

Nociceptive pain is most commonly described as **aching, dull, gnawing, throbbing, cramping.**

- Determine cause for pain and consider appropriate investigations.
- Step 1 analgesics at full dose can be added to Step 2 & 3. Adjuvants may be added to all 3 steps. For severe pain, consider starting both non-opioid & opioid agents simultaneously.
- Consider using the Follow-up Pain Assessment Tool weekly to monitor effect of pain management
- [See: Pain Patient Handout](#)

► Step 1: Mild Pain (1-3/10)

Start non-opioid

- Acetaminophen (Tylenol) 500 - 1000mg PO q6-8hours (max 3grams/24hrs)

If pain localized to small joint:

- Consider a topical NSAID (e.g. Diclofenac (5% or 10%) gel); Apply to affected area BID to TID

Is pain now adequately controlled?

- Yes: Reassess at least monthly using the [Follow-Up Pain Assessment Tool](#)
- No: Proceed to Step 2

► Step 2: Moderate Pain (4-6/10)

Due to the pharmacokinetics and pharmacodynamics, there are no recommended weak opioid agents for the treatment of nociceptive pain.

► Step 3: Severe Pain (7-10/10)

CHANGE weak opioid to a strong opioid, can continue with Step 1

Consider completing an opioid risk tool and order a **bowel routine** ([See: Constipation Guideline](#)). Start with low doses and titrate slowly to effect.

- **Hydromorphone (Dilaudid)** 0.5 - 1.0 mg PO q4h (or 0.2 mg SC). Due to the accumulation of metabolites, monitor closely for signs of toxicity.
- **Fentanyl Transdermal Patch** (for controlled pain) 12 mcg/h q72hours. Not recommended in opioid naïve patients ([Opioid Conversion Table](#)). Also available SL/SC.
- **Buprenorphine Transdermal Patch** (for controlled pain) 5mcg/h q7days. Link to conversion table. Is not covered by Alberta Blue Cross. Access may be limited.
- **Methadone** 1 - 2 mg/day PO (consider referral to Palliative Care; requires specific education and licensing by CPSA.)

Considerations for Opioid Titration:

- Ongoing pain re-assessment is **critical**.
- Titrate analgesics every 3-7 days as needed and tolerated. Slower titration may be required.
- **Titration up the regular Opioid dose:**
 1. Add the total amount of opioid used in the last 24 hours (regular and breakthrough doses). Divide the total dose by 6, and prescribe this amount every 4 hours (q4H).

OR
 2. For ongoing pain exceeding patients pain control targets, adjust as follows:
 - For pain rated 3 - 6, increase dose of opioid by 25%
 - For pain rated 7 - 10, increase dose of opioid by 50%
- **Breakthrough (PRN) dose prescription:** 10% of total 24 hour opioid dose q 1 - 2 hrs PRN.
- If the patient is also taking benzodiazepines, consider titrating down the dose, while opioids are being increased. If not, titrate opioids more slowly.

Is pain now adequately controlled?

- Yes: Reassess at least monthly using the [Follow-Up Pain Assessment Tool](#)
- No: [Refer to Palliative Care](#)

Considerations at End of Life: In the last days of life, see the [End of Life Pain Algorithm](#)

Conservative Kidney Management Acronym Legend

Acronym:	Intended Meaning:
ATC	Around the Clock
BID	Twice Daily
CKD	Chronic Kidney Disease
CKM	Conservative Kidney Management
COPD	Chronic Obstructive Pulmonary Disease
CO ₂	Carbon Dioxide
EOL	End of Life
ESA	Erythropoietin Stimulating Agent
ESKD	End Stage Kidney Disease
GFR	Glomerular Filtration Rate
GI	Gastrointestinal
g/L	Grams per litre
HgB	Hemoglobin
IN	Intranasal
IU	International Units
IV	Intravenous
kg	Kilogram
mcg	Microgram
mg	Milligram
mL	Millilitre

Acronym:	Intended Meaning:
mmol/L	Millimoles per Litre
OTC	Over the Counter
PO	By Mouth
PRN	As Needed
NSAID	Non-steroidal Anti-inflammatory Drugs
q(1-8)d	Every (Time Eg, 2) Days
q(1-8)h	Every (Time Eg, 4) Hours
q(1-8)weeks	Every (Time Eg. 2) Weeks
QHS	At Bedtime
RLS	Restless Leg Syndrome
SC	Subcutaneous
SL	Sublingual
SNRI	Serotonin and Norepinephrine Reuptake Inhibitors
SSRI	Selective Serotonin Reuptake Inhibitors
TCA	Tricyclic Antidepressant
TID	Three Times a Day
>	Greater Than
≥	Greater Than or Equal To
<	Less Than
≤	Less Than or Equal To