



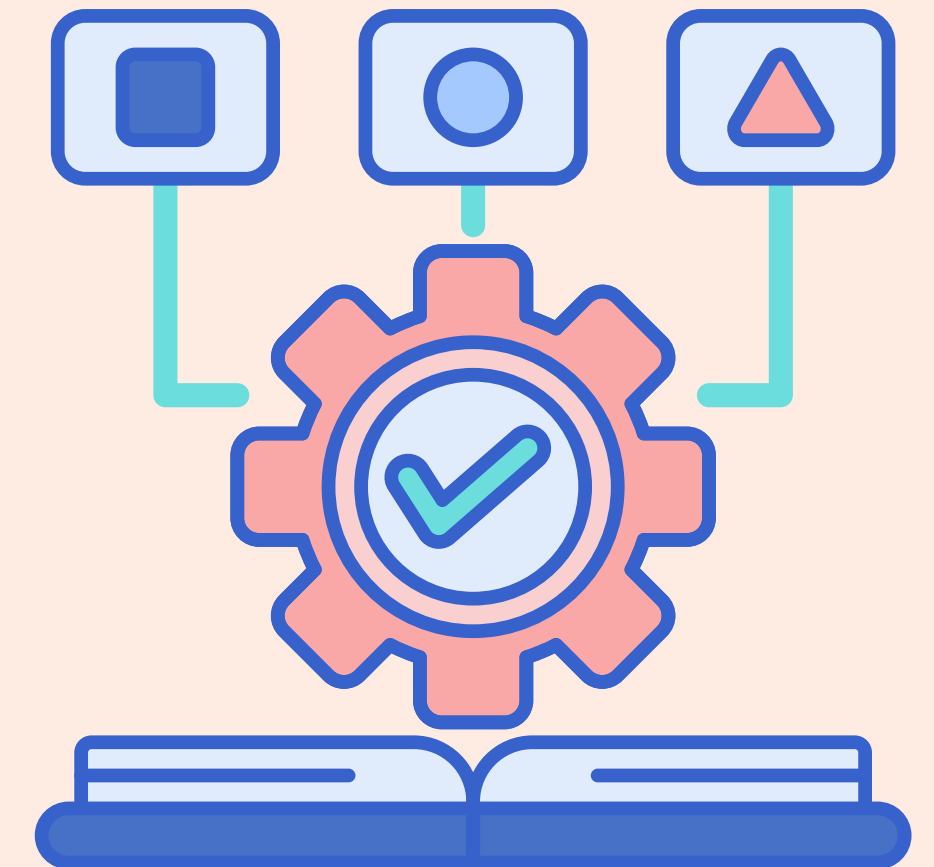
# Assessment and Management of Chronic Pain For MO





# LEARNING OBJECTIVES

- Understand bio psychosocial model of pain
- Understand approach towards Assessment and its importance
- Understand pain relief as an important aspect of quality of care
- Learn WHO analgesic ladder
- Learn drugs in the WHO analgesic ladder and their effective usage

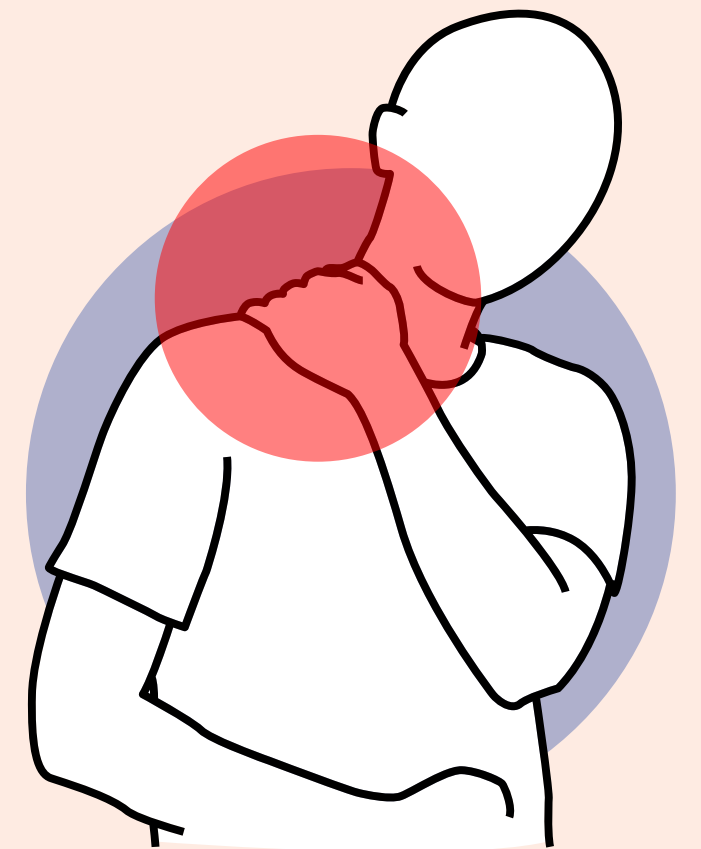




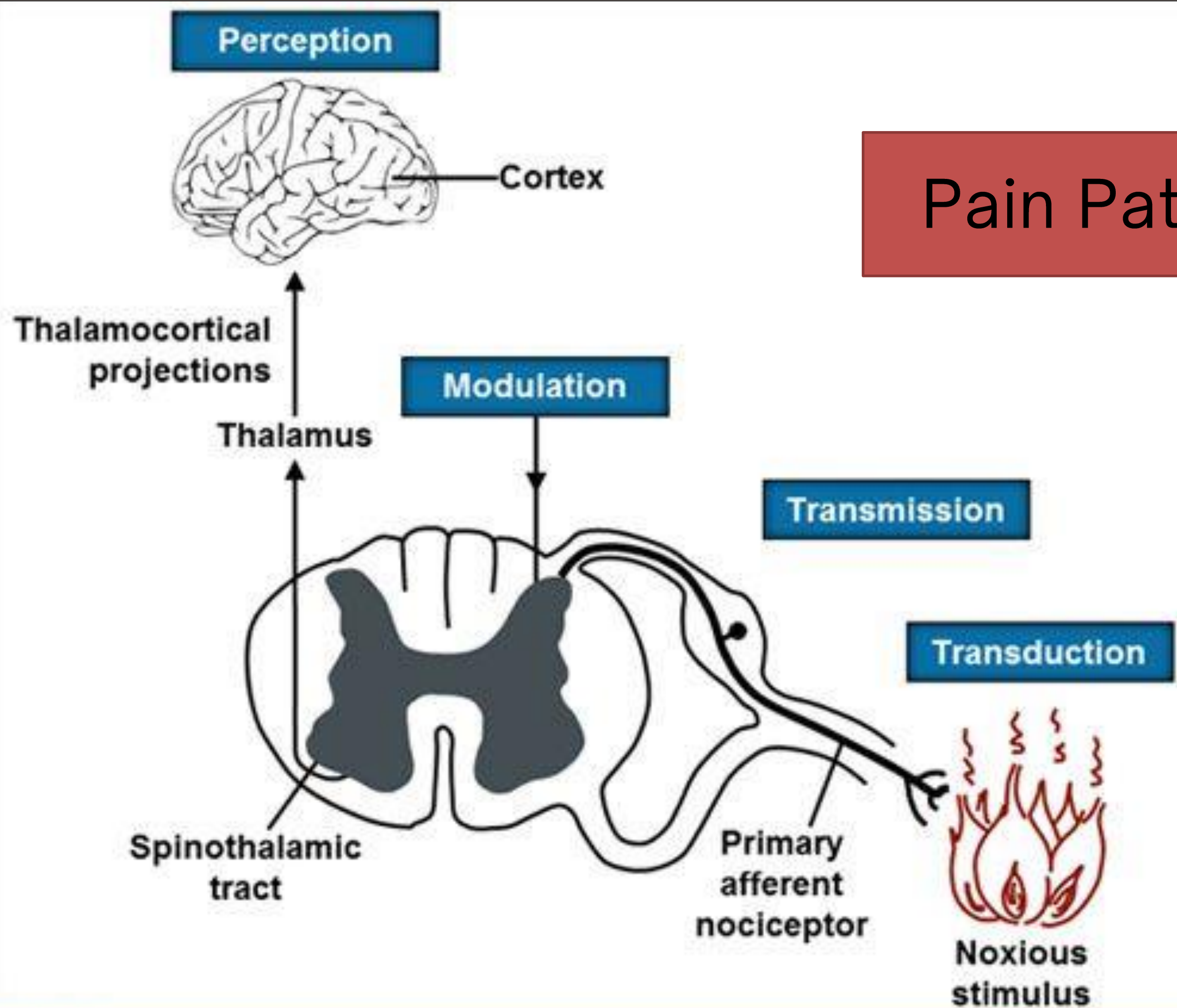
# WHAT IS PAIN?

An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage - IASP-2020

- An unpleasant bodily sensation
- An experienced threat associated with this sensation
- A negative emotion based on this experienced threat







# Pain Pathway



# CASE DISCUSSION

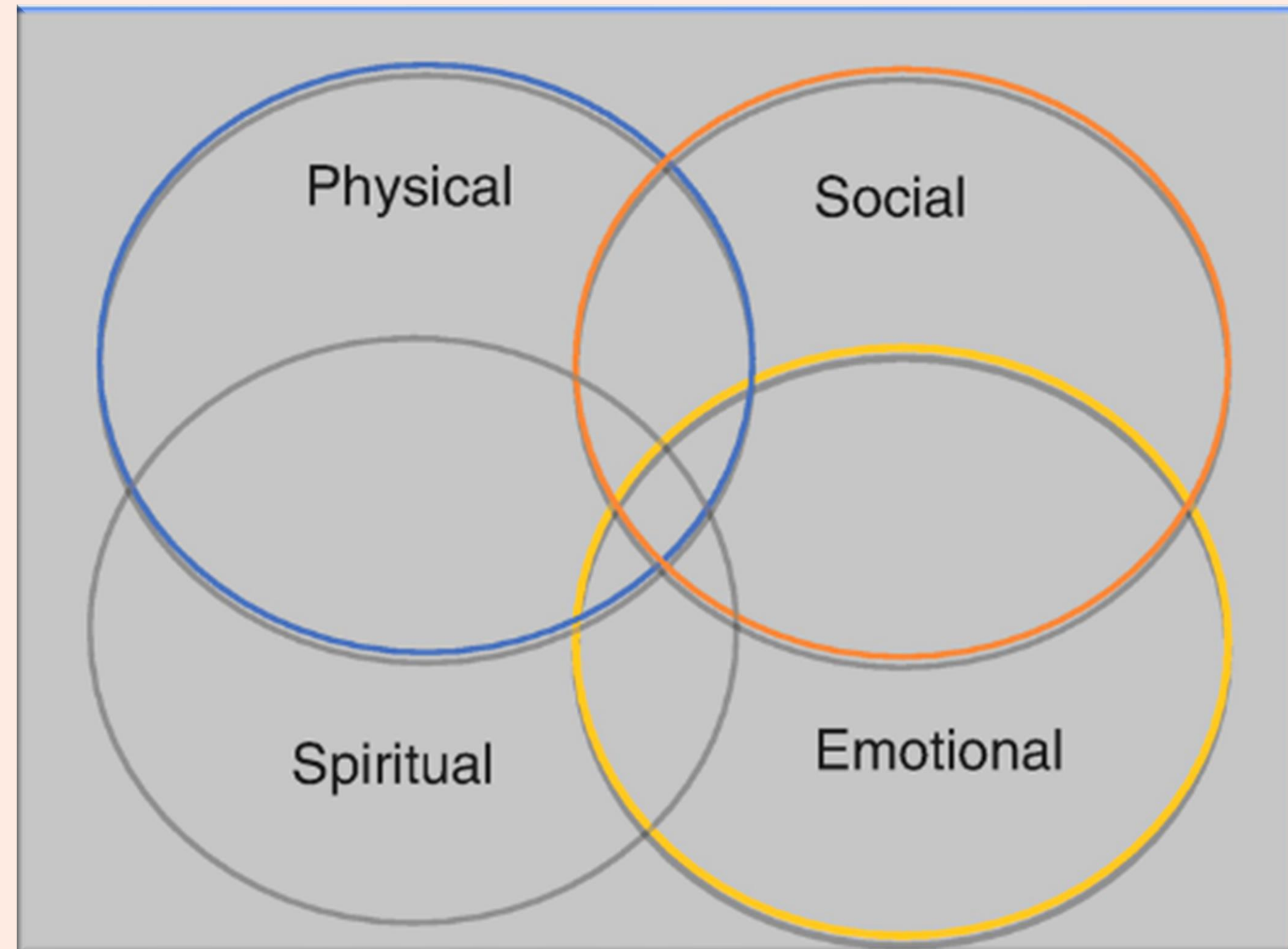
- A 33-year-old female patient (Married, 2 year old son, husband was sole earning member in family and he left job from last 1 year because of her treatment)
- Diagnosis: Carcinoma Right Breast (Post Surgery, Post Radiotherapy)
- Presented to Pain clinic with severe pain all over the body

How will you approach this?



# UNDERSTAND BIO-PSYCHOSOCIAL MODEL OF PAIN

Treat person as a whole





# TOTAL PAIN

## Physical Pain

- Illness (Cancer)
- Cancer Treatment
- Unrelated to Cancer

## Emotional Pain

- Anger at delays in diagnosis
- Anger at therapeutic failure
- Disfigurement
- Fear of pain / death
- Feelings of helplessness

## Spiritual Pain

- What is the point of this all?
- Why has this happened to me?
- Is there any purpose in life?
- Is this a punishment?
- Why me?

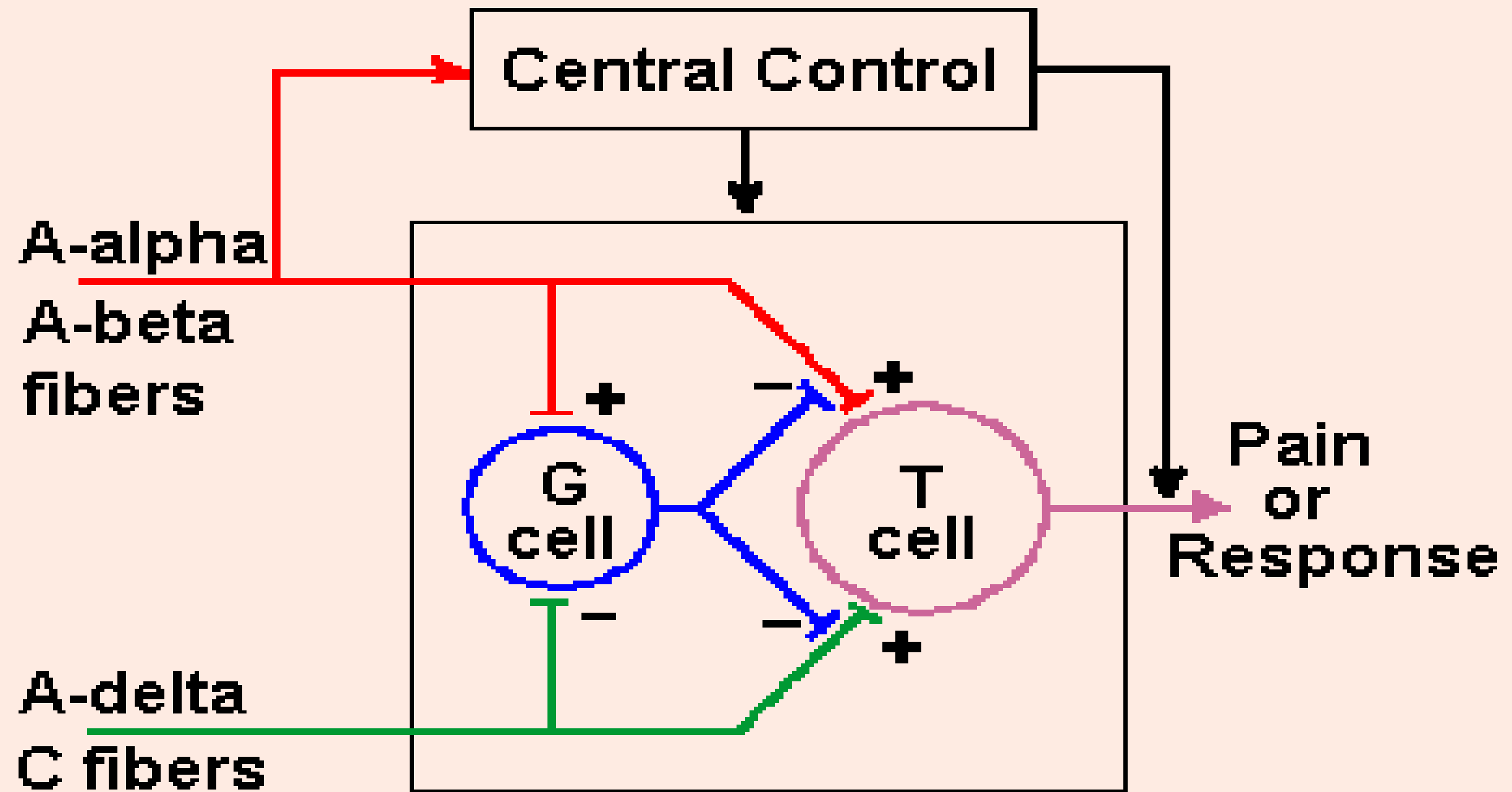
## Social Pain

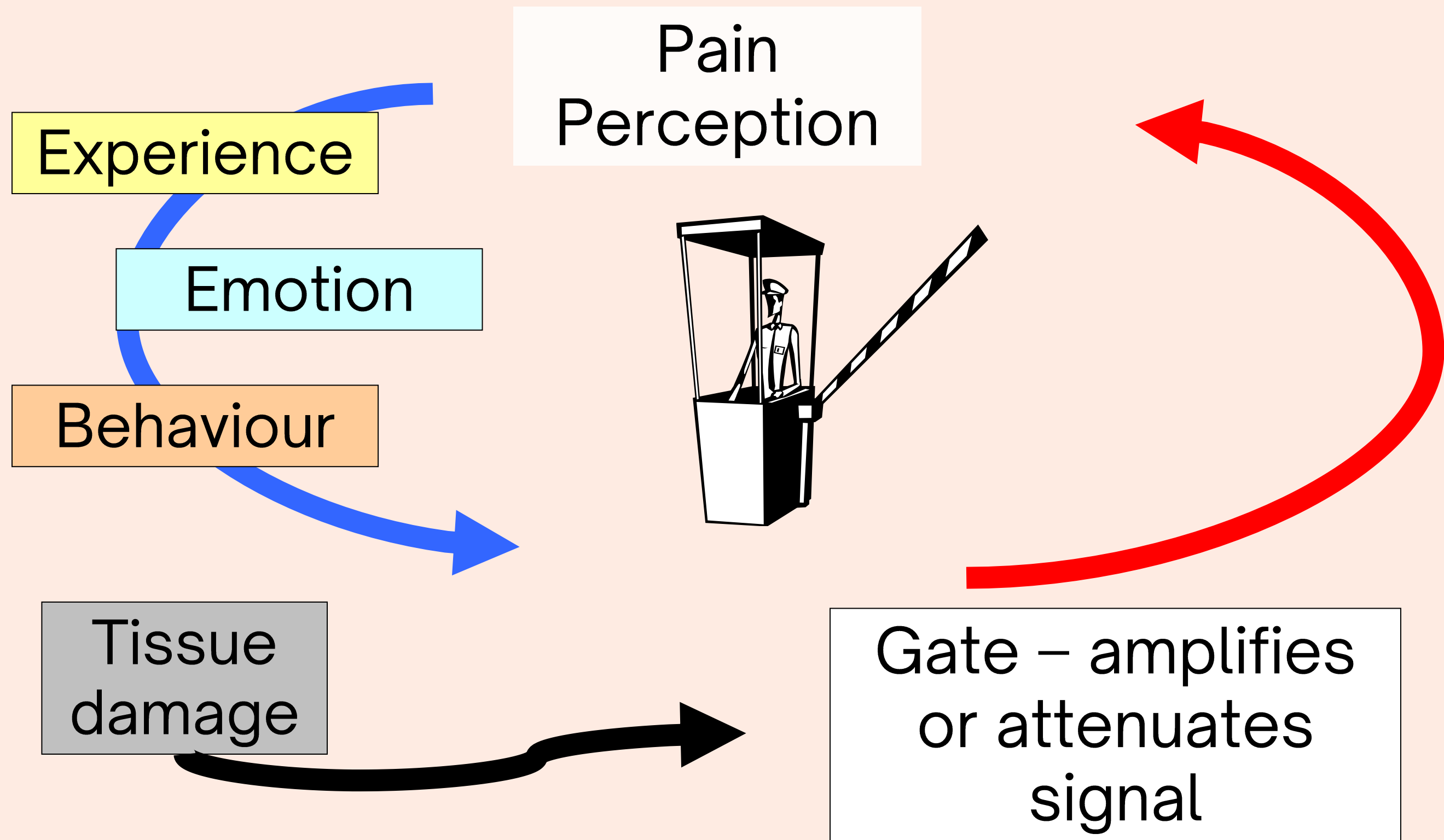
- Worries about family, finances
- Loss of income
- Loss of social role
- Loss of role in the family
- Feeling of isolation



# GATE CONTROL THEORY (MELZACK & WALL, 1965)

- Gate is present in substantia gelatinosa of dorsal horn of spinal cord which can be opened or closed







# OPENING AND CLOSING GATE

Factor	Opens	Closes
Nerve fibres	C fibres	A-beta fibres
Physical	Injury	Medication
Emotional	Anxiety Stress Frustration Depression Tension	Relaxation Optimism Happiness
Behavioural (cognitive)	Boredom	Enjoyable activities Social interaction





# MOST IMPORTANT

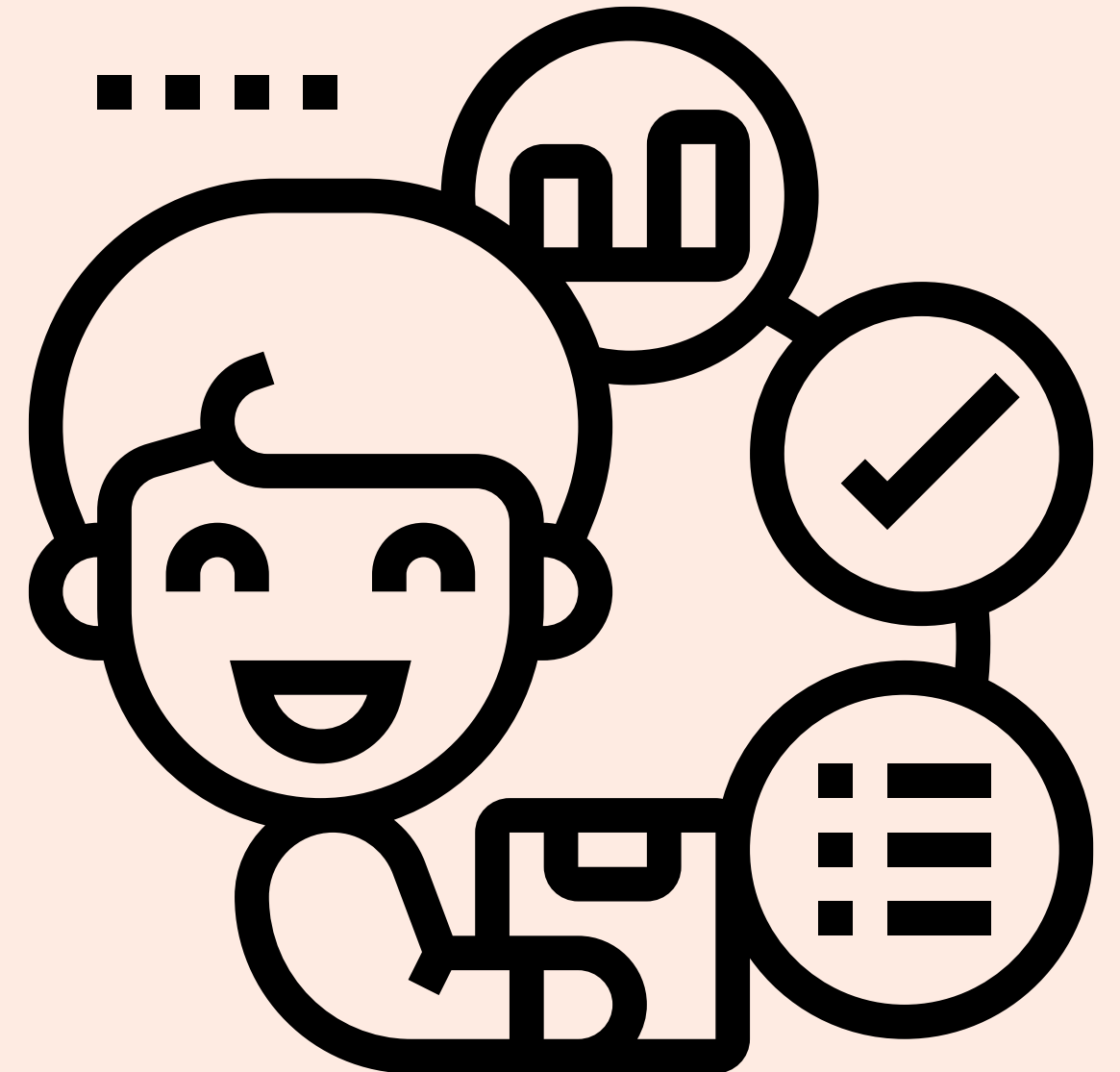
Knowing your patient



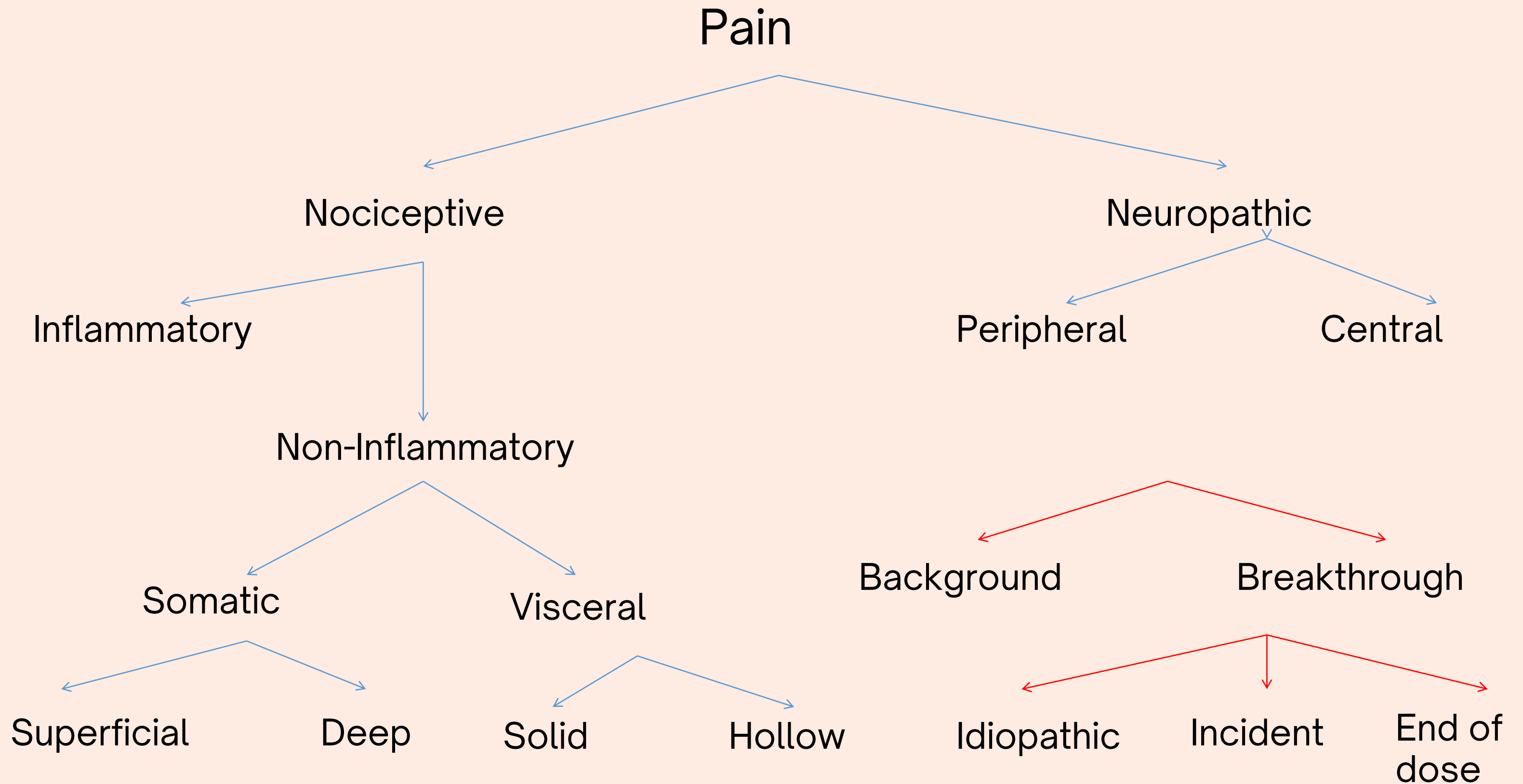


# EVALUATION

- History
- Records
- Investigate if required
- Confirm site
- Identify cause
- Establish trust

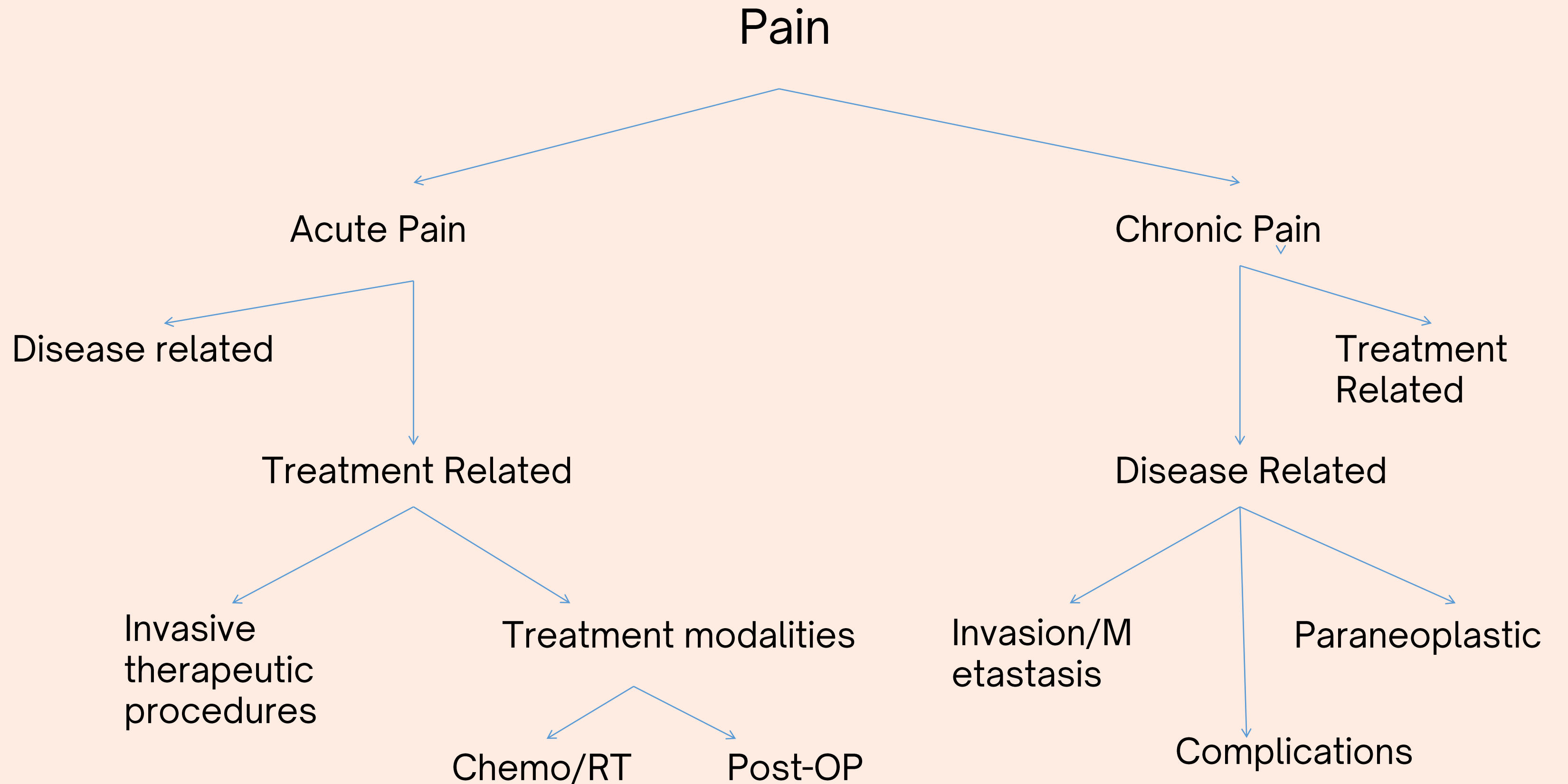


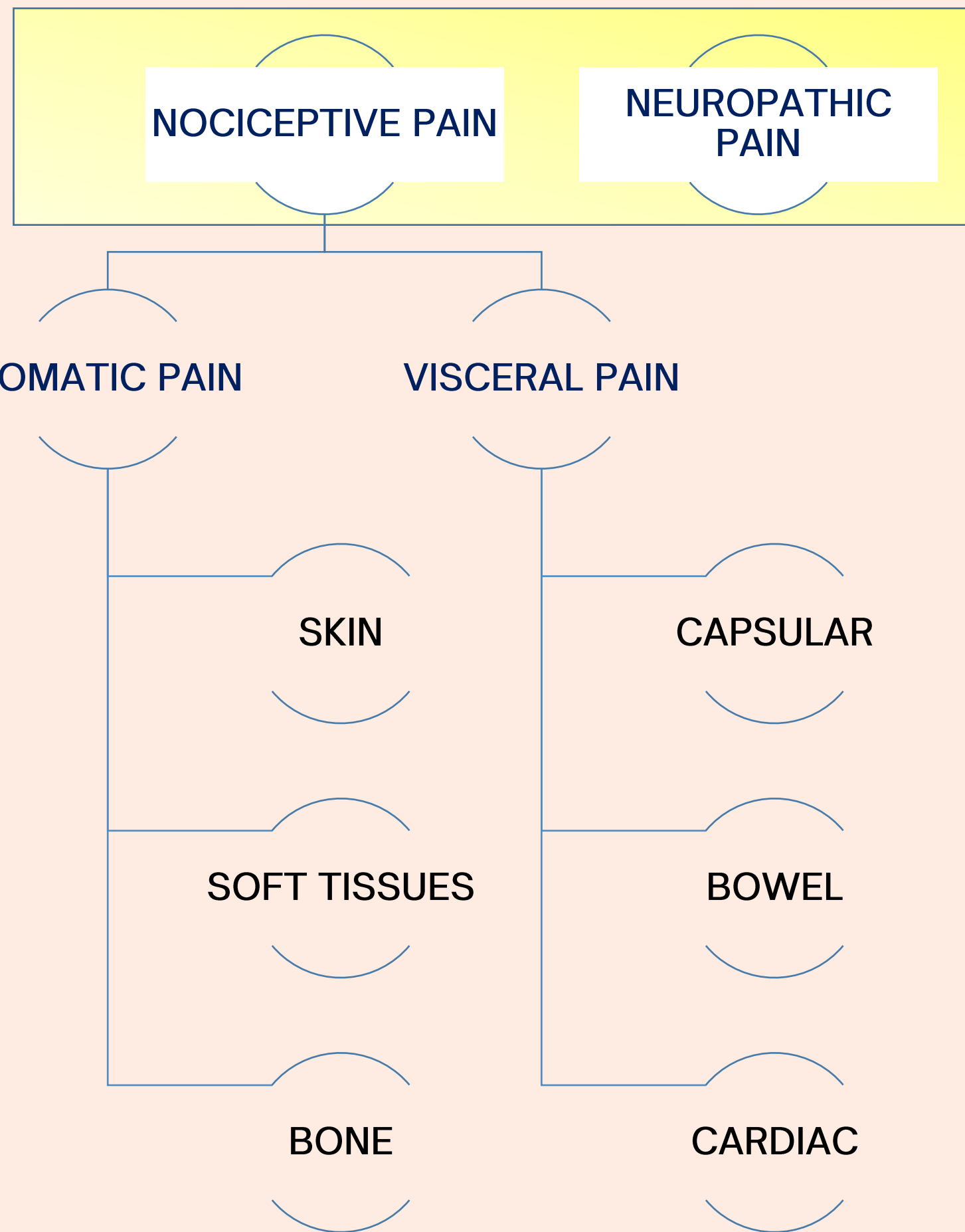
# UNDERSTANDING THROUGH PHYSIOLOGY





# UNDERSTANDING THROUGH ETIOLOGY





## Quality of Pain

Aching  
Superficial  
Dull/sharp

Somatic

Stabbing  
Burning  
Gripping

Capsular

Dull  
Cramping  
Colic

Bowel

Tight  
Squeezing  
Choking

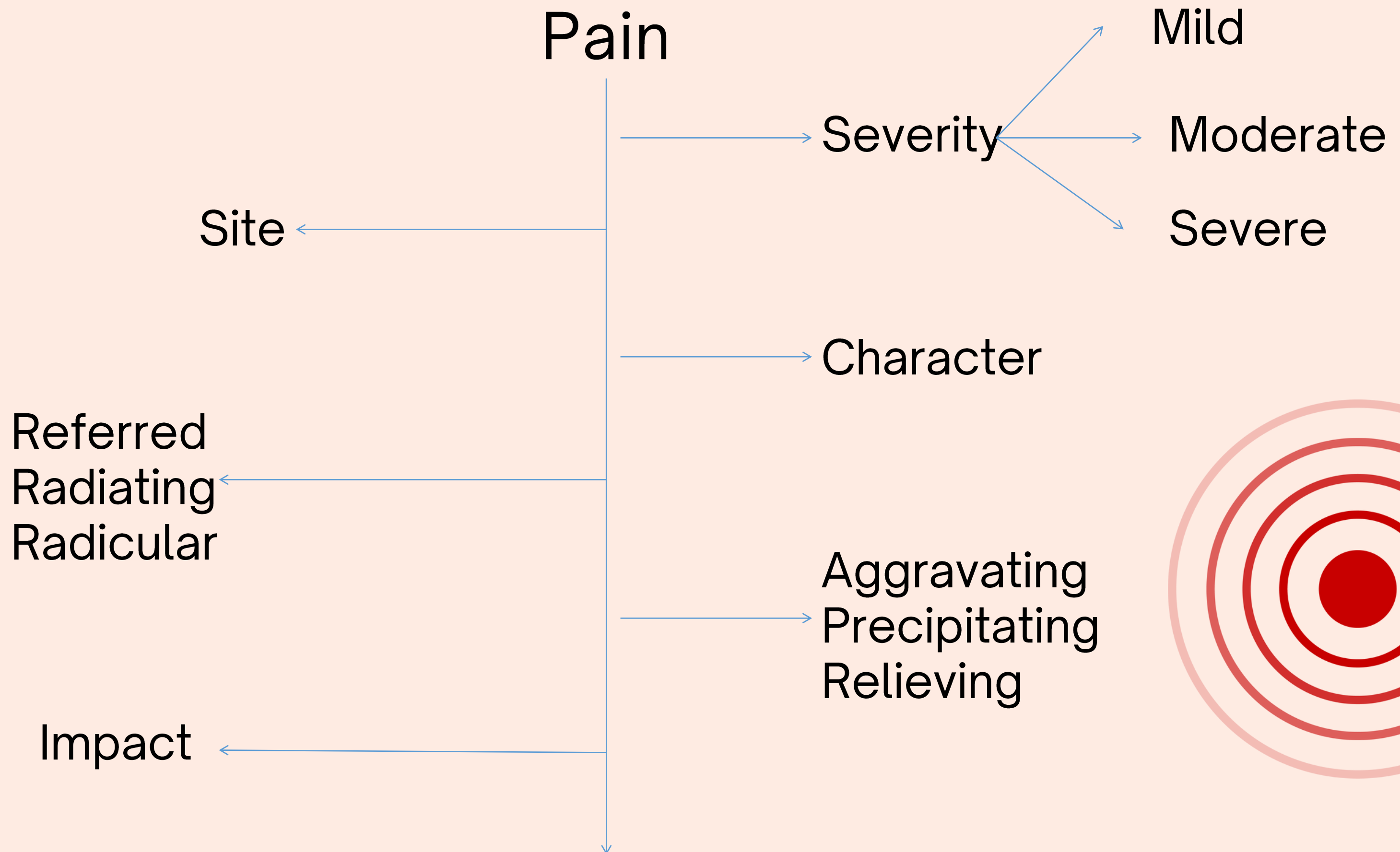
Cardiac

Stinging  
Electric like  
Shooting  
Burning  
Numbness

Neuropathic



# FURTHER EVALUATION REQUIRED







# PQRST PAIN ASSESSMENT METHODS

<b>P=Provocation /Palliation</b>	<p>When pain started? What caused it? What makes it better or worse? What triggers it? Stress? Position? Certain activities?</p> <p><b>What relieves it?</b> Medications, massage, heat/cold, changing position, being active, resting?</p> <p><b>What aggravates it?</b> Movement, bending, lying down, walking, standing?</p>
<b>Q=Quality/ Quantity</b>	<p>What does it feel like? sharp, dull, stabbing, burning, crushing, throbbing, nauseating, shooting, twisting or stretching.</p>
<b>R=Region/ Radiation</b>	<p>Location of Pain? Radiation of Pain?</p>
<b>S=Severity</b>	<p>How severe is the pain?</p>
<b>T=Timing</b>	<p>When/at what time did the pain start? How long did it last? How often does it occur? Is it sudden or gradual?</p>

Remember to document all your observations

# SUMMARY OF ASSESSMENT OF PAIN

- Elicit the distressing concerns for the patient and family
- Determine underlying pathophysiology, cause, and contributing factors
- Review current and past treatments, their effectiveness, and side effects
- Document assessment and plan
- Reassess at regular intervals



If we cannot assess pain, we will never be able to relieve pain  
- Betty R. Ferrell



**WHAT TOOLS/QUESTIONS  
YOU USE TO ASSES PAIN?**





# ASSESSMENT TOOLS

- Unidimensional Scales
  - Visual Analogue Scale (VAS)
  - Numeric rating scale (NRS)
  - Verbal Rating Scale (VRS)
  - Wong-Baker faces pain rating scale
- Multidimensional Tools
  - The McGill Pain Questionnaire (long and short form),
  - The Brief Pain Inventory (BPI)
  - The Pain Thermometer (PT)





- Multidimensional Tools

- The Memorial Pain Assessment Card
- The Wisconsin Brief Pain Questionnaire
- The Edmonton symptom Assessment system (ESAS)
- Multidimensional pain inventory-Screening Chinese version(MPI-SC)
- Neuropathic Pain Scale
- The Leeds Assessment of Neuropathic Symptoms and Signs (LANSS)





### Visual analog scale

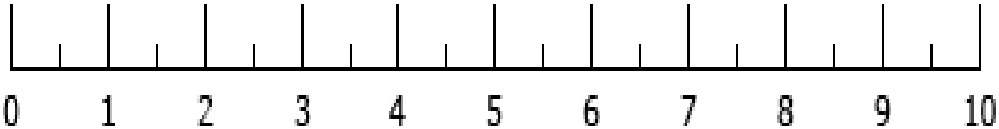
Place a mark on the line below to indicate how bad your pain feels.

No pain  Worst pain imaginable

- Patient is asked to mark a **10 cm line** at a point that corresponds to the degree of pain.
- The VAS score is the distance in millimeters from the left end of the line to the patient's mark.

### Numeric rating scale

What does your pain feel like?

  
No Pain Worst Imaginable Pain

- Patient indicates the number that corresponds to pain severity, either verbally or by marking the scale.

## VAS vs NRS

  
No Pain    Mild    Moderate    Severe    Very Severe    Worst

## Verbal Rating Scale



# UNIDIMENSIONAL TOOLS



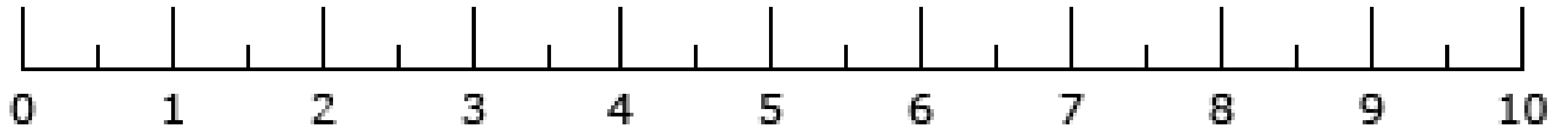
Visual Analogue Scale	Numerical Rating Scale	Verbal Rating Scale
Validated for research	Less sensitive	Easy to Use
Simple to use	Requires patient to be able to translate pain severity to number.	Useful in mildly cognitively impaired
Sensitive to small changes	Not useful in visually impaired, cognitively impaired and children	Insensitive to small changes in pain intensity
Not useful in visually impaired, cognitively impaired and small children		



# NUMERIC RATING SCALE

**Numeric rating scale**

What does your pain feel like?

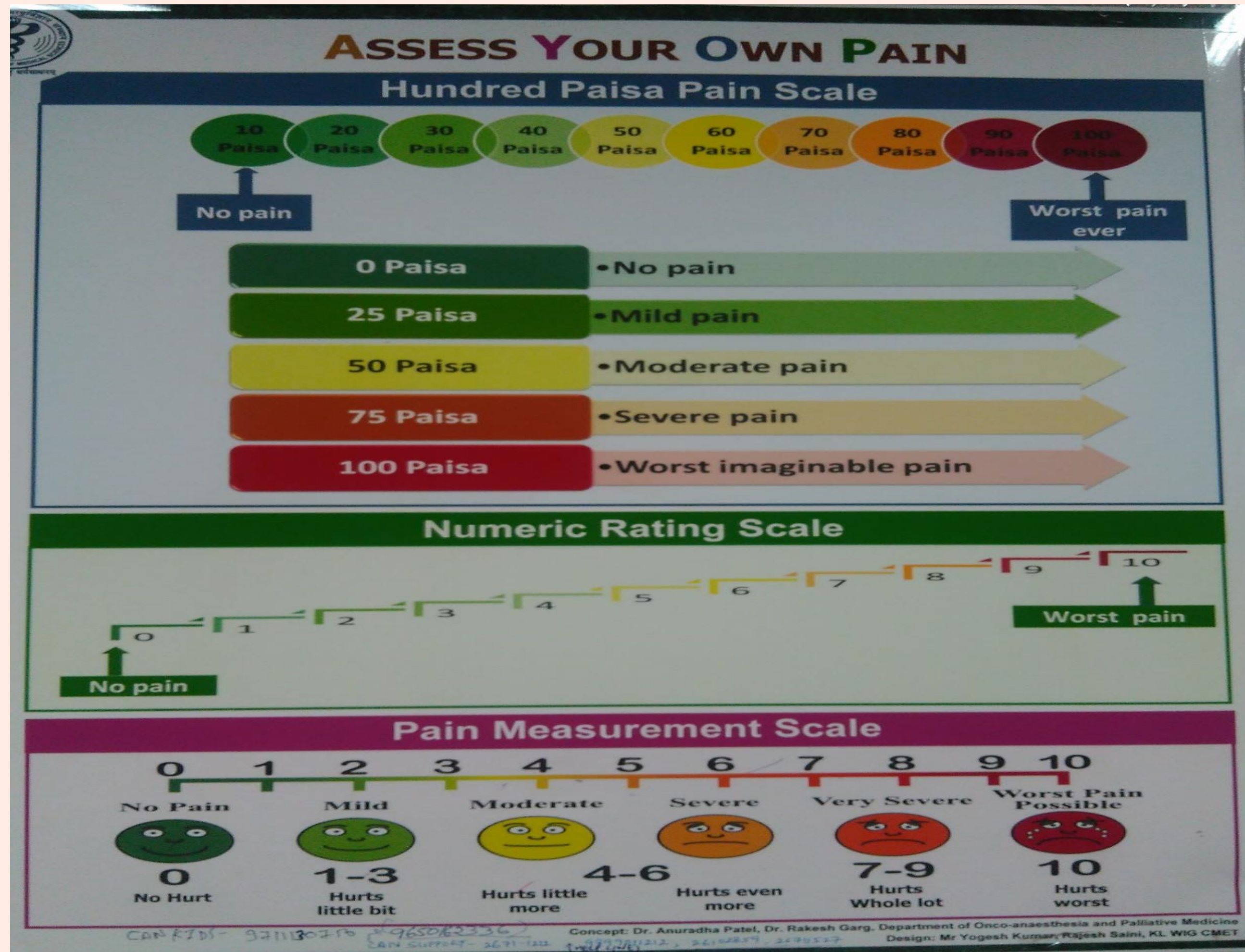


**MILD**

**MODERATE**

**SEVERE**









# Multidimensional Instruments

Time  
Consuming/Useful  
in Research

Provide Complex  
Information about  
Patient Pain

Use in Assessing  
Chronic Pain

# WONG-BAKER FACES PAIN RATING SCALE

## Some important Pain Rating Scales For Paediatric Population



- For persons age three years and older.
- Point to each face using the words to describe the pain intensity.
- Ask the child to choose the face that best describes own pain and record the appropriate number.

# REVISED FLACC PAIN SCORE

Can be used in preverbal children



Categories	Scoring		
	0	1	2
F Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested; appears sad or worried	Frequent to constant frown, clenched jaw, quivering chin; distressed-looking face: expression of fright or panic
L Legs	Normal position or relaxed	Uneasy, restless, tense; occasional tremors	Kicking or legs drawn up; marked increase in spasticity, constant tremors or jerking
A Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense; mildly agitated (eg, head back and forth, aggression); shallow and splinting respirations, intermittent sighs	Arched, rigid, or jerking; severe agitation, head banging; shivering (not rigors); breath-holding, gasping or sharp intake of breath; severe splinting
C Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint; occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent complaints; repeated outbursts, constant grunting
C Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractable	Difficult to console or comfort; pushing away caregiver, resisting care or comfort measures





# PAIN FORMS



## PAIN AND PALLIATIVE ASSESSMENT FORM

Department of Onco-Anaesthesia and Palliative Medicine  
NCI-AIIMS, New Delhi (Jhajjar Campus)



Name:	Date:
Age/Sex:Phone No.:	
NCI/UHID No:	Address:

Current Diagnosis:
--------------------

Stage of cancer:
------------------

Secondaries
-------------

When was cancer diagnosed?
----------------------------

Treatment received: Surgery / Radiotherapy / Chemotherapy / Others
Details:

Present status: On active therapy (CT/RT)/ Advanced malignancy stable/ Advanced malignancy progressive
--

Referral to palliative care ward
1. Referred from DMG 2. Referred from other oncology department 3. Directly presented to palliative department

Indication for referral .....
-------------------------------

Time of presentation to palliative care ward after diagnosis
Less than 8 weeks/ Less than 6 months/6 months to 1 year/ More than 1 year

Primary caregiver-.....
-------------------------

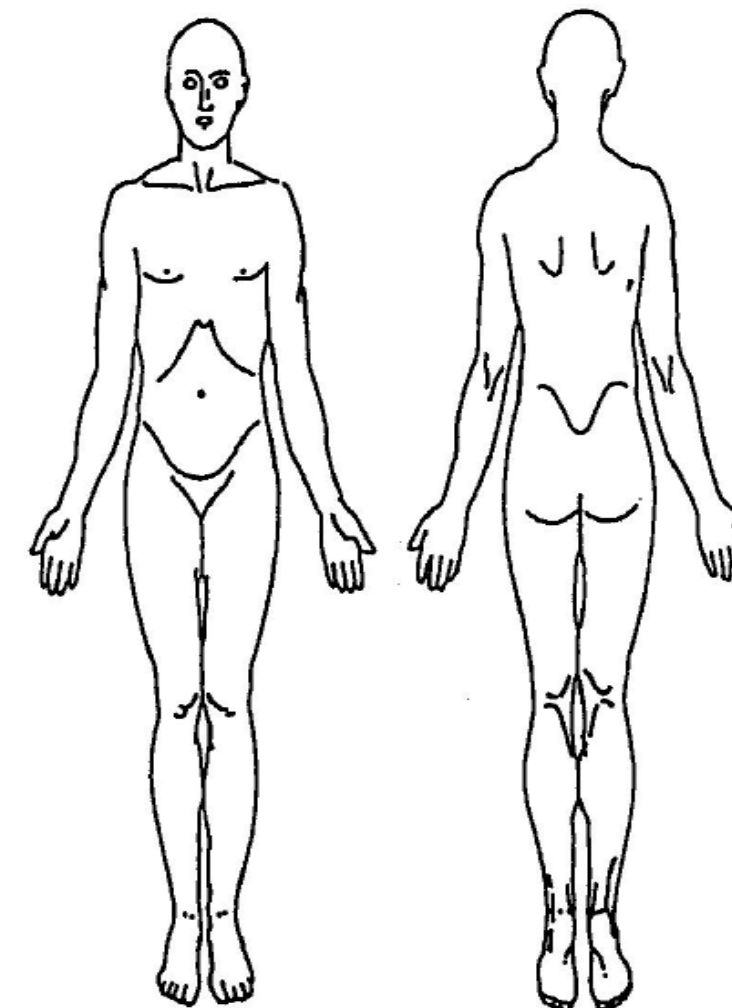
Description of Family Members-
Earning Member-.....Sons.....Daughters-.....
Marriageable Daughters-..... Dependent Children.....

Distance of travel to NCI .....kmsMode of Transport .....
---

Educational qualification:
Uneducated/ 5 <sup>th</sup> Std / 10 <sup>th</sup> Std / 12 <sup>th</sup> Std / Graduate / Postgraduate

Current socio-economic Status-.....
(Income of family)

### Location of pain-



Investigation (Date)	Important Findings





# PAIN FORMS

## PAIN ASSESSMENT

**MAXIMUM PAIN experienced-** 0 / 10 / 20 / 30 / 40 / 50 / 60 / 70 / 80 / 90 / 100

**NRS representing LEAST PAIN-** 0 / 10 / 20 / 30 / 40 / 50 / 60 / 70 / 80 / 90 / 100

**Pain Maximum At-** Through Out / Morning / Afternoon / Evening / Not Specific

**Does It Radiate From The Point Of Origin:** Yes/No .....

**Worsened by Activity:** Yes / No.....

**Position/Posture Gives Relief:** .....

**Have You Received Treatment For Your Pain:**.....

**Pain Relief After Medication:** 0 / 10 / 20 / 30 / 40 / 50 / 60 / 70 / 80 / 90 / 100

**How Long Relief Last-** < 2 Hr / < 4 Hr / < 6 Hr / 6 – 10 Hr /> 10 Hr

**Describe/Nature the Type of Your Pain**

Aching	Throbbing	Burning	Shooting
Dull	Immobilizing	Exhausting	Electric like
Boring	Stabbing	Numbness	Stinging

**How Much Does Pain Interfere with Your Daily Activity-?**

Not at All / A little / Quite a Bit / A lot / Can't do anything

**PAIN DIAGNOSIS**

Somatic / Visceral / Neuropathic / Bony / Mixed

**WHO LADDER STEP:** Step I / Step II / Step III

**OTHER SYMPTOMS:**

Headache	Diarrhoea	Vomiting	Fatigue
Nausea	Fever	Mucositis	Dizziness
Constipation	Shortness of breath	Lymphoedema	Urinary problems
Lack of appetite	Cough	Anxiety	Bleeding
Loss of weight	Insomnia	Depression	Seizures

## COMPREHENSIVE CARE PLAN

**ECOG/Performance status**.....

### **1. Management of symptoms**

Symptoms	Severity (NRS)	Medications

### **2. Record of Interventions if any**

Date	Intervention	Drugs used	Intensity of symptom before intervention	Intensity of symptom after intervention

### **3. Reference to other collaborative departments (with reasons)**

Departments	Reason
Dietary referral	
Physiotherapy referral	
Others	

# FOLLOW-UP FORM

## PAIN AND PALLIATIVE FOLLOWUP FORM

Name-	Date
Age/Sex	Phone no.
NCI/IRCH no.	Address.

	Follow up No. Date-	Follow up No. Date-	Follow up No. Date-	Follow up No. Date-
<b>Symptoms</b>	<b>Severity</b>	<b>Medications</b>	<b>Severity</b>	<b>Medications</b>
Pain : (Site/Type)		<b>Opioid (dose with quantity)</b> Tramadol..... Morphine..... Fentanyl Patch..... Other.....  <b>Other Analgesics:</b> T. PCM..... T. Flexon..... T. Gabapentin..... T. Pregabalin..... Others.....		<b>Opioid (dose with quantity)</b> Tramadol..... Morphine..... Fentanyl Patch..... Other.....  <b>Other Analgesics:</b> T. PCM..... T. Flexon..... T. Gabapentin..... T. Pregabalin..... Others.....
GI prophylaxis		T. Pan 40..... T. Rantac.....		T. Pan 40..... T. Rantac.....
Constipation:		Syp Cremaffin..... T. Dulcolax.....		Syp Cremaffin..... T. Dulcolax.....
Nausea/Vomiting		T. Emset..... T. Perinorm..... Others.....		T. Emset..... T. Perinorm..... Others.....
Dyspnoea:				
Others/Plan :				
Next review Date				
Name of Doctor				





# BACK TO PATIENT

How will you proceed for pain management?

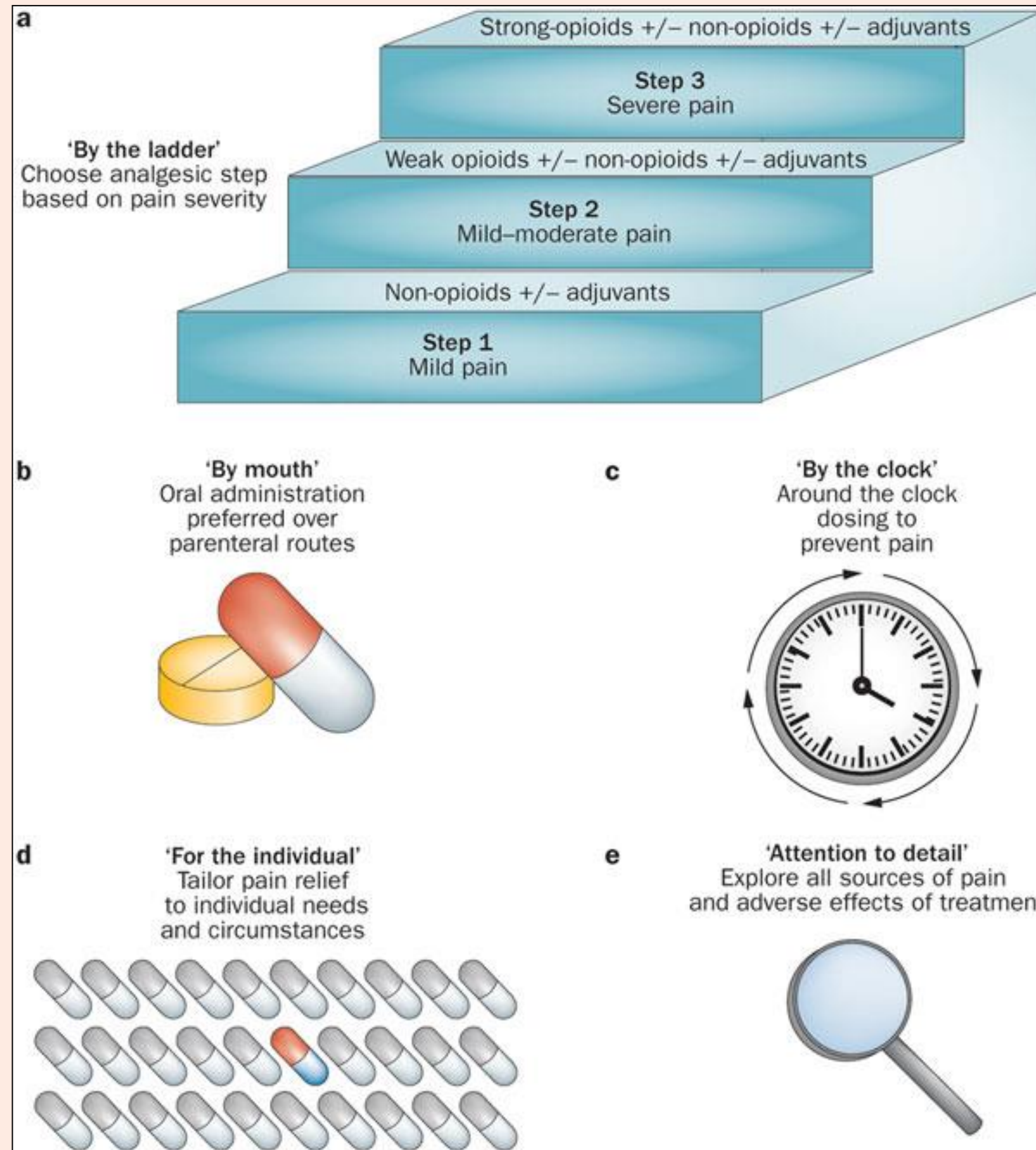


# AIMS OF PAIN MANAGEMENT

- Optimize pain control
- Minimize side effects
- Enhance functional abilities
- Improve quality of life



# WHO LADDER OF PAIN MANAGEMENT







Non Opioid Analgesics	<ul style="list-style-type: none"> <li>• Paracetamol</li> <li>• Non-steroidal Anti-inflammatory Drugs</li> </ul>
Weak Opioids	<ul style="list-style-type: none"> <li>• Codeine</li> <li>• Tramadol</li> </ul>
Strong Opioids	<ul style="list-style-type: none"> <li>• Morphine -1<sup>ST</sup> Line</li> <li>• Diamorphine/Fentanyl/Hydromorphone-2<sup>nd</sup> Line</li> <li>• Methadone-3<sup>rd</sup> Line</li> </ul>
Adjuvant Drugs	<p>Corticosteroids - Pain Caused By Oedema</p> <p>Antidepressants - Neuropatic Pain</p> <p>Anticonvulsant - Neuroapthic Pain</p> <p>Muscle Relaxants - Muscle Cramps</p> <p>Antispamotics - Bowel Colics</p> <p>Antibiotics - Infection Pain</p>

Analgesics should be given..

- By the mouth
- By the clock
- By the ladder

**INDIVIDUALIZE TREATMENT**



# SAFE USE OF ANALGESICS







# NSAIDS

- Mild to moderate pain associated with acute or chronic inflammation
  - Rheumatoid arthritis, Osteoarthritis, Ankylosing spondylitis
  - Acute postoperative pain, Trauma
- Adverse effects
  - Due to COX 1 inhibition- Dyspepsia, Gastroduodenal ulcer, Platelet inhibition, Renal dysfunction
  - COX 2 inhibitors-risk of cardiovascular complications





# NSAIDS

- Diclofenac : 25 -75 mg 12hrly ( max 200 mg) topical preparations available
- Ibuprofen: 200 -800 mg 8 -12 hrly ( max 3200 mg) platelet inhibition
- Ketoprofen: 300-600 mg 6-8 hrly fast elimination
- Naproxen: 250- 500 mg 8 -12 hrly( max 1375 mg) better GI profile
- Piroxicam: 20 mg 12-24 hrly (max 40 mg) long half life
- Mefenamic Acid: 500 mg 8-12 hrly may cause diarrhoea, pancytopenia



# PARACETAMOL

- Mechanism of action: COX 3, Central serotonergic mechanism, central cannabinoid system modulation
- Analgesic, no anti inflammatory activity
- First line agent
- Metabolised in the liver
- Adverse effect: Dose dependent hepatotoxicity
- Dose: Oral 325 -1000mg 6 to 8 hrly ( max not > 4 g/day)





# TRAMADOL FOR MODERATE TO SEVERE PAIN

Total daily dose - 400mg

Best to use in combination with other analgesics

Rapid IV injection of Tramadol can cause seizures



Explain about the Adverse effects

Dizziness, nausea, vomiting, headache, drowsiness, fatigue, sweating, dry mouth, constipation





# TRAMADOL

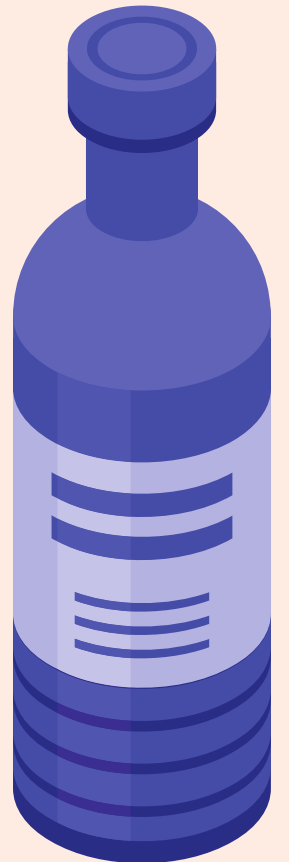
- Centrally acting opioid agonist on  $\mu$  receptor
- Activates monoaminergic spinal inhibition of pain
- Useful alternative to codeine as step-2 opioid
- Dose: 50-100mg 4-6hrly
- Pt whose pain is uncontrolled on 400mg/day, should receive 10-20 mg morphine 4 hrly





# CODEINE

- Acts on  $\mu$  receptor
- Biotransformation to morphine contributes to analgesic action
- Usual doses: 30-60 mg 4-6 hrly (200-400 mg daily)
- Duration of action: 4-6 hrs
- Usually combined with NSAIDS



# ANTICONVULSANTS

Drug	Dose	Mechanism of action	Adverse Effects	Comments
Gabapentin	Start 100-300 mg HS Usual dose 300-1200 mg TDS Max 4800mg/d	Membrane stabiliser by binding to Calcium channel	Dizziness, Somnolence, Fatigue, Peripheral edema.	
Pregabalin	Start 75 mg HS Usual 225- 300 mg BD	same	same	Analgesic effect seen in 3 days.
Carbamazepine	Start 100 mg/d Increase by 200 mg every 3d Max 2000 mg/d	Na Channel Blockade.	Sedation, dizziness, ataxia, diplopia, hepatitis, rash, hyponatremia, Aplastic Anaemia.	TN Monitor LFT CBC, Electrolytes.
Oxcarbazepine	Start 150 mg BD Max 2400 mg/d	Voltage gated Calcium channel modulation Na channel blockade	dizziness, somnolence, ataxia, diplopia, nausea, hyponatremia.	Monitor LFT CBC, Electrolytes.





# CORTICOSTEROID

Corticosteroids are used primarily as potent anti-inflammatory agents. The anti-inflammatory action is mediated via several interacting mechanisms.

## Indication:

- Obstructive syndromes
- Brain metastases
- Spinal cord compression
- Pain relief - Pain caused by a tumour in a confined organ or body cavity, e.g. raised intracranial pressure





## Drug interactions:

- Antagonize oral hypoglycaemics , insulin, anti-hypertensives and diuretics
- Metabolism is accelerated by antiepileptics (Carbamazepine, Phenytoin )
- Concurrent prescription with warfarin increases the INR

### Pharmacokinetics

Rapid absorption  
Metabolised in liver enzyme , mainly excreted in kidney

### Cautions

Diabetes mellitus, psychotic illness.  
peptic ulceration  
Prolonged courses of corticosteroids increase susceptibility to infections

### Adverse Effect

Avascular bone necrosis,Cataract,  
Diabetes mellitus,Infection, Muscle wasting and weakness, Hypertension, Cushingoid features.



# THE WONDER DRUG - MORPHINE

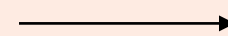
- Used for moderate to severe cancer pain.
- Initially intermediate-release preparation is used.
- Once daily requirement is determined – sustained-released preparation.
- Then intermediate-release preparation – breakthrough pain.





# FORMULATIONS

- Immediate release tablet (5, 10, 30, 60mg)
- Elixir



- Onset: < 30 min
- Peak: within 1 hour
- Duration: 3-4 hrs

- Controlled release tablet (10, 30, 60mg)
- Controlled release suspension



- Onset: ~1 hour
- Peak: 3-6 hours
- Duration: 12 hours



- Mu ( $\mu_1, \mu_2$ )
  - Supraspinal analgesia
  - Euphoria
  - Respiratory depression
  - Physical dependence

- Kappa ( $\kappa_1 - \kappa_4$ )
  - Spinal analgesia
  - Miosis
  - Dysphoria
  - Sedation



**OPIOID  
RECEPTORS**



# ATTENTION TO DETAIL

- Emphasize need for regular administration
- Consider:
  - Previous opioid exposure
  - Age of patient
  - Extent of cancer (hepatic, renal involvement)
  - Concurrent disease
  - Concurrent medications





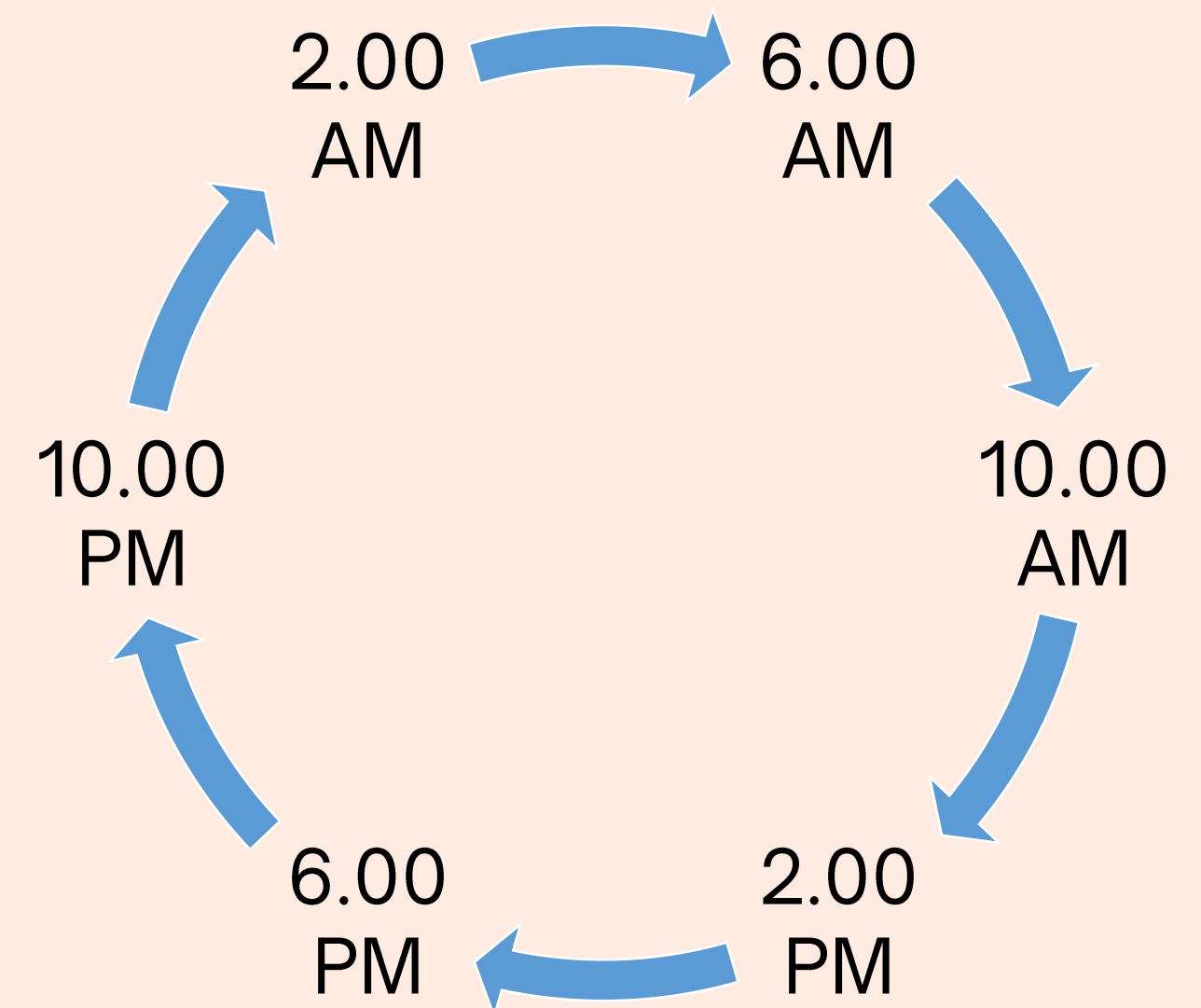
# HOW TO START

- Start at 5mg every 4 hours
- Initial titration better with immediate release preparations
- If pain relief inadequate - increase dose gradually (5 mg increments)
- If patient very drowsy and pain relief adequate - reduce dose by 50%
- Rescue doses when necessary

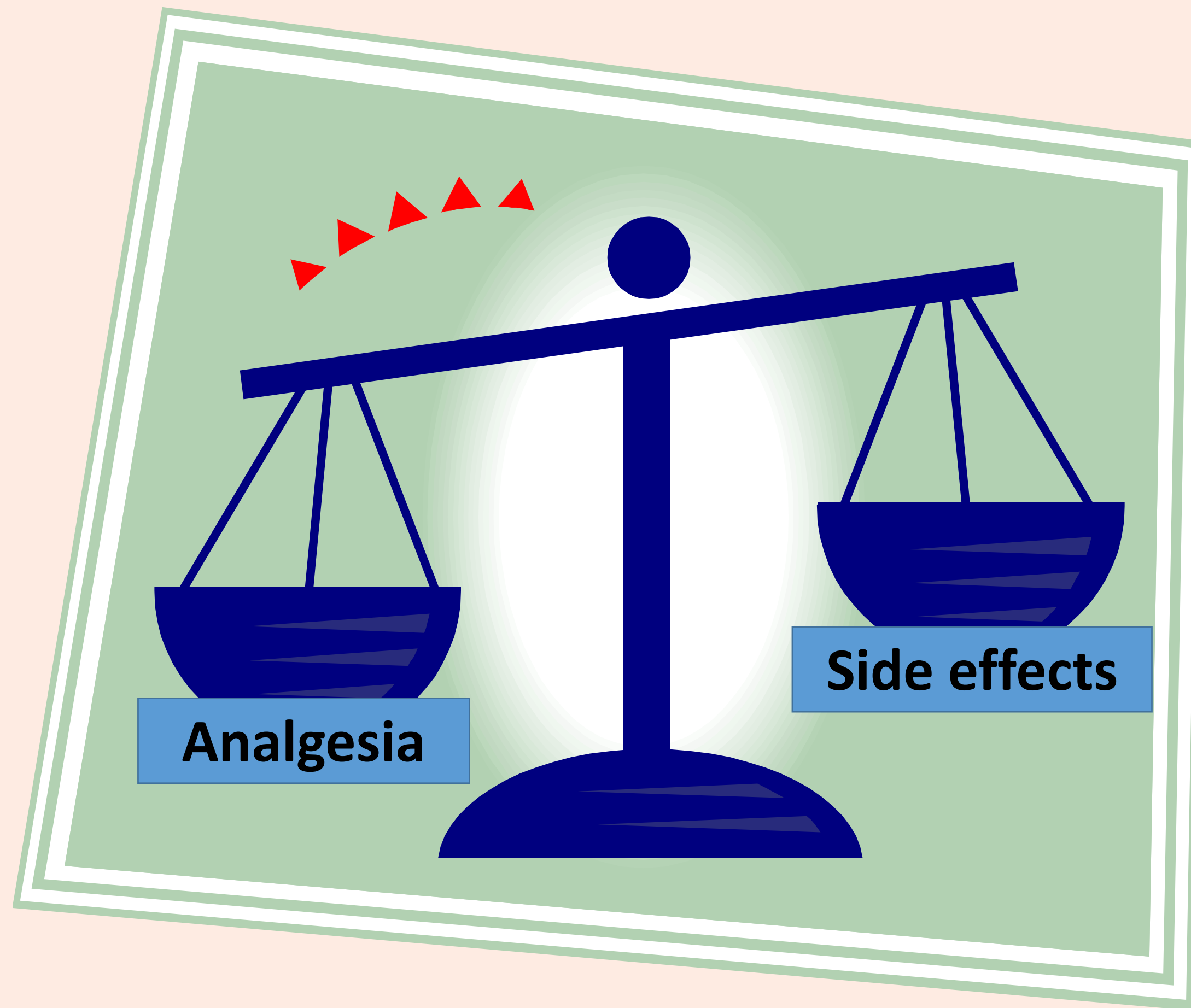




- Regular schedule
- Night doses: through the night or double dose at night
- Evaluate within a week



Rapid IV titration to determine dose for severe pain -  
can be converted to equianalgesic oral dose







# Morphine

## Pharmacology Mnemonics

**M**

- **M**iosis (pin point pupil)

**O**

- **O**rthostatic hypotension

**R**

- **R**espiratory depression

**P**

- **P**hysical dependency

**H**

- **H**istamine release

**I**

- Increased ICP

**N**

- **N**ausea

**E**

- **E**uphoria

**S**

- **S**edation



# MORPHINE: PROBLEMS

- Morphine is scarcely available for majority of needy cancer patients
- Fears of Psychological addiction persists
- Minimal professional education of doctors and nurses in analgesics
- Too much importance is attached to expensive sophisticated methods of administration





# MYTHS AND REALITY OF MORPHINE

## Patients' Perspective

- “If I take Morphine I wont be able to stop – I will become addicted”
- “I have heard that Morphine has lots of side effects and I feel bad enough already”
- “If I take Morphine now, it wont work later on when my pain is worse and I really need it”
- “My doctor recommended Morphine, but that was what my uncle took just before he died”
- “Will morphine hasten death?”





# REALITY

- Oral Morphine can be used safely as there is no ceiling dose effect
- Reassurance: All side effects will generally stop as your body adjusts and constipation can be easily treated
- Morphine is NOT just for people who are dying
- There is no evidence that the correct use of opioids hastens death, in fact it improves QOL and can contribute to lengthening life





# ADDICTION

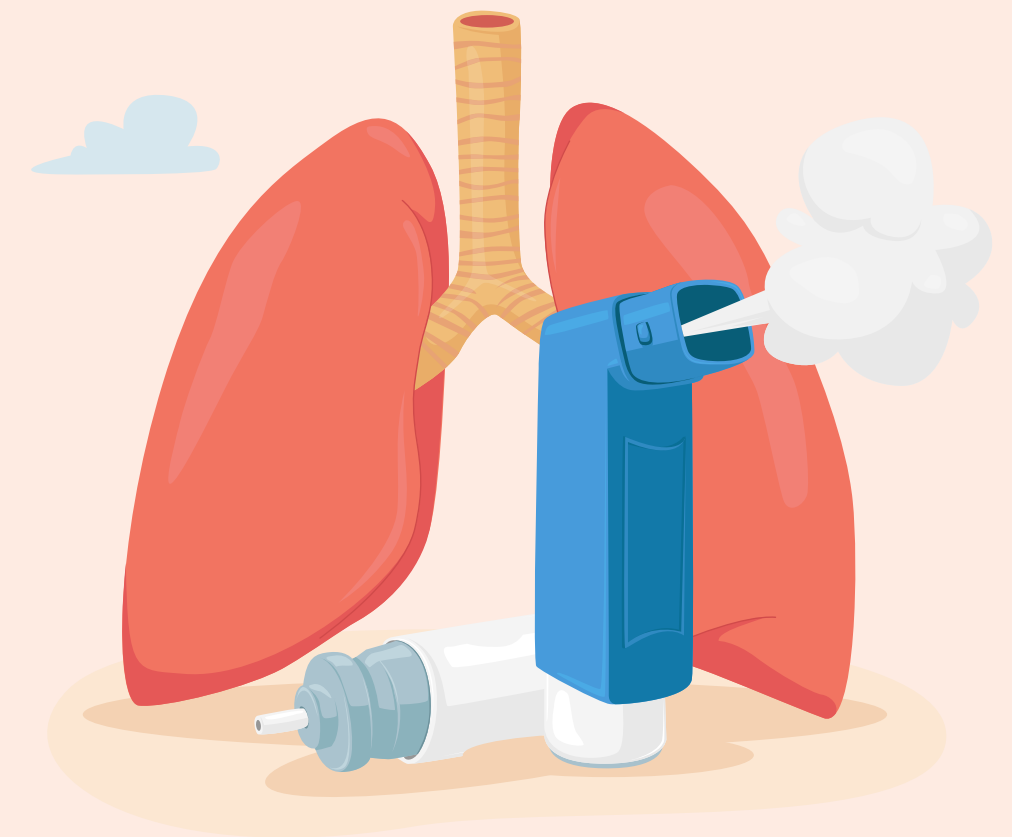
- Fears of patients becoming addicted are exaggerated, extremely rare in palliative care setting with titrated oral morphine therapy
- Reassure your patient that Psychological addiction is extremely rare
- Physiological dependence develops after long time usage





# “DO PATIENTS DIE OF MORPHINE INDUCED RESPIRATORY DEPRESSION?”

- It has a wide therapeutic range (making death unlikely)
- Clinically significant respiratory depression does not occur in cancer patients, when morphine dosage is titrated according to the patients pain, for the pain antagonizes morphine depressant effects





# PSEUDOADDICTION

- Latrogenic syndrome of behavioural changes because of inadequate pain relief
- Ensure pain management is adequate
- Monitor closely
- Adjust frequently to compensate for changes in patients needs
- “Flexibility is the key”





# FENTANYL

- Moderate to severe pain
- Synthetic opioid
- Potency: 100 times more potent than morphine
- Routes: iv, epidural, intrathecal, transdermal
- Doses: 25, 50, 75, 100 mcg/hr





# TRANSDERMAL PATCH

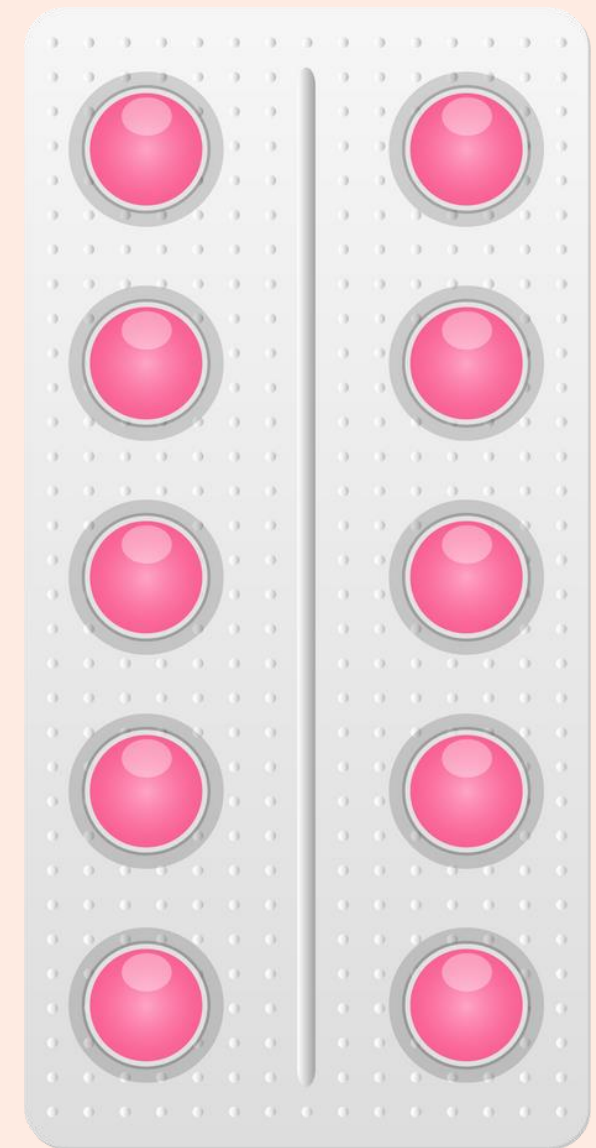
- Effect starts after 12-18 hrs of application
- Replace after 72 hrs
- Concentration decreases 12-18 hrs after patch removal
- Cannot be used if rapid analgesia is required
- Fentanyl accumulates to form a 'depot' in the skin below the patch, from where it gradually enters the circulation





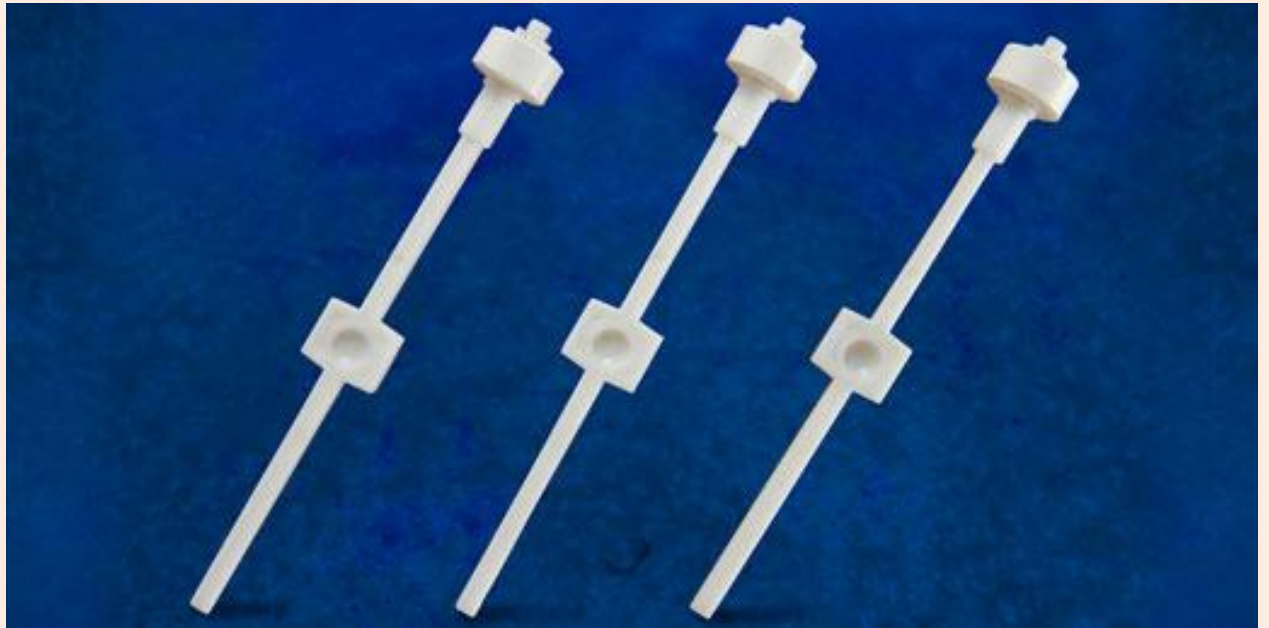
# ORAL TRANSMUCOSAL FENTANYL CITRATE

- Fentanyl 'lollipop'-Fentanyl impregnated raspberry coloured lozenge on a plastic handle
- Available in 200,300,400  $\mu\text{g}$  units, peak effects in 22 min
- Transmucosal fentanyl may provide a non-invasive rapid onset alternative for pt with poor oral or venous access



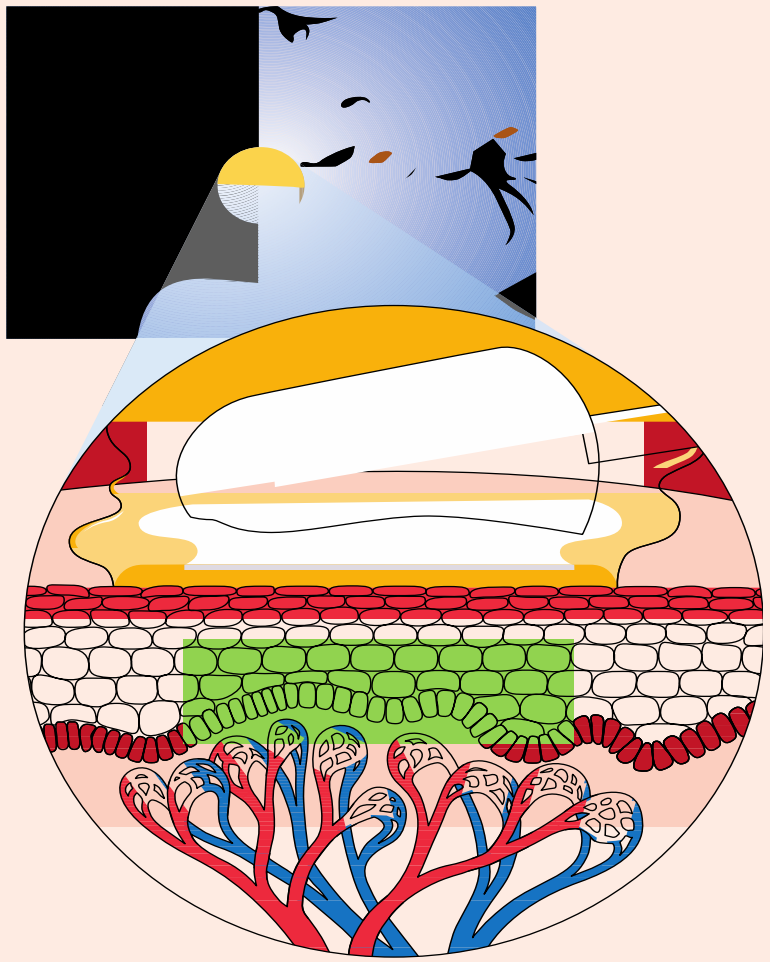
# ORAL TRANSMUCOSAL FENTANYL CITRATE (OTFC)

Patch	OTFC	SC
25 mcg/hr	200mcg	100mcg
50mcg/hr	400mcg	200mcg
75mcg/hr	600mcg	300mcg
100mcg/hr	800mcg	400mcg



## OTFC Vs Oral Morphine

- Statistically superior to PO morphine tablets. However, the differences were small and their clinical relevance uncertain.
- Clinical meaningful pain relief (defined as a  $\geq 33\%$  reduction in pain was 42 vs. 32%
- Cost 80-100 Rs/Lozenge Oral Morphine 1-5 Rs/Tablet





# BUPRENORPHINE

- Moderate to severe pain
- longer duration of action
- Routes: iv, sublingual, transdermal patch
- Patch 5,10,20 mcg/hr -> 7 days, effect starts from 3rd day
- Adverse effects: blurred vision, cough, nausea, confusion, shortness of breath, dizziness





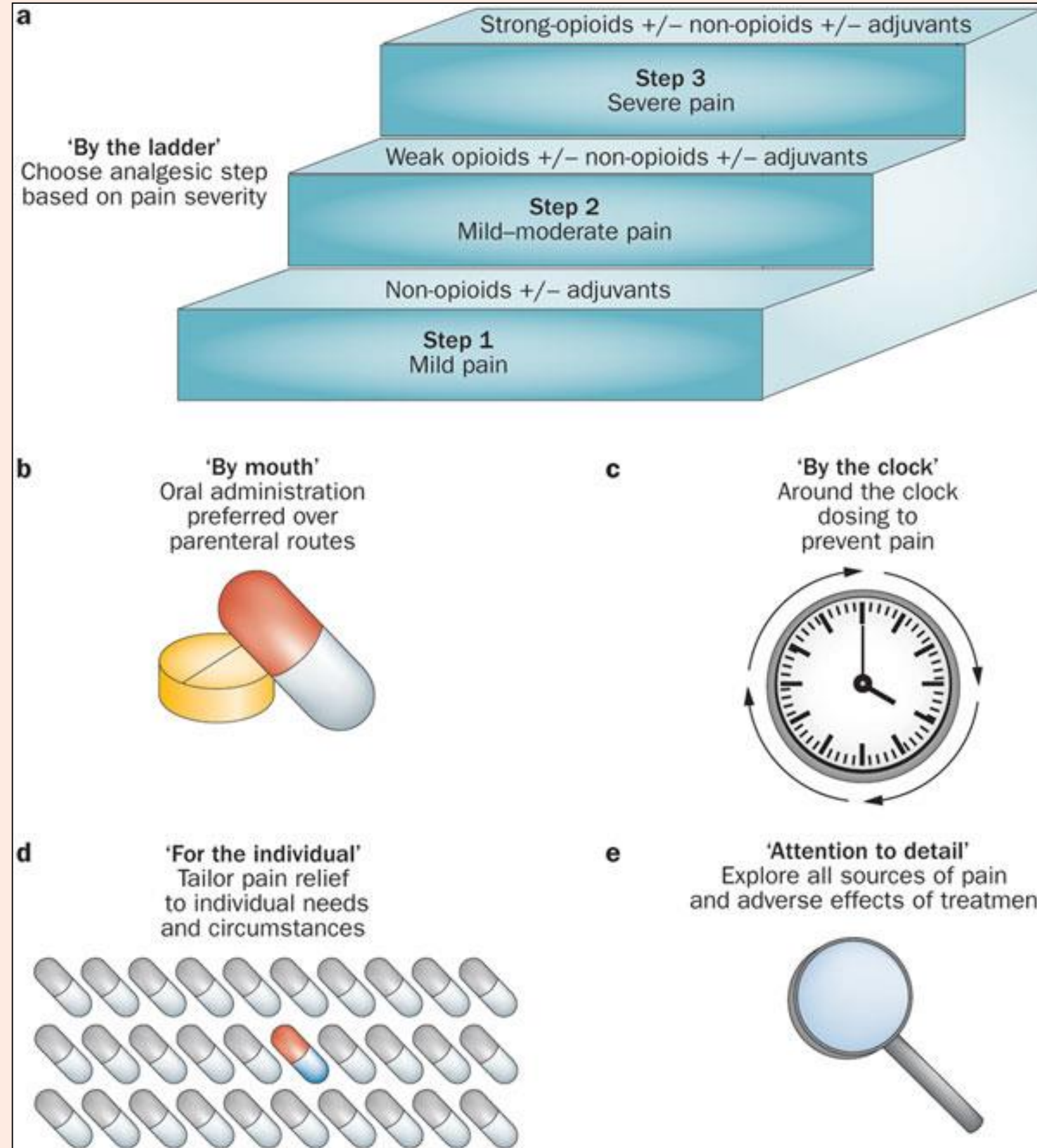


# OPIOID CONVERSION TO MORPHINE

Drug	Potency ratio when compared to Morphine
Codeine	1/10
<u>Tramadol</u>	<u>1/10</u>
Dextropropoxyphene	1/10
Tapentadol	1/5-1/10 ?
Hydrocodone	2/3
Pethidine	1/8
Morphine	1
Hydromorphone	5
Methadone	5-10
Buprenorphine	80-100
<u>Fentanyl</u>	<u>100-150</u>
Oxycodone	1.5



# WHO LADDER







“OPIOPHOBIA”

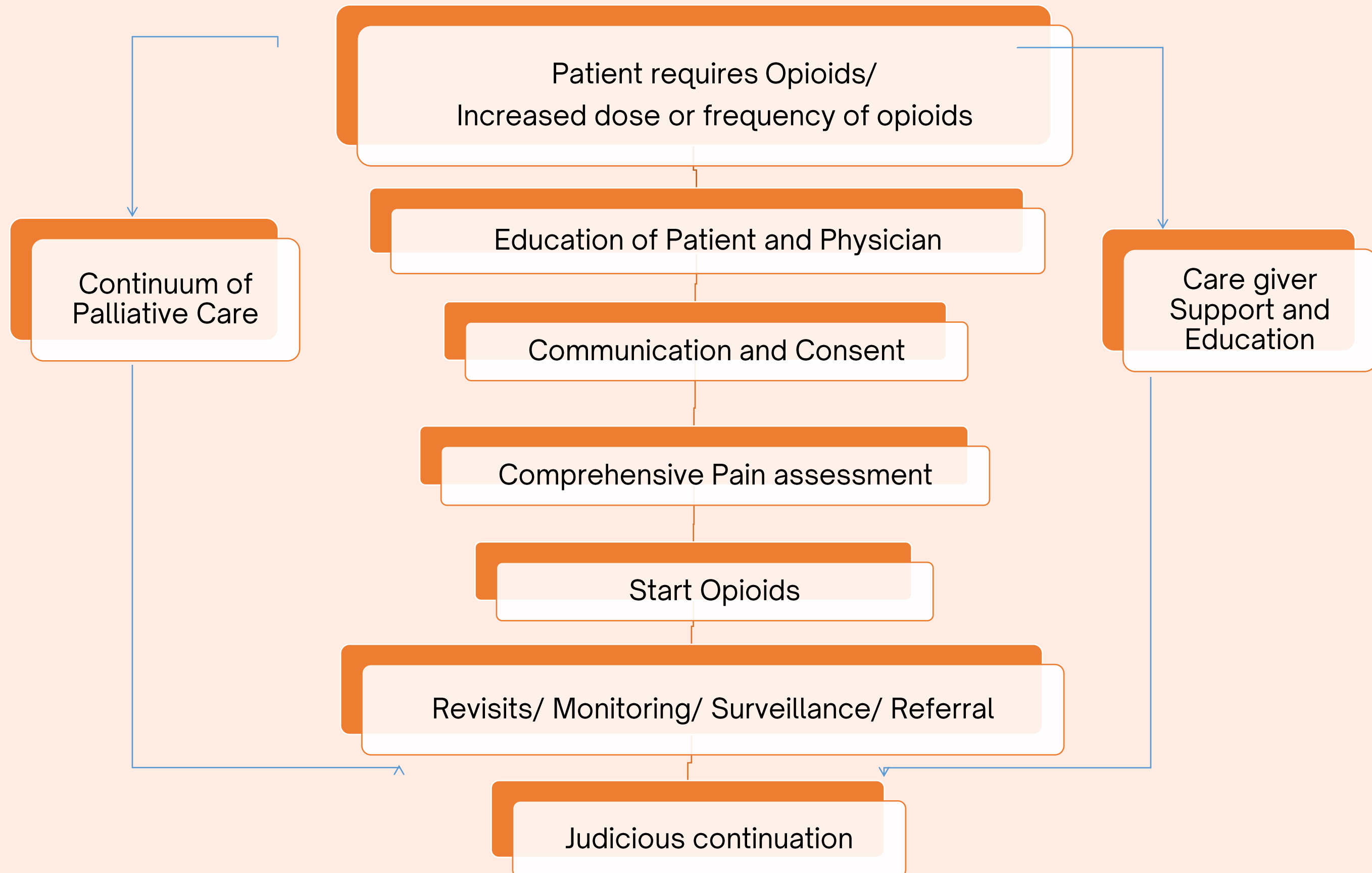




Nurture-The existing resources  
This is cheapest opioid option for us

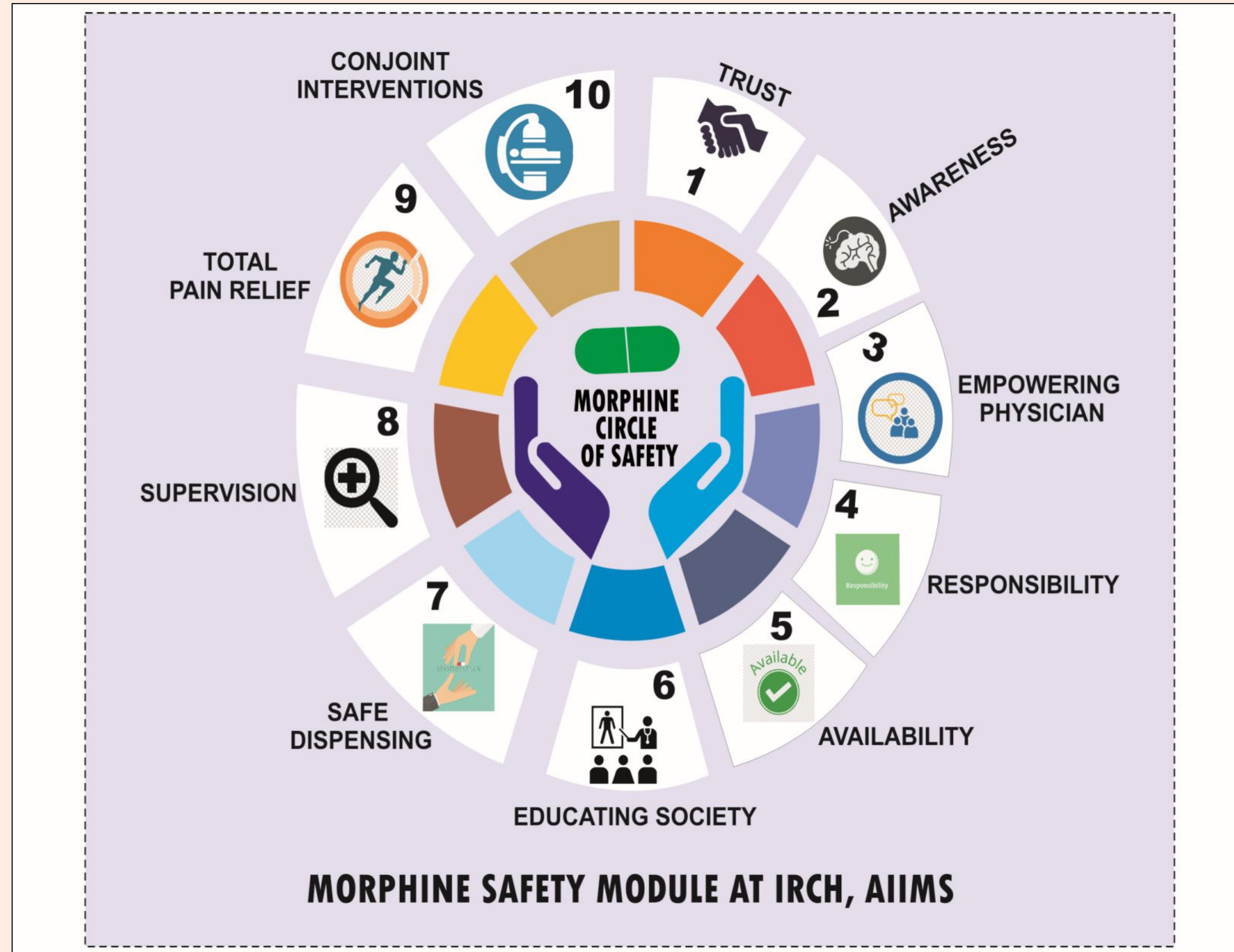


# OPIOID SAFETY PROTOCOL





# MORPHINE SAFETY CIRCLE





# HOW WE DECIDE INTERVENTION?

## Decisive criteria

- Failure to achieve adequate pain with pharmacological means

OR

- In cases of localized, severe pain, the risk and benefit ratio swing in favor of an intervention





# TAKE CARE OF TOTAL PAIN COMMUNICATION



### Total Cancer Pain

Pain is one of the most common and distressing symptoms described by cancer patients. However, it is not purely a physical experience but involves various other components of human functioning, including personality, mood, behavior, and social relations. In an attempt to describe the all-encompassing nature of pain within a “whole-person” framework, Dame Cicely Saunders coined the concept of “total pain” [4]. She suggested that pain has psychological, social, emotional, and spiritual components that make up the “total pain” experience. Yet the contribution of each component will be specific to each individual and his or her situation. This concept has been well accepted in the palliative care community, although some have preferred to broaden it to the concept of “total suffering,” which includes multiple symptoms but also extends beyond the physical to threats to the “intactness” of the person and an impending sense of disintegration of a familiar world [2].



**We have to take urgent action  
Otherwise  
Suffering will Continue**







BEST TREATMENT AVAILABLE

100 % RELIEF

HUMANITY- THE  
WONDER DRUG



# Thank You

