integrated working

NHS West Suffolk Clinical Commissioning Group

PAIN LADDER - CHRONIC PAIN

Pain treatment pathway for non-cancer chronic pain ≥ 3 months duration in adults in primary care[1,2,3,4]

Key Principles

- Consider early referral to West Suffolk Pain Service Single Point of Access in patients with excessive, uncontrolled or rapid escalating opioid requirements, and/or significant pain preventing sleep, function or work, or causing distress
- Progressing through the steps below does not guarantee increased benefit or better pain relief. **Medication does not always work; stop medicines that are not working.**
- 3-monthly medication reviews are recommended for all patients taking regular analgesics; **prioritise Polypharmacy Medication Reviews for patients taking opioids or gabapentinoids**

STEP 1

Assessment and non pharmacological strategies

- Exclude red flags. **Assess pain/impact** and **yellow flags**
- Consider possibility of neuropathic/mixed pain: **neuropathic pain ladder**
- Establish expectations and agreed goals
- Discuss **non pharmacological strategies** and provide **signposting information**
- Consider referral to: **Wellbeing Service, physiotherapy, gentle exercise/weight loss programmes** or TENS

STEP 2

Paracetamol oral/rectal 1g qds
(1g tds if < 50 kg, malnourished, renal or hepatic impairment)
Paracetamol alone is not recommended management for low back pain[3]
+ / OR
Ibuprofen oral 400 mg tds /topical 5% gel tds OR **Naproxen** oral 250-500 mg bd
NSAID at lowest effective dose for shortest period. Consider a PPI.

Consider possibility of neuropathic/mixed pain; refer to neuropathic pain ladder

Ineffective or not tolerated: ***STOP***
Partially effective: consider adding

STEP 3

Codeine oral 15-60 mg qds
Avoid if breast feeding or if patient has experienced excessive response to codeine previously*
OR
Tramadol oral 50-100 mg qds
OR
Meptazinol oral 200 mg 3-6 hourly

Consider referral to West Suffolk Pain Service Single Point of Access. *Consider the use of adjuvants (amitriptyline, duloxetine, gabapentin etc.)* **Click here** *for Condition Specific Advice on Use of Adjuvants.*

Ineffective or not tolerated: ***STOP Step 3 opioid***
Consider Step 4
OPIOIDS ARE OF LIMITED USE FOR THE TREATMENT OF CHRONIC LONG TERM PAIN AND THERE IS SIGNIFICANT RISK OF SIDE EFFECTS AND DEPENDENCY

PLEASE TURN OVERLEAF FOR STEPS 4 & 5

CONTINUED FROM STEPS 1, 2 & 3 OVERLEAF

STEP 4

Consider trial of high dose opioids

OPIOIDS ARE OF LIMITED USE FOR THE TREATMENT OF CHRONIC LONG TERM PAIN AND THERE IS SIGNIFICANT RISK OF SIDE EFFECTS AND DEPENDENCY

Assess risk for long term opioid treatment: History of mental health, substance abuse, overdose, concurrent benzodiazepine use, sleep disordered breathing. **Opioid risk tool**

Decreased risk	Elevated risk
Manage within primary care See Step 4	Refer to West Suffolk Pain Services or seek specialist advice

STEP 5

Trial of high dose opioids

(not to be initiated by non medical prescribers outside specialist areas)

Discuss with patient:

- Risks and benefits of long term opioid therapy and impairment of driving skills
- Provide: **Taking opioids for pain** and **Opioid safety** leaflets
- Agree and document realistic goals of trial e.g. 30-50% reduction in pain intensity, specific functional improvement/improvement in sleep
- Keep a diary of twice daily reports of pain intensity, comments on sleep and activity levels, doses taken and side effects
- Trial opioid for 1-2 weeks if in constant pain; if intermittent flare ups trial for long enough to observe effects on 2-3 episodes of increased pain
- A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and use is intermittent

Further information see Opioids Aware: **Structured approach to prescribing of opioids in chronic pain**

Morphine Sulfate oral solution up to 4-6 hourly: **age related dose**

OR

if patient intolerant to morphine and unable to swallow

Buprenorphine patch or S/L tablets

OR

if patient intolerant to morphine and on advice of West Suffolk Pain Services due to risk of addiction

Oxycodone oral solution up to 4-6 hourly: **age related dose**

Age related dose for oral solution 4-6 hourly

Age	Morphine	Oxycodone
16-39	7.5-12.5 mg	3 mg-6 mg
40-59	5-10 mg	2.5-5 mg
60-69	2.5-7.5 mg	1.25-3 mg
70-85	2.5-5 mg	1.25-2.5 mg
>85	2.5 mg	1.25 mg

- **Prescribe for 1-2 weeks trial, adjust to optimal dose and reassess**
- **DO NOT prescribe opioid dose >90 mg/ 24 hours of oral morphine equivalent unless on advice from the West Suffolk Pain Services (risk of overdose)**
- **HARM > BENEFIT if opioid dose >120 mg/ 24 hours of oral morphine equivalent**

Trial unsuccessful

- Trial ineffective or not tolerated taper down and discontinue opioid over one week, even if no other treatment is available.

Trial successful (and safe to continue)

- Convert to modified release
- Monitor: analgesia, activity, adverse effects, mood, sleep and aberrant behaviours
- Once dose and symptoms are stable, and no additional clinical concerns, review 3-6 monthly
- Consider tapering dose down at reviews

Reassess and review diagnosis and treatment plan and consider referral to West Suffolk Pain Services Single Point of Access and/or condition specific service

KEY MESSAGES

Benzodiazepines: extreme caution if prescribing with strong opioids and short term only.

Dose equivalence and changing opioids:
Seek advice.
High dose opioids are not for chronic back pain, fibromyalgia or headaches.
Poor evidence of benefit in chronic non cancer pain.
Renal impairment: **Seek advice**
Hepatic impairment: Seek advice
Further information: **Opioids Aware**

References: 1. Opioids Aware; 2. PresQIPP 149 Jan 2017; 3. NICE NG 59 Nov 2016; 4. EULAR recommendations for fibromyalgia 2016
*CYP2D6 ultra rapid metabolisers

Produced by the WSCCG Medicines Management Team and West Suffolk Pain Services.
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