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Persistent Pain Prescribing Guidelines

Introduction

These guidelines have been developed by the GPwSIs and Consultant colleagues with extensive experience of prescribing for persistent pain to support GPs providing care for these patients and they should be used in conjunction with the Persistent Pain Management Guideline.

Persistent pain is defined as pain that persists for longer than 3 months. It is not 'acute' pain and frequently does not respond to usual treatments. This is because the problem is with the pain system itself, rather than being related to a specific problem in the body. However, it is imperative that treatable causes for the patient's pain are considered and the necessary clinical assessment +/- referral for specialist advice is sought, where appropriate, before referral into the Persistent Pain Service. This may also need to be re-considered by the GP at times after referral eg if a patient's pain presentation changes, and appropriate action by the GP taken as the Persistent Pain Service is not commissioned as a diagnostic service.

The principles below should be applied when managing persistent pain:

- **A management plan, using the principles of shared decision-making, should be agreed between the clinician and the patient. The discussions with the patient need to consider the bio-psycho-social aspects of persistent pain and address these appropriately. The HNA, PHQ4+2 and PSEQ tools support a patient centred bio-psycho-social approach in General Practice as well as across the Persistent Pain Pathway if a referral is made.**

- **Supporting the patient to maintain/increase physical activity and addressing concerns/fears about aggravating pain are of paramount importance in the management of persistent pain. It is critical that the clinician does not reinforce those fears by, for example, avoiding inappropriate advice regarding prolonged rest for back pain, avoiding the use of terms such as degenerative arthritis or wear and tear arthritis. The Pain Toolkit booklet describes a number of helpful approaches.**

Links to useful resources for Health Care Professionals (HCPs) and/or patients:-

- https://www.youtube.com/watch?v=C_3phB93rvI Explaining persistent pain. https://www.youtube.com/watch?v=NDVV_M__CSI Explaining the effects of opioids.
- http://www.paintoolkit.org/ Pain Tool Kit
- http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English Osteoarthritis: care and management. NICE guidelines [CG177]
- http://guidance.nice.org.uk/CG173/Guidance/pdf/English Neuropathic pain in adults: pharmacological management in non-specialist settings.NICE guidelines [CG173]
- https://www.nice.org.uk/guidance/ng100 Rheumatoid arthritis in adults: management. NICE guidelines [NG100]
- https://www.nice.org.uk/guidance/NG59 Low back pain and sciatica in over 16s: assessment and management NICE guideline [NG59]
- https://www.sign.ac.uk/assets/sign136.pdf SIGN 136 • Management of chronic pain. A national clinical guideline. Health Improvement Scotland.
- https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware Faculty of Pain Medicine: A resource for patients and healthcare professionals
- Sean's story: Patient version, https://youtu.be/l17SjDth4pU Prescriber version, https://youtu.be/BnJHJ9ZlJjY

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Prescribing for Persistent Pain

Prescribing and medicine management for persistent pain remains the responsibility of Primary Care as it does for other long term conditions.

It is vital that clinicians in Primary Care discuss the limitations of medication in the management of persistent pain before prescribing.

Often there is no or very little benefit from medication and a balance has to be struck between any benefit gained and side effects, which are common, that can further impair quality of life. Many people with persistent pain find that their quality of life is better when they are not prescribed any medication.

Before prescribing any medication for persistent pain there must be an agreed measurable improvement within a specified timescale such as >30% or > 50% improvement in VAS, specific improvement in function eg walking distance increased by 100% (ie doubling) or specific improvement in sleep duration etc. This agreed improvement must be clearly documented and measured before and after the specified timescale. **Consider using DRT2010 (attached).**

Some medications, eg neuropathic agents, require titration and will require regular review to assess whether the agreed level of improvement has been achieved. **If medication is found not to be sufficiently effective or is not tolerated it must be gradually withdrawn.**

If medication is found to be beneficial, and it is continued, review of its ongoing effectiveness based upon the agreed measure, side effects, potential drug interactions etc. as well as consideration of the psycho-social needs should be undertaken. This should be undertaken at least every 6 months. This will ensure an holistic approach to pain management that will help to reduce the impact of poly-pharmacy.

Avoid Prescribing Opioids for persistent pain (ie opioids are appropriate for acute pain and for palliative care)

There is very little/no evidence that opioids are effective in the long term management of persistent pain. There is evidence that in some patients high doses of opioids actually worsen their pain. A daily dose above 120mg of Morphine (or the equivalent dose of another opioid. Table available at https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/dose-equivalents-and-changing-opioids) for persistent pain is likely to be harmful.

The levels of habituation, addiction and the rising number of people dying from prescribed opioids are a major concern nationally.

If regular opioids are considered then, again, clear measures of improvement should be agreed and reviewed after 2 weeks. If the target level of improvement is not achieved the opioid should be gradually withdrawn. A request to increase the dose or strength of an opioid prescription as the initial effectiveness has "worn off" is evidence of habituation and an indication to withdraw opioids.

As there is very little/no evidence of benefit to support the use of potent opioids for the management of persistent pain long term they do not appear in this guide for initiation in Primary Care and should only be prescribed after appropriate advice regarding an opioid trial from the Pain Service. Often what is required is a plan to withdraw from opioids either because there is evidence of lack of benefit, habituation/addiction, misuse etc. A useful guide for withdrawal is available at https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/tapering-and-stopping

These prescribing guidelines apply to all patients with persistent pain whether this is musculoskeletal eg OA, RA, back pain etc, neuropathic eg radicular, peripheral, central, atypical etc, or non-MSK eg pelvic, abdominal, genital etc. Where appropriate specific mention is made when and when not to use a particular medication under the "considerations" column.

DRUG	DOSE	CONSIDERATIONS
1) Paracetamol	**1g up to four times a day**	• Consider first
2) NSAIDs	**Naproxen 250-500mg twice a day** **Ibuprofen 400mg three times a day**	• The CV and GI risks of NSAIDS mean that they should only be prescribed following appraisal of the risk benefit ratio and with the agreement of the patient. • Co-prescribe GI protection in >45s, PH dyspepsia etc. • Caution in hypertension, asthma, heart failure and renal impairment. Increased risk of GI bleed in combination with SSRIs • Care needed/contraindicated in patients taking diuretics, ACEI, A2 blockers, Methotrexate and Lithium. • Special care needed in elderly. • Not effective for the central pain of Fibromyalgia • The lowest effective dose of NSAID should be prescribed for the shortest period of time to control symptoms and the need for long-term treatment should be reviewed periodically
3) Topical NSAIDs	**E.g. Ibuprofen gel, Diclofenac gel**	• Can be used for localized persistent pain such as in hand and knee osteoarthritis
4) Topical Capsaicin	**0.025%**	• Can be considered for the management of localized persistent pain in osteoarthritis of the knee, hands etc.
5) Codeine (Low potency opioid)	**15-60mg four times a day as required for short term use only (1-2 weeks) to manage flares after agreeing targets for improvement. Regular use and repeat prescribing should be avoided**	• The active metabolite is Morphine and conversion is variable. • Side effects: Drowsiness, nausea and constipation. Low Addiction/habituation potential. • Caution with higher doses in the elderly. • Consider fixed dose combinations of Co-codamol if appropriate • Short acting opioids may not be effective in chronic pain and cause more adverse effects.

Atypical/neuropathic analgesics

The DN4 (attached) tool should be used to determine whether there is a significant neuropathic component present. Neuropathic agents should usually only be prescribed if the DN4 score is greater than 4.

EFFECTS OF NEUROPATHIC PAIN MEDICATION ON DRIVING AND OPERATING HEAVY MACHINERY

All oral neuropathic pain medications can affect the patient's ability to drive or operate heavy machinery when taken. Patients should be counselled that the effects may be particularly worse during the initiation period and during upward titration of the dose. Patients should be advised not to drive or operate heavy machinery if they feel, for example, that the medication is causing them to feel drowsy, dizzy, unable to concentrate or slower to react than usual. Patients and prescribers are advised to check the DVLA website for the latest information about the laws relating to drugs/medicines and driving (https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals)

Regular review of the effectiveness and the development of side effects to guide dose adjustment or treatment cessation is imperative. The advice below incorporates NICE CG173.

Amitriptyline is the lowest cost choice followed by Gabapentin, then Duloxetine and finally Pregabalin. However given the abuse potential of Gabapentin and Pregabalin, reflected in the legal status of these agents as controlled drugs, care should be taken to minimize deflection/misuse.

Gabapentin and Pregabalin are not effective for low back pain, sciatica, spinal stenosis, or episodic migraine, and their off-label use for these conditions is not advised.

It is therefore sensible to offer Amitriptyline as the initial treatment. If the initial treatment is not tolerated or effective after titration to full dose then offer an alternative. If this is not tolerated or effective after titration to full dose then offer a third alternative.

Nortriptyline remains a choice as, although it is expensive, it can occasionally provide effective pain relief with fewer side effects than the Amitriptyline and NICE decided not to make a recommendation for or against use.

There are no recommendations made on the use of combinations of the above and therefore combination treatment should usually be avoided.

A tricyclic antidepressant should not be prescribed if there is a significant risk of overdose. Use with caution in cardiac disease or in combination with other medications that increase QTc interval.

Be aware of the potential risk of serotonin syndrome when combining a tricyclic antidepressant or duloxetine with other antidepressant medication, or tramadol with an antidepressant, and discuss with the patient. **Do not stop an existing antidepressant without liaison with prescriber.**

DRUG	DOSE	CONSIDERATIONS
Capsaicin cream 0.075% (usually need to start with 0.025% strength to assess tolerance)	**Applied 4 times a day for a 6-8 week trial and continue if effective**	• Can be considered for localised neuropathic pain eg post herpetic neuralgia, peripheral neuropathy etc.
Amitriptyline	**10-75mg in the evening 2 hours before bed Can be titrated by 10mg increments each week. Duration of adequate trial: 6 – 8 weeks (allow 2 weeks at the maximum tolerated dose)**	• Tricyclic antidepressant. • Unlicensed use • Dose titrated by 10mg increments weekly until pain controlled or side effects limit further dose increase. • Effective for improving sleep. • Common side effects; drowsiness, blurred vision, dry mouth and constipation. • Increases risk of falls in elderly
Duloxetine	**60-120mg a day 30mg as a starting dose may be appropriate if there are problems with side effects. Can be titrated by 30mg increments each month Duration of adequate trial: 8 weeks (allow at least 4 weeks at maximum tolerated dose)**	• Inhibitor of serotonin and noradrenaline re-uptake. • Licensed for diabetic neuropathic pain, anxiety, depression and stress incontinence. • Common side effects; nausea, vomiting, constipation, dry mouth, nervousness, weight changes. • Caution in uncontrolled hypertension
Gabapentin	**100-1200mg three times a day Total daily dose can be titrated by 100-300mg increments every 3 days Duration of adequate trial: 3 – 8 weeks for titration (allow 2 weeks at maximum tolerated dose).**	• Slow and rapid titration regimes available. • Licensed for peripheral neuropathic pain. • **Do not prescribe for low back pain, sciatica, spinal stenosis or episodic migraine.** • Lower doses in renal impairment. • Common side effects; nausea, vomiting, weight gain, oedema, dizziness, ataxia, confusion. • Do not stop abruptly.
Pregabalin	**75-300mg twice a day Lower doses in renal impairment – see BNF Total daily dose can be titrated by between 25mg to 150mg each week Duration of adequate trial: 3 – 8 weeks for titration (allow 2 weeks at maximum**	• Slow and rapid titration regimes available dependent upon tolerance • Licensed for for neuropathic pain and generalised anxiety disorder. • Only one in ten patients with fibromyalgia may gain 30-50% improvement. • **Do not prescribe for low back pain, sciatica, spinal stenosis or episodic migraine.** • Common side effects; dry mouth,

	tolerated dose)	constipation, oedema, weight gain, confusion, irritability. • Do not stop abruptly.
Carbamazepine	**200 -1200mg a day Commence on 100mg twice a day. Initially 100mg 1-2 times a day… increased in steps of 100-200mg every 2 weeks, adjusted according to response. Usual effective dose between 200mg 3-4 times a day**	• **Indicated for Trigeminal neuralgia only** • Dose titration is based upon review of symptom control and tolerability. No requirement for serum carbamazepine levels. • Common side effects: tiredness and sleepiness, dizziness, difficulty concentrating and memory problems, confusion, • Unsteadiness, nausea and vomiting, double vision, allergic skin reactions • NB Hepatic and bone marrow toxicity.

Tramadol can be considered for short term use (2-4 weeks only) for neuropathic pain as acute rescue therapy if there is inadequate control with first line neuropathic medication. Therefore using back pain with sciatica as an example the initial treatment recommendation is Paracetamol with an NSAID along with Amitriptyline if required. If pain control is inadequate after 1-2 weeks and whilst Amitriptyline is being titrated over the next 2-4 weeks Tramadol could be added for 2-4 weeks and then withdrawn.

GMMMG guidance is that Lidocaine patches should not be prescribed but NICE CG173 recommends further research is required

Please refer to the BNF/ SPC for further information, including cautions, contraindications, side effects, monitoring and interactions

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Clinical Review following NICE guidelines CG 96 2010 DRT2010

Review at 2 weeks - telephone

Box B Early clinical review

After starting or changing a treatment, perform an early clinical review of dosage titration, tolerability and adverse effects to assess suitability of chosen treatment.

Regular reviews **First & follow up assessment**

DATE	**% improvement (0% no improvement-100% total improvement)**
Analgesia-VAS score	
Functional improvement (ability to do daily physical activities)	
Sleep improvement	
Change in mood	
Overall quality of life improvement	
Able to return to work or stay in work	Y N
Adverse effects	None Mild Major

Box C Regular clinical reviews

Perform regular clinical reviews to assess and monitor effectiveness of chosen treatment. Include assessment of:

- pain reduction
- adverse effects
- daily activities and participation[2] (such as ability to work and drive)
- mood (in particular, possible depression and/or anxiety[5])
- quality of sleep
- overall improvement as reported by the person.

Developed by NHS Kirklees + NHS Bradford+Airedale Medicines Management with Pain Services: Calderdale + Huddersfield NHS Foundation Trust + Bradford Teaching Hospitals NHS Foundation Trust
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Note that low mood and suicidal ideation are more common in people with long term conditions, especially persistent pain, and inquiry about suicidal/self-harm thoughts should form part of the review.

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Neuropathic pain tool patient DN4

Patient assessment Please **tick X** the box that best describes the pain you have at present. Please give to your doctor or nurse when completed	YES	NO
Question 1: *Does the pain have one or more of the following characteristics?* Burning Painful cold Electric shocks	☐ ☐ ☐	☐ ☐ ☐
Question 2: *Is the pain associated with one or more of the following symptoms in the same area?* Tingling Pins and needles Numbness Itching	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

Neuropathic pain tool clinician DN4

Clinician assessment using pin, touch and brush	YES	NO
Question 3: *Is the pain located in an area where the physical examination reveals one or more of the following characteristics?* Hypoaesthesia to touch (reduced sensation) Hypoaesthesia to pin prick (reduced sensation)	☐ ☐	☐ ☐
Question 4: *In the painful area, can the pain be caused or increased by:* Brushing (with a brush or cotton wool)	☐	☐

Score total: [ ]

Yes = 1, No = 0 Score > than **4** is likely to be diagnostic of neuropathic pain

Medicines Management Committee – Calderdale + Huddersfield NHS Foundation Trust
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