NHS
Gateshead Network
Commissioning Consortium

Gateshead Health NHS
NHS Foundation Trust

Gateshead Pain Guidelines for Chronic Conditions

Effective Date:	**13.2.2013**
Review Date:	**13.2.2015**

Gateshead Pain Guidelines: Contents

GATESHEAD PRESCRIBING AND MEDICINES MANAGEMENT COMMITTEE

GATESHEAD PAIN GUIDELINES

Publication Date: 13.2.2013 (replaces March 2009 & Sept 2010 Guidelines)
Review Date: 13.2.2015

1. Development

This guideline was developed by the joint consensus of the Gateshead Prescribing and Medicines Management Committee and the Gateshead Health NHS Foundation Trust Drug & Therapeutics Committee.

The sub-group that developed this guideline were as follows;
Mr G Mankin (Medicines Governance Pharmacist), Dr J Hamilton(Consultant Rheumatologist), Dr A Hughes (Consultant in Palliative Care), Dr. F. McAuley (Consultant Anaesthetist), Dr J Anto (Consultant Anaesthetist), Dr Ola Olukoga (Consultant Anaesthetist), Dr A Pelham (Consultant in Palliative Care), Dr M Sherratt (GP), Mrs M Ridley (Pain Nurse Specialist) and Mrs J Stephenson (Lead for Medicines Management).

The key PCT contact for information is Mrs J Stephenson, Lead for Medicines Management Tel 0191 5297050.

The key contact for GHFT for information is Mr Gavin Mankin, Medicines Governance Pharmacist Tel. 0191 445 2818

2. Background

Pain, although a therapeutic challenge for most medical specialties, is often not optimally managed with the analgesics available. Analgesics are frequently used at sub-therapeutic doses, in inappropriate dosage regimens or ineffectively combined with other agents. These guidelines have been developed to help healthcare professionals with the decision-making progress of analgesic selection and titration. Many patients are inappropriately referred to secondary care pain clinics before optimizing the use of simple analgesics in the treatment of their condition.

3. Aim

To promote the rationale use of analgesics, and associated adjuvant treatment, across both primary and secondary care so that pain is optimally managed in a patient.

To ensure that the referral criteria for secondary care pain clinics is fully understood, and adhered to, prior to a patient's referral from primary care.

4. Implications

Implementation of the attached guidance will improve the safe and effective use of analgesics, and associated adjuvants in Gateshead, thus improving the management of patients with pain. There will be an improvement in the management of these patients in primary care resulting in less referrals to secondary care.

This guidance incorporates local interpretation of NICE Clinical Guideline 96: Neuropathic Pain; March 2010.

5. Implementation & Audit

Copies of the guidelines will be widely circulated across Gateshead. It is intended that various components of these guidelines will be audited over the next 6 months.

6. References

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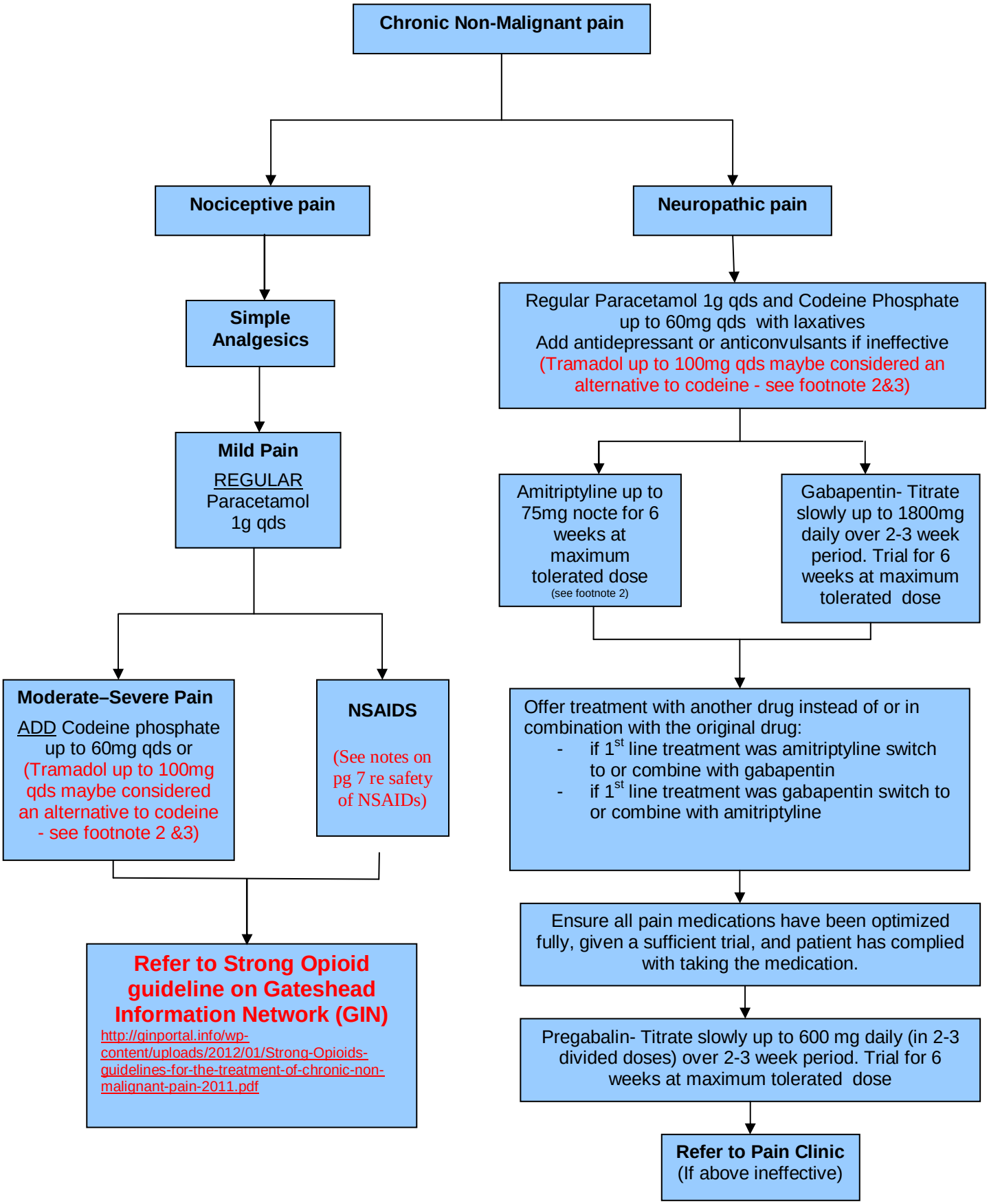
Gateshead Pain Guidelines: Chronic Non-Malignant Pain Guidelines



Gateshead Pain Guidelines: Chronic Non-Malignant Pain Guidelines

Notes:

1. Provided all other pain medications have been optimized, given a sufficient trial, and there are no red or yellow flags, or complex co-morbidities then a trial of pregabalin in primary care may be an option before referral to secondary care.

2. Convulsions have been reported with tramadol at therapeutic doses and the risk may be increased at doses exceeding the usual upper daily dose limit. Patients with a history of epilepsy or those susceptible to seizures should only be treated with tramadol if there are compelling reasons. The risk of convulsions may increase in patients taking tramadol and concomitant medication that can lower the seizure threshold e.g. serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs).

3. Only use Tramadol if constipation severe with codeine despite regular laxatives – tramadol has no clear evidence of benefits over codeine.

4. Codeine 15mg tablets are available on the formulary if required

5. Nefopam may be considered as an alternative in those unable to tolerate codeine and/or tramadol.

6. At all stages in the treatment pathway ensure patient has received adequate education, has been complying with existing medication, and current analgesic medication has been maximised prior to moving to next step.

7. Ensure type of pain has been correctly diagnosed if no response to 1st line analgesics.

8. It may take 4-6 weeks for amitriptyline, gabapentin or pregabalin to have an effect.

9. As amitriptyline can cause drowsiness in some patients, it is recommended that amitriptyline is taken 2-3 hours before going to bed.

10. Take each dose of Gabapentin with plenty of water. Maintaining an adequate fluid balance with Gabapentin will help to reduce possible side-effects.

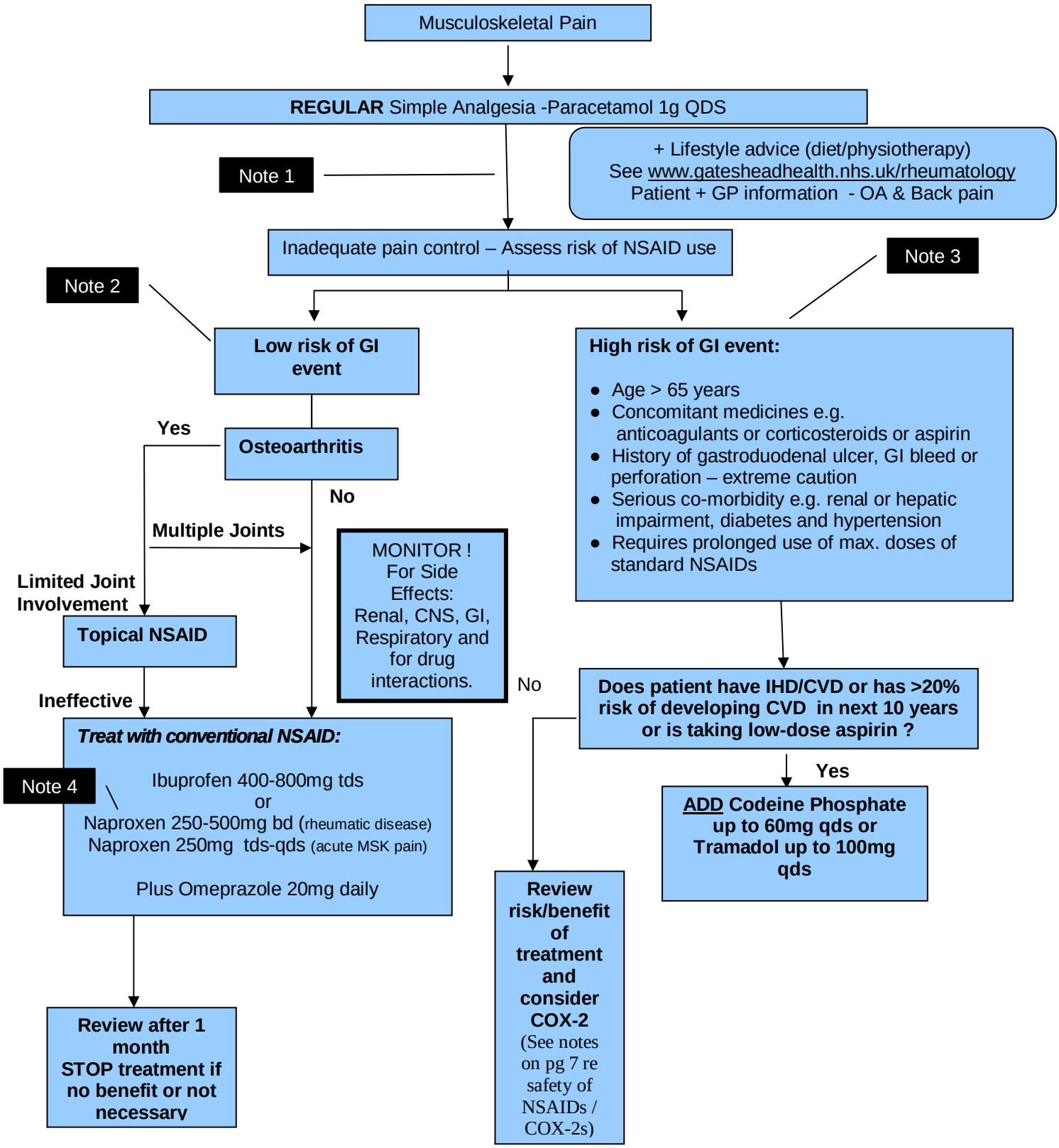
11. Avoid taking antacids within 2 hours of taking Gabapentin.

12. Gabapentin dosing should be titrated in 100mg (daily) increments, rather than 300mg daily, in those patients that are sensitive to sedative side effects and in the elderly.

13. Gabapentin tablets are substantially more expensive than the capsules. When prescribing use the most cost effective strength and formulation.

14. All strengths of pregabalin capsules are the same cost, therefore ensure the correct strength of capsule is prescribed ie 300mg rather than 2 x 150mg**.**

Gateshead Pain Guidelines: Musculoskeletal Pain



Gateshead Pain Guidelines: Musculoskeletal Pain

NOTES

1. Check patient compliance with regular analgesia at full dosage prior to considering a NSAID.

2. NSAIDs are associated with a broad spectrum of adverse events, particularly affecting the GI tract, kidney and platelet function, therefore always ensure:
   (a) There is definite need to use a NSAID.
   (b) The lowest possible dose of the least toxic NSAID is prescribed.
   (c) A patients need for a NSAID is constantly reviewed.
   (d) NSAIDs should be used in caution in patients with GI and/or cardiovascular risk factors
   (e) Be aware of potentially hazardous drug interactions with NSAIDs e.g. risk of increased bleeding if co-prescribed with an SSRI, increased risk of lithium toxicity if co-prescribed with lithium

3. Major risk factors for GI toxicity:
   Age > 65yrs, history of peptic ulcer, history of GI bleed, history of heart disease
   Baseline risk 0.8%, Single factor 2%, Three factors 10%, Four factors 18%

4. Modified-release preparations are generally not recommended; use only if compliance is identified as an issue.

5. Current evidence suggests that selective COX-2 inhibitors, as a class, may cause an increased risk of cardiovascular reactions (e.g.myocardial infarction and stroke) compared with placebo and some NSAIDs, and the risk may increase with dose and duration of exposure. Please note the following contraindications and precautions for COX-2 inhibitors:

   - COX-2 inhibitors are contraindicated in patients with established ischaemic heart disease, cerebrovascular disease or peripheral arterial disease.
   - Caution must be exercised when prescribing COX-2 inhibitors to patients with risk factors for heart disease, such as hypertension, hyperlipidaemia, diabetes and smoking.
   - The lowest effective dose of COX-2 inhibitor should be used for the shortest necessary period. Periodic re-evaluation is recommended, especially for osteoarthritis patients who may only require intermittent treatment.
   - COX-2 inhibitors can cause hypersensitivity reactions and rare, but serious and sometimes fatal, skin reactions. In the majority of cases these occur in the first month of use, and prescribers are warned that patients with a history of drug allergies may be at greater risk.
   - Do not use Etoricoxib 60mg
   - Etoricoxib treatment should not be initiated in patients whose hypertension is not under control.
   - Careful monitoring of blood pressure is advised for patients taking etorcoxib.

   When used in accordance with these additional contraindications and precautions, the balance of benefits and risks remain positive for COX-2 inhibitors when used in their target patient populations.

6. Topical NSAIDs – there is a considerable cost variation in the price of branded products within this group in primary care. At present non-proprietary preparations of ibuprofen gel 5% and 10% gel or piroxicam gel 0.5% are the products of choice.

Gateshead Pain Guidelines: Referral to the Chronic Pain Clinic

The guidelines for referral are as follows:

- Patients must be formally referred to the clinic ***(current pain service specification currently under review Jan 2013).***

The following patients will be seen in pain clinic:

1. Patients with chronic back pain of at least 6 months duration where the pain has been thoroughly investigated by the GP or Physiotherapist:

   a. Neurological and other pathological reason for back pain should be investigated or assessed by the appropriate specialists prior to referral.

   b. Patients with inflammatory disease and Osteoporotic crush fractures should be referred to the Rheumatologists.

   c. If an X-ray or MRI scan is performed prior to referral, a copy of the results should accompany the referral letter.

   d. Simple analgesics should have been prescribed and optimised.

2. Chronic back pain that persists after spinal surgery i.e. the failed back syndrome where there has been an adequate trial of antidepressant and or anticonvulsants and analgesia as outlined.

3. Patients with reflex sympathetic dystrophy or complex regional pain syndrome (CRPS) type 1 or type 2, should be referred as soon as the diagnosis is made or suspected. If the pain has been present in the limb for more than 6 months, an adequate trial of adjuvant antidepressant such as amitriptyline up to 75mg daily for at least 6 weeks after titration up to the maximum dose or an adjuvant anticonvulsant such as gabapentin 1800mg for up to 8 weeks after titration up to the maximum dose should be prescribed before referral.

4. Peripheral neuropathy that has failed to respond to 6 weeks at the maximum dose of amitriptyline (up to 75mg daily), gabapentin (up to 1800mg daily), or pregabalin (up to 600mg daily) (see page 5).

5. Post herpetic neuralgia patients who fail to respond to antidepressants or anticonvulsants as outlined above.

6. Pain of unknown origin greater than 6 months duration which has been extensively investigated as indicated.

7. Patients with a known diagnosis of trigeminal neuralgia should be referred directly to the Neurosurgeons at the Newcastle General Hospital.

Gateshead Pain Guidelines: Referral to the Chronic Pain Clinic

The Service

The Chronic Pain Service will run a Consultation Service for these patients.

Review Appointments

- When seen in clinic, a treatment plan will be drawn up and a list of recommended medication will be sent in a letter to the GP within a fortnight following the consultation.
- A review appointment will only be made where patients need to have interventional procedures or where review by a member of the Chronic Pain team is deemed necessary.

Patient Report

- There would be further support available through a system that allows patients who have been seen or reviewed in clinic to ring the Chronic Pain Nurse Practitioner or the Chronic Pain Secretary to report on the progress of their treatments, after an adequate trial of agreed treatment or recommended medication.
- Where it is deemed necessary to see such patients again, a review appointment will be made and sent in the post to the patient.

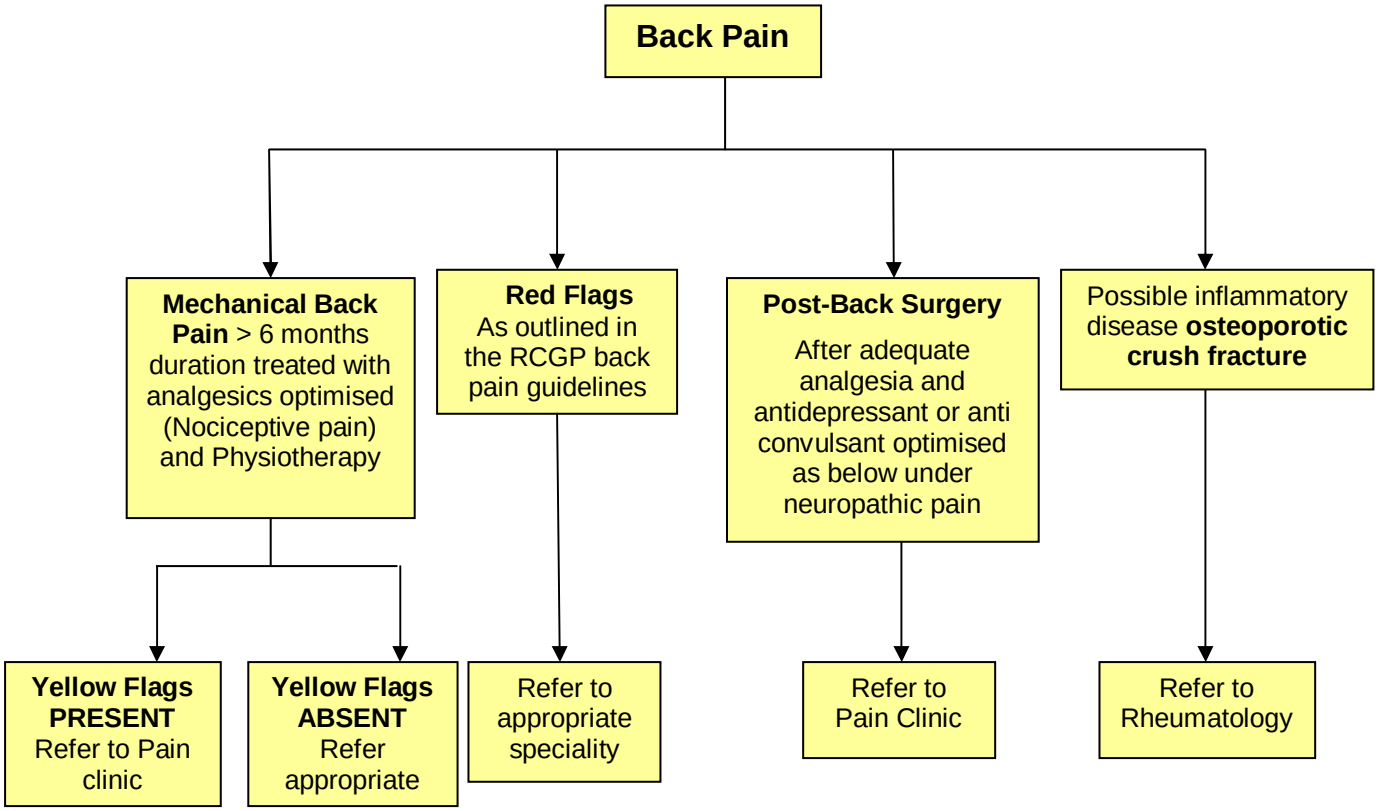
Unlicensed Drugs

- The GP might be advised to prescribe drugs, which are currently not licensed for use in chronic pain.
- Due to the nature of the chronic pain condition, a lot of the drugs used are unlicensed for the treatment of chronic pain in itself.
- Reference is made to the Pain Society publication “The use of drugs beyond licence” where this well-established issue is addressed.
- Further guidance and instructions will be given to the GP by the prescribing consultant where such prescriptions are necessary.
- Prescribers should be aware of the recent GMC Good practice in prescribing and managing medicines and devices publication and the specific requirements to follow when prescribing unlicensed medicines. The document can be accessed via: http://www.gmc-uk.org/Prescribing_Guidance__2013__50955425.pdf

Use of opioids in chronic pain patients

- Refer to the Gateshead Strong Opioid Guidance http://ginportal.info/wp-content/uploads/2012/01/Strong-Opioids-guidelines-for-the-treatment-of-chronic-non-malignant-pain-2011.pdf

Gateshead Pain Guidelines: Chronic Back Pain Referral Guidelines



Back Pain Red Flags

- Presentation under age of 20 or onset over 55
- Non Mechanical pain
- Thoracic pain
- Past history of carcinoma, steroids, HIV
- Unwell, weight loss
- Widespread neurological loss or deficit
- Structural deformity

Back Pain Psychosocial Yellow Flags

These refer to beliefs or behaviour which may predict poor outcomes

- A belief that back pain is harmful or potentially severely disabling
- Fear avoidance behaviour and reduced activity levels
- Tendency to low mood and withdrawal from social interaction
- Expectation of passive treatments rather than a belief that active participation will help

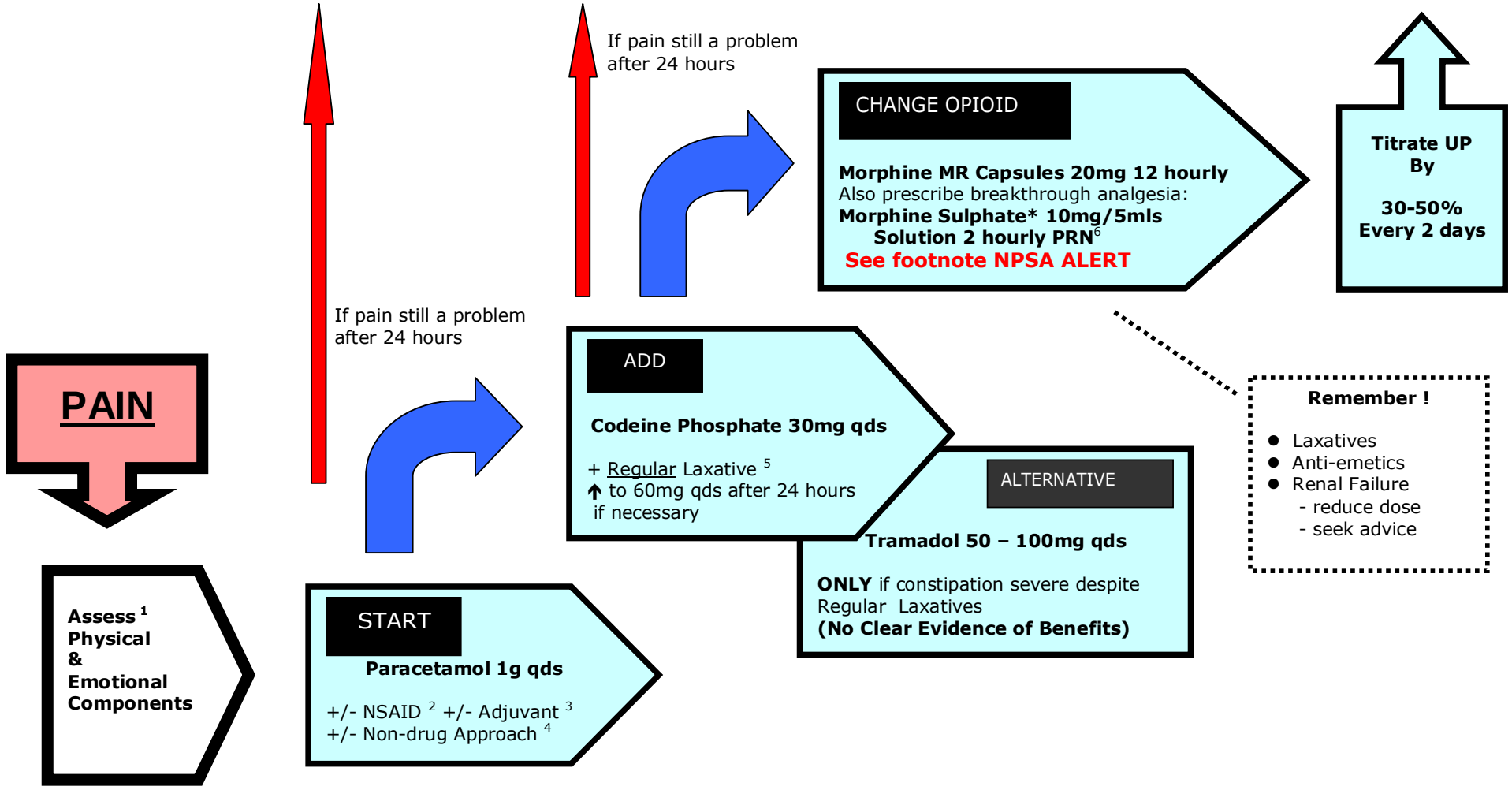
Suggested questions which can be phrased in your own style (as used by the musculoskeletal physiotherapists working on the advice line)

- Have you ever been off work before with back pain?
- I know you are not a doctor but what do you think is the cause of your back pain?
- What sort of things do you expect will help?
- How is your employer responding to your back pain? And the people that work with you?
- How does your family react to your back pain?
- What sort of things are you doing to help yourself cope with your back pain?

Gateshead Pain Guidelines: Chronic Malignant Pain Guidelines: Part A

STARTING TREATMENT

IF SEVERE PAIN: May need parenteral morphine for acute management e.g. morphine 5mg – 7.5 mg subcutaneous injection. Review after 20 minutes and repeat if required.
SEEK ADVICE – Palliative Care Team / Medicines Information

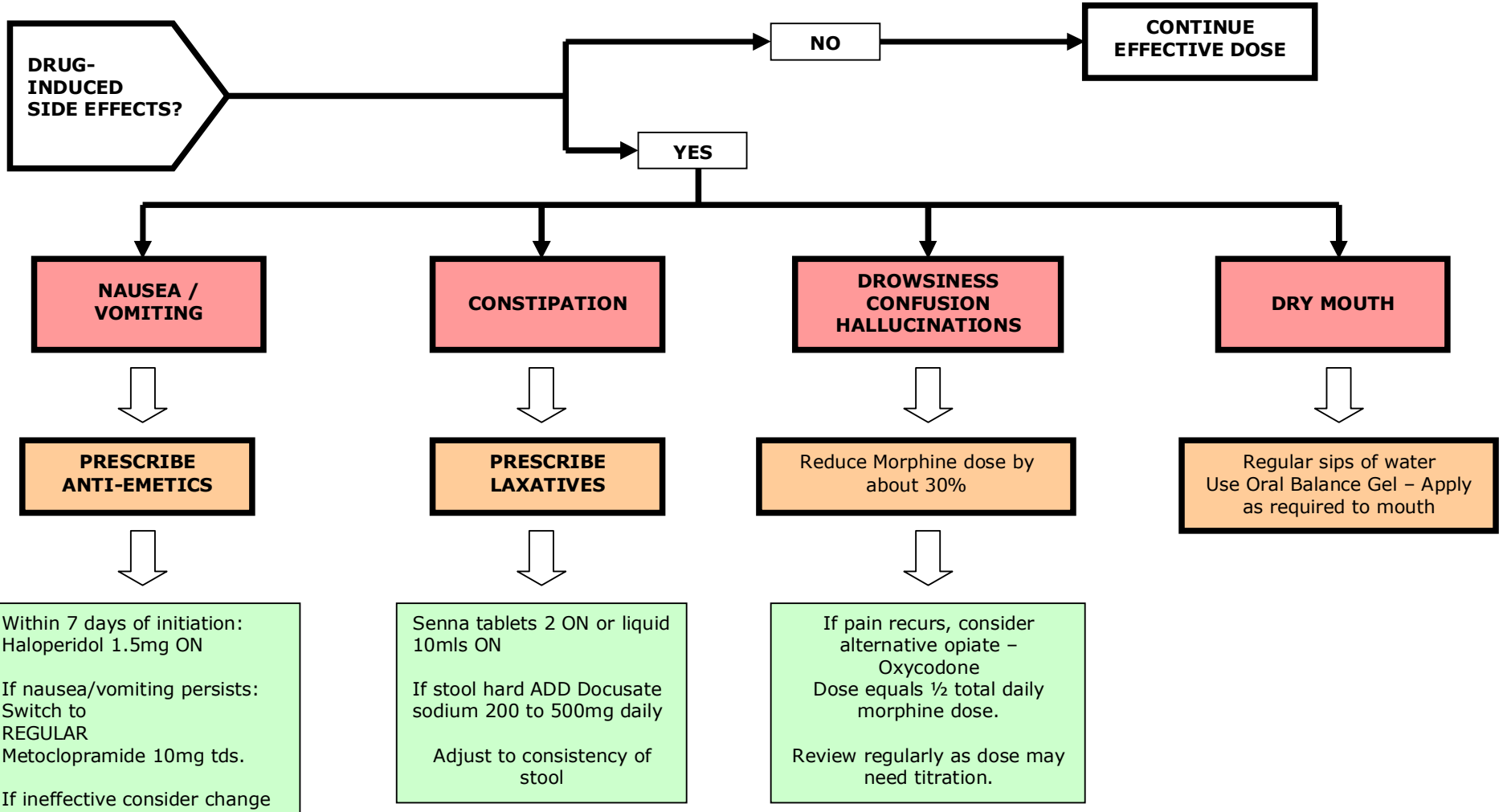


Footnotes:
1. Where possible identify type & cause of pain. Treat reversible causes e.g. constipation
2. NSAID 1st line: Ibuprofen 400mg tds, 2nd line: Naproxen 250mg – 500mg bd. Remember GI / Renal Effects
3. For example: Heat packs, TENS, Radiotherapy
4. Senna 1 or 2 at night, titrating to response. If stool remains hard add docusate 200mg daily.
5. Breakthrough dose of the opioid should be titrated to 1/6th of the total daily dose of regular opioid

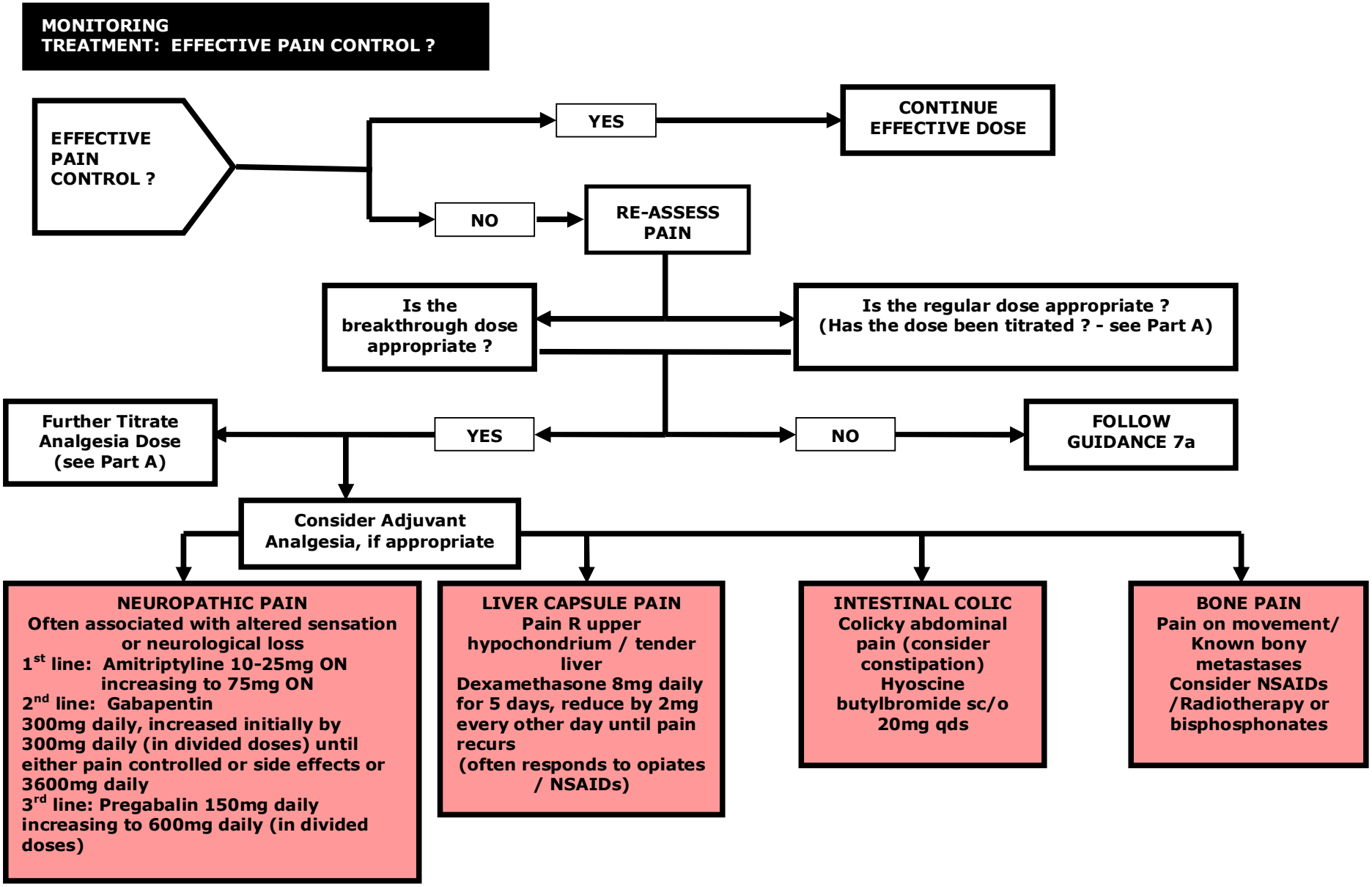
NPSA Rapid Response Report
Before prescribing strong opioid medicines e.g. fentanyl, morphine, oxycodone:

- **Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. This may be done for example through discussion with the patient or their representation (although not in the case of treatment of addiction), the prescriber or through medication records.**
- **Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose).**
- **Ensure they are familiar with the following characteristics of that medicine and formulation:usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, common side effects.**

MONITORING TREATMENT: DRUG-INDUCED SIDE EFFECTS?



For further help, please contact:
Medicines Information, Pharmacy Department ext. 2818 or the Palliative Care Team ext. 6442


MONITORING
TREATMENT: EFFECTIVE PAIN CONTROL ?
EFFECTIVE PAIN CONTROL ?
YES
CONTINUE EFFECTIVE DOSE
NO
RE-ASSESS PAIN
Is the breakthrough dose appropriate ?
Is the regular dose appropriate ? (Has the dose been titrated ? - see Part A)
Further Titrate Analgesia Dose (see Part A)
YES
NO
FOLLOW GUIDANCE 7a
Consider Adjuvant Analgesia, if appropriate
NEUROPATHIC PAIN
Often associated with altered sensation or neurological loss
1st line: Amitriptyline 10-25mg ON increasing to 75mg ON
2nd line: Gabapentin
300mg daily, increased initially by 300mg daily (in divided doses) until either pain controlled or side effects or 3600mg daily
3rd line: Pregabalin 150mg daily increasing to 600mg daily (in divided doses)
LIVER CAPSULE PAIN
Pain R upper hypochondrium / tender liver
Dexamethasone 8mg daily for 5 days, reduce by 2mg every other day until pain recurs
(often responds to opiates / NSAIDs)
INTESTINAL COLIC
Colicky abdominal pain (consider constipation)
Hyoscine butylbromide sc/o 20mg qds
BONE PAIN
Pain on movement/ Known bony metastases
Consider NSAIDs /Radiotherapy or bisphosphonates