The Christie
NHS Foundation Trust

GUIDELINES ON PAIN MANAGEMENT

THE CHRISTIE, GREATER MANCHESTER & CHESHIRE

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Target audience:	*All Clinicians*		

Mechanisms for pain

90% of patients with cancer who develop spinal cord compression have a history of localised spinal pain for some weeks or months prior to its development. This may be described as a constant ache, and is due to bone and soft tissue invasion in relation to vertebral metastases.

Compression of dorsal nerve roots gives rise to radicular pain on one or both sides of the body: pain radiating round in the dermal distribution corresponding to the level of disease, and this is often aggravated by movement.

Compression of the cord itself may be associated with crescendo exacerbation of pain, often localised but may be described as radiating up and down the entire spine; electric shocks or paraesthesiae may be experienced within the spine on coughing, straining or movement.

Following established cord compression and the development of paraparesis or paraplegia, there may be an unpleasant tight band around the trunk at the level of compression. This may be followed by the development of neuropathic pain, e.g. unpleasant hypersensitivity or allodynia (light touch becomes painful), burning sensations or some times stabbing and shooting pains within this band or down the limbs.

Assessment

NB It is important to ask about pain a) at rest b) on movement.

- Site and radiation
- Severity (e.g. score 1/10)
- Impact on sleep
- Level of distress
- Relieving factors e.g. position, response to dose of analgesia
- Check for neuropathic pains or pains “out of the blue” even at rest
- Severity of pain on movement

How to manage pain

PAIN AT REST:

Opiate Analgesia

Opiate-naive patients:
If moderate to severe pain, start regular weak-strong opioid with provision for breakthrough pain by oral and parenteral routes

Patients already on regular strong opioids:
Assess pain at rest and if moderate to severe increase background long acting analgesic by 30-50%

PRN analgesia:

Always prescribe appropriate immediate-release PRN opiate analgesia in all patients, using the lowest effective dose.

Consider use of immediate-release fentanyl preparations (Abstral, Effentora, Actiq, Instanyl, PecFent), particularly where there is:

- Intolerance to 'usual' PRN medications (Oramorph / OxyNorm)
- Movement related (incident) pain
- Difficulty swallowing oral medication

Immediate-release fentanyl preparations can only be used if the patient is already taking at least 60mg (total 24h daily dose) of oral morphine (or equivalent).
For further advice, please contact the Supportive Care Team.

Opioid Antagonist-containing preparations:

Consider TARGINACT MR (Oxycodone/Nalaxone combination tablet) – for moderate to severe pain.
The naloxone component blocks oxycodone-induced constipation. It does not alter the central analgesic effect of Oxycodone.
Targinact is contraindicated in patients with moderate to severe hepatic impairment, and must be used with caution in patients with mild hepatic impairment.
Consult the Supportive Care Team for further advice.

OR
Consider naloxegol to treat opioid-induced constipation (OIC). Naloxegol is a PEGylated derivative of mu-opioid receptor antagonist naloxone. It binds to mu-receptors in the bowel, targeting the underlying cause of OIC. It is a once a day 25mg tablet.
Must only be prescribed by the Supportive care team. Please check with pharmacist for further advice if required.

Consider adjuvant methods of pain relief:

- steroids will have been commenced and can often dramatically reduce the pain associated with spinal cord compression
- where a neuropathic pain has been identified consider the addition of amitriptyline 10-25 mgs. at night, or titration of pregabalin / gabapentin / duloxetine
- consider cautious trial of NSAID if pain not improving within 48 hours of high dose steroids, poor response to opioids or signs of opioid toxicity (N.B. ensure high gastro protection, e.g. iv omeprazole)
- TENS machine
- Referral for an interventional pain procedure (via pain team).

Pain on movement:

This can be more difficult to manage and especially in the short term, e.g. in the first two weeks following radiotherapy, there is often a compromise between possible drug side effects and limitation of activity. Consider the following

- Gentle titration of regular sustained-release opioids (if beneficial / tolerated)
- Fast-acting oral/nasal transmucosal fentanyl pre-movement
- administration of quick acting opioid e.g. morphine s.c. injection about 30 minutes before any anticipated activity
- Entonox prior to movement (but avoid longterm use)
- consider introduction of gabapentin or pregabalin if movement precipitates severe shooting or stabbing pains
- anti-spasmodics e.g. regular baclofen or benzodiazepines to reduce skeletal muscle spasm
- trial of ketamine (seek advice from Supportive Care/Pain team)
- interventional pain relief

In situations where there is frequent or continuous severe pain and/or failure to improve pain control within 24-48 hours, refer to Supportive Care/Pain Team.

For more information and protocols on management of MSCC see:
http://www.christie.nhs.uk/MSCC

CONSULTATION, APPROVAL & RATIFICATION PROCESS

All documents must be involved in a consultation process either locally within a department or division or throughout the trust at relevant board/committee meetings before being submitted for approval.

VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
V1	Aug 2007	Richard Berman	Creation	
V2	Dec 2010	Richard Berman Vivek Misra	Update Review	Updated document Reviewed content
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