NHS
County Durham and Darlington
Area Prescribing Committee

Initial Prescribing Protocol:

Oral Analgesia in Adults with Non-Cancer Pain

- Mild to Moderate Pain
- NSAIDs – Co -morbidities, Cautions and Contra indications
- Neuropathic Pain (excluding Trigeminal Neuralgia)
- Trigeminal Neuralgia

Approved: May 2015 (Updated July 2015)

Review Date: Feb 2017 (unless new evidence becomes available)

Mild to Moderate Pain

Step 1

PRN or regular Paracetamol 1g every 4-6 hours. Maximum 4g in 24 hours. This is a suitable first-line choice for most people with mild-to-moderate pain.

Generally increase to the maximum dose of 1 gram four times a day, before switching to (or combining with) another analgesic.

Step 2

If appropriate substitute the paracetamol with low-dose ibuprofen (200 - 400 mg three times a day). If the person is unable to take a nonsteroidal anti-inflammatory drug (NSAID), use a full therapeutic dose of a weak opioid (such as codeine* 60 mg every 4–6 hours)

Step 3

Add paracetamol (1 gram four times a day) to low-dose ibuprofen (200 - 400 mg three times a day; if necessary, increase the dose of ibuprofen to a maximum of 2.4 grams daily in divided doses).

If the person is unable to tolerate an NSAID, add paracetamol to a weak opioid.

Step 4

Continue with paracetamol 1 gram four times a day. Replace the ibuprofen with an alternative NSAID (such as naproxen 250 mg to 500 mg twice a day).

Step 5

Start a full therapeutic dose of a weak opioid (such as codeine* 60 mg up to four times a day; maximum 240 mg daily) in addition to full-dose paracetamol (1 gram four times a day) and/or an NSAID.

*please note: codeine is a prodrug which need to be metabolised to morphine before it exerts its analgesic effect. Up to 40% of adults have reduced enzyme activity and are unable to metabolise codeine to morphine, therefore codeine may be ineffective in these patients.

For reference codeine 30mg , and dihydrocodeine 30mg, both have a potency which is approximately equivalent to 3mg of oral morphine

NSAIDs – co-morbidities, cautions and contra-indications (taken from online BNF)

http://www.evidence.nhs.uk/formulary/bnf/current/10-musculoskeletal-and-joint-diseases/101-drugs-used-in-rheumatic-diseases-and-gout/1011-non-steroidal-anti-inflammatory-drugs)

(Note – this is an abbreviated list and in all cases the BNF and SPC should be consulted about specific issues relating to specific drugs)

Topical NSAIDs should be used preferentially to oral NSAIDs in patients with hand or knee osteoarthritis e.g. Ibuprofen gel THREE times a day.

Oral 1st line NSAID: ***Ibuprofen 200-400mg THREE to FOUR times a day; if tolerated, and if required this may be increased to a maximum of 2.4g daily. A maintenance dose of 0.6g – 1.2g daily may be adequate.***

Oral 2nd line NSAID: ***Naproxen 250-500mg TWICE a day.***

Use the lowest possible NSAID dose for the shortest period necessary to control symptoms. The balance of cardiovascular and gastro-intestinal risk should be considered before prescribing NSAIDs, particularly in high risk patients.

NSAIDS and gastro-intestinal events

All NSAIDS are associated with serious gastro-intestinal toxicity; the risk is higher in the elderly. Evidence on the relative safety of non-selective NSAIDs indicates differences in the risks of serious upper gastrointestinal side effects – piroxicam, ketoprofen and ketorolac are associated with the highest risk; indomethacin, diclofenac and naproxen are associated with intermediate risk; and ibuprofen with the lowest risk (although high doses of ibuprofen have been associated with intermediate risk). Selective inhibitors of cyclo-oxygenase -2 are associated with intermediate risk of serious upper gastro-intestinal side effects.

Recommendations are that NSAIDS associated with a low risk e.g ibuprofen, are generally preferred to start at the lowest recommended dose and do not use more than one oral NSAID at a time.

The combination of a NSAID and low dose aspirin can increase the risk of gastro-intestinal side-effects; this combination should only be used if absolutely necessary and the patient should be monitored closely.

All NSAIDs (including cyclo-oxygenase-2 selective inhibitors) are contra-indicated in patients with active gastro-intestinal ulceration or bleeding. Piroxicam, ketoprofen, and ketorolac are contra-indicated in patients with any history of gastro-intestinal bleeding, ulceration, or perforation. Other non-selective NSAIDs are contra-indicated in patients with a history of recurrent gastro-intestinal ulceration or haemorrhage (two or more distinct episodes), and in patients with a history of gastro-intestinal bleeding or perforation related to previous NSAID therapy . While it is preferable to avoid NSAIDs in patients with active or previous gastro-intestinal ulceration or bleeding, and to withdraw them if gastro-intestinal lesions develop, nevertheless patients with serious rheumatic diseases (e.g. rheumatoid arthritis) are usually dependent on NSAIDs for effective relief of pain and stiffness. Patients at risk of gastro-intestinal ulceration (including the elderly), who need NSAID treatment should receive gastroprotective treatment; for advice on

the prophylaxis and treatment of NSAID-associated gastro-intestinal ulcers, see section 1.3 of the BNF. NSAIDs should also be used with caution in Crohn's disease or ulcerative colitis, as these conditions may be exacerbated.

Note - GI side effects are due to local irritation and systemic absorption delivering NSAIDs to the gut. If patient is at high risk of GI side effects (including all over 65s) consider GI protection with a PPI (e.g. omeprazole capsules or lansoprazole capsules or tablets)

NSAIDs and cardiovascular events

All NSAID use (including cyclo-oxygenase-2 selective inhibitors) can, to varying degrees, be associated with a small increased risk of thrombotic events (e.g. myocardial infarction and stroke) independent of baseline cardiovascular risk factors or duration of NSAID use; however, the greatest risk may be in those receiving high doses long term.

Cyclo-oxygenase-2 selective inhibitors, diclofenac (150 mg daily) and ibuprofen (2.4 g daily) are associated with an increased risk of thrombotic events. The increased risk for diclofenac is similar to that of licensed doses of etoricoxib. Naproxen (1 g daily) is associated with a lower thrombotic risk, and low doses of ibuprofen (1.2 g daily or less) have not been associated with an increased risk of myocardial infarction.

The lowest effective dose of NSAID should be prescribed for the shortest period of time to control symptoms and the need for long-term treatment should be reviewed periodically.

Elderly

Caution required as increased risk of serious side effects and fatalities.

Cardiac failure, left ventricular dysfunction, hypertension, oedema and other cardiac risk factors

In patients with cardiac impairment, caution is required since NSAIDs may impair renal function (see Side-effects in BNF). All NSAIDs are contra-indicated in moderate to severe heart failure. Diclofenac and the selective inhibitors of cyclo-oxygenase-2 (celecoxib, etoricoxib, and parecoxib) are contra-indicated in ischaemic heart disease, cerebrovascular disease, peripheral arterial disease, and mild to severe heart failure. They should be used with caution in patients with a history of cardiac failure, left ventricular dysfunction, hypertension, in patients with oedema for any other reason, and in patients with other risk factors for cardiovascular events. Other non-selective NSAIDs should be used with caution in uncontrolled hypertension, heart failure, ischaemic heart disease, peripheral arterial disease, cerebrovascular disease, and when used long term in patients with risk factors for cardiovascular events.

All NSAIDs can increase blood pressure; special attention should be paid to blood pressure monitoring during treatment with etoricoxib. If blood pressure rises significantly, alternative treatment should be considered.

Asthma

Any degree of worsening of asthma may be related to the ingestion of NSAIDs, either prescribed or (in the case of ibuprofen and others) purchased over the counter.

Hepatic impairment

NSAIDs should be used with caution in patients with hepatic impairment; there is an increased risk of gastro-intestinal bleeding and fluid retention. NSAIDs should be avoided in severe liver disease; regular monitoring is recommended.

Renal impairment

NSAIDs should be avoided if possible or used with caution in patients with renal impairment; the lowest effective dose should be used for the shortest possible duration, and renal function should be monitored. Sodium and water retention may occur and renal function may deteriorate, possibly leading to renal failure; deterioration in renal function has also been reported after topical use.

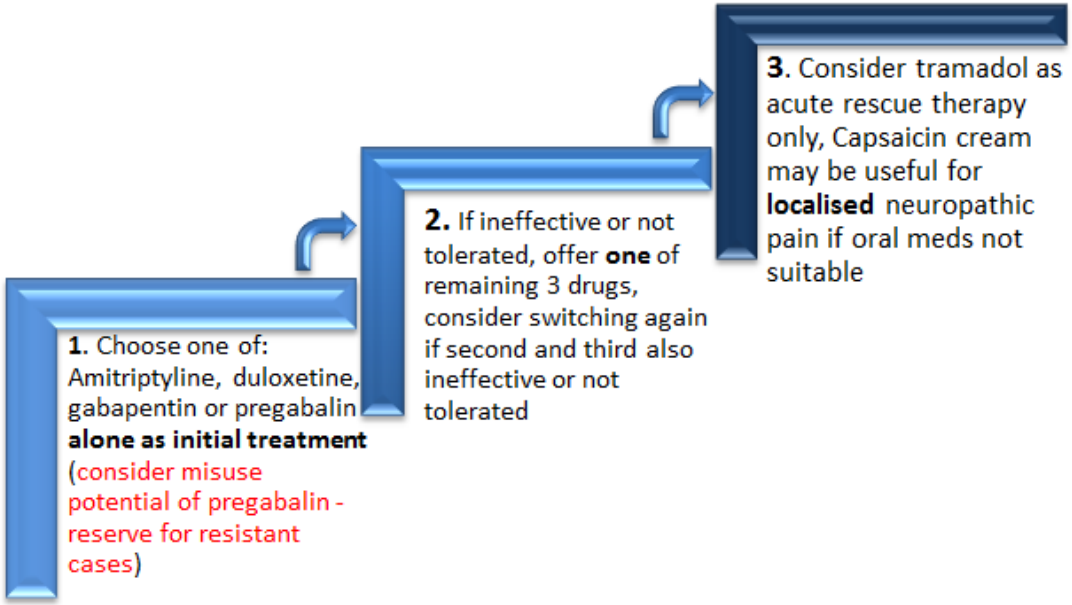
Pregnancy

It is advised to avoid the use of NSAIDs during pregnancy.

Breast-feeding

NSAIDs should be used with caution during breast-feeding

Pharmacological treatment for neuropathic pain – Guidance for prescribers



Key principles of care

- Dosage titration – it may take weeks to reach an effective dose – discuss this with patient
- When introducing a new treatment, take into account any overlap with old treatments, also aim to avoid deterioration in pain control at this stage
- Review new treatments to assess suitability for titration
- For people awaiting referral after initial treatments have failed, consider prescribing a short course of tramadol for pain relief. Prescribe tramadol cautiously, bearing in mind the potential for misuse

Pharmacological treatment for trigeminal neuralgia

Offer carbamazepine as initial treatment for trigeminal neuralgia. If initial treatment with carbamazepine is not effective, is not tolerated or is contraindicated, consider seeking expert advice from a specialist and consider early referral to a specialist pain service or a condition-specific service.

Neuropathic Pain (Taken from NICE CG173)

http://www.nice.org.uk/guidance/cg173/chapter/1-recommendations

All neuropathic pain (except trigeminal neuralgia – see page 9)

Step 1

Offer a choice of one of the following as initial treatment for neuropathic pain (except trigeminal neuralgia)

Amitriptyline: (unlicenced indication) initially 10mg daily at night, gradually increased if necessary to 75mg daily (higher doses only under specialist supervision)

Or

Gabapentin*: Adult over 18 years, 300mg once daily on day 1, then 300mg twice daily on day 2, then 300mg 3 times daily on day 3, *or* initially 300mg 3 times daily on day 1 then increased according to response in steps of 300mg (in 3 divided doses) every 2-3 days up to max. 3.6g daily

Or

Pregabalin*: Adult over 18 years, initially 150mg daily in 2-3 divided doses, increased if necessary after 3-7 days to 300mg daily in 2-3 divided doses, increased further if necessary after 7 days to max 600mg daily in 2-3 divided doses. *(Note – The Lyrica ® brand of Pregabalin , made by Pfizer, holds an exclusive patent for peripheral and central neuropathic pain and should therefore be prescribed by Brand for these conditions - see http://www.england.nhs.uk/wp-content/uploads/2015/03/pregabalin-guidance.pdf for NHS England guidance)*

Or

Duloxetine: Diabetic Neuropathy : Adult over 18 years, 60mg once daily; max 120mg daily in divided doses (Note: In diabetic neuropathy , discontinue if inadequate response after 2 months; review treatment at least every 3 months)

Step 2

If the initial treatment is not effective or is not tolerated, offer one of the remaining three drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.

Consider tramadol only if acute rescue therapy is needed (short term use). This is a schedule 3 controlled drug.

Consider capsaicin cream[4] 0.075% for people with localised neuropathic pain who wish to avoid, or

* Prescribers are reminded of the abuse potential of Gabapentin and Pregabalin and should be alert to patients asking for these drugs by name.

1.1.1 When agreeing a treatment plan with the person, take into account their concerns and expectations, and discuss:

- the severity of the pain, and its impact on lifestyle, daily activities (including sleep disturbance) and participation[1]
- the underlying cause of the pain and whether this condition has deteriorated
- why a particular pharmacological treatment is being offered
- the benefits and possible adverse effects of pharmacological treatments, taking into account any physical or psychological problems, and concurrent medications
- the importance of dosage titration and the titration process, providing the person with individualised information and advice
- coping strategies for pain and for possible adverse effects of treatment
- non-pharmacological treatments, for example, physical and psychological therapies (which may be offered through a rehabilitation service) and surgery (which may be offered through specialist services).

  For more information about involving people in decisions and supporting adherence, see Medicines adherence (NICE clinical guideline 76).

1.1.2 Consider referring the person to a specialist pain service and/or a condition-specific service[2] at any stage, including at initial presentation and at the regular clinical reviews (see recommendation 1.1.6), if:

- they have severe pain **or**
- their pain significantly limits their lifestyle, daily activities (including sleep disturbance) and participation[1] **or**
- their underlying health condition has deteriorated.

1.1.3 Continue existing treatments for people whose neuropathic pain is already effectively managed, taking into account the need for regular clinical reviews (see recommendation 1.1.6).

1.1.4 When introducing a new treatment, take into account any overlap with the old treatments to avoid deterioration in pain control.

1.1.5 After starting or changing a treatment, carry out an early clinical review of dosage titration, tolerability and adverse effects to assess the suitability of the chosen treatment.

1.1.6 Carry out regular clinical reviews to assess and monitor the effectiveness of the treatment. Each review should include an assessment of:

- pain control
- impact on lifestyle, daily activities (including sleep disturbance) and participation[1]
- physical and psychological wellbeing
- adverse effects
- continued need for treatment.

1.1.7 When withdrawing or switching treatment, taper the withdrawal regimen to take account of dosage and any discontinuation symptoms.

Treatment

All neuropathic pain (except trigeminal neuralgia)

1.1.8 Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia)[3].

1.1.9 If the initial treatment is not effective or is not tolerated, offer one of the remaining three drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.

1.1.10 Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use).

1.1.11 Consider capsaicin cream[4] 0.075% for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.

Treatments that should not be used

1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so:

- cannabis sativa extract
- capsaicin patch
- lacosamide
- lamotrigine
- levetiracetam
- morphine
- oxcarbazepine
- topiramate
- tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use)
- venlafaxine.

[1] The World Health Organization ICF (International Classification of Functioning, Disability and Health) (2001) defines participation as 'A person's involvement in a life situation.' It includes the following domains: learning and applying knowledge, general tasks and demands, mobility, self-care, domestic life, interpersonal interactions and relationships, major life areas, community, and social and civil life.

[2] A condition-specific service is a specialist service that provides treatment for the underlying health condition that is causing neuropathic pain. Examples include neurology, diabetology and oncology services.

[3] At the time of publication (November 2013), amitriptyline did not have a UK marketing authorisation for this indication, duloxetine is licensed for diabetic peripheral neuropathic pain only, and gabapentin is licensed for peripheral neuropathic pain only, so use for other conditions would be off-label. In addition, the Lyrica (Pfizer) brand of pregabalin has patent

protection until July 2017 for its licensed indication of treatment of peripheral and central neuropathic pain; until such time as this patent expires generic pregabalin products will not be licensed for this indication and their use for this condition would be off-label and may infringe the patent. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

[4] At the time of publication (November 2013), capsaicin cream (Axsain) had a UK marketing authorisation for post-herpetic neuralgia and painful diabetic peripheral polyneuropathy, so use for other conditions would be off-label. The SPC states that this should only be used for painful diabetic peripheral polyneuropathy 'under the direct supervision of a hospital consultant who has access to specialist resources'. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

Trigeminal neuralgia

1.1.13 Offer carbamazepine as initial treatment for trigeminal neuralgia.

1.1.14 If initial treatment with carbamazepine is not effective, is not tolerated or is contraindicated, consider seeking expert advice from a specialist and consider early referral to a specialist pain service or a condition-specific service.

Trigeminal neuralgia

Step 1

Offer Carbamazepine initially 100mg 1-2 times daily (but some patients may require higher initial dose), increased gradually according to response in increments of 100-200mg every two weeks; usual dose 200mg 3-4 times daily, up to 1.6g daily in some patients

Note: see SPC for notes on therapeutic monitoring of Carbamazepine

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Step 2

If initial treatment with carbamazepine is not effective, is not tolerated or is contraindicated, consider seeking expert advice from a specialist and consider early referral to a specialist pain service or a condition-specific service

Contact details for primary and secondary care pain management teams

Durham Community Pain Management Team

Community based service with clinics in Shotley Bridge and Chester-le-Street community hospitals.

Telephone 01207 584360 (9.00 – 17.00 Monday – Friday)

UHND Pain Management Team

Consultants: Dr D Laird, Dr Siddiqi. Sister: Margaret Hillery

Telephone 0191 333 2601 (9.00 – 17.00 Monday – Friday)

CDDFT Pain Management Team

Based at Bishop Auckland hospital.

Consultants: Dr S Jambulingam, Dr S Roscoe, Dr J Chimappa. Sister: S Mooji

Telephone 01388 455102 (9.00 – 17.00 Monday – Friday)

City Hospitals Sunderland NHS Foundation Trust

Pain Clinic telephone 0191 569 9628 (9.00 – 17.00 Monday – Friday)

Gateshead Health NHS Foundation Trust

Pain Management Service telephone 0191 445 2645 (9.00 – 17.00 Monday – Friday)

North Tees and Hartlepool NHS Foundation Trust

Pain Management Unit (based at University Hospital of North Tees Hospital with an outreach clinic at University Hospital of Hartlepool) telephone 01642 624510 (9.00 – 17.00 Monday – Friday)

For information and advice on managing pain in palliative care

Access the North of England Cancer Network Palliative Care Guidelines at Northern England Strategic Clinical Networks , or contact your local palliative care team.