Development of Chronic Pain Guidelines

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Background

- What is chronic pain?
- Why are these guidelines needed?
- How were they developed…
- Principles of the guidance
- Flags
- Management
- How do we monitor implementation of the guidance?
- How can community pharmacy help with implementation?

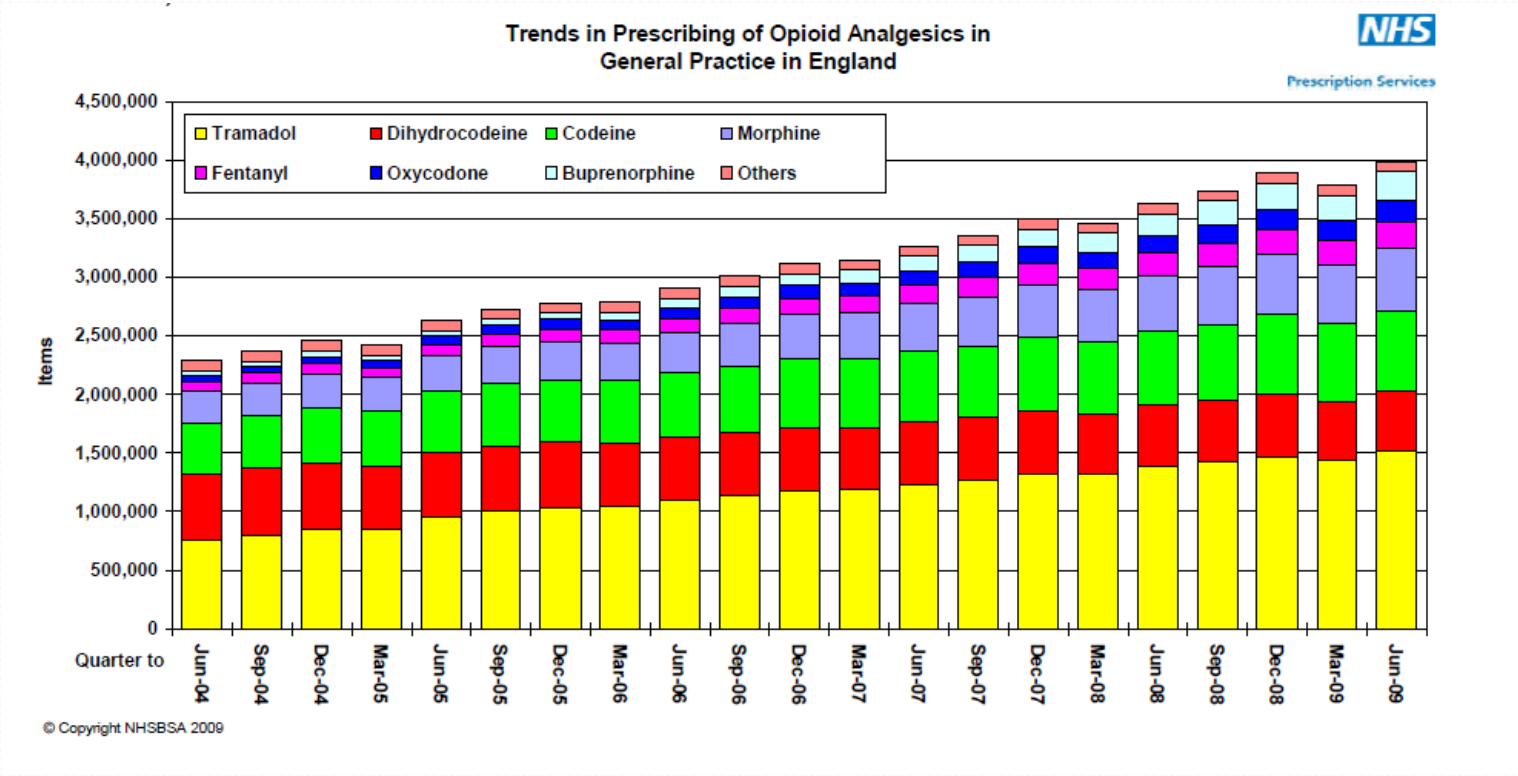
What is chronic pain?

- Defines as pain that persists beyond normal tissue healing time which is assumed to be three months

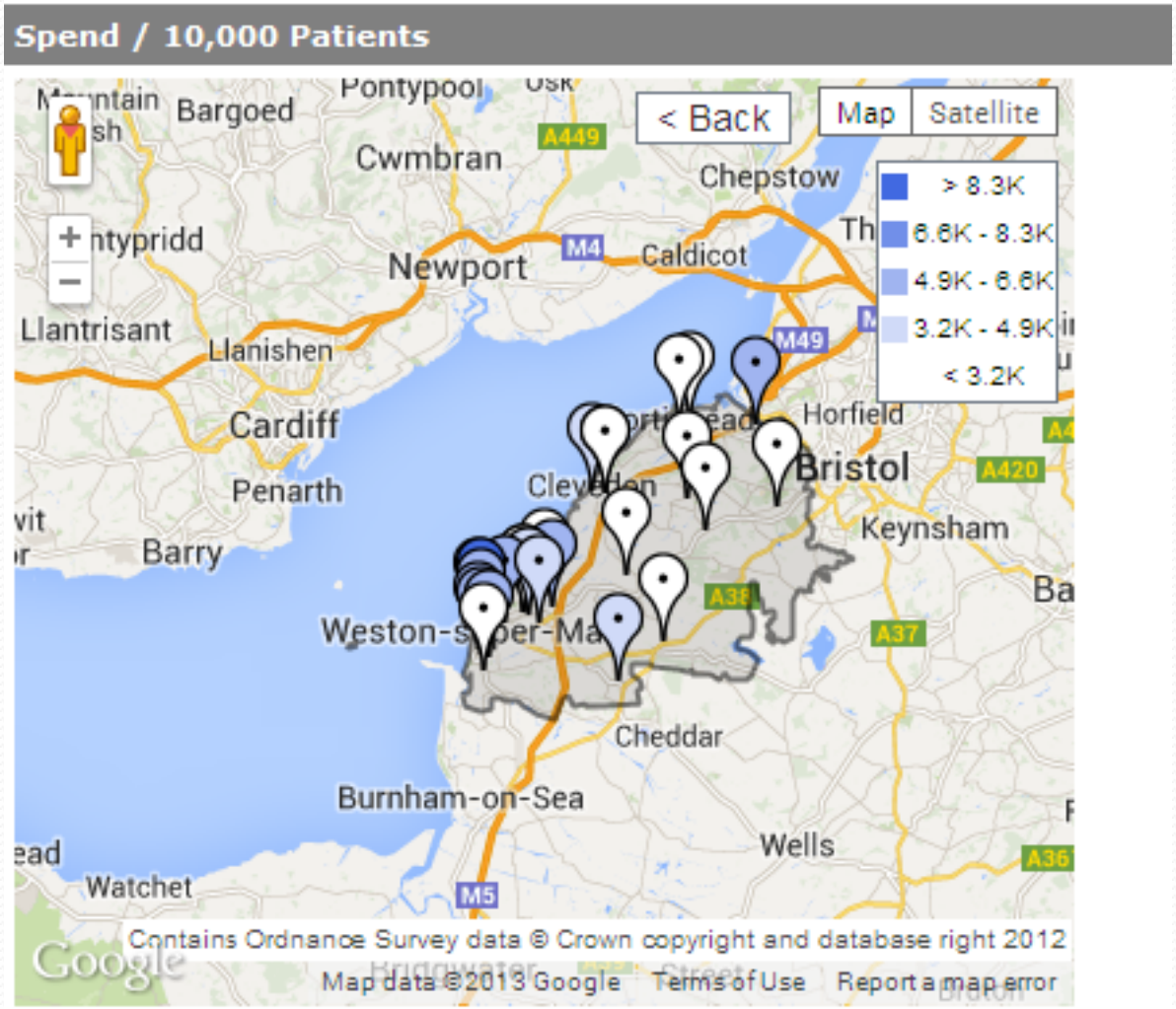
- Pain may be:-
- Nociceptive (caused by activation of 'pain' receptors) -> dull, aching, poorly localised
- Neuropathic (caused by damage to or malfunction of the nervous system) -> burning, tingling, pins and needles
- Mixed

Why do we need chronic pain guidelines?

- Increasing use of opioids…



Prescribing Information (Opioid analgesics)



Why do we need chronic pain guidelines…

- Management of pain is in the realm of the GP…
- Potential deskilling in the management of pain due to QOF?
- Expert opinion is changing
- Chronic pain patients are likely to be regular attendees at the GP surgery
- Need to monitor opioid usage as part of accountable officer responsibilities
- Significant public health concern around long term opioid use
- New drugs (e.g. tapentadol)

Principles of the guidance…

- Designed around an algorithm
- Need for initial baseline assessment and review
- Recognition that pharmacological treatment forms a small part of the overall management of pain
- Safe use of opioid drugs
- When to refer…?

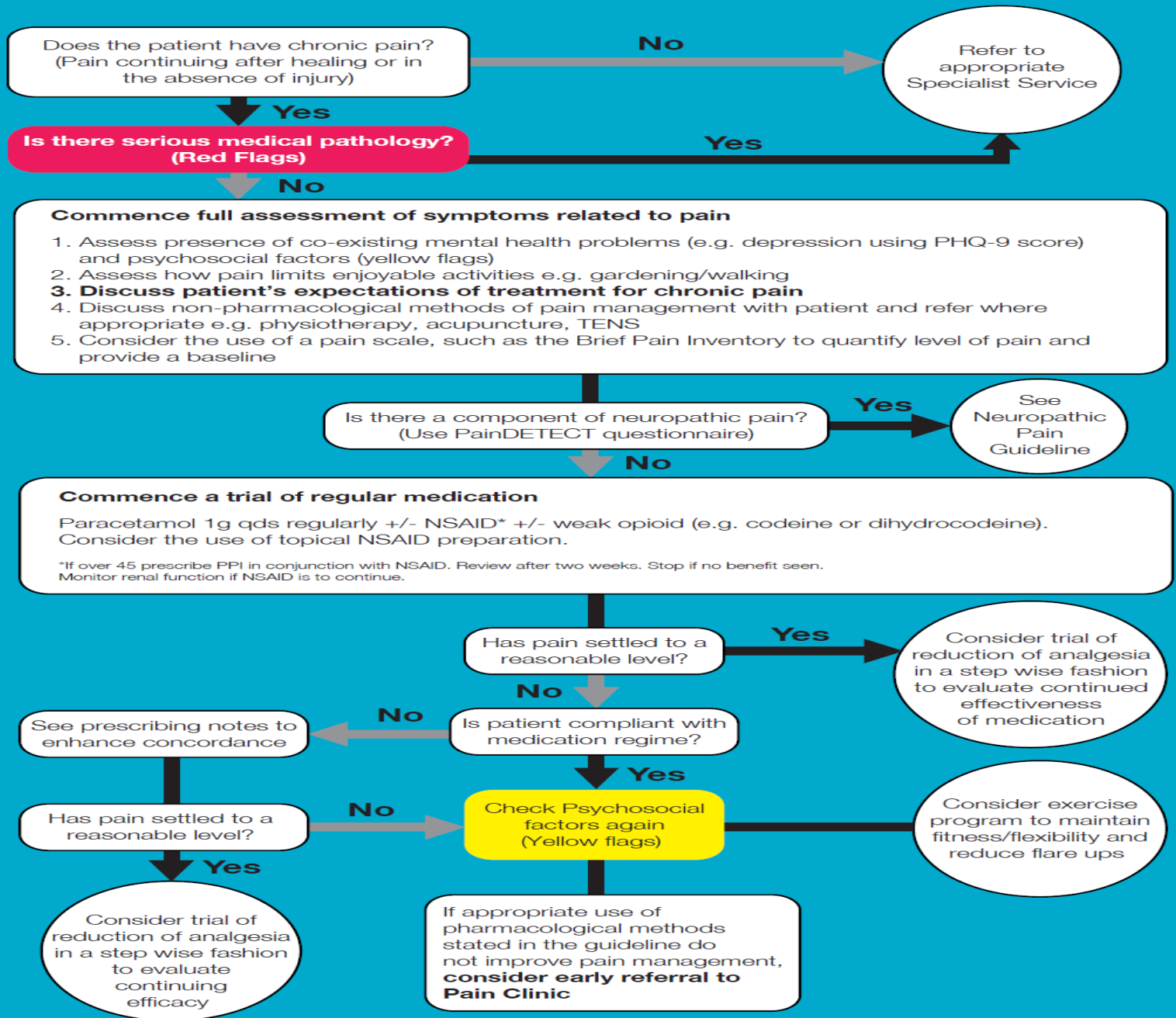
How were the guidelines developed?

- A long process…!
- Recognition that old guidelines did not reflect the opinions and practice of pain management consultants
- Initial draft -> local consultation -> KOL consultation

-> BNSSG Drugs and therapeutics Committee…

…repeat… ad nauseum!

Algorithm for the Management of Chronic (non-cancer) Pain



Assessment of pain…

- Ask how pain limits enjoyable activities
- Discuss patient's expectation of treatment for pain

- Consider use of a pain scale to provide a baseline
- Brief Pain Inventory
- PainDETECT

Assessment of pain…

- Red Flags?
- Indicators of possible more serious underlying conditions.
  - Possible fracture
  - Possible tumour
  - Possible significant neurological deficit
- Yellow Flags?
- Biopsychosocial issues related to chronic pain
  - Depression/ anxiety
  - Attitude/ beliefs to pain
  - Catastrophisation

Management of Chronic Pain

IMPORTANT

- Rarely are we able to 'cure' pain
- The aim of treatment is to allow the patient to do activities which are currently limited by the presence of pain
- Patients expectations of treatment should be managed early on

Medicines play a minor part in managing persistent pain

Non-pharmacological methods of pain relief include TENS, acupuncture, physiotherapy, psychology

The management of pain is multidisciplinary!

Opioids in chronic pain

Important Notes

- The safety and efficacy of long term opioid use is poor
- Do not use injectable opioids or pethidine
- Seek specialist advice earlier rather than later
- Do not use more than 120mg/day morphine (or equivalent)
- If pain has not improved, stop. Do not escalate the dose and seek specialist advice
- Long term opioid use may worsen or prolong symptoms of pain
- **Opioids are not usually helpful in the following conditions:**
  - X Mechanical back pain
  - X Fibromyalgia
  - X Pelvic or abdominal pain
  - X Non-specific visceral pain

The decision to prescribe opioids in these conditions should be made in conjunction with advice from specialist pain management services.

Managing opioids

- The aim of therapy is to modify pain with the lowest possible dose of opioid.
- Review the patient regularly (at least monthly, and more often if there are any concerns) and ensure that requests for dose increases are evaluated carefully. **DO NOT** increase the dose (or give extra medication) without seeing the patient.
- If pain has not settled and ceiling for opioid prescribing is reached (120mg/day morphine or equivalent), **TAPER DOSE AND STOP.**
- It is unlikely that an alternative opioid will work where morphine has not. Efficacy and adverse events are similar for all opioids.
- **Seek specialist advice** if the opioid trial fails and patients request further input in order to help manage their pain.
- Review prescribing regularly.

Opioid potency

Transdermal opioids: Approximate equivalence with oral morphine[4]

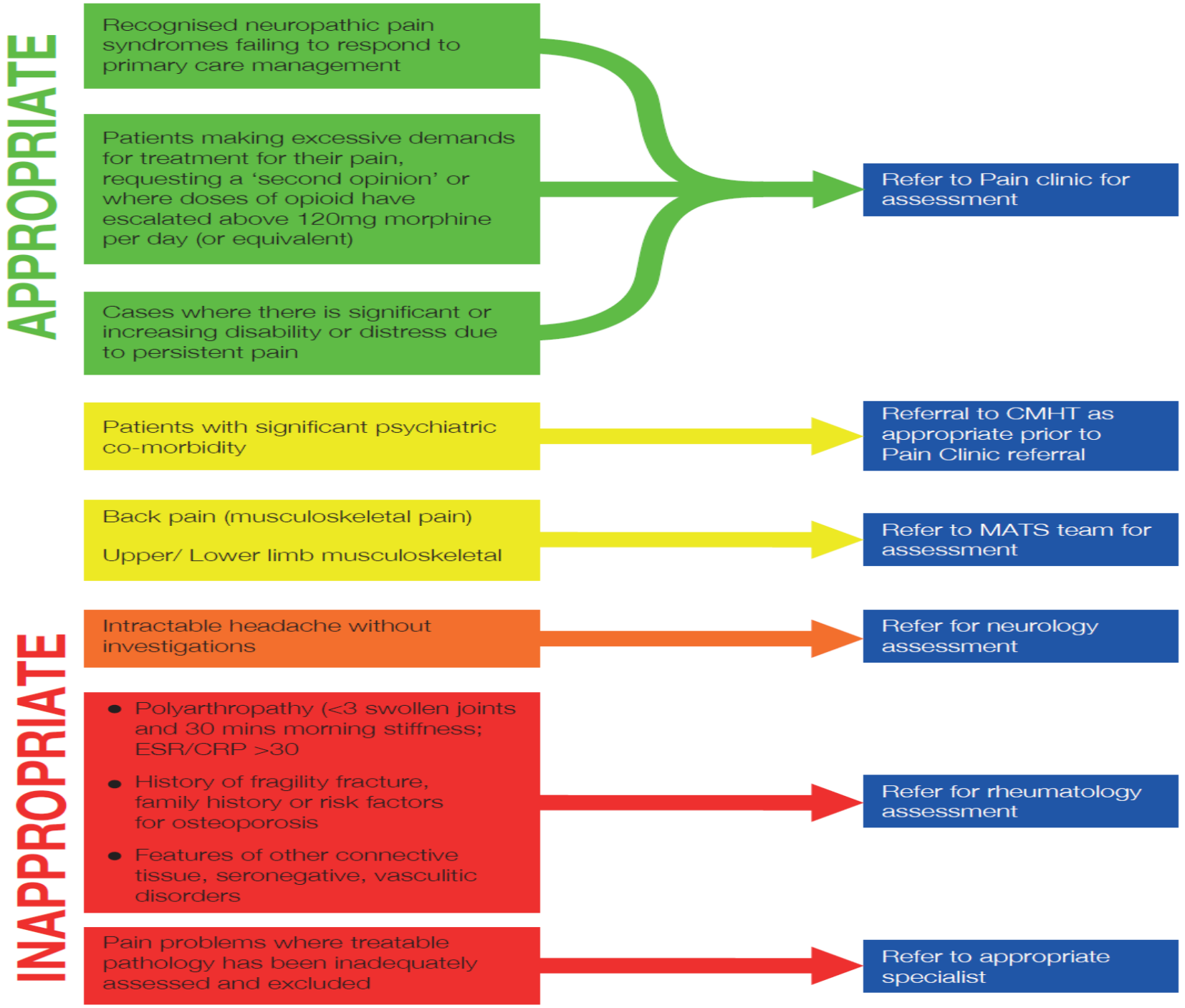
Oral morphine equivalent (mg/24 hrs)	**10**	**15**	**30**	**45**	**60**	**90**	**120**	**180**	**270**	**360**
Transdermal buprenorphine (µg/hr)	5	10	20		35	52.5	70			
Transdermal fentanyl (µg/hr)				12		25		50	75	100

Other opioids

- Oxycodone: Twice as potent as morphine
- Tramadol: at max dose (400mg/d) = 40mg morphine

- A quick note about doses…

- BNF doses are misleading. They should not and do not apply to the doses used in chronic pain


APPROPRIATE
Recognised neuropathic pain syndromes failing to respond to primary care management
Patients making excessive demands for treatment for their pain, requesting a 'second opinion' or where doses of opioid have escalated above 120mg morphine per day (or equivalent)
Cases where there is significant or increasing disability or distress due to persistent pain
Refer to Pain clinic for assessment
Patients with significant psychiatric co-morbidity
Referral to CMHT as appropriate prior to Pain Clinic referral
Back pain (musculoskeletal pain)
Upper/ Lower limb musculoskeletal
Refer to MATS team for assessment
INAPPROPRIATE
Intractable headache without investigations
Refer for neurology assessment
Polyarthropathy (<3 swollen joints and 30 mins morning stiffness; ESR/CRP >30
History of fragility fracture, family history or risk factors for osteoporosis
Features of other connective tissue, seronegative, vasculitic disorders
Refer for rheumatology assessment
Pain problems where treatable pathology has been inadequately assessed and excluded
Refer to appropriate specialist

Implementation of guidance…

- Changing practice takes time!
  - Imbedded practice/ opinion
- Dissemination
  - GPs, nurses, pharmacists
  - Help from pharma
- Monitor
  - Prescribing data (ePACT, Eclipse)
  - Accountable Officer reports
- Challenge
  - Medicines Management teams
  - Practice pharmacists
  - You!

Community Pharmacy…

- Can you think of patients that you see who have chronic pain?
- Average of 10 patients per practice on >120mg/d morphine equivalent
- What can YOU do?


fibromyalgia
pain
patients
manage
symptoms
persistent
NeP
neuropathic
people
disease
sleep
cause
living
chronic
Canadians
include
condition
nerve
affects
neuropathy
impact
described
therapies
difficulty
experience
burning
stabbing
tingling
fatigue
result
treatments
peripheral
person
life
non
associated
aching
functioning
sensations
deep
physical
body
changes
work
quality
injury
severe
difficult
response
common
diabetic
time
shock
diagnose
chronic
spinal
typical
skin
important
stimulus
dysfunction
disturbance
swelling
concentrating
practitioners
searing
surgery
means
costs
induced
health
empowerment
throbbing
options
requires
brain
sharp
electric
frustrating
learning
majority
trigger
shooting
various
medications
unable
reported
temperature
discoloration
limits
million
activities
exercise
ability
study
daily
numbness
complimentary
progressive
average
traumas
improvement
physicians
indicates