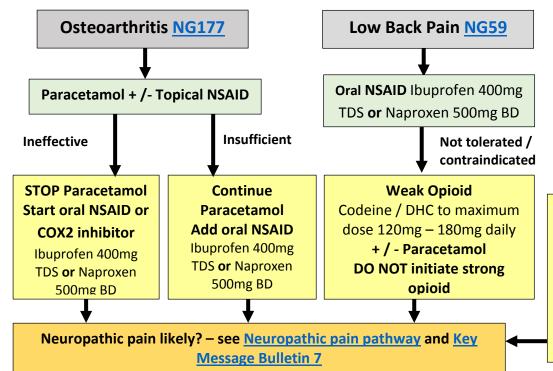
## Advice & Information **Exercise and** activity **Weight loss** Physiotherapy Mental Health & Wellbeing

## Chronic Pain Management Pathway (see also KMB 35 and AGEM Analgesic Formulary)



Paracetamol + / - NSAID
Ibuprofen 400mg TDS or
Naproxen 500mg BD

Not tolerated /
contraindicated

## **ADD Weak Opioid**

Codeine / DHC to maximum dose

120mg – 180mg daily OR

ONLY if oral route not suitable /

moderate to severe renal failure:

Buprenorphine patch 5mcg or 10mcg

(5mcg patch is equivalent to 5 – 10mg

oral morphine daily)

Ensure all non-pharmacologic options have been exhausted before referral to specialist or trial of strong opioid

## Review Opioids (see **KMB 15**)

If opioid regime is **stable** and patient reports substantial relief in symptoms, **review patient every 6 months.** 

If a total daily dose of 60mg oral morphine is reached without demonstrable benefit, the pain is unlikely to be opioid responsive. TAPER AND STOP.

If partial response **do not exceed 120mg daily** without specialist advice.

There is no evidence that one opioid is more effective than another.

Do not use a combination of opioids.

DO NOT initiate Fentanyl patches for non-cancer pain.

Consider Trial of Strong Opioid (see KMB 14)

Opioid naïve patients: titrate with immediate release morphine tablets or liquid. Aim for 30-50% reduction in pain intensity.

If reduction in pain is not achieved following a single dose of immediate relief morphine 20mg, pain is unlikely to be opioid responsive. TAPER AND STOP

Patients who have received 120mg to 180mg DHC OR Codeine daily: initiate 10mg morphine BD. Use cost effective modified release capsules. USE immediate release morphine up to six times daily PRN.

Review within 4 weeks: Patients who benefit from opioids long term will demonstrate a favourable response within 2-4 weeks.

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