Key Messages
For Pain Management Scenarios

County Durham and Darlington
Area Prescribing Committee

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Scope

The purpose of this document is to provide prescribers with key messages when prescribing/de-prescribing for pain management. The key messages should be read in conjunction with the guidelines detailed below.

The guidelines and key messages (Treatment of Neuropathic pain, Strong Opioids and Tapering Opioids) have been developed by the County Durham and Darlington Pain Prescribing Guidelines Task and Finish Group; a sub group of the County Durham and Darlington Area Prescribing Committee and comprised of members from County Durham and Darlington Foundation Trust, North Durham CCG, Durham Dales Easington & Sedgefield CCG and North of England Commissioning Support. The key messages (Managing Persistent Pain and Non-pharmacological Management of Pain) have been approved by both the County Durham and Darlington Pain Management Education Group and also the Pain Management Project Group.

The guidelines:

- Pharmacological Treatment of Neuropathic Pain
- Opiate Prescribing in Persistent (Non-cancer) Pain

Key Messages:

- Managing Persistent Pain
- Non-pharmacological Management of Pain
- Treatment of Neuropathic Pain
- Strong Opioids
- Tapering Opioids for Persistent Pain

All references are provided as a guide and individual patient factors should be taken into account before a change to treatment is initiated.

Please refer to the BNF or Summary of Product Characteristics for further information on medications, side effects, cautions, contra-indications, interactions and formulations.

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MANAGING PERSISTENT PAIN

Ten Key Messages:

1. Ongoing pain is often due to changes in the processing of pain information rather than a symptom of an underlying pathology. Clinical Assessment and explanation of the diagnosis to the patient is part of the therapy.

2. Red flags MUST be excluded before any treatment commenced.

3. Further investigations may be appropriate, but be aware that findings may not always be related to the pain.

4. The World Health Organisation (WHO) pain ladder was devised for cancer pain and, whilst it is a useful tool, it must be remembered it was not developed for ongoing pain. If using the ladder, weak opiates should be **stopped** before a strong opiate started.

5. Establishing whether or not the pain has a **neuropathic** component may help when deciding on a management plan.

6. Managing persistent pain is about effective management and not about finding a cure, as with any other chronic condition. All treatments are aiming to help a patient cope with their pain better. The British Pain Society provides useful information for patients.

7. The education programmes for patients and exercise on referral schemes may be useful to help patients to self-manage.

8. Being active is very important; the less active a patient is, the more painful it is to move, and a vicious cycle ensues.

9. Realistic Goal setting, pacing and planning are useful strategies for managing a pain problem.

10. It is OK to say that nothing more can be given to the patient in terms of medical treatment. It may not be helpful to give the patient false hope with further treatments and referrals, looking for an elusive cure. However, continued support with self-management strategies is essential.

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NON-PHARMACOLOGICAL MANAGEMENT OF PAIN

Ten Key Messages:

1. Referral to a multidisciplinary team (including professionals such as clinical psychologists, physiotherapists, occupational therapists and nurses) experienced in managing pain can contribute to the non-medicinal management of persistent pain (e.g. through pain management and functional restoration programmes).

2. Persistent pain should be assessed and managed using a biopsychosocial model. Psychosocial factors have a significant impact on disability and outcome.

3. Biomedical factors often do not explain the severity of symptoms or disability.

4. Supporting self-management is a central component. Informing and educating people that treating persistent pain is about management and not about finding a cure.

5. Graded exercise and keeping active is effective at helping to manage persistent pain.

6. Evidence has found that self-management support can be more effective in a group versus individual settings: for example, exercise referral schemes and education programmes for patients.

7. Cognitive Behavioural Therapy (CBT) can be effective in helping to manage persistent pain. It is important to note that these therapies should be delivered by appropriately trained and skilled practitioners.

8. Acceptance of their situation can be a challenge for people with persistent pain. Mindfulness and Acceptance and Commitment Therapy (ACT) can help with this. Consider referral to a psychologist or other appropriately accredited professional.

9. Consider referral to a physiotherapist or occupational therapist who can offer individualised management that may include manual therapy, which can be beneficial.

10. Promote self-sufficient behaviours and quality of life by encouraging patients to explore and maintain meaningful activities and interests through goal setting and activity planning.

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TREATMENT OF NEUROPATHIC PAIN

Ten Key Messages:

1. Neuropathic pain is caused by dysfunctional, damaged or injured nerves sending incorrect signals to the brain. It can have a metabolic, infective, traumatic, toxic, inflammatory/autoimmune, vascular, malignancy or musculoskeletal cause.

2. The pain can be spontaneous, or evoked. Continuous or intermittent, superficial. It can be made worse by temperature change or gentle touch.

3. It can be described as burning, sharp, shooting, lancinating, itching, pins and needles, or indescribable in terms of normal reference.

4. Assessment tools such as the LANSS scoring tool or the Pain Detect tool can be used to assist diagnosis.

5. NICE has provided guidance with regards to management of neuropathic pain. Drug choices are amitriptyline, gabapentin, duloxetine or pregabalin for generalised neuropathic pain.

6. General pain management advice can be given as per the Pain Toolkit.

7. If in any doubt as to the underlying disease process, the following investigations should be undertaken: urine (glucose and protein), ESR/c-reactive protein, folate, fasting glucose, U&Es, FBC, vitamin B12, LFT, TFT, HbA1C, appropriate radiology.

8. Pain may not be sensitive to opiates – so if pain persists despite increasing doses of opiates, it is NOT opiate sensitive.

9. Drugs should be titrated (dose changes and speed of titration should be dictated by the patient's tolerance of the medication). If they are not helping, they should be weaned and discontinued and another drug tried. It is about regular review.

10. NICE also provides some Do Not Dos – do not use the following medicines to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so (see local advice for referral criteria to specialist services):

    - tramadol for long-term use
    - morphine
    - cannabis sativa extract
    - capsaicin patch
    - lacosamide
    - lamotrigine
    - levetiracetam
    - oxcarbazepine
    - topiramate
    - venlafaxine

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STRONG OPIOIDS

Ten Key Messages:

1. There is good evidence for the use of strong opioids in acute and cancer pain; there is very little evidence for their use in persistent, non-cancer pain.

2. Persistent pain is often not opiate sensitive, so increasing the dose may have no benefit on the pain. Where there is little benefit, consider tapering the dose down (see also Tapering Opioids for Persistent Pain). There is evidence opioids make persistent pain worse in some individuals.

3. Complete pain relief is rarely achieved; the goal of therapy should be to reduce symptoms enough to support improvement in physical, social and emotional functioning.

4. 80% of patients taking opioids will have at least one adverse effect and these should be discussed before prescribing such medications.

5. Patients must be made aware of the long-term effects of opioids on the endocrine and immune systems. Further information on opioids for patients is available here. The patient should be advised not to drive at the start of therapy, and when doses are increased. They should only then drive if they feel fit to do so. It is their responsibility to inform the DVLA that they are taking such medications (see Department for Transport Guidance).

6. In opioid sensitive patients increase in opioid dose may be indicated to help manage a flare up. Ensure a return to pre-flare levels as soon as possible.

7. Where possible, consider using modified release preparations for regular use. Due to the wide range of modified release preparations available, caution should be exercised to ensure the correct product is selected, and the product should be prescribed by brand where appropriate.

8. Injectable formulations should NOT be used to manage persistent pain; immediate-release preparations should only be used for short periods if clinically relevant, and should be stopped as soon as possible as they have a higher incidence of addiction.

9. There is a significant patient safety risk at doses above 100mg equivalent morphine in 24 hours. If patients have been titrated to 100 mg or more oral morphine equivalent per 24 hours specialist referral or advice is recommended.

10. Fentanyl and buprenorphine patches can be difficult to titrate and so should be avoided in persistent pain unless there is a good clinical indication to use them, e.g. patient unable to swallow.

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TAPERING OPIOIDS FOR PERSISTENT PAIN

Ten Key Messages:

1. Review

Patients on opioids should be regularly reviewed to determine whether opioids are meeting treatment goals and whether opioids can be reduced to lower dosage or discontinued to.

2. To taper?

Consider tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy when your patient:

- Requests dosage reduction
- Does not have clinically meaningful improvement in pain and function
- Is on dosages greater or equal to 100mg morphine sulphate or equivalent /day without benefit
- Shows signs of substance use disorder (e.g. work or family problems related to opioid use, difficulty controlling use)
- Experiences overdose or other serious adverse event
- Shows early warning signs for overdose risk such as confusion, sedation, or slurred speech
- Develops other pathologies eg renal, obstructive sleep apnoea (OSAS), depression, or has increasing polypharmacy

3. Tapering plans

Must be individualised and should minimise symptoms of opioid withdrawal while maximising pain treatment with non-pharmacologic therapies and non-opioid medications.

4. Go slow

A decrease of 10% of the original dose per week is a reasonable starting point. Some patients who have taken opioids for a long time might find even slower tapers (e.g. 10% per month) easier.

5. Discuss

The increased risk for accidental overdose if patients quickly return to a previously prescribed higher dose.

6. Consult/Refer

Co-ordinate with specialists and treatment experts as needed - especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder.

Use extra caution during pregnancy due to possible risk to the pregnant patient and to the foetus if the patient goes into withdrawal

7. Support

Make sure patients receive appropriate psychosocial support. If needed, work with mental health providers and arrange for treatment of opioid use disorder.

Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

8. Encourage

Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first.

9. Adjust/Monitor/Reduce

- Adjust the rate and duration of the taper according to the patient's response.
- Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms
- Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.

10. Inform

Sign-post patients to useful resources which can provide them with extra support/advice. The British Pain Society provides useful information for patients.