

Isle of Wight Healthcare NHS Trust

Chronic Pain: Guidelines for initial management and referral to secondary care.

Purpose

To facilitate the appropriate initial treatment, and referral to specialist services, for those suffering with chronic pain.

Introduction

- Pain is one of the most common reasons that patients present to primary care
- Chronic pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. (International Association for the Study of Pain)
- Statistics show that nearly 1 in 7 people (13%) suffer from chronic pain. It is hardly surprising that people suffering pain consult their doctor up to five times more frequently than others, and this results in nearly 5 million GP appointments each year.
- Two thirds of chronic pain sufferers surveyed in the UK reported inadequate pain control with only 16% saying that they had seen a pain specialist.
- Untreated pain can affect quality of life for sufferers and carers leading to helplessness, isolation, depression, and family breakdown,

Background

- The Royal College of General Practitioners (RCGP) and The Pain Society recommend that primary care physicians and hospital specialists should work together to manage patients in the most appropriate environment.
- Specialist Chronic Pain services are those, which serve the needs of people with complex pain disorders requiring diagnosis and treatment by multi-disciplinary teams. NHS Information Authority (NHSIA)
- It is important to refer early rather than late; these guidelines are designed as an aid to this, by describing a pathway for appropriate referral to the specialist services available on the Isle of Wight.
- Waiting times for specialist pain services may be many months. The RCGP states that it is important to continue to see patients waiting for specialist referral and to modify treatment where appropriate. These guidelines are designed to provide a seamless treatment pathway between primary and secondary care.

Scope

- All patients with chronic pain; i.e. pain following an episode of tissue damage that persists past the time when healing is expected to be complete, usually nominated as 3 months.
- These guidelines are for use by all doctors, both within primary and secondary care, who are treating patients suffering from chronic pain.
- These guidelines should be used for patients of all ages.

Recommendations

- The guidelines are designed as a series of algorithms to be used together to guide management and referral.
- These guidelines are based on established practise throughout the UK. References discussing aspects of this practise are listed at the end of the document.
- A copy of these guidelines will be sent to all consultants and GPs on the Isle of Wight, and will be available on the intranet.
- Patient information can be obtained from the Pain Clinic site on the intranet.

Linked Documents

These guidelines link with the Chronic Pain Opiate Prescription Framework for Non-Cancer pain in Primary and Secondary care on the Isle of Wight.

References

1. Pain in Europe. A 2003 report. Research project by NFO Worldgroup
2. Elliott AM, Smith BH Penny KL et al. The epidemiology of chronic pain in the community. *Lancet* 1999; 354: 1248-52
3. A practical guide to the provision of Chronic Pain Services for Adults in Primary Care. The British Pain Society and the Royal College of General Practitioners.
4. Services for Patients with Pain. London: Clinical Standards Advisory Group 2000
5. Cancer Pain Relief: With a guide to opiate availability. Geneva: World Health Organisation 1996
6. McQuay HJ, Tramer M, Nye BA et al. A systematic review of anti-depressants in neuropathic pain. *Pain* 1996; 68: 217-27
7. Sindrup SH, Jensen TS. Efficacy of pharmacological treatments of neuropathic pain. An update and effect related to mechanism of drug action. *Pain* 1999; 83: 389-400
8. McQuay HJ, Carroll D, Jadad AR, et al. Anticonvulsant drugs for the management of pain: a systematic review. *BMJ* 1995; 311: 1047-52
9. Recommendations for the appropriate use of opioids for persistent non-cancer pain. The British Pain Society 2004
10. The use of drugs beyond licence in Palliative Care and Pain Management. The Association for Palliative medicine and the Pain Society 2002
11. McQuay HJ, Moore AM, Eccleston C, Morley S, Williams A C de C. Systematic review of outpatient services for chronic pain control. *Health Technology Assessment* 1997; Vol 1: No.6
12. Management of depression in Primary and Secondary Care. National Clinical Practise Guideline No.23

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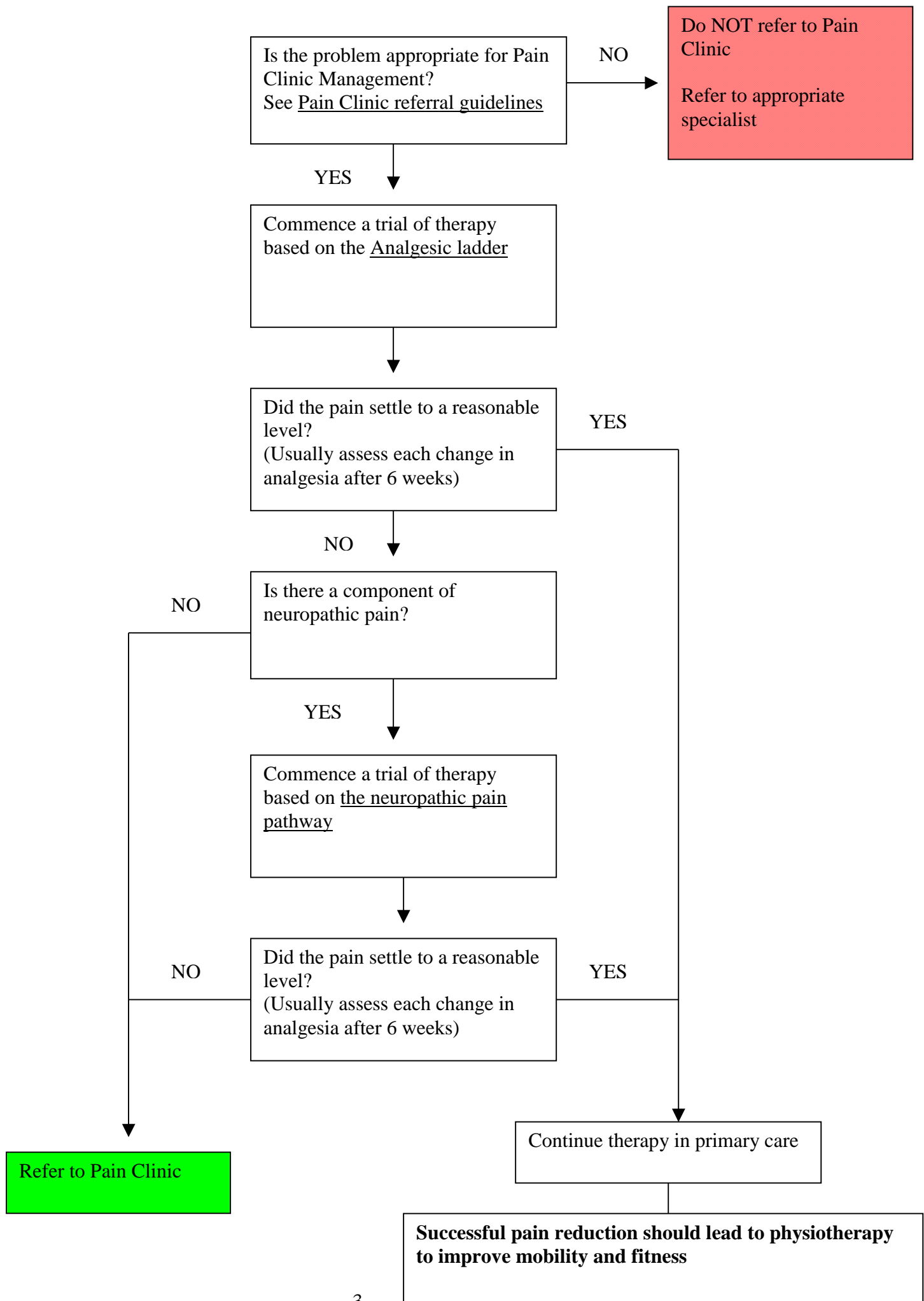
Janssen – Cilag supported the development of these guidelines.

Version **1**

Status **Ratified** **July 2005**

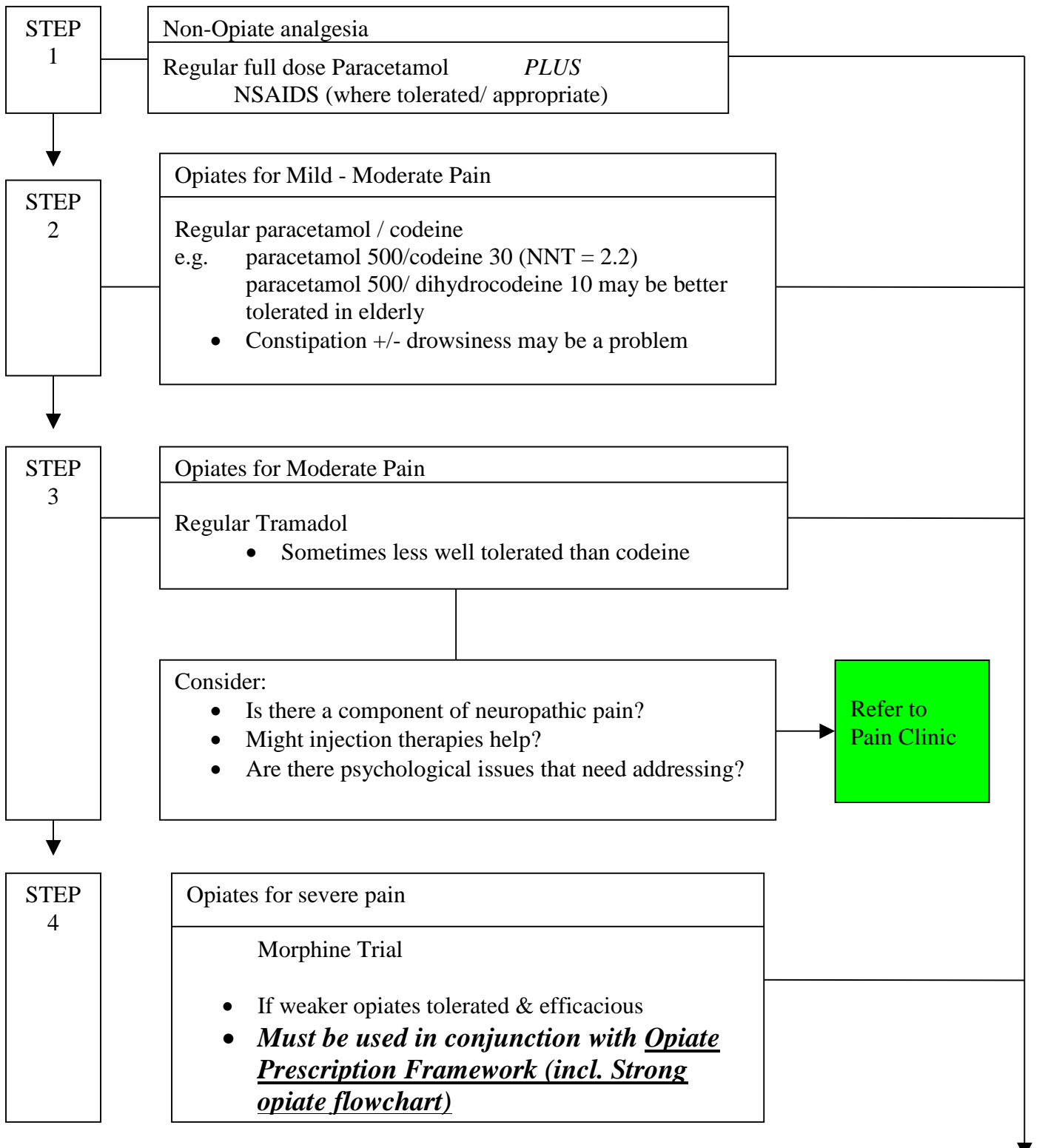
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2: Algorithm for Pain Clinic Referral



3: Analgesic Ladder

Usually assess each change in analgesia after 6 weeks



Offer regular laxatives to patients taking opioids

Consider anti-emetic during first week of opioids

Consider NON-DRUG THERAPIES

EDUCATION, EXPLANATION and REASSURANCE

ENCOURAGE SENSIBLE ACTIVITY

PHYSICAL THERAPIES

TENS

ACUPUNCTURE and other complementary therapies

4: Neuropathic Pain Pathway

Neuropathic Pain Features:

- Described as: “burning”, “electric shocks” or other unpleasant sensations
- Skin in affected areas abnormally sensitive to pain (Hyperaesthesia), touch (Allodynia) or even numb
- Skin in painful areas looks different from normal e.g. atrophic or cyanosed
- May have dermatomal pattern or follow known nerve injury or ischaemia

Adjuvant Drugs should be used in addition to or instead of conventional analgesics such as paracetamol, NSAIDs, codeine and morphine

**TRICYCLIC
ANTIDEPRESSANTS**
(Usual 1st choice therapy)

ANTICONVULSANTS
(1st choice if TCA's contra-
indicated or lancinating pain
–“shocks”)

Amitriptyline

Effective in neuropathic pain and widely used (NNT=3.0)
Analgesic effect separate from anti-depressant effect

Titration table:

Week1	Week2	Week3	Week4	Week5
10mg	20mg	30mg	40mg	50mg

- Taken at night to reduce unwanted sedation
- Gentle titration important to reduce side-effects
- Small doses can be effective, but up to 150mg can be used
- Final dose determined by efficacy / side-effects

If sedation intolerable:

- Nortriptyline or Venlafaxine

If cardiac problems:

- Lofepamine

NOTE:

Evidence suggests that SSRIs are much less effective in neuropathic pain

Gabapentin

NNT similar to TCAs

Titration Table:

	Week1	Week2	Week3	Week4
Am		300mg	300mg	300mg
Middy			300mg	300mg
Nocte	300mg	300mg	300mg	600mg

Continue increasing as above up to 900mg tds (determined by efficacy & side-effects)

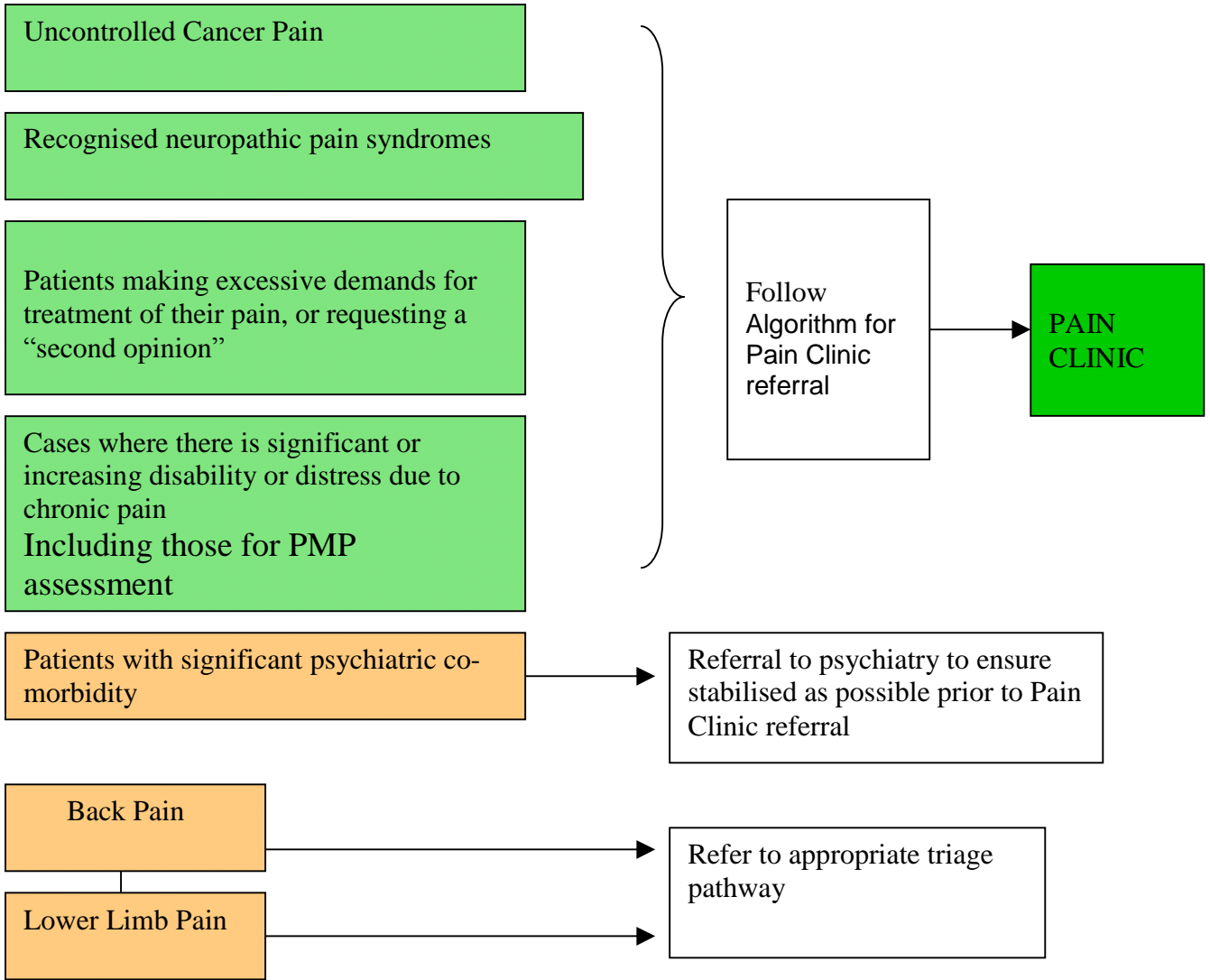
NOTE:

If poor response to single drug:

1. Consider whether nerve block might be effective
(Refer to Pain Clinic)
2. Use combination of TCA and Anti-convulsant

1: Pain Clinic Referral Guidelines

Appropriate



Inappropriate

