NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Chronic Pain Management in Primary Care

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

GUIDELINES FOR THE MANAGEMENT OF CHRONIC NON-MALIGNANT PAIN

The Scottish Chronic Pain model outlines the vital role of primary and community care in the management of those with chronic pain. The aim of chronic pain management within these sectors is to improve self care, health, functional ability, and to enhance a sense of living well with ongoing pain. These aims cannot be achieved without a focus upon supported self-management of pain and increasing a sense of self-efficacy and confidence in service-users to manage ongoing pain more effectively.

Definition of Chronic Pain

In this guideline chronic pain is defined as pain that has been present for more than 12 weeks.

Purpose of the Guidelines

This clinical guideline is an update to an existing GG&C guideline on the management of chronic pain, last updated in 2010. A guideline development group was formed to examine current evidence. In updating the guideline, the group undertook a medical literature review and also incorporated recommendations contained within current national guidelines on the management of chronic pain.

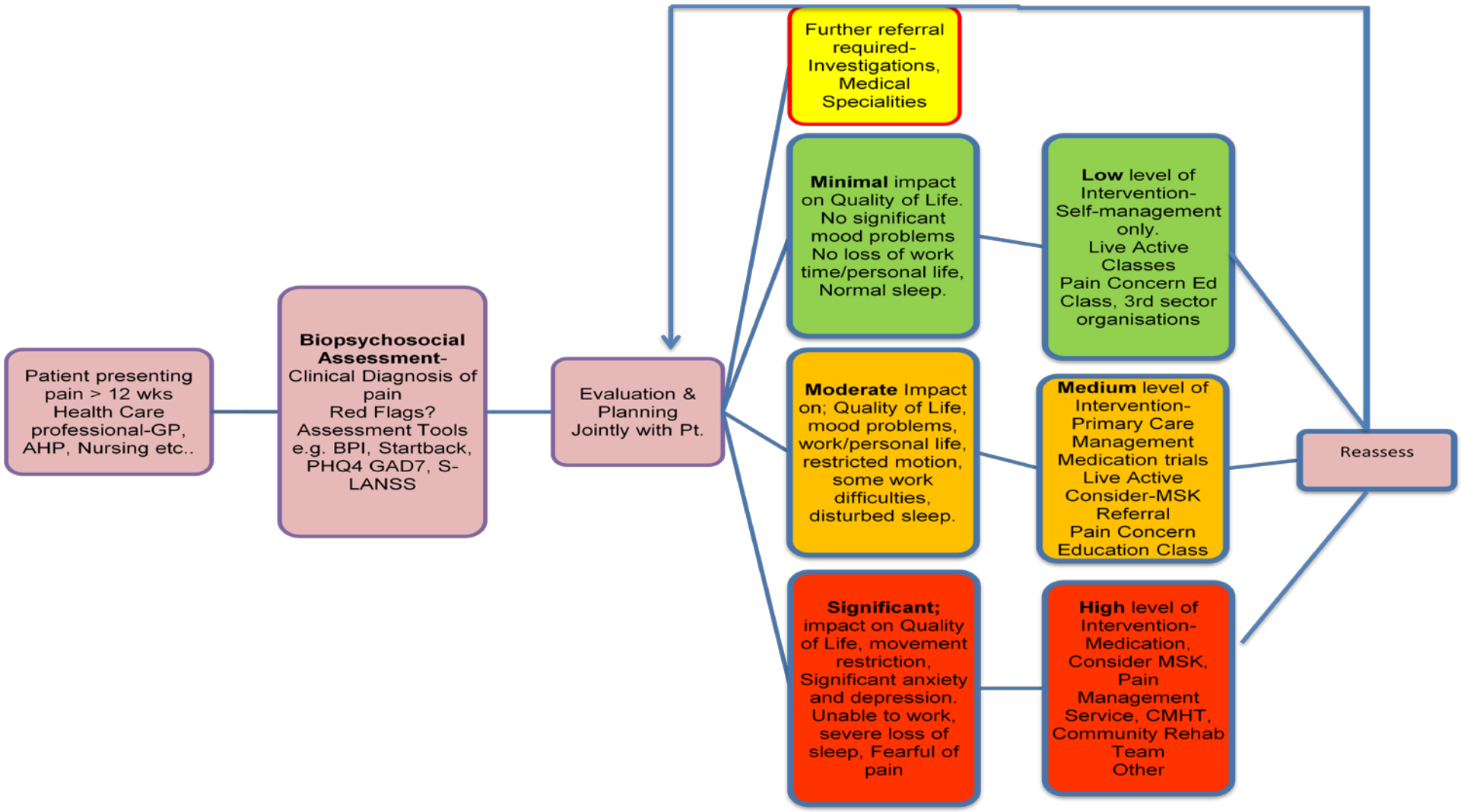
The guidelines are designed to assist health care professionals when they are providing care for adults with chronic pain. They provide recommendations for safe and effective practice in the management of chronic pain. They are not designed to be a rigid protocol and do not supersede clinical judgement. They are not designed to be a barrier to a patient being referred to the hospital based chronic pain service, nor do they aim to transfer work from secondary/acute care to primary care. Chronic pain is a common symptom and it is well recognised that only a small proportion of patients with chronic pain are seen within the Pain Clinic setting.

Whilst these recommendations are suitable for the majority of patients, clinicians should use their clinical judgement to optimise each patient's management.

Users should also refer to local formulary and BNF to inform dosing and prescribing decisions for individual patients (taking into account any precautions, contraindications, dose adjustments and adverse effects of pharmacological treatment).

The following guidelines are also available and should be consulted for patients with specific types of pain -
NHS GGC Chronic non malignant pain opioid guidelines
NHS GG&C Chronic Non malignant Pain Neuropathic Pain Guidelines

Contents


Patient presenting pain > 12 wks Health Care professional-GP, AHP, Nursing etc..
Biopsychosocial Assessment- Clinical Diagnosis of pain Red Flags? Assessment Tools e.g. BPI, Startback, PHQ4 GAD7, S-LANSS
Evaluation & Planning Jointly with Pt.
Further referral required- Investigations, Medical Specialities
Minimal impact on Quality of Life. No significant mood problems No loss of work time/personal life, Normal sleep.
Low level of Intervention- Self-management only. Live Active Classes Pain Concern Ed Class, 3rd sector organisations
Moderate Impact on; Quality of Life, mood problems, work/personal life, restricted motion, some work difficulties, disturbed sleep.
Medium level of Intervention- Primary Care Management Medication trials Live Active Consider-MSK Referral Pain Concern Education Class
Significant; impact on Quality of Life, movement restriction, Significant anxiety and depression. Unable to work, severe loss of sleep, Fearful of pain
High level of Intervention- Medication, Consider MSK, Pain Management Service, CMHT, Community Rehab Team Other
Reassess

1. Initial Assessment

1.1 Identification and management planning

- Patient with chronic pain identified i.e. more than 12 week history of pain
- Patients can be complex and require several consultations for assessment and management planning.

1.2 Assessment Process

- Exclude serious pathology – which could include neoplastic disease, infection, or an underlying medical condition i.e. neurological or rheumatological signs for which there are well recognised approaches to treatment. Urgent referral to other services may also be required for active psychiatric morbidity such as mental health problems pre-dating the pain, current suicidal ideation, etc. Pain should be treated alongside these.
- Red flags specific to back pain/cauda equina syndrome i.e. signs of nerve root compression, bladder/bowel disturbance, gait disturbance or saddle anaesthesia or paraesthesia.
- Explain findings of previous investigation to reassure patient and help them to understand their condition, aiming to prevent over medicalisation and unnecessary treatments. Provide explanations for ongoing pain where possible.
- Biopsychosocial assessment including screening for major medical, psychological, and social issues of the individual is recommended for initial assessment of those with chronic pain. The table below details the important factors included in this type of assessment.

Medical (bio) factors	Psychological factors	Social factors
•Pain history •Aggravating or relieving factors •Pain descriptors •Previous investigation •Previous treatment •Medication •Examination •Red flags •Nociceptive/neuropathic pain	•Mood •Unhelpful beliefs and ideas about the pain •Loss of confidence and fear of movement or going out •Readiness to engage with self-management •Anxiety/stress •Mental health history	•Self care •Family •Benefits •Compensation •Work

1.3 Examples of tools available for assessing chronic pain

- Brief Pain Inventory
- STarT back tool (risk stratification)- we recommend routine use of this in back pain to identify low, medium and high risk patients
- S-LANSS for screening for neuropathic pain

1.4 Screening for psychological predictors for poor outcome (yellow flags):

- Belief that pain and activity are harmful
- Activity decline and fear avoidance
- Low or negative moods, social withdrawal
- Treatment that does not fit best practice
- Problems with claim and compensation
- History of back pain, time-off, other claims
- Problems at work, poor job satisfaction
- Heavy work, unsociable hours
- Overprotective family or lack of support

1.5 Pain Assessment – selection of appropriate pharmacological treatment pain pathway

NHS GGC has guidelines for patients with neuropathic pain. If the pain assessment and physical examination suggest that this is the main source of pain for the patient, this guideline should be followed.

If appropriate refer to the NHS GGC Chonic non malignant pain opioid guidelines

2. Formulating a pain management plan

By the Health Care professional/GP

- Identify pain management options and explain/discuss each option
- Provide patient with a management plan eg goals, pacing, relaxation
- Help facilitate patient's pain management plan decisions
- Encourage patients to be partners in their pain management plan
- Reassess progress at suitable intervals depending on assessment
- Draw up plan for exacerbation/flare up
    - Do current symptoms match original presentation?
    - Medication adjustment: down titrate in between flare ups
    - If no new pathology, reassure, explain and revisit previous advice on self management eg new goals

Assessment at follow up

- Is pain/function/mobility improving? If improving, patient should be managed within primary care.
- Revisit original pain management plan to see if any changes are required
- Return to biopsychosocial assessment template to assess patient if required

3. Self Management Strategies

Self-management approach

Self management programmes are safe, low technology, community based and affordable interventions to help patients better manage their condition.

Supported self-management in primary care plays an important role in a "stepped" care approach to pain management. Effective biopsychosocial assessment and triage can lead to management of appropriate patients within primary care and aid onward referral of users with more complex presentations to more specialised services in secondary care.

The vast majority of chronic pain sufferers can be managed within primary care. Adequate supported self-care plays an important part in ensuring many persistent pain sufferers do not become unduly distressed and disabled over time as their condition becomes long term.

Assessing distress & risk of chronicity:

Initial biopsychosocial assessment of chronic pain in primary care should include the use of recognised and standardised measures of function and distress- e.g. STarT-back tool, and PHQ9/GAD 7. These and other measures should inform the clinician of the appropriateness of managing the individual in primary care and/or referring to specialist services.

Understanding Pain:

Help the person with chronic pain understand the nature of their pain:

- Physiological mechanisms and the role of exacerbating factors, such as low activity, deconditioning and low mood.
- The difference between acute and chronic pain
- Explaining Pain- http://paindata.org/selfmanagement.php
- Medically Unexplained Symptoms Toolkit from NES (www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/mus-long-term-conditions-toolkit.aspx)
- Compassionate and person-centred approach to management can improve outcomes.

Specific interventions may include:

- Understanding and validating the nature of chronic pain as a diagnosis in its own right.
- Helping patients understand the impact of pain upon mood and activity, and the cyclical nature these can have on quality of life.

- Help to understand the role of activity management
  - pacing
  - goal/value setting
  - activity scheduling
  - awareness of the beliefs about pain and activity

- Benefits of exercise in chronic pain, and a key recommendation in SIGN 136 is that exercise in any form (either formal exercise classes, or even just daily housework) should be encouraged; however, giving advice to exercise without any additional explanation or support is unlikely to be effective.

- Providing normalising information on the effect of pain upon mood, and on the role of relaxation, mindfulness and pleasurable activity to help with distress.

- Helping overcome sleep problems by attending to altered sleep patterns such as sleeping through the day, the problems of engaging in wakeful activities when up during the night, and attending to unhelpful or distressing thoughts and feelings which can prevent sleep.

- Health Behaviour Change Approach:
  - Engaging with service users can promote and enhance the motivation to change, and should be considered an important part of chronic pain management.
  - Encouraging patients to verbalise their reasons for behaviour change can be more effective than direct advice.
  - Health professionals should be aware of the impact of their own behaviour in inadvertently reinforcing unhelpful behaviours in those with chronic pain.

Primary care resources:

Supported self management in chronic pain can be delivered in primary and community settings, and by statutory and voluntary services. The GGC Health and Wellbeing Directory- provides an extensive list of resources e.g. physical activity, volunteering & employability, healthy eating etc.http://infodir.nhsggc.org.uk/

Many elements of supported self-management can be delivered more effectively in a group format, such as in classes offered by voluntary agencies such as Pain Concern. http://painconcern.org.uk/free-pain-classes-glasgow/

Referral to Secondary care Specialist Service:

Referral may be made to secondary care Pain Services, particularly where general advice and other interventions have not helped to improve quality of life and self management. Patients referred to specialist pain services are likely to be significantly more distressed and disabled by their pain, and requiring of more intensive input. These patients are likely to represent only a small minority of those suffering from chronic pain. Local referral

guidelines for Pain Management specialist services should be consulted before referrals are made.

Useful links:

- Greater Glasgow and Clyde Pain Management Website- http://paindata.org/
- Pain Toolkit- http://www.paintoolkit.org/

4 Pharmacological Management Strategies

4.1 General Principles

- Medication should be considered as **part** of the management of chronic pain, however it important to discuss with the patient that medication alone will not "cure" chronic pain.
- Record ALL analgesic consumption including OTC medication and identify complementary therapies
- Multimodal analgesia is most effective but requires using drugs with different mechanisms of action, beware of inappropriate polypharmacy
- Apply a stepped approach to pain management and review regularly
- Take into consideration if the patient falls into any of the high risk groups and consider their risk factors when making prescribing decisions taking in to account any misuse/abuse potential
- Stop any medication that is not beneficial and know which drugs require "down-titration"
- It is vital the treatment plan is discussed with, and agreed by the patient. Long term plans should also be agreed, as should arrangements for repeat prescribing
- Use the minimum effective dose of medication to manage chronic pain
- Periodic **review** of treatment and its **effectiveness is essential**

4.2 Choice of medication

Use a pragmatic stepped approach and consider stopping drugs that appear ineffective. If neuropathic pain appears to be present follow the pathway for patients with neuropathic pain where combinations of 2 or more drugs are likely to be beneficial.

Choice of individual drug or combination will be influenced by:

- severity of pain
- presence of neuropathic pain
- co-morbidity and co-prescribing
- risk of drug misuse
- previous drug efficacy
- previous adverse effects
- interactions with other prescribed medication
- clinician experience.

4.2.1. Non-opioid +/– Adjuvant.

Paracetamol
The evidence of benefit from paracetamol varies depending on the type of chronic pain present. There is evidence not to prescribe paracetamol alone for chronic low back pain. However there is better evidence to support the use of paracetamol in knee and hip osteoarthritis. Patients who weigh under 50kg may require a dose reduction.

Oral Non steroidal anti-inflammatory drugs (NSAIDs)
NSAIDs have an established place in therapy in treatment of rheumatoid arthritis and gout and can confer some benefit in chronic low back pain and some forms of osteoarthritis. Cardiovascular and gastro-intestinal risk factors should be considered before prescribing. Lower risk agents should be prescribed first line i.e. naproxen 0.5 -1 g daily or ibuprofen in doses up to 1.2 g daily. These have not been associated with significant thrombotic or cardio-vascular risks. Where one drug is ineffective, a switch to a different NSAID may be helpful. The NHS GGC Oral Non Steroidal Anti-inflammatory Guidelines should be followed. Follow the link or see StaffNet for the guidelines.

Topical NSAIDs .
Topical NSAIDs should be considered in the treatment of patients with chronic pain from musculoskeletal conditions, particularly in patients who cannot tolerate oral NSAIDs.

Topical rubefacients
Topical rubefacients should be considered for the treatment of pain in patients with musculoskeletal conditions if other pharmacological therapies have been ineffective.

Other adjuvant therapies
Anti-epileptic and antidepressant add on therapies can be used for neuropathic pain. The guidelines for treatment of neuropathic pain should be followed.

4.2.2. Weak opioids for mild to moderate pain +/- Non-opioid +/- Adjuvant

Weak opioids are -

- Co-codamol 30/500mg 1-2 tablets four times daily.
- Codeine 30-60mg four times daily (max 240mg/day orally)
- Dihydrocodeine 30mg four times daily (max 120mg/day orally)

Note- co-codamol 8/500; 30/500; codeine phosphate 30mg: dihydrocodeine 30mg; and co-dydramol 10/500 (total formulary only- not preferred list) are the only formulations included in the NHSGGC formulary. There is a note in the formulary to the effect that there is no evidence that the 8/500 formulation of co-codamol is any more effective than paracetamol alone. As dihydrocodeine is equipotent with codeine, the same applies to paracetamol / dihydrocodeine 10/500. The place in therapy of these products is for –

- Elderly people — because they are more susceptible to the adverse effects of weak opioids.
- People with hypothyroidism and adrenocorticoid insufficiency, as opioids can affect endocrine function and lead to hypogonadism and adrenal insufficiency.
- People with moderate-to-severe chronic kidney disease (CKD), stages 3 to 4: estimated glomerular filtration rate (eGFR) 30-59mL/min and 15-29mL/min respectively — as adverse effects may be increased (because elimination time is prolonged).

Tramadol M/R is generally considered to be a weak opioid, however it's dosing and morphine equivalence means that it can also be viewed as a strong opioid.. The dose range is 50-100mg every 4 – 6 hours, maximum 400mg in 24 hours. It is on the NHSGGC total formulary (excluding the modified release preparations) but is restricted for use when simple analgesia has been tried and failed. It is similar in adverse effect profile to codeine and dihydrocodeine but has a greater potential for drug interactions**. It should not be combined with other weak opioids.**

'**Starting low**' and '**Going slow'** is a good strategy for newly prescribed opioids to help minimise the chance of side effects. Low dose codeine or dihydrocodeine in combination with paracetamol can have a place in therapy for patients particularly susceptible to opioid side effects to allow tolerance to develop before titrating up to therapeutic doses

There is a lack of evidence for efficacy of opioids in the long term treatment of chronic pain and there is also considerable risk in using these drugs, such as increased risk of misuse or addiction, this should be explicitly discussed with patients. Patient information leaflets are available explaining the potential long term effects of opioids with dosing schedules for stepping down.

4.2.3 Strong Opioids +/- Non-opioids +/- Adjuvants

Strong opioids include morphine, oxycodone, fentanyl and tapentadol. They should be prescribed **instead** of and not in addition to weak opioids/tramadol. They are best used in conjunction with non-opioid analgesic medication to reduce dosing and spare side-effects. Dose equivalence tables are available to facilitate switching between opioids. However it is important to point out that equianalgesic dose conversions are only estimates and patients may be more sensitive to the new opioid than expected causing e.g life threatening over sedation, respiratory suppression.

Opioids are not effective in every patient and this should be discussed prior to commencing treatment. A realistic aim should be for 30% improvement in pain and/or a significant improvement in functional ability; complete pain relief is rarely achieved with opioids. A clear explanation should be given as to the advantages and disadvantages of opioid therapy, including short-term and long-term side-effects, potential for tolerance and dependence,

and detrimental impact on quality of life. The NHSGGC Chronic non-malignant pain opioid guideline offers useful guidance on patient selection, dosing and the use of patient contracts for using opioids in non-malignant pain.

4.3 Main points to cover with patient when initiating medication

- It is important to discuss patient's aims for pharmacological treatment. Realistic aims include pain reduction and improved quality of life.
- Dosing schedules – this should be appropriate and manageable for the patient. The patient may have previously had the same, or a similar sounding, medication with a different dosing schedule and it is important to eliminate confusion. Consider long acting medication, where appropriate, to simplify dosing schedules
- Discuss expected time to relief of pain – this will probably be one of the patient's main goals and it is important they are given realistic timescales for relief of their pain. If there has been no response to treatment within two-to four weeks, after titration to adequate dose, patients are unlikely to develop a response thereafter. The patient should be regularly re-assessed and medication stopped that is not working effectively. Inform patient that any time scale given is only a guide.
- Side effects – It is important to explain the side effects of medication. Reassure patients if they are likely to resolve and encourage them to report any adverse experiences. Some side effects may require a, possibly temporary, alteration to the patient's lifestyle e.g. sedating medication and driving, and consideration must be given as to whether this is manageable for the patient, or in the patient's best interest.
- Ensure the choice of pharmacological treatment correlates to the patients pain and minimise the risk of over or under medicating

5. Follow-up and onward referral if indicated

- Initially the patient should be followed up to facilitate optimisation of therapy. Medication doses should be increased to the recommended starting dose then titrated against response where appropriate, up to the recommended maximum dose, unless limited by side effects.
- Offer non-pharmacological strategies in addition to, or as alternative to, analgesic drugs.
- Agree the goals of therapy e.g. reduction in pain, improved mood, improved function.
- Agree the length of the initial trial.
- Discuss the potential side effects of all drugs prescribed.
- Discuss the significant risks of specific drugs, especially NSAIDs and opioids.
- Discuss the short term benefits and potential loss of efficacy over time before prescribing opioids.
- Avoid co-prescription of sedative and hypnotic medication where possible and be aware of concomitant alcohol use.
- Be aware of concomitant use of over-the-counter treatments, and advise accordingly.

5.1 Assess whether goals are being met

- Review the efficacy of all drugs after an initial trial at the optimum dose, usually after two weeks (up to four weeks for antidepressants), using the narrative clinical history, a visual analogue scale or numerical scores.
- Most individuals respond in one of two ways: either a good response (at least 30% improvement) or no response.
- Once stability is achieved an initial review should take place no more than six months later.
- Subsequent reviews should be at least annual.
- Schedule review appointments rather than allowing them to be dictated by pain levels. Consider using a recall system to facilitate annual reviews.
- At each review re-assess medication concordance and efficacy, adverse effects, alcohol and illicit drug use, mood, function and review the management plan if appropriate.

5.2 Assess need for dose adjustment / change of therapy

- Plan management of exacerbations.
- Consider trialling two or three other drugs from the same class if the first is ineffective.
- Down-titrate or withdraw ineffective treatments.
- Consider rational multimodal analgesia: avoid co-prescription of drugs from within the same class
- Consider the safety and logic of the prescribing regimen when combining drug treatments.

5.3 Treat flare ups/ breakthrough or acute pain as needed

- Reassure the patient that exacerbations are common, are not necessarily indicative of a worsening of their underlying condition and are likely to settle quickly.
- Reviewing previous episodes may be helpful.
- Reassure the patient that it is safe to maintain normal activities of daily living at a moderate level.
- Discourage patients from resting excessively during an exacerbation.
- Consider re-assessment for new or worsening pathology and the possible need for further investigation.
- Plan for the use of non-pharmacological strategies.
- Avoid the use of short-acting strong opioids - Routine use during exacerbations may increase tolerance and may lead to dose escalation.
- Down-titrate analgesics between exacerbations.

5.4 Assess need for onward referral – see pain clinic referral criteria

When to refer to Pain Clinic services

- Pain/function/understanding not improving after following appropriate use of medication guidelines for neuropathic pain, opioids etc.

In addition it is useful to check referral guidelines for GGC Pain Clinic as listed below:

- 18 years of age (for adult services)
- Pain present for more than 3 months - adverse impact on quality of life
- Understands a cure might not be possible
- Ready to actively engage in self management – not reliant on medication alone; stable mood condition to engage with pain clinic team
- Has had all relevant investigations to exclude treatable pain, results have been explained to them
- Current GG&C Chronic Pain Management guidelines should be followed prior to referral - trials of appropriate medications and referral to MSK physiotherapy where appropriate

Resources:

SIGN 136

Map of Medicine- initial assessment and early management pathway
http://www.ckp.scot.nhs.uk/Published/PathwayViewer.aspx?fileId=1445