Northern Care Alliance NHS Group

Management of pain COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Patients may experience pain due to existing co-morbidities, but may also develop pain as a result of excessive coughing or immobility. Such symptoms should be addressed using existing approaches to pain management.

Patient on no analgesics - mild pain

- Step 1:
  - start **regular** paracetamol (usual dose 1g four times a day)
  - dose reduction is advisable in old age, renal impairment, weight <50kg, etc
- Step 2:
  - persistent or worsening pain: stop paracetamol if not helping pain
  - start codeine 30-60mg four times a day **regularly**
- Step 3:
  - maximum paracetamol and codeine, persistent or worsening pain: stop paracetamol if not helping pain
  - stop codeine
  - commence strong opioid (e.g. oral morphine)

****NSAIDS contraindicated in COVID-19**** (Day, 2020)

Commencing strong opioids

- start either an immediate-release (IR) or a modified-release (MR) preparation
- ALWAYS prescribe an immediate-release morphine preparation prn
- starting dose will depend on existing analgesia – calculate dose required
- monitor the patient closely for effectiveness and side effects
- always prescribe laxatives alongside strong opioids
- always prescribe an antiemetic regularly or prn

Suggested starting doses

- opioid-naïve/frail/elderly
  - morphine 2.5-5mg PO IR 4 hourly
- previously using regular weak opioid (e.g. codeine 240mg/24h)
  - morphine 5mg PO IR 4 hourly or MR 20-30mg BD
  - frail/elderly: use lower starting dose of 2.5mg PO IR 4 hourly or MR 10-15mg BD
- eGFR <30
  - seek advice

Titrating oral opioid dose

- if adjusting the dose of opioid, take prn doses into account
- check that the opioid is effective before increasing the dose
- increments should not exceed 33-50% every 24 hours
- titration of the dose of opioid should stop when either the pain is relieved or unacceptable side effects occur
- if pain control achieved on IR consider conversion to MR opioid (same 24-hour total dose)
- seek specialist advice if analgesia titrated 3 times without achieving pain control / 3 or more prn doses per day / total daily dose of oral morphine over 120mg / day unacceptable side effects

When the oral route is not available

- if analgesic requirements are stable - consider transdermal patches (e.g. buprenorphine, fentanyl)
- if analgesic requirements are unstable consider initiating subcutaneous opioids
- seek specialist advice if necessary
- morphine is recommended as the first line strong opioid for subcutaneous use for patients, except for patients who have been taking oral oxycodone or those with severe renal impairment
- if constant pain, prescribe morphine 4 hourly SC injections or as 24-hour continuous infusion via a syringe driver (McKinley T34)
- conversion from oral to SC morphine: oral morphine 5mg ≈ SC morphine 2.5mg
- wide inter-individual variation exists and each patient should be assessed on an individual basis
- prn doses of 1/10 to 1/6 of regular 24-hour opioid dose should be prescribed 2-4 hourly SC prn