NICE National Institute for Health and Care Excellence

NICE Pathways

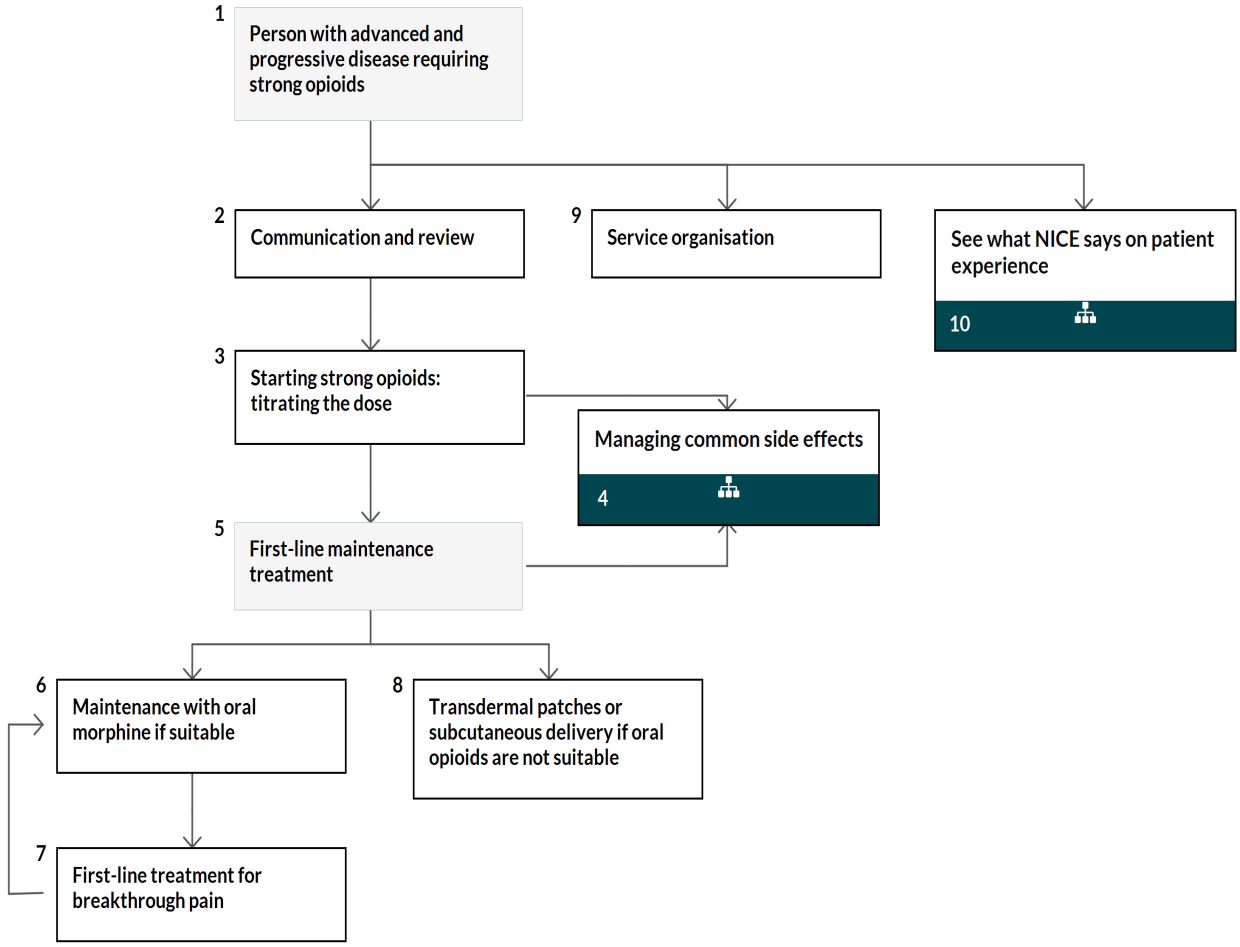
Opioids for pain relief in palliative care overview

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/opioids-for-pain-relief-in-palliative-care
NICE Pathway last updated: June 2017

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Person with advanced and progressive disease requiring strong opioids

No additional information

2 Communication and review

When offering pain treatment with strong opioids to a patient with advanced and progressive disease, ask them about concerns such as:

- addiction
- tolerance
- side effects
- fears that treatment implies the final stages of life.

Provide verbal and written information on strong opioid treatment to patients and carers, including the following:

- when and why strong opioids are used to treat pain
- how effective they are likely to be
- taking strong opioids for background and breakthrough pain, addressing:
  - how, when and how often to take strong opioids
  - how long pain relief should last
- side effects and signs of toxicity
- safe storage
- follow-up and further prescribing
- information on who to contact out of hours, particularly during initiation of treatment.

Offer patients access to frequent review of pain control and side effects.

NICE has produced information for the public explaining its guidance on opioids in palliative care.

3 Starting strong opioids: titrating the dose

When starting treatment with strong opioids, offer patients with advanced and progressive

disease regular oral sustained-release or oral immediate-release morphine (depending on patient preference), with rescue doses of oral immediate-release morphine for breakthrough pain.

For patients with no renal or hepatic comorbidities, offer a typical total daily starting dose schedule of 20–30 mg of oral morphine (for example, 10–15 mg oral sustained-release morphine twice daily), plus 5 mg oral immediate-release morphine for rescue doses during the titration phase.

Adjust the dose until a good balance exists between acceptable pain control and side effects. If this balance is not reached after a few dose adjustments, seek specialist advice. Offer patients frequent review, particularly in the titration phase (also see communication and review [See page 3]).

Seek specialist advice before prescribing strong opioids for patients with moderate to severe renal or hepatic impairment.

4 Managing common side effects

See Opioids for pain relief in palliative care / Managing common side effects of opioids for pain relief in palliative care

5 First-line maintenance treatment

No additional information

6 Maintenance with oral morphine if suitable

Offer oral sustained-release morphine as first-line maintenance treatment to patients with advanced and progressive disease who require strong opioids.

Do not routinely offer transdermal patch formulations as first-line maintenance treatment to patients in whom oral opioids are suitable.

If pain remains inadequately controlled despite optimising first-line maintenance treatment, review analgesic strategy (also see communication and review [See page 3]) and consider seeking specialist advice.

7 First-line treatment for breakthrough pain

Offer oral immediate-release morphine for the first-line rescue medication of breakthrough pain in patients on maintenance oral morphine treatment.

Do not offer fast-acting fentanyl as first-line rescue medication.

If pain remains inadequately controlled despite optimising treatment, consider seeking specialist advice.

8 Transdermal patches or subcutaneous delivery if oral opioids are not suitable

Transdermal patches

Consider initiating transdermal patches with the lowest acquisition cost for patients in whom oral opioids are not suitable and analgesic requirements are stable, supported by specialist advice where needed.

Follow the recommendation on using a recognised opioid dose conversion guide in prescribing controlled drugs.

Subcutaneous delivery

Consider initiating subcutaneous opioids with the lowest acquisition cost for patients in whom oral opioids are not suitable and analgesic requirements are unstable, supported by specialist advice where needed.

9 Service organisation

NICE has published a cancer service guideline on improving supportive and palliative care for adults with cancer.

10 See what NICE says on patient experience

See Patient experience in adult NHS services

Glossary

Background and breakthrough pain

background pain is chronic, persistent pain; breakthrough pain is a transient increase in pain intensity over background pain, typically of rapid onset and intensity, and generally self-limiting with an average duration of 30 minutes

Immediate-release

a dosage form that is intended to release all the active ingredient on administration with no enhanced, delayed or extended release effect

Rescue doses

the dose of analgesic needed for the relief of breakthrough pain

Strong opioids

morphine-like drugs (such as diamorphine, fentanyl, oxycodone, buprenorphine); codeine and dihydrocodeine are weak opioids

Subcutaneous opioids

a subcutaneous injection of opioids is given in the fatty layer of tissue just under the skin

Sustained-release

a dosage form that is designed to release a drug at a predetermined rate by maintaining a constant drug level for a specific period of time with minimal side effects

Transdermal patches

medicated adhesive patches that are placed on the skin to deliver a specific dose of medication through the skin into the bloodstream

Sources

Palliative care for adults: strong opioids for pain relief (2012 updated 2016) NICE guideline CG140

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to

have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.