7.7.1 Analgesics for patients with liver disease

Paracetamol

Paracetamol is safe in patients with chronic liver disease, but a reduced dose of 2–3 g daily is recommended for long-term use.[457]

Pain adjuvants

Adjuvant analgesics such as TCAs and anticonvulsants may be used cautiously for cirrhotic patients with neuropathic pain.[458] Gabapentin or pregabalin may be better tolerated in cirrhosis because of non-hepatic metabolism and a lack of anticholinergic side effects.[458]

Opioids

Prescribers should use additional caution and increased monitoring to minimise risks of opioids in patients with hepatic insufficiency.[8] In these patients, opioids are well known to cause sedation, constipation and precipitate encephalopathy. There is an increased risk for patients with hypoalbuminaemia, and immediate-release as opposed to controlled-release formulations are advised.[458]

Mild pain not controlled with paracetamol may be best managed with either low-dose tramadol or oxycodone (not slow-release formulation) with an increase in laxatives.[458] Fentanyl and buprenorphine are also considered relatively safe. However, combined preparations of slow-release oxycodone and naloxone are not recommended.

In practice

Co-prescription of laxatives is mandatory to avoid constipation and encephalopathy in patients with hepatic insufficiency.

7.8 Opioid therapy for culturally and linguistically diverse patients

7.8.1 Culturally responsive care

Culture, language and religious convictions have an impact on pain sensitivities, assessment and management. There are significant cultural differences in self-care when managing pain, which affect pain relief seeking behaviour.[459,460]

Given the large inter-individual differences in pain behaviours and analgesic requirements in any patient group, pain should be assessed and managed on an individual basis rather than expectations associated with any cultural or ethnic group.[461,462]

There are genetic differences (refer to *Prescribing drugs of dependence in general practice, Part C1: Opioids* – Section 3.1.2 Metabolism and duration of activity) in the metabolism of opioids,[349,463,464] which also need to be considered.

7.8.2 Prescribing opioids to Aboriginal and Torres Strait Islander peoples

High-quality literature to inform acute pain management and opioid use in Aboriginal and Torres Strait Islander peoples is limited or conflicting.[465–468]

As with all patients, comorbidities need to be considered when selecting analgesics. Higher levels of medical comorbidities such as renal failure have been identified within the Aboriginal and Torres Strait Islander population.[469]