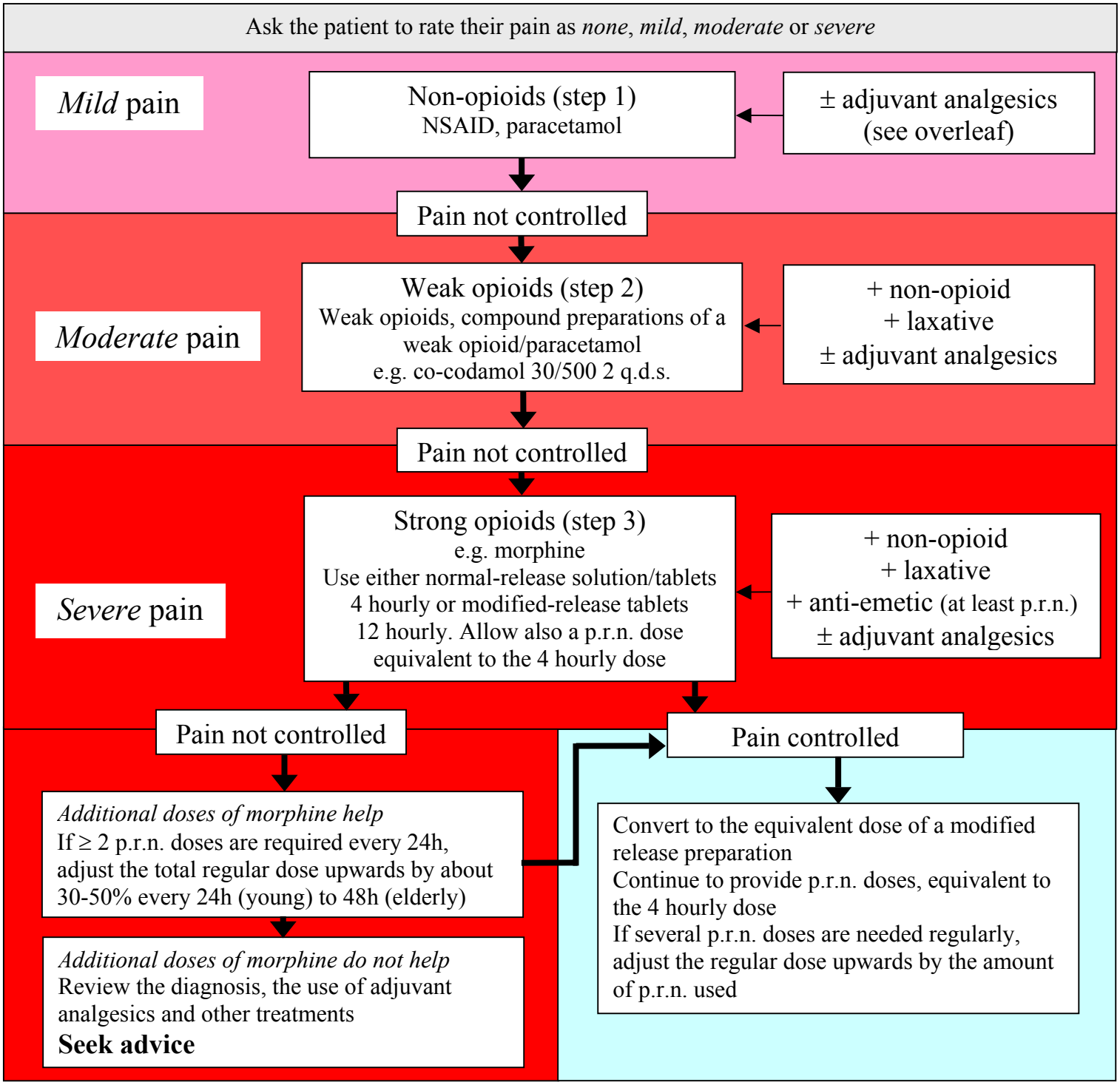
Guidelines for the relief of cancer pain in adults

These guidelines, based on the WHO analgesic ladder, have been produced by the Mid-Trent Cancer Services Network Palliative Care Group (0115 9627988) and are for use by all medical and nursing staff caring for adults with cancer pain. *If you have any questions or require clarification, please make use of the listed resources*.

Important keys to success include:

- accurate evaluation of the pain from the history (use a formal pain assessment tool), examination and appropriate investigation in order to diagnose the cause of the pain
- explanation to the patient and carers and discussing treatment options with them
- administer analgesics regularly
- individualize drug and non-drug approaches and the setting of realistic goals
- regular reassessment of the pain
- referral to the specialist palliative care team if the pain is not being progressively relieved.



Endorsed by the JCSMG May 2001. Published October 2001; review date October 2002.

Additional notes

For information regarding the use and dose of specific NSAIDs, weak and strong opioids see the Palliative Care Formulary (1998), Twycross, Wilcock and Thorp. Also available on the web http://www.palliativedrugs.com.

Morphine prescribing

- usual starting dose is 10mg 4 hourly, titrated every 24h; the elderly and/or those with renal impairment may only require a starting dose of 2.5-5mg 4-6 hourly titrated every 48h or more
- 50% of patients experience nausea, prescribe an anti-emetic for the first 3-5 days e.g. haloperidol 1.5-3mg immediately, at night and p.r.n.
- the dose for breakthrough pain is equivalent to the 4 hourly dose i.e. 1/6 of the total 24h dose
- regular laxatives are necessary, a preparation combining a stimulant and a softener is preferred e.g. co-danthramer.

Alternative strong opioids

Morphine is the strong opioid of choice. Alternative opioids, e.g. *oxycodone, hydromorphone, transdermal fentanyl, methadone* are generally used when there are unacceptable adverse effects with morphine. Each has its own advantages and disadvantages. *Seek guidance*.

Adjuvant analgesics, for use in

- *neuropathic pain*, e.g. anticonvulsants, antidepressants, corticosteroids
- *skeletal muscle cramp*, e.g. benzodiazepines
- *smooth muscle spasm/colic*, e.g. antimuscarinics
- *raised intracranial pressure*, e.g. corticosteroids
- *bone pain*, e.g. bisphosphonates (usually only after use of NSAID + strong opioid + radiotherapy).

Additional measures

- radiotherapy, particularly for bone pain
- nerve blockade, particularly for localised pain or neuropathic pain
- non-drug approaches, e.g. modification of lifestyle, aids for daily living, relaxation, distraction, addressing the psychological, social and spiritual dimensions of the 'total pain' experience.

If there is no progressive control of pain contact the Hospital Support Team for advice.

Resources

	Nottingham City Hospital	**Queens Medical Centre**
Palliative care link nurse and resource file, available on each ward		
Hospital Support team Macmillan Nurses	ext. 46619 or air call	ext. 44119
Palliative Medicine Consultants	Dr R Corcoran ext. 47087 Dr A Wilcock ext. 46450	Dr V Crosby ext. 42585
Specialist Palliative Care Unit (advice available all day, every day) Hayward House Macmillan Specialist Palliative Care Unit (0115) 9627619 or ext. 46619		
Pain anaesthetists	Dr A Ravenscroft ext. 45639	Dr Z Hussain ext. 41194 Dr F Campbell ext. 41194
Other sources of drug information	ext. 47164	ext. 44185

Endorsed by the JCSMG May 2001. Published October 2001; review date October 2002. This guideline has been registered with the Trust. However, clinical guidelines are 'guidelines' only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date.