# Doncaster & Bassetlaw Medicines Formulary

## Section 4.7: Analgesics

**Paracetamol 500mg Tablets/Soluble Tablets**
**Paracetamol 1g Infusion**
**Paracetamol 120mg/5ml and 250mg/5ml Suspension**

Non-Steroidal Anti-Inflammatory Drugs:
(See Section 10.1.1 Non-Steroidal Anti-Inflammatory Drugs)

Weak Opioids:
**Cocodamol 30/500 Tablets/Soluble Tablets**
**Codeine 15mg and 30mg Tablets**

**Tramadol 50mg Capsules/Soluble Tablets***
**Tramadol 100mg Injection***

Strong Opioids:
**Alfentanil 1mg/2ml Injection, 5mg/ml and 5mg/10ml Injection***
**Buprenorphine (Butec) 5microgram/hr, 10microgram/hr and 20microgram/hr Patch***
**Fentanyl Patch (Matrifen) 12microgram, 25microgram, 50microgram, 75microgram and 100microgram Patch***
**Fentanyl 100microgram and 500mcg Injection***
**Fentanyl 2micrograms/ml with 0.1% Bupivacaine 500ml Epidural Infusion***

Instant Release Morphine Preparations:
**Morphine 10mg in 5ml Solution***
**Morphine 10mg, 15mg and 30mg Injection***

Modified Release Morphine Preparations:
**Morphine SR (Zomorph) 10mg, 30mg, 60mg, 100mg and 200mg Capsules***

Instant Release Oxycodone Preparations:
**Oxycodone 5mg/5ml Liquid***

Modified release Oxycodone Preparations:
**Oxycodone SR (Longtec) 5mg, 10mg, 20mg, 40mg and 80mg Tablets***

# Doncaster & Bassetlaw Hospitals NHS Foundation Trust Medicines Formulary

**Section 4.7: Analgesics (continued)**

Drugs for Neuropathic Pain:
**Amitriptyline 10mg, 25mg and 50mg Tablets**
**Gabapentin 100mg, 300mg and 400mg Capsules**
**Pregabalin 25mg, 75mg, 150mg and 300mg Capsules**

Treatment of Acute Migraine Attacks:
**Sumatriptan 50mg and 100mg Tablets**
**Sumatriptan 20mg/dose Nasal Spray**
**Sumatriptan 6mg Injection**
**Zolmitriptan 2.5mg and 5mg Tablets/Soluble Tablets**

**Approved by Drug and Therapeutics Committee: December 2018**
**Review Date: December 2021**

Prescribing Guidance:

See also: Palliative Care Formulary
Doncaster & Bassetlaw Primary Care Neuropathic Pain Management Guidelines
Analgesia in Patients With Impaired Renal Function

**The WHO analgesic ladder:**

Step 1 – **Non-Opioids** (i.e. paracetamol + NSAID + adjuvants, where indicated)

Step 2 – **Weak Opioids in combination with Non-Opioids** (i.e. paracetamol + NSAID + codeine + adjuvants, where indicated)

Step 3 – **Strong Opioids in combination with Non-Opioids** (i.e. paracetamol + NSAID + morphine + adjuvants, where indicated)

**Paracetamol:**

IV Paracetamol should be used only where the oral route is not available. It can be used in preference to rectal paracetamol, where appropriate, as the rectal preparation is more expensive and has unpredictable bioavailability.

Patients weighing less than 50kg should have their dose of IV paracetamol reduced from 1g QDS. The SPC recommends reducing the dose to a maximum of 15mg/kg per dose. However, locally it has been agreed that the following schedule will be used:

| Weight | Dose | Frequency |
|---|---|---|
| =>50kg | 1g | QDS |
| 45 to 49.9kg | 1g | TDS |
| 30 to 44.9kg | 500mg | QDS |
| <30kg | 500mg | TDS |

Revised guidance on the treatment of paracetamol overdose with intravenous acetylcysteine has been issued by the MHRA.

**Soluble Tablets:**

Before considering long-term prescribing of soluble medication, please ensure that the following information has been taken into account.

While soluble dosage forms may appear convenient, it is important to be aware of the sodium content of some formulations, prescribing them with caution and only if there are compelling reasons to do so (see NHS Choices.)

**Non-Steroidal Anti-Inflammatory Drugs:**

See Section 10.1.1 Non-Steroidal Anti-Inflammatory Drugs

**Weak Opioids:**

**Compound Analgesics:**
Co-Codamol 8/500, Co-Dydramol 10/500 and Co-Proxamol are no more effective than Paracetamol alone. These weaker compound preparations should not be prescribed as the amount of opiate is generally felt to be enough to cause side effects (e.g. constipation) but not enough to contribute to analgesia.

**Dihydrocodeine:**
Dihydrocodeine is advocated in breast-feeding women in line with the linked guidance (where codeine is contraindicated – see below and SPS guidance).

Codeine is also not listed as one of the analgesics that can be prescribed by physiotherapy NMPs. Here, dihydrocodeine is a reasonable alternative.

Dihydrocodeine is not included in the formulary for other indications.

**Codeine use in Paediatrics:**

- Codeine is not recommended for children under 12 years of age
- Codeine is not recommended for any child (up to 18 years of age) who undergo tonsillectomy or adenoidectomy (or both) for obstructive sleep apnoea
- Codeine should only be used to relieve acute moderate pain in adolescents (children aged from 12 to 18 years) only if it cannot be relieved by other painkillers - such as paracetamol or ibuprofen. Use should be limited to a maximum of 3 days
- Codeine is contraindicated in all patients of any age known to be CYP2D6 ultra-rapid metabolisers
- Codeine is contraindicated in breastfeeding mothers because it can pass to the baby through breast milk and has been associated with a fatality in the infant.
- Tramadol could be an option in adolescents
- Oral morphine sulphate 0.1 to 0.2mg/kg every 4 to 6 hour may be an alternative (although discharge supply should be limited to a maximum of 12 doses)
- Benzydamine spray (Difflam) may also be helpful may patients undergoing tonsillectomy or adenoidectomy.

For further information, see the MHRA Update.

**Buprenorphine Patches:**

For those patients uncontrolled on weak opioids where stronger opioids (e.g. morphine) are either unsuitable or have been poorly tolerated, or where the oral route is inappropriate.

More information around buprenorphine prescribing is available in the:
Palliative Care Formulary.

Weak opioids should be stopped once the buprenorphine patch is initiated.

**Strong Opioids:**

Before prescribing strong opioids, please read the linked guidance (Opioids Aware).

**Prescribing Strong Opioids:**

Modified release strong opioids should be prescribed by brand name in primary care. Oxycodone liquid is the preferred breakthrough instant-release oxycodone preparation. Longtec is the preferred modified-release oxycodone preparation and Matrifen is the preferred fentanyl patch brand in primary care.

**Fentanyl Patch Administration/Disposal:**

Administration ('peel and press')

- Make sure that the patch will be covered by loose clothing and not stuck under a tight or elasticated band.
- Carefully peel one half of the shiny plastic backing away from the centre of the patch. Try not to touch the sticky side of the patch.
- Press this sticky part of the patch onto the skin.
- Remove the other part of the backing and press the whole patch onto the skin with the palm of your hand.
- Hold for at least 30 seconds. Make sure it sticks well, especially the edges.

Disposing of the patch

- As soon as you take a patch off, fold it firmly in half so that the sticky side sticks to itself.
- Put it back in its original pouch and discard according to local requirements or hand in to your pharmacist.
- Even used patches contain some medicine which may harm children and may be fatal, so keep your used patches out of the sight and reach of children.

Further guidance is available relating to toxicity from accidental exposure.

**Syringe Driver Compatability:**

A database of drug compatibilities in syringe drivers is available at: http://www.palliativedrugs.com/ (registration is required to access this information).

**Analgesics and Dependence:**

There is strong evidence for the potential for Pregabalin, Gabapentin and Tramadol dependence.

Advice for Prescribers on the Risk of the Misuse of Pregabalin and Gabapentin

Advisory Council on the Misuse of Drugs Consideration of Tramadol

Practitioners should prescribe appropriately to minimise the risk of misuse and dependence and potential diversion, particularly in patients with a history of substance misuse or dependence.

**Items for Restricted Prescribing:**

- **Fentanyl 100micrograms, 200micrograms, 300micrograms, 400micrograms, 600micrograms Sublingual Tablets (Abstral)**

For palliative care patients only, reserved as second-line agents due to their cost. In primary care, only following a decision made by multi-disciplinary team and/or other healthcare professional with a recognised specialism in palliative care, see: NHSE Items which should not be routinely prescribed in Primary Care.

NICE CG140 outlines first line treatment for breakthrough pain in patients who can take oral opioids.

- **Oxycodone 5mg/Naloxone 2.5mg Modified Release Tablets (Targinact)**
- **Oxycodone 10mg/Naloxone 5mg Modified Release Tablets (Targinact)**
- **Oxycodone 20mg/Naloxone 10mg Modified Release Tablets (Targinact)**
- **Oxycodone 40mg/Naloxone 20mg Modified Release Tablets (Targinact)**

For palliative care patients only, reserved as second-line agents where constipation is a key consideration

- **Methadone 1ml/ml Liquid**
- **Methadone 5mg Tablets**

For palliative care and chronic pain patients only, reserved as second-line to formulary opioids (i.e. morphine) and laxatives

- **Tapentadol 50mg and 75mg Tablets**
- **Tapentadol 50mg, 100mg, 150mg, 200mg and 250mg Modified Release Tablets**

For palliative care and chronic pain patients only, reserved as third-line to formulary opioids (i.e. morphine)