University Hospitals of North Midlands NHS Trust | North Staffordshire Combined Healthcare NHS Trust | Staffordshire and Stoke on Trent Partnership NHS Trust | NHS North Staffordshire Clinical Commissioning Group | NHS Stoke-on-Trent Clinical Commissioning Group

An at a Glance Guide to Prescribing Analgesics for Non-Malignant Chronic Pain

CHRONIC PAIN

* Medicines have a limited role in the management of patients pain with chronic non-malignant pain.
* Only a minority of patients with chronic pain achieve clinically meaningful pain relief from medicines.
* A biopsychosocial model of chronic pain assessment and a multidisciplinary/multimodal approach to treatment are recommended.
* Self management strategies including maintaining fitness, pacing activities and a generally healthy lifestyle are important.

  Back Pain: http://www.nhs.uk/livewell/backpain/Pages/Backpainhome.aspx
  http://www.nhs.uk/Livewell/Backpain/Pages/low-back-pain-exercises.aspx

  Arthritis: http://www.nhs.uk/Conditions/nhs-fitness-studio/Pages/arthritis-pilates-exercise-video.aspx
* This prescribing guide aims to facilitate the prescribing of appropriate initial treatment.
* The response to treatment (pain relief, functional improvement and side-effects) should be reviewed within 4-6 weeks and medicines continued only if they are of clear functional benefit.
* For further guidance of use of opioids see: http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware
* Please refer to the chronic pain pathway for full clinical and referral details.

Basic analgesic

Regular **paracetamol** 1 g QDS (or appropriate lower dose) +/- **NSAID ibuprofen** 400 mg TDS or **naproxen** 500 mg BD unless contraindicated

Review response & if treatment goals are not met consider :

Step 2 (moderate analgesics)

Starting with co-codamol 8/500 1 or 2 tablets QDS, PRN **titrate up to co-codamol 30/500** 2 tablets QDS. Consider **dihydrocodeine** (30 mg QDS max 240 mg) if patients do not respond to codeine (as this may be due to individual variation in metabolism of codeine).

Review response. If options above are not tolerated or if treatment goals are not met despite regular use, consider:

Switch co-codamol to paracetamol plus **immediate release tramadol.**
Start at 50 mg up to QDS (max. 100 mg QDS).
Set maximum dose, treatment period (e.g. 1 month) and assess response.

Where compliance is an issue consider **buprenorphine patch (Butrans®)**

Starting with 5 mcg/hr patch every 7 days, titrating up to 10 mcg/hr after 2 weeks if needed and review.

Before considering escalating to strong opioids consider

Step 3 (Strong analgesics)

Zomorph®
(morphine sulfate mr)
Start with 10 mg BD
titrated to response by 10mg increments, avoid increasing above 30mg BD without specialist opinion.

Oxycodone modified release
Start with 5mg BD
Increased by 5mg BD increments, avoid increasing above 20mg BD without specialist opinion.

Start Low and Go Slow

* Agree functional goals for opioid treatment with patient.
* Assess each change to analgesic regimen after 4 – 6 weeks and **review** the efficacy of medication in relieving pain, improving function and any side-effects that may impair function.
* Following review, if treatment goals have not been met, after reasonable up-titration, consider weaning down and stopping medication.
* Assess mood (e.g. PHQ-9 Depression Test) and consider treatment for low mood (including referral to community mental health teams).

* There is a lack of evidence for long term effectiveness of opioids in chronic pain.
* Individual risk factors (e.g. age, comorbidities, mental health problems, history of substance misuse/addiction and concurrent psychotropic drugs e.g benzodiazepines) increase risk of harm such as overdose, fall fractures etc.
* Careful consideration is required in these patients.
* Oxycodone is reserved for cases where morphine causes cognitive impairment and in renal impairment.
* Swallowing difficulties: remember Zomorph® capsules can be opened.

Approved by North Staffordshire and Stoke-on-Trent Area Prescribing Committee on 31/05/2017 Review Date: 06/2019
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NEUROPATHIC

Basic analgesic

Regular **paracetamol** 1 g QDS (or appropriate lower dose) +/- **NSAID ibuprofen** 400 mg TDS or **naproxen** 500 mg BD unless contraindicated

Neuropathic pain / Diabetic neuropathy

1st line

Amitriptyline

(not to be used in the elderly 75yrs & over)

Start at 10 mg at night and titrate by 1omg increment. Usual dose 10-30mg maximum 75 mg/day

Gabapentin

(preferred option in the elderly 75years & over)

Titrate up to the lowest tolerated effective dose (e.g. 1800 mg/day).

Review response and consider weaning off & switching (if not effective)

2nd line

Neuropathic pain	Diabetic neuropathy
Consider **amitriptyline** (titrate as above) **and/or** **Pregabalin** starting at 75mg BD (or lower in frail/elderly) and titrate by 25-75mg increments to 150-300mg BD. If not tolerated then wean down and discontinue.	Consider **gabapentin** (titrate as above) **and/or** **Duloxetine** starting at low dose of 30mg/day then titrate to usual dose of 60mg if needed. Gradually titrate up to an effective dose (max. 120mg/day in 2 divided doses**).**

Review response and consider weaning off & switching (if not effective)

3th line

Add **tramadol** 50mg up to QDS.

Titrate up to max. 100mg QDS if needed.

Set treatment period (e.g. 1 month) and acceptable response.

Consider **duloxetine** (titrate as above)

and/or

Pregabalin starting at 75mg BD (or lower in frail/elderly) and titrate by 25-75mg increments to 150-300mg BD.

Review response and consider weaning off & switching (if not effective)

4th line

Tapentadol MR

Start with 50mg BD and titrate by 50mg BD increments as needed, at intervals of 2 weeks and continue at lowest effective dose (max150mg BD before seeking Specialist advice).

Start Low and Go Slow

Anticholinergic burden and CNS side-effects are common with **amitriptyline** particularly in the elderly, therefore should not be used in this group.

* Gradual titration of **gabapentin** in adults starting at 300 mg at night for 3 days, then 300 mg twice daily for 3 days, then 300 mg 3 times daily for 2 weeks then titrate at 100mg-300mg increments according to response is advocated.
* Reconsider if there is no response by 1800mg.
* Slower titration may be required in the elderly, starting at 100mg and increasing by 100mg increments.
* Pregabalin and Gabapentin can enhance the euphoric effects of other drugs such as opiates therefore have a street value .
* Counsel patients on weight gain with pregabalin.

* Caution should be taken when prescribing **tramadol** as it may increase the risk of convulsions in epilepsy or those susceptible to seizures. It also increases risk of CNS toxicity with SSRIs.
* Tramadol is contraindicated in those using mono-amine oxidase inhibitors or within two weeks of their withdrawal.

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