HERPC
Hull & East Riding Prescribing Committee

NON-SPECIALIST ANALGESIA ALGORITHM FOR MANAGING CHRONIC NON MALIGNANT PAIN IN ADULTS

Perform comprehensive assessment to identify type of pain as somatic, visceral or neuropathic. Consider early referral for non-pharmacological methods and coping strategies. Discuss with patient (see pain medicines leaflet, pain flare up leaflet) and refer as appropriate.
For all treatment options: DO NOT USE STRONG OPIOIDS IN LOW BACK PAIN AND SCIATICA (NICE NG59)

- Review adherence and response to treatment 1 month after initiation and if treatment to be continued at 3 -6 monthly intervals thereafter
- Care needed in prescribing opioids, gabapentin and pregabalin to prevent possible addiction and/or misuse. Avoid in combination with other opioids (CNS depression).
- Note for Fibromyalgia there is a lack of evidence for strong opioid use
- Consider gradual reduction / withdrawal of treatment once symptoms controlled
- Refer patients to Community Pain Clinic if
  - Risk or history of substance misuse/ signs of dependency (opiates, gabapentin and pregabalin are addictive and widely misused)
  - intolerant of therapy or treatment options exhausted
  - severe pain

Step 1 (Mild Pain): Paracetamol + / - NSAID

Step 2 (Moderate Pain):
Comprehensive assessment somatic, visceral or neuropathic

Non-Specific: Consider trial of opioid therapy (weak / strong)

Specific: Predominantly neuropathic

Weak Opioid:

First Line: Oral codeine

Second Line: Oral Tramadol (codeine intolerance)

Strong Opioid:

First Line: SR morphine (Zomorph)

Second Line: SR Oxycodone (morphine intolerance)

Oral route contraindicated: Transdermal buprenorphine or transdermal fentanyl

Painful diabetic neuropathy

Other neuropathic pain conditions

First Line:

Oral duloxetine OR
Oral amitriptyline if duloxetine is contraindicated

First Line:

Oral amitriptyline or gabapentin

Consider imipramine or nortriptyline if patient develops adverse effects to amitriptyline.

Review Response at 1 Month. Consider stepping down

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NO REDUCTION IN PAIN OR PERSISTANT SEVERE PAIN AT MORPHINE EQUIVALENT OF 90MG / DAY

Refer to specialist in primary or secondary care

Second Line:
Consider switching to amitriptyline or gabapentin in combination with duloxetine (if not contraindicated)

Consider pregabalin+ if gabapentin is not tolerated.

Second Line:
Consider adding a second drug (amitriptyline, imipramine, nortriptyline or gabapentin) in combination with the first drug (if not contraindicated)

Consider pregabalin+ if gabapentin is not tolerated.

Review Response at 1 Month. Consider stepping down

Conversion ratios (oral to oral)[2-3]

Oral codeine to	oral morphine	divide by 10
Oral tramadol to	oral morphine	divide by 10
Oral oxycodone to	oral morphine	multiply by 2

NO REDUCTION IN PAIN OR PERSISTENT SEVERE PAIN

Refer to specialist in primary or secondary care

While waiting for referral:
Consider oral tramadol as third-line treatment instead of or in combination.

Equivalence Dosing[2-3]

Oral Morphine Mg /24hrs	Oral Oxycodone Mg /24hrs	Transdermal Buprenorphine micrograms /hr	Transdermal Fentanyl micrograms /hr
10	5	5	-
20	10	10	-
40	20	20	12
60	30	-	-
90	45	35	25
120	60	52.5	-
180	90	70	50

This is only an **approximate** guide (doses may not correspond with those given in clinical practice); patients should be carefully monitored after any change in medication and dose titration may be required

Drug	Starting dose	Max dose**
Amitripyline	10mg/day	75mg/day
Gabapentin***	300mg/day	3600mg/day
Duloxetine	30mg/day	120mg/day
Pregabalin***	75mg twice daily	600mg/day
Tramadol	50 to 100mg, 4 hourly	400mg/day

**Dose may change following specialist advice.
***See gabapentin / pregabalin conversion guideline

Reversal of respiratory depression cause by medicinal use of opioids
Whilst there are no clear guidelines and the need to tailor treatment to the patient's response is vital in this scenario, an **initial dose of naloxone 100 micrograms** is advised. Subsequently titrate the dose against the patient's respiratory function and **not** the level of consciousness (aim to achieve a respiratory rate >10/minute; GCS 13–14; and absence of acute withdrawal syndrome). If response to this initial dose is inadequate, give subsequent doses **every 2 minutes** or as necessary should the respiratory function improve then deteriorate again.
Please note: the BNF recommended route for this is by intravenous injection. Intramuscular injection can be used but the onset of action will be slower.

References: NICE CG173, NICE NG59, BNF Sep 2017, 3. Palliative Care Formulary (PCF4)
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