



**Nepalese Association of Palliative Care  
(NAPCare)**

**CLINICAL PRACTICE GUIDELINES FOR  
PALLIATIVE CARE**

**VERSION 1.0**

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## **THE GOALS OF GOOD PALLIATIVE CARE:**

To have as many as possible of 12 common symptom scores be in the mild range (less than 4) on 10-point Likert scale (Pain, tiredness, nausea, depression, anxiety, drowsiness, lack of appetite, shortness of breath, constipation, sleep quantity, sleep quality, feeling physically unwell). With moderate (4,5,6) pain scores, aiming to lower these to a maximum of 3.

Critical background: “Survival is linked to symptom control, and pain management contributes to broad quality of life” (1).

## **GENERAL APPROACH-PSYCHOLOGICAL SUPPORT.**

- Conduct visit in a quiet and private area.
  - Identify all major health problems.
  - Assess patient’s common symptoms and their intensities at every visit.
  - Assess family members’ /caregivers’ distress.
  - Tell patient and accompanying family members that you will do everything you can to relieve the patient’s symptoms.
  - Always schedule a follow-up visit to avoid any patient and family sense of abandonment.
  - Offer to hear about personal, spiritual or cultural concerns of the patient.
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## **PATIENT EDUCATION**

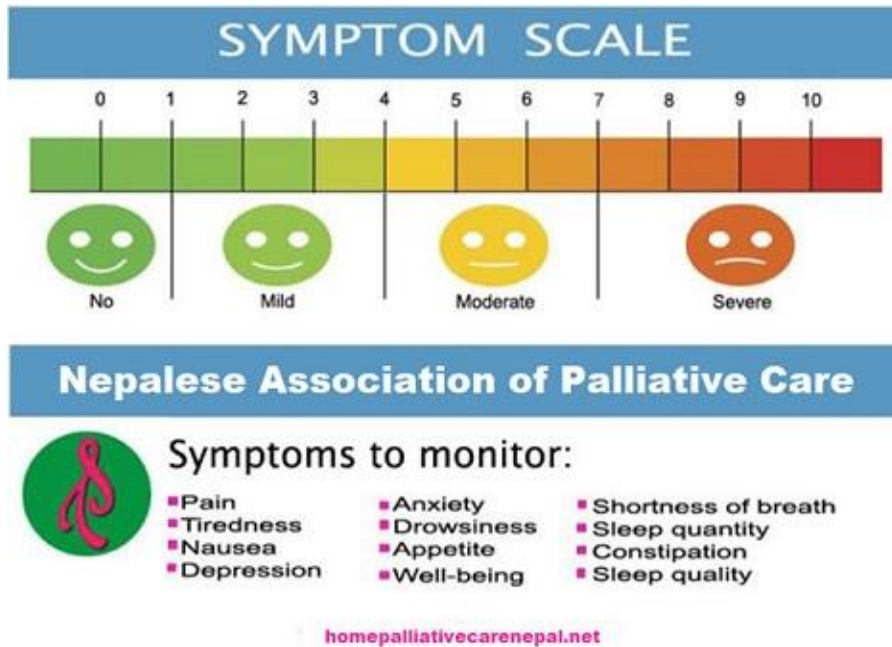
Share each of the following messages with each patient:

- Pain can be controlled.
- All symptoms need attention because they collectively work together to increase distress. Addressing pain, sleep, and GI-related symptoms will usually help with all common symptoms, except shortness of breath.
- Bring a written list of your concerns/worst symptoms to your doctor appointment.
- Make a written note about specific plans for making you feel better.

## ADULT CANCER PAIN

**ASK:** Does the patient report having any pain?

If yes: Score pain using the following combined visual analogue scale:



### Definitions:

Mild pain: Score 1-3

Moderate pain: Score 4-6

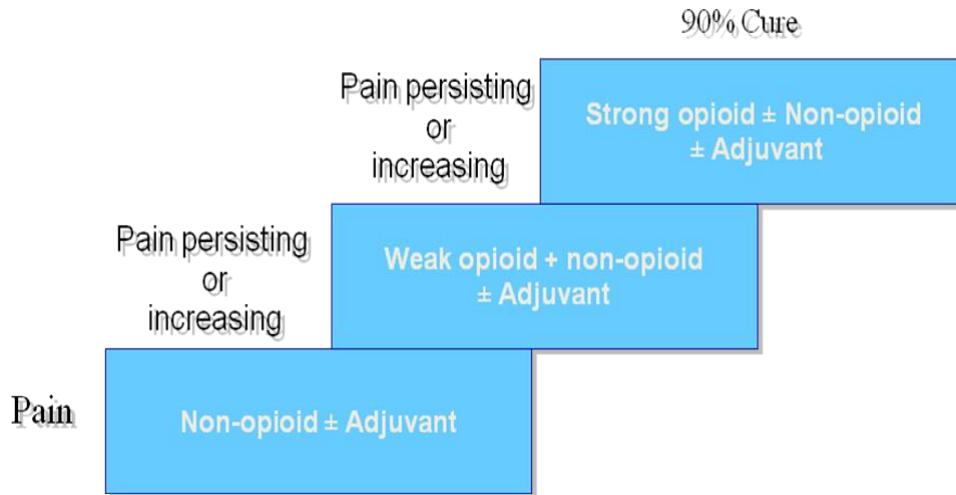
Severe pain: Score 7-10

### THE GOAL

The goal should be to achieve and maintain freedom from pain with usual, and maximal pain scores in the mild range (that is <4). To reach this goal, medicine should be given “by the clock”, that is every 4-6 hours, rather than on demand. Improving pain control lessens anxiety, depression, sleep disturbances, and feelings of physical un-wellness.

This WHO three-step approach emphasizes administering **the right drug in the right dose at the right intervals.**

## WHO Analgesic Ladder



### **STEP 1: MILD PAIN**

- Paracetamol and/or Non-steroidal anti-inflammatory drugs (NSAIDs)
- Add an adjuvant medicine if indicated

### **STEP 2: MODERATE PAIN**

- Mild Opioid
- Add NSAID if indicated
- Add an adjuvant drug if indicated

**STEP 3: SEVERE PAIN**

- Strong Opioid
- Add NSAID if indicated
- Add an adjuvant drug if indicated

**Non-steroidal anti-inflammatory drugs (NSAIDs)**

Most helpful with metastatic bone and soft tissue pain

<b>Drugs</b>	<b>Duration of Action</b>	<b>Dose</b>	<b>Route</b>	<b>Max. in 24 hrs</b>
Diclofenac	8 hours	50 mg	PO/SC/IM*	150 mg
Ketorolac	8 hours	10 – 30 mg	PO/SC/IM*	90 mg
Ibuprofen	6 -8 hours	400–800mg	PO*	2400 mg
Naproxen	8 – 12 hours	250-500mg	PO*	1500 mg
Etoricoxib	24 hours	60-120 mg	PO*	120 mg

\*PO=by mouth; SC=subcutaneously; IM=intramuscularly

Adverse effects of NSAIDs are:

- Gastric erosion
- Impaired renal function
- Changes in platelet function
- Bronchospasm

## **Adjuvants**

Adjuvant analgesics are medications not typically used for pain relief but they are effective for specific types of pain notably visceral, bone, and neuropathic pain. Primary among these agents are:

- Steroids,
  - Antidepressants (amitriptyline 10mg-75mg/day)
  - Anticonvulsants (carbamazepine 100mg-400mg/day) for neuropathic pain
  - Bisphosphonates for bone pain (zoledronic acid 4mg IV) q month.
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**For neuropathic pain** (that is pain caused by nerve compression or injury):

Antidepressant agents such as:

Amitriptyline 10mg, 25mg, 50mg at bedtime. Starting doses 25mg.

Imipramine 25mg, 50mg at bedtime. Starting dose 25mg.

If patient has hypertension or cardiovascular disease, or is a geriatric individual: use SSRI agents like Sertralin 25mg, 50mg. Starting dose in AM: 25mg.

## **Non-Opioids**

Paracetamol 500-1000 mg up to every 6 hours. Upper limit 4 gm/day (Avoid in patients with liver disease)



## OPIOIDS

### Mild Opioids

#### Codeine

- Codeine is a pro-drug that requires an enzyme for breakdown to morphine for pain relief. About 10% people lack this enzyme.
- The recommended adult dose of codeine for pain relief is 15 mg to 60 mg every 4 to 6 hours as required, not to exceed 240 mg in one day.
- 60 mg oral codeine is equi-analgesic to 10 mg oral morphine and morphine is cheaper.

#### Tramadol (Has both opioid and non-opioid properties)

- The recommended dose of Tramadol is 50-100 mg (immediate release tablets) every 4-6 hours as needed.
  - The maximum dose is 400 mg/day.
  - 50 mg of oral Tramadol is equi-analgesic to 10 mg of oral Morphine (5:1). 100 mg IV Tramadol is equi-analgesic to 10 mg IV morphine (10:1).
  - The bioavailability of oral Tramadol is greater than of IV Tramadol.
-

## **Strong Opioids**

### Morphine

Morphine is available in oral doses as:

Sustained release tablets of 10mg, 30mg

Instant/immediate release tablets of 10mg.

Syrup form: 5ml has 10mg morphine

In injectable form with 10mg in a 1 ml ampoule.

- Morphine is the drug of choice for management of patients who have moderate to severe pain because it has a wide therapeutic range, is effective by many routes of administration, and it is relatively inexpensive.
- Starting dose for opioid-naïve patients is 5- 10 mg immediate release morphine (Morphine syrup 2.5ml) orally every 4 hours around the clock.
- If the patient's pain persists after the 4<sup>th</sup> dose, then the dose of morphine can be increased up to 50%.
- The important point is that there is no dose limit.
- When the daily dose is found to adequately control the pain, morphine prolonged release (PR) can be substituted for regular morphine, which is given in two divided doses.
- The total 24-hour dose should remain the same.
- Rescue dose also should be made available for “breakthrough pain” (10% of total 24-hour dose).
- Oral Morphine: SC/IV Morphine = 2:1
- Physical dependence may develop, but it does not develop into addiction.

- Withdrawal symptoms are due to physical dependence.
  - Constipation is the most common side effect. Prescription of opioids should include prescription of laxatives. Morphine reduces gastrointestinal motility and secretion leading to constipation. A stimulant laxative like bisacodyl, reduces the ring contraction and facilitates propulsive activity.
  - Respiratory depression is very rare side effect. Naloxone is antidote if respiratory depression develops. Dilute 400microgram (1amp) in 9ml normal saline and give 2.5ml (100microgram) IV every 1-2 minutes titrating response.
  - Side effects of morphine include:
    - Constipation
    - Nausea
    - Vomiting
    - Dry mouth
    - Sweating
    - Sedation and nausea usually resolve after a few days.
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## MANAGEMENT OF OTHER SYMPTOMS.

In a study of 383 Nepalese patients with incurable cancers, half had moderate to severe tiredness, depression, and anxiety, and two-thirds had poor appetite, and poor sleep quantities and quality (2). In this study 15% and 19% respectively of patients reported severe depression or anxiety.

### ANXIETY

- Use of low dose medication in patients with anxiety who also have moderate pain scores (5-6) is helpful in keeping the needed doses of analgesic medications low.
- Lorazepam (a short acting benzodiazepine) 1mg tablets. Starting dose: 0.5-1 mg once a day.
- Tab Clonazepam may be preferred in patients with poor sleep. Starting dose: 0.25 mg at bedtime.

### DEPRESSION

The two most important management steps are:

- Optimize control and management to lessen physical symptoms.
- Assure the patient that you (the doctor) will do everything possible to help him/her feel better.
- For moderate to severe depression that persists over time after following the two steps above, consider using anti-depressant medication.
  - Be clear that the timeline for benefit from such drugs is long.
  - Be certain of the dose.
  - Give only a limited number of doses to start treatment and schedule a follow up visit within two weeks.

## DISCLAIMER

The Nepalese Association of Palliative Care and the authors of these guidelines have made every effort to assure that the names, doses and schedules of the drugs listed in these guidelines are correct and applicable to Nepalese men and women. There may however be some errors and exceptions which have been missed or not noted. Professional health care givers are urged to check the details of any drugs they are not familiar with by consulting proper authorities. To help assure that the guidelines are as appropriate and accurate as possible please share any particular concerns by writing an email to [palihomecarenepal@gmail.com](mailto:palihomecarenepal@gmail.com).

. The Nepalese Association of Palliative Care and the authors cannot be responsible for problems which follow from use of the drugs listed here, in whatever forms, schedules or doses.

## References

1. [https://www.nccn.org/professionals/physician\\_gls/pdf/pain.pdf](https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf)
2. Love, R.R., Paudel, B.D., G.M.T. Ahsan, Ahamed, S.I.: Symptoms in Nepali patients with incurable cancers: implications for interventions. (Submitted for publication)

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