

## PAIN MANAGEMENT GUIDELINES

1. Use a multi-drug approach. Combine opioids with non-opioids and adjuvant medications.
2. Base administration schedule on the analgesic's duration of effect. Best to use sustained release opioids for scheduled dosing and always use immediate release opioids for rescue or breakthrough dosing.
3. In opioid naïve patients start with low dose, short acting opioids and titrate for effect.
4. Avoid meperidine (Demerol), propoxyphene (Darvon) and the mixed agonist-antagonist opioids (e.g. Stadol, Nubain, Talwin). Do not exceed 4000 mg acetaminophen (APAP) in 24 hours.
5. Non-invasive routes preferred. For severe pain or rapidly escalating pain, it may be necessary to provide intravenous analgesics until the pain is managed. If oral, rectal, or transdermal dosing is no longer practical or appropriate, continuous subcutaneous or intravenous infusions are indicated.
6. **Mild Pain** (rating 1-3) Start with simple analgesics; acetaminophen (APAP) or NSAIDS, with adjuvant analgesics as appropriate.
7. **Moderate to Severe Pain** (rating 4-10) When pain does not respond to non-opioid analgesics and adjuvants, consider adding an opioid. Drugs with APAP, ASA or NSAIDs in combination with opioids limit flexibility of dosing.
8. **Titration:** Increase by 25 to 50% for moderate pain; increase by 50 to 100% for severe pain. Or calculate the average dose of breakthrough medication taken per day and add to the sustained release medication dose (except when breakthrough is taken for incident pain).
9. **Breakthrough Pain Dosing:** Scheduled dosing will maintain stable serum drug levels and provide consistent relief. Patients on long acting opioids or continuous parenteral infusions must have an order for breakthrough pain medication. Frequent breakthrough dosing requires a change in the scheduled sustained release drug dose. Oral breakthrough dose is  $\approx$  10-20% of the oral 24 hour baseline dose. Peak effect of immediate-release opioid is  $\approx$  one hour; may repeat dose every one hour if patient is not sedated. IV/SubQ breakthrough dose is  $\approx$  50 to 100% of the hourly IV/SubQ rate. Peak effect of IV opioids is  $\approx$  10-15 minutes; may repeat dose every 15 minutes if patient not sedated. Peak effect of SubQ opioids is  $\approx$  30 minutes; may repeat dose every 30 minutes if patient not sedated. IM dosing not recommended.
10. When **changing drug or route of administration**, use equianalgesic doses. See drug chart on other side. If changing from one drug to another, the new drug may be more effective, because of differences in potency or drug availability. Start at 2/3 to 3/4 of the amount calculated using the equianalgesic tables. Make sure breakthrough medication is available and titrate dose according to individual patient response.
11. Manage **opioid side effects** aggressively. Patients never become tolerant to the constipating effects of opioids. Always start stimulant laxative/softener combination with opioids.
12. Always **educate patients and caregivers** about pain medications and side effect management.

Pain Sources	Pain Character	Drug Class/Examples
<b>Myofascial Somatic Pain</b>	Constant and well localized.	- Acetaminophen/NSAIDS - Non-Opioid (e.g. Baclofen) - Opioids
<b>Visceral Pain</b>	Injury to sympathetically innervated organs. Pain is vague in quality. Deep, dull, aching. Referred pain.	- NSAIDS - Corticosteroids - Opioids
<b>Bone Pain</b>	Axial skeleton with thoracic and lumbar spine most common.	- NSAIDs: Celecoxib (Celebrex), Ibuprofen, (Motrin), Naproxen (Aleve), Ketorolac (Toradol), and others - Corticosteroids/Bisphosphonates - Radiation Therapy, Radionuclides - Opioids
<b>Neuropathic Pain Nerve Damage Dysesthesia</b>	Injury to some element of the nervous system (plexus or spinal root). Dysesthesia, burning, tingling, numbing, shooting electrical pain. May require higher doses of opioids.	- Anticonvulsants: Gabapentin (Neurontin), Carbamazepine (Tegretol), Clonazepam, (Klonopin), Pregabalin (Lyrica) - Tricyclic Antidepressants: Nortriptyline (Pamelor), Desipramine (Norpramin) - SNRI'S Antidepressants: Duloxetine (Cymbalta), Venlafaxine (Effexor) - Corticosteroids - Topical Anesthetic, Lidocaine Patch 5% (Lidoderm) - Opioids

SIDE EFFECT	OPIOID SIDE EFFECT MANAGEMENT
<b>Constipation</b>	Start with combined senna as stimulant and docusate (Colace) as softener. May increase to 4 tabs bid. If no BM in 2 days add a laxative (Dulcolax, Lactulose, Miralax, Milk of Magnesia). Increase fluids, activity; adjust to effect. Tolerance to opioid related constipation does not occur.
<b>Nausea/ Vomiting</b>	Rule out reversible causes, e.g. constipation. Prochlorperazine (Compazine) 10 mg PO q 6 hr PRN or 25 mg suppository PR q 6 hr PRN. May add Lorazepam (Ativan) 0.5 mg q 6 hr PO/SL, PRN or Metoclopramide (Reglan) (also helpful for early satiety and constipation) 10 mg PO QID. Scopolamine TD (Transderm-Scop) patch 1.5 mg q 3 days is effective for movement related nausea q 72 hrs. Haloperidol (Haldol) 0.5 - 4 mg PO or IV/SQ q 6 hrs.
<b>Respiratory Depression</b>	Rare - closely monitor in opiate naïve patients. Increased risk with obstructive sleep apnea, obesity, on benzodiazepines, or in those with respiratory compromise.

## SCCPI CANCER PAIN MANAGEMENT REFERENCE CARD



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