PRINCIPLES OF PAIN MANAGEMENT AND PRESCRIBING MORPHINE

Keywords: Palliative pain management, palliative morphine, analgesic ladder

AIM

- The appropriate and effective management of pain in palliative care women.

KEY POINTS

1. Multiple factors can influence a woman’s perception of pain.
2. A comprehensive pain history should include:
   - The site(s) of the pain.
   - The severity of the pain.
   - The quality of the pain described in the woman's own words.
   - Any exacerbating and relieving factors.
   - The onset of the pain.
   - Interference with activities of daily living, sleep patterns.
   - The impact on her psychological state.
   - The response to previous and current analgesic therapies.
   - The usual practitioner, duration and doses of opioids confirmed
3. Follow the World Health Organisation (WHO) principles of pain management.

By mouth

- The oral route is preferred
- Use the subcutaneous route as an alternative if the woman is unable to swallow or has constant nausea and vomiting or impaired gut function

By the clock

- Analgesia should be ordered at regular intervals either by short acting analgesia (50% of anticipated daily dose) or long acting opioids (50% of anticipated daily dose).
- Analgesia should not be written up prn unless it is for breakthrough pain.

By the ladder

- The choice of analgesia prescribed is dependent on the type and the severity of the pain.
- The principle of the WHO 3-step ladder is to move up the ladder and titrate doses with or without adjuvant analgesia until acceptable analgesia/function is achieved.
- The WHO ladder should be considered an important component of a flexible approach to adequate analgesia.
PRESCRIBING MORPHINE

1. Morphine is the initial opioid of choice.

2. Choose a different opioid if the woman has
   - Had hallucinations
   - Severe renal impairment
   - Severe nausea / vomiting despite anti emetics
   - A true morphine allergy
   - A previous acute confusional state following use

3. Provide the woman with a clear explanation of the benefits, risks and alternatives of morphine.

4. Address the woman and her family’s fears and misconceptions i.e. addiction, tolerance and early demise.

5. Be aware of the conversion from other analgesia to morphine (e.g. tramadol, codeine).

6. Oral administration of opioids is the preferred route, unless the woman cannot swallow or has uncontrolled nausea and vomiting or severe constipation. In these cases morphine should be given subcutaneously, or alternative opioids used sublingually (buprenorphine).

7. Be aware of the need to modify doses in renal failure and the need to exercise caution in impaired liver function.

8. In women who are opioid naïve, start with 2.5mg to 5.0mg oral short acting morphine four hourly. If morphine is to be given subcutaneously, start with 2.5mg of morphine four hourly. Be aware that to convert oral morphine to equi-analgesia injectable morphine you must divide by 2-3 e.g. 10mg oral morphine is equivalent in effect to 3-5mg morphine by injection. See Clinical Guideline Opioid Conversions.

9. Breakthrough analgesia must be available:
   - The breakthrough dose should be 50-100% of the four hourly dose.
• A breakthrough dose should be given as often as necessary for breakthrough pain, but not more frequently than every 60 minutes to avoid stacking/accumulation with late onset of overdose symptoms.
• If three or more breakthrough doses are consistently required in a 24 hour period, the regular dose should be reviewed.
• If morphine causes excessive drowsiness, limit or reduce the dose and maximise non-opioid analgesia.

10. Titrate the dose to maximise the analgesia and limit the adverse effects.
11. Once the woman's pain is controlled on a short acting opioid, the total 24 hour requirements can be calculated and changed to a long acting preparation of morphine.
   • MS Contin every 12 hours or Kapanol every 12-24 hours.
   • A short acting opioid breakthrough dose must still be prescribed which should be approximately equivalent to 1/6 of the total morphine dose.
   • When changing, ensure the LAST dose of the short acting medication is given with the first dose of the long acting MS Contin or Kapanol.
12. Seek advice from Palliative Care Consultant or Pain Medicine Consultant if unsure or pain remains difficult to control while maintaining safety.

REFERENCES / STANDARDS
Greater Metropolitan Clinical Taskforce. 2008. Gynaecological Cancer Palliative Care. NSW Department of Health. Australia

National Standards – 1- Care provided by the clinical workforce is guided by current best practice
4- Medication Safety
Legislation - Poisons Act 1964
Related Policies - Nil
Other related documents – KEMH Clinical Guidelines Palliative Care

Do not keep printed versions of guidelines as currency of information cannot be guaranteed.
Access the current version from the WNHS website.