DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Management of Non-Malignant Chronic Pain in Primary Care

(Updated based on NICE NG193)

- Chronic pain refers to pain that exist beyond the expected time of healing, usually taken as pain that persists or recurs for more than 3 months. It includes
  - **chronic primary pain** - no clear underlying condition, or the pain or its impact is out of proportion to any observable injury or disease. e.g. fibromyalgia, chronic primary headache and orofacial pain, chronic primary musculoskeletal pain, and chronic primary visceral pain.
  - **chronic secondary pain** - symptom of an underlying condition. e.g. endometriosis, rheumatoid arthritis, spondyloarthritis.

- For Management of osteoarthritis, Backpain & sciatica, Neuropathic pain, Strong opioid in cancer pain, and Deprescribing & safer prescribing of strong opioids in non-malignant pain- see relevant JAPC guidelines. For the treatment of migraine see JUCD Adult headache primary care pathway.

- Assessment and management of pain is complex. Patient presenting with chronic pain should be offered a person-centred assessment to identify factors contributing to the pain, and how the pain affects the person's life.

- Consider each person as an individual and take a holistic, collaborative approach. Acknowledge that living with chronic pain can be distressing. Enable patient to actively participate in their care by effective communication, providing suitable information, and enable shared decision making.

- **Chronic primary and secondary pain can coexist**- a dual approach of managing the underlying condition and the chronic primary pain is important.

- Be aware that initial diagnosis can change with time. Offer a reassessment if a person presents with a change in symptoms such as a flare-up.

- Non-pharmacological methods are the mainstay in the management of chronic pain. When medicines are prescribed they should be used in conjunction with other non-pharmacological approaches such as advice regarding activity, and explanation that complete relief of symptoms may not be a goal of therapy.

- Pharmaceutical management of ***chronic primary pain***
  - NICE no longer recommends initiation of paracetamol, NSAIDs, opioids, antiepileptics including gabapentinoids, and benzodiazepines.
  - Off- label use of antidepressant (amitriptyline, citalopram, duloxetine) may be considered after full discussion of benefits and harms. Reviewed at 4-6 weeks if used.

- The British Pain Society (BPS) and Faculty of Pain Medicine (FPM) of the Royal College of Anaesthetists have both produced position statements expressing valid concerns regarding NICE guideline recommendations on chronic primary pain management, including difficulty in diagnosis; lack of advice on management of flare ups; and risk of potential inappropriate withdrawal of useful medications.

- JAPC support NICE recommendations on chronic primary pain management, but also accept the valid BPS/FPM concerns. JAPC acknowledge that there are currently gaps in capacity and local service provision for non-pharmacological therapies (e.g. acupuncture, exercise programme), as well as specialist pain management and other associated services (e.g. Cognitive behavioural therapy). **JAPC recognise that the new guidance represents significant change in practice and cannot be fully implemented until relevant service provision are in place.**

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Reference

1. NICE NG193 https://www.nice.org.uk/guidance/ng193
2. CKS Chronic pain pain https://cks.nice.org.uk/topics/chronic-pain/
3. The British Pain Society https://www.britishpainsociety.org/
4. Faculty of Pain Medicine of the Royal College of Anaesthetists https://fpm.ac.uk/
5. NICE NG144 Cannabis-based medicinal products. https://www.nice.org.uk/guidance/ng144

Document control	

1. Introduction

This guideline is based on NICE NG193 and aims is to provide guidance for primary care clinicians on the management chronic pain, with specific focus on the *management of* ***chronic primary pain***.

In the UK the prevalence of chronic pain is uncertain, but appears common, estimated to affect between 3- 5 in every 10 people. It is not known what proportion of people with chronic pain either need or wish for treatment. The prevalence of chronic primary pain is unknown but is estimated to be between 1% and 6% in England.

Definitions

Chronic pain

Pain that persists for more than 3 months
Other terms used include persistent pain and long-term pain.

Chronic primary pain

Has no clear underlying condition or is out of proportion to any observable injury or disease.

The mechanisms underlying chronic primary pain are only partially understood and the definitions are fairly new. The clinical presentation is consistent with the ICD-11 definition.

All forms of pain can cause distress and disability, but these features are particularly prominent in presentations of chronic primary pain.

e.g.

- Fibromyalgia (chronic widespread pain)
- chronic primary headache and orofacial pain
- chronic primary musculoskeletal pain
- chronic primary visceral pain.

Chronic secondary pain

Symptom of an underlying condition

e.g.

- Endometriosis
- Headaches
- IBS (local guideline)
- low back pain & sciatica (local guideline)
- neuropathic pain (local guideline)
- osteoarthritis (OA) (local guideline)
- rheumatoid arthritis (RA)
- spondyloarthritis.

Chronic secondary pain and chronic primary pain can coexist.
Diagnosis can change with time. Offer reassessment if a person presents with flare-up.

Flare-up
A sudden, temporary worsening of symptoms. Usually this refers to more intense pain on a day-to-day basis. It can also refer to a change in fatigue, stiffness, function or disease activity. Flare-ups can be unpredictable and the time they last can vary.

2. Patient-centred Assessment

Offer a *patient centred* assessment to identify factors contributing to the pain. The assessment of chronic pain needs to be wide-ranging and comprehensive.

Recognise that chronic primary pain can **coexist** with chronic secondary pain, and that initial diagnosis may change with time.

- Ask the person (and their family/carers) to describe how chronic pain affects their life, and how aspects of their life may affect their chronic pain. This may include:-
    - Lifestyle and day-to-day activities, including work and sleep disturbance
    - physical and psychological wellbeing
    - stressful life events, including previous or current physical or emotional trauma
    - current or history of substance misuse
    - social interaction and relationships
    - difficulties with employment, housing, income, and other social concerns.
- Ask about the person's (and their family/carer) understanding of their condition including causes of the pain, expectations, and outcome of possible treatments.
- Explore a person's strengths as well as the impact of pain on their life.
- In young adults aged 16-25 years, consider age-related differences in presentation of symptoms, the impact of pain on family interactions/ dynamics, education, and social/ emotional development.

<u>Providing information and developing care & support plan</u>

- Acknowledge that living with pain can be distressing.
- Consider each person as an individual and take a holistic, collaborative approach. Enable patient to actively participate in their care by effective communication, providing suitable information (in appropriate format e.g. written, verbal, video etc.), and enable shared decision making.
- Be sensitive to the risk of invalidating the person's experience of chronic pain when communicating normal or negative test results.
- Explain the evidence for possible benefits, risks, and uncertainties of all management options to inform and agree the care and support plan.
- Offer a **reassessment** if a person presents with a change in symptoms such as a **flare-up** of chronic pain. Review the care & support plan, consider investigating & managing any new symptoms, and discuss what might have contributed to the flare-up (but be aware that a cause for the flare-up may not be identified).

Discuss the following advice	**Develop plan**
• symptoms will fluctuate over time and that they may have flare-ups • a reason for the pain (or flare-up) may not be identified, and the pain may not improve or may get worse and may need ongoing management • there **can** be improvements in quality of life even if the pain remains unchanged.	• explore their priorities, abilities and goals • what they are already doing that is helpful • their preferred approach to treatment and balance of treatments for multiple conditions • any support needed for young adults (aged 16 to 25) to continue with their education or training, if this is appropriate.

3. Non-pharmacological Interventions

Non-pharmacological methods are the mainstay in the management of chronic pain. The general principles include:

- **Activity**: the evidence shows that keeping active improves both physical and mental well-being. Being active when in pain can be a challenge and it is therefore important for patients to know that it is safe to be active in spite of pain; provide reassurance that pain does not always indicate harm especially when pain persists for a long time.

  For some patients, weight loss may improve outcomes; support for assistance with weight loss efforts is available from: https://www.livelifebetterderbyshire.org.uk/

- **Encourage self-management**: Self-management can be used from the early stages of management through to long-term management and can complement other therapies. Understand that Medicines are generally less effective for persistent pain than for other types of pain. When medicines are prescribed, they should be used in combination with other treatment approaches to support improved physical, psychological and social functioning. Provide advice and information about diet, weight, alcohol use, smoking, and exercise for improving or maintaining health.

- **Understanding pain**: Persistent non-cancer pain is influenced not only by tissue injury but by a number of emotional, social and cognitive variables. Psychoeducation around pain mechanisms can help to reduce the experience of psychological threat. Fear is a major driver that can contribute to persistent pain. Education helps reduce fear, promote understanding and resilience, and enable recovery of confidence and activity. Every clinical interaction has the potential to do this. It is important that patients with chronic pain understand that treatments tend not to be very effective and that the aim is to support them in functioning as well as possible. (FPM)

- **Psychological approaches**: the evidence shows that pain is associated with anxiety and stress; therefore, it may be helpful to use relaxation techniques and/or psychological approaches (such as cognitive behavioural therapy) to help to manage the pain. High levels of anxiety, stress and pain may lead to sleep disturbance; hence, sleep restoration strategies may also be helpful.

This section represents a very brief overview of non-pharmacological management of chronic pain and, if the GP requires more detailed assessment and treatment, then a **referral to specialist services, such as the pain clinic, the physiotherapy service, a pain management programme (for group-based management of mood and activity) or the Health Psychology Service (for management of mood, adjustment and coping issues) is strongly recommended.**

For the management of chronic primary pain, NICE recommends

- *Offer* supervised group exercise programme
- *Consider* psychological therapy (acceptance and commitment therapy (ACT) or cognitive behavioural therapy (CBT)
- *Consider* a single course of acupuncture or dry needling, within a traditional Chinese or Western acupuncture system, *only if* it is delivered as per described by NICE in a community setting. **Note acupuncture for pain management is not currently commissioned in Derbyshire.** See position statement.
- Do NOT offer biofeedback, TENS, ultrasound, or interferential therapy due to lack of evidence on benefit.

4. Pharmacological Management for Chronic Primary Pain

Medicines are generally less effective for persistent pain than for other types of pain. When medicines are prescribed, they should be used in conjunction with non-pharmacological interventions.

Consider an antidepressant **after a full discussion of the benefits and risk/ harms**.
The use of antidepressant to treatment chronic primary pain is **off- label**.

The choice of which antidepressant will depend on individual factors e.g. concomitant disease/ existing medications. See table below.

Explain that an antidepressant may help with quality of life, pain, sleep and psychological distress, even in the absence of a diagnosis of depression.

Review efficacy/ side effect after 4-6 weeks.
Stop and reconsider/try an alternative if no emotional or functional improvement is seen.

1st line options:

Drug	Suggested dose	Considerations
Amitriptyline	Start at the lowest possible dose (5-10mg) at night. Increased in steps of 10-25 mg every 1-2 weeks as required. Usual max. dose 75mg	✓ Established use in neuropathic pain ❖ High anticholinergic burden ❖ C/I significant cardiac problems e.g. arrhythmias, heart block or immediate post MI
Citalopram	20mg daily Increase after 3-4 weeks in steps of 20mg daily if required. Max. 40mg daily (Max. 20mg daily in elderly)	✓ Lowest cost ❖ Susceptible to QT-interval prolongation SSRIs:- ❖ ↑ risk of bleeding with concomitant NSAID/ aspirin/ anticoagulants ❖ Risk of exacerbating or precipitating hyponatraemia especially in elderly ❖ Small ↑ risk of postpartum haemorrhage
Duloxetine	60mg daily	✓ Lowest anticholinergic burden ✓ Established use in diabetic neuropathy ❖ Highest cost

Alternative options if above not suitable

Drug	Suggested dose	Considerations	
Fluoxetine	20mg daily, increase after 3-4 weeks if required. Max. 60mg daily (elderly max. 40mg daily)	✓ Preferred in children/ young people (depression) ❖ Possible small risk of congenital cardiac defects	SSRIs:- ❖ ↑ risk of bleeding with concomitant NSAID/ aspirin/ anticoagulants ❖ Risk of exacerbating or precipitating hyponatraemia especially in elderly ❖ Small ↑ risk of postpartum haemorrhage
Sertraline	50mg daily, increasing in steps of 50mg if required. Max. 200mg daily	✓ Safe in patients with unstable angina or recent MI ✓ Drug interactions less likely ❖ Higher cost compared to other SSRIs	
Paroxetine	20 mg in the morning, no evidence of greater efficacy at higher doses	❖ High anticholinergic burden ❖ Short half-life more often associated with withdrawal syndromes than other SSRIs	

Hyponatraemia – most antidepressants are associated with hyponatraemia, with the highest risk being with SSRIs and SNRIs. Recommendation is for baseline serum sodium and repeat within first month. Risk is greater in older adults or those taking concurrent natriuretic medicines e.g. diuretics or with low body weight or in warm weather. Management- consider other cause of hyponatraemia, stop

antidepressant and monitor serum sodium. Consider switching to another class if appropriate. See further advice from SPS.

For advice on **switching between antidepressants** please refer to JAPC guideline Depression and the use of antidepressants

NICE recommends Do NOT initiate

- paracetamol
- non-steroidal anti-inflammatory drugs (NSAIDs)
- opioids
- antiepileptic drugs including gabapentinoids (gabapentin & pregabalin)*
- benzodiazepines
- antipsychotic drugs or ketamine
- local anaesthetics (topical or intravenous)*
- corticosteroid or local anaesthetic/corticosteroid combination trigger point injections
- Nabilone, dronabinol, THC (delta-9-tetrahydrocannabinol), combination of cannabidiol (CBD) with THC

* unless part of a clinical trial for complex regional pain syndrome

The British Pain Society (BPS) and Faculty of Pain Medicine (FPM) of the Royal College of Anaesthetists have both produced position statements expressing concerns regarding NICE recommendations on chronic primary pain management, including

- difficulty in diagnosis
  - poorly understood underlying mechanism- no clear underlying condition does not mean that chronic primary pain is a single entity.
  - chronic primary and secondary pain often co-exist
  - NICE uses ICD-11 classification which does not reflect clinical practice or current research base
- lack of advice on management of flare ups; in particular, short-term use of analgesics is not offered
- potential inappropriate withdrawal of supervised short-term therapies which can work safely in carefully selected and monitored patients.
- risk that patients who are diagnosed with chronic primary pain, and who subsequently develop secondary pain are neither recognised nor treated appropriately.

JAPC support NICE recommendations on chronic primary pain management but also accept the valid BPS/FPM concerns. JAPC acknowledge that there are currently gaps in capacity and local service provision for non-pharmacological therapies (e.g. acupuncture, exercise programme), as well as specialist pain management & other associated services (e.g. Cognitive behavioural therapy).

JAPC recognise that the new guidance represents significant change in practice and cannot be fully implemented until relevant service provision are in place.

Commissioning arrangements for these services are outside of JAPC scope.

Follow up

Follow up people with chronic pain who are taking analgesics at least annually, and more frequently if medication is changed, or the pain syndrome and/or underlying comorbidities alter.

- Confirm the ongoing need for and effectiveness of the medication
- screen for adverse effects
- adjust the dose or discontinue as appropriate using a holistic polypharmacy approach

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

5. Existing Pharmacological treatment for chronic primary pain

If a person is already taking treatments for chronic primary pain, which are no longer recommended by NICE (e.g. opioids or gabapentinoids), explain the lack of evidence for these medicines for chronic primary pain. **Use shared decision-making process to agree a shared plan**.

- **if they report benefit at a safe dose and few harms**- agree a shared plan for continuing safely *or*
- **if they report little benefit or significant harm**- explain the risks of continuing and encourage and support them to reduce and stop the medicine if possible.
    - Explore additional or alternative methods of managing pain.
    - discuss with the person any problems associated with withdrawal.
    - A staged reduction plan may be required.

A joint statement of clarification regarding patients already on medication has been released by the FPM, BPS, The Chronic Pain Policy Coalition, and the Royal College of General Practitioners to highlight the following:-

- NICE definition of Chronic Primary Pain includes many of the more complex pain conditions (e.g. fibromyalgia, Complex Regional Pain Syndrome) which can be challenging to manage for both the health care professional and especially for the patients concerned.
- changes to medical/drug management need to be handled carefully and with due diligence.
- The new medication management principles are for Chronic Primary Pain and do not extend to other forms of Chronic Pain or Acute Pain (pain of less than 3 months duration)
- When patients are already taking medication for Chronic Primary Pain, the NICE recommendations should be viewed as an ideal opportunity within routine consultations to review continued medication usage.

JAPC recognises that withdrawing some existing medications may not be feasible/ appropriate, especially for stable patients, and also partly due to current limitations in capacity and service provision for alternative non-pharmacological treatment options.

Pragmatically, patient should be provided with relevant information where appropriate. See JAPC Deprescribing & Safer prescribing of opioids in non-malignant pain and opioid resources page to support review of existing opioid medication in chronic pain.

6. Criteria for referral to pain clinic

Consider specialist referral for people with chronic pain (urgency depending on clinical judgment) if:

- There are red flag signs and symptoms that may indicate serious underlying pathology.
- Non-specialist management is failing, and chronic pain is poorly controlled.
- Patient with relevant drug allergies or patient intolerant of standard analgesics
- There is significant distress.
- Where specific specialist intervention or assessment is required.
- Chronic regional pain syndrome is suspected.
- Worsening of correctable cause

Referral to a pain clinic should be carefully considered before starting patients on strong opioids (such as morphine) because **patients may be reluctant to stop these drugs once they are commenced on them**.

Criteria for referral to Health Psychology Service (area formerly covered by North Derbyshire and Hardwick CCGs)

General Practice can refer directly to the Health Psychology service for patients with any kind of chronic pain presentation where they are interested in exploring and would benefit from an individualised psychological approach to support them to:

- manage and influence their pain symptoms
- cope with pain medication and make decisions about treatment
- adjust to changes in everyday life due to their pain and/or treatment
- recover from low mood, anxiety and stress associated with their pain and/or treatment

Inclusion criteria are adults (18+), where enduring or severe mental health issues are stable enough for a patient to be well enough to access and benefit from health psychology approach (with adequate Recovery Team assessment and support) and where any substance misuse has been recognised and been appropriately treated and managed. Patient referrals can be made via e-mail to health.psychology@nhs.net.

Criteria for referral to Pain Management Programme (area formerly covered by North Derbyshire and Hardwick CCGs) – see appendix 5

For adults (18+) who are experiencing difficulties with pain and who would be interested in engaging with an educational group approach, the programme combines explaining the physiological and psychological mechanisms involved in the pain experience. Exploring strategies to help improve both physical function and mood, adopting a gentle approach to making enjoyable and rewarding lifestyle changes that can significantly impact on medication use and quality of life. Many previous participants have said that attending the programme has given them the support and encouragement, guidance and confidence needed to take control of their pain and do something about it. The programme is run jointly by Health Psychology and Physiotherapy. The programme runs in Chesterfield and Clay Cross. Patients can be referred directly to the Pain Management Programme, Physiotherapy Service, Walton Hospital.

Access to Derby Royal Hospital Pain Management Clinic psychology services

There is no direct referral route, but access can be arranged "in-house". Aims include for patients to:

- manage and influence their pain symptoms via values-based objectives
- adjust and adapt to changes required in everyday life to manage their pain optimally
- recover from low mood, anxiety and stress associated with their pain

For patients who would benefit from a psycho-educational group, they can be referred in-house for a half day Self-Management Session. Patients may then opt into a full Pain Management Programme, co-run between psychology, physiotherapy, and Nurse Specialists. Invited into the psychological elements of Pain Clinic are adults (18+) who are ready to make changes; where enduring or severe mental health issues are stable enough to access and benefit from health psychology (with adequate Recovery Team assessment, risk monitoring and support) and where any substance misuse has been recognised and been appropriately treated and managed.

Resources

- Live Well With Pain:
  - For people living with pain: https://my.livewellwithpain.co.uk
  - For clinicians: https://livewellwithpain.co.uk
- Goal-setting information leaflet and templates to use with people with chronic pain in care planning: https://my.livewellwithpain.co.uk/resources/self-management/goal-setting/
- JAPC Opioid Resources http://www.derbyshiremedicinesmanagement.nhs.uk/medicines-management/clinical-guidelines/opioid-resources
- Faculty of Pain Medicine https://fpm.ac.uk/
- NHS Medicines- Amitriptyline for pain and migraine, Duloxetine patient information leaflet
- British pain society- Amitriptyline, Duloxetine patient information leaflet

Useful contacts

UHDB - Chronic pain (outpatient services). Referral pain proforma can be found at https://www.uhdb.nhs.uk/service-chronic-pain General appointments or queries 01332 786086
Health Psychology Service, Walton Hospital, Chesterfield. 01246 515520

Appendix 1: North Derbyshire pain management programme referral

DCHS Pain Management Programme Inclusion/Exclusion Guidelines for Referrers

Version: 1 (01/12/2017)

1. Background/Aims

The Pain Management Programme is a multiple disciplinary group intervention aimed at service users with chronic, ongoing pain. Chronic, persistent pain is defined as pain that has remained for more than 3 months. The groups are run in Chesterfield and Clay Cross. This programme is jointly run by Psychology and Musculoskeletal Physiotherapy clinicians and is for people who are seeking to manage chronic musculoskeletal pain.

The focus of the programme is on improving quality of life, supporting people to live with their condition and placing emphasis on restoration of function rather than treating pain. The aims of the programme are to to increase understanding of how pain works in order to reduce psychological threat and encourage the development of effective coping strategies, to improve physical and psychological well-being, to improve self-management , as well as aiming to improve appropriate use of medication and decrease the demand on General Practice resources. To enable clinicians referring in to the Pain Management Programme have a clear understanding of appropriate referral criteria and process

2. Intended Users:

- GP's
- Nurse Practitioners
- AHP's including Physiotherapists, OT's, Podiatrists and Clinical Psychologists
- Pain Clinic, Orthopaedic and Rheumatology Consultants

3. Definitions/Terms Used:

Persistent pain: pain that has lasted for a period of 3months or more
Malignant source of pain: pain from cancer

4. Full Details of Guidelines

INCLUSION

- Pain that has persisted for more than 3 months.
- Understand it is a group programme of 6 sessions
- Motivated, willing and able to participate.
- No recent significant changes in symptoms.
- Patient has been appropriately medically screened e.g. for cancer and red flags

EXCLUSION

- Under 18's
- Malignant source of pain
- Unstable medical conditions still under active investigations or medical/surgical treatment
- Unstable mental health conditions. (We can treat people who have a stable mental health condition and/or have suicidal ideation but low intent.)
- On-going investigations for aetiology of pain.
- Current drug or alcohol misuse.

Please include all relevant medical history and drug history and send referrals to:
PMP, Physiotherapy Department, Peter McCarthy Suite, Walton Hospital, Whitecotes Lane, Chesterfield, S40 3HW
Group sessions are run on Thursday afternoons in Chesterfield and on Tuesday afternoons at Clay Cross Hospital.

Referral Form:

Chronic Pain Management Programme Referral

Please complete all sections of the form – on the reverse are the inclusion and exclusion criteria.

Patient Name: _____

Date of Birth: _____ NHS no: _____

Address: _____

_____

Daytime Tel No: _____

GP Name: _____ GP Code: _____

GP Practice: Address_____

Diagnosis / duration of problem

Relevant Medical History e.g. including depression/anxiety etc.

Previous treatment for this condition e.g. surgery, physiotherapy, referral to pain clinic etc.

Current drug therapy and dosage – please include print out of meds if appropriate

Relevant investigations / test results – please provide printout/copies if appropriate

Signature:_____ Date of referral:_____

Name of referrer:_____