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:

Money Advice Scotland	0141 572 0237
Social Work Department	0141 287 8700
Benefit Agency Enquiry line	0800 882 200
Citizen's Advice Scotland	0131 667 0156
Prescription Advice Line	0800 917 7711

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

PHN = Post Herpetic Neuralgia
CRPS = Complex Regional Pain Syndrome

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continued

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

NOTES ON USE OF ANTICONVULSANTS FOR PAIN

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- 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
- Give patient specific information leaflet – see GG&C pain resource pack
- Start low and go slow, see specific dose recommendations