Guidelines for the Management of Chronic Non-Malignant Pain (CNMP) in Primary Care
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Chronic Non-Malignant Pain (CNMP) covers a wide variety of painful conditions which can lead to disability, not only because of physical symptoms, but also psychosocial factors that accompany physical pain. It can be defined as pain that persists after the point that complete healing should have occurred (3-6 months), can be continuous or intermittent and can also be experienced by those who do not have any evidence of tissue damage. It can lead to disability due to a range of interacting physical, psychological and social factors.

Those people who are less able to adapt their lives to cope with the pain experience may have accompanying quality of life issues including disrupted sleep, depression, anxiety, fear avoidance and social withdrawal.

CNMP categories covered by these guidelines are:
- Musculoskeletal - OA, RA, fibromyalgia and low back pain.
- Face and head pain- migraine and headache.
- Neuropathic pain

Adequate assessment and accurate diagnosis is essential for specific treatment options to be pursued.

Pharmacological interventions should be increased to full therapeutic and tolerated dose before switching or adding a different agent. Pain is a biologically complex phenomenon and there is rationale for combining drugs with different mechanisms of action.

All treatment strategies need to be individualised to specific patient requirements and tolerance. There are non-pharmacological elements to the management of pain that need to be considered and are not covered in these guidelines. NICE guidance CG88 (low back pain) and CG59 (osteoarthritis) do stress the importance of exercise:
- Patients with low back pain should be advised to stay physically active and to exercise (NICE CG88)
- Exercise should be a core treatment for people with osteoarthritis, irrespective of age, comorbidity, pain severity or disability (NICE CG59).

The principles of the three step World Health Organisation (WHO) analgesic ladder have been used to produce the pain pathways below.

Please note: these guidelines are not intended to cover Palliative Care.

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1 Produced by NHS Surrey following consultation with Pain clinicians: November 2010
Discussed by Surrey Area Prescribing Committee April 2011  Review date: November 2012
Acknowledgement to Hartlepool Stockton-on-Tees NHS Trust
### Guidelines for the Management of Chronic Non-Malignant Pain (CNMP) in Primary Care

*not including neuropathic pain (NeP)* (see page 3 & 4)

#### Step 1
**Paracetamol +/- topical NSAIDs**

**Simple analgesia**
- Regular Paracetamol: 1g QDS
  - Consider offering topical NSAIDs for pain relief in addition to core treatment for people with knee or hand osteoarthritis.
  - Paracetamol and / or topical NSAIDs should be considered ahead of oral NSAIDs or opioids.
  - Ensure patient has been taking regularly before moving to next step.

#### Step 2
**Regular paracetamol + oral NSAID, weak opioid or both**

**Oral NSAIDs**
- Where paracetamol or topical NSAIDs provide insufficient pain relief then consider the addition of an oral NSAID to regular paracetamol.
  - 1st line: Ibuprofen or Naproxen (see Surrey APC guidance Aug 2010). If initial NSAID not effective try switching to alternative NSAID.
  - All oral NSAIDs have analgesic effects of a similar magnitude.
  - What is patient’s renal function?
  - No greater benefit with modified release preparations so prescribing a standard release preparation is recommended.
  - Prescribe a PPI (omeprazole 20mg or lansoprazole 15mg daily) in appropriate patients (NICE CG88 recommends in people over 45).
  - NSAIDs should be used at the lowest effective dose for the shortest possible period of time.

**Weak Opioids**
- 1st line: Add Codeine Phosphate (max 240mg daily)
- 2nd line: switch to Tramadol 50mg capsules (maximum dose 400mg daily)
- 3rd line: switch to Buprenorphine (BuTrans) patch- may be useful only for people that have not responded to maximum dose oral analgesia and that require continuous release pain control (approximately 7-10% of European Caucasians are unable to metabolise codeine and therefore get no analgesic effect or side effects.) Also consider in patients who are nil by mouth, with mild to moderate renal impairment, frail/elderly.
  - Consider use of prophylactic anti-emetic for first 7-10 days of therapy. Initiate on 5mcg/hr patch and adjust dose at 3 day intervals.
  - Consider prescription for laxative and counsel patient
  - Consider the risks and benefits of prescribing opioids, particularly in elderly patients giving consideration to risk of opioid dependence and side effects.
  - There is no evidence to show that low-dose weak opioid and paracetamol preparations (e.g. Co-codamol 8/500mg, Co-dyrdamol) are more effective than paracetamol alone (still lead to opioid side effects).
  - Effervescent co-codamol 30/500 have a high Na+ content
  - Titrate to maximum tolerated dose before switching agents.
  - Doses may need to be reduced in renal impairment - consider using short acting drugs if high doses are required.

#### Step 3
**Before initiating a strong opioid consider if the patient has Neuropathic element to their pain (see NeP guidelines)**

**Strong opioids – Important- please see page 5 before initiating.**

Consider offering for short-term use in people with severe pain. Patients should be reviewed monthly, consider referring people requiring prolonged use. Prescribe laxatives.

**Stop weak opioids.**
- 1st line: Morphine sulphate MR with oral morphine sulphate solution for breakthrough pain.
- 2nd line: Switch to oxycodone MR where patient has intolerable side effects to morphine or has poor response to morphine.

Doses may need to be reduced in patients with renal impairment.

- Initiate morphine sulphate MR 10mg bd (or see page 8) with morphine sulphate solution at 1/6th of total daily dose for breakthrough pain. (4 hourly, requirement of more than 2 to 3 doses in 24 hours indicates that morphine sulphate MR needs to be increased). Titrate according to response so that use of morphine solution is hardly required.
- Note: morphine sulphate MR 10mg is dose equivalent to oxycodone MR 5mg.
- British Pain Society recommends that if patients do not achieve useful relief of pain when titrated to doses between 120-180mg morphine equivalent per 24 hours they should be referred to a specialist in pain medicines.

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2 Produced by NHS Surrey following consultation with Pain clinicians: November 2010

Discussed by Surrey Area Prescribing Committee April 2011. Review date: November 2012

Acknowledgement to Hartlepool Stockton-on-Tees NHS Trust
Neuropathic pain (NeP) is an enigmatic condition (pain arising from a lesion or dysfunction of the nervous system) and is caused by abnormally stimulated nerves, unlike the majority of nociceptive (or somatic) pains, caused by direct damage to tissues involved. Possible causes include nerve damage due to trauma or conditions such as diabetes, herpes zoster (shingles) and trigeminal neuralgia. Consider NeP in ongoing conditions, e.g. sciatica, neck pain, and low back pain. It can also be a feature of underlying conditions, e.g. cancer, that require investigation.

Signs and symptoms
- **Hyperalgesia** - increased sensitivity to normal pain stimulus e.g. temperature.
- **Allodynia** - pain created by a stimulus that does not ordinarily produce pain, e.g. wearing clothes.
- **Autonomic signs** include skin changes such as oedema, shininess, change of perspiration.
- **Motor** - dystonia, weakness and paralysis, and fasciculations.
- **Dysasthesia** - an unpleasant, abnormal sensation.

Trigger words used by patients to describe the pain include ‘burning’, ‘shooting’, ‘tingling’, ‘electric shock’, ‘sharp’, ‘nagging’, ‘walking on hot coals’. NeP can be spontaneous or evoked, continuous or intermittent and is often worse at the end of the day.

NeP is thought to affect 2-4% of the general population. Patients beliefs and perceptions of the pain and its cause, coping strategies, mood changes, disturbed sleep and anxiety all need to be addressed. Treating anxiety or depression first might reduce the need for analgesics. Realistic goals must be set - pain free status is not usually achievable and 20-50% reduction in pain is a commonly used end-point in clinical trials.

Initiative on Methods, Measurement, and Pain Assessment in Clinical Trial (IMMPACT)

<table>
<thead>
<tr>
<th>Change</th>
<th>Type of improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20% decrease pain intensity</td>
<td>Minimally important</td>
</tr>
<tr>
<td>At least 30% pain intensity decrease</td>
<td>Moderately important</td>
</tr>
<tr>
<td>At least 50% pain intensity decrease</td>
<td>Substantial</td>
</tr>
</tbody>
</table>

>30% is taken to be moderately or substantially important.

Complex regional pain syndrome (reflex sympathetic dystrophy)-

In this condition there is a window of opportunity to treat it before it becomes chronic and untreatable. If suspected, refer urgently to Pain Clinic.

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3 Reviewed by Mandeep Allingham, Prescribing advisor North West Surrey CCG Dec 2013
Discussed at Surrey Prescribing Clinical Network Jan 2014
**Treatment of Neuropathic pain** (for Diabetic Neuropathy see page 5)

- Improve safety by having review periods at 2, 4, then 8 weeks. 8 weeks is accepted as being an appropriate time to trial neuromodulatory medication, however, it should be 8 weeks ON the median effective dose, i.e. gabapentin 600mg tds; or pregabalin 150mg bd, or amitriptyline 25mg-50mg.
- If the drug is effective, continue for 6 months then wean to assess whether it is still required.
- There is lack of evidence for the efficacy of topical lidocaine for treating NeP in non speciality settings. It is only licensed in postherpetic neuralgia.

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Non-opioid analgesic/baseline analgesia: Paracetamol 1g QDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2</td>
<td>Tricyclic antidepressant (TCA) - unless contra-indicated. NB: TCAs are not licensed for use as painkillers although they have proven efficacy. Amitriptyline- titrate slowly to reduce side effects.</td>
</tr>
<tr>
<td>Step 3</td>
<td>Anticonvulsant- 1st choice if TCA contraindicated or lancinating pain (electric shock-like piercing or stabbing sensation)- Gabapentin</td>
</tr>
<tr>
<td>Step 4</td>
<td>If patient has mixed symptoms and not pure NeP consider initiation of Tramadol if acute rescue therapy is required. Increase dose according to response to a maximum dose of 100mg QDS. Treatment should be for short term use only</td>
</tr>
<tr>
<td>Step 5</td>
<td>Refer to secondary care pain clinic if:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>10mg</td>
<td>20mg</td>
<td>30mg</td>
<td>40mg</td>
<td>50mg</td>
</tr>
</tbody>
</table>

- Take at night to reduce ‘hangover effect’ and promote sleep.
- Usual maximum dose is 50mg daily but 75mg may be used if patient deriving benefit with limited side effects.
- Titrate down slowly if stopping therapy.
- Co-prescribing of Tramadol and Amitriptyline should be avoided due to the increased risk of CNS toxicity.

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td>300mg</td>
<td>300mg</td>
<td>300mg</td>
<td>300mg</td>
</tr>
<tr>
<td>Midday</td>
<td>300mg</td>
<td>300mg</td>
<td>300mg</td>
<td>300mg</td>
</tr>
<tr>
<td>Night</td>
<td>300mg</td>
<td>300mg</td>
<td>300mg</td>
<td>300mg</td>
</tr>
</tbody>
</table>

- Continue increasing as above to maximum 1200mg TDS - minimum time to reach a dose of 3600mg is a total of 3 weeks determined by efficacy and side effects. May need to wait up to 2 weeks to experience maximum benefit.
- Anticonvulsants should be weaned down but not stopped suddenly (or inadvertently run out of). Advice should be given to patient and carer(s) of possible drowsiness and effect on driving.

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>75mg</td>
<td>150mg</td>
</tr>
<tr>
<td>PM</td>
<td>75mg</td>
<td>150mg</td>
</tr>
</tbody>
</table>

**NOTE: TDS dose is not necessary for treatment of Neuropathic pain**

It may take several weeks to achieve maximal effect with pregabalin. If improvement is satisfactory continue treatment and consider gradually reducing the dose over time if improvement is sustained.

**Pregabalin** may be used if gabapentin is effective but not well tolerated. When gabapentin is ineffective a trial of pregabalin may be considered (initial dose 75mg bd increasing after 3-7 days if required up to a maximum dose of 300mg bd). Dose may need to be reduced in impaired renal function.

Consider use of *nortriptyline* if side effects of amitriptyline are not tolerated or in patients with cardiac disease. Patients should be encouraged to persist with treatment as some tolerance to side-effects seems to develop.
Treatment of Diabetic Neuropathy

- In patients with diabetes, poor glycaemic control is a key risk factor for peripheral diabetic neuropathy.
- A Canadian Health Technology Assessment concludes that in patients with neuropathic pain there is no statistically significant difference in clinical response rates between tricyclic antidepressants, anticonvulsants and serotonin-norepinephrine reuptake inhibitors (SNRIs) ([http://www.cadth.ca/publication/870](http://www.cadth.ca/publication/870)).

**Step 1**

<table>
<thead>
<tr>
<th>Tricyclic antidepressant (TCA)- unless contra-indicated. NB: TCAs are not licensed for use as painkillers although they have proven efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amitriptyline- titrate slowly to reduce side effects.</td>
</tr>
<tr>
<td><strong>Week 1</strong></td>
</tr>
<tr>
<td>10mg</td>
</tr>
<tr>
<td>• Take at night to reduce ‘hangover effect’ and promote sleep.</td>
</tr>
<tr>
<td>• Usual maximum dose is 50mg daily but 75mg may be used if patient deriving benefit with limited side effects.</td>
</tr>
<tr>
<td>• Titrate down slowly if stopping therapy.</td>
</tr>
</tbody>
</table>

**Step 2**

<table>
<thead>
<tr>
<th>Anticonvulsant-1st choice if TCA contraindicated or lancinating pain (electric shock-like piercing or stabbing sensation)-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gabapentin</td>
</tr>
<tr>
<td><strong>Day 1</strong></td>
</tr>
<tr>
<td>Morning</td>
</tr>
<tr>
<td>Midday</td>
</tr>
<tr>
<td>Night</td>
</tr>
<tr>
<td>• Continue increasing as above to maximum 1200mg TDS - minimum time to reach a dose of 3600mg is a total of 3 weeks determined by efficacy and side effects. May need to wait up to 2 weeks to experience maximum benefit.</td>
</tr>
<tr>
<td>• Anticonvulsants should be weaned down but not stopped suddenly (or inadvertently run out of). Advice should be given to patient and carer(s) of possible drowsiness and effect on driving</td>
</tr>
</tbody>
</table>

**Step 3**

<table>
<thead>
<tr>
<th>Duloxetine 60mg once daily. In trials a total daily dose of 120mg (60mg twice daily) was not found to be superior to 60mg per day.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response is seen within one week and is unlikely if not seen by eight weeks. Once response is seen, patient should be reviewed every 3 months.</td>
</tr>
<tr>
<td>Contraindicated in (for full details see SPC):</td>
</tr>
<tr>
<td>Liver disease resulting in hepatic impairment</td>
</tr>
<tr>
<td>Severe renal impairment (creatinine clearance &lt;30 ml/min)</td>
</tr>
<tr>
<td>Abrupt discontinuation of duloxetine should be avoided. When stopping treatment with duloxetine the dose should be gradually reduced over a period of at least one to two weeks in order to reduce the risk of withdrawal reactions.</td>
</tr>
</tbody>
</table>

**Step 4**

<table>
<thead>
<tr>
<th>Refer to secondary care specialist diabetes or pain clinic if:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient’s symptoms are unresponsive to treatment and an acceptable reduction in pain is not achieved.</td>
</tr>
<tr>
<td>• The patient is responding but suffering unacceptable side-effects and all options above have been considered.</td>
</tr>
<tr>
<td>• The patient does not want drug therapy.</td>
</tr>
<tr>
<td>• Need further advice or diagnosis on the particular clinical symptom set.</td>
</tr>
<tr>
<td>• Biopsychosocial needs and difficulty in managing/coping.</td>
</tr>
</tbody>
</table>
Additional information on use of opioids for treatment of CNMP

There are few trial data for use of opioids for more than 12 weeks and therefore the safety and efficacy of long term opioid use is uncertain. They have long term endocrine and immunological effects. Before initiating opioids, a comprehensive assessment by the clinician is important. Patients with depression, anxiety, or other psychiatric or psychological co-morbidities will need additional support and monitoring to avoid problem drug use. Patients with a history of addiction to opioids or other drugs need referral to services with expertise in pain medicine. Goals of therapy should be agreed before a trial of opioids and treatment should be reviewed at least monthly. Requests for dose increases by the patient need to be evaluated carefully.

A guide for clinicians regarding opioid prescribing see appendix 1.

A useful booklet for patients to refer to can be found on www.britishpainsociety.org/book_opiod_patient.pdf

**Morphine Sulphate MR** is the strong opioid of choice as immediate release opioids may be associated with tolerance and problem drug use. Most patients will develop tolerance to the side effects of morphine (except constipation). If patients suffer from nausea when first starting morphine a short course of metoclopramide may be appropriate until tolerance develops. A laxative should always be prescribed with morphine (see constipation guidelines). Patients with significant renal or hepatic impairment may need a reduced dose of morphine. An immediate release preparation given at longer intervals than normal is more appropriate than using a modified release preparation in these patients. Consider referring these patients to secondary care pain clinic.

Withdrawal symptoms occur if opioids are stopped suddenly or if the dose is reduced abruptly.

**Intolerance** to morphine may result in switching to an alternative oral therapy. Care should be taken with dose conversion. 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.

**Opioid rotation** of strong opioids may be considered if the patient seems to have reached a dose threshold on their existing treatment. The starting dose of the new drug should be half the equivalent of the existing drug dose and titrated as necessary to achieve optimum pain relief.

**Oxycodone** has an efficacy and side-effect profile similar to that of morphine. There are no advantages in using oxycodone as first-line for moderate to severe pain, so for reasons of familiarity, availability and cost morphine is the first choice strong opioid. Oxycodone is an alternative for the small number of patients who develop intolerable adverse effects with oral morphine or who do not respond to morphine.

**Tramadol** is neither more effective nor better tolerated than other weak opioid analgesics for moderate to severe pain and its safety profile is problematic. The CSM has advised that treatment with tramadol should be short term and intermittent and therefore it is not recommended as a first line agent. Where use of tramadol is considered necessary for control of chronic pain, the use of SR preparations of tramadol should be considered (Marol® is the PCT preferred brand). Co-prescribing of tramadol and amitriptyline should be avoided due to the increased risk of CNS toxicity with this combination.
Information about Drugs NOT recommended as first line choice

Transdermal Patches should be reserved for use in the limited number of patients who are unable to tolerate oral medications or if morphine is contra-indicated e.g. renal impairment.

Fentanyl patches should not be prescribed under any circumstances for opioid naïve patients. Note-they are only licensed for use in chronic intractable pain. Take care with calculation of dose equivalents. A 25mcg patch is equivalent to 90mg morphine per day (see conversion chart). When starting, evaluation of the analgesic effect should not be made before the system has been worn for 24 hours. Previous analgesic therapy should be phased out gradually from time of first patch application; if necessary dose should be adjusted at 48-72 hour intervals in steps of 12-25micrograms/hour. NOTE- it may take up to 25hours for the plasma concentration to decrease by 50%. In view of long duration of action, patients who have had severe side-effects should be monitored for up to 24 hours after patch removal.

Fixed dose combination products (e.g. Co-codamol 30/500mg) do not allow titration to the most effective analgesic dose to match the individual’s requirements and so have a limited role. Low-dose weak opioid and paracetamol preparations (e.g. Co-codamol 8/500mg, Co-dydramol) still lead to opioid adverse effects and there is no evidence to show that they are more effective than Paracetamol alone.
Co-proxamol is no longer licensed in the UK.

Tramacet® is a fixed dose combination of Tramadol 37.5mg and a subtherapeutic dose of Paracetamol 325mg. Prescribing of this product is not routinely recommended as it offers little advantage in terms of efficacy, adverse effects or convenience over standard analgesics.

Vimovo®(naproxen ec 500mg/ esomeprazole IR 20mg) is not recommended for use as there is little advantage over use of NSAID + PPI as separate components.

Pregabalin – This is not recommended as a first line treatment option for neuropathic pain contrary to NICE guidance. Valid clinical reasoning supports current PCT recommendations based on a health economics analysis.

Lidocaine patches (Versatis®) have not been assessed by NHS Surrey for nociceptive pain (note only licensed for the symptomatic relief of neuropathic pain associated with previous herpes zoster infection) and is therefore currently not recommended to be prescribed in primary care.

Targinact® (Oxycodone / naloxone): prescribing of this product is not routinely recommended. This product is considerably more expensive than oxycodone prescribed as a single component. Also opioid use may not be the only cause of constipation.

Rubefacients / intra-articular hyaluronan injections / chondroitin or glucosamine are not recommended for the treatment of osteoarthritis (NICE CG 59).

Meptazinol is associated with rebound pain and an unacceptable level of side effects and is therefore not recommended to be prescribed routinely

Effervescent or soluble formulations offer no advantage in patients who are able to swallow tablets, contain high concentrations of sodium and are expensive. These formulations should be avoided unless there are specific indications (e.g. swallowing difficulties).

Once daily preparations: There is little good evidence to suggest clinical advantage of once daily dosing

5 Produced by NHS Surrey following consultation with Pain clinicians: November 2010
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Acknowledgement to Hartlepool Stockton-on-Tees NHS Trust
Opioid dose conversion chart

These conversion ratios are approximate and are only intended as a guide. Patients’ response to opioids varies widely and they should be monitored for response and side effects when any opioid is initiated.

<table>
<thead>
<tr>
<th>Codeine</th>
<th>Tramadol</th>
<th>Morphine</th>
<th>Oxycodone</th>
<th>Fentanyl Patch</th>
<th>Buprenorphine Patch</th>
</tr>
</thead>
<tbody>
<tr>
<td>24h total dose (mg)</td>
<td>24h total dose (mg)</td>
<td>24h total dose (mg)</td>
<td>24h total dose (mg)</td>
<td>(mcg/h)</td>
<td>(mcg/h)</td>
</tr>
<tr>
<td>30-60</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-120</td>
<td>50-100</td>
<td>10-15</td>
<td></td>
<td></td>
<td>10 (BuTrans)</td>
</tr>
<tr>
<td>120-180</td>
<td>100-150</td>
<td>15-20</td>
<td>5-10</td>
<td></td>
<td>20 (BuTrans)</td>
</tr>
<tr>
<td>300-400</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>20</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>30</td>
<td></td>
<td></td>
<td>35 (Transtec)</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>45</td>
<td>25</td>
<td></td>
<td>52.5 (Transtec)</td>
<td></td>
</tr>
<tr>
<td>120</td>
<td>60</td>
<td></td>
<td></td>
<td>70 (Transtec)</td>
<td></td>
</tr>
<tr>
<td>180</td>
<td>90</td>
<td>50</td>
<td></td>
<td>105 (Transtec)</td>
<td></td>
</tr>
<tr>
<td>280</td>
<td>140</td>
<td>75</td>
<td></td>
<td>140 (Transtec)</td>
<td></td>
</tr>
<tr>
<td>360</td>
<td>180</td>
<td>100</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

**Breakthrough or rescue dose:** Oral Morphine 1/6 of 24 hour oral dose

Link to opioid conversion calculator:


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6 Produced by NHS Surrey following consultation with Pain clinicians: November 2010
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Acknowledgement to Hartlepool Stockton-on-Tees NHS Trust
**Guidance for safe NSAID prescribing**

Don’t use them unless you have to

- The only way to avoid NSAID side-effects is not to use them
- Paracetamol works for many (See sheet ‘Why prescribe Paracetamol’)
- Employ non-drug interventions routinely
- Consider short-term course (1-2 weeks) of topical NSAID

If you have to use them, use them wisely

- The balance of benefits and risks needs to be carefully assessed; think about CV, GI and renal issues routinely
- Use a **SAFER** drug (ibuprofen up to 1200mg per day or naproxen) in the lowest effective dose and for the shortest period of time N.B Diclofenac has a similar CV risk to Coxibs.
- NSAID users should be a high priority for medication review: Are NSAIDs effective/needed? Drug holidays? Don’t issue repeat prescriptions without review.

**Proton Pump Inhibitor**

- Advised by NICE guidance for patients with osteoarthritis and patients over 45 with low back pain who are prescribed a NSAID
- PPI of lowest acquisition cost should be prescribed
- Coxibs should be considered only in those at high GI risk, but consider also the cardiovascular risks.
- All patients taking oral steroids and NSAID should be prescribed gastroprotection (especially if co-prescribed low dose aspirin.)

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**Why prescribe Paracetamol?**

Patients' opinion of paracetamol is poor, perhaps because of its wide availability 'over the counter' in supermarkets and other outlets.

**However**

- Paracetamol is recommended at step 1 of the WHO analgesic ladder.
- Paracetamol is a very effective drug when taken regularly.
- Paracetamol should be prescribed first line as the starting point of any acute or chronic analgesic regime.
- Paracetamol has a very low incidence of side-effects making it a very safe drug at therapeutic doses; however a dose reduction may be needed if a patient has severe hepatic impairment.
- Paracetamol offers the advantages of low cost, high bioavailability. Quick onset of action and the choice of several formulations.
- Paracetamol used in conjunction with a weak opioid significantly increases efficacy over the use of the opioid alone.

**Prescribing Paracetamol with weak opioids**

The Oxford league table of analgesics quotes the following data:

- The number needed to treat (NNT) for the combination of paracetamol 1g with codeine 60mg is 2.2 which is much lower than for codeine on its own (16.7). NNT are calculated for the proportion of patients with at least 50% pain relief over 4-6 hours compared with placebo in randomised, double-blind, and single-dose studies in patients with moderate to severe pain.

The efficacy is reduced if either the paracetamol or the codeine dose is reduced thus demonstrating the limitations of fixed dose combinations with low dose weak opioids such as co-codamol 8/500 or co-dydramol 10/500.

**Combination analgesics**

- There are several combined paracetamol and weak opioid preparations available e.g. co-codamol, tramacet, co-dydramol and Remedeine®.
- These do not allow flexibility of opioid doses in response to pain.
- Low dose codeine and dihydrocodeine can still induce opioid side-effects but offer little benefit over paracetamol alone.
- The prescribing of expensive combination products such as Remedeine® and Tramacet® should be avoided.

**References**

- Drug Update No 64, Tramacet. Regional Drug and Therapeutics Centre July 2004.
- World Health Organisation Pain Relief Ladder. May 2002
- Prodigy Guidance – Osteoarthritis and Rheumatoid Arthritis
- British National Formulary 59 march 2010
Appendix 1

Opioids for persistent pain
Summary of guidance on good practice from the British Pain Society

A consensus statement prepared on behalf of the British Pain Society, Faculty of Pain Medicine of the Royal College of Anaesthetists, Royal College of General Practitioners and the Faculty of Addictions of the Royal College of Psychiatrists


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This advice relates to the use of strong opioids (and weak opioids at doses higher than recommended in BNF) for persistent pain.

Cautions
- The safety and efficacy of long term opioid use is uncertain (there are few trial data for use more than 12 weeks), although use may be appropriate in some cases of persistent pain (somatic, visceral or neuropathic).
- Local and national prescribing guidance should be followed carefully.
- Medication for pain should be used only as part of a wider management plan aimed at reducing disability and improving quality of life.
- Opioids should not usually be used as first line therapy for pain.
- Opioids should not be used in children or pregnant women without specialist advice, and they should be used with caution in older people (particularly those with medical co-morbidity).
- Patients with a history of addiction to opioids or other drugs need referral to services with expertise in pain medicine and addiction management.
- Patients should not drive when starting opioids or adjusting dose or if they feel unfit to drive.

Prescribing
- Comprehensive assessment is important; patients with depression, anxiety, or other psychiatric or psychological co-morbidity will need additional support and monitoring to avoid problem drug use.
- Goals of therapy should be agreed before a trial of opioids; complete pain relief is unlikely, and treatment success is demonstrated by the patient becoming able to do things that the pain currently prevents. Treatment should be reviewed at least monthly, more often if there are any concerns.
- Start with a low dose and titrate up according to analgesia and side effects. Doses greater than 180 mg morphine daily (or equivalent) require specialist advice.
- Where possible use regular dosing with modified release preparations; immediate release opioids may be associated with tolerance and problem drug use.
- Efficacy and adverse effects are similar for all opioids, though patients may tolerate one drug better than another.
- Requests for dose increase need careful evaluation.
- NEVER prescribe opioid injections, or pethidine in any form, for the management of persistent non-cancer pain (unless on the advice of a specialist pain management team).
- If care is shared between hospital and community, be clear who is responsible for prescribing. Within the GP practice, only one clinician should be signing repeat opioid prescriptions. Acute prescriptions may be safer if there are concerns.

Adverse effects
- 80% of patients taking opioids will experience at least one adverse effect e.g. constipation, nausea, itching, dizziness. Side effects should be managed promptly with laxatives, anti-emetics etc as appropriate.
- Opioid toxicity (sedation, slow respiration, cyanosis) is more likely with increasing age, co-morbidity, co-prescribing, and if opioids are taken with alcohol or illicit drugs.
- Opioids have long term endocrine and immunological effects.
- Withdrawal symptoms occur if opioid is stopped/dose reduced abruptly e.g. sweating, yawning, abdominal cramps. This is common with Tramadol even after a short course.
- Addiction is characterised by impaired control over use, craving and continued use despite harm.
- Opioid induced hyperalgesia may occur: pain becomes more diffuse and qualitatively different from pre-existing pain. Specialist advice is needed.

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