This guideline is designed to help primary care clinicians manage adult patients presenting with chronic pain. It advises on initial treatment and suggests where referral to specialist services may be considered.

These guidelines have been written independently and ratified by the BNSSG Drugs and Therapeutic Committee. The printing of this document was funded by Pfizer Ltd.

Version 7 – October 2013
Guideline for the management of chronic (non-cancer) pain in Primary Care/non-specialist centres and referral to specialist secondary care services

Chronic pain is defined as pain that persists beyond normal tissue healing time which is assumed to be three months.

Purpose of the Guidance

This guideline is designed to help primary care clinicians manage adult patients presenting with chronic pain. It advises on initial treatment and suggests where referral to specialist services may be considered.

The guidelines are designed as a set of algorithms to be used together to guide management and referral. They are based on established practice throughout the UK and appropriate NICE guidance.1,2

It should be emphasised that medicines play a minor part in managing persistent pain. Maintaining fitness, pacing activities and a generally healthy lifestyle are important. Non-pharmacological methods of pain relief such as TENS, acupuncture and physical methods in the reduction of muscle spasm are equally important.

Attention should be paid to the biopsychosocial factors that influence an individual's response to pain. Importantly, all patients should be screened for common mental health problems that may be both risk factors and consequences of difficult to control pain.

It is important to understand the patient’s expectations in the management of their pain. Rarely is it possible to become completely pain free. The goal of pain management is to minimise the impact of pain, enabling the patient to improve their quality of life.

Content of the guideline

1. Algorithm for the management of chronic (non-cancer) pain
2. Identification of Red and Yellow flags in chronic pain
3. Management of Neuropathic/Mixed Neuropathic and Nociceptive pain
4. Prescribing opioids for chronic (non-cancer) pain
5. Pain Clinic Referral Guidelines

Referral to Specialist Services

These guidelines are designed to help primary care clinicians manage the majority of cases of chronic pain presented to them. In the event that a referral to the Pain Clinic is considered, the referral pathway for chronic pain highlights appropriate referrals and alternative pathways.
Algorithm for the Management of Chronic (non-cancer) Pain

1. Assess presence of co-existing mental health problems (e.g. depression using PHQ-9 score) and psychosocial factors (yellow flags)
2. Assess how pain limits enjoyable activities e.g. gardening/walking
3. Discuss patient's expectations of treatment for chronic pain
4. Discuss non-pharmacological methods of pain management with patient and refer where appropriate e.g. physiotherapy, acupuncture, TENS
5. Consider the use of a pain scale, such as the Brief Pain Inventory to quantify level of pain and provide a baseline

Commence a trial of regular medication
Paracetamol 1g qds regularly +/- NSAID* +/- weak opioid (e.g. codeine or dihydrocodeine). Consider the use of topical NSAID preparation.

*If over 45 prescribe PPI in conjunction with NSAID. Review after two weeks. Stop if no benefit seen. Monitor renal function if NSAID is to continue.

Has pain settled to a reasonable level?

Check Psychosocial factors again (Yellow flags)
If appropriate use of pharmacological methods stated in the guideline do not improve pain management, consider early referral to Pain Clinic

Consider exercise program to maintain fitness/flexibility and reduce flare ups

Consider trial of reduction of analgesia in a step wise fashion to evaluate continued effectiveness of medication

Is patient compliant with medication regime?

See prescribing notes to enhance concordance

Refer to appropriate Specialist Service

Is there serious medical pathology? (Red Flags)

Has pain settled to a reasonable level?
Yes
No

Commence full assessment of symptoms related to pain

See Neuropathic Pain Guideline

Is there a component of neuropathic pain? (Use PainDETECT questionnaire)
Yes
No

Does the patient have chronic pain? (Pain continuing after healing or in the absence of injury)
Yes
No

No
**Identification of Red and Yellow Flags in chronic pain**

**Red flags** are clinical indicators of possible serious underlying conditions requiring further medical intervention. Red flags were designed for use in acute low back pain, but the underlying concept can be applied more broadly in the search for serious underlying pathology in any pain presentation.

<table>
<thead>
<tr>
<th>Differential Diagnosis</th>
<th>Red Flags from patient history</th>
<th>Red flags from examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible fracture</td>
<td>- major trauma</td>
<td>Evidence of neurological deficit (in legs or perineum in the case of low back pain)</td>
</tr>
<tr>
<td></td>
<td>- minor trauma in elderly or osteoporotic</td>
<td></td>
</tr>
<tr>
<td>Possible tumour or infection</td>
<td>- Age &lt;20 or &gt;50 years old</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- History of cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Constitutional symptoms (fever, chills, weight loss)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Recent bacterial infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- IV drug use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Immunosupression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Pain worsening at night or when supine</td>
<td></td>
</tr>
<tr>
<td>Possible significant neurological deficit</td>
<td>- Severe or progressive sensory alteration or weakness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Bladder or bowel dysfunction</td>
<td></td>
</tr>
</tbody>
</table>

**Yellow Flags (biopsychosocial issues related to chronic pain)**

Prescribers should be aware of the existence of ‘Yellow flags’ early in the management of chronic pain. Identification (and subsequent management) of yellow flags will improve the overall management of pain.

The factors which highlight the patient’s risk of chronicity can be identified using the ‘yellow flags’ system:

- **Attitudes** - towards the current problem. Does the patient feel that with appropriate help and self management they will return to normal activities?

- **Beliefs** - The most common misguided belief is that the patient feels they have something serious causing their problem – usually cancer. ‘Faulty’ beliefs can lead to **catastrophisation**

- **Compensation** - Is the patient awaiting payment for an accident/injury at work/RTA?

- **Diagnosis** - or more importantly **iatrogenesis**. Inappropriate communication can lead to patients misunderstanding what is meant, the most common examples being ‘your disc has popped out’ or ‘your spine is crumbling’

- **Emotions** - Patients with other emotional difficulties such as ongoing depression and/or anxious states are at a high risk of developing chronic pain

- **Family** - There tends to be two problems with families, either over bearing or under supportive
Management of Neuropathic/Mixed Neuropathic and Nociceptive pain

Introduction

Neuropathic pain is difficult to treat. Medications are probably the most effective intervention but fewer than a third of patients respond to any given drug. Different classes of drug have distinct and relevant mechanisms of action for neuropathic pain so if the first drug class that is tried does not work it is rational to try an alternative medication.

Pain reduction with all types of drug used in neuropathic pain is modest, with most drugs reducing the intrusiveness of pain rather than providing substantial pain relief.3

Recognising and diagnosing neuropathic pain

➣ As per the Algorithm for the Management of Chronic (non-cancer) Pain, assess the patient for any potential Red Flags and refer as appropriate.
➣ Conduct an assessment of pain using the PainDETECT questionnaire to ascertain presence of neuropathic pain.

Possible causes

• Diabetes, herpes zoster (shingles)
• Consider neuropathic pain in ongoing conditions e.g. sciatica, neck pain, low back pain
• Neuropathic pain can be a feature of an underlying disease e.g. cancer, that will require investigation

Signs and symptoms

• Neuropathic pain can be spontaneous or evoked, continuous or intermittent
• Often worse at the end of the day
• Can be made worse by hot or cold, touch or movement (even wearing clothes)
• Patients are unresponsive to conventional analgesics
• Skin in painful area may look different from normal e.g. atrophic or cyanosed

Trigger words to aid diagnosis – always encourage patients to describe their pain

Key words you will hear when a patient describes neuropathic pain are:

Burning, Shooting, Stabbing

Sensory signs and symptoms

• Allodynia – pain produced by a stimulus that does not normally produce pain e.g. touch pressure, warmth
• Dysaesthesia – an unpleasant, abnormal sensation e.g. insects crawling over skin
• Hyperaesthesia – increased sensitivity to stimulation
• Hyperalgesia – an increased response to a stimulus which is normally painful

Management of neuropathic/mixed pain

• Please see the chart on the following page for guidance on the pharmacological management of neuropathic/mixed pain

Role of opioids in the management of neuropathic/mixed pain

• A trial of opioid therapy may be considered for neuropathic pain unresponsive to tricyclic antidepressants or antiepileptic drugs. Refer to section entitled ‘Prescribing opioids for chronic (non-cancer) pain’
Pharmacological management of neuropathic/mixed pain (not including diabetic neuropathy)

Non-opioid analgesic/baseline analgesia

Paracetamol 1g four times a day Continue as patient moves through Steps 2 -3

Tricyclic antidepressant (usually first choice)

Amitriptyline

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>10mg</td>
<td>20mg</td>
<td>30mg</td>
<td>40mg</td>
<td>50mg</td>
</tr>
</tbody>
</table>

- Analgesic effect is separate from antidepressant effect
- Best taken in the evening to reduce ‘hangover effect’ e.g. 6-8pm
- Slowly titrate to reduce side-effects but ensure titration occurs even if dose is later reduced
- The minimum effective dose is usually 50mg daily, but up to 100mg can be used if patient is deriving benefit with limited side-effects
- Review after 4-6 weeks at maximum tolerated dose. Stop if no perceived benefit and consider an anticonvulsant.
  - If partial benefit felt at maximum tolerated dose of TCA consider addition of an anticonvulsant
- Side-effect profiles are similar, but alternative TCAs e.g. nortriptyline may be used if amitriptyline is not well tolerated

Anticonvulsant – 1st choice if TCAs are contraindicated or lancinating pain (“electric shocks”)

Gabapentin

<table>
<thead>
<tr>
<th>Morning</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>300mg</td>
<td>300mg</td>
<td>300mg</td>
<td>300mg</td>
<td></td>
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</tbody>
</table>

- If dose increases are tolerated, consider faster (daily) dose titration. If elderly/frail a slower titration may be necessary
- Continue increasing as above to maximum 900mg three times a day – determined by efficacy and side effects
- Review after 6-8 weeks at maximum tolerated dose. Taper and stop if no benefit felt

2nd line – if gabapentin gives good effect but side-effects cannot be tolerated

Pregabalin

<table>
<thead>
<tr>
<th>Day 1*</th>
<th>Day 2</th>
<th>Day 8</th>
<th>Day 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning 75mg</td>
<td>75mg</td>
<td>Review after 7 days and increase dose if necessary</td>
<td>75mg</td>
</tr>
<tr>
<td>Night 75mg</td>
<td>75mg</td>
<td>150mg</td>
<td>150mg</td>
</tr>
</tbody>
</table>

- *a lower starting dose may be appropriate for some people
- Consider starting titration at lower dose in elderly or in patients who are susceptible to side-effects
- Pregabalin is ‘flat priced’ across the dose ranges. Therefore increase the strength of the capsule rather than simply increasing the number taken

Also consider...

A trial of opioids may be considered for neuropathic pain unresponsive to tricyclic antidepressants or antiepileptic drugs. Refer to section entitled ‘Prescribing Opioids for chronic (non-cancer) pain’.

FOR SECONDARY CARE PAIN SPECIALIST RECOMMENDATION ONLY

- **Lidocaine plaster** – for post herpetic neuralgia or according to NICE clinical guideline 96 where other treatment options have failed or cannot be used due to co-morbidities. A maximum 4 week trial should be used to establish efficacy and the prescription should cease if good effect is not established. Plasters can be cut to match the size of the affected focal site, therefore, not all patients will require a full plaster to be used each day
- **Duloxetine** – 3rd line where other neuropathic agents have failed or for a clear diagnosis of diabetic neuropathy
Prescribing opioids for chronic (non-cancer) pain

Important Notes
- The safety and efficacy of long term opioid use is poor
- Do not use injectable opioids or pethidine
- Seek specialist advice earlier rather than later
- Do not use more than 120mg/day morphine (or equivalent)
- If pain has not improved, stop. Do not escalate the dose and seek specialist advice
- Long term opioid use may worsen or prolong symptoms of pain
- Opioids are not usually helpful in the following conditions:
  - Mechanical back pain
  - Fibromyalgia
  - Pelvic or abdominal pain
  - Non-specific visceral pain

The decision to prescribe opioids in these conditions should be made in conjunction with advice from specialist pain management services.

Prescribing

1. Assessment and Goal Setting

  Assess the patient before commencing a trial of opioids
  This should include indicators of anxiety, depression or other psychiatric/psychological co-morbidities (see section on Yellow Flags for more information). Such patients will require additional support and monitoring.

  Goals of therapy should be agreed with the patient
  Complete pain relief is unlikely, and success should be measured by the patient being able to do things that pain currently prevents.

2. Dose Titration

  ➢ Start with a low dose of modified release morphine (e.g. Zomorph 10mg bd). Titrate this dose according to analgesic effect and side effects.

  ➢ Review once the dose reaches 30mg bd morphine (or equivalent) and taper and stop if no benefit is felt at this dose.

  ➢ DO NOT use doses greater than 120mg morphine daily. DO NOT prescribe immediate release ‘breakthrough’ medication.

  ➢ For patients who exhibit considerable variability in symptoms of pain, or who have predictable changes in the intensity of pain, consider a short term (max. seven days) trial of immediate release morphine (e.g. Sevredol 10mg tablets) to be used when pain is at its worst, or when pain is predicted to increase in intensity as a means of evaluating whether opioids are going to play a role in long term management.

  Review after one week and discontinue the ‘immediate release trial’ if no benefit is reported or it is deemed that more consistent dosing may be more appropriate.
3. Review

➢ The aim of therapy is to modify pain with the lowest possible dose of opioid. Patients with non-cancer chronic pain should not normally experience ‘breakthrough’ pain and thus should not require immediate release opioids in addition to modified release capsules. If this is not the case, review for red flags and seek specialist advice.

➢ Review the patient regularly (at least monthly, and more often if there are any concerns) and ensure that requests for dose increases are evaluated carefully. **DO NOT** increase the dose (or give extra medication) without seeing the patient.

➢ If pain has not settled and ceiling for opioid prescribing is reached (120mg/day morphine or equivalent), **TAPER DOSE AND STOP.**

➢ It is unlikely that an alternative opioid will work where morphine has not. Efficacy and adverse events are similar for all opioids.

➢ **Seek specialist advice** if the opioid trial fails and patients request further input in order to help manage their pain.

➢ Review prescribing regularly. Aim to taper the dose intermittently as a means of establishing continued utility.

➢ Consider reduction or stopping opioid in patients with considerable pain despite opioid therapy. This approach is unlikely to increase symptoms of pain but may reduce harmful side effects.

**Note:** If care is shared between the GP practice and specialist pain management service, **be clear who is responsible for prescribing.** Within the GP practice, repeat prescriptions should only be signed by the clinician responsible for the patient’s care.

**Cautions**

• Medication for pain should be used only as part of a wider management plan aimed at reducing disability and improving quality of life

• Opioids should not be used in pregnant women without specialist advice, and should be used with caution in older people (particularly those with co-morbidities)

• Patients with a history of addiction to opioids or other drugs (including alcohol) need referral to services with expertise in pain medicine and addiction management

• Patients should not drive when starting opioids or adjusting dose or if they feel unfit to drive

**Adverse effects**

• 80% of patients will experience at least one adverse effect. e.g. constipation, nausea, itching, dizziness. These should be treated promptly with laxative, antiemetics etc

• Opioid toxicity (sedation, reduced respiratory rate, cyanosis) are more likely with increasing age, co-morbidity, co-prescribing or if opioids are taken with alcohol or illicit drugs

• Opioids have long term endocrine and immunological effects

• Withdrawal symptoms occur if opioid is stopped or if the dose is reduced abruptly e.g. sweating, yawning, abdominal cramps

• Addiction is characterised by impaired control over use, craving and continued use despite harm

• Opioid induced hyperalgesia may occur: pain becomes more diffuse and qualitatively different from pre-existing pain. Specialist advice is needed
Opioids agreed for use across Bristol, North Somerset and South Gloucestershire (BNSSG)\(^4\)

**First Line**
Morphine SR (Zomorph capsules) 10mg twice daily

(Maximum dose of 60mg twice daily or equivalent dose of alternative opioids before referral to specialist pain management team).

➢ Increase dose by no more than 10mg twice daily at a time. Review regularly (at least monthly during dose titration).

**N.B.** Consider trial of ‘immediate release’ morphine under certain circumstances (refer to section 2 of page entitled ‘Prescribing opioids for chronic (non-cancer ) pain’).

**Second Line**
(Change opioid if adequate analgesia but intolerable side effects with morphine).

**Oxycodone** (no evidence that this has fewer side effects)

• Use where morphine is not tolerated. (N.B. ensure that adverse effects such as constipation and nausea have been managed before switching to oxycodone)
• Use modified release oxycodone
• Note that oxycodone is twice the potency of morphine (oral doses). Therefore 10mg twice daily oxycodone is equivalent to 20mg twice daily morphine
• Targinact (oxycodone + naloxone) is NOT recommended for use and is not part of the BNSSG Joint Formulary

**Other drugs**

**Tramadol** (associated with withdrawal symptoms on cessation even after short term use)

• Has mixed opioid/SNRI activity and may have a role in the management of mixed/neuropathic pain
• Start at 50mg twice a day titrate dose according to analgesic effect
• At maximum dose (400mg/day) tramadol is equivalent to 40-80mg morphine per day
  - Conversion rates vary between patients. If conversion is to be considered in a patient taking 400mg/day tramadol, start with morphine 10mg \(bd\) and titrate according to response

**Tapentadol** (Modified Release - TLS AMBER) should be reserved for the management of severe chronic pain in adults who cannot tolerate other strong opioids e.g. morphine sulphate or oxycodone, on recommendation of the pain team. Transfer of prescribing in to Primary Care must be accompanied by a Shared Care Protocol and be the subject of regular review.
**Tapentadol** (Immediate Release - TLS RED) should not be prescribed in Primary Care.

**Transdermal Patches** e.g. buprenorphine and fentanyl

• should be **reserved** for patients with **stable** pain who cannot tolerate oral medication, or where there are compliance issues.
• Fentanyl is a potent opioid and should **never** be used in an opioid naïve patient
• Fentanyl 25mcg/h is equivalent to morphine 90mg/day. Doses in excess of this should only be prescribed with the involvement of the specialist pain management service

Refer to the chart overleaf for other dose equivalents.
Prescribing Notes
It is suggested that only 1 in 6 people take their medication as intended by the prescriber. Giving consideration on how to improve a patient’s concordance with medication helps to maximise the benefit of the drug prescribed.

For example:

✓ Use simple language and avoid medical terms

✓ Discuss reasons for treatment and consequences of not treating the condition. Ensure the information is tailored, clear, accurate, accessible and sufficiently detailed

✓ Seek the patient’s view on their condition

✓ Agree on a course of action before prescribing

✓ Explain what the drug is, its function, and (if known and not too complex) its mechanism of action

✓ Keep the drug regime as simple as possible - *od* or *bd* dosing preferable, especially long-term

✓ Seek the patient’s views on how they will manage the regime within their daily schedule and try to tie in with daily routine (e.g. take one in the morning when you get up)

References

1. NICE CG 88 – Low Back Pain (Full guidance) Accessed online at: 
   http://guidance.nice.org.uk/CG88/Guidance
2. NICE CG 59 – Osteoarthritis (Full guidance) Accessed online at: 
   http://www.nice.org.uk/CG59
3. Management of persistent pain in secure environments (need correct reference)
4. Bristol, North Somerset and South Gloucestershire Joint Formulary. Accessed online at: 
   http://www.bnssgformulary.nhs.uk/Joint-Formulary-Committee/
5. The British Pain Society 2010 Opioids for persistent pain: Good practice. Accessed online at: 
   http://www.britishpainsociety.org/pub_professional.htm
6. NICE CG 76 – Medicines Adherence (Full guidance) Accessed online at: 

Version 7 – October 2013. Written by Dr Rachel Britton (Senior Pharmaceutical Advisor) 
NHS North Somerset. Ratified by BNSSG Drugs and Therapeutics Committee.
Pain Clinic Referral Guidelines

This chart should be used if a primary care clinician feels that a referral to the Pain Clinic is the next course of action for a patient with chronic pain.

**APPROPRIATE**

- Recognised neuropathic pain syndromes failing to respond to primary care management
- Patients making excessive demands for treatment for their pain, requesting a ‘second opinion’ or where doses of opioid have escalated above 120mg morphine per day (or equivalent)
- Cases where there is significant or increasing disability or distress due to persistent pain

**INAPPROPRIATE**

- Patients with significant psychiatric co-morbidity
- Back pain (musculoskeletal pain)
  - Upper/ Lower limb musculoskeletal
- Intractable headache without investigations
- Polyarthropathy (<3 swollen joints and 30 mins morning stiffness; ESR/CRP >30)
- History of fragility fracture, family history or risk factors for osteoporosis
- Features of other connective tissue, seronegative, vasculitic disorders
- Pain problems where treatable pathology has been inadequately assessed and excluded

**Referrals**

- Refer to Pain clinic for assessment
- Referral to CMHT as appropriate prior to Pain Clinic referral
- Refer to MATS team for assessment
- Refer for neurology assessment
- Refer for rheumatology assessment
- Refer to appropriate specialist