NHS
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County Durham & Tees Valley CCGs Pain Prescribing Guidance for Non-Cancer Pain in Primary Care

This document is designed to guide prescribing for chronic primary and chronic secondary, non-cancer pain in primary care. Prescribing advice is also provided for the presentation of acute pain

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Chronic Primary Pain Management – treatment options

County Durham and Tees Valley Formulary - https://joint-formulary.tees.nhs.uk/

Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain - https://www.nice.org.uk/guidance/ng193	
Treatment options	Notes
Consider an antidepressant, either amitriptyline, citalopram, duloxetine, fluoxetine, paroxetine, or sertraline, for people aged 18 years and over to manage chronic primary pain, after a full discussion of the benefits and harms. Seek specialist advice if pharmacological management with antidepressants is being considered for young people aged 16 to 17 years. If an antidepressant is offered to manage chronic primary pain, explain that this is because these medicines may help with quality of life, pain, sleep, and psychological distress, even in the absence of a diagnosis of depression. If a person with chronic primary pain is already taking any of the medicines in recommendation, review the prescribing as part of shared decision making: • explain the lack of evidence for these medicines for chronic primary pain and • agree a shared plan for continuing safely if they report benefit at a safe dose and few harms or • explain the risks of continuing if they report little benefit or significant harm, and encourage and support them to reduce and stop the medicine if possible	this is currently an off-label use of these antidepressant **Do not initiate** any of the following medicines to manage chronic primary pain in people aged 16 years and over: • antiepileptic drugs including gabapentinoids, unless gabapentinoids are offered as part of a clinical trial for complex regional pain syndrome (see the recommendation for research on pharmacological interventions) • antipsychotic drugs • benzodiazepines • corticosteroid trigger point injections • ketamine • local anaesthetics (topical or intravenous), unless as part of a clinical trial for complex regional pain syndrome (see the recommendation for research on pharmacological interventions) • local anaesthetic/corticosteroid combination trigger point injections • non-steroidal anti-inflammatory drugs • opioids • paracetamol

Chronic Secondary Pain Management – treatment options

County Durham and Tees Valley Formulary - https://joint-formulary.tees.nhs.uk/

Headaches in over 12s: diagnosis and management https://www.nice.org.uk/guidance/cg150	
Treatment options	**Notes**
Tension type headache **Acute -** Consider aspirin, paracetamol or an NSAID for the acute treatment of tension-type headache, considering the person's preference, comorbidities, and risk of adverse events. **Do not offer opioids for the acute treatment of tension-type headache** **Prophylaxis -** Consider a course of up to 10 sessions of acupuncture over 5 to 8 weeks for the prophylactic treatment of chronic tension-type headache**.**	1st line NSAID – Ibuprofen 2nd line - Naproxen Because of the association with Reye's syndrome, preparations containing aspirin should not be offered to under 16s
Migraine, with or without aura **Acute -** Offer combination therapy with oral triptan and NSAID **or** oral triptan and paracetamol, taking into account the person's preference, comorbidities, and risk of adverse events. **For young people aged 12 to 17 years** consider a nasal triptan in preference to an oral triptan. If oral preparations (or nasal preparations in young people aged 12 to 17 years) ineffective or not tolerated, offer a non-oral preparation of metoclopramide or prochlorperazine **and** consider adding a non-oral NSAID or triptan if these have not been tried **Prophylaxis** - offer topiramate or propranolol NB. off-label use of topiramate in children and young people	1st line triptan – Sumatriptan 2nd line – Frovatriptan Sumatriptan nasal spray is currently a non-formulary choice Only a buccal preparation of prochlorperazine is licensed for this indication. This was an off-label use of metoclopramide in children and young people People with depression and migraine could be at an increased risk of using propranolol for self-harm. Women of childbearing age must be using a highly effective method of contraception.
Predictable Menstrual related migraine - that does not respond adequately to standard acute treatment, consider treatment with frovatriptan (2.5 mg twice a day) or zolmitriptan (2.5 mg twice or three times a day) on the days migraine is expected	
Cluster Headache **Acute -** Offer oxygen and/or a subcutaneous or nasal triptan for the acute treatment of cluster headache NB. Off-label use of subcutaneous triptans in under 18s. Nasal triptans did not have a UK marketing authorisation for this indication When using oxygen for the acute treatment of cluster headache: – use 100% oxygen at a flow rate of at least 12 litres per minute with a non-rebreathing mask and a reservoir bag and – arrange provision of home and ambulatory oxygen **Prophylaxis -** Consider verapamil for prophylactic treatment during a bout of cluster headache (initiated under specialist supervision).	
Medication overuse headache Be alert to the possibility of medication overuse headache in people whose headache developed or worsened while they were taking the following drugs for 3 months or more: – triptans, opioids, ergots, or combination analgesic medications on 10 days per month or more or – paracetamol, aspirin or an NSAID, either alone or any combination, on 15 days per month or more Explain to people with medication overuse headache that it is treated by withdrawing overused medication. Advise people to stop taking all overused acute headache medications for at least 1 month and to stop abruptly rather than gradually	

Low back pain and sciatica in over 16s https://www.nice.org.uk/guidance/ng59

Treatment Options	Notes
Do not offer paracetamol alone for managing low back pain	
Consider oral NSAIDs for managing low back pain, considering potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age.	1st line NSAID – Ibuprofen 2nd line - Naproxen
When prescribing oral NSAIDs for low back pain, think about appropriate clinical assessment, ongoing monitoring of risk factors, and the use of gastroprotective treatment	1st line GI protection – omeprazole or lansoprazole
Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective.	**Do not routinely offer** opioids for managing chronic sciatica **Do not offer** gabapentinoids, other antiepileptics, oral corticosteroids or benzodiazepines for managing sciatica as there is no overall evidence of benefit and there is evidence of harm **Do not offer** selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors or tricyclic antidepressants for managing low back pain. **Do not offer** spinal injections for managing low back pain

Rheumatoid arthritis in adults https://www.nice.org.uk/guidance/ng100

Treatment Options	Notes
For adults with **newly diagnosed** active RA: • first-line treatment with DMARD monotherapy using oral methotrexate, leflunomide or sulfasalazine as soon as possible and ideally within 3 months of onset of persistent symptoms. • hydroxychloroquine for first-line treatment as an alternative to oral methotrexate, leflunomide or sulfasalazine for mild or palindromic disease	NB. These drugs will be initiated by secondary care specialist and can be managed in primary care via shared care
Further pharmacological management can be considered using biological and targeted synthetic DMARDs	These drugs tend to be RED for secondary care prescribing only
Symptom control Consider oral non-steroidal anti-inflammatory drugs (NSAIDs, including traditional NSAIDs and cox II selective inhibitors), when control of pain or stiffness is inadequate. Take account of potential gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age and pregnancy	1st line NSAID – Ibuprofen 2nd line – Naproxen 1st line GI protection – omeprazole or lansoprazole COX II inhibitors are non-formulary choices

Osteoarthritis https://www.nice.org.uk/guidance/cg177

Treatment Options	Notes
Oral analgesia Consider offering paracetamol for pain relief in addition to core treatments. Regular dosing may be required. Paracetamol and/or topical non-steroidal anti-inflammatory drugs (NSAIDs) should be considered ahead of oral NSAIDs, cyclo-oxygenase 2 (COX-2) inhibitors or opioids	Core treatments • Access to appropriate information • Activity and exercise • Interventions to achieve weight loss if the person is overweight or obese Topical NSAID – Ibuprofen 5% (can be bought OTC) or Capsaicin 0.025%

	Do not offer rubefacients for treating osteoarthritis.
Where paracetamol or topical NSAIDs are ineffective for pain relief for people with osteoarthritis, then substitution/addition with an oral NSAID/COX-2 inhibitor should be considered	1st line NSAID – Ibuprofen 2nd line – Naproxen 1st line GI protection – omeprazole or lansoprazole COX II inhibitors are non-formulary choices
If paracetamol or topical NSAIDs are insufficient for pain relief for people with osteoarthritis, then the addition of low dose opioid analgesics could be considered. Risks and benefits should be considered, particularly in older people	1st line opioid – low dose codeine
Intra-articular corticosteroid injections should be considered as an adjunct to core treatments for the relief of moderate to severe pain in people with osteoarthritis..	Do not offer intra-articular hyaluronan injections for the management of osteoarthritis

Spondyloarthritis in over 16s https://www.nice.org.uk/guidance/ng65

Treatment options	Notes
Axial Spondyloarthritis Offer NSAIDs at the lowest effective dose to people with pain associated with axial spondyloarthritis, and think about appropriate clinical assessment, Ongoing monitoring of risk factors, and the use of gastroprotective treatment. If an NSAID taken at the maximum tolerated dose for 2–4 weeks does not provide adequate pain relief, consider switching to another NSAID.	1st line NSAID – Ibuprofen 2nd line – Naproxen 1st line GI protection – omeprazole or lansoprazole
Biological DMARDs – adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for the treatment of ankylosing spondylitis and non-radiographic Spondyloarthritis in over 16s: diagnosis and management (NG65)	RED drugs, use limited to secondary care
Psoriatic arthritis and other peripheral spondyloarthritis **Secondary care** - Consider local corticosteroid injections as monotherapy for non-progressive monoarthritis. Offer standard disease-modifying anti-rheumatic drugs (DMARDs) to people with: • peripheral polyarthritis • oligoarthritis • persistent or progressive monoarthritis associated with peripheral spondyloarthritis	DMARDS will be covered via shared care
Consider NSAIDs as an adjunct to standard DMARDs or biological DMARDs to manage symptoms If NSAIDs do not provide adequate relief from symptoms, consider steroid injections (local or intramuscular) or short-term oral steroid therapy as an adjunct to standard DMARDs or biological DMARDs to manage symptoms.	1st line NSAID – Ibuprofen 2nd line – Naproxen 1st line GI protection – omeprazole or lansoprazole

Endometriosis https://www.nice.org.uk/guidance/ng73

Treatment options	Notes
Analgesics For women with endometriosis-related pain, discuss the benefits and risks of analgesics, taking into account any comorbidities and the woman's preferences. Consider a short trial (for example, 3 months) of paracetamol or a non-steroidal anti-inflammatory drug (NSAID) alone or in combination for first-line management of endometriosis-related pain	1st line NSAID – Ibuprofen 2nd line – Naproxen
If a trial of paracetamol or an NSAID (alone or in combination) does not provide adequate pain relief, consider other forms of pain management and referral for further assessment.	1st line GI protection – omeprazole or lansoprazole

Neuromodulators and neuropathic pain treatments – see below **Hormonal treatments** NICE has produced a patient decision aid on hormonal treatment for endometriosis. • Explain to women with suspected or confirmed endometriosis that hormonal treatment for endometriosis can reduce pain and has no permanent negative effect on subsequent fertility. • Offer hormonal treatment (for example, the combined oral contraceptive pill or a progestogen) to women with suspected, confirmed, or recurrent endometriosis. • If initial hormonal treatment for endometriosis is not effective, not tolerated or is contraindicated, refer the woman to a gynaecology service, specialist endometriosis service (endometriosis centre) or paediatric and adolescent gynaecology service for investigation and treatment options.	

Neuropathic Pain in adults https://www.nice.org.uk/guidance/cg173

Treatment Options	Notes
All neuropathic pain (except trigeminal neuralgia) Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia) If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 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 Consider capsaicin 0.025% cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.	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) • venlafaxine • sodium valproate Also avoid use of Lidocaine Nortriptyline
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.	Combination therapy is commonly prescribed for neuropathic pain. It may also be a helpful option as a stepwise approach if initially used drugs are insufficient at reducing pain. Combination therapy may also result in better tolerability because smaller doses of individual drugs are often used when combined with other drugs

Irritable Bowel Syndrome in adults https://www.nice.org.uk/guidance/cg61

Treatment options	Notes
Pharmacological therapy People with IBS should be advised how to adjust their doses of laxative or antimotility agent according to the clinical response. The dose should be titrated according to stool consistency, with the aim of achieving a soft, well-formed stool (corresponding to Bristol Stool Form Scale type 4) Consider tricyclic antidepressants (TCAs) as second-line treatment for people with IBS if laxatives, loperamide or antispasmodics have not helped. Start treatment at a low dose (5–10 mg equivalent of amitriptyline), taken once at night, and review regularly. Increase the dose if needed, but not usually beyond 30 mg.	Do not recommend lactulose, as it may cause bloating TCAs did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented

Management of Acute Pain

Nociceptive pain treatment pathway

Medications should be an adjunct to general measures such as advice about activity and sleep, physiotherapy, and explanation that complete relief of symptoms is not a goal of therapy. Before prescribing review and discuss with the patient, using shared decision making and agreeing an overall management plan, incorporating drug and non-drug treatment. Non-pharmacological treatment may be effective in reducing symptoms and disability in some people with long-term (chronic) pain and can also augment and complement analgesic use. Healthcare professionals responsible for helping people manage chronic pain should be familiar with non-pharmacological interventions available including physical and psychological therapies and local availability of these services.

Step 1 – self-management		
For minor pain, whether for acute or minor persistent pain, patients can usually access over the counter pain medicines such as paracetamol or ibuprofen. Patients should be encouraged to self-manage their health for minor ailments including mild pain symptoms e.g., aches and sprains, headache, period pain and back pain.		
Step 2 – regular paracetamol		
Paracetamol	1g every 4-6 hours Patients weighing <50kg may require dose adjustment Maximum 4g per 24 hours	Effective 1st line analgesic in acute pain. Some patients may be at increased risk of toxicity at therapeutic doses, particularly those with body weight under 50kg and those with risk factors for hepatotoxicity. Ensure this is prescribed at maximum dose before escalating analgesia. Effervescent tablets have high sodium content (18.6mmol / tablet). Taking the maximum dose of paracetamol = 8g of sodium per day. Undertake local risk assessment before use. Available to purchase over the counter (up to 100 from pharmacies).
Step 3 – add NSAID		
Use the lowest possible NSAID dose for the shortest period necessary. Carefully assess benefits and risks; think about CVD, GI sensitivity, renal issues, and hepatic disease. All patients on NSAID at high risk of having serious GI adverse events should routinely be co-prescribed gastro-protection (lansoprazole 15mg or omeprazole 20mg). See appendix for further information. Topical NSAIDs may be recommended for localised pain, however patients should be encouraged to purchase OTC.		
Ibuprofen	1.2g daily in 3-4 divided doses	In line with MHRA guidance - prescribe at the lowest possible dose for the shortest period of time. Ibuprofen has lowest GI risk of standard NSAIDs. Daily doses less than 1200mg are not associated with increased thrombotic risk. Can be used for migraine and dysmenorrhoea.
Naproxen	500mg – 1g daily in 1-2 divided doses	Doses of less than 1g daily are not associated with increased thrombotic risk. Longer duration of action than ibuprofen. For use in mild to moderate pain. Can be used for dysmenorrhoea.
Step 4 – add codeine (weak opioid)		
Codeine	30mg – 60mg every four hours when necessary to a maximum of 240mg daily	Review past treatment. Consider potential for medication diversion. Use lowest effective dose. Do not use if contraindicated. Consider laxatives.

		Consider stopping NSAID if appropriate. If short term do not add to repeat medication templates.

Codeine Non-Responders

Approximately 5-10% of the population are believed to be poor metabolisers of codeine, and if the initial response to its introduction does not have an expected pain reduction, then consider the possibility the patient may be classed as a codeine non-responder. The absence of CYP2D6 means codeine cannot be metabolised to its active metabolite. Other drugs that utilise this gene for metabolism are also affected in this cohort; therefore avoid the use of Hydrocodone or Oxycodone.
Options below should be considered for this cohort before moving on to step 5 of the treatment pathway.

Tramadol I/R Capsules

Tramadol uses 2 distinct pathways for its metabolism, one of which is CYP2D6. Therefore, it may only be partially effective in codeine non-responders. A short course trial is recommended in patients, with a reassessment of its effectiveness advised within a month of initiating it.

Typical doses of 50-100mg up to QDS are recommended.

Tramadol as M/R can only be initiated under the advice of a pain specialist.

Oral morphine solution 10mg/5ml

Age-appropriate dose (see table) no more than 6 times daily.

Regularly review quantities prescribed, alongside effectiveness in pain management.
Consider the need for M/R morphine if patient constantly using high quantities, but also take caution around the risk of addiction, and possibility of patients who may inadvertently exceed dose limits.

Age	Dose	
	mg	mL
16-39 years	7.5 – 12.5mg	3.75 – 6.25mL
40-59 years	5 – 10mg	2.5 – 5mL
60-69 years	2.5 – 7.5mg	1.25 – 3.75mL
70-85 years	2.5 – 5mg	1.25 – 2.5mL
>85 years	2.5mg	1.25mL

Low-strength buprenorphine 7-day patches

Consider first if renal impairment, poor swallowing, or morphine intolerance.
Start with Butec 5mcg/hour patch and can increase up to 15mcg/hour. Do not increase more than once every 2-4 weeks.
If needing to consider higher doses, seek advice from specialist pain teams.

Step 5 – review clinical assessment if no response to treatments, stop previous treatments and consider switch to strong opioid (tramadol OR morphine)
See APC statement – County Durham & Tees Valley APC position on prescribing in persistent pain contains important advice for prescribers

Initiation of strong opioids should only be considered when all other options have proven ineffective.
Evidence shows opioids are only effective for up to a maximum of 6 months, patients should be reviewed on a regular basis.
Do not add short term opioids to repeat medication templates.

Opioids Aware Key Messages

Opioids Aware is a resource for patients and healthcare professionals to support prescribing of opioid medicines for pain. It is written by the Faculty of Pain Medicine in partnership with Public Health England.

- There is little evidence that opioids are helpful for long-term (chronic) pain.
- A small proportion of people may obtain good pain relief with opioids in the long term if doses can be kept low and use is intermittent, but it is difficult to identify these people at the start of treatment.
- **The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/ day, but there is no increased benefit.**
- If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available.
- A detailed assessment of the emotional influences on the person's pain experience is essential for people with long-term (chronic) pain who also have refractory and disabling symptoms, particularly if they are on high opioid doses.

Tramadol (CD)	Immediate release only	Tramadol is a schedule 3 controlled drug Tramadol M/R should ONLY be prescribed if advised by pain specialists Tramadol and Paracetamol combination products, such as Tramacet, are non-formulary and should NOT be prescribed
Morphine sulphate	Prescribe by brand	Stop codeine/ tramadol Use Zomorph capsules where available as preferred brand The national threshold and for Tees Valley is to remain below 120mg daily, but across County Durham the threshold must be kept below 100mg daily

Avoid use and review patients	
Co-codamol	Co-codamol is not recommended and its use is discouraged due to inflexibility in dosing. Paracetamol and codeine should be prescribed separately. If co-codamol is used, this should be in tablet form, not the effervescent preparation which has a higher salt content.
Co-proxamol	**Co-proxamol should not be prescribed under any circumstances for new patients**; existing patients should be converted to alternative analgesics. Co-proxamol has an unfavourable adverse-events profile, particularly toxicity in accidental and intentional overdose. The MHRA Drug Safety Update (January 2011) further confirms the cardiac risks associated with co-proxamol. NHS England (November 2017) supports the deprescribing of co-proxamol.
Dihydrocodeine	Dihydrocodeine is not recommended for regular use (either alone or in combination with paracetamol as co-dydramol) has a shorter half-life and the effects are more likely to lead to abuse.
Diclofenac	Diclofenac is not recommended due to its risk of cardiovascular effects. Diclofenac is contraindicated in patients with established ischaemic heart disease, peripheral arterial disease, cerebrovascular disease, or congestive heart failure. MHRA (2014): Diclofenac: new contraindications and warnings
COX-2 inhibitors	Cox-2 inhibitors are not recommended because of their risk of adverse cardiovascular effects. Etoricoxib is contra-indicated in certain patients with hypertension due to its cardiovascular risk profile. MHRA (2015): Cox-2 selective inhibitors and non-steroidal anti-inflammatory drugs (NSAIDs): Cardiovascular safety
Indometacin	Prescribing of indometacin is not recommended.
Nefopam	**Nefopam should not be initiated for acute or chronic pain**, or continued post discharge following secondary care acute initiation. CCG position statement regarding nefopam.
Rubefacients	Prescribing of topical rubefacient preparations is not recommended. Topical rubefacient preparations may contain nicotinate and salicylic acid compounds, essential oils, capsicum, and camphor which are all irritants. The evidence available does not support the use of topical rubefacients in acute or chronic musculoskeletal pain. Rubefacients should not be offered to treat osteoarthritis. Stop any prescribing. NICE states that capsaicin patches should not be used for neuropathic pain in non-specialist settings, unless advised by a specialist.
Tapentadol	**Prescribing of tapentadol is not recommended**.
Buprenorphine patches	Reserved only for patients unable to tolerate the side effects of oral opiates or have difficulty swallowing, have compliance issues, or renal impairment. Large risk of overdose in opioid naïve patients. Buprenorphine 5mcg/hr patches are approximately equivalent to 12mg oral morphine per day. Buprenorphine 35mcg/hr patches are approximately equivalent to 84mg oral morphine per day[1].
Fentanyl patches	Not recommended. Fentanyl patches are highly addictive and have limited value in non-malignant chronic pain therefore should only be used on the recommendation of a pain specialist.
Oxycodone	Not recommended first-line. Oxycodone and morphine sulphate have similar safety and efficacy profiles; however, morphine sulphate is significantly less costly than oxycodone. There is a lack of evidence from high quality comparative trials that other opioids have advantages over morphine in terms of either efficacy or side effects.
Oxycodone/ naloxone (Targinact®)	Not recommended. Randomised controlled trials have only compared with standard-release oxycodone, NOT with other strong opioids such as morphine, with regular laxatives. There is no data showing that combined oxycodone and naloxone reduce the need for laxatives in the long-term.

Management of Medication Related Side Effects

Proton Pump Inhibitors – advice on when to initiate a PPI with an NSAID

Where an NSAID is indicated, and to reduce the risk of gastrointestinal adverse effects, the lowest effective dose for the shortest duration of treatment should be used. As PPIs have become widely used, evidence has started to emerge regarding their long-term safety and potential for adverse effects. Clinicians should consider the risks and benefits when considering prescribing long-term PPIs and ensure regular review.

All patients on NSAIDs at high risk of having serious GI adverse events should routinely be co-prescribed gastro-protection.

High risk factors are:

- Patients >45 years of age receiving long-term regular NSAID
- Patients ≥65 years of age receiving short-term of intermittent NSAID
- Dual antiplatelet therapy
- Past history of PUD
- Concomitant oral anticoagulant/ antiplatelet/ NSAID

Or have two or more risk factors:

- ≥65 years of age
- Oral corticosteroid use
- Dyspepsia or GORD symptoms
- SSRIs

Severe co-morbidity (malignancy, HF (NYHA III-IV), significant liver or renal disease (e.g., CKD 4&5 and cirrhosis)

Lansoprazole or omeprazole are the preferred formulary choices for gastro-protection.

Licensed doses of proton pump inhibitors used for gastro protection for people who require continued NSAID treatment:

Proton Pump Inhibitor	Dose for NSAID prophylaxis
Lansoprazole	15–30 mg once daily
Omeprazole	20 mg once daily
Esomeprazole	20 mg once daily
Pantoprazole	20 mg once daily

Management of opioid induced constipation

At least 40% of patients experience constipation whilst taking opioid-based analgesia. Patients should be given general advice about fluid intake, exercise and eating plenty of fruit and vegetables.

If medication is necessary, the combination of a stimulant and osmotic laxative is the most appropriate treatment for opioid induced constipation (i.e., to avoid bulk forming laxatives which are usually the mainstay of constipation treatment).

Suggested regime:

- Senna 15-30mg at night **and**
- Macrogol sachets 1-3 sachets per day

Other options are docusate sodium and sodium picosulphate. If patient presents with faecal impaction, then Macrogol up to 8 sachets per day is the first line of treatment.

Specialist only drugs for constipation due to opioid usage:

Naloxegol should be prescribed only on the advice of a specialist.

Methylnaltrexone is a non-formulary drug.