CHRONIC NON PALLIATIVE PAIN (> 6 months) IN ADULTS – Primary Care Treatment Pathway

Initial Assessment
- Exclude serious pathology / red flags (investigate / refer as necessary).
- Investigate and manage any underlying condition.
- Determine pain type - nociceptive, mixed, neuropathic. Typical features of neuropathic pain: burning, shooting, allodynia, hyperalgesia, unpredictable, abnormal sensations. For neuropathic pain follow local guidelines.
- Determine baseline severity of pain & functional impact. Use visual analogue or numerical rating scales (pain scales available from the British Pain Society).
- If musculoskeletal pain offer manual therapy in addition to or instead of analgesics if appropriate.

Consider early specialist referral
- Where pain is severe or not responding to management.
- Patients considered at increased risk of poor outcomes. For back pain consider use of Keele STarT Back Tool.

Before prescribing
- Determine use of over-the-counter (OTC) treatments / complementary therapies.
- Offer British Pain Society leaflet Managing your pain effectively using over-the-counter medicines (pdf).
- Agree and document achievable pain goal e.g. 50% reduction in pain, improved function.
- Advise on risks/benefits of medication, regime and target dose.
- Avoid effervescent preparations, particularly with hypertension (due to salt content).
- Prescribe single-constituent analgesics where appropriate, to allow independent titration of each drug.
- Avoid low dose compound analgesics (e.g. co-codamol 8/500 mg and co-dydramol 10/500 mg).
- Consider full dose compound analgesic (codeine/paracetamol 30/500mg) in chronic stable pain.
- DO NOT initiate immediate release morphine (e.g. Oramorph®) for chronic pain.

At Review
- Increase dose as guided by pain response and side-effects to lowest effective dose or target dose.
- Review after 1 month (at least 2 weeks on target dose). Review updated pain scale & functional response:

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>Adequate pain benefit with tolerable side-effects</td>
<td>Continue medicine at current dose &amp; review regularly Consider dose reduction and withdrawal once stable</td>
</tr>
<tr>
<td>Marginal pain benefit with tolerable side-effects</td>
<td>Consider dose and pain relief vs side-effects: If not at target dose – titrate to target dose If target dose achieved – move to next step</td>
</tr>
<tr>
<td>No pain relief or intolerable side-effects</td>
<td>Change therapy / move to next step</td>
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</tbody>
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STEP 1 — START paracetamol (increase to maximum dose of 1 gram four times a day).

STEP 2 – STOP paracetamol. START ibuprofen (400mg three times a day).

STEP 3 – START paracetamol (1 gram four times a day) WITH ibuprofen (400mg three times a day).

STEP 4 – CONTINUE paracetamol (1 gram four times a day). STOP ibuprofen START naproxen (250mg to 500mg twice a day). Consider substitution with topical NSAID gel for musculoskeletal pain.

STEP 5: ADD codeine (30mg to 60mg up to four times a day; maximum 240mg daily) to STEP 4.

STEP 6: Replace codeine with tramadol (50mg to 100mg every 6 hours; maximum 400mg daily. (NB: 400mg daily of tramadol is approximately equivalent to 50mg daily of morphine).

Patients who cannot swallow tablets or liquids or have short bowel syndrome: Buprenorphine patch (Butrans®) Start with: 5mcg/hr weekly patch Max: 10mcg/hour weekly patch Refer non-responders to pain consultants.

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REFER NON-RESPONDERS TO PAIN SPECIALIST
While awaiting specialist appointment CONSIDER replacing tramadol with morphine modified release 12 hourly oral preparation (10mg twice daily, titrate to maximum of 20mg twice daily after 1 month)

For further prescribing information, refer to full guideline
CHRONIC NON PALLIATIVE PAIN (>6 months) IN ADULTS – Secondary Care Treatment Pathway

Refer to full guideline for further information & advice on opioids, including management of side-effects & dose conversion

A multidisciplinary assessment will be undertaken to determine individualised drug & non-drug treatment
This may involve a combination of physiotherapy, acupuncture, hydrotherapy, interventional therapy including steroid injections or radiofrequency treatments or psychologically based interventions.

Prescribing Information for Strong Opioids

- Direct the patient to the Faculty of Pain Medicine web-based patient information: 'Taking opioids for pain'.
- Advise patient on benefit/side-effects of strong opioids.
- Determine baseline severity of pain (BPI short form) and functional impact.
- Agree and document achievable pain goal e.g. 20% reduction in pain, improved function.
- Start with a low dose and titrate upwards according to pain/functional response and side effects.
- Advise patient on titration regime and target dose before next appointment (with specialist).
- Supportive medications (laxatives and anti-emetics) to be co-prescribed to minimise side-effects.
- Aim to establish the patient on long-acting opioid with no immediate release opioid. Consider non-opioids or weak opioids for mild breakthrough pain and immediate release morphine (eg Oramorph) for more severe pain.
- Provide comprehensive information to GPs on management between specialist appointments (see below).

**Morphine** modified release 12 hourly oral preparation

- Usually start at 10mg twice daily and titrated up to a maximum of 50mg twice daily if effective and tolerated

**Oxycodone** modified release 12 hourly oral preparation

- Usually start at a lower than equivalent morphine dose or consider phased conversion if on large morphine dose
- Usually titrated up to a maximum of 30mg twice daily if effective and tolerated

**Fentanyl patches**

- 1st line in patients unable to swallow oral medicines
- Usually start with ‘12’ or ‘25’ patch (12 or 25 micrograms/hour for 72 hours) and titrated to a maximum of a ‘50’ patch (50 micrograms/hour for 72 hours) if effective and tolerated

**Tapentadol** modified release 12 hourly oral preparation

- Usually start at 50mg twice daily and titrate up to 150mg twice daily if effective and tolerated
- **Do NOT use immediate release tapentadol for breakthrough pain**
- **Specialist responsibilities:**
  - **To prescribe for first 3 months** while dose being titrated and stabilised and patient reviewed
  - Complete tapentadol notification pro-forma
  - Assess patient within 3 months of starting treatment and complete 3 month follow up pro-forma
  - **Treatment only to continue if 20% improvement in pain scale score AND a score of 5-7 on the Patient Global Impression of Change form**
  - If ineffective change back to the most effective/best tolerated previously used strong opioid
  - If effective after 3 months **prescribe a further 1 month** and transfer prescribing responsibility to GP with comprehensive ongoing management information (see below)
  - Follow up patients at 3 monthly intervals for the 1st year. Complete annual follow up pro-forma

Information to be included within letter from specialist to GP for each patient:

- Name of medication and current dose
- Titration schedule and target dose to increase to before next appointment
- Dose tapering information if medicine is being changed or discontinued
- Advice on management of side-effects and supportive medication (laxatives and anti-emetics)
- Advice on the use of non-opioids, weak opioids and immediate release morphine for ‘breakthrough’ pain
- Advice if intolerance including next treatment option (starting dose, titration schedule & target dose)
- Details of next scheduled appointment with specialist
- Details of GP review schedule and any specific monitoring requirements
- Contact details for pain clinic for further advice for GP