Management of Chronic Pain in Patients above 16 years of age - The Overarching Pain Guideline for Primary Care Clinicians		
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PATIENT CENTERED ASSESSMENT

People experiencing persisting pain have complex care needs that can be challenging to meet in primary care settings. Effective pain management for most people will require a collaborative approach where the person is informed, listened to and actively involved, to the extent that they wish, in decision making.

Clear, responsive, and compassionate communication between clinician and person is a strong determinant of levels of engagement and will typically have a strong influence on treatment outcomes. How something is said is just as important as the what is said, non -verbal communication, body language, tone of words and eye contact.

TALKING ABOUT PAIN–HOW THIS AFFECTS LIFE AND HOW LIFE AFFECTS PAIN

Develop an understanding of the person as an individual to identify factors contributing to pain and how the pain affects the person's life. Wherever possible, and only with permission, family members and/or others in caring roles should be invited to attend sessions on understanding pain and its emotional effects.

Hear the persons pain story. Ask them to describe how chronic pain affects their life and how their life may affect their chronic pain. Try and open conversation away from symptoms to explore what pain means to the individual and their family. Consider:

- Lifestyle and day-to-day activities, including work and sleep disturbance.
- Physical, psychological wellbeing and stressful life events.
- Social interaction and relationships.
- Difficulties with employment, housing, and income.

- Values, beliefs and behaviours, the persons view on living well.
- What makes pain worse.
- The skills they have for managing their pain.
- What helps when pain is difficult to control.

- Their understanding of the causes of their pain.
- Understanding of treatments and investigations so far.
- Their (and their family or carers) expectations of what might happen in the future in relation to their pain.
- Their understanding of the outcome of possible treatments.

PROVIDING ADVICE AND INFORMATION

Invest in forming a therapeutic alliance with the person. Work to the **'ask- provide- ask'** rule, ask permission before giving information, provide the information and ask what they made of the information as well as how that fits with their understanding of pain.

Give people time and space to process information. Ensure that factors such as physical or learning disabilities, sight, speech or hearing problems and difficulties with reading, understanding or speaking English are addressed so that the patient can participate as fully as possible in their care.

Where possible give a clear diagnosis and share an explanation of chronic pain with the person. Incorporate aspects of the person's pain story and their own ideas and beliefs into the explanation. Discuss the likelihood that symptoms will fluctuate over time and that they may have flare-ups and that a reason for the pain (or flare-up) may not be identified.

Share that there can be improvements in quality of life even if the pain remains unchanged and that it is possible to 'live well', despite the pain. Provide reassurance to people that acute pain can heal, and chronic pain can be managed.

DEVELOPING A CARE AND SUPPORT PLAN

Chronic pain is an interplay of physical, psychological, and behavioural factors. Discuss a care and support plan that considers factors in ALL these areas. Explore in the discussions:

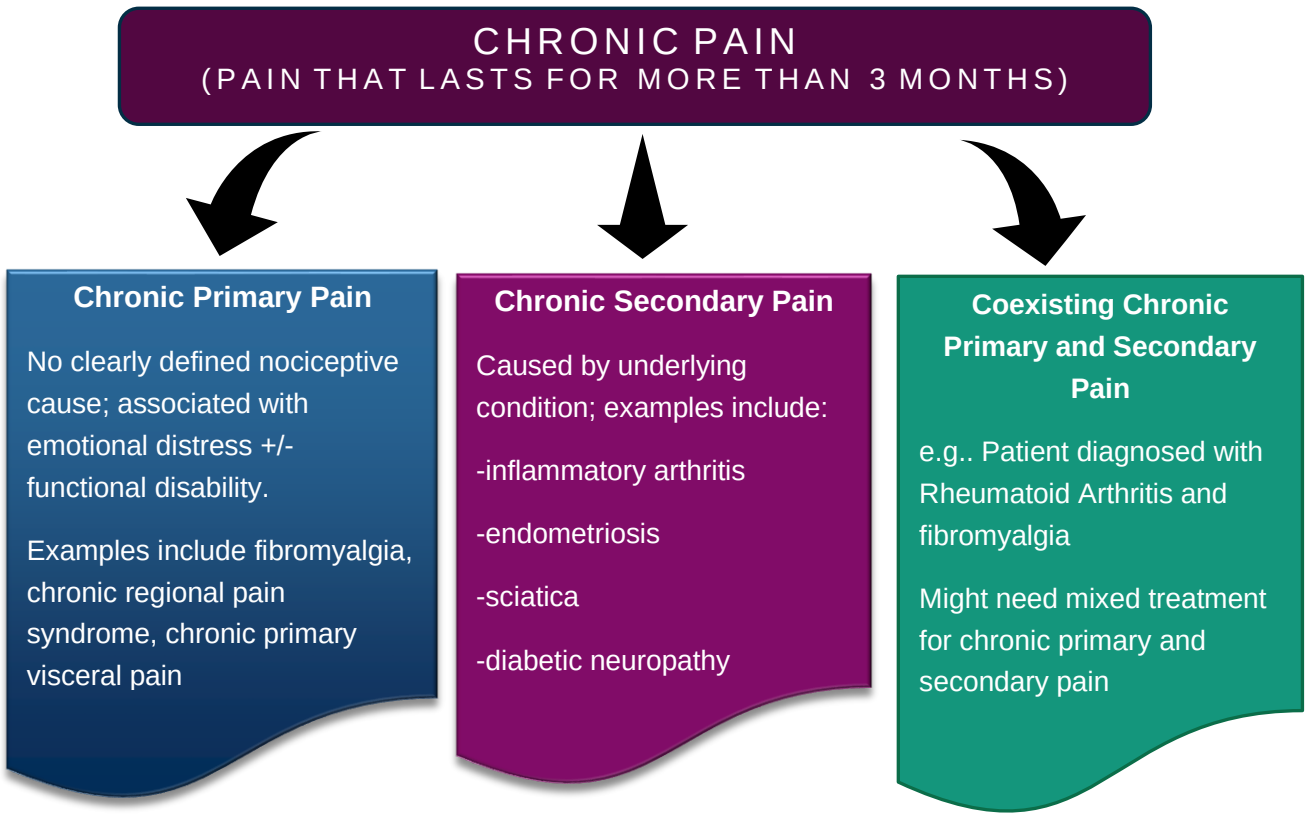
- The persons priorities, abilities, and goals and why these are important to them. How would life be different if they made these changes?
- What steps they have already taken to help them reach their goals and what possibilities for action do they see?
- Their preferred approach to treatment and balance of treatments for multiple conditions, recognising the challenges that this might bring as well as some thinking about how these challenges might be managed by them and with support of others / their care team.

Ensure support needed for young adults (16-25 years old) to continue with their education or training, if this is appropriate. This includes support needed with transitioning between services (paediatric to adult services) as well as any support needed by those with caring responsibilities.

When first developing the care plan and at all stages of care. Make sure the evidence for possible benefits, risks, and uncertainties of all management options have been explored and the person has enough information to make an informed choice. Please see local guidance on De-prescribing and STOMP or refer to the NICE guideline (NG197) if more information is required.

CHRONIC PAIN (PRIMARY AND SECONDARY)

THE NEW CLASSIFICATION OF CHRONIC PAIN AS PER NICE GUIDELINE [NG193]



CHRONIC PRIMARY PAIN

- Consider an antidepressant, either amitriptyline, citalopram, duloxetine, fluoxetine or sertraline for people aged 18 years and over to manage chronic primary pain, after a full discussion of the benefits and harms. The doses of SSRIs and SNRIs should be in line with BNF recommendations for depression. Explain that this is because these medicines may help with quality of life, pain, sleep, and psychological distress, even in the absence of a diagnosis of depression.

- Do NOT initiate any of the following to manage chronic primary pain: **Gabapentinoids, Opioids, Paracetamol, Antipsychotics, Benzodiazepines, Corticosteroid trigger point injections, ketamine or TENS machine.**

- If a person with chronic primary pain is already taking any of the above medicines review the prescribing as part of shared decision making:
  - explain the lack of evidence for these medicines for chronic primary pain **and**
  - agree a shared plan for continuing safely if they report benefit at a safe dose **or**
  - explain the risks of continuing if they report little benefit or significant harm and encourage and support them to reduce and stop the medicine if possible. Please see NICE guideline for prescribing and managing withdrawal from dependence forming medication.

Refer to specialist services if in doubt or diagnosis needs confirming.

ASSESSMENT OF CHRONIC PAIN – A QUICK GUIDE

Is the person being assessed experiencing chronic pain?

Yes

No

This guide does not apply.

Use biopsychosocial approach to assess impact on the patient's daily activities, sleep, work, emotional wellbeing, physical wellbeing, social life.

Is there an underlying cause for the chronic pain?

Yes

Chronic Secondary Pain

1. Use relevant local or NICE guidance to manage underlying condition e.g. Headaches in Adults, Lower Back Pain, Sciatica, Neuropathic Pain.
2. Assess if pain or its impact is disproportionate to the underlying condition. If yes, then consider adding options included in the management of chronic primary pain.

No

Chronic Primary Pain

Management options include:

- Exercise programmes
- Psychological therapies (ACT, CBT)
- Antidepressants (off-license)
- Acupuncture (Currently not commissioned in Nottinghamshire ICS)

Do NOT initiate any of the following to manage chronic primary pain:

- Gabapentinoids
- Opioids
- Paracetamol
- Antipsychotics
- Benzodiazepines
- Corticosteroid trigger point injections
- Ketamine
- TENS machine.

Patients prescribed the above for Chronic Primary Pain should be reviewed and a shared management plan agreed based on risk versus benefit of taking these medicines. Opioid deprescribing for persistent non-cancer pain is a useful guideline if patient is willing to taper.

Clinicians should review their patients at least annually with aim to reduce pain killers even if patient is stable. Agree with patient how fast, how much and how to manage a "flare-up" during this period. Regular (two or four-weekly) reviews might be necessary in some cases. Clinician must ensure that patient has sufficient supply of their medications to avoid withdrawal symptoms. For more specific information please visit NICE guideline [NG215] on Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults.

MANAGEMENT OF OSTEOARTHRITIS IN PRIMARY CARE

Risk Factors in Osteoarthritis

Modifiable

- Obesity (accounts for 25% of OA cases)
- Muscle strength
- Injury
- Occupation
- Smoking

Non-modifiable

- Age > 40 years old
- Sex (Females more affected)
- Genetics

CORE MANAGEMENT

Patient Education

Exercise

Weight Loss

PHARMACOLOGICAL OPTIONS

Paracetamol, Topical NSAIDs, Capsaicin cream 0.025%

Systemic side-effects sill possible with topical NSAIDs.

Paracetamol – Caution dosing for patients weighing < 50kg.

Oral NSAIDs

Ibuprofen, naproxen, Celecoxib, Nabumetone and Indometacin

NSAIDs – Caution GI and cardiovascular risks.

For more information see

www.nottinghamshireformulary.nhs.uk

Opioids

Codeine, dihydrocodeine

Renal impairment: buprenorphine patches are an option as dose adjustment not required (max. 20mcg/hrs).

Opioids – Caution with co-prescribing sedative medicines and potential for withdrawals.

PATIENT EDUCATION

Excellent resources for patients and their families, including educational videos, are available on:

- Versus Arthritis **https://www.versusarthritis.org/about-arthritis/conditions/osteoarthritis/**
- Arthritis and Musculoskeletal Alliance **arma.uk.net**
- The NHS information leaflet **Osteoarthritis**

PHYSICAL ACTIVITY

Advise your patients on muscle strengthening exercises, aerobic fitness training, and pacing of activities (balance of activities and rest, ideally integrating physical activity into the person's daily routine).

- Patient can access free online classes through ESCAPE-pain website.
- Patients aged 18 years old and above, who require guided exercise (e.g.. those with dementia or learning difficulties), are now able to access First Contact Physiotherapy Service offered as an alternative to seeing their GP for MSK conditions.

WEIGHT LOSS

- For patients within Nottinghamshire County Council. Change Point Obesity Prevention and Weight Management Service provided by Everyone Health. Patients can self-refer via telephone: 0333 005 0092 Mon-Fri 8am-6pm (24hr voicemail). Secure Email: **EH.ChangePointNotts@nhs.net**
- For patients within Nottingham City Council. Slimming World. Patients BMI >25 (>23 BAME). Face to face group sessions looking at healthy eating and diet. Self-refer though this link Weight Management Referral (qualtrics.com) or call 01773 546055.
- This is a useful resource for dietary advice https://www.bda.uk.com/resourceDetail/printPdf/?resource=osteoarthritis-diet
- Everyone Health no longer takes referrals for adult patients over with BMI>35 who are not suitable for Tier 2. Please see Bariatric Surgery (Tier 3)

Please refer to local MSK service if specific or more guide support is required.

Osteoarthritis can be diagnosed and managed clinically without an X-ray (NICE Osteoarthritis: care and management; CG177); however imaging might be required if more conservative treatments such as knee replacement or injections are considered. Further information, including Nottinghamshire MSK radiology guidelines are available on TeamNet.

NICE (CG 177) lists intra-articular steroid injections as adjunctive option to core treatments for the relief of moderate to severe pain caused by osteoarthritis. Before considering injections assess if patient struggles with the symptoms below:

- They suffer from moderate to severe pain that is not being managed on analgesia.
- Night pain or pain at rest.
- Limitation of function due to poorly controlled pain

It is important to note that repeat injections are allowed after 4 months from the previous procedure and not more than three times per year. If patient is considering surgical intervention the injections should not be performed at least six months before hand due to risk of infection.

Patients with known inflammatory pain but presenting symptoms of overlapping neuropathic pain might benefit from an addition of neuropathic pain agent. Please see our local guideline for more information.

REPORTING CONTROLLED DRUGS INCIDENTS

The CDAO of North Midlands (Derbyshire, Nottinghamshire, Shropshire and Staffordshire) is Samantha Travis. Please see contact details below.

Tel: 0113 8254717 Generic Email: England.northmidlandscd@nhs.net

The Controlled Drugs Team has produced bespoke guidance in the form of newsletters for the Safe management of CDs in Care Homes and for Private CD Prescribers and Private Paramedics. Copies of the guidance can be found at www.cdreporting.co.uk .

USEFUL READ CODES

SYSTMONE READCODES

- Chronic pain – 1M52
- Chronic pain review – 66n
- Patient counselled – 6721
- Medication stopped ineffective – 8BI7
- Doctor stopped drug ineffective – 8B350
- Treatment not tolerated – 8I7
- Opioid drug dependence – E240z
- Non-dependent opioid abuse – E255z
- Poisoning by opioids – SyuFB

EMIS READCODES

- Opioid dependence
- Nondependent opioid abuse
- Non-opioid analgesic
- Harmful use of opioid

*SNOMED CT is a structured clinical vocabulary for use in an electronic health record. SNOMED codes are currently recommended to be used in in electronic care records and can be searched for on Primary Care Domain Reference Set Portal - NHS Digital .

RESOURCES FOR CLINICIANS

RESOURCE NAME	RESOURCE DESCRIPTION AND WEBSITE ADDRESS
NICE - Neuropathic pain in adults: pharmacological management in non-specialist settings (CG 173)	This guideline covers managing neuropathic pain (nerve pain) with pharmacological treatments (drugs) in adults in non-specialist settings. https://www.nice.org.uk/guidance/cg173
APC local guidelines and the De-prescribing and STOMP guide	Resources including clinical information and handy leaflets for patients and clinicians. https://www.nottsapc.nhs.uk/guidelinesformularies/ https://www.nottsapc.nhs.uk/de-prescribingstomp/
British National Formulary Online	https://bnf.nice.org.uk/
Live Well with Pain	An online resource for GPs and pain specialists to help increase skills and confidence in working with people who live with persistent pain. https://livewellwithpain.co.uk/
Opioids Aware	A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain. https://www.fpm.ac.uk/opioids-aware
MHRA Drug safety updates	https://www.gov.uk/drug-safety-update
Moving Medicine	A useful resource to help healthcare professionals integrate physical activity conversations into routine clinical care. https://movingmedicine.ac.uk/
Faculty of Pain Medicine - PILs	Patient information leaflets on medications and interventions commonly used to treat persistent pain https://fpm.ac.uk/patients/patient-info
Pain Toolkit	https://www.paintoolkit.org/
Brief Pain Inventory	Screening Questionnaire http://www.npcrc.org/files/news/briefpain_short.pdf
Pain DETECT questionnaire	painDETECT-Questionaire-01.pdf (specialistpainphysio.com)
NHS How to get to sleep	Sleep restoration strategies https://www.nhs.uk/live-well/sleep-and-tiredness/10-tips-to-beat-insomnia/
Mind website	Explains sleep and mental health, gives practical suggestions and information about where to get support. https://www.mind.org.uk/information-support/types-of-mental-health-problems/sleep-problems/about-sleep-and-mental-health/
INSIGHT - Nottingham Mental Health Services Mid-Notts' (Mansfield and Ashfield, Newark and Sherwood area)	Offers various support including CBT. This service is free, confidential and covers anyone 18+ years who are registered with a GP in the Nottinghamshire area. https://www.insightiapt.org/locations/nottingham/
Let's Talk – Wellbeing Nottingham City and parts of Nottinghamshire.	Let's Talk - Wellbeing is available to people aged 18 and over who are registered with a GP in Nottingham and parts of Nottinghamshire. https://www.nottinghamshirehealthcare.nhs.uk/ltwb-contact-us
Safer Opioid Management Leaflet	Opioid de-prescribing aid for clinicians (page 13)
Medicines Safety Improvement Programme	NHSEI workspace/resource centre on Future NHS Platform.
Medicines and Falls Chart	https://www.nottsapc.nhs.uk/media/1501/falls_medicines_chart.pdf
Understanding Pain in less than five minutes	https://www.youtube.com/watch?v=5KrUL8tOaQs&t=3s

SUMMARY OF NICE GUIDELINES RELATED TO PAIN MANAGEMENT

NICE Guidance	Do Not Do Statements	Link access to detailed information
Low back pain and sciatica in over 16s: assessment and management (NG59)	• Do not offer paracetamol alone for managing low back pain. • Do not routinely offer opioids for managing acute low back pain • Do not offer opioids for managing chronic low back pain. • Do not offer selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors or tricyclic antidepressants for managing low back pain. • Do not offer anticonvulsants for managing low back pain.	https://www.nice.org.uk/guidance/ng59
Osteoarthritis: care and management (CG177)	• Do not offer rubefacients • Do not offer glucosamine or chondroitin products • Do not offer intra-articular hyaluronan injections	https://www.nice.org.uk/guidance/cg177
Neuropathic pain in adults: pharmacological management in non-specialist settings (CG173)	Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so: • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol long-term • venlafaxine • sodium valproate	https://www.nice.org.uk/guidance/cg173
Rheumatoid arthritis in adults: management (NG100)	• Do not offer the combination of tumour necrosis factor-α (TNF-α) inhibitor therapy and anakinra for RA. • Do not use ultrasound for routine monitoring of disease activity in adults with RA. • Do not let concerns about the long-term durability of prosthetic joints influence decisions to offer joint replacements to younger adults with RA.	https://www.nice.org.uk/guidance/ng100

Spondylarthritis in over 16s: diagnosis and management (NG65)	• Do not rule out the possibility that a person has spondylarthritis solely on the presence or absence of any individual sign, symptom, or test result.	https://www.nice.org.uk/guidance/ng65
Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management (NG206)	• Do not advise people with ME/CFS to undertake exercise that is not part of a programme overseen by an ME/CFS specialist team, such as telling them to go to the gym or exercise more, because this may worsen their symptoms. • Do not offer any medicines or supplements to cure ME/CFS. • Do not offer the Lightning Process, or therapies based on it, to people with ME/CFS. • Do not offer people with ME/CFS: ○ any therapy based on physical activity or exercise as a cure for ME/CFS ○ generalised physical activity or exercise programmes – this includes programmes developed for healthy people or people with other illnesses ○ physical activity or exercise programmes that are based on deconditioning and exercise avoidance theories as perpetuating ME/CFS.	https://www.nice.org.uk/guidance/ng206
Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain (NG193)	Do not offer biofeedback to people aged 16 years and over to manage chronic primary pain. Do not offer any of the following to people aged 16 years and over to manage chronic primary pain because there is no evidence of benefit: • TENS • ultrasound • interferential therapy. Do not initiate any of the following medicines to manage chronic primary pain in people aged 16 years and over: • antiepileptic drugs including gabapentinoids, unless gabapentinoids are offered as part of a clinical trial for complex regional pain syndrome (see the	https://www.nice.org.uk/guidance/ng193

	recommendation for research on pharmacological interventions) • antipsychotic drugs • benzodiazepines • corticosteroid trigger point injections • ketamine • local anaesthetics (topical or intravenous), unless as part of a clinical trial for complex regional pain syndrome (see the recommendation for research on pharmacological interventions) • local anaesthetic/corticosteroid combination trigger point injections • non-steroidal anti-inflammatory drugs • opioids • paracetamol.	
Headaches in over 12s: diagnosis and management (CG150)	• Do not refer people diagnosed with tension-type headache, migraine, cluster headache or medication overuse headache for neuroimaging solely for reassurance. • Do not offer opioids for the acute treatment of tension-type headache. • Do not offer ergots or opioids for the acute treatment of migraine. • Do not offer gabapentin for the prophylactic treatment of migraine. • Do not routinely offer combined hormonal contraceptives for contraception to women and girls who have migraine with aura. • Do not offer paracetamol, NSAIDS, opioids, ergots or oral triptans for the acute treatment of cluster headache.	https://www.nice.org.uk/guidance/cg150

Appendix 1

SAFER OPIOID MANAGEMENT
KNOW THE RISKS

Opioids are effective pain killers especially for acute pain, but there is little evidence that they help in long-term pain.

Various opioids may be prescribed for the same purpose.
Oral morphine equivalent daily dose (OMEDD) has been used to make their strength comparison easier.

Codeine
30mg - 8 tabs a day = 30 mg (OMEDD)

Sevredol
20mg - 3 tabs a day = 60mg (OMEDD)

Tramadol
50mg - 8 caps daily = 80mg (OMEDD)

Tapentadol
200mg - 2 caps daily = 120 mg (OMEDD)

Oxycodone
60mg - 2 caps daily = 180mg (OMEDD)

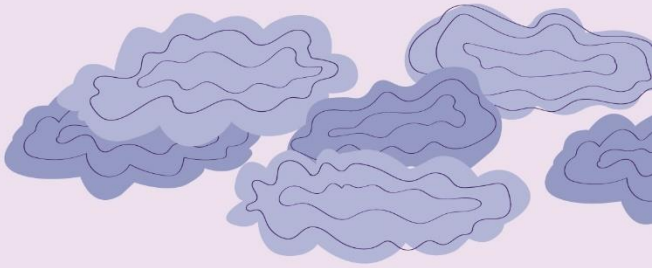
Morphgesic SR
100mg - 2 caps daily = 200mg (OMEDD)

Fentanyl
75mcg/hrs patch = 225mg (OMEDD)

ORAL MORPHINE EQUIVALENT DAILY DOOSE (OMEDD)

Fentanyl
100mcg/hrs patch= 300mg (OMEDD)

Burprenorphine (sublingual tablets)
8mg - 1 tabs daily= 320mg (OMEDD)



As the oral morphine equivalent daily dose increases, the risk of serious harm due to side effects increases as well.

Long-term use of opioids is associated with endocrine abnormalities such as:
- **absence of period in women**
- **erectile dysfunction (impotence)**
- **low sex drive**
- **infertility**
- **low mood and fatigue**

Recent studies demonstrated that prolonged use of opioids can lead to abnormal pain sensitivity called 'hyperalgesia'.

Opioids can cause sleep apnoea, breathing problems, respiratory depression and even death.

Information source:
Faculty of Pain Medicine UK
ANZCA Opioid Calculator
GOV.UK Opioids: risk of dependence and addiction

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1.1	Michalina Ogejo	February 2023	Added information about SNOMED (p.8), link to medicines and falls chart (p.9), and link to video: Brainman – Understanding Pain in less than 5 minutes (p.9)