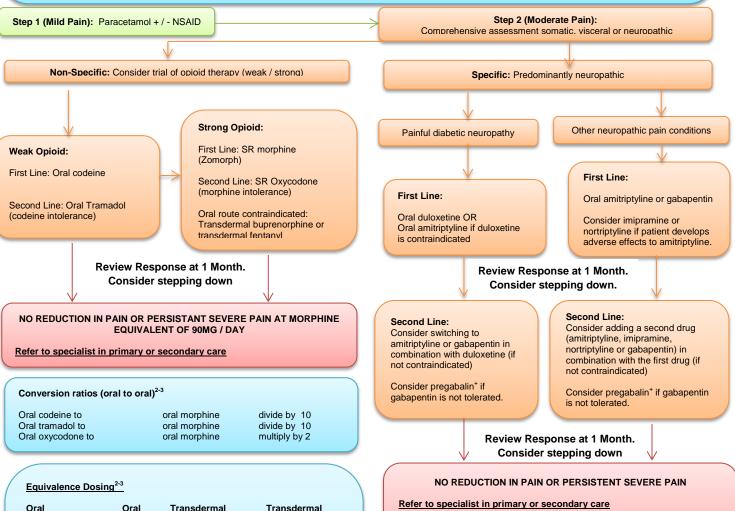
NON-SPECIALIST ANALGESIA ALGORITHM FOR MANAGING CHRONIC NON MALIGNANT PAIN IN ADULTS

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
- 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)
 - 0 intolerant of therapy or treatment options exhausted
 - severe pain 0



Oral	Oral	Transdermal	Transdermal
Morphine Mg /24hrs	Oxycodone Mg /24hrs	Buprenorphine micrograms /hr	Fentanyl micrograms /hr
10	5	5	_
20	10	10	
40	20	20	12
10 20 40 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

While waiting for referral:

Consider oral tramadol as third-line treatment instead of or in combination.

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

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.

^{**}Dose may change following specialist advice.
***See gabapentin / pregabalin conversion guid