Cancer Pain – Pediatric

This practice algorithm has been specifically developed for MD Anderson using a multidisciplinary approach and taking into consideration circumstances particular to MD Anderson, including the following: MD Anderson’s specific patient population; MD Anderson’s services and structure; and MD Anderson’s clinical information. Moreover, this algorithm is not intended to replace the independent medical or professional judgment of physicians or other health care providers. This algorithm should not be used to treat pregnant women.

Note: This consensus algorithm excludes patients who are in the ICU, perioperative or pre-procedural settings, or are currently receiving epidural or intrathecal analgesia.

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For patients not currently taking opioids:
- Consider consulting Child Life or other complimentary therapies (Appendix A)
- Consider non-opioids (Appendix E) or if contraindicated, consider weak opioids (Appendix G), as needed for pain

For patients currently taking opioids:
- Consider consulting Child Life or other complimentary therapies (Appendix A)
- Continue current analgesic regimen or consider dose changes as clinically indicated
- If patient is currently taking a long-acting opioid, consider adding a short-acting opioid for breakthrough pain. The breakthrough dose is calculated as 10-20% of the total daily dose, given every 1 to 4 hours.
- Manage opioid induced side effects as clinically indicated (Appendix K).
  For patients on opioids, ensure a scheduled bowel regimen.

Pain adequately controlled?
No
- Reassess pain, PPG, and using appropriate pain scale determine current score.
- If using opioids, reassess opioid side effects every 4 hours or at each interaction and subsequent visit
- Consider consulting Child Life or other complimentary therapies (Appendix A)
- Consider increasing scheduled opioid dose by 30-50%. If scheduled opioid is increased, recalculate the breakthrough dose based on the new total daily dose. The breakthrough dose is calculated as 10-20% of the total daily dose, given every 1 to 4 hours.
- Manage opioid induced side effects as clinically indicated (Appendix K)
  For patients on opioids, ensure a scheduled bowel regimen.
- Consider specialty consult

Yes
- Continue current analgesic regimen
- Consider starting/adjusting opioid dose

For patients not currently taking opioids:
- Consider consulting Child Life or other complimentary therapies (Appendix A)
- Administer short-acting opioids - choose from weak or strong opioids (Appendix G)

For patients currently taking opioids:
- Consider consulting Child Life or other complimentary therapies (Appendix A)
- Consider increasing scheduled opioid dose by 30-50%. If scheduled opioid is increased, recalculate the breakthrough dose based on the new total daily dose. The breakthrough dose is calculated as 10-20% of the total daily dose, given every 1 to 4 hours.
- Manage opioid induced side effects as clinically indicated (Appendix K)
  For patients on opioids, ensure a scheduled bowel regimen.
- Consider specialty consult

Pain adequately controlled?
No
- Reassess pain, PPG, and using appropriate pain scale determine current score.

Yes
- Titrate scheduled and short-acting opioids.
- Consult specialty service

NOTE: For all patients: Consider using appropriate adjuvants (Appendix F) and/or complementary therapies (Appendix A), bowel regimen (Appendix K), patient education (Appendix L), and psychosocial support as appropriate (Appendix M).

Department of Clinical Effectiveness V2
Approved by the Executive Committee of the Medical Staff on 05/30/2017
Pain crisis\(^6\)

Severe pain and/or PPG\(^3\) not met

Evaluate and treat pain and psychosocial distress that is contributing to pain expression\(^4,5\)
- If significant anxiety related to pain, administer opioids prior to sedating anxiolytics.

For patients not currently taking opioids:
- Administer short-acting opioids - choose from strong opioids (Appendix G).

For patients currently taking opioids:
- Consider increasing scheduled opioid dose by 50-100%.
  
  If scheduled opioid is increased, recalculate the breakthrough dose based on the new total daily dose. The breakthrough dose is calculated as 10-20% of the total daily dose, given every 1 to 4 hours.
- Manage opioid induced side-effects as clinically indicated, (Appendix K). For patients on opioids, ensure a scheduled bowel regimen.
- Ongoing assessment is necessary for pain, distress\(^6\) and opioid side effects until patient stable.

NOTE: For all patients: Consider using appropriate adjuvants (Appendix F) and/or complementary therapies (Appendix A), bowel regimen (Appendix K), patient education (Appendix L), and psychosocial support as appropriate (Appendix M).

Consult Pediatric Specialty Service\(^4\)

Assess for pain at each visit or interaction\(^2\).
Use appropriate pain scale\(^3\) to determine baseline pain score.

PPG = personalized pain goal
1 See Adult Cancer Pain algorithm when clinically indicated.
2 See Appendix B for Comprehensive Pain Assessment.
3 See Appendix C & D
4 Consultation services that specialize in pain management: Acute Pain, Pain Medicine, Palliative/Supportive Care, Pediatric ICU and Integrative Medicine (Appendix M for description of services).
5 For additional information see the Distress Screening & Psychosocial Management Algorithm
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 for more than 24 hours.
Assess for pain at each visit or interaction¹. Use appropriate pain scale² to determine baseline pain score.

Mild pain and/or PPG met

Moderate pain and/or PPG not met

Pain crisis³

Consider evaluation in emergency center, hospitalization, or specialty consultation⁴

For patients not currently taking opioids:
- Consider consulting Child Life or other complimentary therapies (Appendix A)
- Consider non-opioids (Appendix E) or if contraindicated, consider weak opioids (Appendix G), as needed for pain.

For patients currently taking opioids:
- Consider consulting Child Life or other complimentary therapies (Appendix A)
- Continue current analgesic regimen or consider dose changes as clinically indicated
  - If patient is currently taking a long-acting opioid, consider adding a short-acting opioid for breakthrough pain. The breakthrough dose is calculated as 10-20% of the total daily dose, given every 1 to 4 hours.
  - Manage opioid induced side-effects as clinically indicated (Appendix K). For patients on opioids, ensure a scheduled bowel regimen.

For patients not currently taking opioids:
- Consider consulting Child Life or other complimentary therapies (Appendix A)
- Administer short-acting opioids - choose from weak or strong opioids (Appendix G)

For patients currently taking opioids:
- Consider consulting Child Life or other complimentary therapies (Appendix A)
- Consider increasing scheduled opioid dose by 30-50%. If scheduled opioid is increased, recalculate the breakthrough dose based on the new total daily dose. The breakthrough dose is calculated as 10-20% of the total daily dose, given every 1 to 4 hours
  - Manage opioid induced side-effects as clinically indicated (Appendix K). For patients on opioids, ensure a scheduled bowel regimen
  - If opioid induced neurotoxicity (OIN)⁵: consider hospitalization and evaluation in the emergency room, opioid rotation (Appendix H), and/or specialty consultation⁴.
  - Consider specialty consult⁴

Note: For all patients: Consider using appropriate adjuvants (Appendix F) and/or complementary therapies (Appendix A), bowel regimen (Appendix K), patient education (Appendix L), and psychosocial support as appropriate (Appendix M).

Pain adequately controlled?
- Yes
  - Continue analgesic and bowel regimen, education and psychosocial support as appropriate
- No
  - Reassess pain, PPG, and using appropriate pain scale determine current score at subsequent visit or interaction
  - If using opioids, reassess opioid side effects at subsequent visit or interaction

Pain adequately controlled?
- Yes
  - Reassess pain, PPG, and using appropriate pain scale determine current score at subsequent visit or interaction
  - If using opioids, reassess opioid side effects at subsequent visit or interaction
- No
  - Consider specialty consultation⁴ for uncontrolled pain

PPG = personalized pain goal
¹See Appendix B for Comprehensive Pain Assessment
²See Appendix C & D
³Pain crisis or emergency is defined as severe pain, new onset, or exacerbation of previously stabilized pain, accompanied by significant distress or if present for more than 24 hours.
⁴Consultation services that specialize in pain management: Acute Pain, Pain Medicine, Palliative/Supportive Care, Pediatric ICU and Integrative Medicine (Appendix M for description of services).
⁵Opioid induced neurotoxicity (OIN) can include drowsiness, cognitive impairment, confusion, hallucinations, myoclonic jerks (Appendix K).

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Opioid naïve: Includes patients who are not chronically receiving opioid analgesic 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 “receiving at least 60 mg of morphine daily, at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer” for adult patients. The pharmaceutical industry’s definition of opioid tolerant for pediatric patients is generally a patient receiving the equivalent of 1 mg/kg per day of oral morphine for 1 week or more.

Incomplete cross-tolerance: Reduce dose of new opioid by 30 to 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 pages 2 to 4 of this algorithm for titration recommendations.

Dosing frequency: For long-acting opioids, dosing frequency is typically every 12 hours to 24 hours depending on the agent. Refer to Appendix G for Opioid Dose Considerations.

Breakthrough pain: Doses of short-acting opioids for breakthrough pain should be 10 to 20% of the total daily dose given every 1 to 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).

Organ dysfunction: Use additional caution when converting opioids in 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, dexocine) 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 0.4 mg/mL (1 mL) ampule into 9 mL of normal saline for total volume of 10 mL to achieve a 0.04 mg/mL concentration. Give 0.04 mg (1 mL) via slow IV push every 30 to 60 seconds until symptom improvement. DO NOT administer undiluted naloxone 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 G 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 K.

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. For example, fentanyl will continue to be released from the skin 12 to 36 hours after transdermal patch removal.
Cancer Pain – Pediatric

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APPENDIX A: Complimentary Therapy

Integrative medicine refers to an evidence informed approach to bringing these complementary approaches into conventional medical care. Complementary approaches may be provided safely by individuals with proper training. Such approaches can provide support to patients and their caregivers. Benefits can include helping to provide relief for symptoms such as: pain, nausea, and anxiety. Complementary approaches may offer also opportunities for increased socialization, motivation, and improving coping skills. Complementary approaches to consider include such modalities as: expressive arts (music therapy, art therapy) and movement approaches (yoga, dance). Contact information for accessing these services are below:

Music Therapy, Integrative Medicine Center

(713) 794-4700 clinic
A physician’s order for Music Therapy is required for individual services. Group programs are also offered with no referral needed.

Arts in Medicine Program
Kevin Long, MBA, BBA – Director of Pediatric Operations
(713) 563-5481 office
Email KRLong@mdanderson.org
Services are for patients and families in a wide range of arts activities. Two categories of service: individual consultations and group arts activities. Services are rendered via an informal referral process.

Pediatric School
Kris Frost, M.Ed, Program Coordinator
713-792-5145 office
Email MKFrost@mdanderson.org
Education program offers art class daily, one day utilizing a pottery wheel. Kids’ yoga class is provided by Child Life. Music therapy in the play room.

Pediatric Clinical Psychology Services
Pediatric clinical psychology services are initiated by consultation. The Pediatric On-Call Schedule denotes provider and contact information. Psychological interventions can be provided to patients who are struggling through acute or chronic pain.
Cancer Pain – Pediatric

This practice algorithm has been specifically developed for MD Anderson using a multidisciplinary approach and taking into consideration circumstances particular to MD Anderson, including the following: MD Anderson’s specific patient population; MD Anderson’s services and structure; and MD Anderson’s clinical information. Moreover, this algorithm is not intended to replace the independent medical or professional judgment of physicians or other health care providers. This algorithm should not be used to treat pregnant women.

Note: This consensus algorithm excludes patients who are in the ICU, perioperative or pre-procedural settings, or are currently receiving epidural or intrathecal analgesia.

APPENDIX B: Comprehensive Pediatric Pain Assessment

The comprehensive pain assessment should include the following:

1. Pain:
   a. For each site of pain, determine intensity level using the appropriate pain scales based on age and developmental level (Appendix C FLACC Behavioral Pain Assessment Categories and Appendix D Wong-Baker FACES Pain Rating Scale).
   b. Evaluation of medical history includes: oncologic or other significant medical illnesses, medication history, relevant imaging and laboratory studies.
   c. Physical examination.
   d. Assess for presence of sedation and common opioid side effects (Appendix K).

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.

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 (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).

4. Personalized Pain Goal (PPG):
   a. 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 emergencies¹.

¹ Pain related to an oncologic emergency requires assessment and treatment (for example, surgery, steroids, radiotherapy, antibiotics) along with an emergent consultation. Oncologic emergencies include:

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

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APPENDIX C: FLACC Behavioral Pain Assessment Categories
(For patients under 3 years of age or non-verbal or as clinically appropriate)

<table>
<thead>
<tr>
<th>FLACC Behavioral Pain Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Face</td>
</tr>
<tr>
<td>Legs</td>
</tr>
<tr>
<td>Activity</td>
</tr>
<tr>
<td>Cry</td>
</tr>
<tr>
<td>Consolability</td>
</tr>
</tbody>
</table>

Each of the five categories is scored from 0-2, resulting in a total score between 0 and 10.
The FLACC scale was developed by Sandra Merkel, MS, RN, Terri Voepel-Lewis, MS, RN and Shobha Malviya, MD at C. S. Mott Children’s Hospital, University of Michigan Health System, Ann Arbor, MI.
APPENDIX D: Wong-Baker FACES Pain Rating Scale
(For patients 3 to 18 years old or as clinically appropriate)
### APPENDIX E: Non-opioids Recommended Pediatric Starting Doses

**CAUTION:** All of these agents are antipyretic and may mask fever; use caution in patients receiving 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, tocoline magnesium salicylate) and the COX-2 selected NSAID, celecoxib (see table below), may have less effects on platelets, but should still be used with caution in a patient receiving myelosuppressive chemotherapy.

Non-opioids include: acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs); the 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>10-15 mg/kg/dose (max 1,000 mg) PO every 4-6 hours</td>
<td>Less than 12 years old: 5 doses (75 mg/kg) per day Greater than or equal to 12 years: 4,000* mg</td>
<td>Available PO, IV or per rectum(^1). At higher doses, can cause fatal hepatotoxicity and renal damage. Does not have anti-inflammatory effect.</td>
</tr>
<tr>
<td></td>
<td>12.5 mg/kg (max 650 mg) IV every 4 hours or 15 mg/kg (max 1,000 mg) IV every 6 hours</td>
<td>Single dose: 1,000 mg/dose; Daily dose: 4,000* mg daily</td>
<td>IV acetaminophen is formulary restricted.</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>4-10 mg/kg/dose (max 800 mg) PO every 6-8 hours</td>
<td>Less than 12 years old: 40 mg/kg/day Greater than or equal to 12 years: 3,200 mg</td>
<td>Inhibits platelet aggregation, can cause gastrointestinal side effects or renal failure. Use with caution in patients at high risk(^2).</td>
</tr>
<tr>
<td>Celecoxib</td>
<td>10 to 25 kg: 50 mg twice daily Greater than 25 kg: 100 mg twice daily</td>
<td>400 mg</td>
<td>Does not affect platelet aggregation; can cause renal insufficiency.</td>
</tr>
<tr>
<td>Ketorolac</td>
<td>Single-dose treatment: 0.5 mg/kg (max: 15 mg) IV Multiple-dose treatment: 0.5 mg/kg (max 30 mg) IV every 6 hours</td>
<td>120 mg Max 5 days</td>
<td>Limit treatment to 5 days. Use is contraindicated in patients with advanced renal impairment or patients at risk for renal failure due to volume depletion. Inhibits platelet aggregation; can cause gastrointestinal side effects.</td>
</tr>
</tbody>
</table>

* Manufacturers of over-the-counter acetaminophen recommend no more than 3,000 mg daily

\(^1\) The following drugs are not approved in children: Aspirin and Naproxen.

\(^2\) Contraindicated in neutropenic patients.

\(^3\) Patients at high risk of serious gastrointestinal side effects or renal damage from NSAIDs include: smokers, previous history of peptic ulcer, currently receiving corticosteroids, anticoagulants, or presence of existing renal disease, cardiac or liver impairment.
APPENDIX F: Adjuvant “Co-analgesics” for Pediatric 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></td>
<td>Gabapentin</td>
<td><strong>Day 1:</strong> 5 mg/kg/dose (max 300 mg/dose) PO at bedtime</td>
<td></td>
<td>Dose may be further titrated to a maximum dose of 3,600 mg/day</td>
</tr>
<tr>
<td>(various NP types)</td>
<td></td>
<td><strong>Day 2:</strong> 5 mg/kg/dose (max 300 mg/dose) PO BID</td>
<td></td>
<td>Used in PHN and NP. May cause drowsiness, dizziness, and peripheral edema.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Day 3:</strong> 5 mg/kg/dose (max 300 mg/dose) PO TID</td>
<td></td>
<td>Dose adjust for renal impairment.</td>
</tr>
<tr>
<td>Topiramate</td>
<td></td>
<td>6-12 years (weight greater than or equal to 20 kg): 15 mg PO daily for 7 days, then 15 mg PO BID</td>
<td>200 mg</td>
<td>Used in NP. May cause acidosis, drowsiness, dizziness, and nausea. Dose adjust for renal impairment and hepatic dysfunction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater than or equal to 12 years: 25 mg PO at bedtime for 7 days, then 25 mg PO BID and titrate up to 50 mg PO BID</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tricyclic Antidepressants</strong></td>
<td>Amitriptyline</td>
<td>0.1 mg/kg PO at bedtime; titrate as tolerated over 3 weeks to 0.5-2 mg/kg at bedtime</td>
<td>25 mg/dose</td>
<td>Consider for continuous and shooting neuropathic pain. Caution use in frail patients those with glaucoma or arrhythmias. May cause sedation, arrhythmias, dry mouth, orthostasis, and urinary retention. Consider duloxetine for NP or DN. Caution use 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, nonsteroidal anti-inflammatory drugs, warfarin, and other anti-coagulants may add to this risk. Taper slowly.</td>
</tr>
<tr>
<td>(TCA)</td>
<td></td>
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</tr>
</tbody>
</table>

**Key:**
- **DN** = diabetic neuropathy
- **NP** = neuropathic pain
- **FM** = fibromyalgia
- **PHN** = postherpetic neuralgia
- **MAOIs** = Monoamine oxidase inhibitors
- **SNRIs** = Serotonin-norepinephrine reuptake inhibitors
- **TCAs** = tricyclic antidepressants
- **TGN** = trigeminal neuralgia

1 The following drugs are not approved in children: pregabalin, carbamazepine, oxcarbazepine, tiagabine, nortriptyline, desipramine, duloxetine, venlafaxine and tizanidine.
### APPENDIX F: Adjuvant “Co-analgesics” commonly used for Pediatric 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>Muscle Relaxants</strong> (muscle pain, spasm)</td>
<td>Baclofen²</td>
<td>Less than 2 years old: 2.5–5 mg PO every 8 hours; titrate dose every 3 days to max daily dose 2–7 years old: 7.5–10 mg PO every 8 hours; titrate dose every 3 days in increments of 5–15 mg/day to max daily dose Greater than or equal to 8 years old: 10–15 mg PO every 8 hours; titrate dose every 3 days in increments of 5–15 mg/day to max daily dose</td>
<td>Less than 2 years old: 40 mg/day 2–7 years old: 60 mg/day Greater than or equal to 8 years old: 80 mg/day</td>
<td>Caution use in patients with seizures, cardiovascular disease, glaucoma, myasthenia gravis, renal or hepatic impairment, patients on tricyclic antidepressants or MAOIs. May cause anticholinergic effects and significant drowsiness. Methocarbamol: may repeat course after drug free interval of 48 hours.</td>
</tr>
<tr>
<td>Cyclobenzaprine</td>
<td>Greater than or equal to 15 years old: 5 mg PO three times daily</td>
<td>30 mg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metaxalone</td>
<td>Greater than 12 years old: 400 mg PO three times daily</td>
<td>3,200 mg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methocarbamol</td>
<td>Greater than or equal to 16 years old: 500 mg PO four times daily 1,000 mg IV every 8 hours</td>
<td>4,000 mg/day; IV for 3 days maximum if PO not possible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Corticosteroids</strong> (inflammation, nerve compression)</td>
<td>Dexamethasone</td>
<td>1 mg/kg/day IV or PO in divided doses every 6 hours Standard dose 4–16 mg/day</td>
<td>16 mg/day</td>
<td>May cause impaired healing, infection, thrush, hyperglycemia, weight gain, myopathy, stomach upset, psychosis, emotional instability.</td>
</tr>
</tbody>
</table>

*MAOI = monoamine oxidase inhibitors
TCAs = tricyclic antidepressants

¹ The following drugs are not approved in children: pregabalin, carbamazepine, oxcarbazepine, tiagabine, nortriptyline, desipramine, duloxetine, venlafaxine and tizanidine.

² Intrathecal formulation not on MD Anderson Cancer Center Formulary
# APPENDIX G: Pediatric Opioid Dose Considerations

(Weaker medications are listed at the beginning of Appendix G)

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Initial short-acting dose in an opioid naïve patient</th>
<th>Onset (minutes) (hours)</th>
<th>Peak Effect</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: PO Dose:</td>
<td>1 - 2 mg/kg/dose (max 25-50 mg)</td>
<td>30 – 60</td>
<td>1.5</td>
<td>3 – 7</td>
<td>Short-acting: every 4-6 hours</td>
<td>Short-acting: 50 mg tablets Long-acting: 100, 200, 300 mg tablets</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>PO</td>
<td>0.1-0.2 mg/kg/dose (max 5-10 mg)</td>
<td>10 – 20</td>
<td>1 – 3</td>
<td>4 – 8</td>
<td>Short-acting: every 6 hours</td>
<td>Short-acting in combination with acetaminophen: 5, 7.5, 10 mg tablets; 2.5 mg/5 mL liquid</td>
</tr>
</tbody>
</table>

¹The following drugs are not approved in children: tapentadol and oxymorphone
²Note: Must consider all forms of acetaminophen or ibuprofen medications (combination and individual) when determining total daily dosing. Manufacturers of over-the-counter acetaminophen recommend no more than 3,000 mg daily.
³When used with TCAs, MAOIs, SSRIs, SNRIs, or 2D6 or 3A4 inhibitors.
### APPENDIX G: Pediatric Opioid Dose Considerations

#### (Weaker medications are listed at the beginning of Appendix G)

<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><strong>Morphine</strong></td>
<td>PO: 0.2-0.5 mg/kg/dose (max 5-15 mg)</td>
<td>30</td>
<td>0.5 – 1</td>
<td>3 – 6</td>
<td>Short-acting: PO: every 4 hours</td>
<td>Short-acting: 15, 30 mg tablets; 10 mg/5 mL, 20 mg/5 mL, 20 mg/mL liquid</td>
<td>Available as tablet or liquid preparation. Short-acting preparations can be given via PEG tube.</td>
</tr>
<tr>
<td></td>
<td>IV/SC: 0.05-1 mg/kg/dose (max 2-3 mg)</td>
<td>5-10</td>
<td>N/A</td>
<td>N/A</td>
<td>Long-acting: varies by product</td>
<td>Long-acting: 15, 30, 60, 100 mg tablets</td>
<td>Available alone or in combination with acetaminophen. For example, oxycodone 5 mg with acetaminophen 325 mg (Percocet®).</td>
</tr>
<tr>
<td><strong>Oxycodone</strong></td>
<td>PO: 0.1-0.2 mg/kg/dose (max 5-10 mg)</td>
<td>10 – 15</td>
<td>0.5 – 1</td>
<td>3 – 6</td>
<td>Short-acting: every 4 hours</td>
<td>Short-acting: 5, 15, 30 mg tablets; 5 mg/5 mL, 20 mg/mL Liquid</td>
<td>Available as tablet or liquid preparation. Short-acting preparations can be given via PEG tube.</td>
</tr>
<tr>
<td></td>
<td>IV/SC: 0.03-0.06 mg/kg/dose (max 1-3 mg)</td>
<td>15 – 30</td>
<td>0.5 – 1</td>
<td>3 – 5</td>
<td>Long-acting: every 12 hours</td>
<td>Long-acting: 10, 15, 20, 30, 40, 60, 80 mg tablets</td>
<td>Available alone or in combination with acetaminophen. For example, oxycodone 5 mg with acetaminophen 325 mg (Percocet®).</td>
</tr>
<tr>
<td><strong>Hydromorphone</strong></td>
<td>PO: 0.03-0.06 mg/kg/dose (max 1-3 mg)</td>
<td>15 – 30</td>
<td>0.5 – 1</td>
<td>3 – 5</td>
<td>Short-acting: every 4 hours</td>
<td>Short-acting: 2, 4, 8 mg tablets; 1 mg/mL liquid</td>
<td>Long-acting: 8, 12, 16, 32 mg tablets</td>
</tr>
<tr>
<td></td>
<td>IV/SC: 0.01-0.015 mg/kg/dose (max 0.5-1.5 mg)</td>
<td>15 – 30</td>
<td>N/A</td>
<td>4 – 5</td>
<td>IV/SC: every 4 hours</td>
<td>Long-acting: 8, 12, 16, 32 mg tablets</td>
<td>Available alone or in combination with acetaminophen. For example, oxycodone 5 mg with acetaminophen 325 mg (Percocet®).</td>
</tr>
</tbody>
</table>

1 MAOI = monoamine oxidase inhibitors  
2 SSRI = selective serotonin reuptake inhibitors  
3 SNRI = Serotonin norepinephrine reuptake inhibitor

1 The following drugs are not approved in children: tapentadol and oxymorphone

2 Note: 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 dosing.
APPENDIX H: Pediatric Equianalgesic Opioid Dose Conversion

Note: The equianalgesic doses (oral and parenteral) can be affected by interpatient variability, type of pain (for example, acute versus chronic), chronic administration, and tolerance. The following table should serve only as a guide when switching from one opioid to another. It is recommended to reduce the dose of the new opioid by 30 to 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 for changing parenteral opioid to oral opioid</th>
<th>Conversion Factor for changing oral opioid to oral morphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30 mg</td>
<td>10 mg</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20 mg</td>
<td>N/A</td>
<td>N/A</td>
<td>1.5</td>
</tr>
<tr>
<td>Hydrocodone 2</td>
<td>30 mg</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>10 mg</td>
<td>1 mg</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5 mg</td>
<td>1.5 mg</td>
<td>5</td>
<td>Should be managed by clinicians experienced in pain management.</td>
</tr>
<tr>
<td>Fentanyl 3</td>
<td>N/A</td>
<td>100 mcg</td>
<td>N/A</td>
<td></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. See Appendix M for details.

1 This Equianalgesic Opioid Dose Conversion Chart is also available in Lexicomp®.
2 Based on clinical experience, 6-8 tablets (hydrocodone 5 mg and acetaminophen 325 mg) may be changed to morphine ER 15 mg every 12 hours.
3 See Appendix 1 for transdermal conversion.

Continued on next page
APPENDIX H: Pediatric Equianalgesic Opioid Dose Conversion - continued

Steps for Opioid Rotation:
1. Stop current opioid regimen.
2. Calculate total dose of current opioid (scheduled and breakthrough 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).

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

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 PRN every 1 hour.
7. Titrate new opioid regimen until adequate analgesia is achieved.

Opioid Rotation Example: Rotation from morphine PCA (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:

\[
\frac{10 \text{ mg IV morphine}}{120 \text{ mg IV morphine over 24 hours}} = \frac{30 \text{ mg PO morphine}}{X \text{ mg PO morphine over 24 hours}} \Rightarrow X = 360 \text{ mg PO morphine}
\]

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

\[
\frac{30 \text{ mg PO morphine}}{360 \text{ mg PO morphine}} = \frac{20 \text{ mg PO oxycodone}}{X \text{ mg PO oxycodone}} \Rightarrow X = 240 \text{ mg PO oxycodone}
\]

4. Calculate for incomplete cross-tolerance. After a 30-50% dose reduction, the oxycodone dose calculated above should be between 120 and 168 mg per day.
5. Calculate scheduled pain dose. Extended release (ER) oxycodone is dosed every 12 hours; recommend ER oxycodone 60 mg every 12 hours (based on tablet availability).
6. Calculate breakthrough pain dose as 10-20% of 120 mg oxycodone dose and administer PRN every 1 hour. Immediate release (IR) oxycodone is between 12 and 24 mg per dose and may be administered every 1 to 4 hours; Based on tablet availability recommend IR oxycodone 10 to 20 mg every 1 to 4 hours as needed for breakthrough pain.
7. Titrate new opioid regimen until adequate analgesia is achieved.
<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>50 mcg/mL (5 mL vial for injection) PCA syringe supplied as 2,750 mcg/55 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.</td>
</tr>
<tr>
<td>Transdermal patch¹</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%</td>
</tr>
<tr>
<td>Transmucosal lozenge (Actiq⁶)</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%</td>
</tr>
<tr>
<td>Sublingual Tablet (Abstral⁶)</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 to 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 the long systemic 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.
- Prior to processing initial prescriptions for rapid onset fentanyl, the prescriber must register with the TIRF REMS Access Program and complete a Prescriber and Patient agreement.

**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 IV fentanyl.
1. 24 hour morphine dose is 90 + 90 = 180 mg
2. Decrease 180 mg by 30 % for incomplete tolerance = 126 mg
3. 1 mg IV morphine = 2.5 mg oral morphine = 10 micrograms IV fentanyl, then new 24 hour morphine dose of 126 mg = 24 hour IV fentanyl dose of 504 micrograms
4. Divide 24 hour fentanyl dose calculated by 24 hours = 21 micrograms/hour

Thus an appropriate starting dose for IV fentanyl/hour (as basal rate in PCA) is 20 micrograms/hour.

¹After 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 mcg to mcg basis.
APPENDIX I: Fentanyl - continued

Transdermal Fentanyl (TDF) Dosing:

Option 1: 2 mg oral morphine is approximately 1 mcg per hour transdermal fentanyl
Example: Total daily dose of morphine 100 mg translates to approximately 50 mcg 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>25</td>
<td>12</td>
</tr>
<tr>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>75</td>
<td>37</td>
</tr>
<tr>
<td>100</td>
<td>50</td>
</tr>
<tr>
<td>125</td>
<td>62</td>
</tr>
<tr>
<td>Each additional 25 mg/day</td>
<td>An additional 12 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 system removal, 17 hours or more are required for a 50% decrease in serum fentanyl concentrations.

Must prescribe short-acting opioid for breakthrough pain.
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, Cancer Pain, Palliative/Supportive Care, Pediatric ICU and Integrative Medicine (Appendix M for description of services).

a. Calculate total dose of opioid (scheduled and breakthrough 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 every hour for breakthrough pain.

APPENDIX J: Pediatric 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 naive 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>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>0.01-0.03 mg/kg/dose</td>
<td>6-8 minutes</td>
<td>5 doses per hour</td>
<td>0.0-0.03 mg/kg/hour</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>0.003-0.004 mg/kg/dose</td>
<td>6-8 minutes</td>
<td>5 doses per hour</td>
<td>0.0-0.004 mg/kg/hour</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.5-1 mcg/kg/dose</td>
<td>6-8 minutes</td>
<td>5 doses per hour</td>
<td>0.5 mcg/kg/hour</td>
</tr>
</tbody>
</table>

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, Cancer Pain, Palliative/Supportive Care, Pediatric ICU and Integrative Medicine (Appendix M for description of services).

a. Calculate total dose of opioid (scheduled and breakthrough 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 every hour for breakthrough pain.
# APPENDIX K: Pediatric Opioid Side Effects – Prevention and Management

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Prevention</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedation</td>
<td>- Discontinue other sedating medications if appropriate&lt;br&gt;- Educate all patients receiving opioids drowsiness may result for a few days following initiation or increase in opioid regimen.</td>
<td>- Consider rotation or dose reduction of opioid if sedation persists&lt;br&gt;- Consider psychostimulant:&lt;br&gt; 1. Methylphenidate (Ritalin®) 2.5-5 mg PO once or twice daily (last dose no later than 4 pm to avoid insomnia). Suggested time 8 am and 12 noon daily or&lt;br&gt; 2. Modafinil 100 mg once or twice daily.</td>
</tr>
<tr>
<td>Opioid Induced Neurotoxicity</td>
<td>Eliminate nonessential CNS activating or depressing drugs (for example: benzodiazepines)</td>
<td>- Consider reversible causes such as metabolic disorders, liver or renal dysfunction, dehydeation, hypercalceinia, organic brain disease; treat as appropriate. &lt;br&gt;- Consider one or more of the following:&lt;br&gt; 1. Opioid rotation (see Appendix G)&lt;br&gt; 2. Opioid dose reduction or discontinuation&lt;br&gt; 3. Discontinue other offending drugs (benzodiazepines)&lt;br&gt; 4. Hydration&lt;br&gt; 5. Symptomatic treatment with haloperidol 1-5 mg PO, IV, or SC every 4 hours as needed&lt;br&gt;- Avoid using naloxone even if delirium is thought to be due to opioid use</td>
</tr>
<tr>
<td>Respiratory depression</td>
<td>- Monitor sedation and respiratory status (respiratory rate and oxygen saturation) during the first 24 hours in opioid naïve patients.&lt;br&gt;- Titrate opioids cautiously.&lt;br&gt;- Consider dose reduction or opioid rotation if patient has excessive sedation.</td>
<td>- Call primary team, HOLD opioids, provide supplemental oxygen.&lt;br&gt;- If patient minimally responsive or unresponsive and respiratory rate less than or equal to 6, administer naloxone. Recommended dose: Naloxone 0.4 mg diluted in 9 mL saline, 1 mL IV push, repeat 1-2 minutes until patient 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.)&lt;br&gt;- If patient is actively dying, DNR (do not resuscitate) and receiving comfort care, naloxone administration may not be appropriate.</td>
</tr>
</tbody>
</table>

Continued on Next Page
### APPENDIX K: Pediatric Opioid Side Effects – Prevention and Management - continued

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Prevention</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea, Vomiting</td>
<td>- Titrate opioid dose slowly and steadily.</td>
<td>1. Investigate for other causes of nausea (for example, constipation, bowel obstruction, chemotherapy or other medications) and treat per guidelines. Initiate scheduled antiemetics. Example: Metoclopramide 0.1-0.2 mg/kg (maximum 10 mg/dose) 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 analgesia is satisfactory, reduce opioid dose by 25%. 4. Consider opioid rotation if nausea remains refractory.</td>
</tr>
<tr>
<td></td>
<td>- Provide antiemetics available with opioid prescription.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Metoclopramide 0.1-0.2 mg/kg (maximum 10 mg/dose) PO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Patients at high risk of nausea consider scheduled antiemetics for 5 days and then change to as needed.</td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td>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 plus stool softener: For example: Senokot-S (senna 8.6 mg plus docusate 50 mg), - 2 to 6 years: ½ tablet once daily (maximum 1 tablet twice daily) - 6 to 12 years: 1 tablet once daily (maximum 2 tablets twice daily) - Greater than 12 years: 2 tablets twice daily and titrate to a maximum of 9 tablets/day 2. Ensure adequate fluids, dietary fiber and exercise if feasible. 3. Prune juice followed by warm beverage may be considered. 4. Consider potential causes of constipation (such as recent opioid dose increase, use of other constipating medications, new bowel obstruction) 2. Increase Senokot-S (or senna and docusate tablets if using separate) and add 1 or both of the following: a. Milk of Magnesia oral concentrate (1,200 mg/5 mL) 15-30 mL PO once or twice daily. b. Polyethylene glycol (Miralax) 0.7-1.5 g/kg (maximum 17 g/dose) in 4-8 ounce beverage 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. 5. 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 magnesium citrate - 2 to 6 years: 60-90 mL once or in divided doses - 6 to 12 years: 90-210 mL once or in divided doses - Greater than 12 years: 240 mL once 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</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX L: Pain Management Education for Pediatric Patients 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 (Patient Packet 1). 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. 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 (Patient Packet 2).
   A. Morphine and morphine-like medications are often used to relieve pain
   B. When opioids are used to treat cancer pain, addiction is rarely a problem
   C. Taking opioids now will not affect later effectiveness
   D. Discuss potential side-effects of opioids, and its 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

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 print out 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
      • New pain, change in pain, or pain not relieved with medication
      • Nausea and vomiting that prevents eating for 1 day
      • No bowel movements for 3 days
      • Difficulty arousing the patient from sleep easily during daytime
      • Confusion

Continued on next page
APPENDIX L: Pain Management Education for Pediatric Patients and Family Prior to Discharge - continued

3. Pain Education Discharge/Resource Checklist - continued:

C. MD Anderson has multiple resources for pain management
   ● Specialty services for pain management at MD Anderson include: Acute Pain, Pain Medicine, Palliative/Supportive Care, Pediatric ICU and Integrative Medicine (Appendix M for description of services). Referral from primary service is required.
     Pain Management, 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. Website: http://www.mdanderson.org/departments/integrative-medicine-program. Located in the Main Building, Floor 1, outside and east of Clark Clinic main entrance - Main, free-standing building located outside and east of the Clark Clinic main entrance, near the Aquarium (R1.2000); Mays Clinic, Floor 2, near The Tree Sculpture
   ● The Learning Center(s) provide the latest 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, Floor 4, Elevator A R4.1100 713-745-8063,
Levit Learning Center, Mays Clinic, Floor 2, Near Tree Sculpture ACB2.1120 (Mon-Fri 9-4pm 713-563-8010).
APPENDIX M: Pediatric Specialty Services Consultation Guidelines

MD Anderson offers several coordinated pain specialty core services, consisting of Acute Pain, Pain Medicine, Palliative/Supportive Care, Pediatric ICU and Integrative Medicine. Guidelines for consultation to these services include the following:

A. For a patient whose pain remains uncontrolled for more than 24 hours, consider a consult to one of the specialty core services.
   Included in this group are:
   - Substance use disorders - except tobacco (current or past history).
   - Emotional, behavioral, and mental disorders.
   - Cognitive disorders.
   - Communicative disorders.
   - Developmental disabilities.
   - Vision and hearing impairments and disabilities.
   - Refractory symptoms and dying patient.

B. For postoperative and perioperative pain: Acute Pain Medicine and Integrative Medicine.

C. For acute pain in inpatients: Pain Medicine in cases of pre-existing chronic pain.

D. For patients with chronic pain and no evidence of active cancer: Pain Medicine (Chronic Pain) and Integrative Medicine.

E. For patients with evidence of active cancer with pain as the sole or predominant symptom: Pain Medicine or Palliative/Supportive Care Service; consider Integrative Medicine.

F. For patients with evidence of active cancer and pain accompanied by multiple symptoms: Palliative/Supportive Care; consider Integrative Medicine.

G. For patients with pain in the context of cancer in the palliative stage or end of life: Palliative/Supportive Care; consider Integrative Medicine.

H. For patients who need continuous infusions of medications when other measures previously listed have failed and pain is therefore intractable: Pediatric ICU
**SUGGESTED READINGS**


Continued on next page
SUGGESTED READINGS - continued


Cancer Pain – Pediatric

This practice consensus statement is based on majority opinion of the 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:

Anne Marie Alcala, RN-BC
Thuy-Van Do, RPH
Larry Driver, MD
Suzanne Gettys, PharmD
Yoliette Goodman, MBA
Gabriel Lopez, MD
Kevin Madden, MD
Rodrigo Mejia, MD
Maria E. Mireles, PharmD
Pascal Owusu-Agyemang, MD
Keyuri Popat, MD
Eden Mae C. Rodriguez, PharmD
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Core Development Team Or use to identify core team leads
Clinical Effectiveness Development Team