**Key Points in Pain Management**

See [Scottish Palliative Care Guidelines](http://www.palliativecareguidelines.scot.nhs.uk/)

See also [GGC Palliative Care website](http://www.palliativecareggc.org.uk/) for information / links

* Assessment is key e.g. is the pain likely to respond to opioids? Remember that not all pains will respond to opioids

* Morphine should be the first line oral opioid
* Avoid prescribing opioids with decimal points!
* Be careful with medicine selection on EMIS/VISION – the most concentrated form of an opioid may be the first one to appear on the drop down menu
* Codeine / dihydrocodeine 10mg orally ~ morphine 1mg orally
* Morphine 10mg orally ~ morphine 5mg SC ~ diamorphine 3mg SC
* Morphine 10mg orally ~ oxycodone 5mg orally
* Seek specialist input if considering fentanyl
  + Only for stable pain
  + Large dose equivalence range
  + Slow to reach ‘steady state’
  + Long residual action when removed
* Hydromorphone / alfentanil / methadone require specialist advice
* Remember to co-prescribe an anti-emetic at the start of opioid therapy e.g. metoclopramide / haloperidol
* Remember a laxative for all patients on opioids (stimulant and softener) - patients on transdermal fentanyl may need less laxatives
* Remember CD prescription requirements - dose must be included for all preparations, ‘as directed’ is not sufficient
* Consider the WHO analgesic ladder - prescribe paracetamol and add stronger analgesic to this
* NSAIDs can be very useful for some pains
* Adjuvant therapy particularly for neuropathic pain