Basingstoke and North Hampshire NHS
NHS Foundation Trust

Winchester and Eastleigh NHS
Healthcare NHS Trust

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University Hospitals NHS Trust

Persistent Pain

Guidelines for the Pharmacological management of pain in Primary Care/ Non-specialist Centres and referral to Specialist Secondary Care Services

Approved by Basingstoke, Southampton and Winchester District Prescribing Committee.

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Persistent Pain

Guidelines for the pharmacological management of pain in Primary Care/ Non-specialist Centres and referral to Specialist Secondary Care Services.

Purpose

To facilitate the appropriate initial treatment and referral to specialist services, for adults suffering with persistent pain. Update of guidelines published 2006.

Introduction

- Pain is one of the most common reasons that patients present to primary care.
- Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. (International Association for the Study of Pain IASP)
- Persistent pain is pain that continues when the healing process has occurred or in the absence of tissue injury (IASP). A DVD is available from the Royal College of General Practitioners (RCGP)/British Pain Society (BPS) to explain this.
- It is known that there are widespread changes within the nervous system that give rise to persistent pain (Siddall, 1997).
- The chances of recovery are small. Only 1 in 20 patients report no pain, five years after first reporting persistent pain.
- According to the British Pain Society, one in seven people are thought to suffer from persistent pain and twenty percent of those reports suffering for more than 20 years. People with pain consult their doctor up to five times more frequently than others, resulting in nearly 5 million GP appointments each year.
- Two thirds of persistent pain sufferers surveyed in the UK reported inadequate pain control with only 16% saying that they had seen a pain specialist.
- Untreated pain can affect quality of life for sufferers and their carers, leading to helplessness, isolation, depression and family breakdown.
- A stepped approach to care is recommended for clinical management (www.18weeks.nhs.uk).
- One study using the GP research database found that changes of medicines were less frequent in neuropathic pain if patients were started on an antidepressant or anticonvulsant.

Background

- The Royal College of General Practitioners (RCGP) and The Pain Society recommend that primary care physicians and hospital specialists should work together to manage patients in the most appropriate environment.

- Specialist Pain services serve the needs of people with complex pain disorders requiring diagnosis and treatment by a multi-disciplinary teams (Information Centre Specialty by Treatment function).
- It is important to refer early rather than late; these guidelines are designed as an aid to this, by describing a pathway for appropriate referral to the specialist services available in the Hampshire and Southampton City areas.
- Waiting times for specialist pain services may be several weeks (the standard wait is 6 weeks from referral to initial assessment). The RCGP states that it is important to continue to see patients awaiting specialist referral and to modify treatment where appropriate.
- These guidelines are designed to facilitate the treatment pathway between primary and secondary care.

Scope

- All patients aged 18 years or over, with persistent pain.
- For use by all prescribers, both within Primary and Secondary Care.

Recommendations

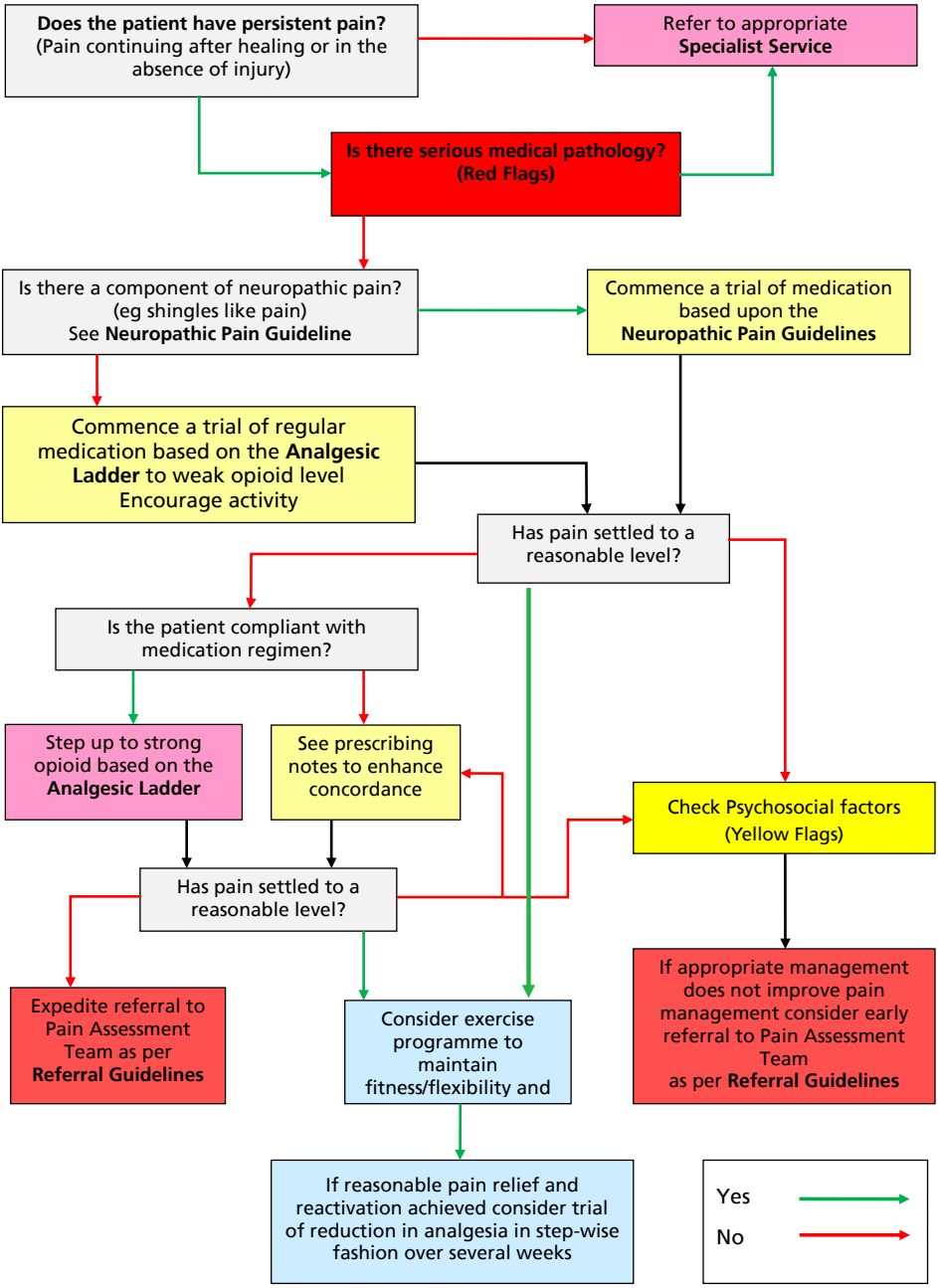
- The guidelines are designed as a series of algorithms to be used together to guide management and referral.
- They are based on established practice throughout the UK. References are listed below.
- It should be emphasised that medicines play only a minor part in managing persistent pain. Maintaining fitness, pacing activities and a generally healthy lifestyle are important. Non-pharmacological methods of pain relief such as TNS, acupuncture, physical methods in the reduction of muscle spasm are equally important. All patients should be screened for common mental health problems that may result from experiencing difficult to control pain. A mental health needs assessment should be made before starting strong opioids.

References

- The British Pain Society and Royal College of General Practitioners. A practical guide to the provision of Chronic Pain Services for adults in Primary Care. Available from http://www.britishpainsociety.org/NAPP_RESOURCEPACK.pdf
- Nicholas MK, Molloy AR, Brooker C. Using opioids with persisting, noncancer pain: A biopsychosocial perspective. Clinical Journal of Pain, 2006; 22(2): 137-146.
- Siddall PJ and Cousins, MJ. Neurobiology of Pain. International Anesthesiology Clinician, 1997 Spring; 35(2):1-26. Review.
- Hall Gillian C, Carroll Dawn, Parry David, and McQuay Henry J. Epidemiology and treatment of neuropathic pain: the UK primary care perspective. Pain, 2006, 122(1-2):156-62.
- Finnerup N B, Otto M, McQuay H J, Jensen T S, and Sindrup S H. Algorithm for neuropathic pain treatment: an evidence based proposal. Pain, 2005, 118(3):289-305
- The Oxford Pain Internet Site. www.jr2.ox.ac.uk/bandolier/booth/painpag/
- The General Practice Research Database. http://www.gprd.com/home/
- The Cochrane Database. http://www.cochrane.org/ also available through the National Library for Health
- National Library for Health. http://www.library.nhs.uk/Default.aspx

Produced by Emma Davies, Specialist Pharmacist - Pain Services, SUHT. July 2009.

Algorithm for the Pharmacological Management of Persistent Pain



Analgesic Ladder - Assess each change to analgesic regimen after 4 – 6 weeks

Step 1

Non-opioid analgesic / baseline analgesia

Paracetamol 1g four times a day

Continue as patient moves through Steps 2 - 4

Step 2

Opioids for moderate to severe pain

1ST LINE

Dihydrocodeine 30mg four times a day (maximum 240mg daily dose)

- Efficacy: Up to 10% of caucasians may be unable to metabolise codeine to morphine – dihydrocodeine does not rely on this process for action, therefore may be a better choice and can be used to determine if the patient responds to weak opioids. Co-drugs e.g. Co-dydramol, co-codamol may improve compliance in a responsive patient but may have a higher incidence of side-effects and are more difficult to titrate to need due to the fixed doses of each component.

2nd LINE

Buprenorphine Patch (Butrans) – starting dose 5mcg/hour increased to maximum 20mcg/hour

- Low dose buprenorphine patch (Butrans) changed weekly is second line for patients unable to tolerate dihydrocodeine, co-drugs etc. e.g. side effects of constipation unresponsive to laxatives, drowsiness etc.

Tramadol – starting dose 50mg up to four times a day increased to maximum 100mg four times a day

- Tramadol is an alternative opioid and possesses serotonergic and adrenergic properties too. It is generally not well tolerated in elderly patients and can cause psychiatric reactions in patients of all ages. Drowsiness is a commonly reported side-effect. It can lower seizure threshold so should be used with care in epileptic patients.

Opioid equivalence

Dihydrocodeine	Tramadol	Buprenorphine patch (Butrans)	Morphine SR
240mg total daily dose	50mg four times daily	20 mcg/hour	20mg bd

- All opioids should be started at the lowest possible dose (equivalence) and titrated up.
- Tolerability: Nausea, dizziness can be dose related. Start at low doses and increase slowly. Slow release

Step 3

Opioids for severe pain

1st LINE

Morphine SR (Zomorph capsules) 20mg twice daily

(Maximum dose of 60mg twice daily before referral to Pain Assessment Team)

Consider; • Increase dose by no more than 10mg twice daily at a time

2ND LINE (Change opioid if adequate analgesia but intolerable side-effects with Morphine)

- Oxycodone SR tablets – reduced incidence of hallucinations and nausea
- Fentanyl patch – may accumulate less in renal failure and have reduced incidence of constipation
- Buprenorphine (Transtec) – may accumulate less in renal failure and has reduced incidence of constipation. Dose equivalence to other opioids is less reliable however, so it is preferable to use other strong opioids before buprenorphine.
- **If opioid use does not improve function or doses start escalating due to poor effect, it is likely the patient has non-opioid responsive pain and they should be tailed off and stopped.**
- **Opioids should be reviewed every six months and doses reduced as soon as possible to the lowest effective dose.**

Opioid equivalences

Morphine SR	Fentanyl patch	Oxycodone SR tablets	Buprenorphine patch (Transtec)
20mg bd	12 mcg/hour	10mg twice daily	35mcg/hour

- Care in pregnancy / breastfeeding – if continued use is necessary, use lowest possible dose. Avoid Tramadol. Inform Obstetrician.

Additional information. Consider;

- Regular laxatives for patients taking opioids (moderate – severe pain) e.g Magnesium hydroxide and Senna. Encourage regular fluid intake.
- Anti-emetics during first 2 weeks of opioid therapy – Cyclizine normally first line
- Consider non-drug therapies – education, explanation and reassurance. Pacing activities, physical therapies, TNS machine, acupuncture and complementary therapies
- **Non-steroidal anti-inflammatory drugs are not appropriate for Persistent Pain management**

Opioids that are NOT recommended:

Pethidine, Diconal, Sublingual Buprenorphine, Actiq (fentanyl lozenge), Effentora and Abstral (sublingual fentanyl), Meptazinol, Pentazocine

Short acting opioids are not recommended in the management of severe persistent pain

Neuropathic Pain

Recognising and diagnosing neuropathic pain

Many possible causes

- Diabetes, herpes zoster (shingles)
- Consider neuropathic pain in ongoing conditions e.g. sciatica, neck pain, low back pain
- Neuropathic pain can be a feature of an underlying disease e.g. cancer, that will require investigation

Signs and symptoms

- Neuropathic pain can be spontaneous or evoked, continuous or intermittent
- Often worse at the end of the day
- Can be made worse by hot or cold, touch or movement (even wearing clothes)
- Patients are unresponsive to conventional analgesics
- Skin in painful area may look different from normal e.g. atrophic or cyanosed

Trigger words to aid diagnosis – always encourage patients to describe their pain.
Key words you will hear when a patient describes neuropathic pain are:

Burning Shooting Stabbing

Sensory signs and symptoms

- Allodynia – pain produced by a stimulus that does not normally produce pain e.g. touch pressure, warmth
- Dysaesthesia – an unpleasant, abnormal sensation
- Hyperaesthesia – increased sensitivity to stimulation
- Hyperalgesia – an increased response to a stimulus which is normally painful

Medication management (use in addition to or instead of conventional analgesics)

Step 1

Non-opioid analgesic / baseline analgesia

Paracetamol 1g four times a day

Continue as patient moves through Steps 2 - 3

Step 2

Can be combined with Step 3 to maximise treatment

Tricyclic antidepressant (usually first choice)

Amitriptyline

Week 1	Week 2	Week 3	Week 4	Week 5
10mg	20mg	30mg	40mg	50mg

- Analgesic effect is separate from antidepressant effect
- Best taken in the evening to reduce 'hangover effect'
- Slowly titrate to reduce side-effects
- Normal maximum dose is 50mg daily but up to 100mg can be used if patient is deriving benefit with limited side-effects
- Side-effect profiles are similar but alternative TCAs nortriptyline, dosulepin may be used if amitriptyline is not well tolerated

Step 3

Anticonvulsant – 1st choice if TCAs are contraindicated or lancinating pain ("electric shocks")

Gabapentin

	Week 1	Week 2	Week 3	Week 4
Morning		300mg	300mg	300mg
Midday			300mg	300mg
Night	300mg	300mg	300mg	600mg

- Continue increasing as above to maximum 900mg three times a day – determined by efficacy and side-effects

FOR SECONDARY CARE PAIN SPECIALIST RECOMMENDATION ONLY

- Pregabalin (Lyrica) – 2nd line where gabapentin is effective but not well tolerated. 3rd line if steps 2 and 3 have failed.
- Lidocaine plaster (Versatis) – for focal neuralgia where other treatment options have failed or cannot be used due to co-morbidities etc.
- Duloxetine (Cymbalta) – 3rd line where other neuropathic agents have failed and patient has concurrent depression. Initiation should be discussed with patient's mental health team.

Pain Clinic Referral Guidelines

APPROPRIATE

- Recognised neuropathic pain syndromes failing to respond to primary care management
- Patients making excessive demands for treatment for their pain, or requesting a 'second opinion'
- Cases where there is significant or increasing disability or distress due to persistent pain.
  Includes those for PMP assessment

→ **Follow Algorithm for Pain Team referral** → **Pain Assessment Team**

- Patients with significant psychiatric co-morbidity → **Referral to psychiatry to ensure as stabilised as much as possible prior to Pain Clinic referral**

- Back pain musculoskeletal pain
- Upper/Lower limb Musculoskeletal

→ **Refer to appropriate Triage pathway**

INAPPROPRIATE

- Intractable headache without investigations → **Refer for Neurology assessment**
- Polyarthropathy (<3 swollen joints and 30 minutes morning stiffness; ESR /CRP >30)
- History of fragility fracture, family history or risk factors for osteoporosis
- Features of other connective tissue, seronegative, vasculitic disorders

→ **Refer for Rheumatology assessment**

- Pain problems where treatable pathology has been inadequately assessed and excluded → **Refer to appropriate Specialist**

When there is a clear statement by a Pain Consultant that there are no further therapeutic options, the GP is advised to contact the Pain Clinic Consultant directly for advice e.g. via secretary

Red and Yellow Flags

Summary

Red flags are clinical indicators of possible serious underlying conditions requiring further medical intervention. Red flags were designed for use in acute low back pain, but the underlying concept can be applied more broadly in the search for serious underlying pathology in any pain presentation.

Yellow flags are psychosocial indicators suggesting increased risk of progression to long-term distress, disability and pain. Yellow flags were designed for use in acute low back pain. In principle they can be applied more broadly to assess likelihood of development of persistent problems from any acute pain presentation.

Red Flags

Differential diagnosis	Red Flags from patient history	Red Flags from examination
Possible fracture	•Major trauma •Minor trauma in elderly or osteoporotic	• Evidence of neurological deficit (in legs or perineum in the case of low back pain)
Possible tumour or infection	•Age < 20 or > 50 years old •History of cancer •Constitutional symptoms (fever, chills, weight loss) •Recent bacterial infection •Intravenous drug use •Immunosuppression •Pain worsening at night or when supine	
Possible significant neurological deficit	•Severe or progressive sensory alteration or weakness •Bladder or bowel dysfunction	

The presence of red flags in acute low back pain suggests the need for further investigation and possible specialist referral as part of the overall strategy. If there are no red flags present in this situation it is safe to reassure the patient and move ahead with a multimodal management approach.

Yellow Flags

Attitudes and Beliefs	• Pain is harmful or severely disabling • Expectation that passive treatment rather than active participation will help • Feeling that 'no-one believes the pain is real' – may relate to previous encounters with health professionals
Emotions and Behaviour	• Fear-avoidance behaviour (avoiding activity due to fear of pain) • Low mood and social withdrawal
Other psychosocial factors	• Poor family relationships or history of abusive relationships • Financial concerns particularly related to ill-health or ongoing pain • Work related factors e.g. conflict over sick-leave, ability to perform current job tasks • Ongoing litigation related to persistent pain condition

The presence of multiple psychosocial factors indicates the need for a multi-disciplinary approach to care.