**Palliative Pain: Question 1**

**Mrs R. Brown of Flat 57C, Chisleworth Road, Whitechapel, DOB 23/05/1935 has pain from metastatic ovarian cancer, and has been receiving:**

* **Oramorph® (Morphine Sulphate) solution 20 mg 4 hourly for analgesia and 20 mg as required**
* **In the last 24 hours Mrs Brown has required four 20 mg prn doses**

**She is now being prepared for discharge. You have been asked to write her TTA (to take away) prescription and discharge note for the GP (14 days supply).**

1. **Convert her dose of Oramorph® solution to a 12 hourly modified release (MR) preparation of morphine, and prescribe breakthrough analgesia at an appropriate dose.**
2. **What information would you include in the prescription on a TTA for Morphine MR and Oramorph® solution?**
3. **What other prophylactic medications – and at what doses – should you co-prescribe for this patient?**

**a)** Morphine MR dose = **100mg BD PO**

* 20mg 4 hourly = 20mg x 6 doses = 120mg
* + Four 20 mg prn doses = 80 mg
* Total: 120 mg + 80 mg = 200mg used in 24hours

Oramorph® solution **30mg PRN 4 hourly PO**

* (30 mg is ~ 1/6th total daily dose)
* This is a CD– highlight

**b)** Prescription requirements:

* Patients’ full name, home address and/or hospital number and, where appropriate DOB
  + **Mrs R. Brown of Flat 57C, Chisleworth Road, Whitechapel, DOB 23/05/1935**
* Drug name & formulation
  + **Morphine sulphate MR tablets**
* Strength
  + **100 mg tablets**
* Dose to be taken/frequency
  + **twice daily/ BD orally/PO**
* Total quantity and dosage units in words and figures
  + **Please supply 28 (twenty-eight) 100 mg tablets**
* **Full signature and printed name of the prescriber**
* **Date**

**c)** Prophylactic medications:

* **Prophylactic laxatives – senna /macrogol /docusate regularly**
* **N&V – cyclizine 50mg 8 hourly**
* *Choice as per Trust guidance, BNF doses.*

**Question 2**

**Unfortunately, Mrs Brown’s pain worsens on the day before discharge. She has also experienced some hallucinations and some symptoms of neuropathic pain (e.g. numbness, burning or shooting, ‘pins and needles’).**

**What change(s), if any, would you make to the current treatment?**

* **Neuropathic pain** is generally managed by **tricyclic antidepressants / certain antiepileptic drugs**. It may respond only partially to opioid analgesics.
* Like any analgesic, these drugs have a ceiling effect for pain relief and side effects. Unlike conventional analgesics their side effects are often noticed by the patient before the ceiling effect for pain relief is reached. Therefore, the drugs should be given slowly and titrated upwards over a period of time with careful monitoring of side effects.
* Likewise, discontinuation should follow a ‘stepped approach’ and the patient should be commenced on a reducing dose regime. This can be discussed with the pharmacist.
* The usual dose of **Amitriptyline** (first line) for pain management is between **10 mg to 150 mg, normally given at bedtime.** In general, it may take up to 2 weeks or more for the patient to start feeling better.
* If the above ineffective or poorly tolerated, **Pregabalin can be started at a dose of 150 mg per day, given as 2-3 divided doses.** Based on individual patient response and tolerability, the dose may be titrated upwards – see BNF.
* **Oxycodone** here would be the rational alternative to Morphine, in view of the hallucinations.
* The total daily dose (morphine 200mg) –*as per BNF conversion table* – would be oxycodone **132mg**. However, the patient’s pain was not controlled with 200mg Morphine daily. Particular care should be taken when checking the safety of increased doses. For example, for oral morphine or oxycodone in adult patients doses should not normally be more than 50% higher than the previous dose (NPSA guidance).
* So a reasonable approach in this case would be to switch to **Oxycodone MR 75mg BD** (total daily dose = 150mg)