NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Oral Analgesia, (adult/ surgical) Queen Elizabeth University Hospital

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Approval Group:	South Sector Clinical Governance Forum

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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		Effective From	January 2023
	Acute Pain Service Guidelines (Adult / Surgical) **Oral Analgesia**	Review Date	January 2025
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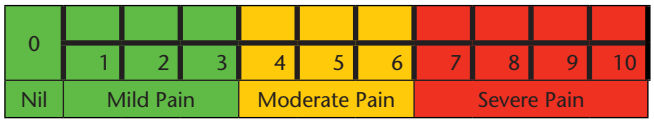
When there are no contraindications, the oral route is the route of choice for the administration of most analgesic drugs being simple, effective and well tolerated by most patients.
Two or three drugs may be used in combination to manage severe acute pain as the combination of medications with different sites of action improves pain relief. This is called "multimodal analgesia".
Medication should be taken regularly at sufficient doses to achieve patient comfort.
Recognising a person in pain should lead to thorough pain assessment, with the development of a treatment plan based on the "Analgesic Ladder".

Step 1: Mild Pain = Pain Score 1-3
PARACETAMOL up to 1g* four times daily



Step 2: Moderate Pain = Pain Score 4-6
Paracetamol up to 1g four times daily +
Dihydrocodeine 30mg four times daily
OR
Paracetamol up to 1g four times daily
CODEINE 30mg four times daily
OR
PARACETAMOL 1g* + TRAMADOL 50mg-100mg four times daily
Paracetamol up to 1g four times daily
Consider addition of NSAID if: No history of peptic ulceration, asthma, aspirin sensitivity, renal impairment, bleeding problems, caution in patients aged > 65

Step 3: Severe Pain = Pain Score 7-10
Paracetamol up to 1g four times daily + Dihydrocodeine 30mg four times daily
OR
PARACETAMOL* up to 1g + codeine 30-60 mg
OR
PARACETAMOL* up to 1g + TRAMADOL 50mg–100mg four times daily

Consider addition of NSAID if: No history of peptic ulceration, asthma, aspirin sensitivity, renal impairment, bleeding problems, caution in patients aged > 65
AND
Immediate release MORPHINE 5-10mg 1-2hrly as required for breakthrough pain (reduce dose in elderly)
Modified release opioids should not routinely be prescribed for the management of Acute Pain (unless part of a specific Protocol) and should have a planned discontinuation date.
Immediate release (IR) oral morphine or oxycodone as required for breakthrough pain, as per local protocol
Oral morphine (IR) 10mg equivalent to oxycodone (IR) 5mg
Patients should not receive step 2 opioids if recieving modified release (MR) opioids (e.g. Zomorph/Oxypro)

***Paracetamol**

Oral Paracetamol: 1g four times daily (usual maximum dose). Consider dose reduction in patients with low body weight (< 50kg), renal/liver impairment or chronic malnourishment, chronic alcoholism to 15mg per kg dose. (Up to four times daily: refer to therapeutics handbook).

Only prescribe co-codamol if patient already takes this at home. For new prescriptions always prescribe paracetamol and dihydrocodeine or codeine separately. See Therapeutic Handbook

****Co-codamol 30/500** contains Paracetamol therefore dosage adjustment may be required (see above).

It is unrealistic to expect patients will be pain free; the goal of acute pain management is to **optimise analgesia to achieve good functional ability** with minimal adverse side effects.

Drug	Uses	Side effects
Paracetamol	Good for mild pain. Improves effects of other analgesics for moderate to severe pain. Can be used at any step of the ladder.	Generally very safe.
NSAIDs e.g. Ibuprofen or Naproxen	Good for mild / moderate pain but useful for most nociceptive pain. Can be used at any step of the ladder.	Risk must be individually assessed. **CONTRAINDICATED:-** aspirin or NSAID hypersensitivity (caution with asthma) heart failure renal insufficiency (oliguria, hypotension) history GI ulceration bleeding issues CAUTION:- patients > 65 years
WEAK OPIOIDs e.g. Codeine or Dihydrocodeine Tramadol	Good for moderate pain. May ease neuropathic pain	Generally safe but may cause:- nausea / vomiting constipation itch sleepiness / dizziness / confusion (potential over sedation) respiratory depression. More likely to affect the elderly, frail or renal impairment; use half dose
STRONG OPIOIDs e.g. Morphine such as Oramorph or Sevredol. N.B. Morphine is prescribed on an **age-related** basis rather than weight.	Good for moderate / severe pain.	Same as weak opioids. Morphine (immediate release) **Caution** in frail patients or renal impairment ≤ 70 years 10 mg Morphine every 1 - 2 hours (monitor sedation level and respiratory rate). > 70 years, is frail, or has renal or liver impairment 5mg every 1 - 2 hours (monitor sedation and respiratory rate). **Suggest review if >3 doses required within 6 hours.**

NOTE: check in BNF or GG&C Therapeutics Handbook before prescribing for a patient

References

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