.

If pain is still >50% of starting level (or you are unsure), [ask for help](#)

## 5. Opioid adverse effects in palliative care

Adverse effect	Management
<b>Constipation</b>	Regular laxative. Use stimulant (eg. senna or bisacodyl) plus laxative with softening action (eg. docusate or lactulose).
<b>Nausea / vomiting</b>	<i>If gastric stasis</i> (large volume vomiting): metoclopramide 10-20mg 8-hourly SC initially, followed by domperidone PO 10-20mg 8-hourly <i>In other cases:</i> haloperidol <sup>o</sup> 2.5mg SC <sup>Δ</sup> or 1.5 - 3mg PO at night
<b>Dry mouth</b>	Local measures (eg. water spray, iced drinks)
<b>Sedation Confusion Nightmares Hallucinations Urinary retention Myoclonus</b>	Sedation due to opioids is usually mild and self-limiting (2-5 days). First exclude other, more common, causes (eg. drugs, hypercalcaemia) <i>If due to opioid:</i> reduce opioid dose, but if pain returns contact pain or palliative care specialist for advice on alternative opioids. <b>NB. Opioids should not be used for sedating or 'settling' a patient</b>
<b>Fear of opioid</b>	Information: psychological dependence, respiratory depression and tolerance are rare. Correctly used, opioids do not hasten death or shorten life.
<b>Respiratory depression or severe sedation</b>	<i>If respiratory rate less than 8/min <b>AND</b> SpO<sub>2</sub> = &lt;90%:</i> Reduce opioid dose. Give oxygen by face mask. Insert IV access cannula Dilute 400microg naloxone in 10ml normal saline Give naloxone IV: titrate in 40 microg. steps <b>Always titrate the naloxone to produce improvement <i>without reversing the analgesia.</i></b> Continue with naloxone infusion (see BNF). If unsure, contact pain or palliative care specialist for advice.
<b>Opioid withdrawal</b> (shivery, colic, diarrhoea)	Restart opioid, then reduce dose in 30% steps over at least 5 days. If withdrawing from transdermal fentanyl, contact pain or palliative care specialist

**If unpleasant adverse effects persist for >48 hours, (or you are unsure), [ask for help](#)**

## 6. Is the pain persisting?

- **Is the concordance poor?** Check if drug instructions are clear and understandable
- **Is this a new pain?** Work back through Part 1
- **Is there unresolved fear, anger or depression?**  
Exclude depression and anxiety state and check the support available
- **Is there a different way of administering the analgesic?** Check parts 1 & 3

**If pain is still >50% of starting level (or you are unsure), [ask for help](#)**

### Key to abbreviations

NSAID = non steroidal anti-inflammatory drug  
TENS = transcutaneous electrical nerve stimulation  
SpO<sub>2</sub> = oxygen saturation by pulse oximetry

CR = controlled release  
IM = intramuscular  
IR = immediate release  
IV = intravenous  
TD = transdermal  
PR = rectal  
SC = subcutaneous.

tabs = tablets  
caps = capsules  
soln = solution

<sup>o</sup> = unlicensed use    <sup>Δ</sup> = unlicensed route

# Information for Doctors and Nurses Seeking Help and Advice on Palliative Care

Newcastle and North Tyneside Palliative Care Strategy Group (April 2008)

## Hospice services

Telephone numbers correct as of 27 June 07

**Marie Curie Centre** 219 1000  
Fax: 219 1099

**St. Oswald's Hospice** 285 0063  
Fax: 246 9072

**Out of hours advice line: 273 3435**

## Other services (in alphabetical order)

**Primary Care Response Team** Newcastle Tel: 275 5880

**Community Nursing Support Team** North Tyneside Tel: 220 5947

**Freeman Palliative Care Team** 213 7221 ext. 37221` Fax: 223 1430

**Marie Curie Nurses** contact local Primary Health Care Team

**NCCT Palliative Care Support Team** Direct: 256 3615 (internal: 23615) Fax: 256 3203

**Newcastle Community Palliative Care Services** Direct: 226 1315 Fax: 219 5204

**North Tyneside Palliative Care Team** Direct: 220 5959 Fax: 220 5955

**Northgate Learning Disability Palliative Care Team** 01670 394 808 Fax: 01670 394 175

**RVI Palliative Care Support Team (adult)** Direct: 282 4019 (internal: 24019) Fax: 282 5466

**RVI Paediatric Oncology Support Team** Direct: 282 0294 (internal 20294) Fax: 282 0284

## Other information: Texts

### **Oxford Textbook of Medicine, 3<sup>rd</sup> ed.**

(Doyle D, Hanks G, Cherny N, Calman K eds) Oxford: Oxford University Press, 2004  
The major reference textbook for palliative care.

### **Guide to Symptom Relief in Palliative Care, 5<sup>th</sup> ed**

(Regnard C, Hockley J) Oxford: Radcliffe Medical Press, 2004

Clinical decision format text for rapid advice written mostly by NCN clinicians. The plan is for this book to merge online with the 'Palliative Medicine Handbook' (see below)

### **Helping the patient with Advanced Disease: a workbook**

(Regnard C, ed) Oxford: Radcliffe Medical Press, 2003

These are 56 CLiP (Current Learning in Palliative Care) 15 minute worksheets written by NCN clinicians. They are also available online (see below)

### **Palliative Care Formulary, 2<sup>nd</sup> ed**

(Twycross RG, Wilcock A, Thorp S) Oxford: Radcliffe Medical Press, 2002

The 'BNF' of palliative care- also available online (see below)

### **Introduction to Palliative Care**

(Twycross RG) 1998 Oxford: Radcliffe Medical Press

Well respected textbook on palliative care

## Other resources: Websites

All these sites are free to access.

### **Palliative Medicine Handbook** <http://book.pallcare.info/>

(author: Ian Back). Comprehensive, referenced online textbook. The plan is for this book to merge online with the 'Guide to Symptom Relief in Palliative Care' (see above)

### **CLiP (Current Learning in Palliative Care):** [www.helpthehospices.org.uk](http://www.helpthehospices.org.uk) (Click on 'e-learning').

Nearly 60 online self-learning workshops on palliative care that can also be downloaded and used in tutorials.

### **Palliative Drugs Formulary:** [www.palliativedrugs.com](http://www.palliativedrugs.com)

*Palliative Drugs*: national palliative care formulary with advice on drugs relevant to palliative care.

### **Clinical knowledge summaries:** [www.cks.library.nhs.uk](http://www.cks.library.nhs.uk)

An aid to diagnosis and treatment. Developed in Newcastle and includes palliative care sections edited by local clinicians.

# Advice for Doctors and Nurses on Managing Pain in Adult Palliative Care

(August 2007)

## Scope and purpose

Guidelines for doctors and nurses on managing pain in adults with any progressive life-threatening or life-limiting illness. These are basic guidelines only, and further advice can be obtained from local palliative care teams (see below).

## This advice

- was initially written by a wide multidisciplinary group of clinicians from Newcastle
- is based on current evidence and knowledge of pain control
- fulfils the criteria of the Benchmarking Review of locally derived guidelines on the control of cancer pain (National Council for Hospice and Specialist Palliative Care Services, August 2000)
- was reviewed by the Newcastle and North Tyneside Drugs and Therapeutics Panel in 2003
- was updated in August 2007 by the Trust Palliative Care Team
- is intended primarily as advice to health care staff on managing pain in advanced disease

## Notes on when to seek help

Palliative care is the care of people with advanced, progressive and life-threatening or life-limiting disease. It is the right of all patients to receive effective palliative care and the duty of all professionals to enable this. In many cases doctors and nurses will be able to deliver this care. Occasionally, further help and advice ensures more effective palliative care.

### Consider seeking help in the following situations:

#### • Unfamiliar situations

*Diagnosis:* a diagnosis that is uncommon in your practice may present new problems.

*Symptoms:* a symptom that is uncommon to you may have a simple solution you can obtain on discussing the problem with a specialist. Other symptoms need the patient to be seen by a palliative care specialist.

*Drugs:* some symptoms in palliative care need drugs or routes of delivery that may be uncommon in your practice. Using resource texts, internet or discussing the drug with a specialist may be all you need.

#### • Persistent or severe symptoms

Physical or psychological problems can sometimes be difficult to resolve. If first and second line treatments have failed, discussion with, or a visit by, a palliative care specialist can offer new options.

#### • Complex situations

Some patients have a complex mix of physical, psychological, social, ethical and spiritual issues which can make clear cut decisions difficult. Discussion with a palliative care specialist can help you to see the situation more clearly.

## Types of palliative care help and advice available

**Telephone advice:** discussion with a medical or nurse specialist in palliative care.

**Outpatients:** available at both Newcastle Hospices and in some hospital combined clinics. These can be arranged to allow detailed assessments of problems.

**Day Hospice:** available in St. Oswald's Hospice, Marie Curie Hospice and The Green, Wallsend. Other day services are available further away. Specialist day centre care gives patients a change of scene, and access to nursing, physiotherapy and OT help, medical help if needed, complimentary therapy and giving family some respite.

**Day Treatment:** available at St. Oswald's Hospice offers treatments such as transfusions, drug titration, and first dose drug monitoring, complimentary therapy and a lymphoedema clinic.

**Cancer Care at Home:** provides nursing support for carer relief, early discharge from hospital, end-stage disease or in time of crisis. The care managed in partnership with the local Primary Health Care Team.

**Community and hospital palliative care teams:** all hospitals and communities in the area now have access to specialist nursing and medical palliative care advice. These teams will see patients in hospital, home, nursing or residential homes or community hospitals.

**Inpatient care:** available at both Newcastle Hospices. Full interdisciplinary specialist palliative care team available: speciality consultants, registrar and junior medical staff, 24 hour medical cover, 24 hour specialist nursing care, physiotherapy, occupational therapy, social work support, chaplaincy, cognitive behavioural therapy and complimentary therapy, all backed by extensive volunteer support programs.

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