Basingstoke, Southampton and Winchester District Prescribing Committee

hosted by **West Hampshire Clinical Commissioning Group**

Chronic Pain Prescribing Guidelines

Guidelines for the Pharmacological Management of Chronic, Non-Malignant, Non-Palliative Pain in Primary Care / Non-Specialist Centres

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Purpose

- To facilitate appropriate prescribing in primary care and referral to specialist services for adults suffering with chronic (persistent), non-malignant, non-palliative pain.

Introduction

- Chronic pain is usually defined as pain that has lasted for more than three months.[i]
- It sometimes begins with an injury but the pain does not resolve as expected; sometimes it is not clear how a chronic pain has started.
- Chronic pain is usually not a sign of on-going tissue damage but may relate to changes in the peripheral and central nervous system that occur over time so that the pain signalling becomes self-sustaining over a prolonged period.
- Common types of chronic pain include low back pain, pain related to arthritis and pain related to injury to a nerve or other part of the nervous system
- People with chronic pain consult their doctor up to five times more often than those without, accounting for approximately 22% of GP appointments each year.[ii]
- Poorly managed chronic pain can affect quality of life for sufferers and their carers. It can lead to deconditioning, disability, helplessness, isolation, depression and family breakdown.

Scope

- All patients aged 18 years or over, with chronic, non-malignant, non-palliative pain.
- For use by all non-specialist prescribers within primary and secondary care. (Pain specialists may, with justification provided, prescribe outside of these guidelines but in accordance with formulary agreements).

How to use these guidelines

- This document is designed to guide prescribing for chronic pain.
- When medicines are prescribed they should be used in combination with other treatment approaches to support improved physical, psychological and social functioning.
- The document is based on NICE and SIGN guidelines, the Royal College of Anaesthetists ‘Opioids Aware’ pages and established practice throughout the UK.
- It is a guide and needs to be used in the context of the individual patient and the experience of the practitioner responsible for their care.

The aim of pharmacological management of chronic pain

- Chronic pain is difficult to treat, with most types of drug treatment helping only a small percentage of patients. Therefore it is important to manage expectations.[iii]
- The goals of treatment should be to manage symptoms sufficiently to enable patient to improve their social, emotional and physical functioning.
- It is important to help patients understand what chronic pain is. Encourage and educate patients to self-manage their condition in order to live well with pain. Reassure patients that physical activity does not usually cause further tissue damage.
- Non-pharmacological treatment may be effective in reducing symptoms and disability in some people with long-term (chronic) pain and can also augment and complement analgesic use.
- Healthcare professionals that are responsible for helping people manage with chronic pain should be familiar with the range of such non-pharmacological interventions – including physical and psychological therapies and the local availability of these services.
- It is important to carry out regular review and reassessment to determine that there is continued value from using a particular medication.
- More information at: NICE Medicines optimisation in long-term pain

Use of strong opioids in chronic pain – Opioids Aware Key Messages

- Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.
- A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and especially if use is intermittent (however it is difficult to identify these people at the point of initiation).
- The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.
- If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.
- Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain is essential.

Opioids Aware is a resource for patients and healthcare professionals to support prescribing of opioid medicines for pain. It is written by the Faculty of Pain Medicine in partnership with Public Health England

Drug Driving

- It is an offence to drive whilst impaired due to taking drugs (prescribed or not). For further information see: https://www.gov.uk/drug-driving-law
- Patient info leaflet : https://www.rcoa.ac.uk/system/files/FPM-Driving-and-Pain-patient-information.pdf

Simple and topical analgesics

NSAIDS

- Ibuprofen up to 1200mg a day or naproxen up to 1,000mg a day
- First line for low back pain
- CV and GI risk to be taken into consideration NICE KTT13 NSAIDs
- Consider topical NSAID ahead of oral NSAID in osteoarthritis

Paracetamol

- Max 1000mg QDS
- First line in osteoarthritis. Regular dosing may be required.
- Caution in low body weight, malnutrition, dehydration, alcohol dependence (NICE CKS Analgesia Mild to Moderate)

Topical Capsaicin

- Consider topical capsaicin for knee or hand arthritis as an adjunct to core treatment (250 micrograms per gram Zacin 0.025% – apply QDS)

Opioids

- Opioids are poorly effective for long-term pain.
- For a small proportion of patients, opioids may be successfully used as part of a broader plan including non-pharmacological treatments and self-management.
- Patients should understand the potential harms of opioids, the arrangements for review and circumstances under which the treatment will be discontinued.
- Once established, the continuing benefit of opioid therapy and potential harms should be reviewed at regular intervals (at least every 6 months).
- If a patient reports reasonable pain relief from a medication regimen in the longer term, it is necessary to taper medications intermittently to assess whether the symptoms have resolved spontaneously or whether the patient is relatively pain free because of continued efficacy of medication.
- Opioids are traditionally referred to as 'weak' or 'strong' due to their potency at the mu opioid receptor. However, it is safer and more logical to consider the total daily morphine equivalent dose in order to compare the overall amount of opioid being given. See Morphine dose equivalence tables
- Oral route is the preferred route of administration.
- Do not use opioids for chronic low back pain.
- **If an opioid is ineffective DISCONTINUE**
- **Don't mix opioids, choose one.** Prescribing a combination of opioids is not recommended. There is no analgesic benefit but increases the risk of side effects and of accidental overdose.

NB: Research has shown that no improvement in pain relief was found by adding short-acting opioids as rescue use medication for patients using long term opioids (SIGN 136)

For further detail, see Opioids Aware advice on a Structured Approach to Prescribing Opioids. This includes advice on trialling opioids, long term prescribing, tapering and stopping, and switching between opioids.

https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/structured-approach-to-prescribing

Adverse Effects

- Common side effects include nausea, vomiting, constipation, pruritus, dizziness, dry mouth and sedation.
- Long term harms include falls and fractures, endocrine abnormalities (including sexual dysfunction, depression and fatigue), immunosuppression and hyperalgesia.
- Opioids have multiple effects on respiratory physiology. Respiratory depression is a much-feared harm associated with the use of opioids. It is most likely to be a potential problem if there has been a large, often unintended dose increase, or changes in formulation or route of administration.
- Elderly people are more susceptible to the adverse effects of opioids.

Codeine, Dihydrocodeine and Tramadol

- For the treatment of mild-to-moderate pain in people who have an inadequate response to paracetamol and/or a nonsteroidal anti-inflammatory drug.
- Tramadol is an opioid and also inhibits the uptake of serotonin and norepinephrine. Use in caution in conjunction with antidepressants due to risk of serotonin syndrome. Tramadol should be avoided in epilepsy as it lowers seizure threshold.
- See NICE CKS Analgesia Mild to Moderate for further information on dosages and cautions.

Morphine

- Ensure the patient is provided with sufficient information to make an informed decision about their treatment. Taking Opioids for Pain information leaflet can be found on the Opioids Aware pages.
- Agree desired outcomes with the patient e.g. reduced intensity of pain, improved specified function, improved sleep.
- Supply one to two weeks of immediate release morphine liquid or tablets 5-10mg prn.
- The patient should keep a diary reporting on all doses taken, pain intensity, activity levels, sleep and side effects.
- A trial using fixed doses of MR preparations may be tried, there may need to be one or more upward dose escalations and therefore the trial would take three weeks or more.
- Immediate release preparations may be most appropriate when the pain is intermittent or variable, MR preparations may be most appropriate for persistent pain through the day and night.
- It is usually expected that pain reduction of at least 30% should be achieved in order to continue prescribing. Functional goals should also be agreed.
- A successful short term trial does not predict long term efficacy.
- Agree arrangements for review with patients.
- Best practice is to keep the opioid dose as low as possible. Doses of 120mg morphine equivalence per day should be considered high dose and increase risk to the patient.

Buprenorphine Patches

- Should be reserved for patients who are unable to tolerate the side-effects of oral morphine or have difficulty swallowing, have compliance issues, or renal impairment due to higher acquisition cost.

Other Opioids

- There is little evidence that one opioid is more effective or associated with fewer side effects than others. Therefore, morphine should be the drug of first choice.
- There is no place for rapid onset drugs such as pethidine, transmucosal/sublingual fentanyl or injectable opioids in the management of persistent non-cancer pain.

Tapering and Stopping Opioids

- All drugs prescribed for pain should be subject to regular review to evaluate continued efficacy, and periodic dose tapering is necessary to evaluate on-going need for treatment.
- In addition, it is important to taper or stop the opioid regimen if:
    - the medication is not providing useful pain relief.
    - the harms outweigh benefits (usually at doses above 120mg oral morphine equivalent/24hours).
    - the underlying painful condition resolves
    - the patient receives a definitive pain relieving intervention (eg, joint replacement)
    - the patient develops intolerable side effects
    - there is strong evidence that the patient is diverting his/her medications to others
- **The dose of drug can be tapered by 10% weekly or two weekly.**
- Usually stopping medicines makes no difference to the pain but can make people feel better.

Neuropathic Pain

Intro

- 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.
- Tramadol should only be considered as a rescue medication when people are awaiting referral to specialist pain services after initial treatment has failed. It is therefore only suitable for short term use.
- Consider capsaicin cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate oral treatments.
- Morphine is NOT recommended

NB: Pregabalin and gabapentin carry a risk of dependence and may be misused or diverted (Advice for prescribers on the risk of the misuse of pregabalin and gabapentin)

Choice of treatment

Amitriptyline

- 10mg at night increased gradually up to a max of 75mg according to response

OR

Gabapentin

- Titration to an effective dose can be accomplished over a few days - 300mg once a day on day 1, 300mg twice a day on day 2 and 300mg three times a day on day 3. Continue to increase using increments of 300mg per day given in three divided doses.
- Titrations can be done more slowly and treatment is more likely to succeed if patient led, stopping at the point where the benefits outweigh the side effects.
- SIGN Guideline 136 recommends at least 1200mg per day
- MHRA/CHM advice (October 2017): Gabapentin has been associated with a rare risk of severe respiratory depression even without concomitant opioid medicines. Patients with compromised respiratory function, respiratory or neurological disease, renal impairment, concomitant use of central nervous system (CNS) depressants, and elderly people might be at higher risk of experiencing severe respiratory depression and dose adjustments may be necessary in these patients.

OR

Pregabalin

- Initially 150 mg daily in divided doses, then increased if necessary after 3–7 days to 300 mg daily in divided doses. Can be further increased after 7 days up to 600 mg daily in divided doses.
- Titrations can be done more slowly and treatment is more likely to succeed if patient led, stopping at the point where the benefits outweigh the side effects.
- SIGN Guideline 136 recommends at least 300mg daily.

OR

Duloxetine

- 60mg once daily.
- To reduce nausea and vomiting, can be initiated at 30mg once daily, increasing to 60mg after 2 weeks.

Trigeminal Neuralgia only

- Carbamazepine: Initially 100 mg 1–2 times a day, some patients may require higher initial dose, increase gradually according to response; usual dose 200 mg 3–4 times a day, increased if necessary up to 1.6 g daily.

Lidocaine Plasters

The NHS England Guidance for CCGs document 'Items which should not routinely be prescribed in primary care'[iv] recommends the following:

- Advise CCGs that prescribers in primary care should not initiate lidocaine plasters for any new patient (apart from exceptions below)

- Advise CCGs to support prescribers in deprescribing lidocaine plasters in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.

- Advise CCGs that if, in exceptional circumstances, there is a clinical need for lidocaine plasters to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.

Capsaicin Cream

- For post-herpetic neuralgia and painful diabetic neuropathy
- 750 micrograms per gram (Axsain 0.075%), apply 3-4 times a day

For further guidance, see NICE CG 173 Neuropathic pain in adults: pharmacological management in non-specialist settings

[i] Faculty of Pain Medicine. (2018) *Opioids Aware.* [Online] Available at: https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/condition-patient-context/about-pain (Accessed 16/10/2018)
[ii] Royal College of General Practitioners (2018) [Online] Available at: http://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/chronic-pain.aspx (Accessed 16/10/2018)
[iii] NICE. (2018) *Medicines Optimisation in Long Term Pain*. [Online] Available at: https://www.nice.org.uk/advice/ktt21 (Accessed 16/10/2018)
[iv] NHS England. (2017) *Items which should not routinely be prescribed in primary care: Guidance for CCGs*. [Online] Available at: https://www.england.nhs.uk/wp-content/uploads/2017/11/items-which-should-not-be-routinely-precscribed-in-pc-ccg-guidance.pdf (Accessed 16/12/2018)