Cancer Pain – Adult

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

Note: This consensus algorithm excludes pediatrics (see Cancer Pain - Pediatric algorithm), patients who are in the ICU, pre-procedural settings, perioperative (see Peri-Operative Pain Management algorithm), or currently receiving epidural or intrathecal analgesia.

TABLE OF CONTENTS

- Pain Assessment and Treatment - Inpatient ................................................................. Page 2
- Pain Assessment and Treatment - Outpatient ............................................................. Page 3
- Quick Reference Guide ............................................................................................. Page 4
- APPENDIX A: Comprehensive Pain Assessment ....................................................... Pages 5-6
- APPENDIX B: Non-opioids ....................................................................................... Page 7
- APPENDIX C: Opioid Dose Consideration ................................................................. Pages 8-9
- APPENDIX D: Opioid Side Effects – Prevention and Management ......................... Pages 10-11
- APPENDIX E: Specialty Services Consultation Guidelines ....................................... Page 12
- APPENDIX F: Adjuvant “Co-analgesics” for Neuropathic Pain Syndromes and Chronic Pain ........... Pages 13-14
- APPENDIX G: Pain Management Education for Patient and Family Prior to Discharge .......................... Pages 15-16
- APPENDIX H: Equianalgesic Opioid Dose Conversion ........................................... Pages 17-18
- APPENDIX I: Treatment Services ............................................................................. Page 19
- APPENDIX J: Fentanyl .............................................................................................. Pages 20-21
- APPENDIX K: Patient Controlled Analgesia (PCA) .................................................. Page 22
- Suggested Readings ................................................................................................. Pages 23-24
- Development Credits ............................................................................................... Page 25

Department of Clinical Effectiveness V13
Approved by The Executive Committee of the Medical Staff on 05/16/2023
Cancer Pain – Adult (Inpatient)

**Assess for pain** and personalized pain goal (PPG)

- **Pain score ≤ 3 and/or PPG met**
  - For patients not previously receiving opioids: choose non-opioids (Appendix B) or if contraindicated, use weak opioids (Appendix C), as needed for pain
  - For patients currently taking opioids:
    - If no side effects, continue current scheduled opioid regimen. For breakthrough pain, prescribe short acting opioids (Appendix C) as 10-20% of 24 hour opioid dose every 4 hours as needed. If patient is taking more than 4 breakthrough doses/24 hours, may consider increasing scheduled opioids by 20-30%.
    - Manage opioid induced side effects (Appendix D); if indicated, may benefit from decrease/change in opioids
  - Consider specialty consult

- **Pain score ≥ 4 and/or PPG not met**
  - For patients not previously on opioids: administer short-acting opioids - choose from weak or strong opioids (Appendix C)
  - For patients currently taking opioids:
    - Increase opioid dose
      - Consider increasing scheduled opioid dose by 30-50%
      - Calculate short-acting opioid dose as 10-20% of prior 24 hour opioid dose
      - Manage opioid induced side effects (Appendix D); if indicated, may benefit from decrease/change in opioids
      - Consider specialty consult

**Manage both pain and psychosocial distress**:

- Rapidly titrate short-acting opioids
- If significant anxiety related to pain, administer opioids prior to sedating anxiolytics
- Consider specialty consult
- Ongoing assessment for pain, distress and opioid side effects until patient stable

**Reassess pain, PPG, and opioid side effects**

- For patients not previously receiving opioids: choose non-opioids (Appendix B) or if contraindicated, use weak opioids (Appendix C), as needed for pain
- For patients currently taking opioids:
  - If no side effects, continue current scheduled opioid regimen. For breakthrough pain, prescribe short acting opioids (Appendix C) as 10-20% of 24 hour opioid dose every 4 hours as needed. If patient is taking more than 4 breakthrough doses/24 hours, may consider increasing scheduled opioids by 20-30%.
  - Manage opioid induced side effects (Appendix D); if indicated, may benefit from decrease/change in opioids
  - Consider specialty consult

**Reassess as clinically appropriate based on patient’s condition**

- Pain decreased and/or PPG met:
  - Reassess pain, PPG, and opioid side effects
  - Pain decreased and/or PPG met?
    - Yes
      - Reassess pain, PPG, and opioid side effects
    - No
      - Titrate scheduled and short-acting opioids
      - Consider consult to specialty services
      - Reassess pain, PPG, and opioid side effects

- Pain crisis
  - Rapidly titrate short-acting opioids
  - If significant anxiety related to pain, administer opioids prior to sedating anxiolytics
  - Consider specialty consult
  - Ongoing assessment for pain, distress and opioid side effects until patient stable
  - Continue current analgesic regimen
  - Consider starting or adjusting scheduled opioid dose if using > 3 short-acting doses in a 24 hour period

**NOTE: For all patients:** Consider using appropriate adjuvants (Appendix F) and/or complementary therapies, bowel regimen (Appendix D), patient education (Appendix G), and psychosocial support (Appendix E) as appropriate
Assess for pain\(^1\) and personalized pain goal (PPG)\(^2\)

- Pain score ≤ 3 and/or PPG met
  - For patients not previously receiving opioids: choose non-opioids (Appendix B) or if contraindicated, use weak opioids (Appendix C)
  - For patients currently taking opioids:
    - Continue analgesic regimen. Prescribe short-acting opioids, as 10-20% of 24 hour scheduled opioid dose, every 2-4 hours as needed. If patient is taking > 4 breakthrough doses/24 hours, may consider increasing scheduled opioids by 20-30%
    - Manage opioid induced side-effects (Appendix D); if indicated, may benefit from decrease/change in opioids

- Pain score ≥ 4 and/or PPG not met
  - For patients not previously receiving opioids: choose from weak or strong opioids (Appendix C)
  - If pain expected to be continuous, consider scheduling opioids around the clock or long-acting opioids (Appendix C)
  - For patients currently taking opioids:
    - Scheduled opioid: increase dose by 30-50% of prior scheduled dose or equal to calculated prior 24 hour opioid dose, whichever is higher. Administer as around the clock regimen of short-acting opioids or long-acting opioids.
    - Calculate short-acting opioids as 10-20% of new opioid regimen and administer every 2 hours as needed
    - For opioid induced neurotoxicity (OIN): consider hospitalization and evaluation in the emergency room, opioid rotation (Appendix H), and/or specialty consultation
    - Manage other side effects if present (Appendix D)
    - Consider specialty consultation

Consider referral to Chronic Pain or Supportive Care, evaluation in Acute Cancer Care Center or hospitalization

Reassess pain, opioid side effects and PPG as clinically indicated

- Side effects resolved and PPG met?
  - Yes
    - Continue analgesic and bowel regimen, education and psychosocial support as appropriate
  - No
    - Consider specialty consultation for uncontrolled pain and/or side effect management

Pain crisis\(^6\)

\(^1\) See Appendix A for Comprehensive Pain Assessment
\(^2\) Refer to Pain Management Policy (#CLN0540)
\(^3\) Opioid induced neurotoxicity (OIN) symptoms include drowsiness, cognitive impairment, confusion, hallucinations, myoclonic jerks
\(^4\) Specialty consultation services that specialize in pain management: Acute Pain, Chronic Pain, Palliative/Supportive Care, and Integrative Medicine (see Appendix E for description of services)
\(^5\) Opioid induced gastrointestinal side effects: constipation, nausea, emesis (see Appendix D)
\(^6\) Pain crisis or emergency is defined as severe pain, new onset or exacerbation of previously stabilized pain, accompanied by significant distress or if present > 24 hours

Note: For all patients: Consider using appropriate adjuvants (Appendix F) and/or complementary therapies, bowel regimen (Appendix D), patient education (Appendix G), and psychosocial support (Appendix E) as appropriate
Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

Cancer Pain – Adult

Department of Clinical Effectiveness V13
Approved by The Executive Committee of the Medical Staff on 05/16/2023

Quick Reference Guide

- **Opioid naïve**: Includes patients who are not chronically receiving opioid analgesics on a daily basis and therefore have not developed significant tolerance
- **Opioid tolerant**: Patients who are chronically receiving opioid analgesics on a daily basis. The FDA identifies this group as those receiving at least one of the following for at least 1 week:
  - Morphine 60 mg orally daily
  - Oxycodone 30 mg orally daily
  - Oxymorphone 25 mg orally daily
  - Hydrocodone 60 mg orally daily
  - An equivalent dose of another opioid
- **Incomplete cross-tolerance**: Reduce dose of new opioid by 30-50% when switching from one opioid to another to account for tolerance to a currently administered opioid that does not extend completely to other opioids. Consequently, this phenomenon tends to lower the required dose of the new opioid.
- **Dose titration**: Adjusting the dose of an opioid should be individualized for each patient; refer to Page 3 of this algorithm for titration recommendations
- **Dosing frequency**: For long-acting opioids, dosing frequency is typically every 8-24 hours depending on the agent. Refer to Appendix D for Opioid Dose Considerations.
- **Breakthrough pain**: Doses of short-acting opioids for breakthrough pain should be 10-20% of the total daily dose given every 1-4 hours as needed. Breakthrough opioids can be given as frequently as every 1 hour for oral doses or every 15 minutes if IV (assuming normal renal/hepatic function).
- **Elderly/organ dysfunction**: Use additional caution when converting opioids in elderly patients (age ≥ 65 years), and/or patients with hepatic, renal, or pulmonary dysfunction. Codeine, morphine, hydromorphone, and oxycodone should be used with caution in patients with decreased renal function.
- **Opioids NOT recommended for cancer pain**: Meperidine and mixed agonist-antagonists (pentazocine, nalbuphine, butorphanol) should be avoided
- **Withdrawal symptoms**: Nausea, vomiting, diarrhea, anxiety, and shivering are common symptoms of opioid withdrawal. A gradual taper is recommended when discontinuing opioids.
- **Overdose**: Symptoms may include respiratory depression, constricted pupils, and decreased responsiveness. Naloxone is used to reverse the effects of an opioid. To administer, dilute naloxone 0.4 mg/mL (1 mL) ampule into 9 mL of sodium chloride 0.9% (NS) for total volume of 10 mL to achieve a 0.04 mg/mL concentration, and give 0.5 mL (0.02 mg) via slow IV push every 2 minutes until patient is more awake and respiratory status improves. DO NOT administer undiluted due to risk of precipitating rapid withdrawal, which may cause severe pain or seizures.
- **Chemotherapy-related, intermittent pain**: This type of pain may be managed with weak opioids (e.g., tramadol) or combination opioid preparations (e.g., hydrocodone with acetaminophen, etc.). See Appendix D for Opioid Dose Considerations, or refer to a drug information reference for additional information.
- **Constipation** is a common side effect with opioid use. Consider starting a bowel regimen in all patients taking opioids. Refer to Appendix E.
- **Duration of drug effect**: Any residual drug in the patient’s system must be accounted for and an assessment of any residual effects from discontinued long-acting opioids must be made before any new opioid is started. Example: fentanyl will continue to be released from the skin 12-36 hours after transdermal patch removal.
- **The Texas Prescription Monitoring Program (PMP)** is an electronic database that tracks controlled substance prescriptions. It can help identify patients who may be misusing prescription opioids or other prescription medications and who may be at risk for overdose. Clinicians are encouraged to check the Texas PMP prior to initial opioid prescribing and at regular intervals. The program is now available through OneConnect and can also be accessed at https://texas.pmpaware.net/login
The comprehensive pain assessment should include the following:

1. **Pain**:
   a. For each site of pain, determine intensity level using the appropriate pain assessment tool (see below). Tools using 0 to 10 point scales can be categorized as follows:
      - 0 = no pain, 1-3 = mild pain, 4-6 = moderate pain, 7-10 = severe pain
   b. Assess the following at rest and with activity: location and orientation, type (acute, chronic, acute exacerbation of chronic pain), onset, pathophysiology (somatic, visceral, neuropathic), frequency (continuous, intermittent, breakthrough, incidental), temporal factors such as aggravating and alleviating factors, duration, and etiology (e.g., tumor, non-tumor related, fracture)
   c. Evaluation of medical history includes: oncologic or other significant medical illnesses, medication history, relevant imaging and laboratory studies
   d. Physical examination
   e. Assess for presence of sedation and other opioid side effects (Appendix D)

### Adult Pain Assessment Tools

**Selection of the Appropriate Pain Assessment Tool**

- **Adult Patient Age ≥ 18 years (not intubated/mechanically ventilated)**
  - Cognitively intact and Able to subjectively communicate pain level
    - Numeric Rating Scale
    - Wong-Baker FACES scale
  - Not able to subjectively communicate pain level, nonverbal
    - Revised FLACC (face, legs, activity, cry, consolability) scale (r-FLACC)

- **Adult Patient Age ≥ 18 years and intubated/mechanically ventilated (ICU/PICU)**
  - Sedated and/or Not able to subjectively communicate pain level, nonverbal
    - Behavioral Pain Scale (BPS)
    - Wong-Baker FACES scale
  - Not Sedated
    - Cognitively intact and Able to subjectively communicate pain level
      - Numeric Rating Scale

---

1 The Numeric Rating Scale is the first choice for adult patients who are able to subjectively communicate pain level unless deemed appropriate based on patient preference.
APPENDIX A: Comprehensive Pain Assessment - continued

2. Function:
   a. Evaluate patient’s ability to ambulate, perform activities of daily living (ADL), range of motion (ROM), deep breathing, and coughing
   b. Assess restrictions related to pain
   c. Document patient’s functional ability

3. Psychosocial issues:
   a. Evaluate patient distress, family support, psychiatric history, patient/family knowledge and beliefs surrounding pain and its management, and risk factors for under treatment of pain including underreporting, prior treatment of pain and response to other pain medications, concerns about addiction to pain medications or side effects, extremes of age, gender, cultural barriers, communication barriers, and prior history of drug abuse
   b. Document patient’s assessment of psychological distress

4. Personalized Pain Goal (PPG):
   Determine the verbal or written goal stated by the patient describing the desired level/intensity of pain that will allow the patient to achieve comfort in physical, functional, and psychosocial domains

In addition to Comprehensive Pain Assessment, rule out or treat pain related to oncologic emergencies

---

1 Pain related to an oncologic emergency requires assessment and treatment (e.g., surgery, steroids, radiotherapy, antibiotics) along with an emergent consultation. Examples of oncologic emergencies include:

- Bowel obstruction/perforation
- Leptomeningeal metastasis
- Brain metastasis
- Fracture or impending fracture of weight-bearing bone
- Epidural metastasis/spinal cord compression
- Pain related to infection
APPENDIX B: Non-opioids

CAUTION: All of these agents are antipyretic and may mask fever; use with caution in patients on myelosuppressive chemotherapy. Non-steroidal anti-inflammatory drugs (NSAIDs) may have antiplatelet effects that can increase the risk of bleeding in patients who are thrombocytopenic or receiving myelosuppressive chemotherapy and likely to become thrombocytopenic. Non-acetylated salicylates (e.g., salsalate, choline magnesium trisalicylate and the COX-2 selected NSAID celecoxib) may have less effects on platelets, but should still be used with caution in a patient receiving myelosuppressive chemotherapy.

Non-opioids include acetaminophen and NSAIDs; they may be used alone or in combination with opioids for pain management. NSAIDs are useful adjuvant analgesics for bone pain.

**Recommended Starting Doses:** The choice of non-opioid must depend on the individual risk/benefit balance for each patient. The mechanism of action and side effect profile of each option is different.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Recommended Starting Dose</th>
<th>Maximum Daily Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>500-1,000 mg PO every 6 hours as needed</td>
<td>Single dose: 1,000 mg/dose; Daily dose: Weight &lt; 50 kg: 3,750 mg; Weight ≥ 50 kg: 4,000 mg¹</td>
<td>At higher doses, can cause fatal hepatotoxicity and renal damage. Avoid use in hepatic dysfunction. Does not have anti-inflammatory effect.</td>
</tr>
<tr>
<td></td>
<td>650 mg IV every 4 hours 1,000 mg IV every 6 hours</td>
<td>IV acetaminophen is formulary restricted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>650 mg PR every 6 hours as needed</td>
<td>Use rectal route with caution in patients with thrombocytopenia and/or neutropenia</td>
<td></td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>200-800 mg PO every 6 hours as needed</td>
<td>3,200 mg²</td>
<td>Inhibits platelet aggregation, can cause gastrointestinal side effects or renal failure. Use with caution in patients at high risk³.</td>
</tr>
<tr>
<td>Naproxen</td>
<td>500 mg PO initial, then 250 mg every 4 hours as needed</td>
<td>1,500 mg</td>
<td>Inhibits platelet aggregation, can cause gastrointestinal side effects or renal failure. Use with caution in patients at high risk³.</td>
</tr>
<tr>
<td>Celecoxib</td>
<td>200-400 mg PO every 12 or 24 hours as needed</td>
<td>400 mg</td>
<td>Does not affect platelet aggregation; can cause renal insufficiency</td>
</tr>
<tr>
<td>Ketorolac</td>
<td>15-30 mg IV or PO every 6 hours as needed</td>
<td>120 mg</td>
<td>Evaluate after 8 doses and limit treatment to 5 days. Reduce dose by 50% if age &gt; 65 years old or weight &lt; 50 kg. Use is contraindicated in patients with advanced renal impairment or patients at risk for renal failure due to volume depletion. Inhibits platelet aggregation and can cause gastrointestinal side effects.</td>
</tr>
</tbody>
</table>

¹ Manufacturers of over-the-counter acetaminophen recommend no more than 3,000 mg daily
² Due to increased adverse effects with higher doses, recommended maximum daily dose for chronic use is 2,400 mg
³ Patients at high risk of serious gastrointestinal side effects or renal damage from NSAIDs include: elderly (age > 60 years), smokers, previous history of peptic ulcer, currently receiving corticosteroids, anticoagulants, or presence of existing renal, cardiac or liver impairment
<table>
<thead>
<tr>
<th>Opioid</th>
<th>Initial short-acting dose in an opioid naïve patient</th>
<th>Onset (minutes)</th>
<th>Peak effect (hours)</th>
<th>Duration (hours)</th>
<th>Initial scheduled dosing in opioid naïve patients</th>
<th>Available oral dose formulations</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Route Dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>PO IV/SC 30-60 mg N/A</td>
<td>30-60</td>
<td>1-1.5</td>
<td>4-8</td>
<td>Short-acting: 30-60 mg every 6 hours Long-acting: N/A</td>
<td>Short-acting 1: 15, 30, 60 mg tablets Long-acting: N/A</td>
<td>Available alone or in combination with 300 mg acetaminophen. Avoid use in renal and/or hepatic dysfunction.</td>
</tr>
<tr>
<td>Tramadol</td>
<td>PO IV/SC 25-50 mg N/A</td>
<td>30-60</td>
<td>1.5</td>
<td>3-7</td>
<td>Short-acting: 25 mg PO every 6 hours Long-acting: 100 mg ER daily</td>
<td>Short-acting (IR) 1: 50 mg tablets; Long-acting (ER) 3: 100, 200, 300 mg tablets</td>
<td>Increased risk of serotonin syndrome. May lower seizure threshold. Maximum daily dose 400 mg; consider lower doses if history or increased risk of seizures. Use with caution in renal and/or hepatic dysfunction.</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>PO 50-100 mg</td>
<td>&lt;60</td>
<td>1.25-1.5</td>
<td>4-6</td>
<td>Short-acting: PO every 4-6 hours Long-acting: PO every 12 hours</td>
<td>Short-acting 1: 50, 75, 100 mg tablets Long-acting 3: 50, 100 mg tablets</td>
<td>Avoid MAOIs, SSRIs, or SNRIs due to potential risk for serotonin syndrome. Maximum daily doses: tapentadol IR 600 mg and tapentadol ER 500 mg. Use with caution in renal and/or hepatic dysfunction. Avoid use if creatinine clearance &lt; 30 mL/minute.</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>PO IV/SC 5-10 mg N/A</td>
<td>10-20</td>
<td>1-3</td>
<td>4-8</td>
<td>Short-acting: 5-10 mg PO every 6 hours Long-acting: hydrocodone ER (Hysingla®ER) 20 mg PO once daily hydrocodone ER (Zohydro® ER) (non-formulary) PO 10 mg every 12 hours</td>
<td>Short-acting 1: 5, 7.5, 10 mg tablets; 2.5 mg/5 mL liquid, in combination with acetaminophen 2 Long-acting 3: hydrocodone ER (Hysingla®ER) 20, 30, 40, 60, 80, 100, 120 mg tablets hydrocodone ER (Zohydro® ER) (non-formulary) 10, 15, 20, 30, 40, 50 mg tablets</td>
<td>Doses greater than 160 mg/day of hydrocodone ER (Hysingla® or Zohydro® ER) have been associated with increased risk of QTc prolongation. Use with caution in renal and/or hepatic dysfunction.</td>
</tr>
</tbody>
</table>

1 Short acting formulations may be given via enteral tubes (e.g., nasogastric tube, percutaneous endoscopic gastrostomy (PEG) tube, gastric tube)  
2 Must consider all forms of acetaminophen (combination and individual) when determining total daily dosing. Manufacturers of over-the-counter acetaminophen recommend no more than 3,000 mg daily.  
3 Do not crush, chew, or dissolve long-acting formulations  
4 When used with TCAs, MAOIs, SSRIs, or SNRIs, or 2D6 or 3A4 inhibitors  
5 Avoid use of tramadol ER when creatinine clearance < 30 mL/minute
APPENDIX C: Opioid Dose Consideration (Weaker medications are listed at the beginning of Appendix C) - continued

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Initial short-acting dose in an opioid naïve patient</th>
<th>Onset (minutes)</th>
<th>Peak Effect (hours)</th>
<th>Duration (hours)</th>
<th>Initial scheduled dosing in opioid naïve patients</th>
<th>Available oral dose formulations</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Route 1</td>
<td>Dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>PO</td>
<td>5-15 mg</td>
<td>30</td>
<td>0.5-1</td>
<td>3-6</td>
<td>Short-acting: 5-10 mg PO every 4 hours; 2-4 mg IV every 4 hours</td>
<td>Short-acting 1: 15, 30 mg tablets; 10 mg/5 mL, 20 mg/5 mL, 20 mg/mL liquid Long-acting 2: 15, 30, 60, 100, 200 mg tablets</td>
</tr>
<tr>
<td></td>
<td>IV/SC</td>
<td>2-3 mg</td>
<td>5-10</td>
<td>-</td>
<td>-</td>
<td>Long-acting: 15 mg PO every 12 hours, or 20 or 30 mg PO once daily</td>
<td></td>
</tr>
<tr>
<td>Oxycodone</td>
<td>PO</td>
<td>5-10 mg</td>
<td>10-15</td>
<td>0.5-1</td>
<td>3-6</td>
<td>Short-acting: 5 mg PO every 4 hours Long-acting: 10 mg PO every 12 hours</td>
<td>Short-acting 1: 5, 10, 15, 30 mg tablets; 5 mg/5 mL, 20 mg/mL liquid Long-acting 2: 10, 15, 20, 30, 40, 60, 80 mg tablets</td>
</tr>
<tr>
<td></td>
<td>IV/SC</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>PO</td>
<td>5-10 mg</td>
<td>no data</td>
<td>0.5-1</td>
<td>3-6</td>
<td>Short-acting: 5 mg PO every 4 hours Long-acting: 5 mg PO every 12 hours</td>
<td>Short-acting 1: 5,10 mg tablets Long-acting 2: 5, 10, 15, 20, 30, 40 mg tablets</td>
</tr>
<tr>
<td></td>
<td>IV/SC</td>
<td>0.5 mg</td>
<td>5 - 10</td>
<td>N/A</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>PO</td>
<td>1-3 mg</td>
<td>15-30</td>
<td>0.5-1</td>
<td>3-5</td>
<td>Short-acting: 2 mg PO every 4 hours Long-acting: 8 mg PO every 24 hours</td>
<td>Short-acting 1: 2, 4, 8 mg tablets; 1 mg/mL liquid Long-acting 2: 8, 12, 16, 32 mg tablets</td>
</tr>
<tr>
<td></td>
<td>IV/SC</td>
<td>0.5-1.5 mg</td>
<td>15-30</td>
<td>N/A</td>
<td>4-5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Short acting formulations may be given via enteral tubes (e.g., nasogastric tube, percutaneous endoscopic gastrostomy (PEG) tube, gastric tube)
2 Do not crush, chew, or dissolve long-acting formulations
3 Must consider all forms of acetaminophen (combination and individual) when determining total daily dosing.

Manufacturers of over-the-counter acetaminophen recommend no more than 3,000 mg daily.
### Side Effect | Prevention | Management
---|---|---
**Sedation**<br>Inpatient setting: Assess sedation using the Richmond Agitation Sedation Scale (RASS) as indicated<br>• Discontinue other sedating medications if appropriate<br>• Educate all patients receiving opioids drowsiness may result for a few days following initiation or increase in opioid regimen<br>• Consider rotation or dose reduction of opioid if sedation persists<br>• Consider psychostimulant: 1. Methylphenidate (Ritalin®) 2.5-5 mg PO once or twice daily (last dose no later than 4 pm to avoid insomnia). Suggested times: 8 am and 12 noon daily. Needs controlled substance Class II (CII) prescription or<br>• Consider modafinil 100 mg once or twice daily

**Opioid induced neurotoxicity**<br>Risk factors: <br>• High opioid dose<br>• Dehydration<br>• Renal failure<br>• Preexisting borderline cognition and/or delirium<br>• Use of other psychoactive drugs<br>• Eliminate non-essential CNS activating or depressing drugs (e.g., benzodiazepines)<br>• Consider reversible causes such as metabolic disorders, liver or renal dysfunction, dehydration, hypercalcemia, organic brain disease; treat as appropriate.<br>• Consider one or more of the following: 1. Opioid rotation (see Appendix H) 2. Opioid dose reduction or discontinuation 3. Discontinue other offending drugs (benzodiazepines) 4. Hydration 5. Symptomatic treatment with haloperidol 1-5 mg PO, IV, or SC every 4 hours as needed<br>• Avoid using naloxone even if delirium is thought to be due to opioid use<br>• Refer to Delirium – Adult Inpatient algorithm as indicated

**Respiratory depression**<br>• Monitor sedation and respiratory status (respiratory rate and oxygen saturation) during the first 24 hours in opioid naïve patients<br>• Titrate opioids cautiously<br>• Consider dose reduction or opioid rotation if patient has excessive sedation<br>• Call MD, HOLD opioids, provide supplemental oxygen<br>• If patient minimally responsive or unresponsive and respiratory rate is ≤ 8 bpm, administer naloxone. Recommended dose: naloxone 0.4 mg diluted in 9 mL sodium chloride (0.9%) for total volume of 10 mL, give 0.5 mL (0.02 mg) via slow IV push every 2 minutes until patient is more awake and respiratory status improves. (Half life of naloxone is short and patient may need naloxone infusion for long-acting opioids. If no change with naloxone, rule out other causes for the respiratory depression.)<br>• If patient is actively dying, DNR (do not resuscitate) and receiving comfort care, naloxone administration may not be appropriate

---

**Disclaimer:** This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.
### APPENDIX D: Opioid Side Effects – Prevention and Management - continued

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Prevention</th>
<th>Management</th>
</tr>
</thead>
</table>
| Nausea, Vomiting    | • Nausea and vomiting may be associated with opioid initiation or high doses of opioids  
|                     | • Titrate opioid dose slowly and steadily  
|                     | • For patients at high risk of nausea consider scheduled antiemetics for 5 days and then adjust as needed | 1. Investigate for other causes of nausea [e.g., constipation, bowel obstruction, chemotherapy (refer to [Adult Antiemetic Management of Chemotherapy-Induced Nausea and Vomiting (CINV) algorithm](#)) or other medications] and treat per guidelines. Initiate scheduled antiemetics, if indicated.  
Example: metoclopramide 5 to 10 mg PO, IV, or SC every 6 hours  
2. Add or increase non-opioid or adjuvant medications for additional pain relief so opioid dose can be reduced  
3. If pain control/regimen is satisfactory, reduce opioid dose by 25%  
4. Consider opioid rotation if nausea remains refractory (see [Appendix H](#)) |
| Constipation        | Unless alterations in bowel patterns such as bowel obstruction or diarrhea exist, all patients receiving opioids should be started on laxative bowel regimen and receive education for bowel management.  
|                     | 1. Stimulant laxative:  
|                     | For example: senna 8.6 mg PO, 2 tablets/day and titrate up to maximum 9 tablets/day  
|                     | 2. Ensure adequate fluids, dietary fiber and exercise if feasible  
|                     | 3. Prune juice followed by warm beverage may be considered | 1. Assess potential causes of constipation (such as recent opioid dose increase, use of other constipating medications, new bowel obstruction)  
2. Increase senna and add 1 or both of the following:  
   a. Milk of magnesia oral concentrate (1,200 mg/5 mL) 10 mL PO 2-4 times daily  
   b. Polyethylene glycol (Miralax™) 17 grams in 8 ounce beverage PO daily  
3. If no response to above, perform digital rectal exam (DRE) to rule out low impaction (do not perform if neutropenic, thrombocytopenic, or post-operative bowel surgery)  
Continue above steps and  
• If impacted: disimpact manually if stool is soft. If not, soften with mineral oil fleet enema before disimpaction. Follow up with milk of molasses enemas until clear with no formed stools.  
• Consider use of short-acting analgesics before disimpaction  
• If not impacted on rectal examination, patient may still have higher level impaction. Consider abdominal imaging and/or administer milk of molasses enema along with 8 ounces of magnesium citrate orally.  
4. MethylNaltrexone (Relistor®) may be given to patients who meet the following criteria:  
• Patient experiencing opioid-induced constipation  
• Patient has not demonstrated an adequate response to other laxative therapy  
• Patient does not have a known or suspected mechanical gastrointestinal obstruction |
APPENDIX E: Specialty Services Consultation Guidelines

MD Anderson offers three coordinated pain specialty core services, consisting of Acute Pain Medicine, Chronic Pain Medicine and Palliative/Supportive Care, as well as Integrative Medicine.

Consult to one of the specialty core services should be considered for any patient whose pain remains uncontrolled for > 24 hours. Special patient population in which pain assessment and management may be especially challenging include the following:

- Substance use disorders - except tobacco (current or past history)
- Developmental disabilities
- Emotional, behavioral, and mental disorders
- Vision and hearing impairments and disabilities
- Cognitive disorders
- Refractory symptoms and dying patient
- Communicative disorders
- Cognitive disorders

<table>
<thead>
<tr>
<th>Type of Pain</th>
<th>Specialty Services Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postoperative and perioperative pain</td>
<td>Acute Pain Medicine and/or Integrative Medicine; refer to <a href="#">Peri-Operative Pain Management algorithm</a></td>
</tr>
<tr>
<td>Acute pain in inpatients</td>
<td>Chronic Pain Medicine in cases of pre-existing chronic pain</td>
</tr>
<tr>
<td>Chronic pain and no evidence of active cancer</td>
<td>Chronic Pain Medicine and/or Integrative Medicine</td>
</tr>
<tr>
<td>Evidence of active cancer with pain as the sole or predominant symptom</td>
<td>Chronic Pain Medicine, Palliative/Supportive Care Service, and/or Integrative Medicine</td>
</tr>
<tr>
<td>Evidence of active cancer and pain accompanied by multiple symptoms</td>
<td>Palliative/Supportive Care and/or Integrative Medicine</td>
</tr>
<tr>
<td>Pain in the context of cancer in the palliative stage or end of life</td>
<td></td>
</tr>
<tr>
<td>Suspected opioid addiction</td>
<td>Request a consult to one of the specialty core services for a referral to a treatment program. See Appendix I for Treatment Services.</td>
</tr>
</tbody>
</table>

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.
## APPENDIX F: Adjuvant “Co-analgesics” for Neuropathic Pain Syndromes and Chronic Pain

<table>
<thead>
<tr>
<th>Drug Class and Uses</th>
<th>Medication</th>
<th>Recommended Starting Dose</th>
<th>Maximum Daily Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anticonvulsants</strong> (various NP types)</td>
<td>Gabapentin</td>
<td>100-300 mg PO daily</td>
<td>3,600 mg PO per day in 3 divided doses</td>
<td>Used in PHN and NP. May cause drowsiness, dizziness, peripheral edema. Dose adjust for renal impairment.</td>
</tr>
<tr>
<td></td>
<td>Pregabalin</td>
<td>25-75 mg PO twice daily</td>
<td>600 mg PO per day in 3 divided doses</td>
<td>Used in DN, PHN, FM, and NP. May cause drowsiness, dizziness, peripheral edema. Dose adjust for renal impairment.</td>
</tr>
<tr>
<td></td>
<td>Carbamazepine</td>
<td>100 mg PO twice daily</td>
<td>1,200 mg PO per day in 2 divided doses</td>
<td>May cause acidosis, drowsiness, dizziness, nausea. Dose adjust for renal impairment and hepatic dysfunction.</td>
</tr>
<tr>
<td></td>
<td>Oxcarbazepine</td>
<td>150-300 mg PO daily</td>
<td>2,400 mg PO per day in 2 divided doses</td>
<td>Used in TGN and NP. Associated with aplastic anemia, agranulocytosis, bone marrow suppression, severe dermatologic reactions, hyponatremia. May cause drowsiness, dizziness, nausea. Significant drug interactions. Avoid in hepatic dysfunction.</td>
</tr>
<tr>
<td></td>
<td>Topiramate</td>
<td>25-50 mg PO twice daily</td>
<td>200 mg PO twice per day</td>
<td>Used in NP. May cause acidosis, drowsiness, dizziness, nausea. Dose adjust for renal impairment and hepatic dysfunction.</td>
</tr>
<tr>
<td></td>
<td>Tiagabine</td>
<td>4 mg PO at bedtime</td>
<td>8 mg PO per day</td>
<td>Used in NP. May produce seizures in patients with history of seizures. May cause drowsiness, dizziness, diarrhea. Use with caution if hepatic dysfunction. Higher doses result in increased side effects.</td>
</tr>
<tr>
<td><strong>Tricyclic Antidepressants</strong> (TCA)</td>
<td>Amitriptyline</td>
<td>10-25 mg PO at bedtime</td>
<td>150 mg PO at bedtime</td>
<td>Consider for continuous and shooting neuropathic pain. Caution in elderly or frail, or patients with glaucoma or arrhythmias. May cause sedation, arrhythmias, dry mouth, orthostasis, urinary retention.</td>
</tr>
<tr>
<td></td>
<td>Nortriptyline</td>
<td>10-25 mg PO at bedtime</td>
<td>75 mg PO at bedtime</td>
<td>Consider duloxetine for NP, DN and musculoskeletal pain. Caution in patients with seizures; avoid MAOIs, other SSRIs or SNRIs due to potential for serotonin syndrome. Duloxetine may increase the risk of bleeding events. Concomitant use of aspirin, NSAIDs, warfarin, and other anticoagulants may add to this risk. Taper slowly.</td>
</tr>
<tr>
<td></td>
<td>Desipramine</td>
<td>10-25 mg PO at bedtime</td>
<td>150 mg PO at bedtime</td>
<td></td>
</tr>
<tr>
<td><strong>Serotonin-Norepinephrine Reuptake Inhibitors</strong> (SNRI)</td>
<td>Duloxetine</td>
<td>20-30 mg PO daily</td>
<td>60 mg PO per day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Venlafaxine</td>
<td>37.5 mg PO daily</td>
<td>225 mg PO per day</td>
<td></td>
</tr>
</tbody>
</table>

DN = diabetic neuropathy  
NP = neuropathic pain  
FM = fibromyalgia  
MAOI = monoamine oxidase inhibitors  
PHN = postherpetic neuralgia  
SNRIs = serotonin-norepinephrine reuptake inhibitors  
TCAs = tricyclic antidepressants  
SNRIs = serotonin-norepinephrine reuptake inhibitors  
TGN = trigeminal neuralgia  
SSRIs = selective serotonin reuptake inhibitors  

Continued on next page
APPENDIX F: Adjuvant “Co-analgesics” commonly used for Neuropathic Pain Syndromes and Chronic Pain – continued

<table>
<thead>
<tr>
<th>Drug Class and Uses</th>
<th>Medication</th>
<th>Recommended Starting Dose</th>
<th>Maximum Daily Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Muscle relaxants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(muscle pain, spasm)</td>
<td>Baclofen¹</td>
<td>5 mg PO twice daily</td>
<td>80 mg PO per day in 3-4 divided doses</td>
<td>Caution in patients with seizures, cardiovascular disease, glaucoma, myasthenia gravis, renal or hepatic impairment, patients on TCAs or MAOIs, or advanced age. May cause anticholinergic effects and significant drowsiness.</td>
</tr>
<tr>
<td></td>
<td>Cyclobenzaprine</td>
<td>5 mg PO three times daily</td>
<td>30 mg PO per day in 3 divided doses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diazepam</td>
<td>2-10 mg PO three to four times daily</td>
<td>40 mg per day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metaxalone</td>
<td>400 mg PO three times daily</td>
<td>3,200 mg PO per day in 3-4 divided doses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methocarbamol</td>
<td>500 mg PO four times daily 1,000 mg IV every 8 hours</td>
<td>4,000 mg per day in 3-6 divided doses; IV for 3 days maximum if PO not possible</td>
<td>Methocarbamol IV: may repeat course after drug free interval of 48 hours</td>
</tr>
<tr>
<td></td>
<td>Tizanidine</td>
<td>2-4 mg PO at bedtime</td>
<td>36 mg per day in 2-3 divided doses</td>
<td></td>
</tr>
<tr>
<td><strong>Corticosteroids</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(inflammation, nerve compression)</td>
<td>Dexamethasone</td>
<td>Varies by clinical situation (IV or PO) Standard dose 4-16 mg/day</td>
<td>Varies by clinical situation</td>
<td>May cause impaired healing, infection, thrush, hyperglycemia, weight gain, myopathy, stomach upset, psychosis, emotional instability</td>
</tr>
</tbody>
</table>

¹Intrathecal formulation not on MD Anderson Cancer Center Formulary

MAOI = monoamine oxidase inhibitors
TCAs = tricyclic antidepressants

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.
APPENDIX G: Pain Management Education for Patient and Family Prior to Discharge

Management of cancer pain is an integral component of cancer care. Patient education in the following areas should be provided to patients.

1. **General Pain Education:** Specific teaching information is available in Patient Education-On Line. Education should include the following:
   A. Relief of pain is important and there is no benefit to suffering with pain
   B. Expect optimal treatment for pain and side effects
   C. Pain can usually be well controlled with oral medications. There are many options available to control pain.
   D. Non-drug treatments can also be helpful for pain relief. Some examples include:
      - Acupuncture
      - Heating pads or cold packs
      - Rest
      - Biofeedback
      - Imagery
      - Trancutaneous electrical nerve stimulation (TENS)
      - Breathing and relaxation exercises
      - Massage, pressure or vibration
      - Distraction
      - Prayer or meditation
   E. Communication with healthcare team is critical to pain management and avoiding serious side effects. Communication should include:
      - Patient understanding about how to rate their pain type, severity/intensity, and personalized pain goals (PPG). A numeric pain scale should be provided with explanation.
      - Potential problems or side effects of pain medications
      - Concerns about difficulty in obtaining medications (such as cost or inadequate amount of tablets)

2. **Specific Information Related to Opioid Use** (such as morphine and related medications). Specific teaching information is available in Patient Education-On Line.
   A. Morphine and morphine-like medications are often used to relieve pain
   B. When opioids are used to treat cancer pain and taken only as prescribed, addiction is rarely a problem
   C. Taking opioids now will not diminish later effectiveness
   D. Discuss potential side effects of opioids, and their prevention and management
   E. Prevention of constipation will be needed by most patients
   F. Opioids are controlled substances that need to be properly safeguarded in the home
   G. Opioids must be used with caution, and should not be mixed with alcohol or illicit substances
   H. Opioids must be stored and disposed of properly. MD Anderson’s Floor 2 Pharmacy and Mays Clinic Pharmacy are authorized collection locations, and medications can be disposed of in the green bins.

*Continued on next page*
APPENDIX G: Pain Management Education for Patient and Family Prior to Discharge - continued

3. Pain Education Discharge/Resource Checklist:
   A. A written plan for pain medications, listing all medications to be used with dosage and frequency. Provide patient with printed copy of updated medication reconciliation.

   B. Written information on who to call (provider, service, phone number) for pain issues and plan for follow up care. Instruct patient/caregiver to call if:
      - Problems in obtaining prescriptions or taking the medication
      - Nausea and vomiting that prevents eating for 1 day
      - Difficulty arousing the patient from sleep easily during daytime
      - New pain, change in pain, or pain not relieved with medication
      - No bowel movements for 3 days
      - Confusion

   C. MD Anderson Cancer Center has multiple resources for pain management
      - Online resources – Patient Education Online is available for MD Anderson staff at http://inside2.mdanderson.org/apps/pe or for patients at https://my.mdanderson.org
      - Specialty services for pain management include: Acute Pain Medicine, Chronic Pain Medicine, Palliative/Supportive Care, and Integrative Medicine. Referral from primary service is required. Chronic Pain, Palliative/Supportive Care, and Integrative Medicine have clinics 5 days a week.
        - Integrative Medicine services such as acupuncture, massage, and mind-body therapies are available through online consults or by calling 713-794-4700.
        - Further information can be found at https://www.mdanderson.org/patients-family/diagnosis-treatment/care-centers-clinics/integrative-medicine-center/clinical-services.html
      - The Law and Levit Learning Centers provide information about health, cancer, and cancer prevention. Available resources include:
        - Journals, consumer health magazines and newsletters
        - Online journals, electronic books and databases
        - Free booklets
        - Topic-specific binders
        - Books, audios and videos
        - DVDs and videotapes

   Law Learning Center: Main Building, 4th floor, near elevator A (Room R4.1100). 713-745-8063
   Levit Learning Center: Mays Building, 2nd floor, near elevator T (ACB.2.1120). 713-563-8010
APPENDIX H: Equianalgesic Opioid Dose Conversion

Note: This chart is based on the Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/opioids/providers/prescribing/guideline.html). The equianalgesic doses (oral and parenteral) can be affected by interpatient variability, type of pain (e.g., acute versus chronic), chronic administration, and tolerance. The following table should serve as a guide when switching from one opioid to another. It is recommended to reduce the dose of the new opioid by 30-50% to account for incomplete cross tolerance, and to periodically monitor for efficacy and adverse reactions and the dose adjusted accordingly.

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Oral Dose (PO)</th>
<th>Parenteral Dose (IV/SC)</th>
<th>Conversion Factor: Parenteral to Oral Opioid</th>
<th>Conversion Factor: Oral Opioid to Oral Morphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>15 mg</td>
<td>6 mg</td>
<td>2.5</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>10 mg</td>
<td>N/A</td>
<td>N/A</td>
<td>1.5</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>15 mg</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>5 mg</td>
<td>0.5 mg</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4 mg</td>
<td>1.5 mg</td>
<td>2.5</td>
<td>4</td>
</tr>
<tr>
<td>Fentanyl¹</td>
<td>N/A</td>
<td>60 mcg</td>
<td>N/A</td>
<td>Should be managed by clinicians experienced in pain management</td>
</tr>
</tbody>
</table>

Methadone and buprenorphine should only be initiated and managed by clinicians experienced in pain management. Consider consult to pain specialists if needed.

¹ See Appendix J for transdermal fentanyl conversion
APPENDIX H: Equianalgesic Opioid Dose Conversion - continued

Steps for Opioid Rotation:
1. Stop current opioid regimen
2. Calculate total dose of current opioid (scheduled and PRN doses) used in the previous 24 hour period
3. Calculate the dose of the new opioid using the equianalgesic dose conversion table (from previous page) and conversion equation (below)

\[
\frac{\text{Equianalgesic dose per route of CURRENT opioid}}{24 \text{ hour dose per route of CURRENT opioid}} = \frac{\text{Equianalgesic dose per route of NEW opioid}}{24 \text{ hour dose per route of NEW opioid}}
\]

4. Calculate for incomplete cross-tolerance between opioids. Decrease the target dose from step 3 by 30-50% to obtain the new opioid dose.
5. Calculate scheduled pain dose. Divide the new opioid dose (from step 4) by number of doses to be given over 24 hours and administer as scheduled doses.
6. Calculate breakthrough pain dose as 10-20% of calculated new opioid dose to administer as needed every 1 hour
7. Titrate new opioid regimen until adequate analgesia is achieved

Opioid Rotation Example: Rotation from morphine PCA\(^1\) (total daily dose of 120 mg IV) to oral oxycodone
1. Stop current opioid regimen
2. Calculate dose of current opioid (scheduled and PRN doses) used in the previous 24 hours which equals 120 mg IV morphine
3. Calculate the dose of the new opioid using the equianalgesic dose conversion table and conversion equation (below)

a. Calculate IV morphine to PO morphine based on conversion table and conversion equation:

\[
\frac{6 \text{ mg IV morphine}}{120 \text{ mg IV morphine over 24 hours}} = \frac{15 \text{ mg PO morphine}}{X \text{ mg PO morphine over 24 hours}}
\]

\[X = 300 \text{ mg PO morphine}\]

b. Calculate PO morphine to PO oxycodone based on conversion table:

\[
\frac{15 \text{ mg PO morphine}}{300 \text{ mg PO morphine}} = \frac{10 \text{ mg PO oxycodone}}{X \text{ mg PO oxycodone}}
\]

\[X = 200 \text{ mg PO oxycodone}\]

4. Calculate for incomplete cross-tolerance. After a 30-50% dose reduction, the oxycodone dose calculated above should be between 100-140 mg per day.
5. Calculate scheduled pain dose. Extended release (ER) oxycodone is dosed every 12 hours; recommend oxycodone ER 60 mg every 12 hours (based on tablet availability).
6. Calculate breakthrough pain dose as 10-20% of recommended 120 mg oxycodone dose and administer as needed every 1 hour.

Immediate release (IR) oxycodone is between 12 and 24 mg per dose and may be administered every 1-4 hours.

Based on tablet availability recommend oxycodone IR 10-20 mg every 1-4 hours as needed for breakthrough pain.
7. Titrate new opioid regimen until adequate analgesia is achieved
APPENDIX I: Treatment Services

Note: Most treatment facilities require insurance coverage or sufficient payment to cover treatment. If patient has insurance, call the customer service number to find a facility in-network to avoid a large out-of-pocket debt.

- Treatment Facilities for Alcohol and Drug Abuse
  Houston, Texas
  (800) 304-2219
- Bay Area Recovery Center
  1807 FM 517
  East Dickinson, Texas 77539
  (713) 705-3457
- The Council on Alcohol and Drugs
  Houston, Texas
  www.councilonrecovery.org
- Clearinghouse for treatment, education, and recovery groups, etc.
  303 Jackson Hill St.
  Houston, Texas 77007
  (713) 914-0556, (281) 866-7557
- UT Health Houston Behavioral and Biomedical Science Building
  941 East Rd. First floor
  Houston, Texas 77054
  (713) 500-3784
- Hazelden Betty Ford
  Multiple locations around the country
  (866) 831-5700
- The Treehouse
  Scurry, Texas (South of Dallas)
  (888) 683-1406
- St. Joseph Hospital
  1401 St. Joseph Parkway
  Houston, Texas 77002
  (713) 575-1000, (800) 466-0792
- West Oaks Hospital (Dr. George Santos)
  https://westoakshospital.com/
  6500 Hornwood
  Houston, Texas 77074
- UT Health Harris County Psychiatric Center (HCPC)
  2800 South MacGregor Way
  Houston, TX 77021
  (713) 741-5000
- SAMHSA, Substance Abuse and Mental Health Services Administration
  Behavioral Health Treatment Services Locator:
  https://www.samhsa.gov/find-treatment
  Enter patient’s address and zip code on website
  (800) 622-4357
- The Menninger Clinic
  12301 S. Main St.
  Houston, Texas 77035-6207
  (713) 275-5000
- Narcotics Anonymous
  www.na.org
  Houston area Narcotics Anonymous
  www.hascona.com
  (713) 661-4200
### APPENDIX J: Fentanyl

<table>
<thead>
<tr>
<th>Dosage Forms</th>
<th>Onset</th>
<th>Peak</th>
<th>Duration</th>
<th>Doses Available per Formulary</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenteral (IV/Subcutaneous)</td>
<td>Almost immediate</td>
<td>Several minutes</td>
<td>0.5-1 hour</td>
<td>0.05 mg/mL (5 mL vial for injection) PCAs supplied as 2,500 mcg/50 mL</td>
<td>Bioavailability 90%; Do not cut patch, apply heat, or use in patients who develop fever - results in faster onset, shorter duration, and possible overdose. After transdermal patch removal, continued absorption of fentanyl occurs from the skin. Delayed administration of another long-acting opioid should be considered due to persistent serum levels of fentanyl. Due to differences in bioavailability, fentanyl products are not interchangeable on a microgram-to-microgram basis.</td>
</tr>
<tr>
<td>Transdermal patch</td>
<td>12-24 hours</td>
<td>24-72 hours</td>
<td>48-72 hours</td>
<td>12 (delivers 12.5), 25, 50, 75, 100 mcg/hour</td>
<td>Bioavailability 50%; not interchangeable on a microgram-to-microgram basis with other fentanyl products.</td>
</tr>
<tr>
<td>Transmucosal lozenge (Actiq®)</td>
<td>5-15 minutes</td>
<td>20-40 minutes</td>
<td>Related to blood level</td>
<td>200, 400, 600 mcg</td>
<td>Bioavailability 54%; not interchangeable on a microgram-to-microgram basis with other fentanyl products.</td>
</tr>
<tr>
<td>Sublingual Tablet (Abstral®)</td>
<td>5-15 minutes</td>
<td>30-60 minutes</td>
<td>2 hours</td>
<td>100, 200, 300, 400, 600, 800 mcg</td>
<td></td>
</tr>
</tbody>
</table>

### Drug specific characteristics:
- Fentanyl is 80-100 times more potent than morphine. Fentanyl is not recommended for initial use in opioid naïve patients. Use in non-opioid tolerant patients may lead to fatal respiratory depression.
- Transdermal fentanyl should only be used in patients with stable opioid requirements. Due to its long half-life of 17 hours, the dose may be difficult to titrate if pain is not well-controlled.
- When initiating transdermal fentanyl, patients should use short-acting opioids as needed until efficacy is obtained (peak effect 24-72 hours).
- Titrate patients on transdermal fentanyl no more frequently than every 3 days after initial dose, and then every 6 days thereafter. Initial evaluation of maximum analgesic effect should not be made before 24 hours.
- Caution with CYP450 3A4 inhibitors, which can increase fentanyl plasma concentrations.
- May be used in patients with renal dysfunction.
- Prior to processing initial outpatient prescriptions for transmucosal immediate release fentanyl (TIRF), the prescriber must enroll with the TIRF Risk Evaluation and Mitigation Strategy (REMS) Program.

### Morphine to Fentanyl conversion: 1 mg of IV morphine or 2.5 mg of oral morphine = 10 micrograms of IV fentanyl

Example: Conversion from oral morphine ER 90 mg every 12 hours to fentanyl IV
1. 24-hour morphine dose is 90 + 90 = 180 mg
2. Decrease 180 mg by 30% for incomplete tolerance = 126 mg
3. 1 mg morphine IV = 2.5 mg morphine oral = 10 micrograms fentanyl IV, then new 24-hour morphine dose of 126 mg = 24 hour fentanyl IV dose of 504 micrograms
4. Divide 24-hour fentanyl dose calculated by 24 hours = 21 micrograms/hour
5. Thus an appropriate starting dose for fentanyl IV per hour (as basal rate in PCA) is 20 micrograms/hour

Continued on next page
APPENDIX J: Fentanyl - continued

Transdermal Fentanyl (TDF) Dosing:

**Option 1:** 2 mg oral morphine is approximately 1 microgram *per hour* transdermal fentanyl

Example: Total daily dose of morphine 100 mg translates to approximately 50 micrograms transdermal patch, to be applied every 72 hours

**Option 2:** Calculate the total daily dose of morphine and then use the following table to select the appropriate patch strength

<table>
<thead>
<tr>
<th>Oral Morphine (mg/day)</th>
<th>Transdermal Fentanyl (mcg/hour)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-90</td>
<td>25</td>
</tr>
<tr>
<td>91-150</td>
<td>50</td>
</tr>
<tr>
<td>151-210</td>
<td>75</td>
</tr>
<tr>
<td>211-270</td>
<td>100</td>
</tr>
<tr>
<td>Each additional 60 mg/day</td>
<td>An additional 25 mcg/hour</td>
</tr>
</tbody>
</table>

**Note:** This table should **NOT** be used to convert from TDF to other therapies because this conversion to TDF is conservative. Use of this table for conversion to other analgesic therapies can overestimate the dose of the new agent.

- To convert patients to another opioid, remove the transdermal fentanyl patch and titrate the dose of the new analgesic based upon the patient's report of pain until adequate analgesia has been attained. Upon patch removal, 17 hours or more are required for a 50% decrease in serum fentanyl concentrations.
- Must prescribe short-acting opioid for breakthrough pain
APPENDIX K: Patient Controlled Analgesia (PCA)

Suggested initial PCA settings: All opioid doses must be individualized (use the institutional order set for all new PCA orders and dose changes)

1. Opioid naïve patients

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Demand (PCA) dose (dose range)</th>
<th>Lock out interval (minutes)</th>
<th>1-hour dose limit (optional)</th>
<th>Continuous dose (basal)</th>
<th>Nurse bolus as needed for pain</th>
<th>Nurse bolus interval (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (milligrams)</td>
<td>1 mg (0.5-2.5)</td>
<td>10-30 min</td>
<td>4 mg</td>
<td>see below</td>
<td>2-4 mg</td>
<td>2</td>
</tr>
<tr>
<td>Hydromorphone (milligrams)</td>
<td>0.2 mg (0.1-0.5)</td>
<td>10-30 min</td>
<td>0.8 mg</td>
<td>see below</td>
<td>0.5-1 mg</td>
<td>2</td>
</tr>
<tr>
<td>Fentanyl (micrograms)</td>
<td>10 mcg (5-25)</td>
<td>10-30 min</td>
<td>40 mcg</td>
<td>see below</td>
<td>25 mcg</td>
<td>2</td>
</tr>
</tbody>
</table>

a. Patient should be alert and demonstrate ability to administer demand dose for pain. If concerns about cognitive failure or significant anxiety, consider Specialty Consultation: Acute Pain, Chronic Pain, Supportive Care (see Appendix E for description of services).
b. Carefully consider adding continuous (basal) dose after 12-24 hours if using frequent demand doses or if pain not controlled. Suggested basal dose is 30-50% of average hourly dose.
Example: The 12-hour total morphine demand dose is 20 mg, calculate continuous dose as 20/12 = 1.7 mg/hour then 1.7 X 0.3 (30%) = 0.5 mg/hour basal rate

2. Opioid tolerant patients (currently receiving opioid therapy)

PCA orders should take into account the patient’s current opioid regimen, clinical situation (severity and etiology of the pain, side effects from opioids, baseline drowsiness, need for opioid rotation). If there are significant side effects, drowsiness, confusion, respiratory or central nervous system concerns, it is recommended to call for Specialty Consultation: Acute Pain, Chronic Pain, Palliative/Supportive Care (see Appendix E for description of services) for PCA ordering.
a. Calculate total dose of opioid (scheduled and PRN doses) used in the previous 24-hour period
b. Use Equianalgesic Opioid Dose Conversion table (Appendix H) to calculate dose of IV opioid being considered for PCA. Decrease dose by 30-50% to adjust for lack of complete cross tolerance to obtain new IV dose.
c. Divide new IV dose (from above step) by 24 hours, to obtain hourly (basal) dose
d. Calculate demand (PCA) dose as 10-20% of new IV opioid dose to use as needed for pain every hour
SUGGESTED READINGS

Agency for Healthcare Research and Quality (AHRQ): Management of Cancer Pain Volumes I and II


Continued on next page
SUGGESTED READINGS - continued


Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.
Cancer Pain – Adult

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

DEVELOPMENT CREDITS:

This practice consensus statement is based on majority opinion of the cancer pain experts at the University of Texas MD Anderson Cancer Center for the patient population. Evidence regarding specific clinical outcomes associated with the use of this or similar pain algorithms applied in comprehensive cancer centers is sparse. Other algorithms or approaches may produce similar or better outcomes. These experts included:

Core Development Team Lead
Shalini Dalal, MD (Palliative Care Medicine)

Workgroup Members
Eduardo Bruera, MD (Palliative Care Medicine)
Diana Cauley, PharmD (Pharmacy Clinical Programs)
Larry Driver, MD (Pain Medicine)
Olga N. Fleckenstein, BS
Dhanalakshmi Koyyalagunta, MD (Pain Medicine)
Kristy Nguyen, PharmD (Pharmacy Clinical Programs)
Keyuri U. Popat, MD (PeriOperative Medicine)
Suresh K. Reddy, MD (Palliative Care Medicine)
Alan D. Valentine, MD (Psychiatry)
Monica Wattana, MD (Emergency Medicine)
Mary Lou Warren, DNP, APRN, CNS-CC*

* Clinical Effectiveness Development Team