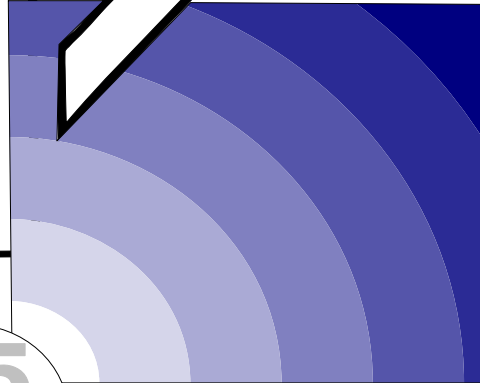
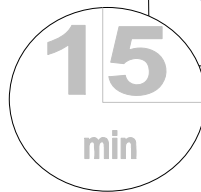


CLIP



15 minute Worksheet



Helping the patient with pain

4: Choosing an analgesic

Intermediate level

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Aim of this worksheet

To understand the principles of choosing an analgesic.

How to use this worksheet

- You can work through this worksheet by yourself, or with a tutor.
- Read the case study below, then work on the questions overleaf.
- The work page is on the right side, the information page is on the left.
- Work any way you want: you can try answering from your own knowledge (in which case fold over the information page), you can use the information page (this is not cheating- you learn as you find the information), or you can use other sources of information
- It should take you about 15 minutes. If anything is unclear, discuss it with a colleague.
- If you think any information is wrong or out of date let us know
- Use the activity on the back page and take this learning into your workplace.

Case study

Pat is a 36 year old woman, married with two sons aged 12 and 9. She had problems with her bowels for several months before some rectal bleeding made her see her GP. Investigations revealed a carcinoma of the sigmoid colon with liver metastases. She copes with some denial and refuses to tell her sons.

She has colic, a skin pressure pain, a neuropathic pain and a pain due to muscle tension.

v13: 2008

Types of analgesic

Primary analgesics

Non-opioids eg. paracetamol, nefopam.

Weak opioid agonists eg. codeine, dihydrocodeine, dextropropoxyphene.

Strong opioid agonists eg. morphine, diamorphine, hydromorphone, fentanyl, oxycodone.

Opioid partial agonist/antagonists
eg. buprenorphine.

Nonsteroidal anti-inflammatory drugs (NSAIDs)
eg. ibuprofen.

NMDA antagonists eg. ketamine, methadone

Nitrous oxide (1:1 with oxygen as Entonox).

Secondary analgesics

(also called co-analgesics or adjuvant analgesics)

Adrenergic pathway modifiers eg. clonidine.

Antibiotics

Anticonvulsants eg. carbamazepine, gabapentin

Antidepressants eg. amitriptyline, venlafaxine

Antispasmodics eg. hyoscine butylbromide.

Antispastics eg. baclofen.

Corticosteroids eg. dexamethasone.

Membrane stabilising drugs
eg. flecainide, mexiletine, lidocaine

Nonsteroidal anti-inflammatory drugs (NSAIDs)
eg. ibuprofen.

NB. NSAIDs are weak primary analgesics, but their main action is through a secondary anti-inflammatory action, hence they are in both lists

Analgesic staircase

The WHO staircase uses non-opioids, weak opioids and strong opioids as the three steps.

The most obvious limitation is that this approach only works for pain that responds to opioids:

- opioids are not local anaesthetics and they cannot 'numb' all pain.
- many pains respond poorly to opioids (eg. colic, neuropathic pain, pressure sores, fracture)

There are two consequences:

- 1) The WHO staircase encourages the use of secondary analgesics at every stage
- 2) It's necessary to think about an analgesic staircase for every person and pain.

Creating an individualised analgesic staircase

Pains can have many causes, and several pains can co-exist, sometimes in the same site. Each patient therefore needs an individualised analgesic staircase.

- For skin pressure pain the staircase is very different and might have these three steps:
 - 1) Pressure relieving aids and position changes
 - 2) Topical ibuprofen gel, oral paracetamol or oral diclofenac.
 - 3) If the pain is severe, ketamine or spinal analgesia.
- In severe pain in cancer, it may be worth starting with opioids since several pains are often present together and one of these is commonly opioid-sensitive.
- If the remaining pain has a neuropathic element then start up the 'neuropathic pain staircase':
 - amitriptyline 10mg at night (lower if elderly or frail). Titrate the dose to pain and adverse effects. Typical dose range is 25-50mg at night, but some people need (and tolerate) doses up to 150mg at night.
 - add carbamazepine 100mg 8-hourly, or if this is not tolerated try gabapentin 100mg 8-hourly. Titrate the dose to pain and adverse effects. For gabapentin some people need (and tolerate) up to 1200mg 8-hourly.
 See also the CliP worksheet on *Persisting Pain*.
- If the above fail, try the next steps of ketamine or spinal analgesia- these will need referral to a pain or palliative care specialist.

Frequent follow up is often needed.

Principles

- Different analgesics work with different pains
- Some analgesics work through secondary mechanisms
- Different pains may need different analgesics

Not all analgesics are the same- so we have to make choices. Some analgesics work directly by blocking pain pathways- these are primary analgesics. Others work through an indirect mechanism- these are secondary analgesics.

Think it over

- Think of some primary analgesics (eg. what you'd use for a headache)
- Think of analgesics that work by a secondary mechanism (eg. what you'd use for colic). These are called secondary analgesics.

Primary analgesics

Secondary analgesics

The World Health Organisation suggested you should start with simple analgesics, building up to more potent ones in several steps. They called this the **analgesic staircase**.

Write

Write in the steps of the WHO analgesic staircase



Q. Would all pains respond to this approach?

Q. Where do the secondary analgesics fit in this staircase?

Write

Try writing an analgesic ladder for Pat's skin pressure pain.



FURTHER ACTIVITY: Choosing an analgesic

Review the analgesics of a patient with pain:
-identify which are primary analgesics and which are co-analgesics.

FURTHER READING: Choosing an analgesic

Journal articles

Hanks GW, Conno F, Cherny N, Hanna M, Kalso E, McQuay HJ, Mercadante S, Meynadier J, Poulain P, Ripamonti C, Radbruch L, Casas JR, Sawe J, Twycross RG, Ventafridda V. Expert Working Group of the Research Network of the European Association for Palliative Care. Morphine and alternative opioids in cancer pain: the EAPC recommendations. *British Journal of Cancer*. 2001; **84**(5): 587-93.

Hawkins C, Hanks GW. The gastroduodenal toxicity of nonsteroidal anti-inflammatory drugs: a review of the literature. *Journal of Pain and Symptom Management*. 2000; **20**(2):140-51.

Hawley P, Forbes K, Hanks GW. Opioid rotation: Does it have a role? *Palliative Medicine*. 1998; **12**(1): 60-4.

Hanks GW, Forbes K. Opioid responsiveness. *Acta Anaesthesiologica Scandinavica*. 1997; **41**: 154-8.

Twycross RG. Palliative care in the past decade and today. *European Journal of Pain*. 1999; **3**(SUPPL. A): 23-9.

Twycross RG. The fight against cancer pain. *Annals of Oncology*. 1994; **5**(2):111-2.

Resource books and websites

A Guide to Symptom Relief in Palliative Care, 5th ed. Regnard C, Hockley J. Abingdon: Radcliffe Medical Press, 2004

Cancer Pain Relief and Palliative Care. Geneva : WHO, 1990.

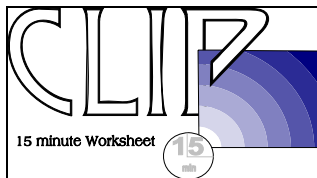
Oral Morphine, Information for Patients, Families and Friends. Twycross R., Lack S.A. Beaconsfield Publishers. 1988.

Oxford Textbook of Palliative Medicine 3rd ed. Doyle D, Hanks G, Cherny NI, Calman K eds. Oxford : Oxford University Press, 2003.

PCF3- Palliative Care Formulary, 3rd ed. Twycross RG, Wilcock A. Oxford: Radcliffe Press, 2008. Also on www.palliativedrugs.com

Symptom Management in Advanced Cancer, 3rd edition. 2001. Twycross RG, Wilcock A. Abingdon: Radcliffe Medical Press.

Wall and Melzack's textbook of pain, 5th ed. Stephen B. McMahon and Martin Koltzenburg, eds. Edinburgh : Elsevier Churchill Livingstone, 2006.



Current Learning In Palliative care
An accessible learning programme for health care professionals

15 minute worksheets are available on:

- An introduction to palliative care
- Helping the patient with pain
- Helping the patient with symptoms other than pain
- Moving the ill patient
- Psychological needs
- Helping patients with reduced hydration and nutrition
- Procedures in palliative care
- Understanding and helping the person with learning disabilities
- The last hours and days
- Bereavement

Also available online on

www.helptheospices.org.uk (click on 'e-learning')