Kent Community Health NHS
NHS Foundation Trust

East Kent Chronic Pain Medication Guidelines

(non-specialist)

Also endorsed by:

East Kent Hospitals University NHS
NHS Foundation Trust

East Kent Prescribing Group NHS

These guidelines are for primary care prescribing of adult patients with non-malignant chronic pain. When patients have failed on these and are seen in specialist clinics, more complicated regimes might be suggested.

Your CCG may have preferred formulations for the different drugs. These are available on Scriptswitch and Eclipse.

Contents

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With thanks to all colleagues from KCHFT, EKHUFT, Pilgrims Hospice and the four CCG prescribing teams, who reviewed this document, for their valuable comments.

Initial assessment

See **Map of Medicine** (NHS Evidence via your Athens account).
Pain – initial assessment and early management.
(there are also pathways for specific pain conditions).

SOCRATES pain assessment

S – site
O – onset
C – characteristics
R – radiation
A – associated symptoms
T – timing
E – exacerbating/alleviating
S – severity

Problematic pain:

Pain associated with, or with the potential to cause, significant disability and/or distress.

Screening questions:

Over the past two weeks has the pain been bad enough to interfere with your day to day activities?

During the past two weeks have you felt worried or low in mood because of this pain?

If yes, look for the four Ds:

- Depression.
- Disability.
- Drug use – problematic.
- Diagnostic uncertainty.

Risk (of long-term/problematic pain) stratification for musculoskeletal pain:

Keele University StarT Back Tool:
www.keele.ac.uk/sbst/startbacktool

Types of pain

Nociceptive pain

- Peripheral sensory neurones (nociceptors) respond to noxious stimuli.
- Painful region localised at the site of injury.
- Often described as throbbing, aching or stiffness.
- Usually time-limited but can be chronic (e.g. osteoarthritis).
- Responds to conventional analgesics.

Neuropathic pain

- Lesion or disease in the peripheral or central nervous system.
- Described as shooting, electric shock-like, burning.
- Commonly associated with tingling or numbness.
- Painful region not necessarily same as site of injury.
- Pain occurs in the neurological territory of the affected structure (nerve, root, spinal cord, brain).
- Almost always chronic condition (e.g. post-herpetic neuralgia, post-stroke pain).
- Responds poorly to conventional analgesics.

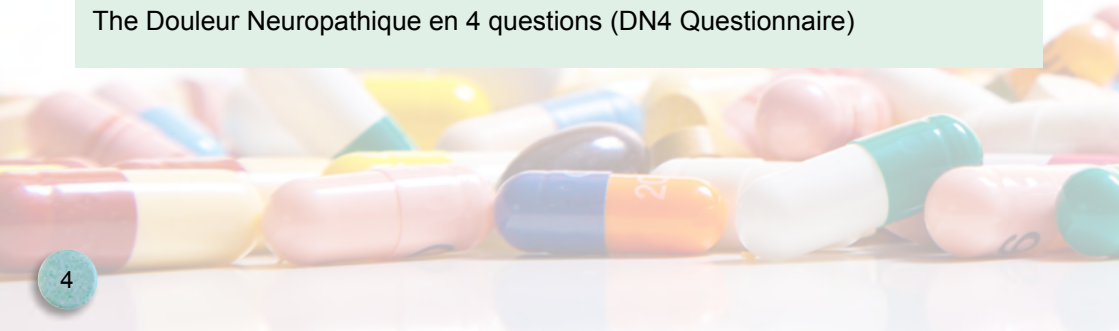
Mixed

Example of co-existing pain: herniated disc causing low back pain and lumbar radicular pain.

PainDETECT Questionnaire – helps to determine NPP:
www.pfizerpatientreportedoutcomes.com

Others suitable for primary care:
The Leeds Assessment of Neuropathic Symptoms and Signs (LANSS Pain Scale)

The Douleur Neuropathique en 4 questions (DN4 Questionnaire)



Nociceptive pain drugs

WHO analgesic ladder for chronic nociceptive pain
(originally designed for cancer pain):

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

www.britishpainsociety.org/static/uploads/resources/files/patient_pub_otc.pdf
BPS booklet: Managing your pain effectively using over the counter (OTC) medicines (2010).

Paracetamol

- 1g tds, 4th dose only if appropriate
  (with very low renal clearance, paracetamol clearance also at risk).

+/- NSAID:

- Lowest effective dose for shortest period required.
- Renal and CV monitoring.
- Consider need for GI protection.
- Naproxen first choice.

If not enough, add **codeine** – 8, 15, 30mg
Provide preparation without paracetamol, rather than co-codamol.

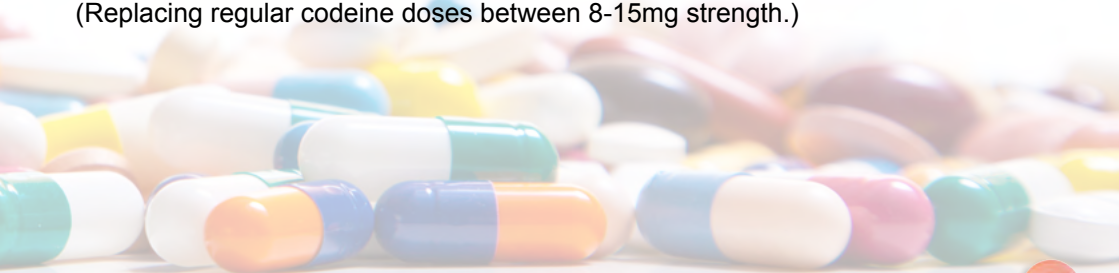
Consider:

- 10 per cent or more of Caucasian population do not metabolise codeine.
- 1-2 per cent ultra-rapid metabolisers (Ethiopian/Arabian) = toxic.

Alternatives to codeine could be very low dose slow release versions of other opioids.

- MST 5mg bd.
- Butrans patches 5ug/h once per week.

(Replacing regular codeine doses between 8-15mg strength.)



Controlled drugs

Tramadol

- Initiate 50-100mg, when needed, up to 3 or 4 times per 24h.
- Max dose 400mgs per 24hrs (+/- Paracetamol 1g 3-4x/day).
- Caution in elderly, epileptic patients and those on anti-depressants.

(Tramadol is dual-acting: also serotonergic/noradrenergic action)

If adequate pain control on regular dose,
consider SR/MR formulation 100-200mg bd

Note: Tramacet (paracetamol 325mg/tramadol 32.5mg) is an expensive combination with an inadequate paracetamol dose. Rather prescribe paracetamol x 2 plus tramadol 50mg x 1.

Morphine

- 12h release 5mg bd, up to 60 mg bd.
- Immediate release: Sevredol 10mg. Small supply, 1 when needed, only for breakthrough pain (instead of liquid morphine).

Further options (not first line):

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

Note: Tapentadol and Targinact are both for specialist recommendation only.

Be aware of Equi-analgesic value of opiods:

Codeine mg p.o: Morphine mg p.o = 10:1
Tramadol mg p.o: Morphine mg p.o = 5:1
Buprenorphine ug/h patch: Morphine mg p.o = 1:1.7
Oxycodone mg p.o: Morphine mg p.o = 1:2
Fentanyl ug/h patch: Morphine mg p.o = 1:3.5

When switches are calculated, initially **reduce** answer by 30 per cent for safety.

These figures are to give you an understanding of relative strength.
High dose opiate switches can be problematic and it would be acceptable to seek advice from a pain clinic.

EKHUFT conversion chart

Oral opioid/24 hours divide 24 hour dose by two for 12 hourly dose modified release six for four hourly dose immediate release			Transdermal opioid patch	
Morphine/ 24 hour mg	Oxycodone/ 24 hour mg	Tramadol/ 24 hour mg	Fentanyl 72 hour patch mcg/hour	Buprenorphine Butrans change every 7 days (B) Transtec change every 72 hours (T) mcg/hour
	Calculated by dividing oral morphine dose by 2	Calculated by multiplying oral morphine dose by 5		
20	10	100	–	10 B
40-45	20	200	12	20 B
60	30	300	–	–
80	40	400	–	–
90	45	X	25	35 T
100	50	X	–	–
120	60	X	–	–
140	70	X	37	52.5 T
180	90	X	50	70 T
200	100	X	–	–
230	115	X	62	70 + 35 T
270	135	X	75	70 + 52.5 T
300	150	X	–	–
360	180	X	100	140T

Long-term problems opiates

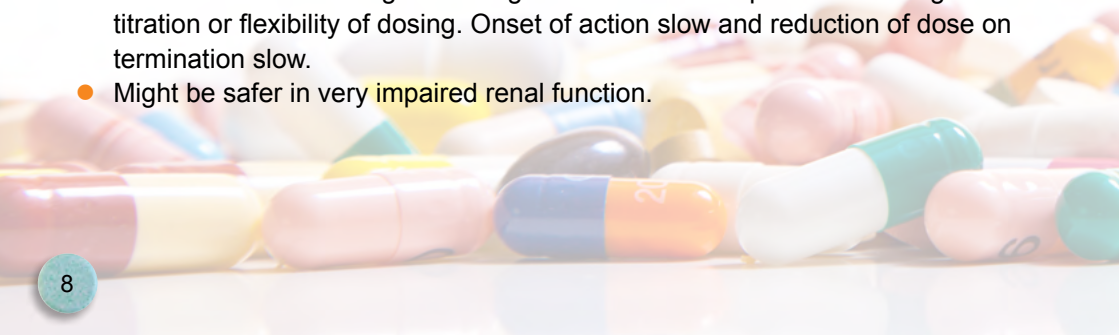
- Tolerance/addiction.
- Hyperalgesia.
- Reduced immunity.
- Reduced hormonal function including infertility and low cortisol.
- Increased risk of diabetes and osteoporosis.
- Increased risk of mortality.

Opiate safety

- Equi-analgesic total opioid load above morphine sulphate 120mg/24h not recommended in primary care.
- Increased function and reduction in pain needs to be demonstrated.
- Complete Opiate Risk Tool, if uncertain.
- Consider Treatment Agreement (opiate contract).
- Consider short prescriptions, for example weekly.
- Amount on script match instructions and time period.
- Single type of opiate rather than multiple combinations of opiates.
- Bulk of opiate load from long acting opiates.
- Ensure patient aware of difference between slow release and short acting opioids.
- Avoid liquids for breakthrough. If appropriate, small amounts only with correct measurements. Rather use immediate release tablets.
- Dementia: Controlled drugs are not dosset box packed. Check who will issue the meds or change patches.

When are opioid patches appropriate?

- Swallowing or absorption problems.
- Difficulty with compliance/concordance with oral opiates.
- Concerns re substance misuse.
- Opiate responsive pain and problems tolerating other opiates tried.
- Indicated for stable long term usage – not suitable for patients needing titration or flexibility of dosing. Onset of action slow and reduction of dose on termination slow.
- Might be safer in very impaired renal function.



Switching opiates

- when opiates are effective but tolerance or side-effects developing
- to enable dose reduction and eventual discontinuation, when treating hyperalgesia
- suspected codeine metabolising problems only indication for "non-response" switching.

Opiate related information:

BPS booklet: Opioids for persistent pain information for patients (2010).
www.britishpainsociety.org/static/uploads/resources/files/book_opioid_patient.pdf

BPS booklet: Opioids for persistent pain: Good Practice (information for clinicians) (2010) new version scheduled for publication March 2015.
www.britishpainsociety.org/static/uploads/resources/files/book_opioid_main.pdf

BPS booklets: Pain and problem drug use: information for patients (2007) (currently being updated).
www.britishpainsociety.org/static/uploads/resources/files/book_misuse_patients.pdf

Opiate Risk Tool (< 1minute scoring system to assess risk).
www.opioidrisk.com/node/887

See addendum:

Controlled Drug Contract East Kent
A guide for patients with chronic pain about managing constipation KCHFT

Neuropathic pain drugs

NICE recommends only amitriptyline, gabapentin, pregabalin, duloxetine.
NICE recommends single drug, rather than combining (primary care).

Low dose tricyclic antidepressant (TCA)

Note: that only amitriptyline in current NICE guidelines.

Amitriptyline or nortriptyline

- 10-75mg nocte.
- Titrate upwards over four to five weeks.
- Use as a trial for at least six to eight weeks.

Note: Nortriptyline might be better tolerated in the elderly but consider marked cost increase compared to amitriptyline.

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/dizziness.
- Dose: 60mg-120mg/day (if for bladder indications too, divide daily dose in two).

Note: In Diabetic Peripheral Neuropathic Pain (DPNP), only small percentage of patients show obvious response difference between average and higher dose.

Contra-indicated: uncontrolled Hpt/ abnormal liver function/ GFR< 30.
Non-UK licencing include 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.
Adapt dose for stages of renal impairment: see BNF.
Use as a trial for at least six to eight weeks.
Remember equal spacing (on waking, mid-afternoon, bedtime).

Or pregabalin:

25-75mg nocte for 3-7 days.
25-75mg BD for 3-7 days.
75-150mg BD for 3-7 days.

Standard dose 150 mg bd, Max dose 300 mg bd (twice daily prescribing, not tds).
Adapt dose for stages of renal impairment: see BNF.

If anticonvulsants ineffective, or limited efficacy, consider referral to pain clinic.
Do not withdraw abruptly.

Neuropathic pain – related information:

Faculty of Pain Medicine drug leaflets:

www.fpm.ac.uk/system/files/FPM-Amitriptyline_0.pdf
www.fpm.ac.uk/system/files/FPM-Nortriptyline_0.pdf
www.fpm.ac.uk/system/files/FPM-Duloxetine_0.pdf
www.rcoa.ac.uk/system/files/FPM-Pregablin_2.pdf
www.fpm.ac.uk/system/files/FPM-Gabapentin_0.pdf

BPS booklet: *Use of medicines outside of their UK marketing authorisation in pain management and palliative medicine – information for patients (2012).*
www.britishpainsociety.org/static/uploads/resources/files/book_useofmeds_patient.pdf

Information for patients on the NICE neuropathic pain pharmacological guideline:
www.nice.org.uk/guidance/cg173/resources/information-for-the-public-drug-treatments-for-neuropathic-pain-pdf

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 capsiacin cream 0.025 per cent.
- Post-herpetic neuralgia or discrete focal areas of cutaneous neuropathy: Capsaicin cream 0.075 per cent.

Note: Versatis patches (five per cent lidocaine) could also be used for PHN, but specialist recommendation only and not for non-NPP use).

Monitoring (the four A's)**:**

- **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 patient taking medication as agreed in the management plan?

Do

- 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 prescribing screen.
- Make only one change at a time in order to assess whether the medication is working.
- Explain to patients 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 (OIC) adequately.
- Be aware of abuse potential tramadol IR, gabapentin and pregabalin, not just opiates.

Do not prescribe

- Benzodiazepines
- co-proxamol
- short-acting dihydrocodeine
- Tramacet
- pethidine/diconal/meptazinol/pentazocine
- home injectables
- novel breakthrough preparations, for example lollipops, sprays, etc.

Non-pharmacological considerations

- Physiotherapy/spinal rehabilitation classes.
- Exercise on Prescription.
- Expert Patient Programme.
- Involving Health Trainers.
- TENS machine.
- Weight Management Service.
- Could an intervention (for instance a nerve block) be appropriate?

Patient information booklets

Chronic pain – a self-help guide.
www.moodjuice.scot.nhs.uk/chronicpain.asp

The Pain Self Care Toolkit booklet.
www.paintoolkit.org

BPS booklet: Understanding and Managing Pain (2010).
https://www.britishpainsociety.org/static/uploads/resources/files/book_understanding_pain.pdf

References:

BPS. Opioids for persistent pain: Good practice.
The British Pain Society, January 2010.

Compass Therapeutic Notes on the Use of Strong Opioids in non-cancer pain.
January 2011.
www.hscbusiness.hscni.net/pdf/Strong_Opioids_in_Chronic_Non-cancer_Pain.pdf

NICE. The pharmacological management of neuropathic pain in adults in non-specialist settings CG173. November 2013.
www.nice.org.uk/guidance/cg173

NICE. Osteoarthritis .Care and management in adults. CG 177. February 2014.
www.nice.org.uk/guidance/cg177

Problematic pain – redefining how we view pain?
C. Barker, A Taylor and M Johnson. British Journal of Pain 2014, Vol 8(1) 9-15

SIGN Guideline 136: Management of Chronic Pain.
www.sign.ac.uk/guidelines/fulltext/136/annexes.html

Also see these documents:

Controlled Drug Contract East Kent.
Constipation Management in Adults with Chronic Pain.

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.

By Dr Tim Williams. www.paintoolkit.org

Notes

Contact

Pain services in East Kent consist of a comprehensive multidisciplinary service within primary care and an interventional service within secondary care to support patients to develop self management strategies, enhance their quality of life and reduce dependency on healthcare services. There is a Single Point of Access based at St. Augustine's Business Centre, where all letters are triaged by senior clinicians on a daily basis.

Chronic Pain Referral Point (East Kent)
St Augustine's Business Centre
125 Canterbury Road
Westgate-on-Sea
Kent CT8 8NL

Email: kcht.chronicpainreferralpoint@nhs.net
Phone: 0300 1232105 or 0300 1232531
Fax: 08712 214988

Referrals can be made via Choose and Book (indirectly bookable) to Chronic Pain Referral Point (East Kent).