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Managing breakthrough pain in adults with cancer
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Independent expert commentary provided by Dr Wei Lee

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Abbreviations used in this review:

ABPAT = Alberta Breakthrough Pain Assessment Tool; **ATC** = around-the-clock; **BAT** = Breakthrough Pain Assessment Tool; **BTcP** = breakthrough cancer pain; **ED** = emergency department; **ER** = extended release; **HCPs** = healthcare professionals; **HCRU** = healthcare resource utilisation; **IR** = immediate release; **NRS** = numerical rating scale; **QoL** = quality of life; **ROOs** = rapid-onset opioids; **SAOs** = short-acting opioids; **S-LANSS** = Self-completed Leeds Assessment of Neuropathic Symptoms and Signs; **SPID30** = Sum of Pain Intensity Differences at 30 minutes; **TDD** = total daily dose.

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Breakthrough cancer pain (BTcP) is a distinct, highly prevalent pain syndrome in people with cancer, characterised by transient, severe pain flares despite otherwise controlled breakthrough pain on maintenance opioids. It is common across palliative care, radiation oncology and medical oncology, and has major implications for function, mood, and health service use. This Education Series summarises the clinical characteristics and healthcare burden of BTcP, the clinical tools used to diagnose BTcP, along with detailed descriptions of BTcP episode characterisation. The article will also discuss how BTcP can be managed through careful assessment and the appropriate use of pharmacological treatment, alongside non-pharmacological strategies. Key factors in BTcP management include patient- and caregiver-focused education, self-management, and ongoing reassessment over time. This Education Series was sponsored by Menarini Australia Pty Ltd.

Background

Background pain (BP) is a common occurrence in patients with cancer, often made tolerable by continued opioid therapy. In contrast, breakthrough pain (BTcP) is defined as either a transient flare of pain that occurs spontaneously, or a transient flare of pain linked to specific predictable or unpredictable triggers, despite stable and effectively controlled BP.[1] BTcP is defined as a spectrum of different entities and can be classified into either of the following two categories – spontaneous pain (idiopathic pain), and incident pain (precipitated pain). Incident pain can be classed into one of three sub-categories as follows:[1]

1. Volitional incident pain: often brought on by a voluntary act such as walking
2. Non-volitional incident pain: often occurs due to an involuntary act (e.g., coughing)
3. Procedural pain: related to a therapeutic intervention such as a wound dressing

BTcP has a reported prevalence of 40–80% among oncology patients.[2] Clinical features of BTcP include the onset, duration, and frequency of each episode.[3] The typical duration of untreated BTcP episodes can range from 1–360 minutes, with a general median of 60 mins.[3] Pain can suddenly reach maximum intensity anywhere between 1–240 minutes, with a general reported median pain intensity peak at around 10 minutes.[3] The frequency of episodes can range between 1 episode per month to 24 episodes per day, with a median of 3 episodes per day.[3]

BTcP can have a significant impact on the wellbeing of oncology patients, leading to decreased functional impairment, an increased risk of depression and anxiety, social isolation, and mobility limitations.[4,5] Further symptoms can include sleep disruption leading to insufficient sleep, psychological distress, unbearable pain, and reduced ability to feel pleasure from life.[6–9] Daily social activities and work capacity can also be reduced significantly.[9,10] Thus, BTcP can have a marked impact on the quality of life (QoL) of both patients and caregivers.[11] Poor BTcP management can expose the patient to a further worsening of conditions, and these circumstances can compel patients to potentially discontinue chemotherapy treatments, either due to side effects and medication discomfort, or pain management failing to meet patient needs.[4,8] This thereby threatens the likelihood of patient survival.[12,13]

BTcP has the potential to cause a significant burden to healthcare systems. For example, in a study of patients with breast cancer in the US, healthcare resource utilisation (HCRU) was examined for a 1-year follow-up period from the treatment-related pain condition diagnosis. HCRU included the total number of hospitalisations, the total length of inpatient stays, emergency department (ED) visits, physician visits, and outpatient service visits per survivor. After adjustment for baseline healthcare costs and utilisation, the total annual all-cause healthcare costs per patient were 47% higher in survivors with pain as compared to matched survivors without pain. Hospitalisations accounted for 70% of the total costs, ED services accounted for 16%, followed by physician visits (10%). The adjusted annual total HCRU per patient was higher among survivors with pain than among those without pain, accounting for hospitalisations per patient, all-cause annual outpatient service use, hospital length of stay in days, and emergency department visits.[14] Thus, patients with cancer with BTcP are likely to sustain higher direct medical costs than patients without BTcP, significantly increasing healthcare system burden.[14,15]

A recent gap analysis of BTcP diagnosis and management within the Australian healthcare system highlighted the five following interrelated areas for improvement:[16]

1. Inconsistent definitions of BTcP amongst healthcare professionals.
2. Assessment and measurement gaps via validated tools are limited by perceived respondent burden and diagnostic value.
3. A current heterogenous approach to BTcP exists with limited comparative evidence for rapid onset opioids (ROOs) versus immediate-release (IR) opioid administration, and dosing strategies.
4. Current implementation and systems barriers including workflow, prescription complexity and clinician training needs.
5. Equity in opioid supply balanced with restricted access to vulnerable populations.

Assessment of BTcP

Common sites for BTcP include the abdomen, upper limbs, shoulders, lower limbs, pelvis and hips, back, and chest.[16,17] BTcP can occur due to various triggers or precipitants. Most of these precipitants were physical movements, such as movement during sleep, walking, or coughing. However, BTcP episodes can also arise during rest.[18]

The pathophysiology of BTcP can be categorised into three groups (nociception, neuropathic, or nociplastic [or central sensitisation] pain), which may provide clues about the mechanisms contributing to BTcP in the individual.[2,19] Somatic nociception can be attributed to bone metastases or contact with inflamed or infected mucosal tissue, while visceral nociception is caused by distension or sub-occlusion of the visceral organs, e.g., acute episodes of tenesmus.[2,19]

Use of structured tools

While adequate patient assessment is essential to determine the characteristics and impact of BTcP, distinguishing BTcP from poorly managed background pain can be challenging.[20] Patient history needs to be evaluated for diagnosis of breakthrough pain, and in patients with normal cognitive function, self-reporting is relied upon for manifestation of BTcP. The numerical rating scale (NRS) performs better in distinguishing between background pain and peak pain intensity.[21] Following this, the Alberta Breakthrough Pain Assessment Tool (ABPAT) and Breakthrough Pain Assessment Tool (BAT) can be used for BTcP assessment.

The ABPAT was designed to characterise the patient's breakthrough pain, by consultation with multiple international experts and pre-testing among patients with BTcP.[22] However, the ABPAT requires further validation[7] and its length (i.e., 22 pages) precludes use in clinical practice; it is usually used within a research context.[23,24]

BAT was more recently developed in accordance with international guidelines to assess BTcP by healthcare professionals (HCPs) working in various clinical settings, i.e., hospital, hospice, and community.[23] The BAT comprises 2 pages (14 questions in total), and assesses the location of pain, frequency, duration, severity, potential triggers, current pain medication strategies, and QoL impact.[23] BAT is thus brief, reliable, and assesses the multidimensional aspects of pain.[23] These aspects signify the validity of BAT as a valid assessment tool for BTcP in clinical practice.[23,24] However, due to concerns about respondent burden and perceptions that BAT does not directly inform analgesic selection, the adoption of BAT into regular clinical use has been limited across the Australian healthcare landscape.[16]

A working group recently highlighted that any future development of BTcP assessment tools should establish clear definitions between actual BTcP and BTcP subtypes. Such distinctions can enable more precise, mechanism-based analgesics individually tailored to pain characteristics.[16]

Expert comment

BTcP is a distinct yet prevalent entity of cancer pain. While its definition is evolving and remains contentious at times, it is generally accepted to be a transient flare of pain in the context of stably controlled background pain. Typically, its onset is rapid with a short duration lasting less than an hour. BTcP may have nociceptive, neuropathic, and nociplastic (central sensitisation) components, or a mixture of these components.

Accurate assessment necessitates a detailed history and examination, correlating with available investigation findings (e.g., imaging) to delineate malignant versus non-malignant causes of pain and guide management. When assessing nociceptive BTcP, detailed exploration of the temporal characteristics (e.g., rapid vs gradual onset/offset; short vs long duration; relation to analgesia) is vital to differentiate them from other types of cancer pain (e.g., end-of-dose failure of around-the-clock analgesia) and inform the selection of analgesia choices (e.g., rapid onset opioids vs oral immediate release opioids).

A detailed assessment of the response to analgesia is important. Partial opioid analgesic response typically implies the need for increasing the current opioid dose to relieve inadequate analgesia, while no analgesic response or worsened pain (i.e., opioid induced hyperalgesia with nociplastic pain) after opioid analgesia may indicate the need for opioid switch and/or consider non-opioid alternatives (e.g., ketamine). Tolerability of analgesia should be assessed, and agents selected to minimise the side-effect profile for the individual.

Physical examination findings of a difference in sensation between non-painful and painful areas on pressure or rubbing can indicate a neuropathic component of pain. The S-LANSS scale can be used to differentiate neuropathic pain from nociceptive pain.

The presence of pain experience disproportionate to the nature and extent of injury or pathology, a neuroanatomically illogical pain pattern, and hypersensitivity to sensory stimuli (e.g., bright light, cold/heat, sound/noise, chemical stimuli) suggests a central sensitisation (nociplastic) pain component. Further clinical assessment of pressure pain threshold and temporal summation and/or the use of the Central Sensitisation Inventory can be helpful.

General principles of management

Multidisciplinary, mechanism-based approach

In most cases (65–76%), the underlying cause of BTcP is a direct effect of cancer. BTcP management should be tailored to the cause, pathophysiology, and clinical features of the pain.[5] As treatment options are numerous, direct consultation with the relevant oncology team is highly recommended. Whilst there is good evidence for the efficacy of oncological treatments, such as conventional radiotherapy, in managing background pain, there is limited evidence for their efficacy in BTcP management.[1] However, there is emerging evidence to suggest certain oncological treatments (e.g., samarium, zoledronic acid treatment) may indeed be effective in managing certain types of breakthrough pain.[28] Treatment of underlying causes, such as bone metastasis, bisphosphonates, corticosteroids, RANKL (receptor activator of nuclear factor kappa-B ligand) inhibition, or interventional pain procedures (neurodestruction or neuromodulation) can also be carried out.[5,29]

Addressing background pain

Cancer-related background pain management should be integrated into cancer treatment plans throughout the care continuum.[17] The WHO 3-step ladder operates as a framework of principles rather than a rigid protocol, allowing adaptation to the patient's needs.[17]

The modification and optimisation of background analgesia have proven to be useful approaches in BTcP management.[30] Strategies include titration of opioid analgesics, which can be effective in reducing the frequency and/or intensity of movement-related volitional pain.[31] The European Association for Palliative Care guidelines state that suitable titration of baseline opioids must always precede administration of individual 'rescue' medication for BTcP.[31] However, the opioid titration strategy can be limited by the existence or development of dose-dependent adverse effects (e.g., sedation).[32] Switching the opioid of choice and/or administration route can also reduce BTcP severity due to movement-related volitional pain. Adjuvant analgesics can be effective in reducing the impact of specific BTcP syndromes (e.g., antiepileptics for neuropathic pain, anti-spasmodics for visceral pain).[33] In addition, adjuvant drugs (agents with non-analgesic functions) can provide relief from the adverse effects of analgesic drugs or pain-related complications,[34] enabling effective titration of analgesic drugs, thereby reducing BTcP impact.

Aligning management with goals of care

For effective, ethical management of BTcP, HCPs should optimise individualised care to improve QoL for patients with BTcP by communicating effectively and setting goals with patients and caregivers. The patient's condition, including disease stage, physical performance, and personal preferences, should be considered when managing BTcP effectively.[1]

The onset of analgesia for short-acting opioids (SAOs) is typically 30–45 minutes, while it is 5–15 minutes for ROOs.[35] SAO-induced analgesia often lasts longer than the pain episode, which can result in sedation.[35] In general, the background (basal) analgesic does not predict the BTcP dose. Thus, the doses are titrated for all ROOs and are not proportional to the background dose.[35] Sometimes the initial dose chosen is inadequate for pain control, and addition of an SAO is required.[35] Titration usually takes 24 to 48 hours and often requires regular contact with the patient for reassurance and advice.[36] The maximum number of advised ROO treatments for BTcP in 24 hours is generally 4.[35] If more treatments are required, then the background dose should be increased.[34]

Adequate management of BTcP patients can also be affected by whether they are in a home or clinical setting.[35] For effective management of BTcP in a home setting, given the extreme variability of BTcP episodes within the same patient, each dose of ROOs should ideally be titrated. However, this is not always practical, particularly in home-care or end-stage patients.[36] Patients can also present with concerns about having medications in the home and the risk posed to the other occupants (n=1), while some patients express wanting medication before pain onset.[36] Furthermore, while background pain can be managed, it is more difficult to manage BTcP episodes at home, due to difficulties putting a pain management regimen into practice by patients and family caregivers.[37]

Considering opioid misuse concerns in vulnerable populations, current screening tools may not be appropriate for use in advanced cancer. Currently, further interdisciplinary work and consensus methods are needed to not only define opioid misuse, but to inform balanced risk management strategies, risk screening, and intervention.[16]

Finally, the satisfactory management of BTcP strongly depends on adequate reassessment of the patient. Reassessment objectives should include assessing treatment efficacy, tolerability, and any changes in the nature of breakthrough pain. Inadequate reassessment may lead to the continuance of ineffective and/or inappropriate treatment for BTcP.[1]

Patient and caregiver education[36,38]

Education about BTcP is viewed favourably by patients, family caregivers, staff, and colleagues. For patients with BTcP, education empowers them to understand their circumstances, to provide information to HCPs, and to discuss aspects of their care. This allows patients to provide feedback on the effectiveness of pain management. Furthermore, BTcP-educated patients are more empowered to self-manage their care as they wish. From a clinical perspective, education is essential to dispelling myths and misconceptions surrounding BTcP, such as fear of opioid addiction and concerns about adverse events.

Non-pharmacological strategies

A variety of non-pharmacological methods can be used by patients. These include movement modifications such as rubbing/massage, psychological approaches such as distraction and relaxation techniques, and local measures such as applying heat or cold.[7,37] However, there is little evidence to support their effectiveness in the treatment of BTcP.[1]

Pharmacological strategies

Table 1 outlines the current pharmacological treatments that are available in Australia to manage pain.

Table 1. Pharmacological treatments available in Australia to manage pain.

Category	Generic name	Brand name(s)	Route	Indication
Immediate-release opioids	Morphine	Anamorph[39] and Ordine[40]	Oral	Short-term management of severe pain for which other treatment options have failed, are contraindicated, not tolerated or otherwise inappropriate to provide sufficient management of pain[41]
	Oxycodone	Endone[42] and OxyNorm[43,44]	Oral (Endone and OxyNorm), and IV injection or infusion, and SC injection or infusion (OxyNorm)	Moderate-to-severe chronic pain unresponsive to non-narcotic analgesia[42]
Fast-acting opioids	Morphine (injectable)	Various[45]	SC	For the relief of severe pain not responsive to non-opioid analgesics[46]
Rapid-acting opioids	Fentanyl citrate (sublingual tablet)	Abstral[47]	Sublingual	Treatment of BTcP in adults with cancer already receiving maintenance opioid therapy for chronic cancer pain[47–49]
	Fentanyl citrate (buccal tablet)	Fentora[48]	Buccal	
	Fentanyl citrate (oral transmucosal lozenge)	Actiq[49]	Oral transmucosal	

BTcP = breakthrough cancer pain; **IV** = intravenous; **SC** = subcutaneous.

Immediate-release opioids

IR opioids are short-acting oral formulations with an onset of around 30–45 minutes and remain the initial treatment of choice for most BTcP, as they provide analgesic effects more quickly over a shorter period.[41] In Australia, it is recommended that breakthrough doses of IR opioids such as morphine, oxycodone and hydromorphone are calculated depending on the regular background dose. This is done by dividing the total daily dose (TDD) the patient is being administered by 6 (e.g., if the TDD morphine is 60 mg, then the breakthrough dose will be 10 mg). This calculation is to be used as a general guide, as some patients may manage BTcP with smaller doses (in which case TDD is to be divided by 12 for calculating breakthrough dose), while some require higher doses of medication.[50]

While methadone is available in Australia, due to its complex pharmacodynamic and pharmacokinetic natures, specialist supervision is required for methadone administration for BTcP alleviation.[51]

Fast-acting opioids

Fast-acting opioids commonly refer to injectable fentanyl or sufentanil given via subcutaneous injection, with an onset of ~5–15 minutes.[52] Transdermal fentanyl itself can be considered as a fast-acting opioid for BTcP use, when BTcP is not adequately managed by other short-acting opioids.[53]

Rapid-onset opioids

Rapid-onset opioids (ROOs) have a rapid onset of action and relatively short duration of analgesia, ideal for treating BTcP.[54] BTcP-specific ROOs are transmucosal fentanyl formulations specifically developed for BTCP with rapid onset (~5–15 minutes) and short duration, delivered via sublingual, buccal, or intranasal routes.[35] Until approximately 2000, IR opioids were heavily relied upon as rescue medication for BTcP. However, treatment of BTcP with oral IR opioids can require 30–45 minutes to produce an analgesic effect, which can last for 3–6 hours.[55] Furthermore, pain management relying on an around-the-clock (ATC), extended release (ER) opioid for BTcP episodes results in a high level of opioid exposure (**Figure 1A**).[55] Thus, the patient may be left waiting for at least 30 minutes to receive adequate pain relief and may concurrently endure high-dose opioid-induced analgesia, resulting in a higher risk of neurological, gastrointestinal, and other side effects 2–5 hours after the BTcP has even subsided.[55] However, using a lower dose of an ATC ER opioid along with an IR opioid results in less total opioid exposure, and thus insufficient management of BTcP, due to the lag between dosing and analgesia onset (**Figure 1B**).[55]

ROOs exhibit a fast onset from 10–15 minutes to a clinically detectable analgesic effect. Their duration of action is 1–2 hours, in contrast to the 3–6 hour duration of IR opioids, making ROOs an ideal drug family of choice for BTcP (**Figure 1C**).[55,56] As there are multiple formulations of ROOs (e.g., sublingual, buccal, nasal spray),[55] an important factor to consider when choosing the best ROO for each patient is their oral and nasal mucosal condition, along with patient preference and access to medications (**Figure 2**).

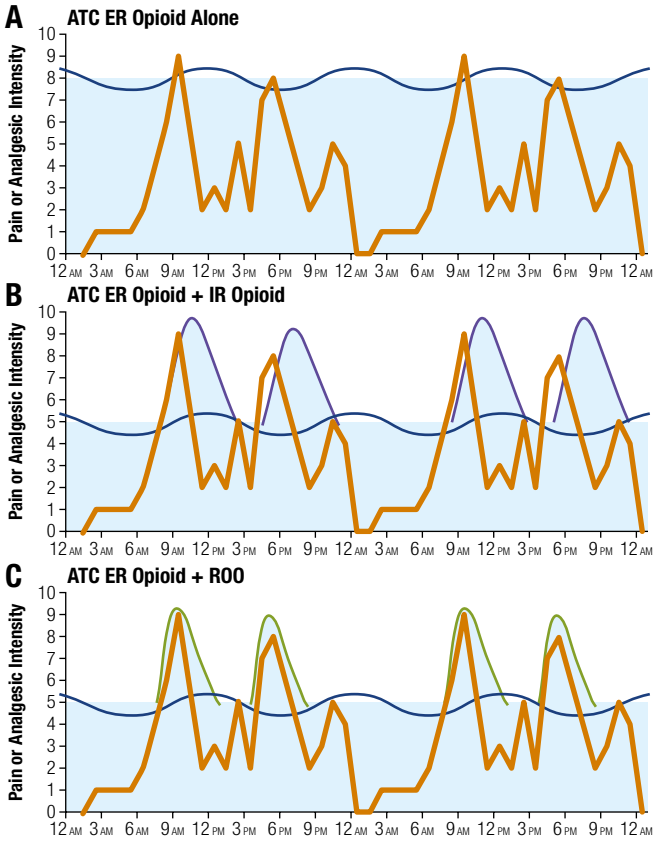

Figure 1. Time course of cancer pain with various treatment strategies.
Cancer pain is indicated by the orange line. Blue shading indicates total opioid exposure. (**A**) ATC every 12 hours ER opioid medication (blue line) indicates poor matching of analgesia to BTcP episode occurrence. (**B**) Lower dosage ATC ER opioid medication, with IR opioid medication (purple line) for BTcP indicates a lag effect for analgesia when compared to transient BTcP. (**C**) The same ATC ER opioid dosage as in panel B; BTcP controlled with a ROO (green line), demonstrating effective management and analgesic effect. Adapted from Simon et al. (2014).[55]
ATC = around-the-clock; **BTcP** = breakthrough cancer pain; **ER** = extended release; **IR** = immediate release.

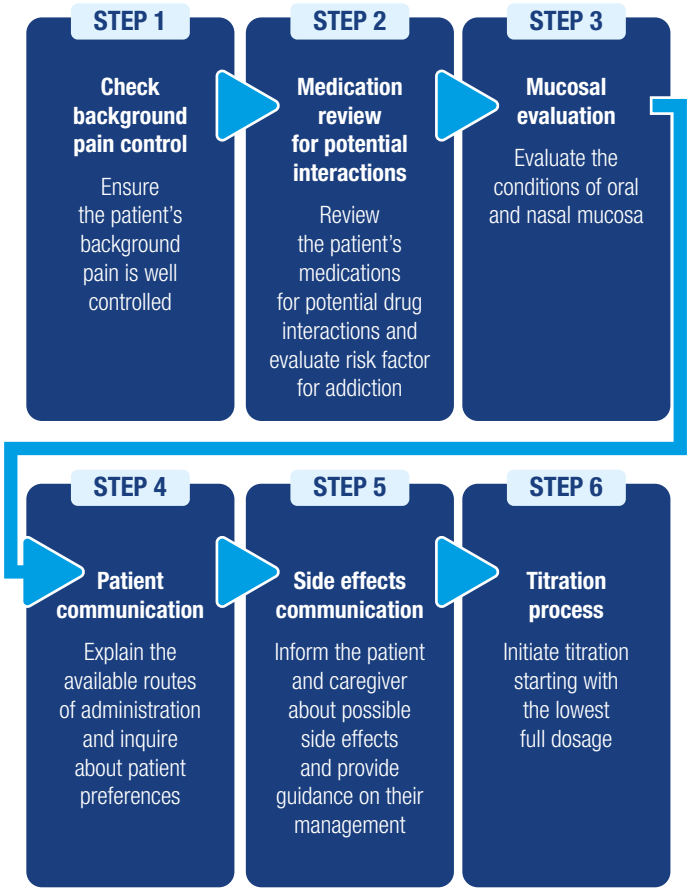

Figure 2. Decision-making process for choosing the optimal ROO in BTcP treatment.
Adapted from Romualdi et al. (2025).[38]

Sublingual fentanyl (Abstral) is currently the most commonly used ROO in Australia.[57] It is a highly regulated, Schedule 8 controlled drug indicated for the management of BTcP in adults with cancer already receiving maintenance opioid therapy for chronic pain or background pain.[58] It should only be administered to patients who are considered tolerant to their opioid therapy for persistent cancer-related pain.[56] Patients are considered opioid tolerant if they ingest at least 60 mg of oral morphine daily, or an equianalgesic dose of another opioid for a week or longer.[58] It must be individually titrated until the optimal maintenance dose for ongoing treatment of BTcP is achieved.[58] The optimal dose should provide adequate analgesia with an acceptable level of adverse events.[58]

Sublingual fentanyl provides rapid-onset analgesia for BTcP in opioid-tolerant adults, with significantly greater pain intensity reduction versus placebo from 10 minutes and sustained through 60 minutes after dosing.[58] In the pivotal phase III trial, patients titrated to an effective 100–800 µg dose achieved superior SPID30 and consistent improvements in pain relief across age, sex, dose and background opioid subgroups.[58] The safety profile reflects typical opioid effects (very common nausea, constipation, somnolence, headache).[58] Serious adverse events that have been reported include life-threatening respiratory depression, dependence and misuse, CNS depressant interactions, adrenal insufficiency, androgen deficiency, sleep-related breathing disorders, and rare events, such as central sleep apnoea, pancreatitis and sphincter of Oddi spasm.[58] Thus, it should only be used in carefully selected, closely monitored opioid-tolerant patients with cancer.[58]

In practice, many services report logistical barriers to ROO administration due to complex titration requirements.[16] This complexity requires not only structured quality improvement processes, but a multidisciplinary approach involving physicians, nurses, pharmacists and regulatory bodies.[16] Further, new development of standardised adaptable forms, instructions and charting, and the alignment of nomenclature and indications with regulatory requirements could also help. Another suggested measure is written guidance that combines clear instructions and directives, incorporating reference algorithms.[16]

Expert comment

Management of BTcP needs to be tailored to the individual patient through a mechanistic approach that targets the underlying pain mechanisms and causes. A holistic approach focusing on the construct of "total pain", addressing the biopsychosocial needs of the individual using a multidisciplinary approach, should be the standard. While numerous pharmacological interventions are effective, non-pharmacological interventions, such as exercise, mindfulness, and various psychotherapeutic approaches, are important for sustaining improvement.

The foundational treatment of cancer-induced BTcP is based on opioids. When choosing opioid treatment, clinicians need to consider the temporal characteristics of the pain, the underlying mechanisms, organ dysfunctions and co-morbidities (e.g., hepatorenal and cognitive impairment) that might impact on medication safety and compliance.

For BTcP episodes with rapid onset/offset and short duration (<1 hour), the use of ROOs would be desirable, whereas pain episodes with gradual onset and longer duration may be better managed with non-ROOs. However, ROOs cannot be administered in patients who are opioid-naïve; they require patients to be already on at least 60mg of oral morphine equivalent daily dose of opioids to ensure safety and tolerability. The correct titration of ROOs requires education for patients, carers and nurses to ensure follow-up of the analgesic response 30 minutes after the first ROO administration, to consider an add-on dose. Setting the expectation for patients that adequate analgesia is achieved only after the titration process is complete and the maintenance dose is determined is important to avoid premature discontinuation of ROOs.

For neuropathic BTcP, opioid adjuncts such as antidepressants (i.e., tricyclic and serotonin noradrenaline reuptake inhibitors), gabapentinoids (e.g., pregabalin and gabapentin), and other agents (e.g., valproate, clonidine, baclofen) should be considered. Individuals with nociplastic (central sensitisation) elements of pain would often benefit from pain education and psychotherapeutic interventions, aiming to reduce catastrophising behaviours and improve the sense of mastery and self-efficacy towards total pain. Treatment should be titrated to improve functional outcomes rather than solely the subjective pain score, thereby reducing exaggerated pain responses and pain hypersensitivity. Pharmacological interventions overlap with neuropathic pain agents such as tricyclic antidepressants and gabapentinoids but also include N-methyl-D-aspartate antagonists such as ketamine, methadone, and lignocaine.

For patients with a history of aberrant behaviours of opioid use, caution needs to be exercised when using ROOs with frequent monitoring. A useful alternative may be the use of buprenorphine-based treatment, as well as maximising non-opioid alternatives.

Take-home messages

- BTcP is a rapid, transient flare of severe pain occurring despite otherwise well-controlled background pain in patients with cancer and can occur spontaneously or by incidental activities (e.g., movement).
- BTcP is common, can occur multiple times per day, and causes major impairment in function, sleep, mood, independence, and overall quality of life for patients and caregivers.
- Thorough assessment must cover background pain, detailed BTcP episode characteristics, and regular reassessment, often supported by structured tools such as BAT.
- Management should be multidisciplinary and mechanism-based, optimising background analgesia, using appropriate rescue opioids (including ROOs for transient pain flares), and incorporating non-pharmacological strategies.
- Education and support for patients and caregivers are essential to enable safe self-management, dispel opioid-related fears, and align treatment with individual goals of care.

Expert concluding comments

The appropriate management of BTcP relies on a comprehensive pain assessment, tailoring treatment to the pain characteristics and mechanisms, and a multidisciplinary team approach to improve comfort and functional outcomes for individuals.

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Patients and the general public can benefit from clear educational materials and awareness interventions to support the responsible use of opioids.[7] For the most up-to-date version of this statement please visit mediscene.com.au/responsible-use-of-opioids-statement or scan the QR code.

PBS Information: Authority required for the treatment of breakthrough pain. Refer to PBS Schedule for full authority information.

Please review the Approved Product Information before prescribing. The Product Information can be accessed at https://rss.medsinfo.com.au/fk/pi.cfm?product=fkpabsst or scan the QR code.

WARNINGS - Limitations of Use – Because of the risks associated with the use of opioids, Abstral should only be used in patients for whom other treatment options, including non-opioid analgesics, are ineffective, not tolerated or otherwise inadequate to provide appropriate management of pain. **Hazardous and harmful use** – Abstral poses risks of hazardous and harmful use which can lead to overdose and death. Assess the patient's risk before prescribing and monitor regularly during treatment. **Life threatening respiratory depression** – Serious, life-threatening or fatal respiratory depression may occur with Abstral. Modify dosing and monitor at-risk patients closely, especially on initiation or after dose increase. **Concomitant use of benzodiazepines and other CNS depressants, including alcohol,** may result in profound sedation, respiratory depression, coma, and death. Use the minimum effective dose and treatment duration and monitor for respiratory depression and sedation. Caution patients not to drink alcohol. See approved PI.

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