NHS
Oldham
Clinical Commissioning Group

Primary Care Management Guide

Clinical Pathway: PERSISTENT PAIN – PRIMARY CARE MANAGEMENT GUIDE

Management in primary care and minimum referral criteria for specialist care.

Referral letter must demonstrate adherence to guidance or state specific clinical indications for variance from the guidelines.

Do not recommend any specific interventions if a referral is being made

History • Defined as pain that persists beyond three months. • Includes back pain, OA pain, widespread pain syndrome, complex regional pain syndrome, facial pain, pelvic pain, neuralgic pain. • Clarify character of pain (use DN4 to determine if neuropathic), site and severity (use pain scale and body chart), aggravating/relieving factors, impact on function, associated symptoms e.g. mood, anxiety, sleep disturbance, fatigue, weight loss etc. • Consider differential diagnoses. • Explore ideas, concerns and expectations. • Previous treatments including effectiveness and side effects. • Assess impact using PHQ4+2 and Health Needs Assessment (HNA) Tool. • Assess self-efficacy using PSEQ. • **PHQ4+2, HNA and PSEQ are completed by the patient**	
Examination *(Dependent upon the site of pain and potential differential diagnoses)* • Low back pain – examine as per specific referral guides. • Appropriate specific joint examination • Widespread pain syndrome – Note new guidelines (See Ref 1 and 2 below) • Complex regional pain syndrome – altered colour and temperature of affected limb, hyperalgesia, allodynia, oedema, alteration in sweating, reduced range of movement, weakness, trophic changes. • Facial pain – ENT, oropharyngeal and CNS examinations. • Pelvic pain – abdominal and pelvic examinations. Consider examining the spine • Neuralgic pain – appropriate regional CNS examination if indicated. • Check BMI and assess for sleep apnoea if indicated using the Epworth sleepiness score.	

Investigations *(Dependent upon the site and potential differential diagnosis)*

- Low back pain – red flag screening blood tests if indicated.
- Widespread pain syndrome – FBC, U+E, LFT, bone profile, TFT, ESR, CRP if indicated
- Complex regional pain syndrome – usually no investigations indicated in primary care
- Facial pain – Usually no investigation indicated in primary care. May warrant ENT, Maxillo-facial or neurology referral for further investigation.
- Pelvic pain – FBC, ESR, CA125, U&E HVS, endocervical swabs, pelvic ultrasound. Gynaecology referral may be indicated for further investigation e.g. laparoscopy.
- Neuralgic pain – if related to peripheral neuropathy of unknown cause check FBC, B12, LFT, U+E, bone profile, TFT, blood glucose/HbA1c, CRP and ESR.
- **Vitamin D analysis is not indicated for the investigation of widespread pain**

Primary Care Management *(As a guide primary care management is appropriate if PSEQ 40-60/60 and/or HNA identifies three or fewer areas)*

- An holistic approach to pain management should consider the bio-psycho-social impact/effects
- Prioritise management based upon the patient's self-completed HNA Tool.
- Agree, using the principles of shared decision making, an appropriate care plan which supports self-care wherever possible.
- Use of the Pain Toolkit supports self-care (www.paintoolkit.org)
- Advice to stay active.
- Reassure pain does not mean harm, damage or injury.
- If pain is associated with reduced physical activity or deconditioning consider referral to health improvement services or physiotherapy.
- Consider referral to primary care mental health team in keeping with NICE guidance if depression or anxiety present.
- Sleep disturbance and fatigue: discuss sleep hygiene techniques.
- **Persistent pain tends not to respond to medication and improvement in pain VAS score or function should be agreed. If there is insufficient improvement the medication should be withdrawn.**
- Amitriptyline 10-75mg can be considered to improve sleep quality.
- Paracetamol is usually the analgesic of first choice and taken as required to manage flares of pain.
- NSAID e.g. Naproxen 500mg bd with PPI cover if PH dyspepsia or over 45.

(NSAIDs are not effective for neuropathic pain or fibromyalgia)

- Or weak opioid, e.g. codeine or dihydrocodeine M/R, for very short periods.
- Potent opioids should only be prescribed after discussion with or under the c/o a GPwSI/Consultant with a clear opioid trial plan.
- Amitriptyline 10-75mg (unlicensed use), Gabapentin 100mg-1200mg three times a day (licensed for peripheral neuropathic pain), Pregabalin (if Gabapentin not tolerated) 75-300mg twice a day (lower doses in renal impairment) or Duloxetine 30-120mg (licensed for diabetic peripheral neuropathy) can be considered for neuropathic pain. NICE CG173: Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia). If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.
- **Do not offer Gabapentin or Pregabalin for back pain, sciatica, claudicant neuropathic pain in spinal stenosis or migraine.**
- Nortriptyline 10-75mg (unlicensed use) can be considered if amitriptyline not tolerated due to drowsiness.
- Trigeminal neuralgia only – Carbamazepine 200-1200mg per day in divided doses
- Consider contra-indications and interactions (including OTC) when prescribing.

Referral into Tier 2 Persistent Pain Service *(As a guide referral should be considered if PSEQ <40/60 and/or HNA identifies more than three areas of impact)*

- GP to consider what management can be or continue to be provided in primary care and include in the referral letter. Also include information about previous treatment/support/therapy tried and outcome.
- Referral letter to include NHS Oldham CCG defined minimum dataset including BMI.
- Completed PHQ4+2, PSEQ and HNA Tool to be attached.
- **DO NOT MAKE ANY RECOMMENDATIONS REGARDING SPECIFIC INTERVENTIONS.**
- Do discuss the evidence based bio-psycho-social approach to pain management provided locally which focusses on supported self-care, functional rehabilitation and psychological support if required
- The Pain Service will discuss, using the principles of shared decision making, appropriate approaches to persistent pain management with the patient as part of the assessment process.

1. ***CMAJ September 17, 2013 vol. 185 no. 13 First published May 6, 2013, doi: 10.1503/cmaj.121414***
2. ***http://www.arthritisresearchuk.org/~/media/Files/Education/Synovium/S39-Summer-2013.ashx***

3. ***SIGN 136 • Management of chronic pain. A national clinical guideline. Health Improvement Scotland***

4. ***NICE guideline CG173 - Neuropathic pain in adults: pharmacological management in non-specialist settings.***