

Optimising analgesia for adult inpatients with chronic or persistent non-malignant pain

This is a controlled document. If you are using a printed copy, check it against the guidelines site to ensure you are using the latest edition.

Print copies must be destroyed after use.

1. Pain assessment

Ask the patient to describe their pain using a pain assessment tool at rest and on function. Document worst pain score on the flowsheet. Assess for neuropathic pain descriptors and ask about what improves pain and what makes it worse.

2. Multimodal analgesia

Find out what the patient normally does to relieve their pain physically, psychologically, and pharmacologically and implement these measures where possible. Check notes to see if patient is seeing Chronic Pain Service as an outpatient and if they have a flare up plan. Involve pharmacist to reconcile medications. Optimise analgesia for any acute on chronic pain¹. Frail and/or older patients require significantly less opioid to achieve the same level of analgesia²: Initial doses should be reduced to 25-50% of the doses used in young healthy patients. Δ Think Kidney. These medications and their metabolites may also accumulate, especially in patients with renal impairment necessitating an increase in the dosing interval. In the older person with frailty (because of low muscle mass) eGFR may over-estimate renal function. Remember: codeine is broken down to morphine. Always refer to current BNF for specific drug and dose information³.

3. Neuropathic pain

With caution in older people: consider adding a small dose of a tricyclic antidepressant at night, e.g., amitriptyline 10mg (titrating upwards as side effects permit over a period of weeks to a maximum dose of 75mg at night³); and/or a regular anticonvulsant, e.g. gabapentin (titrate, as per BNF, according to side effects whilst observing liver and kidney function to a maximum of 3.6g daily in 3 divided doses³). Be mindful that concurrent prescription of drugs that manipulate serotonin may put the patient at risk of serotonin crisis. Concurrent prescription of gabapentin or pregabalin and opioids may cause sedation and respiratory depression⁴.

4. Consider asking for help

Patients with chronic pain frequently have complex needs. Seek help from pharmacy or the Inpatient Pain Team. Referral to the psychiatric liaison team for inpatient psychological input/mental health input or Chronic Pain Clinic as an Outpatient may be required.

Who to call for help?

Inpatient Pain Service: available in normal working hours:

- Respond to inpatients with complex pain issues
- Are able to liaise with colleagues in the Outpatient/Chronic Pain Team

Staff can contact the Inpatient Pain Nurse via EPIC orders or:

FPH Bleep 5252 or ext 134571 (Monday to Saturday 08:30-16:30)

WPH Bleep 4820 or ext 154435 (Monday to Friday 08:30-16:30)

HWD 07776633562 (or bleep 4820 if no response) (Tuesday to Saturday 08:30-16:30)

- Out of hours for urgent advice the owning medical team can contact the on-call anaesthetist on: FPH Bleep 5002 HWD/WPH 07768463877

When contacting the pain team or anaesthetist please ensure the patient's own medical team have reviewed and optimised the analgesia and that you have the patient's MRN to hand.

OUTPATIENT CHRONIC PAIN SERVICE ADMIN TEAM : 0300 6134201 option 4 option 4.

fhft.pain.clinic@nhs.net

5. Opioids

- Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for chronic or long-term pain.
- A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).
- The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit. Tapering or stopping high dose opioids needs careful planning and collaboration.
- If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available.
- If opioids are started or escalated during admission the intention to reduce once crisis has passed should be explained to patient and opioids reduced or before discharge with a clear plan for GP to review and reduce in community if patient discharged on new/additional opioids.
- Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.⁵

6. Converting from one opioid analgesic to another

Sometimes opioid switching is advised to reduce issues with tolerance. This usually requires specialist advice, e.g., from pain team or pharmacist. When switching opioids, one would normally mathematically underestimate the dose (except for tapentadol) as the patient may find the switched to formulation to be more potent than the switched from. The tables below are for guidance only.

What is equal to what dose of oral morphine table^{3, 6}

Drug	Equivalent to
Morphine 10mg IV/IM/SC	Morphine sulfate oral solution 30mg
Tramadol capsules/soluble tablets 100mg	Morphine sulfate oral solution 10mg
Codeine phosphate tablets/syrup 60mg	Morphine sulfate oral solution 6mg
Oxycodone immediate release capsules/liquid 5mg (6.6mg)	Morphine sulfate oral solution 10mg
Oxycodone modified release tablets 10mg	Oral morphine sulfate modified release 15mg
Tapentadol modified release tablet 50mg	Oral morphine sulfate modified release 20mg

Transdermal opioids: Approximate equivalence with oral morphine

Oral morphine equivalent (mg/24 hours)	12	24	30	48	60	84	120	126	168	180	240
Transdermal buprenorphine (micrograms/hour)	5	10		20		35		52.5	70		
Transdermal fentanyl (micrograms/hour)			12		25		50			75	100

Transdermal opioids take 12 to 24 hours to come to peak efficacy, are difficult to titrate to pain, and are not licensed or suitable for acute pain.

Buccal or sublingual immediate release fentanyl products must not be prescribed or administered for non-malignant pain.

References

1. FHFT [Optimising analgesia for adult inpatients with acute pain](#)
2. FHFT [Analgesia for managing acute pain in older people and/or those with frailty](#)
3. Joint Formulary Committee (2024) 'Prescribing in palliative care', in *British National Formulary*. Available at: <https://www.medicinescomplete.com/#/content/bnf/PHP107735> (Accessed: 4 November 2024).
4. MHRA drug safety update (2021) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/962557/F_eb-2021-DSU-PDF_final.pdf
5. Faculty of Pain Medicine (2020) Opioids Aware <https://fpm.ac.uk/opioids-aware>
6. Faculty of Pain Medicine (2020) Approximate equi-analgesic potencies of opioids for oral administration <https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/dose-equivalents-and-changing-opioids>

Full version control record

Version:	3
Guidelines Lead(s):	Karin Cannons, Nurse Consultant Pain Management Dr Mohjir Baloch, Consultant and Clinical Lead Outpatient/Chronic Pain Service
Contributor(s):	
Lead Director / Chief of Service:	Dr Subodh Tote, CoS for Anaesthetics
Library check completed:	04 November 2024
Ratified at:	Anaesthetic Clinical Governance: 22/01/25 Noted at Nursing and Midwifery Quality Board: 06/02/25 Noted at FHFT Drug and Therapeutics Committee: 12/02/25
Date Issued:	20 February 2025
Review Date:	February 2028
Pharmaceutical dosing advice and formulary compliance checked by:	Norsyakira Mahfuza, January 2025
Key words:	Chronic pain, persistent non-malignant pain, chronic non-malignant pain

This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1	Oct 2018	K Cannons, C Roques B Nawarski	Final	First trust-wide guideline
2	Dec 2021	K Cannons, C Roques B Nawarski	Final	Scheduled review
3	Jan 2025	K Cannons	Final	Revised ready for sign off

Related Documents

Document Type	Document Name
Guideline	Optimising analgesia for adult inpatients with acute pain
Guideline	Analgesia for managing acute pain in older people and/or those with frailty