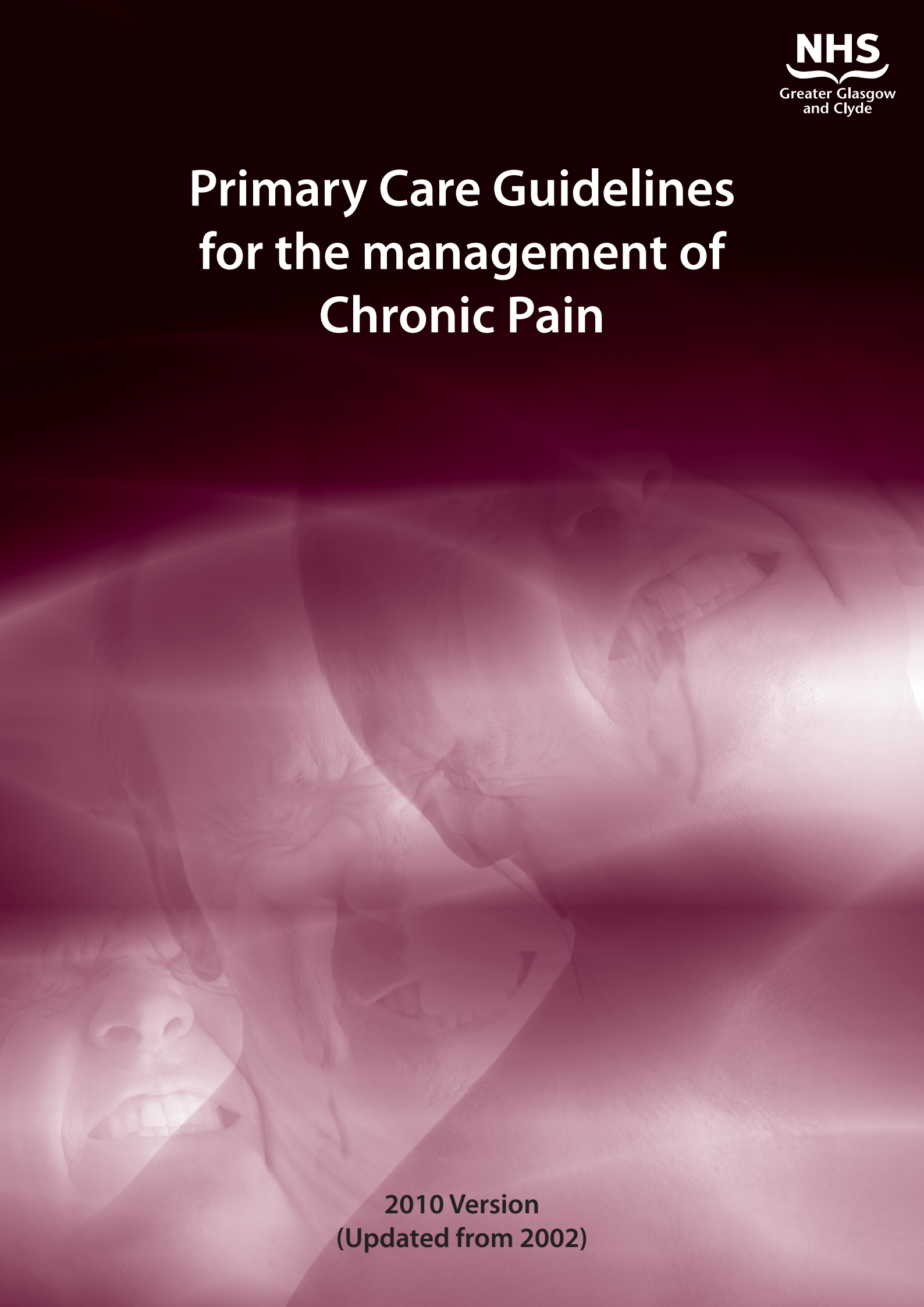
NHS
Greater Glasgow and Clyde

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:

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

GUIDELINES FOR THE MANAGEMENT OF CHRONIC PAIN

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

- Explain to patient that these drugs can improve pain
- 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

NEUROPATHIC PAIN GUIDELINES

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

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.
- Second line management are opioid drugs e.g. MST or Oxycodone [4-6].
- Some specific first line choices - Capsaicin 0.075% cream for focal cutaneous neuropathy (PHN, DN) and Carbamazepine for trigeminal neuralgia (TN).

In general

- Start low and go slow.
- If 1 drug is partially effective consider adding a 2nd rather than substituting. [7]

References

1. Merskey and Bogduk. IASP 1994 Classification of chronic pain 2nd edition
2. Hughes Richard. Peripheral neuropathy. BMJ 2002 324 466...
3. Finnerup N.B.et al. Algorithm for neuropathic pain treatment: an evidence based proposal. Pain 2005; 118: 289-305.
4. Gimbel J.S. Controlled release oxycodone for pain in diabetic neuropathy: a randomised controlled trial. Neurology 2003; 60: 927-33.
5. Recommendations for the appropriate use of opioids in persistent non cancer pain. www.britishpainsociety.org.uk
6. Ballantyne Jane. Medical progress:opioid therapy for chronic pain. NEJM 2003; 349: 1943-53.
7. Gilron I et al. Morphine, Gabapentin or their combination for neuropathic pain. NEJM 2005; 352: 1324-34.

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.

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 liscenced for TN).

Duloxetine 60 mg per day has been approved by the SMC for painful diabetic neuropathy. It is restricted to specialist initiation as second or third line therapy

Lidocaine 5% medicated plaster (Versatis) is for use only in patients who are intolerant of first line therapies for PHN or where these therapies have been ineffective.

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.

OSTEOARTHRITIS OF HIPS AND KNEES

DIAGNOSIS

OSTEOARTHRITIS?

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

NO

CONSIDER EARLY REFERRAL TO RHEUMATOLOGIST IF

- < 50 years old
- systemic upset suggestive of gout, connective tissue disease or septic arthritis
- Inflammatory arthritis (suggested by morning stiffness > 60 mins)

YES

STEP 1

1. Paracetamol
2. +/- Topical NSAID*
3. Consider Topical Capsaicin 0.025%

STEP 2 — **EITHER**

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**

+/-

1. Oral NSAIDs †

STEP 3

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

INFLAMMATORY FLARE UP OF KNEE PAIN

May occur at any step
Consider Intra-articular injection of steroid (use sparingly) & specialist referral

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.arthritiscare.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

GREATER GLASGOW BACK PAIN SERVICE

Guidelines on the management of Low Back Pain

Bladder/bowel disturbance, gait disturbance, saddle anaesthesia/paraesthesia
SUSPECTED CAUDA EQUINA

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EMERGENCY REFERRAL TO A&E
(with letter addressed to receiving ORTHO surgeon)

NERVE ROOT PROBLEM +/- LOW BACK PAIN

- Leg pain greater than back pain
- Radiation to foot/toes
- Numbness/paraesthesia same distribution as pain
- Altered reflexes/muscle weakness

NO LUMBAR SPINE IMAGING REQUIRED BEFORE REFERRAL

DRUG THERAPY

ANALGESICS – use at regular intervals

- 1st line – paracetamol
- 2nd line – NSAIDs – Ibuprofen has least incidence of GI side effects

NERVE PAIN – for Nerve Root pain (Sciatica) see guidelines on Neuropathic pain
eg low-dose Amitriptyline, Gabapentin

MUSCLE RELAXANTS – short term only – 1 week max

1. diazepam
2. baclofen

SPINAL STENOSIS
General leg(s) pain produced by prolonged standing or walking and relieved by flexion i.e. sitting or bending forward. Pain claudicant in nature and usually relieved by rest

NO LUMBAR SPINE IMAGING REQUIRED BEFORE REFERRAL TO PHYSIOTHERAPIST

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GP management for 2 weeks at most
Give Back Pain Advice Sheet
http://www.nhsggc.org.uk/content/default.asp?page=home_Back%20Pain%20Service

↓

If not resolved refer to physiotherapy
Either write or consider asking patient to self-refer to physiotherapy
Will be seen within 2 weeks if acute
Otherwise within 5 weeks

↓

Physiotherapy evaluation
Assessment includes full Red Flag Screening

One to one treatment | **Group treatment in physio-led back class**

↓

Physiotherapy re-assessment no later than 6 weeks including screening for Red Flags and Psychosocial barriers to recovery (Yellow Flags)
Physiotherapist liaises with GP about ongoing treatment

OPTIONS INCLUDE:

- Systematically unwell?
- Previous diagnosis of cancer?
- Possible infectious cause?
- New/altered back pain <20 or >55 years + raised ESR or abnormal FBC or LFTs?

X-rays are NOT recommended to investigate serious pathology as a cause of low back pain

↓

REFER URGENTLY TO APPROPRIATE SPECIALITY
Consider West of Scotland Malignant Spinal Cord Compression Guidelines

http://www.beatson.scot.nhs.uk/content/

NON SPECIFIC LOW BACK PAIN

- No signs of serious pathology
- No nerve root problems
- Mechanical back pain

NO LUMBAR SPINE IMAGING REQUIRED BEFORE REFERRAL EVEN FOR THOSE WITH SUSPECTED LUMBAR OSTEOPOROTIC FRACTURE (see Osteoporosis guidelines)

Physiotherapist will arrange suitable imaging as required

IF ACUTE DISTRESS – Muscle relaxants:
Avoid opioids: Modify activities

PROVIDE REASSURANCE – "expect recovery"

- Address psychosocial factors
- Symptomatic measures – local ice or heat
- Avoid bed rest. Stay as active as possible
- Supply Back Pain Advice Sheet

Discharge to normal activity. All patients can self refer back to physiotherapy

Referral **Via GP** to a multi-disciplinary pain clinic

Patient Education Class

Refer to an orthopaedic surgeon. Specialist Physiotherapist can refer DIRECTLY to named ORTHOPAEDIC/ NEUROSURGICAL SPINAL Surgeon with up to date MRI scan of lumbar spine (MRI scan requested by specialist Physio)

PSYCHOLOGY. Refer to enhanced back classes for patients with symptoms of less than 1 year at risk of chronicity

Discharge to Local Authority exercise classes "Vitality"

"LIVE ACTIVE" Scheme (Exercise referral scheme **Via GP** for the physically inactive)

OPIOIDS FOR CHRONIC NON CANCER PAIN,

Abridged-11/08 (unabridged version & references can be found through the StaffNet Clinical Guidelines web page)

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.

May improve	Unlikely to improve
improvement with acute opioids in the past	no improvement with acute opioids in the past
failed with conventional non-opioid drugs failed with non drug therapy	
pain diagnosis nociceptive neuropathic combined	pain diagnosis unclear ? somatoform disorder

2. - SCREEN out patients at high RISK of DEPENDENCY

Patients at higher risk of abusing opioids. Provider Bulletin 00-04.May 2000 & [1]

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)
– **C**ut down, **A**nnoyed, **G**uilty, **E**ye-opener

SOAPP - **S**creener and **O**pioid **A**ssessment for **P**atients with **P**ain
- 14 Q's – self administered

PDUQ - **P**rescription **D**rug **U**se **Q**uestionnaire
- 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 administrating opioids in chronic non malignant pain. [1,3]
Step 2 opioid drugs are replaced entirely with Step 3

Choice of drug.	- use a single agent ie: a long acting Mu agonist
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.

Drug	Dose
1st line - Morphine Sulphate MR (MST)	10mg BD up to a maximum of 90mg BD
2nd line – Oxycodone MR (Oxycontin)	5mg BD up to a maximum of 60mg BD

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]

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

* see Pan-Glasgow Palliative Care Algorithm
** Pseudoaddiction is the patient's attempt to obtain better pain relief. When pain is relieved, these behaviours cease.

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