The Christie
NHS Foundation Trust

# GUIDELINES ON PAIN MANAGEMENT

## THE CHRISTIE, GREATER MANCHESTER & CHESHIRE

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| Procedure Reference: | | Version: | *V6* |
| Document Owner: | Dr V. Misra | Accountable Committee: | *Acute Oncology Group Network MSCC Group* |
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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 (REF). This may be due to bone (somatic) 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 which corresponds to the level of disease, and 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 partial paralysis of limbs which may occur on coughing, straining or movement. There may be an unpleasant tight band around the trunk at the level of compression: neuropathic pain, an unpleasant hypersensitivity or allodynia (light touch becomes painful), burning sensation or stabbing and shooting pain within this band or down the limbs.

## Pain Assessment

Assess pain at rest and on movement

Site
Radiation
Severity e.g. score 1/10
Relieving factors e.g. position, response to dose of analgesia
Exacerbating factors – e.g. movement, straining
Neuropathic pains e.g. Sudden onset, catching
Effect on activities of daily living e.g. sleep, mood, *personal care
Assess pain at rest and on movement.

## Pain management

Paracetamol and milder analgesia's may not help with the pain experienced with MSCC – however paracetamol may compliment opioids if given regularly.

### Opiate - naive patients:

If moderate to severe pain, start a regular opioid with provision for breakthrough opioids, orally or the subcutaneous (SC) route.

| Medication | Dose | Frequency | Route | |
|---|---|---|---|---|
| Morphine Sulphate IR | 5mg | 4 hourly | Oral | Prescribe on regular side of drug chart |
| Morphine Sulphate IR | 5mg | 1-2 hourly PRN | Oral | For breakthrough pain |
| Morphine Sulphate | 2.5mg | 1-2 hourly PRN | SC | If oral route not possible – consider syringe driver if requiring more than 3 doses in 24hrs |
| Oxycodone IR | 2.5mg | 4 hourly | Oral | Prescribe on regular side of drug chart |
| Oxycodone IR | 2.5mg | 1-2 hourly PRN | Oral | For breakthrough pain |
| Oxycodone | 1.25mg | 1-2 hourly PRN | SC | If oral route not possible – consider syringe driver if requiring more than 3 doses in 24hrs |

After review these can be switched to the long acting opioids.

Consider reducing the doses of opioids for frail, elderly, hepatic or renally impaired patients – please refer to the Supportive Care Team or your local Palliative Care Team for support and advice.

Prescribe laxatives (refer to guidelines on managing bowel function) and first line antiemetic's so either:-

| Medication | Dose | Frequency | Route |
|---|---|---|---|
| Haloperidol **OR** | 0.5-1.5 mg | Nocte | Oral |
| Metoclopramide | 10mg | TDS | Oral |

Metoclopramide – not recommended in younger patients as at risk of extra-pyramidal effects
Metoclopramide and Haloperidol not suitable in Parkinson's disease – will need alternative antiemetic's prescribing.

### If oral route not suitable can have SC or a syringe pump started

If opioid induced constipation is suspected then other preparations are available – please refer to the Supportive Care Team or your local Palliative Care Team for support and advice.

### Patients already on regular strong opioids:

Assess the patient's pain at rest and if moderate to severe increase the background long acting analgesia by 30-50% based on their PRN opioid usage in the last 24hrs. Increase the breakthrough analgesia to reflect this – approximately 1/6$^{th}$ of the total long acting dose.

## Steroids *Essential in MSCC*

| Day | Dexamethasone dose | Route | Frequency | Notes |
|---|---|---|---|---|
| 0 | 16mg | PO/IV/SC | Stat dose | Loading dose as soon as possible following assessment, unless contraindicated. |
| 1 onwards | 8mg | PO/IV/SC | Twice daily* | After MSCC has been excluded, surgery has been completed or radiotherapy has been started reduce to 8mg OD gradually reduce steroid dose to zero.<br><br>Ensure gastric protection with a PPI when giving high dose steroids. |
| *BD = twice daily (8am and 2pm) | | | | |

Blood sugar montioring needs to be completed daily while on high dose steroids (see 'Guidelines on steroid usage' https://www.christie.nhs.uk/patients-and-visitors/services/metastatic-spinal-cord-compression-mscc/information-for-professionals/guidelines

## Neuropathic pain

Where a neuropathic pain has been identified consider the addition of the medication below:

| Medication | Dose | Frequency | Other |
|---|---|---|---|
| Amitriptyline | 10mg PO<br>1st Line | Nocte | Increase every 3-7days - maximum dose 75mg<br>*Avoid in hepatic impairment* |
| Gabapentin | Start at 300mg PO<br>2nd Line | TDS | Increase every 3-7 days - maximum 1200mg<br>*monitor renal function* Seek Specialist advice if eGFR is < 60ml/min (Renal drug handbook) |
| Pregabalin | Start at 75mg PO<br>2nd Line | BD | Increase dose every 3-7 days. Maximum 300mg.<br>*monitor renal function* Seek Specialist advice if eGFR is < 60ml/min (Renal drug handbook |
| Duloxetine | Start at 30mg PO | OD | When other treatments have failed – seek specialist advice when considering increasing the dose<br>*Reduce starting doses in hepatic and renal impairment*so use with caution |

Consider reducing the doses in frail, elderly, hepatic or renally impaired patients.

To increase the starting doses please refer to the Greater Manchester Pain and Symptom control Guidelines 5th Edition (2019).

## Pain on Movement

Immediate release oral transmucosal fentanyl preparations may be an option – refer to the Supportive care team or local Palliative Care Teams – they are particularly useful where there is:

- Intolerance to the 'usual' PRN medications (Morphine / Oxycodone)
- 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).
Fentanyl transdermal patches unsuitable for unstable pain – 25mcg patch is equivalent to 60mg oral morphine so not for opioid naïve patients.

Fentanyl Products should only be initiated by or on advice from the Supportive Care Team or local Palliative Care services as they are specialist medicines.

### Consider adjuvant methods of pain relief:

- Steroids will have been commenced and can often dramatically reduce the pain associated with spinal cord compression.
- Administration of quick acting opioid e.g. morphine PO or SC about 30 minutes before any anticipated activity.
- 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 gastro protection, e.g. PO or IV PPI e.g. omeprazole or pantoprazole) if no contraindications.
- Anti-spasmodic e.g. diazepam or lorazepam to reduce skeletal muscle spasm.
- Referral for an interventional pain procedure (via pain team).
- Entonox prior to movement (but avoid long term use), this needs to be prescribed.
- (Clinical guidance on the use of Entonox clinical).
  https://hive.xchristie.nhs.uk/Interact/Pages/Content/Document.aspx?id=14437&SearchId=

**In situations where there is frequent or continuous severe pain and/or failure to improve pain control within 24-48 hours, and/or patient taking <120mg oral morphine equivalent in a 24hr period, please refer to The Supportive Care Team or your local Specialist Palliative Care team.**

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

And for further advice please referral to **the Greater Manchester Pain and Symptom control guidelines (5th edition 2019)**

## 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<br>Vivek Misra | Update<br>Review | Updated document<br>Reviewed content |
| V3 | Nov 2013 | Richard Berman<br>Vivek Misra | Update<br>Review | Updated document<br>Reviewed content |
| V4 | Jan 2016 | Richard Berman<br>Sasha Kong | Review<br>Update | <br>Updated content |
| V5 | Jan 2018 | Richard Berman<br>Laura Flanagan | Review | Updated content |
| V6 | Nov 2020 | Caroline Morris | Review | Updated content |