Clinical Guidelines for Narcotics

The narcotics stated here refer to narcotic analgesics such as Morphine, Codeine, Opium Alkaloids, Meperidine (Pethidine), Pentazocine and other Opioids. These drugs have special medical uses, but due to their ease in inducing severe psychological and physiological dependence, which affects patients' health, the doctor must cautiously prescribe according to regulation so as not to interfere with the law.

I. Drug Usage Principles

1. Usage should strictly be limited to the indications.
2. Drugs may not be abused upon patient request.
3. Oral dosage forms should be used as possible to avoid unnecessary intravenous injections.
4. Stepwise drug usage should be practiced.
5. Prescription should be as according to rules for narcotics and no telephonic prescription is allowed.

II. Precaution

1. Usage is not suitable for patients with decreased level of consciousness.
2. Usage is not suitable for patients in shock or inadequate respiratory functioning, but if usage is necessary, caution must be practiced.
3. Continuous use in acute pain control for more than 3 days is not recommended.
4. In the treatment of chronic non-cancer pain, the "Physician Guidelines on Clinical Use of Narcotics in Chronic Non-Cancer Pain" should be consulted for usage.
5. For cancer pain control, usage should follow the Guidelines for Drug Usage in Cancer Induced Pain

III. Pain Control

1. Management Principles

(1) Prior to usage, history-taking, physical examination and tests should be done to evaluate the cause of pain, degree of severity and other body abnormalities.

(2) Planning for pain control treatment.

(3) Continuous observation and care.

2. Classification and Control of Pain

(1) Acute Severe Pain: Narcotics may be given for short period:

a. Fracture and Trauma
b. Burns
c. Wound post surgery
d. Analgesia for surgery
e. Acute myocardial infarct and other ischemic pain from acute arterial obstructions
f. Acute Aortic Dissection
g. Biliary Colic or Acute Cholecystitis
h. Renal Colic
i. Acute Pancreatitis
j. Acute Pleuritis
k. Acute Pericarditis

(2) Cancer Pain

a. Principles of Drug Usage
   i. Only suitable for pain induced by organ tissue invasion by cancer cells and not pain due to other co-morbid diseases.
   ii. The diagnosis of cancer must be confirmed, best with tissue histological diagnosis.
   iii. Oral usage (By the Mouth) should be used when possible.
   iv. Scheduled usage (By the Clock) is better than p.r.n. usage.
   v. Management of pain should follow Stepwise usage (By three Ladders).

b. Treatment Guidelines for Patients Who Have Not Been Exposed to Narcotics

<u>First-Line Drugs:</u>

For mild pain non-narcotic analgesics should first be used

i. Acetaminophen: 500mg 4-6 times per day, or 1g 3-4 times per day. Continuous usage with large doses should not exceed 10 days.
ii. Aspirin: 300-600mg, 4-6 times per day.
iii. When necessary and where no contraindication exists, Ibuprofen 200mg 4 times per day or other non-steroidal anti-inflammatory drugs (NSAIDS) may be added.

<u>Second-Line Drugs:</u>

When mild pain is not controlled with first-line drugs, Codeine Phosphate 30-60mg 2-4 times per day may be used. Where necessary,

NSAIDS or Analgesic Adjuncts (Anti-convulsives, Anxiolytics, Anti-depressants and Psychiatric Medication) may be added.

Third-Line Drugs:

Oral Morphine should be used first for severe Pain and where necessary, NSAIDS or Analgesic Adjuncts (Anti-convulsives, Anxiolytics, Anti-depressants and Psychiatric Medication) may be added. In patients who cannot take medication orally, intravenous administration may be used. An anesthetist should be consulted where epidural or intrathecal morphine injection is required.

c. Treatment Guidelines for Patients on Long-term Use of Narcotics

First-Line Drugs:

Oral Codeine Phosphate. Where necessary, NSAIDS or Analgesic Adjuncts (Anti-convulsives, Anxiolytics, Anti-depressants and Psychiatric Medication) may be added.

Second-Line Drugs:

Oral Morphine.

i. Morphine Hydrochloride or Morphine Sulfate tablet every 4 hours.
ii. Morphine Hydrochloride or Morphine Sulfate syrup, every 4 hours.
iii. Slow-Release Morphine Sulfate tablet (MS Contin) every 8 to 12 hours.

Where necessary, NSAIDS or Analgesic Adjuncts (Anti-convulsives, Anxiolytics, Anti-depressants and Psychiatric Medication) may be added.

Third-Line Drugs:

Continuous Morphine injection.

Fourth-Line Drugs:

Morphine used in epidural or intrathecal injections should not contain any preservatives. When the above drugs are ineffective, nerve excision, nerve block or neural plexus ablation may be considered.

d. Contraindications

i. Patients who refuse orders or are not compliant.
ii. Inadequate cooperative attitude from patient or family.
iii. Non-cancer induced pain.

3. Chronic Non-Cancer Induced Pain

Please refer to the "Physician Guidelines on Clinical Use of Narcotics in Chronic Non-Cancer Induced Pain".

IV. Medical Uses Other than Pain-Control

1. For Acute Pulmonary Edema

For cardiac-induced acute pulmonary edema in adults, intravenous Morphine Hydrochloride or Morphine Sulfate 3-5mg may be used.

2. Antitussive

Many Over-The-Counter medications contain low doses of Codeine, but if used according to the recommendations drug dependence usually does not occur, however with long-term high-dose usage there is the risk of inducing drug dependence.

When hemoptysis follows severe coughing, short-course Codeine Phosphate 15-30mg, 3-4 times per day or antitussives containing appropriate Opium dosages may be used.

For Patients with bronchiectasis, tuberculosis or lung cancer who have excessive hemoptysis or severe coughing, intramuscular Morphine Hydrochloride or Morphine Sulfate 5-10 mg may be administered.

3. For Diarrhea

In a minority of patients with specific diseases that cause uncontrolled chronic diarrhea, a short-course oral anti-diarrhea medication containing Opium may be given.