Non-Cancer Pain Management – Nocioceptive pain drugs

Before prescribing

- **Conduct a comprehensive assessment of pain, agree and document goals of therapy, length of initial therapy.** BPS/MoM pain assessment pathway; BPS Pain Scale Keele University StarT Back Tool: www.keele.ac.uk/sbst/startbacktool
- Refer to appropriate specialist if any red flag symptoms[4].
- **Use SOCRATES pain assessment: S**ite, **O**nset, **C**haracteristics, **R**adiation, **A**ssociated symptoms, **T**iming, **E**xacerbation/alleviating, **S**everity
- **Consider patient self-help tools** www.paintoolkit.org . **Offer advice on non-pharmacological approaches and/or consider referral to other services** e.g. Transcutaneous Electrical Nerve Stimulation (TENS) machine, weight loss programmes, or psychological therapies.
- Ensure drug choice takes into account patient history, age, co-morbidities and co-prescribing. Choice of drug should be made in conjunction with the patient following an informed discussion including adverse effects, risks, long term efficacy of drugs.

Before changing medicines, ensure use of maximum tolerated doses, patient compliance and patient adherence to self-help advice

WHO analgesic ladder

Step 1 = non-opioid +/- adjuvant
Step 2 = weak opioid +/- non-opioid +/- adjuvant
Step 3 = strong opioid +/- non-opioid +/- adjuvant
Strong is considered an opiate load = or > 60mg/24h

Before considering long term strong opioids, consider that there is little evidence supporting safety and efficacy of long term use.
Consider the associated risks of increased mortality, endocrine impairment and immunosuppression

Other controlled drugs – NOT for 1st line initiation

Oxycodone orally (12h release and immediate release)
Fentanyl patches every 72h
Buprenorphine (Transtec) patches 2 x a week

Buprenorphine patches should be reserved for patients with concordance & swallowing issues

Regular paracetamol 1g tds, 4th dose only if appropriate **+/-**
NSAID lowest effective dose for shortest period required
Ibuprofen or Naproxen first choice
Renal and CV to be monitored. Consider need for GI protection

Regular paracetamol + codeine +/- NSAID

Provide codeine as 8, 15, 30mg with paracetamol rather than as co-codamol
For non-responders who have been compliant with medicines, before changing therapy, determine if neuropathic pain symptoms are present which may trigger a diagnosis of neuropathic pain. If so, manage according to neuropathic pain pathway

If codeine is ineffective, possibly consider very low dose slow release versions of other opioids Starting with e.g. MST 5mg daily or Buprenorphine patches 5ug/h once a week

Strong opioids

Tramadol – initiate 50-100mg when needed, up to 3 or 4 times per 24 h
Maximum dose 400mg per 24h (+/- Paracetamol 1g 3-4 x a day)
Caution in the elderly, epileptic patients and those on anti-depressants
If adequate pain control on regular dose, consider SR formulation 100-200mg bd
Tramacet is an expensive combination with inadequate paracetamol dose
Morphine - 12h modified release bd, up to 60mg bd – (capsules are better value)
Immediate release: Sevredol 10mg. small supply one prn for breakthrough pain
Maximum dose of morphine 120mg/24h. Higher doses are not recommended outside specialist management)

During long term opioid treatment, conduct reviews at least monthly for the first six months after stable dosing has been achieved and at least biannually thereafter.
If inadequate response refer to Pain Clinic before considering higher doses of opioids (as mortality 10 times higher)

Equi-analgesic value of opioids

- Codeine mg oral: Morphine oral = 10:1
- Tramadol mg oral: Morphine mg oral = 5:1
- Buprenorphine ug/h patch: Morphine mg oral = 1:1.7
- Oxycodone mg oral: Morphine mg oral = 1:2
- Fentanyl ug/h patch: Morphine mg oral = 1:3.5

*When switches are calculated, initially **reduce** answer by 30% for safety*

For further information on:

- Long term problems with opiates
- Opiate safety and opiate switching etc
- *Link to guidelines on website*

Ten top tips for GPs managing pain summary

1. **S**elf-managing with confidence is the aim of management
2. **E**xpect persistent pain to be a long term condition so you can take your time
3. **L**isten to the pain story from start to finish (appointment one)
4. **F**orm with patient person-centred goals for the future (appointment two and onwards)
5. **M**etaphors can be used to explain persistent pain concepts to patients
6. **A**nalgesia should be kept simple and effective
7. **N**europathic pain may require special attention
8. **A**sk about life – it's not all about the pain. Consider sleep, mood, activity etc
9. **G**ive strong opiates with extreme caution and careful review
10. **E**ncourage continuity with a limited number of involved healthcare professionals

For further advice, contact the pain clinic: Email: kcht.chronicpainreferralpoint@nhs.net Tel: 0300 1232105 or 0300 1232531 Fax: 08712 214988

East Kent Prescribing Group

Neuropathic Pain

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- **Consider patient self-help tools** www.paintoolkit.org . **Offer advice on non-pharmacological approaches and/or consider referral to other services** e.g. Transcutaneous Electrical Nerve Stimulation (TENS) machine, weight loss programmes, or psychological therapies.

Ensure drug choice takes into account patient history, age, co-morbidities and co-prescribing. Choice of drug should be made in conjunction with the patient following an informed discussion including adverse effects, risks, long term efficacy of drugs.

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Low dose tricyclic Antidepressant (TCA)

Only amitriptyline in current NICE guidelines

Amitriptyline or nortriptyline

- 10-75mg nocte
- Titrate upwards over 4 to 5 weeks
- Use as a trial for at least 6 to 8 weeks

Nortriptyline may be better tolerated in the elderly but is considerably more expensive
Take care in cardiac risk, BPH and epilepsy
Low doses are safe in renal impairment

Patients who do not benefit/tolerate one TCA may benefit from alternative TCA
If TCAs fail, consider switching to duloxetine (SNRI)

Duloxetine

- Start with 20-30mg at night. Might need co-prescription initially for nausea and dizziness
- Dose: 60mg – 120mg/day

Contraindicated: uncontrolled Hpt/abnormal liver function/GFR<30
Non-UK licencing includes fibromyalgia and osteoarthritis pain

Anti-convulsants

Gabapentin

Consider starting once per day at night
100-300mg nocte for 3-7 days, then
100-300mg BD for 3-7 days, then
100-300mg TDS for 3-7 days
If tolerated titrate to 600mg TDS
Use as a trial for at least 6-8 weeks

OR Lyrica*

25-75mg nocte for 3-7 days
25-75mg BD for 3-7 days
75-150mg BD for 3-7 days
Standard dose 150mg BD
Maximum dose 300mg BD

If anticonvulsants ineffective or limited efficacy, consider referral to pain clinic

- *Only brand of pregabalin licensed for neuropathic pain*

Specific condition considerations

- Diabetic neuropathy: duloxetine +/- gabapentin/pregabalin
- Widespread body pain: gabapentin/pregabalin, duloxetine and OTC magnesium supplements
- Trigeminal neuralgia: Carbamazepine
- Hand/knee OA: topical NSAID or capsaicin cream 0.025 percent
- Post-herpetic neuralgia or discrete focal areas of cutaneous neuropathy:
- Capsaicin cream 0.075%

Note: Versatis patches (5% lidocaine) could also be helpful for PHN but specialist recommendation only and not for non-NPP use.

NICE recommends single drug rather than combining (Primary care).
If the first agent chosen is not helpful, then use an alternative as a sole agent (or in combination on specialist recommendation only)
NB: Neuropathic pain responds poorly to conventional analgesics

Do not prescribe

- Benzodiazepines
- Co-proxamol
- Short-acting dihydrocodeine
- Tramacet
- Pethidine/diconal/meptazinol/pentazocine
- Home injectables
- Novel breakthrough preparations e.g. lollipops, sprays

Do – for all pain types

- Ensure type of pain is correctly identified
- Make sure the chosen drug is actually providing benefit and at optimum tolerated dose before considering adding another
- **Stop** drugs that are not working and **remove** from the repeat screen
- Make only one change at a time to assess whether the medication is working
- Explain to the patient the drugs are not expected to provide a total reduction in pain but rather should help them function better
- Consider need for a Medicines Use Review by a community pharmacist
- Remember to ask about Over the Counter (OTC) medication also taken
- Consider falls risk
- Manage Opiate Induced Constipation adequately
- Be aware of abuse potential of tramadol IR, gabapentin and pregabalin, not just opiates

Monitoring

- **Analgesia -** is the medication still providing useful pain relief?
- **Adverse effects –** what side effects is the patient experiencing and can these be managed more effectively?
- **Activity –** does the patient maintain suitable physical and psychosocial functioning?
- **Adherence –** is the patients taking medication as agreed in the management plan?

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Please visit the CCG website http://www.southkentcoastccg.nhs.uk/about-us/prescribing-recommendations/?categoryesctl9275711=17024 for the full East Kent chronic pain medication guidelines (non-specialist)