PERSISTENT PAIN – PRIMARY CARE MANAGEMENT GUIDE

A guide has been produced by the Pain Service in Pennine MSK Partnership for your GP to use to discuss with you how they can help to support you live with your persistent pain.

Following your initial assessment we have asked your GP to consider arranging an appointment to discuss the appropriate sections of the guide with you and we would encourage you to take up this opportunity.

The information provided is quite detailed and is based upon the existing evidence of what can be helpful. In particular the sections about medication are very detailed and many medications in the lists may not be appropriate for your pain. However the guide helps to support you and your GP to make an informed decision about what may or may not be appropriate for you. It is also intended to help you and your GP decide if it is appropriate for you to reduce and/or stop some of your current medication.

The guide is primarily produced for your GP's information so, if you do access the information on-line, please do not make any decisions about this without having had a full discussion with your GP.

The Greater Manchester Pain Resource hub has a wealth of clinician and patient resources, especially relating to opioid medications and withdrawal.
https://padlet.com/PatientSafetyTeamHInM/greater-manchester-pain-management-resources-hub-uf9wj95w1pfmutn8

Persistent pain – Primary Care Management Guide

History

- Defined as pain that persists beyond three months **and is not amenable to curative treatment.**
- Therefore **all** patients should have completed any investigations to determine that the cause of their pain is not curable.
- Includes all musculoskeletal pain (not amenable to surgery/DMARDs etc), widespread pain syndrome, complex regional pain syndrome, facial pain, pelvic pain, neuralgic pain
- Clarify character of pain (use DN4 to determine if neuropathic), site and severity (use pain scale and body chart), aggravating/relieving factors, impact on function, associated symptoms e.g. mood, anxiety, sleep disturbance, fatigue, weight loss etc.
- Consider differential diagnoses.
- Explore ideas, concerns and expectations.
- Review previous treatments including effectiveness and side effects.
- Assess impact using PHQ4+2 and priorities for support using the Health Needs Assessment (HNA) Tool and assess self-efficacy using PSEQ. (Pages 5-7 below)
- **Note: PHQ4+2, HNA and PSEQ must be completed by the patient and not a health care professional**

Examination *(Dependent upon the site of pain and potential differential diagnoses)*

- Low back pain – examine as per specific referral guides.
- Appropriate specific joint examination
- Chronic widespread pain ie Fibromyalgia. Diagnosis can often be made in Primary Care.
- Complex regional pain syndrome – altered colour and temperature of affected limb, hyperalgesia, allodynia, oedema, alteration in sweating, reduced range of movement, weakness, trophic changes.
- Facial pain – ENT, oropharyngeal and CNS examinations.
- Pelvic pain – abdominal and pelvic examinations. Consider examining the spine
- Neuralgic pain – appropriate regional CNS examination if indicated.
- Check BMI and assess for sleep apnoea if indicated using the Epworth sleepiness score.

Investigations *(Dependent upon the site and potential differential diagnosis)*

- Low back pain – red flag screening blood tests if indicated.
- Chronic widespread pain – FBC, U+E, LFT, bone profile, TFT, ESR, CRP only if indicated to exclude other causes.
- Complex regional pain syndrome – usually no investigations indicated in Primary Care
- Facial pain – Usually no investigation indicated in primary care. May warrant ENT, Maxillo-facial or neurology referral for further investigation.
- Pelvic pain – FBC, ESR, CA125, U&E HVS, endocervical swabs, pelvic ultrasound. Gynaecology referral may be indicated for further investigation e.g. laparoscopy.
- Neuralgic pain – if related to peripheral neuropathy of unknown cause check FBC, B12, LFT, U+E, bone profile, TFT, blood glucose/HbA1c, CRP and ESR.
- **Vitamin D analysis is not indicated for the investigation of widespread pain**

Primary Care Management *(As a guide primary care management is appropriate if PSEQ 40-60/60 and/or HNA identifies three or fewer areas)*

- An holistic approach to pain management should consider the bio-psycho-social impact/effects - **Prioritise management** based upon the patient's self-completed HNA Tool.
- The PSEQ should be repeated after a suitable period, eg 3 months, after interventions in Primary Care have been provided to assess impact.
- Agree, using the principles of shared decision making, an appropriate care plan which supports self-care wherever possible.
- Use of the Pain Toolkit (**www.paintoolkit.org**) or the resources available at **https://www.pmskp.org/services/persistent-pain/**supports self-care.
- **Stay Active** - Provide advice and encouragement, refer to local scheme such as OCL or social prescribing for support.
- Reassure pain does not mean harm, damage or injury.
- If pain is associated with reduced physical activity or deconditioning consider referral to health improvement services or physiotherapy.
- **Depression and Anxiety** – commonly co-exist with persistent pain. Consider referral to primary care mental health team in keeping with NICE guidance if present.
- **Sleep disturbance and fatigue**: discuss sleep hygiene techniques or CBT for insomnia via Healthy Minds.
- **Medication –** please see Persistent Pain Prescribing section but for quick summary **–**
- **Persistent pain tends not to respond well to medication,** focusing on addressing the psycho-social impacts of pain has been shown to be most beneficial, rather than just trying to "treat" the pain with medication. If medication is prescribed then specific improvements in pain VAS score and/or function should be agreed within a clear time frame. If at review there is insufficient improvement or the impact of side effects outweighs any benefit then the medication should be withdrawn.
- **Amitriptyline-** titration from 10mg up to 75mg can be considered to improve sleep quality. NB: Assess the potential anti-cholinergic burden (**http://www.acbcalc.com/**) when considering prescribing Amitriptyline.
- **Paracetamol** is usually the analgesic of first choice and taken as required to manage flares of pain.
- **NSAID** at the lowest effective dose for the shortest duration of intermittent use e.g. Naproxen bd with PPI cover if PH dyspepsia or over 45. (NSAIDs are **not** effective for neuropathic pain or fibromyalgia)
- **Low potency opioid**, e.g. codeine or dihydrocodeine M/R, for very short periods for flares of mechanical joint/spinal pain if an NSAID is not tolerated or ineffective.
- **Potent opioids** should be avoided in persistent pain.. There is **little** evidence to support the long term use of Opioids for persistent pain.
- **Gabapentin and Pregabalin** are **not** effective for Fibromyalgia, the radicular neuropathic pain (sciatica) associated with nerve root compression, non-neuropathic back pain (NICE NG59).
- **Other Neuropathic pain** - Titration of :- Amitriptyline 10-75mg, Gabapentin 100mg-1200mg three times a day (licensed for peripheral neuropathic pain), Pregabalin (if Gabapentin not tolerated) 75-300mg twice a day (lower doses in renal impairment) or Duloxetine 30-120mg (licensed for diabetic peripheral neuropathy) can be considered for neuropathic pain (if confirmed by the use of DN4). Note the MHRA patient safety alerts re Pregabalin and Gabapentin. If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.
- Nortriptyline 10-75mg (unlicensed use) can be considered if amitriptyline not tolerated due to drowsiness. NB: anti-cholinergic burden is identical to Amitriptyline.
- Trigeminal neuralgia only – Titration of Carbamazepine 200-1600mg per day in divided doses can be considered.

Consider contra-indications and interactions (including OTC) when prescribing.

Referral into Tier 2 Persistent Pain Service *(As a guide referral should be considered if PSEQ <40/60 and/or HNA identifies more than three areas of impact)*

- **Pain Services offer an evidence based bio-psycho-social approach to pain management which focusses on supported self-care, functional rehabilitation and psychological support if required.**
- First consider what management can be provided, or continue to be provided in Primary Care and include the detail in the referral letter. Also include information about previous treatment/support/therapy tried and outcome.
- **Ensure all investigations are complete.**
- Referral letter to include NHS Oldham CCG defined minimum dataset including BMI.
- Completed PHQ4+2, PSEQ and HNA Tool to be attached. Please include the support provided in primary care, based upon the use of these tools, in the referral letter.
- **DO NOT MAKE ANY RECOMMENDATIONS REGARDING SPECIFIC INTERVENTIONS.**
- Please ensure that your patient is aware that the service provides the above support to help them live their lives better with their ongoing pain and assess whether your patient is ready to engage with such an approach.
- The Pain Service will discuss, using the principles of shared decision making, appropriate approaches to persistent pain management with the patient as part of the assessment process.
- **Spinal Injections – Lumbar epidurals and trigger point injections have been decommissioned across Greater Manchester since 2017 following NICE guidance.**

1. ***NICE guideline CG173 - Neuropathic pain in adults: pharmacological management in non-specialist settings.*** ***https://www.nice.org.uk/guidance/cg173***
2. ***www.bmj.com/content/369/bmj.m1315***
3. ***NICE NG59: Low back pain and sciatica in over 16s: assessment and management*** ***https://www.nice.org.uk/guidance/ng59***
4. ***NICE NG193: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain https://www.nice.org.uk/guidance/ng193***
5. ***GMMMG Opioid Prescribing for Chronic Pain: Resource Pack https://gmmmg.nhs.uk/wp-content/uploads/2021/08/Final-Opioid-Resource-Pack-Approved-CSB-August-2018.pdf***

Persistent Pain Medication Review in Primary Care

GPs have a pivotal role in the management of people with the long term condition of persistent pain as a consequence of their holistic and continuing relationship as well as holding the lifelong clinical record. Only Primary Care can review and amend, with their patients' participation, the repeat prescriptions issued.

The following list of indicators, although not exhaustive, provides a focus for a medication review and we would ask that GPs consider undertaking a review at regular intervals, eg 6 monthly, and ideally before any referral or after the initial assessment within the pain service. We may also provide specific advice at times and we would ask that this is also taken into consideration.

I. History of little or no pain relief from current medication

- Persistent pain tends not to respond well to medication and a balance has to be struck between any benefit gained and side effects experienced that can further impair quality of life. Many people with persistent pain find that their quality of life is best when they are prescribed little or no medication for their pain.
- Consider the benefits and side effects of current pain medication(s) and, if appropriate, discuss withdrawal if there is no benefit or if the impact of the side effects is greater than the benefit.
- Review the priorities identified within the HNA tool and consider how these may be addressed using non-pharmacological support.

II. History of little or no benefit from current medication prescribed for the impact of pain ie for depression, anxiety or sleep disturbance.

- Consider the benefit and side effects of the current medication prescribed for the impact of pain and, if appropriate, discuss withdrawal along with alternative management strategies and/or alternative medication.

III. History of side effects from current medication prescribed for pain relief or for the impact of pain.

- Consider the benefit and side effects of the current medication and if appropriate discuss withdrawal of one or more and consider alternative management strategies and/or medication.
- Persistent pain tends not to respond well to medication and a balance has to be struck between any benefit gained and side effects experienced that can further impair quality of life. Many people with persistent pain find that their quality of life is best when they are prescribed little or no medication for their pain.

IV. History of falls, confusion, memory problems or excessive fatigue.

- Consider the benefit and side effects of all, ie not just for pain, current medication and, if appropriate, discuss withdrawal of one or more and consider alternative management strategies and/or medication.
- Persistent pain tends not to respond well to medication and a balance has to be struck between any benefit gained and side effects experienced that can further impair quality of life. Many people with persistent pain find that their quality of life is best when they are prescribed little or no medication for their pain.
- See section VII. below

V. Current prescription of an oral NSAID/COX2 inhibitor to be taken regularly.

- Consider the current dose, effectiveness and side effects of the NSAID/COX2 inhibitor alongside NICE CKS NSAIDs-prescribing issues:-
- Consider whether the indication for the use of an NSAID/COX2 inhibitor is appropriate (BNF, NICE Guidance etc.)
- When prescribing an NSAID, individual risk factors for adverse effects should be taken into account and include any contraindications, drug interactions, medical history, and any monitoring requirements.
- If an NSAID is indicated, the lowest effective dose should be used for the shortest possible duration of intermittent use.
- Consider the appropriate NSAID/COX2 inhibitor with or without a PPI dependent upon the individual risk of GI adverse effects.

VI. Current prescription of opioids

- Review the current dose, side effects and benefits of the current opioid prescription and discuss the lack of evidence of benefit in long term use and the potential risks of the development of tolerance and addiction. Discuss slow withdrawal as appropriate.
- The use of regular opioids eg Codeine, Tramadol, Morphine, Oxycodone etc. whether in tablet or patch form is not recommended for persistent pain as there is little evidence of effectiveness in the long term and significant risk of side effects and the development of dependence. (Opioids Aware, Faculty of Pain Medicine)
- Advice regarding opioid withdrawal, and other resources, is available at the Faculty of Pain Medicine's website **https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/tapering-and-stopping**
- Note that in non-palliative care practice doses of opioids above a Morphine equivalence of 120mg a day are associated with a greater risk of harm and can cause hyperalgesia (increased pain)
- Note the conditions listed under the "Cautions" section of the BNF when opioids are prescribed as these increase the risk of harm
- Note that the risk of respiratory depression is increased when opioids are prescribed with Benzodiazepines, eg Diazepam, Temazepam etc. and Gabapentinoids, eg Gabapentin and Pregabalin.
- Note the serotonergic risks when Tramadol or Tapentadol are co-prescribed with tri-cyclic or SSRI anti-depressants. Other drug interactions listed in the BNF should also be considered.
- Note that Tramadol and Tapentadol can increase the risk of fits in those prone to seizures or in combination with other medications that can increase the risk of fits.

VII. Current prescription of the tri-cyclic antidepressants, Amitriptyline or Nortriptyline.

- Review the indication for, current dose, side effects and benefits of the prescribed tri-cyclic and consider the following.
- Amitriptyline or Nortriptyline are not effective for the management of non-neuropathic pain ie mechanical joint or spinal pain.
- Calculate the anti-cholinergic burden score (use the calculator at **http://www.acbcalc.com/**) from all the medication (not just pain medication) prescribed (and OTC eg antihistamines) to your patient. Note that an ACB score of 3 or more is associated with an increased risk of falls, confusion and mortality. This risk increases the higher the ACB score is and with age and especially in people 65 years or older.
- Review the potential for the development of serious serotonergic effects from the interactions with other prescribed medication.
- Review other potential interactions, cautions etc as per the BNF
- Discuss any medication changes as appropriate.

VIII. Current prescription of the Gabapentinoids, Gabapentin or Pregabalin.

- Review the indication for, current dose, side effects and benefits of the Gabapentinoid prescribed and consider the following.
- Gabapentinoids are not effective for the radicular neuropathic pain (sciatica) associated with nerve root compression, non-neuropathic back pain (NICE NG59), neuropathic pain secondary to spinal stenosis or for migraine. (**https://www.bmj.com/content/369/bmj.m1315**)
- Gabapentinoids are not recommended for the management of primary central persistent pain eg fibromyalgia (NICE NG193)
- Consider and discuss the MHRA safety alerts for Gabapentin, **https://www.gov.uk/drug-safety-update/gabapentin-neurontin-risk-of-severe-respiratory-depression**, or Pregabalin, **https://www.gov.uk/drug-safety-update/pregabalin-lyrica-reports-of-severe-respiratory-depression** as appropriate.
- Neuropathic analgesics, eg Amitriptyline, Gabapentin, Pregabalin and Duloxetine, can sometimes help ease the pain of peripheral neuropathy although their benefit is often limited and they are often associated with significant side effects. Duloxetine is licensed for diabetic peripheral neuropathic pain only, and gabapentin is licensed for peripheral neuropathic pain only, so use for other conditions would be off-label. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. If the use of a neuropathic analgesic is considered after discussion of these limitations an agreed treatment goal must be defined, such as a 30% reduction in the VAS score for pain intensity, and regular review will be required to monitor for effectiveness and side effects. Titration trials of the neuropathic agents can be considered in rotation if required as per the persistent pain prescribing guide and NICE CG173.

IX. Age over 65 and prescribed more than 5 regular repeat prescription medicines that includes medication for pain or the impact of pain.

- Consider undertaking a medication review using the STOPP START Medication Review Tool at Appendix 5 of the Toolkit for General Practice at **https://www.england.nhs.uk/wp-content/uploads/2017/03/toolkit-general-practice-frailty-1.pdf**
- Polypharmacy in those over 65 is associated with increased risks of harms from drug interactions, side effects, changes in drug metabolism etc.

Pennine MSK
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Patient Name _____NHS Number_____Date_____

PHQ4 plus 2

Over the past few weeks have you been bothered by these problems?	Not at all	Several days	More days than not	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not be able to stop or control worrying	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3

Pain Intensity and Interference

In the last month, on average, how would you rate your pain? (That is your usual pain at times you were in pain.)

Use the scale from 0 to 10, where 0 is “no pain” and 10 is “pain as bad as it could be”

No pain **As bad as pain could be**

0	1	2	3	4	5	6	7	8	9	10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is “no interference” and 10 is “unable to carry on any activities”

No Interference **Unable to carry on any activities**

0	1	2	3	4	5	6	7	8	9	10

Health Needs Assessment
Changing how pain affects your life

Pain can affect peoples' lives in many ways. This check list shows some of the problems and difficulties due to longstanding pain.

Please help us understand the main problems **at present** that **you** feel are important to improve your quality of life and self-manage with more confidence.

Please follow the two steps below and tick (✓) the boxes below related to your needs.

Name: **Date of birth:**

STEP 1	**Do you have any problems or difficulties with:**		
	1	❑	Walking or moving about
	2	❑	Lack of fitness and stamina
	3	❑	Balance or recurrent falls
	4	❑	Side effects or other problems with current pain medication e.g. tablets etc.
	5	❑	Pain symptoms or pain relief
	6	❑	Understanding why longstanding pain occurs
	7	❑	An unhelpful pattern of activity of doing too much, getting more pain, then doing too little
	8	❑	Eating the right sort of foods
	9	❑	Disturbed sleep
	10	❑	Managing mood changes of depression, anger, anxiety or worry
	11	❑	Tiredness or lack of energy
	12	❑	Relationship difficulties; with partner, family, work etc.
	13	❑	Sex life
	14	❑	Remaining in work or returning to work and/or training
	15	❑	Financial or money difficulties
	16	❑	Current legal claim linked with the pain problem
	17	❑	Concerns about your carer/partner, their health or other problems
	18	❑	Other difficulties that you feel are important to change, for example, concerns about housing, hobbies, leisure or social events with friends or visiting the church or mosque. Please describe here: --- --- ---
STEP 2	If you ticked more than **three areas of your life**, please **circle the three** most important to change at present. Thank you for helping us to understand your needs and issues due to pain.		

Name:

Date of Birth:

NHS No:

PSEQ

Date……

1) Managing your pain

Please rate **how confident** you are that **you can do** the following things at present, **despite the pain.** To answer, **circle** *one* of the numbers on the scale under each item, where 0 = "Not at all confident" and 6 = "Completely confident".

For example:

Not at all confident						Completely confident
0	1	2	(3)	4	5	6

Remember, this questionnaire is not asking whether or not you have been doing these things, but rather **how confident you are that you can do them** at present, **despite the pain.**

	Not at all confident						Completely confident
I can enjoy things, despite the pain.	0	1	2	3	4	5	6
I can do most of the household chores (eg. tidying-up, washing dishes, etc.) despite the pain.	0	1	2	3	4	5	6
I can socialise with my friends or family members as often as I used to do, despite the pain.	0	1	2	3	4	5	6
I can cope with my pain in most situations.	0	1	2	3	4	5	6
I can do some form of work, despite the pain ("work" includes housework, paid and unpaid work).	0	1	2	3	4	5	6
I can still do many of the things I enjoy doing, such as hobbies or leisure activities, despite the pain.	0	1	2	3	4	5	6
I can cope with my pain without medication.	0	1	2	3	4	5	6
I can still accomplish most of my goals in life, despite the pain.	0	1	2	3	4	5	6
I can live a normal lifestyle, despite the pain.	0	1	2	3	4	5	6
I can gradually become more active, despite the pain.	0	1	2	3	4	5	6