GPs at the Deep End

Pioneer Scheme Day-release programme

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Horselethill Road, Glasgow

Chronic pain management

With Dr Colin Rae, Anaesthetics consultant Stobhill, Pamela Gavin Physiotherapist, Laura McAllister Clinical Psychologist, Diane Watson Pharmacist,

Pain

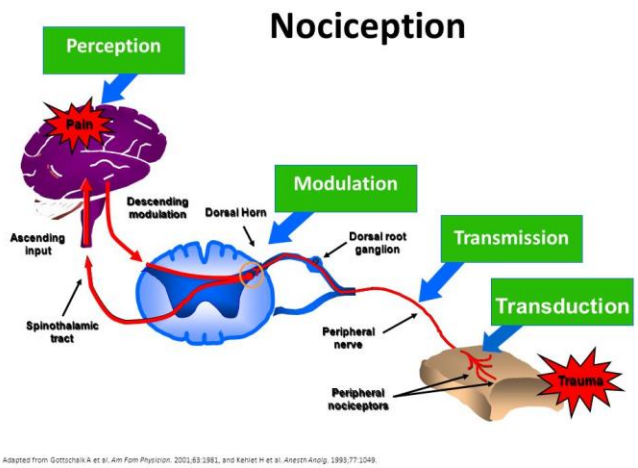
The IASP definition states it is

"An unpleasant sensory and emotional experience with actual or potential tissue damage or an experience described in such terms..."

Chronic Pain

"A chronic and persisting sensation for longer than would be expected within the normal time frame for tissue healing"

Pain transduction: current conceptual approach



Adapted from Gottschalk A et al. *Am Fam Physician*. 2001;63:1981, and Kehlet H et al. *Anesth Analg*. 1993;77:1049.

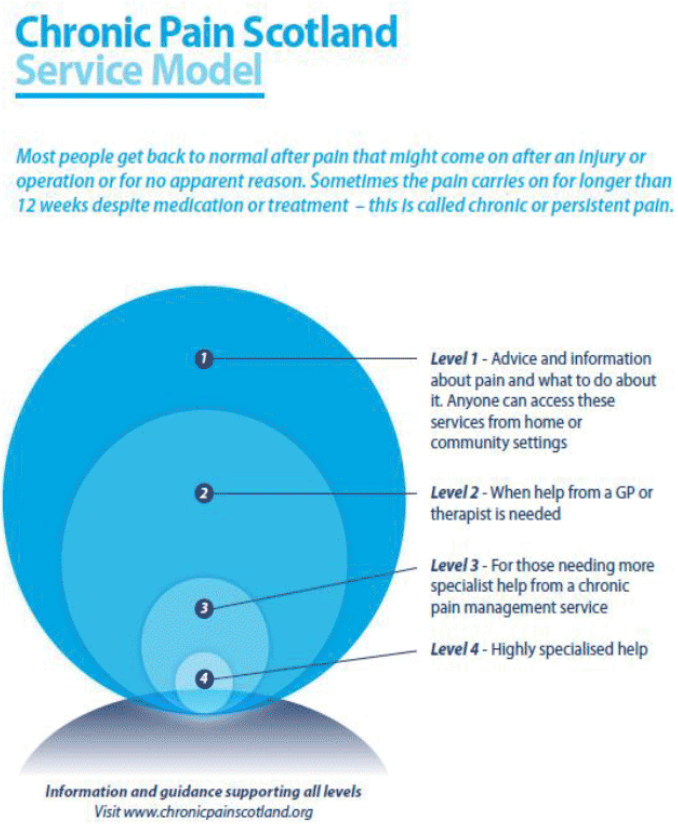
Scottish government recognized long term health condition

Nicola Sturgeon as Heath Secretary in 2008 stated the Scottish government recognized chronic pain as a long term health condition thereby giving it a political focus and also legitimizing it which has lead to NHS and government efforts to address it:

NHS

Chronic pain is defined by Healthcare Improvement Scotland (HIS) as 'continuous, long-term pain lasting more than 12 weeks or pain persisting after the time that healing would have been expected to occur after trauma or injury'. It can be associated with other diseases, but can also occur as a condition by itself.

Now a drive to ensure Health Boards have chronic pain services



Scottish Government

The establishment of a Ministerial Steering Group (MSG) on Chronic Pain, which was chaired by Scottish Ministers in November 2014, began. In 2017 it was decided that following the establishment of the National Advisory Committee for Chronic Pain, the functions of the Ministerial Steering Group would be transferred into the new Committee tasked with how best to achieve the range and type of support required for patient with chronic pain and support ongoing developments to aid patients with chronic pain.

SIGN guidelines: the only evidence based international guideline

SIGN guideline 136: quick reference

ASSESSMENT

✓ A concise history, examination and biopsychosocial assessment, identifying pain type (neuropathic/nociceptive/mixed), severity, functional impact and context should be conducted in all patients with chronic pain. This will inform the selection of treatment options most likely to be effective.

✓ Referral should be considered when non-specialist management is failing, chronic pain is poorly controlled, there is significant distress, and/or where specific specialist intervention or assessment is considered.

✓ A compassionate, patient-centred approach to assessment and management of chronic pain is likely to optimise the therapeutic environment and improve the chances of successful outcome.

SUPPORTED SELF MANAGEMENT

C **Self management resources should be considered to complement other therapies in the treatment of patients with chronic pain.**

✓ Healthcare professionals should signpost patients to self help resources, identified and recommended by local pain services, as a useful aide at any point throughout the patient journey. Self management may be used from an early stage of a pain condition through to use as part of a long term management strategy.

PHARMACOLOGICAL THERAPIES

✓ Patients using analgesics to manage chronic pain should be reviewed at least annually, and more frequently if medication is being changed, or the pain syndrome and/or underlying comorbidities alter.

Non-opioid analgesics (simple and topical)

B **NSAIDs should be considered in the treatment of patients with chronic non-specific low back pain.**

B **Cardiovascular and gastrointestinal risk needs to be taken into account when prescribing any non-steroidal anti-inflammatory drug.**

C **Paracetamol** (1,000-4,000 mg/day) **should be considered alone or in combination with NSAIDs in the management of pain in patients with hip or knee osteoarthritis in addition to non-pharmacological treatments.**

A **Topical NSAIDs should be considered in the treatment of patients with chronic pain from musculoskeletal conditions, particularly in patients who cannot tolerate oral NSAIDs.**

A **Topical capsaicin patches** (8%) **should be considered in the treatment of patients with peripheral neuropathic pain when first line pharmacological therapies have been ineffective or not tolerated.**

B **Topical lidocaine should be considered for the treatment of patients with postherpetic neuralgia if first line pharmacological therapies have been ineffective.**

B **Topical rubifacients should be considered for the treatment of pain in patients with musculoskeletal conditions if other pharmacological therapies have been ineffective.**

Opioids

B **Strong opioids should be considered as an option for pain relief for patients with chronic low back pain or osteoarthritis, and only continued if there is ongoing pain relief. Regular review is required.**

B **Patients prescribed opioids should be advised of the likelihood of common side effects such as nausea and constipation.**

✓ All patients on strong opioids should be assessed regularly for changes in pain relief, side effects and quality of life, with consideration given to a gradual reduction to the lowest effective dose.

B **It may be necessary to trial more than one opioid sequentially, as both effectiveness and side effects vary between opioids.**

✓ Opioid rotation should be considered for chronic pain that is likely to respond to opioids, if there are problems with efficacy or side effects.

C **Signs of abuse and addiction should be sought at re-assessment of patients using strong opioids. Routine urine drug testing, pill counts or prescription monitoring should not be used to detect problem use.**

B **Currently available screening tools should not be relied upon to obtain an accurate prediction of patients at risk of developing problem opioid use before commencing treatment.**

✓ There should be careful assessment of pre-existing risk factors for developing opioid misuse. In patients where opioid therapy is indicated, but there is an increased risk of iatrogenic opioid misuse, specialist advice should be sought. The minimal effective dose should be used to avoid increased problems of fracture and overdose that may occur on higher doses.

D **Specialist referral or advice should be considered if there are concerns about rapid-dose escalation with continued unacceptable pain relief, or if >180 mg/day morphine equivalent dose is required.**

Anti-epilepsy drugs

A **Gabapentin** (titrated up to at least 1,200 mg daily) **should be considered for the treatment of patients with neuropathic pain.**

A **Pregabalin** (titrated up to at least 300 mg daily) **is recommended for the treatment of patients with neuropathic pain if other first and second line pharmacological treatments have failed.**

A **Pregabalin** (titrated up to at least 300 mg daily) **is recommended for the treatment of patients with fibromyalgia.**

B **Flexible dosing may improve tolerability. Failure to respond after an appropriate dose for several weeks should result in trial of a different compound.**

B **Carbamazepine should be considered for the treatment of patients with neuropathic pain. Potential risks of adverse events should be discussed.**

Antidepressants

✓ Patients with chronic pain conditions using antidepressants should be reviewed regularly and assessed for ongoing need and to ensure that the benefits outweigh the risks.

A **Tricyclic antidepressants should not be used for the management of pain in patients with chronic low back pain.**

A **Amitriptyline** (25-125 mg/day) **should be considered for the treatment of patients with fibromyalgia and neuropathic pain** (excluding HIV-related neuropathic pain).

✓ It may be appropriate to try alternative tricyclic antidepressants to reduce the side effect profile.

A **Duloxetine** (60 mg/day) **should be considered for the treatment of patients with diabetic neuropathic pain if other first or second line pharmacological therapies have failed.**

A **Duloxetine** (60 mg/day) **should be considered for the treatment of patients with fibromyalgia or osteoarthritis.**

B **Fluoxetine** (20-80 mg/day) **should be considered for the treatment of patients with fibromyalgia.**

B **Optimised antidepressant therapy should be considered for the treatment of patients with chronic pain with moderate depression.**

✓ Depression is a common comorbidity with chronic pain. Patients should be monitored and treated for depression when necessary.

Combination therapies

A **Combination therapies should be considered for patients with neuropathic pain** (a pathway for patients with neuropathic pain can be found in Annex 3).

A **In patients with neuropathic pain who do not respond to gabapentinoid** (gabapentin/pregabalin) **alone, and who are unable to tolerate other combinations, consideration should be given to the addition of an opioid such as morphine or oxycodone. The risks and benefits of opioid use needs to be considered.**

PSYCHOLOGICALLY BASED INTERVENTIONS

✓ Healthcare professionals referring patients for psychological assessment should attempt to assess and address any concerns the patient may have about such a referral. It may be helpful to explicitly state that the aims of psychological interventions are to increase coping skills and improve quality of life when faced with the challenges of living with pain.

Pain management programmes

C **Referral to a pain management programme should be considered for patients with chronic pain.**

Unidisciplinary education

C **Brief education should be given to patients with chronic pain to help patients continue to work.**

Chronic pain association

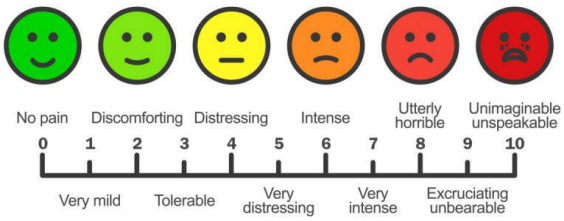
- Increases with age
- Increases with deprivation
    - 10 year mortality for all cause death 1.8 higher in those with chronic pain
    - Decreased productivity and increased rate of worklessness
    - Weak & strong opioid prescribing highest volume in SMID 1 and least in 5 (least deprived)

Chronic pain management clinic in GGC:

1 for whole north Glasgow at Stobhill, 1 in south Glasgow at the new Victoria and one at Inverclyde for Clyde catchment

- MDT approach
- Chronic pain a condition largely refractive to medical management
- Physiotherapist try to shift focus to regaining function and quality of life
- Psychologist aid and help to break down mental barriers that might impair this
- Clinical pharmacist advise on medication, and undertake clinical reviews with aims of rationalization and de-escalation as able

- Anaesthetic input for medical prescribing/procedures but very much not just escalating therapy: now much more attuned to realistic medicine (https://beta.gov.scot/news/realising-realistic-medicine/)
- Challenges include no detectable outcome measures, and that pain in itself is a subjective sensory and emotional experience with many confounding factors such as anxiety & depression
  - Difficult to medically treat/cure
  - No one treatment will work for everyone
  - Complete remission unrealistic
  - Need to aid realistic expectations
  - Helping patients achieve their normal activities of daily living is a primary aim rather than decreasing there pain
  - The WHO analgesic ladder who originally intended for those patients with cancer and pain, not really chronic pain i.e. a long term condition
  - New evidence suggests >90ML MST daily is associated with more SEs and risks than benefit
  - Often patients have mental health issues that go along with their pain and this must be considered too
  - Pain clinic cannot accept any patient where suicide is a risk
  - Suggest referring patients once diagnosis/investigations are complete as clinic not set up for diagnostic service, rather it's about managing symptoms



Example of a face pain scale when trying to quantity pain

❖ **Useful resources:**

- www.britishpainsociety.org/
- www.iasp-pain.org
- http://www.paindata.org/
- http://www.neurosymptoms.org/
- https://www.glasgowlife.org.uk/communities/good-move/live-active
- http://www.nhsggc.org.uk/about-us/professional-support-sites/physical-activity/services/vitality/
- https://www.rcoa.ac.uk/faculty-of-pain-medicine
- https://www.rcoa.ac.uk/faculty-of-pain-medicine/e-pain
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