Appendix 4C: Guidance on the Management of Chronic Non-Malignant Pain

**Chronic Pain**

- Patient reporting persistent pain – not responded to treatment > 3 months.
- Serious causes should be excluded
- Pain is a complex condition requiring a holistic approach and self-management.
- Assessment

**Assessment**

- Pain is subjective therefore, the patients self-report of pain is the most reliable indicator and where possible, the patient should actively participate in the process of pain assessment.
- Various tools can be used to help assess pain including verbal rating scales (VRS e.g. mild/moderate/severe) and numerical rating scales (NRS Pain scored on 0-10 scale where 0 is no pain and 10 is worst pain imaginable)
- Completion of body descriptor charts (attached to guidance) and descriptor words may be useful
- DN4 tool can be used to identify neuropathic components (also attached)

**Non Pharmacological Measures**

- **Patient info & booklet** – Control Pain-Live Life
- Give positive messages and encouragement about sensible activity and continuing work.
- Beneficial exercise regimes include pilates, yoga, T’ai Chi, walking and swimming.
- Consider a course of Physiotherapy if appropriate to their condition.
- Consider TENS- see [https://sites.google.com/site/fifepaininfo/](https://sites.google.com/site/fifepaininfo/) (please cut & paste link in to browser if link does not work)
- Consider acupuncture if available—especially for musculoskeletal pains.
- There are a list of books relating to pain management on the Book prescription scheme which patients may find useful- these are available in **all** libraries in Fife
- There are a number of voluntary sector agencies that provide useful information including:
  - Pain Association Scotland [www.painassociation.com](http://www.painassociation.com)
  - Arthritis Care [www.arthritiscare.org.uk](http://www.arthritiscare.org.uk)
  - Pain Concern [www.painconcern.org.uk](http://www.painconcern.org.uk)
  - Fibromyalgia UK [www.fibromyalgia-associationuk.org/](http://www.fibromyalgia-associationuk.org/)
Pharmacological Management of Chronic Pain

- **Use the WHO pain ladder** – see Formulary section 4.7 and 10.1 for choice of medications and prescribing guidance at each step.
- Regular medication is generally better than ‘as required’.
- Many chronic pains have a mixed aetiology and may be both nociceptive and neuropathic in origin and combinations of medications may be required.
- Expectations must be set that medication is unlikely to eradicate pain completely; the aim would be to try and reduce pain to tolerable/manageable levels.
- The benefit from taking the medication should outweigh the inconvenience or side-effects from taking them - this may require several trials and reviews of medication before the right combination is found.
- Pain medications should be assessed for benefit on an ongoing basis particularly if patients are requiring ever increasing doses of opioid based medication - consider using adjuvant medication if appropriate.
- Patients should be empowered to ‘step up’ the ladder when necessary and safely ‘step down’ when pain is controlled.
- Try a periodic gradual reduction in medications (one at a time).
- Sleep pattern may be improved with low dose amitriptyline or nortriptyline.
- Treat depression if appropriate with an appropriate choice of antidepressant from Fife Formulary.
- Leaflets to support medications are available from the Fife Pain website [https://sites.google.com/site/fifepaininfo/home/medication-advice](https://sites.google.com/site/fifepaininfo/home/medication-advice)

### Pain Management WHO Ladder

<table>
<thead>
<tr>
<th>Step 1: Mild</th>
<th>Paracetamol</th>
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</table>
| **Step 2: Moderate** (add weak opioid) | 1st Line: Co-codamol 30/500 (Paracetamol + codeine)  
2nd line: Paracetamol + Tramadol |
| **Step 3: Severe** (add strong opioid) | 1st line: Paracetamol + Morphine Sulphate SR  
(preferred brand Zomorph®)  
2nd line: Paracetamol + Oxycodone MR |

Consider Analgesics, NSAIDs & neuropathic adjuvants in combination at all stages. See Neuropathic guidance below and NSAID guidance in Ch 10

**Step 1: Mild pain**
- Paracetamol should be used regularly at a dose of 2x500mg four times daily
- Tablets or caplets are the preferred formulation not capsules
- Patients with low body weight (>33kg to <50kg) max daily dose is 60mg/kg not exceeding 3g
- Patients > 50kg with risk factors for hepatotoxicity the max dose per administration is 1g (i.e 2 x 500mg). **Maximum daily dose is 3g**
Step 2: Moderate pain

- Where paracetamol alone is insufficient introduction of a weak opioid in addition to regular paracetamol is appropriate
- Due to issues with diversion of codeine/dihydrocodeine, the preferred product in NHS Fife is co-codamol 30/500
- Where patients cannot tolerate TWO co-codamol 30/500 tablets or to allow them to alter their pain medication in response to pain levels, use standard paracetamol in combination with co-codamol (max of 4g daily of paracetamol) REMIND patients- DO NOT EXCEED maximum daily dose of paracetamol due to potential liver damage.
- Use of co-codamol 15/500 should be restricted to patients unable to tolerate 30/500 strength or unable to cope with combining co-codamol 30/500 with paracetamol. A leaflet to support this can be found on the Fife Pain website
- Where use of co-codamol 30/500 is not tolerated or ineffective a trial of regular paracetamol and tramadol should be used
- The combination product Tramacet® should not be prescribed as there is insufficient Paracetamol as a component
- Standard 50mg tramadol capsules should be used in a dose of 50-100mg up to four times daily
- Modified release tramadol preparations should only be prescribed for use in night time breakthrough pain, to aid compliance or if there are side-effects with immediate release tramadol. NHS Fife formulary preferred brand is Tramulief®, which is a 12-hour release formulation.
- Both co-codamol or tramadol should be introduced slowly, gradually building up the opioid dosing to help prevent side effects
- Constipation may be a problem with all opioids and the patients should be forewarned and advised appropriately to make lifestyle modifications and use formulary stimulant +/- softening laxatives where required. See formulary section 1.6
- Co-codamol and tramadol should not be prescribed together – it may be more appropriate to move to step 3 of the ladder and/or re-assess pain for any neuropathic component not being treated
- Total daily dosing of codeine at 240mg and tramadol at 400mg have morphine daily equivalences of 24mg and 60-80mg respectively. This should be considered when stepping up the ladder.
Step 3: Severe Pain

- Morphine remains the **first line** strong opioid in chronic pain.

- Guidance on use of strong opioids in Chronic non malignant pain has been issued by the British Pain Society & the RCGP and can be found online [www.britishpainsociety.org/book_opioid_main.pdf](http://www.britishpainsociety.org/book_opioid_main.pdf)

- There is limited evidence for **long term** use of opiates in chronic non malignant pain. Further guidance will be available from pain info website.

- As with all pain medicines ongoing use of strong opioids in long term pain management should be reviewed regularly and withdrawn if not effective.

- Dosing should be reduced where possible to avoid potential difficulties with withdrawal and/or opioid induced hyperalgesia (“wind up of pain” or increased sensitivity to pain).

- If patients do not achieve useful relief of pain when titrated to doses between 120-180 mg morphine equivalent per 24 hours, referral to a specialist in pain medicine is strongly recommended.

- Oxycodone should only be initiated 2nd line if the patient is intolerant of morphine or it lacks efficacy.

- Modified release preparations should be prescribed in combination with an immediate release preparation to allow treatment of breakthrough pain.

- Patients prescribed a strong opioid should have access to regular prophylactic laxatives - a combination of a formulary choice stimulant and softening laxative is recommended. See section 1.6 of Fife Formulary.

- Zomorph® is the preferred brand of morphine sulphate M/R and should be prescribed by brand.

- Care should be taken to avoid unintentional changes to brands of modified release preparations and they should therefore be prescribed by brand name.

- In chronic pain therapy with transdermal fentanyl is restricted to third line in patients intolerant of 1st and 2nd line choices or where patients are unable to swallow and have stable pain.

- Matrifenic® is the preferred brand of fentanyl patch.

- Transdermal Buprenorphine (either as Butrans® 7 day patch or Transtec® 4 day patch) are not currently approved for use in NHS Scotland by the SMC – an individual patient treatment request form (IPTR) should be submitted and approved before prescribing.

- Pethidine has no role in managing chronic pain conditions due to short analgesic duration.
Neuropathic Pain Guidance

Fife Integrated Pain Management Service

Neuropathic Pain

Trigeminal Neuralgia?

Carbamazepine
Initially 100mg daily or 100mg twice daily
Increase gradually according to response
Usual dose: 200mg three or four times a day; max 1.6g daily
Check FBC & LFTs every 6 months

Surgery may be an option- refer to neurology

Burning/shooting pain
1st line Amitripyline then Nortriptyline if cannot tolerate amitriptyline (off-label indications). Initial dose 10mg in the evening (approx 10-12 hrs before preferred waking time). Increasing in 10mg increments with at least weekly intervals to a maximum of 75mg daily in the evening. If no response after 4-6 weeks withdraw slowly

Pain Controlled?

Yes

Regular Review & Management by GP

Pain Controlled?

No

Partially or no

2nd line trial Gabapentin as per guidance – see below

TCA contra-indicated or not tolerated

Regular Review & Management by GP

Pain Controlled?

Yes

No

3rd line trial of Pregabalin as per guidance – see below

Trial Gabapentin PLUS Amitriptyline / Nortriptyline if TCA appropriate

No and mixed pain aetiology

No and localised pain

Trial of Pregabalin as per guidance
Assess after 3 months at maximum tolerated dose
Restrict to 3rd line use

Trial of Tramadol +/- 1st & 2nd line choices.
If no response after 4 weeks withdraw gradually
Restrict to 3rd line use

Trial of Capsaicin Cream.
Assess after 6-8 weeks
Restrict to 3rd line use

Pain Controlled?

TCA contra-indicated or not tolerated

Yes

No

Partially or no

Referral to Fife Integrated Pain Management Service

Author: FIPMS Version No.: 1 Date: August 2012 Review Date: September 2014
Approved on behalf of NHS Fife by the Fife ADTC Date: August 2012
**Slower dose titration**

- **WEEK 8am 2pm 10pm**
  - 1: 0 0 300mg
  - 2: 300mg 0 300mg
  - 3-7: 300mg 300mg 300mg
  - 8: 300mg 300mg 600mg
  - 9: 600mg 300mg 600mg
  - 10: 600mg 600mg 600mg

  For 4 weeks then assess response; dose can be further increased by 300mg every few days to maximum tolerated dose or a maximum of 3.6g daily in 3 divided doses. i.e. maximum of 1200mg three times a day.

**Fast-track dose titration**

- **DAY 8am 2pm 10pm**
  - 1: 0 0 300mg
  - 2: 300mg 0 300mg
  - 3-7: 300mg 300mg 300mg
  - 8: 300mg 300mg 600mg
  - 9: 600mg 300mg 600mg
  - 10: 600mg 600mg 600mg

  For 4 weeks then assess response; dose can be further increased by 300mg every few days to maximum tolerated dose or a maximum of 3.6g daily in 3 divided doses.

**Titrated dose from 300mg daily (100mg daily in the elderly or frail) to a maximum dose tolerated or a maximum of 3.6g (slower dose titration pathway may help with tolerance of side effects)**

**GABAPENTIN dose in reduced renal function**

- **CrCl* 50-79ml/min**
  - 200mg TDS - 600mg TDS**
- **CrCl* 30-49ml/min**
  - 100mg TDS - 300mg TDS**
- **CrCl* 15-29ml/min**
  - 100mg TDS on alternate days - 200mg TDS**

  Consider titration of dose on a weekly basis rather than daily.

  *CrCl (creatinine clearance) is not the same as eGFR unless SA=1.73m². Use formula below to calculate CrCl.

  ** TDS is three times a day

  For patients with end stage renal failure or those receiving renal replacement therapy please contact the Renal Pharmacist on 01383 623623 x29738 for advice.

**Gabapentin dose will have to be reduced as per SPC***

**Impaired Renal function?**

- **Yes**
  - Gabapentin dose will have to be reduced as per SPC***

- **No**
  - Titrated dose from 300mg daily (100mg daily in the elderly or frail) to a maximum dose tolerated or a maximum of 3.6g (slower dose titration pathway may help with tolerance of side effects)

**Neuropathic pain not controlled by tricyclic antidepressant (TCA) or TCA contra-indicated?**

- Consider trial of Gabapentin
  - Prescribe as capsules

**N.B Continue Tricyclic with gabapentin if patient has sleep pattern benefit from TCA**

**Consider 3rd line choices (if Pregabalin see guidance for switching) or refer to Fife Integrated Pain Management Service**

**Prescribe acutely for 3 months and assess patient**

- **PAIN Controlled?**
  - **Yes**
    - Add to repeat Rx; Annual review and management by GP
    - Trial reducing dose slowly to assess ongoing response/need at least annually
    - Re-check U&E

  - **No**
    - Trial reducing dose slowly to assess ongoing response/need at least annually
    - Re-check U&E

  * SPC = Summary Product Characteristics available for Gabapentin brand on www.medicines.org
**Pregabalin Guidance - RESTRICTED**

**3rd line use only**

- **Neuropathic pain** - not controlled by or tolerated first and second line choices of tricyclic antidepressant (TCA) and Gabapentin

  - Stop Gabapentin
  - Consider trial of **Pregabalin**
  - Prescribe as twice daily dosing using correct strength capsules

  - Titrate dose from 75mg twice a day (25mg twice a day in elderly or frail) to the maximum dose tolerated not exceeding 300mg twice a day

  - Prescribe acutely for 3 months and assess patient response. Slowly withdraw if no benefit

  - No → Refer to Fife Integrated Pain Management Service

  - Yes → Impaired Renal function?

  - No

  - Yes → Impaired Renal function?

  - No → Add to repeat Rx; Annual review and management by GP

  - Trial reducing dose slowly to assess ongoing response/need

  - Re-check U&E

  - Yes → Pregabalin dose will have to be reduced as per SPC*

  - N.B Continue Tricyclic with pregabalin if patient has sleep pattern benefit from TCA

**PREGABALIN dose in reduced renal function**

- CrCl* ≥ 30 - <60 ml/min: 75mg – 300mg daily as a twice a day dose
- CrCl* ≥ 15 - <30ml/min: 25 or 50mg daily – 150mg daily as once daily or twice a day dose

  Consider titration of dose on a weekly basis rather than daily

  * CrCl is **not the same as eGFR unless SA=1.73m². Use formula below to calculate CrCl (creatinine clearance). For patients with end stage renal failure or those receiving renal replacement therapy please contact the Renal Pharmacist on 01383 623623 x29738 for advice.**

  \[
  \text{CrCl} = \frac{140 - \text{age} (\text{in years})}{\text{mass (in kg)}} \times \frac{1}{\text{serum creatinine (in mg/dL)}}
  \]

  * SPC = Summary Product Characteristics available for pregabalin brand on www.medicines.org
Dose calculation of Gabapentin and Pregabalin in patients with renal impairment

- Dose reduction of Gabapentin and Pregabalin in patients with compromised renal function must be individualised according to Creatinine clearance (CrCl).
- This is not identical to eGFR reported by the labs and dose related information is only available for manufacturers for CrCl.
- To calculate CrCl use Cockcroft-Gault equation:

**Cockcroft-Gault Equation**

\[
\text{Creatinine Clearance} = \frac{(140-\text{Age}) \times \text{Body weight (Kg)}}{\text{Serum Creatinine}} \times \begin{cases} \text{1.04 Females or 1.23 Males} \end{cases}
\]

- For overweight patients Ideal (Lean) body weight should be used

Calculations for Approximation of "Lean" Body Weight (kg)

- for Males Kg = Height (cm) - 100;
- for Females Kg = Height (cm) - 105

Conversion of Gabapentin to Pregabalin

(Reference: Tayside issue 118 November 2010)

Switching from gabapentin has not been investigated in clinical studies but it is recommended that when it is necessary to discontinue or substitute gabapentin with an alternative medication this should be done gradually, over a minimum of one week.

The following switch approach would be reasonable:

- Replace gabapentin 300mg three times a day with pregabalin 100mg twice a day
- Replace gabapentin 600mg three times a day with pregabalin 200mg twice a day
- Replace gabapentin 900mg three times a day with pregabalin 200mg twice a day
- Replace gabapentin 1200mg three times a day with pregabalin 200mg twice a day.

- The dose of pregabalin can be further increased depending on response and tolerability to a maximum of 300mg twice a day.

Patient factors such as response to gabapentin and tolerability of previous drugs (including gabapentin) should be considered. For example, if gabapentin had to be titrated slowly due to adverse effects, then this may also be required for pregabalin.
DN4 – QUESTIONNAIRE

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions.

INTERVIEW OF THE PATIENT

QUESTION 1:
Does the pain have one or more of the following characteristics? YES NO

- Burning ................................................................. ☐ ☐
- Painful cold .......................................................... ☐ ☐
- Electric shocks ...................................................... ☐ ☐

QUESTION 2:
Is the pain associated with one or more of the following symptoms in the same area? YES NO

- Tingling ............................................................... ☐ ☐
- Pins and needles ................................................... ☐ ☐
- Numbness ............................................................ ☐ ☐
- Itching ................................................................. ☐ ☐

EXAMINATION OF THE PATIENT

QUESTION 3:
Is the pain located in an area where the physical examination may reveal one or more of the following characteristics? YES NO

- Hypoesthesia to touch .......................................... ☐ ☐
- Hypoesthesia to pinprick ...................................... ☐ ☐

QUESTION 4:
In the painful area, can the pain be caused or increased by: YES NO

- Brushing? .............................................................. ☐ ☐

YES = 1 point
NO = 0 points

Patient’s Score: /10

A score ≥4 is diagnostic of neuropathic pain
PAIN DESCRIPTOR CHART
PAIN WORDS

Circle any words which describe your pain, you may choose as many as you like.

Aching          Agonising           Annoying        Beating       Blinding          Boring                Burning          Cold
Cool       Cramping           Cruel        Crushing           Cutting        Drawing             Dreadful         Drilling
Dull            Exhausting         Fearful            Flashing      Flickering        Freezing             Frightful        Gnawing
Grueling         Heavy         Hot           Hurting        Intense         Itching          Penetrating       Piercing
Lacerating    Lancinating        Miserable     Nagging    Nauseating       Numb          Penetrating       Piercing
Pinching           Pressing            Pricking        Pulling     Pulsing        Punishing          Quivering       Radiating
Rasping           Scalding            Searing         Sharp     Shooting       Sickness          Smarting       Sore
Splitting           Spreading           Squeezing       Stabbing         Stinging           Suffocating         Taut         Tearing
Tender        Terrifying            Throbbing     Tight         Tingling           Tiring          Torturing       Troublesome
Tugging           Unbearable          Vicious          Wrenching       Wretched

How does your pain change with time?

Which word or words would you use to describe the pattern of your pain?

Brief    Constant    Continuous    Intermittent    Momentary    Periodic    Rhythmic    Steady    Transient
Criteria for referral to Fife Integrated Pain Management Service

If you are seeking Medication advice then please refer to advice and guidance on our website by following this link [https://sites.google.com/site/fifepaininfo/](https://sites.google.com/site/fifepaininfo/) and the Appendices in the Fife Formulary on Pain Management before referring.

### Referral

- Patient is over **18 years of age**
- Pain has been present for more than 3 months and is causing significant distress
- **Patient is accepting that a “cure” may not be possible and is ready to adopt a Pain Self management approach.**
- Treatable pathology has been adequately assessed and treated (including referral to appropriate speciality if necessary), any appropriate investigations have been carried out.
- The patient accepts that all appropriate medical interventions have been completed and is **not seeking further investigations.**
- Basic pain management has been followed as per the Pain Management guidelines & Top tips (Found on Fifepaininfo website)
- A low dose tricyclic anti-depressant or anti neuropathic medication has been trialled if appropriate.
- The Patient should have completed a course of Physiotherapy if appropriate to their condition.
- The Patient should have had a trial of a TENs device if appropriate eg back, neck or other MSK pain

Please **Do Not** refer for, or suggest to the patient that they may receive any specific pain management intervention e.g. injection procedures, acupuncture, as this may not be appropriate for the patient and can lead to difficulty in communication.

### Exclusion Criteria

- Patients **under** 18 years of age
- Patients for whom further investigation or treatment is planned
- Patients still awaiting test results
- Inflammatory MSK conditions - consider rheumatology referral
- Patients with red flags - refer to appropriate specialist
- Patients with chaotic alcohol/drug dependency behaviour – refer to Fife Addictions Services
- Significant mental health problems unrelated to pain that are **not appropriately managed.**
- Headache – refer to neurology in the first instance

### Re-referral

Patients should **NOT** be re-referred for the same pain problem once all therapeutic options have been exhausted, **unless they are now accepting of a pain self-management rehabilitative approach.**

Please **Do direct the patient to the Fifepaininfo website for information**