If eGFR less than 30ml/min see Renal Failure page 21

In most cases pain can be improved for patients. If not improving; seek Specialist Palliative Care advice, especially if:

- Complex, multiple pains where assessment is difficult;
- Pain appears to be resistant to usual measures or not responding to morphine doses equivalent to or exceeding 120 mg morphine in 24 hours;
- Difficulty in managing pain due to adverse effects of medication or compliance or administration.

CONCEPT of TOTAL PAIN

Should prompt healthcare professionals to consider ALL possible influences on the individual's pain experience:

- **PHYSICAL**
- **SPIRITUAL**
- **SOCIAL**
- **PSYCHOLOGICAL**

Success in pain management depends on

- regular review of the pain and its causes
- effectiveness of treatment
- acceptability of the proposed treatment to the patient

The patient's understanding, fears, concerns and previous experience of pain, as well as their expectations of treatment will all influence each individual's experience of pain and its effective management.

NEUROPATHIC PAIN AGENTS

AMITRIPTYLINE—start 10 mg OD increased to 25 mg OD after 3-7 days and then by 25 mg every 1—2 weeks as tolerated to a maximum of 75 mg daily

GABAPENTIN—start 100 mg OD increase to 100 mg BD after 2-3 days to 100 mg TDS after 2-3 days and then by increments of 100 mg every 2-3 days depending on response to a maximum dose of 900 mg TDS

PREGABALIN—start 25 mg BD and increase by 25 mg every 2-3days to a maximum dose of 300 mg BD

DULOXETINE– start at 30 mg OD and increase to 60 mg OD after 2 weeks—stop if no response after 2 months. Maximum dose 120 mg OD

Start with either an anticonvulsant or an antidepressant and titrate dose as above. Response takes a number of days to become apparent. For common side effects see BNF.

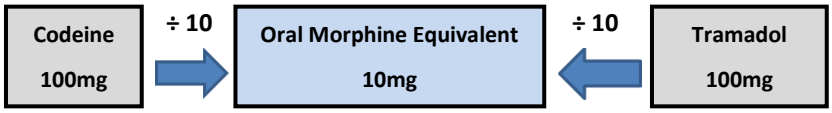
A GUIDE TO EQUIVALENT DOSES OF OPIOID DRUGS

Use the table as a guide (not a set of definitive equivalences) to identify an appropriate starting point for your prescribing decision. **ALL** prescribing decisions must be based on a **full clinical assessment**. **Higher opioid doses may be needed for some patients—seek advice**

Think about the role of adjuvant medication **before** rotating opioids, changing the dose or route. For guidance on conversion to a transdermal fentanyl patch see Pg 7. For guidance on conversion to CSCI see Pg 20.

Consider **reducing prescribed opioid dose by 30-50%** if converting from one route to another route (e.g. transdermal to oral or oral to subcutaneous) or there is concern about **opioid toxicity** (confusion, drowsiness, myoclonic jerks, slowed respiration, pin-point pupils).
Never increase an opioid dose by more than 50% of the previous 24 hour regular dose without SPECIALIST ADVICE

Consider prescribed doses of moderate opioids (Codeine and Tramadol). Factor these in when converting to regular morphine (or other strong opioid) or when calculating PRN dosages.



	Morphine (mg)					Oxycodone (mg)					Fentanyl Patch (mcg/hr)	Buprenorphine Patch (mcg/hr)
Route	Oral			SC		Oral			SC			
	24hr total	12hrly MR dose	PRN	CSCI 24h	PRN	24hr total	12hrly MR dose	PRN	CSCI 24h	PRN		
Dose	20	10	3	10	2	10	5	2	5	1	-	-
	30	15	5	15	3	15	*	3	7.5	1	12 micrograms	10 micrograms
	40	20	7	20	3	20	10	3	10	2	-	-
	50	25	8	25	4	25	*	6	13	2	-	20 micrograms
	60	30	10	30	5	30	15	5	15	3	25 micrograms	-
	70	35	12	35	6	35	*	6	18	3	-	30 micrograms
	80	40	13	40	7	40	20	7	20	3	-	-
	100	50	17	50	8	50	25	8	25	4	-	-
	120	60	20	60	10	60	30	10	30	5	50 micrograms	-

Seek specialist advice for higher doses

* When equal divided doses not possible due to tablet strength e.g. Oxycodone 25mg/24hrs . Prescribe equal doses at higher or lower level e.g. 10mg BD or 15mg BD, dependent on clinical judgement *

Manufacturer's ratios (2:1) have been used to convert oral morphine to oral oxycodone and to convert oral oxycodone to SC oxycodone. Experimentally determined ratios (100:1) have been used to calculate opioid equivalent doses for Fentanyl & Buprenorphine transdermal patches