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Pharmacological Treatment of Pain

Before initiating or escalating pain medication, GPs (or other prescribers) need to consider optimal care, risks against benefits, information and the perspective of the care team, including the resident (when possible) and their family.

1. **Responses to medication** may vary from resident to resident and by health conditions. Be prepared to trial and reassess analgesia and side effects and change medication strategy if necessary. Failure with one medication does not preclude success with another medication of the same class.
2. When pain is persistent, use **"around-the-clock"** medication administration.
3. For **mild acute nociceptive pain**, use paracetamol. Short term, low dose non-steroidal anti-inflammatory drugs (NSAIDs) can be used with caution. If simple analgesia proves inadequate, then a trial of adjuvant medication is worth considering.
4. **Topical treatments** can be considered.
5. For **moderate to severe nociceptive pain and neuropathic pain**, consider multimodal analgesia using paracetamol, a NSAID, and an opioid. But monitor side-effects and manage carefully.
6. **Opioids** can be added in combination with partially effective first- and second-line pharmacological treatment. Use of high doses of opioids over long periods of time can also cause increased pain sensitivity or opioid induced hyperalgesia.
7. Chronic persistent pain is difficult to manage. For chronic nociceptive pain, **non-pharmacological strategies** are the preferred option. Opioids are less effective for chronic nociceptive pain and need careful management.
8. **Chronic neuropathic pain** is difficult to manage. Consider the role of antidepressant and antiepileptic adjuvant drugs (for example post-shingles, osteoarthritis and sensitisation, cancer pain).