CANCER PAIN MANAGEMENT

Disclaimer

The information in the guide is meant to help decide on the treatment approach to each patient individually. Therefore, the professional's advice is to take full responsibility of their safety and know their limits. Before treating your patient using this guideline be sure that your patient is well diagnosed and has been treated before. Every professional should take full responsibility for the safety of their patient.
This guide reflects opinions synthesized from an organized group of experts into a written document. It should reflect the expert views of the treatment of the disease.
The team of professional experts reviewed the guidelines and discussed it with the panel of individuals who are well versed on the topic of interest while carefully examining and discussing the scientific data available.
This guideline has been designed to provide a practical and accessible guidance for health care practitioners. It is the responsibility of treating physicians to decide what is suitable for their patients. Therefore, the guidelines are not a substitute for the attending doctor's clinical judgment

MEDICATIONS: (Use multi-modal analgesia) (Refer to table 3 for appropriate doses depending on pain severity):

- □ Patient should not be on Hydroxyurea
- □ Analgesia to be administered within 30 minutes of presentation

Mild Pain (Pain score 1-4/10) Start with a non-opioid or a weak opioid	
□ Acetaminophen	(500 mg q4hr PO and 500 mg q1h PRN). (Max 4mg/day). *Contraindicated if liver dysfunction.
□ Codeine	30-60 mg q4hr PO regularly and q1hr PO PRN for rescue doses. Maximum dose 400 mg/day *Codeine can also be given subcutaneously for patients who are unable to take oral medications).
□ Tramadol	-Immediate release: 25 to 50 mg every 6 hours as needed. The dose may be increased as needed and tolerated to 50 to 100 mg every 4 to 6 hours (max: 400 mg/day). -Extended release : 100 mg once daily; titrate by 100 mg/day increments every 5 days as needed (maximum: 300 mg/day)

***If the pain persists or worsens: Optimize the above dose of the analgesic and if this does not improve the pain, switch to a stronger opioid (e.g. Morphine, Oxycodone, Hydromorphone): E.g., If morphine is chosen, the starting dose is 5mg q4h PO regularly and 2.5 mg q1hr PO PRN for rescue doses.

Other medication for mild pain:

NSAID (Choose 1 only) (Contraindicated if renal dysfunction, GI bleeding or coagulopathy): (pain score 3-5)

□ Ketorolac	15- 30mg IV Q6-8 h as needed (Dose for elderly and those under 50 kg) (max 120mg/day) OR * 1 spray (15.75 mg) in each nostril every 6-8 h in adults <65 year and weight ≥ 50 kg
*Contraindicated if use as prophylactic analgesic in major surgery, in the setting of CABG ,Labor or delivery , breastfeeding , advanced renal impairment ,bleeding risk ,active peptic ulcer disease	
□ Ibuprofen	400-800mg PO Q6-8 h as needed (max 3200mg/day)

Moderate to Severe Pain (Pain score ≥ 5/10) Start with a stronger opioid (e.g., Oxycodone, Morphine or Hydromorphone).

□ **Morphine**	5mg q4h regularly and 2.5mg or 5mg PO 1qh PRN for breakthrough pain.
□ **Hydromorphone**	1mg q4h regularly and 0.5mg (1mg is more practical) q1h PO for PRN.
□ **Oxycodone**	5mg q4h PO regularly and 5mg q1h PO PRN.

other **medication for severe pain:**
NSAID (Choose 1 only) (contraindicated if renal dysfunction, GI bleeding or coagulopathy):

Non-NSAID: □ **Acetaminophen**	500-1,000 PO Q4-6 h (max 4000mg/day) x 24 hours * Contraindicated if liver dysfunction.
□ **Ibuprofen**	200-400 q4-6h (max: 3,200; 2,400; 1,200)
□ **Diclofenac**	In some patients, initial 50, 100 TID (max : 150) * Patch available—to be applied twice daily to painful area (intact skin only), Gel and solution dosing joint specific
□ **Indomethacin**	20 mg 3 times daily or 40 mg 2 or 3 times daily. (maximum dose 150 ; 200) * Contraindicated if history with urticaria , asthma and proctitis

For Tingling and Burning Pain

□ **Amitriptyline** 10 to 25 mg once daily at bedtime; may gradually increase dose in 10 to 25 mg increments at intervals ≥1 week up to 150 mg/day given once daily at bedtime or in 2 divided doses .

□ **Nortriptyline** 10 to 25 mg once daily at bedtime; may increase as tolerated as soon as every 3 days up to 150 mg/day
*Patients with neuropathic pain and an inadequate response to nortriptyline alone may benefit from a combination with gabapentin.

□ **Gabapentin**

- Immediate release: 100 to 300 mg 1 to 3 times daily increase dose to a target dose range of 300 mg to 1.2 g 3 times daily.
- Extended release: 300 mg at bedtime; increase dose to a target dose of 900 mg to 3.6 g once daily .

□ **Carbamazepine** 100 mg 3 times daily administered enterally in combination with opioids .

□ **Prednisone** (if swollen)

*Dose depends upon condition being treated and response of patient.

*Consider alternate day therapy for long-term therapy.

*Discontinuation of long-term therapy requires gradual withdrawal by tapering the dose.

Additional note

* Titrate the dose, over the next few days, to achieve good pain control noting that:

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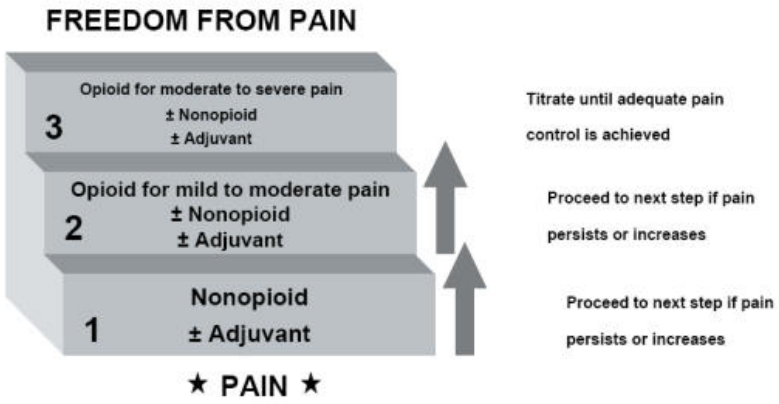


More than three PRN doses per day can be an indicator that pain may not be adequately controlled.

Determine the new dose by increasing the total daily opioid dose by 25-75% depending on the severity of the pain or by using the following formula:

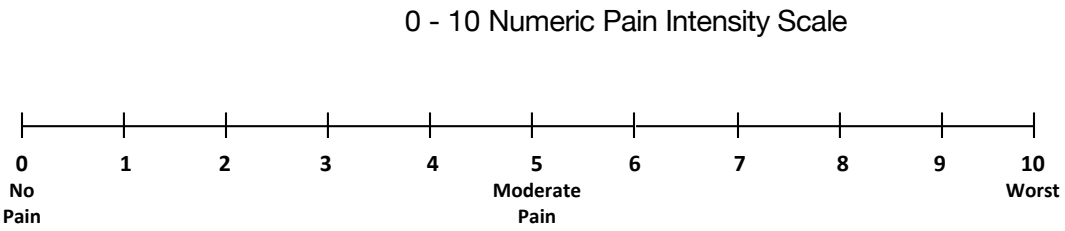
Add the number of breakthroughs being used in a 24-hour period to the total daily dose. Then divide by 6 to get the 4qh doses.

* If unsuccessful in controlling the pain with the above measures, or if toxicity occurs, switch to a different opioid.

* Adjuvants may be used but first optimize the opioids.

Table 3: Pain Rating Scale: Use the following scale for pain assessment:

- 1 – 3 Mild
- 4 – 6 Moderate
- 7 – 10 Severe



Signature Date Physician Name