Primary Care Guidelines for the management of Chronic Pain

2010 Version
(Updated from 2002)
GUIDELINES FOR THE MANAGEMENT OF CHRONIC PAIN

JAN 2009

Using the Guidelines
- The guidelines are evidence-based
- The guidelines are for use in primary care
- Regular Staged consultations are required, however more brief supportive/fine tuning consultations may be needed in between
- The guidelines are designed to guide pain management in primary care and to complement GG&C NHS secondary and tertiary care pain management services
- It is expected that the guidelines will be followed prior to referral to secondary care

Basic Principles
- Management in three common causes of pain is detailed in the specific guidelines which follow, in addition a new guideline on the appropriate use of opioids for non malignant pain has been developed
- Encourage self management and responsibility for control of pain
- Provide information on self help groups (see GG&C NHS pain resource pack)
- Make sure adequate verbal and written information is given about diagnosis and management of pain (see GG&C NHS pain resource pack)
- Continuity of care is important – try and offer pain management by the same person
- Be aware of and treat anxiety and depression
- Formulate a management plan in partnership with the patient

Correct Misconceptions
From the start:
- Reassure and offer support
- Be positive, stress that pain can be controlled/improved
- Be realistic about the patient’s expectations and goals
- Stress that appropriate exercise is good - REST is NOT GOOD for chronic pain

BASELINE ASSESSMENT

1) Measure pain
- Use visual analogue scale (VAS) or numerical rating scale (NRS, 0-10)

2) Document physical function
- Sit from standing unaided and vice versa
- Dress and undress unaided
- Walk with ease
- For back pain refer specifically to Oswestry Pain questionnaire

3) Assess effect of pain on;
- Sleep
- Mood
- Occupation
- Relationship
- Leisure activities
- Quality of Life
Monitor response to pain management by;
- Pain VAS or NRS - 30% improvement is a good outcome
- Improvement in function, sleep, mood and quality of life etc.
- Reduction in analgesic consumption
- Reduction in number of consultations per month

Referral to Pain Clinic
Only GPs, hospital consultants and specialist physiotherapists may refer patients with pain lasting longer than expected, and only after appropriate investigations
- In general, referral should only occur after these guidelines have been followed
- If necessary please consult with pain specialist about advice on;
  - severe pain unresponsive to appropriate therapy
  - urgent referrals for analgesic blocks eg: PHN, CRPS
- Referral letter should be comprehensive and include;
  - full pain history and all previously tried treatments

State Benefits
Stress the importance of not giving up employment even if a period of sick leave is required.

Useful numbers are:
<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money Advice Scotland</td>
<td>0141 572 0237</td>
</tr>
<tr>
<td>Social Work Department</td>
<td>0141 287 8700</td>
</tr>
<tr>
<td>Benefit Agency Enquiry line</td>
<td>0800 882 200</td>
</tr>
<tr>
<td>Citizen’s Advice Scotland</td>
<td>0131 667 0156</td>
</tr>
<tr>
<td>Prescription Advice Line</td>
<td>0800 917 7711</td>
</tr>
</tbody>
</table>

Leaflet HC11 for help with prescription costs
Pre-payment certificate – 3 monthly or yearly

PHN = Post Herpetic Neuralgia
CRPS = Complex Regional Pain Syndrome
NON PHARMACOLOGICAL MANAGEMENT

1) Activity
Remaining active stops loss of fitness and improves physical and mental well-being
• Consider referral to GG&C NHS exercise referral scheme
• Consider referral to physiotherapist for assessment and advice on maintaining activity and pain relieving measures, such as TENS (Transcutaneous Electrical Nerve Stimulation) etc.
• Weight loss or stabilisation may be required to maintain optimal weight

2) Activity Cycling versus Pacing
People with persistent pain often vary their activity depending on their daily pain. This results in cycles of over activity during good days, and under activity during bad days. Doing too much on good days is often followed by increased pain, forcing the person to rest. This can lead to reduced fitness, increased pain and often the individual will become fearful of activity. This cycle will create a downward spiral in activity and further produce more pain and fear.

Setting a baseline of regular activity can be difficult because many people over-estimate what they think they should be doing. People should be encouraged to do small amounts of activity on a regular basis and be advised that this activity should not exacerbate their pain. This will result in improved fitness and a greater tolerance of activity allowing the person to gradually increase what they are able to do.

Practical tip:
Break task down into smaller components
For example:
• Doing 30 minutes of housework in the morning, and the same again in the afternoon as opposed to trying to do all the housework in one go. This 30 minute period of activity should be gradually increased over a period of weeks and months.
• Similarly, a walk could be broken down into more manageable periods and gradually built up over time.

3) Relaxation can be helpful
• Pain may be associated with tension and anxiety
• Consider using information and relaxation tapes

4) Complementary Therapies may be beneficial but are not scientifically proven

PHARMACOLOGICAL MANAGEMENT
GENERAL PRINCIPLES
• Identify over the counter (OTC) medication and Complementary Therapies
• Record ALL analgesic consumption
• Multimodal analgesia is most effective but requires using drugs with different mechanisms of action, beware of inappropriate polypharmacy
• Use the WHO pain ladder approach and the enclosed guidelines
• Reinforce the importance of compliance, appropriateness and frequency of drug use
• Medication may need to be optimised gradually
• STOP any medication that is not beneficial
• Have a strategy for long term medication and repeat prescribing
• Periodic review for dose reduction/withdrawal to ensure drug is still effective and required
• Remind patients about the safe storage of medication
NOTES ON THE USE OF NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

- Explain to patients about possible side effects
- Use lowest dose possible for shortest period of time
- Be careful of drug interactions, particularly with warfarin, ACE inhibitors, other hypertensives and lithium
- NSAIDs can be used in conjunction with paracetamol to enhance pain relief and possibly allow reduction in dose of NSAID
- Low dose ibuprofen has the least incidence of gastric side effects
- The following groups are at high risk for gastric side effects:
  - Over 65 yrs, current or history of peptic ulcer disease, smoker, high alcohol intake and those on regular steroid therapy
- Consider COX2 selective agents or GI protection in these groups instead (see GG&C NHS Guidelines on NSAIDs)

NOTES ON USE OF AMITRIPTYLINE FOR PAIN

- It is important to explain to patients that only a select few antidepressants can improve pain. They are used at a lower doses than when used for depression
- They may take several weeks to act
- Side effects can be felt immediately but often improve over time
- Drowsiness can occur. If it does, do not drive or work machinery
- Drowsiness will be exacerbated by alcohol
- Taking these drugs at 6 PM helps avoid residual effects the following morning
- If insomnia occurs the medication can be taken in the morning
- Give patient specific information leaflet – see GG&C pain resource pack
- Start low and go slow, see specific dose recommendations

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- Start low and go slow, see specific dose recommendations
Neuropathic Pain
Defined as “Pain initiated or caused by a primary lesion or dysfunction of the nervous system”. [1]

Signs and symptoms
• Burning
• Throbbing
• Electric shocks/spasms
• Numbness
• Not relieved by rest.

Examples of Neuropathic Pain
• Post herpetic neuralgia (PHN)
• Diabetic neuropathy (DN)
• Trigeminal neuralgia (TN)
• Nerve root pain

Examples of Neuropathic Pain
It is important to establish a diagnosis and explain implications to the patient, especially chronicity, associated symptoms and compliance with treatment. [2]

Medicines
• Simple analgesics seldom effective.
• NSAIDS seldom effective.
• Two first line approaches - Tricyclic antidepressants e.g. Amitriptyline [3] or the anti-epileptic drug Gabapentin.

Tricyclic antidepressants
• Amitriptyline (imipramine or nortriptyline if sedation or hypotension is a problem and both have the same dose and titration schedule).
• Explain to patient:
  o Distinguish analgesic from antidepressant activity.
  o Side effects may improve with time.
• Take nocte (2 hours before sleep) to minimise drowsiness the following day.
• Start with 10mg in over 70’s and increase in 10mg increments every half to one week to maximum of 100mg.
• In younger age group start with 25mg and increase in steps of 25mg every half to one week again to100mg maximum.
• 4 weeks of maximum tolerated dose before benefits judged.

Second line management are opioid drugs e.g. MST or Oxycodone [4-6].

Anti-epileptic drug
• Gabapentin.
• Explain to the person:
  o Distinguish analgesic from anti-epileptic activity.
  o Side effects can improve with time.
• Start with 100mg nocte in frail, elderly and increase by the same amount every day. Titrate to effect, but not above 1800 mg per day.
• In younger age group start at 300mg nocte and increase to 600 mg TDS after 1 week and possibly to 900mg TDS after 2nd week.
• Allow 4 weeks of maximum tolerated dose before effects judged.

Alternative anti-epileptic drugs include pregabalin (SMC approved as third line therapy) or carbamazepine (only licenced for TN).

Tramadol and potent Opioids [5] [6]
(refer to opioid guidelines)

Duration of treatment
• Depends on improvement (partial or complete).
• May require long term treatment.
• If significant improvement, any withdrawal should be on trial basis every 6 months.
• If no improvement, refer to secondary care.
OSTEOPHARYNGITIS OF HIPS AND KNEES

INFLAMMATORY FLARE UP OF KNEE PAIN
May occur at any step
Consider intra-articular injection of steroid (use sparingly) & specialist referral

OSTEOARTHRITIS? YES
• Morning stiffness < 30 mins
• Pain worse late in day
• Getting off knee is common
  (stiffness after inactivity)
• X-ray not essential for diagnosis

CONSIDER EARLY REFERRAL TO RHEUMATOLOGIST IF
• < 50 years old
• Systemic upset suggestive of gout, connective tissue disease or septic arthritis

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DIAGNOSIS

CONSIDER EARLY REFERRAL TO RHEUMATOLOGIST IF
• < 50 years old
• Systemic upset suggestive of gout, connective tissue disease or septic arthritis

EITHER
1. Oral NSAIDs †
2. Consider conversion to Paracetamol + Tramadol**

STEP 1
1. Paracetamol
2. +/- Topical NSAID*
3. Consider topical capsaicin 0.025%

STEP 2
1. Cocodamol: 8/500 or 30/500, up to 2 tabs QID or Codydramol: 10/500 2 tabs QID
2. Consider conversion to Paracetamol + Tramadol**

STEP 3
1. Amitriptyline
2. Consider conversion to strong opioids ††
3. Consider referral to:
   Orthopaedic Surgeon
   Rheumatologist
   Chronic Pain Clinic.

NON-PHARMACOLOGICAL MANAGEMENT - ALL STAGES †††
General Principles:
Encourage appropriate activity
If obese advise weight loss and nutritional advice

Consider Referral:
Physiotherapy
• Advice, Exercises
• TENS, Acupuncture
• Appliances e.g. walking stick

Occupational Therapy
• Activities of Daily Living

Self Management:
Group programmes
• Arthritis Care
  (0808 800 4050 or www.arthritis-care.org.uk)
• Pain Association Scotland
  0800 783 6059 or www.painassociation.com

Information
• Arthritis Research Campaign
  (01246 558033 or www.arc.org.uk)
• Pain Concern
  01620 822572 or http://www.painconcern.org.uk

PRESCRIBING MATTERS – ALL STAGES
Discuss risks vs benefits with patients and carers
Refer to GGC Formulary for preferred drug choices

Regular analgesia may have benefits in terms of
• Pain control
• Function

Modified release preparations may be beneficial in patients with proven compliance problems or in whom early morning stiffness is a problem

* Efficacy is proven only for up to 6 weeks
** Restricted to use where simple analgesia has failed or is not tolerated. This excludes modified-release and combination preparations i.e.: not Tramacet.
† See NHSGG Anti-inflammatory Guidelines 2006 (Combining topical and systemic NSAIDs is unproven)
†† See NHSGGC Opioid Guideline 2008
††† See NHSGGC Guidelines for the Management of Chronic Pain
Patients may be managed by the General Practitioner, the Pain Clinic or by shared care. This Guideline is to aid the primary care team in managing chronic pain patients with opioids.

1. **Consider if a trial of potent OPIOID (Step 3) medication is INDICATED.** Opioid drug is added on to patient’s pre-existing non-opioid analgesic medication. Tramadol is NOT considered a Step 3 opioid in this guideline.

<table>
<thead>
<tr>
<th>May improve</th>
<th>Unlikely to improve</th>
</tr>
</thead>
<tbody>
<tr>
<td>improvement with acute opioids in the past</td>
<td>no improvement with acute opioids in the past</td>
</tr>
<tr>
<td>failed with conventional non-opioid drugs</td>
<td></td>
</tr>
<tr>
<td>failed with non drug therapy</td>
<td></td>
</tr>
<tr>
<td>pain diagnosis</td>
<td></td>
</tr>
<tr>
<td>nociceptive</td>
<td>pain diagnosis unclear</td>
</tr>
<tr>
<td>neuropathic</td>
<td>? somatoform disorder</td>
</tr>
<tr>
<td>combined</td>
<td></td>
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</tbody>
</table>

2. **SCREEN out patients at high RISK of DEPENDENCY**

Patients at higher risk of abusing opioids. Provider Bulletin 00-04.May 2000 &

| Active or PMH of alcohol or other drug abuse                               |
| borderline personality disorders                                           |
| depression or psychotic disorders                                          |
| current or previous suicide attempts                                      |
| household members with drug abuse/psychiatric issues                       |
| poor response to opioids previously                                       |
| off work for more than 6 months                                           |

Screening tools to aid in assessing addiction include;

- **CAGE** (for alcohol)
  - Cut down, Annoyed, Guilty, Eye-opener
- **SOAPP** - Screener and Opioid Assessment for Patients with Pain
  - 14 Q’s – self administered
- **PDUQ** - Prescription Drug Use Questionnaire
  - 20 min semi-structured interview
- **TABLE**  - The four “C’s” by Savage

**SEE APPENDIX FOR QUESTIONNAIRE**

3. **DEFINE a SUCCESSFUL OUTCOME** before opioid trial is started. 1-3

Patients should achieve significant pain relief (~30% improvement in pain visual analogue scale VAS). They should also achieve benefits in secondary parameters such as activities of daily living or quality of life.

**IF DECISION IS TO PROCEED WITH OPIOID TRIAL**
GENERAL RULES for administering opioids in chronic non malignant pain. 1,3

Step 2 opioid drugs are replaced entirely with Step 3

<table>
<thead>
<tr>
<th>Choice of drug.</th>
<th>- use a single agent ie: a long acting Mu agonist</th>
</tr>
</thead>
</table>
| Trial regimen   | - regular monitoring  
- single doctor responsible for drug prescription  
- treat side effects early or prophylactically  
Consider  
- a signed contract between the practitioner and patient  
- random drug testing of blood, urine or saliva |

START with **LOW DOSE** and increase slowly as tolerated to achieve required pain relief.

ORAL route is PREFERRED. Avoid immediate release drugs like sevredol or oxynorm.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st line - Morphine Sulphate MR (MST)</td>
<td>10mg BD up to a maximum of 90mg BD</td>
</tr>
<tr>
<td>2nd line – Oxycodone MR (Oxycontin)</td>
<td>5mg BD up to a maximum of 60mg BD</td>
</tr>
</tbody>
</table>

TRANSDERMAL. Fentanyl preparations may be preferable;
- when the patient has problems with swallowing or GI absorption.
- may result in less sedation or constipation (Ref 8, 9 in unabridged version)

| Fentanyl | Durogesic DTrans (mcg/hr) – 12, 25, 50, 75, 100  
generic forms available (except for 12 mcg/hr)  
(change every 72 hours – some patients get better analgesia if patch is changed at 48 hours) |

- pharmacokinetic characteristics of the different fentanyl patch formulations differ, so it is recommended to prescribe the fentanyl patch by trade name to avoid confusion and switching between different generics and DTrans.  
- ensure skin is intact, clip hair (don’t shave), avoid electric blankets, sauna etc. (beware if pyrexial), slow onset  
- 12 hours for therapeutic effect, steady state can take up to 6 days (if already on an opioid – give 10-15% of 24 hour dose 3-4 hrly for the 1st 18 hrs)  

REGULAR ASSESSMENT is required (weekly or monthly) to ensure  
- ongoing efficacy  
- if not successful, either stop trial slowly or consider trial of alternative opioid  
- if successful, continue with less frequent reviews if dose is stable (patients may not require opioids long-term as the pain condition may improve, or no longer be responsive to opioids. Ween opioid every 6-12 months to see if still required)  
- minimal side effects  
- nausea* - metoclopramide 10 mg PO TDS  
- constipation* - combination of stimulant (senna) and softener (lactulose)  
- itch - chlorphenamine 4 mg (but often is not responsive)  
- no evidence of drug abuse  
- opioid therapy should be withdrawn (slowly) if patient is abusing drugs  
- early opioid withdrawal symptoms are; red eyes, abdominal cramps, muscle aches.
**OPIOIDS FOR CHRONIC NON CANCER PAIN, continued**

Signs of drug misuse or addiction. 10

<table>
<thead>
<tr>
<th>Yellow flags (similar to pseudoaddiction**)</th>
<th>Red flags</th>
</tr>
</thead>
<tbody>
<tr>
<td>- complaining for more opioids</td>
<td>- prescription forgery or loss</td>
</tr>
<tr>
<td>- requests “specific” opioids</td>
<td>- stealing or selling drugs</td>
</tr>
<tr>
<td>- drug hoarding in good spells</td>
<td>- injecting drug</td>
</tr>
<tr>
<td>- openly acquiring other opioids</td>
<td>- concurrent abuse of alcohol or other drugs</td>
</tr>
<tr>
<td>- unsanctioned increase in dose</td>
<td>- multiple dose escalations</td>
</tr>
<tr>
<td>- resistant to change in therapy despite “tolerable” adverse effects</td>
<td>- frequent drug seeking from other sources</td>
</tr>
<tr>
<td></td>
<td>- deterioration of function</td>
</tr>
<tr>
<td></td>
<td>- resistant to change in therapy despite clear adverse effects</td>
</tr>
</tbody>
</table>

* see Pan-Glasgow Palliative Care Algorithm

** Pseudoaddiction is the patient’s attempt to obtain better pain relief. When pain is relieved, these behaviours cease.