Persistent Pain Prescribing Guidelines

Introduction

The pharmacological management of persistent pain requires an holistic approach and regular appropriate review and this is best provided by the patient's General Practitioner.

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.

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.**

- **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:-

- http://www.paintoolkit.org/

  Pain Tool Kit resources for Health Care Professionals (HCPs) and patients

- http://www.britishpainsociety.org/

  For HCPs

- https://www.britishpainsociety.org/static/uploads/resources/files/pain_scales_eng.pdf

  Pain scales for HCPs

- https://www.britishpainsociety.org/static/uploads/resources/files/book_opioid_main.pdf

  British Pain Society's Opioids for persistent pain: Good practice. For HCPs

- http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English

Osteoarthritis: care and management. NICE guidelines [CG177] For HCPs

- http://guidance.nice.org.uk/CG173/Guidance/pdf/English

  Neuropathic pain in adults: pharmacological management in non-specialist settings.NICE guidelines [CG173] For HCPs

- http://guidance.nice.org.uk/CG79/NICEGuidance/pdf/English

  Rheumatoid arthritis in adults: management. NICE guidelines [CG79] For HCPs

- http://guidance.nice.org.uk/CG88/NICEGuidance/pdf/English

  Low back pain in adults: early management. NICE guidelines [CG88] For HCPs

- http://www.sign.ac.uk/pdf/SIGN136.pdf

  SIGN 136 • Management of chronic pain. A national clinical guideline. Health Improvement Scotland. For HCPs

- https://www.rcplondon.ac.uk/guidelines-policy/pain-assessment-pain-older-people

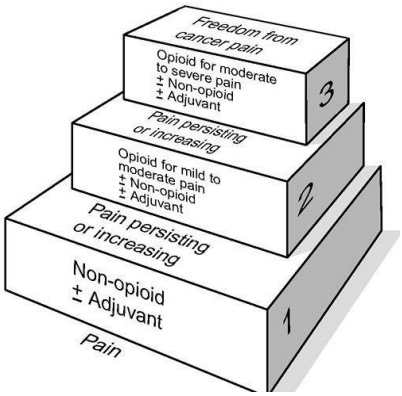
  Royal College of Physicians : Pain: Assessment of pain in older people. For HCPs

The Analgesic Ladder

Regular dosing of analgesia for patients with persistent pain has been shown to be superior to 'as required' dosing. However if a patient's pain severity fluctuates then variation in the timing, ie as required dosing, may be appropriate.

The purpose of the ladder is to provide a hierarchical approach to the initiation, titration and cessation of analgesic medications. It is imperative that there is regular review to balance the need to control pain with the need to minimise untoward effects and to rationalise the patient's repeat medication to minimise the potential for drug interaction.

Although it was developed and validated only for the treatment of cancer pain, the World Health Organization analgesic ladder is widely used to guide basic treatment of acute and chronic pain. There is little good quality evidence for its use in chronic pain, but it does provide an analgesic strategy for non-specialists.



It is critical to safe prescribing that medication should be discontinued if it is ineffective.

At each review an assessment of pain control, side effects, potential drug interactions etc along with consideration of the psycho-social needs and approaches to pain management should be undertaken. This will ensure an holistic approach to pain management as this will help to reduce the impact of poly-pharmacy and reduce the need to use more potent opioids. Use BNF dose conversion tables when switching opioids.

- **Opioids may be less effective in the management of persistent pain and a decision to use them should only be made after serious consideration of the potential harm and also after discussion of these risks with the patient.**
- **Use of an opioid risks the development of tolerance: this may lead to increases in dose with increases in side effects and reductions in the quality of life.**
- **Consider using an atypical/neuropathic agent before using a strong opioid and do not prescribe more than one opioid at a time.**
- **The use of a strong opioid without a full bio-psycho-social assessment and an agreed self-management plan should be avoided. An opioid should only be continued if there is clear evidence of a functional improvement and/ or improvement in quality of life.**
- **The use of short acting opioids for persistent pain should be avoided and specifically should not be used for "breakthrough" pain**
- **It is often necessary in patients with persistent pain to use more than one class of analgesic drug.**

Use of a screening tool to assess for the risk of developing opioid dependence should be considered before prescribing opioids eg the Opioid Risk Tool (*BMJ 2013;346:f2937)*

DRUG	DOSE	CONSIDERATIONS
1) Paracetamol	**1g four times a day**	• Safest analgesic. • **Should be the first used and maintained/added to.**
2) NSAIDs	**Naproxen 250-500mg twice a day** **Ibuprofen 400mg three times a day** **Celecoxib 100mg twice a day (Low CV risk at this dose and can be co-prescribed when the patient is taking low dose aspirin without inhibiting the anti-platelet function) Licensed for OA, RA and Ank. Spond.**	• 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. The NSAIDS listed are associated with a lower level of risk. • 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.
3) Codeine (Low potency opioid)	**15-60mg four times a day**	• 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.
4)Dihydrocodeine (Low potency opioid)	**60-120mg M/R twice a day**	• Consider as an alternative to short acting Codeine
5) Tramadol (Moderate potency opioid)	**M/R 100-200mg twice a day**	• The active metabolite is O – desmethyltramadol and conversion is variable • Significant proportion of the population are intolerant. • Side effects: Nausea, vomiting, drowsiness, dizziness, constipation and sweating. Seizure risk is increased with other drugs that lower seizure threshold. Serotonin toxicity with SSRIs. • Caution with higher doses in the elderly. • Modified release preparations more appropriate for chronic pain • **Recommended for only short term use in neuropathic pain**

6) Buprenorphine (Moderate potency opioid)	**5-20mcg/hour for 7 days patch** **Consider increase to 40mcg/hr if no (or minimal) side-effects and some benefit**	• Potent opioid at high dose • Use with caution in opioid naïve patients. Opioid agonist and antagonist properties may trigger withdrawal in those with opioid dependence • Side effects: Nausea, vomiting, sedation, confusion in the elderly and constipation. • Use very cautiously in the elderly. • Evaluate benefits/side effects carefully and regularly. • Initiation and titration should be undertaken after discussion with or under GPwSI/Consultant supervision
7) Morphine (High potency opioid)	**M/R 10-60mg twice a day**	• Initiation and titration should be undertaken after discussion with or under GPwSI/Consultant supervision
8) Fentanyl (High potency opioid)	**12-50mcg/hour for 72 hours patch** **Consider increase beyond this only if some benefit and no (or minimal) side-effects**	• Higher doses usually not appropriate. • Use with caution in opioid naïve patients. • Side effects: Nausea, vomiting, sedation, confusion in the elderly and constipation. • Use very cautiously in the elderly. • Evaluate benefits/side effects carefully and regularly. • Initiation and titration should be undertaken after discussion with or under GPwSI/Consultant supervision
9) Oxycodone (High potency opioid)	**M/R 10-40mg twice a day**	• Use with caution in opioid naïve patients. • Side effects: Nausea, vomiting, sedation, confusion in the elderly and constipation. • Use very cautiously in the elderly. • Evaluate benefits/side effects carefully and regularly. • Expensive • Initiation and titration should be undertaken after discussion with or under GPwSI/Consultant supervision

Atypical/Neuropathic Analgesia

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.

It is therefore sensible to offer Amitriptyline or Gabapentin as the initial treatment. If the initial treatment is not tolerated or effective then offer the alternative. If this is not tolerated or effective then offer the choice of Duloxetine or Pregabalin and again switch if the first of these is not tolerated or effective.

Nortriptyline remains a choice as, although it is expensive, it can occasionally provide effective pain relief with fewer side effects than the above.

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

Topical Capsaicin 0.075% can be considered for localised neuropathic pain but education of the patient on how to apply this treatment is necessary. Capsaicin patch was not recommended.

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
Amitriptyline	**10-75mg in the evening 2 hours before bed** **Can be titrated by 10mg increments each week.**	• 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
Nortriptyline	**10-75 mg in the evening 2 hours before bed** **Can be titrated by 10mg increments each week**	• Tricyclic antidepressant • Unlicensed use • Only consider if amitriptyline is not tolerated • Dose titrated by 10mg increments weekly until pain controlled or side effects limit further dose increase. • Common side effects; may be less sedating than amitriptyline, 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 tolerance** **Can be titrated by 30mg increments each month**	• 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**	• Slow and rapid titration regimes available. • Licensed for peripheral neuropathic pain but is used off license for other neuropathic pain. • 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**	• Slow and rapid titration regimes available dependent upon tolerance • Licensed for for neuropathic pain and generalised anxiety disorder. • Common side effects; dry mouth, 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**	• **<u>Indicated for Trigeminal neuralgia only</u>** • 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 • Note hepatic and bone marrow toxicity.

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

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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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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