Part IV
Use of Potent Opioids for Chronic Pain Management

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Long-Term Management of Chronic Pain

If during the therapy of chronic pain, sufficient attenuation of nociception can not be achieved with a peripheral analgesic (i.e., acetaminophen, NSAIDs), an opioid has to be added in order to reach the therapeutic goal (Figure IV-1). However, it is also possible to start with opioid therapy in those patients who complain of intense tumor-related pain or in patients with other severe painful symptoms. In such cases, one immediately can start with an opioid Step 3 of the analgesic ladder (Table IV-2). Such strategy has to be carefully weighed in particular if pain is due to the extension or the progression of the underlying disease, where peripheral analgesics and/or weak opioids are insufficient in action.

The extent to which pain responds to opioid analgesics varies depending on both patient and pain characteristics. No pain is predictably unresponsive to opioids. Neuropathic pain can respond to opioids, although the response may be incomplete. All patients with moderate to severe cancer pain should have a trial of opioid analgesia, using the following paradigm (Figure IV-2):

1. A patient’s treatment should start at the step of the WHO analgesic ladder appropriate for the severity of the pain.
2. Prescribing of primary analgesia should always be adjusted as the pain severity alters.
3. If the pain severity increases and is not controlled on a given step, move upwards to the next step of the analgesic ladder. Do not prescribe another analgesic of the same potency.
4. All patients with moderate to severe cancer pain, regardless of etiology, should receive a trial of opioid analgesia. Chronic pain in patients with cancer is usually