key points

SELECTED BY
Dr Linden Ruckert
GP, North London

The SIGN guidelines are used across the UK and outline the basic knowledge expected of a non-palliative care specialist. They were published in June 2000 and since that time there have been further developments in the use of alternative opioids. The management of incident pain and opioid toxicity are not covered in depth by the guidelines.

In acute on chronic pain in the terminal stages of an illness, changing the dose of a fentanyl patch will produce a relatively slow change in plasma levels. The easiest and most effective way to control pain is to supplement the patch using continuous subcutaneous infusion (CSCI) of opioid via a syringe driver.

Incident pain, which is pain caused by an action of the patient, such as movement, is a particular problem with bone metastases. It is best managed with the prophylactic use of a normal-release opioid, for example oral transmucosal fentanyl citrate (OTFC). Fentanyl is rapidly absorbed from the buccal mucosa, with onset of pain relief in five to ten minutes and a peak plasma level in 20 minutes. Duration of action is about two hours. There is no relationship between the baseline opioid dose and the dose of OTFC required to manage breakthrough pain.

It is important to take a careful pain history, as patients often have more than one pain and these may have different aetiologies. For example, the patient may need gabapentin for the neuropathic element.

'Terminal agitation' is often a manifestation of delirium. Frequent precipitants include infection, metabolic derangement and drugs, such as opioids, which give rise to opioid toxicity. Opioid toxicity may produce hyperalgesia and allodynia: patients complain that they are 'sore all over', with any touch being painful. Failure to recognise this rare phenomenon may lead to further escalation of the opioid dose and worsening of the problem. Haloperidol is the treatment of choice for delirium and is particularly useful for treating vivid distressing dreams and hallucinations. Haloperidol 2.5–5mg can be added to the SC infusion for symptomatic relief.

There are several opioids available in the UK. These vary in their physiochemical properties and there appears to be genetic polymorphism in the opioid receptors found in the population. These factors result in a variation in intensity of analgesic effect and differences in the degree of severity of opioid side-effects. Unfortunately, at present one cannot predict who will tolerate which opioid best.

When switching between opioids, conversion tables should be consulted. It is safest to reduce the dose of the new opioid by one-third to allow for the fact that the patient will have developed some tolerance to the new opioid through previous opioid exposure.