N3. Provide support for any psychosocial and spiritual concerns identified during comprehensive assessment which may be contributing to cancer-related pain.

(NCCN)

N4. Consider referral to an occupational therapist for assessment and management. (Consensus)

N5. Consider referral to a clinical psychologist for psychological therapies and support. (Consensus)

N6. Consider music, either prerecorded or with a music therapist (NCCN, ASCO 2022)

N7. Offer to discuss any complementary therapies the person may wish to consider and provide reliable information about the evidence for their effectiveness and risks. (Consensus)

Pharmacological management

Recommendations
P1. Analgesic treatment should start with drugs indicated by the WHO analgesic ladder appropriate to the severity of pain. (ESMO) In adults (including older persons) and adolescents with pain related to cancer, non-steroidal anti-inflammatory drugs (NSAIDs), paracetamol and opioids generally should be used at the stage of initiation of pain management, either alone or in combination, depending on the clinical assessment and pain severity, in order to achieve rapid, effective and safe pain control. (WHO) As an alternative to weak opioids, low doses of strong opioids could be an option. (ESMO) (There is no high quality evidence to support or refute the use of paracetamol and/or an NSAID either by themselves or in combination with opioids. (ESMO)
P2. If pain is constant and is moderate or severe or continues despite treatment with paracetamol or NSAIDs, consider a regular oral opioid. (ESMO, NCCN) • For opioid-naïve people with pain related to cancer with normal renal and hepatic function, start with the lowest possible dose to achieve acceptable analgesia and patient goals. • Individual titration, e.g. normal-release morphine administered every 4 hours plus rescue doses (up to hourly) for breakthrough cancer pain is recommended in clinical practice. (ESMO) For people with intermittent pain, opioids should be initiated as immediate release and PRN (as needed) to establish an effective dose, with early assessment and frequent titration. (ASCO 2016, ASCO 2022) If 3-4 doses are needed per day consistently consider the addition of a long acting opioid. (NCCN) • In older or frail people, starting doses should be lower. Prior to initiating opioid therapy, clinicians, people with cancer pain, and caregivers should discuss goals regarding functional outcomes, and pain intensity, as well as any concerns about opioids (ASCO 2016, ASCO 2022) and shared expectations (including opioid down titration and cessation. (Consensus) For people who are candidates to begin opioid treatment, clinicians may offer any of the opioids available. Qualifying statement. The decision of which opioid is most appropriate should be based on factors such as pharmacokinetic properties, including bioavailability, route of administration, half-life, neurotoxicity, and the cost of the different drugs. Tramadol and codeine have limitations that may make them less desirable than other opioids in this setting. Tramadol is a pro-drug, that has limitations in dose titration related to a low threshold for neurotoxicity, and has potential interactions with other drugs at the level of cytochrome P450 (CYP) 2D6, 2B6, and 3A4.Codeine is a prodrug, requiring CYP2D6 to allow it to be metabolised to morphine to achieve analgesic effects.(ASCO 2022)