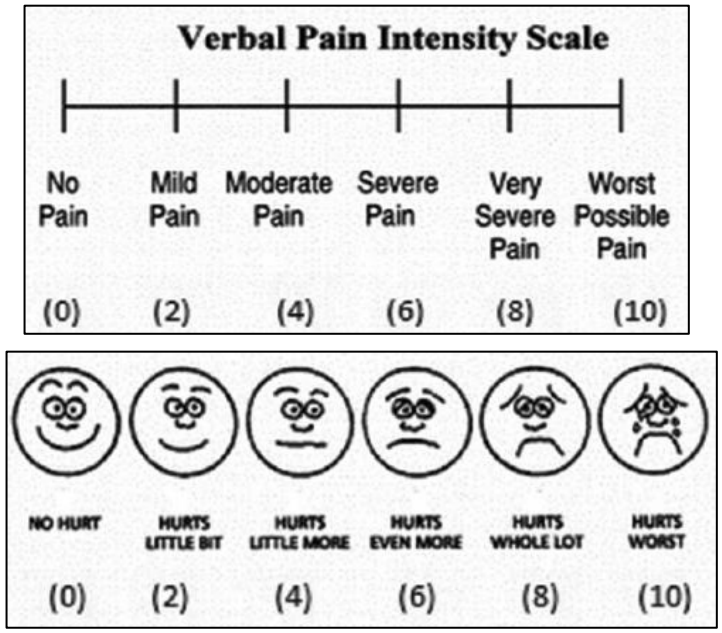
Acute and Chronic Pain Guidelines

Validated pain scales

- Use a validated pain scale appropriate for the needs of the individual: Verbal rating scale, Abbey (cognitive impairment) or smiley faces (children)
- Document where on the scale the person indicates their resting pain score to be (allowing that pain on movement may be one or two points higher on the scale), and evaluate the change over time
- Manage expectations: it is unlikely that someone will move from very severe pain to no pain in just a few days, but if they are able to use analgesia to ***reduce*** their pain, this should allow the person to stay active, which is shown to improve long-term outcomes
- Use the person's baseline resting pain score to determine the initial management strategy on the following page. If the pain score on movement is 3 or more points higher on the scale than the resting score then use an intermediate score for the baseline assessment



Diagnosis and referral

This guidance is intended to support clinicians in the management of acute or chronic pain as a symptom and to aid patient recovery with a holistic and evidence based approach. It is not intended as a diagnostic tool. Clinical decision aids to support appropriate diagnosis and referral for people presenting to primary care with acute or chronic pain can be found in Ardens auto-consultations on Systm-ONE and/or QMaster on Emis. Where diagnostic uncertainty remains in spite of use of these tools, specialist advice should be sought through CRS Advice and Guidance or Consultant Connect

Acute pain

The principle of acute pain management is rapid achievement of adequate analgesia, enabling the person to engage in exercise and resume activities of normal daily living (ADL). In truly acute pain, sub-therapeutic analgesia in the early stages may increase the risk of this becoming chronic pain as inability to engage in ADLs and exercise leads to muscle wasting, impairing recovery. Analgesia for acute pain is rarely required to longer than 1-4 weeks.

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Acute pain management:

Non-pharmacological strategies

Pain is multi-faceted and there is growing evidence that non-pharmacological strategies are equal to, or more important, than medicines in pain management.

Discuss the following as part of a pain consultation:

- Provide patient with relevant supportive information e.g. Faculty of pain leaflets "About pain", "thinking about opioid treatment of pain" and NHS choices "self-help tips to ease pain"
- Reassure patient that the degree of pain does not correlate well with the amount of tissue damage
- Some people find relief from non-medicine treatments such as physiotherapy, TENS machine, acupuncture, yoga, meditation, use of heat and cold
- The value of any activity that the person enjoys should not be underestimated; craft, music, volunteering, book clubs, spending time with loved ones may all help distract from pain and release endorphins, reducing reliance on medicines
- Encourage all patients to sign up for psychological support such as cognitive behavioural therapy, https://me.silvercloudhealth.com/signup or iAPT: https://www.northessexiapt.nhs.uk/mid-essex

"Staying active and continuing usual activities, even though there may be initial pain and discomfort, usually results in a faster recovery from symptoms, less chronic disability and less time off work"

- **Prolonged bed rest is now known to be harmful**

Pharmacological strategies:

Pharmacological management (use together with non-pharmacological strategies for optimum outcomes)	
Mild pain / Step 1 Pharmacy Medicine #SelfCare #AskYourPharmacist	**Lower back pain:** Ibuprofen 400mg TDS OR topical 5% gel OR Naproxen 250-500mg TDS +/- paracetamol as below **Other cause of pain:** Paracetamol 1g QDS (reduce to TDS if <40kg, malnourished or renal / hepatic impairment), oral or rectal +/- NSAID as above
Is neuropathy likely? Use LANSS or Pain DETECT tool to assess, if so, stop any opioids and refer to neuropathic pain guideline.	
Moderate pain / Step 2 ADD a weak opioid	As for Step 1 plus: **Codeine oral 15-60 mg QDS** Avoid if breastfeeding or patient has experienced excessive response to codeine previously
Severe pain / Step 3 STOP weak opioid, add strong opioid	As for Step 1 plus: **Morphine sulphate** oral solution at age appropriate dose 4-6 hourly (see table), maximum 100mL supply *Patients who progressed from step 2 may be poor metabolisers of codeine, they are therefore unlikely to respond to tramadol or oxycodone.*

Age related dose of oral morphine solution 10mg/5mL, 4-6 hourly	
16-39 years	7.5 – 12.5 mg
40-59 years	5 – 10 mg
60-69 years	2.5 – 7.5 mg
70–85 years	2.5 – 5 mg
>85 years	2.5 mg

Re-assess pain after 3 days		
Change in pain score:	**Action:**	**Next review:**
≥30-50% reduction in pain score	Ensure person is staying active and continuing usual activities. Reduce by one step on pain pathway. Continue to reduce analgesics as function improves until able to stop. If opioids are still required, not more than 7 days supply.	7 days if opioids are continued
< 30% reduction in pain score/ no improvement	Increase strategy by one step in pathway above. If already at step 3, go to Step 4 on next page	3 - 7 days or sooner if pt request

If prescribing opioid analgesics, see also Prescribing opioids box on page 3

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Escalation of pharmacological management in continued or increased acute pain:

STEP 4) Do not start at this level

Continue Step 1 and non-pharmacological strategies

Convert 1/3 of the total daily dose of morphine (that is actually taken) into modified release

And continue with PRN immediate release morphine sulphate

- Total daily morphine dose (modified release plus immediate release) not to exceed 60mg / 24 hours
- Patient to complete opioid contract if not already done so

Maximum of 7 days, do NOT add to repeat

TABLE 2: Second (or third) re-assessment

Change in pain score:	Action:	Next review:
30-100% reduction in pain score	Ensure person is staying active and continuing usual activities. Reduce by one step on pain pathway. Continue to reduce analgesics as function improves until able to stop. If opioids are still required, not more than 7 days supply.	7 days if opioids are continued.
< 30% reduction in pain score or worsening pain (and currently at STEP 2 or 3)	Escalate to next STEP	3 – 7 days then repeat this re-assessment
< 30% reduction in pain score or worsening pain (and already at STEP 4)	If pain unable to be controlled with increasing doses, may warrant further investigation into source of pain or rapid referral for MRI. Contact pain team via CRS Advice and Guidance (MEHT) or via Consultant Connect (CHUFT)	As guided by specialist

Prescribing Opioids

Agree treatment goals with an emphasis on improvement of the patient's quality of life and function and that the goal of treatment is to enable the person to engage in light exercise and ADLs which will speed recovery, opioids may manage the symptoms of pain in the short term but will not treat the route cause.

Adjuvant use of regular paracetamol has been shown to reduce opioid requirement by up to 30%, patients should not be prescribed opioids unless they are also taking regular paracetamol (unless there is a contraindication to its use)

Manage the patient expectation: a 30% reduction in pain score is considered a good outcome, the aim of acute pain management is rapid analgesia and withdrawal from medication as soon as possible

Consider use of an opioid treatment agreement outlining the rights and responsibilities of the doctor and the patient. There is a template on the CCG website

Patients should be warned that opioids can impair the ability to drive. It is illegal in England and Wales to drive with legal drugs in the body if it impairs driving. [DVLA]

Identify high risk patients e.g. elderly; patients on concomitant CNS depressants, those with renal or hepatic impairment, doses in such groups may need to be more conservative and these patients monitored more closely for adverse effects

Patients should be advised to purchase laxatives OTC (such as senna or docusate) to prevent or treat opioid related constipation

Acute pain that continues beyond six weeks is a high risk of progressing to chronic pain, attempt to wean down opioids at regular intervals and remind patients of the importance of non-pharmacological strategies (page 2)

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Chronic pain "pain that persists beyond usual healing time or that is >3 months (whichever is shorter)"

Anxiety and depression are common co-morbidities with chronic pain. Seek psychiatric advice to stabilise as much as possible before continuing to pain management. Even those who do not currently identify as having depression or anxiety may be at a high risk of developing it. It is advised that ALL chronic pain patients self-refer to either the fully supported iAPT service or to SilverCloud for self-directed psychological therapies. https://www.northessexiapt.nhs.uk/mid-essex

Patient has been through the acute pain pathway, complex pathology ruled out following further investigation / referral and is still requiring opioids

- Further increasing opioids is unlikely to be effective, only about 10% of chronic pain cases respond to opioid therapy
- Opioid-induced hyperalgesia (where continued use of opioids actually worsens or causes pain) should be considered
- Do not increase current opioids
- If not previously considered, assess if neuropathic pain is a factor (using LANSS or PainDETECT tools and if so, refer to neuropathic pain guidelines
- Attempt to wean down current opioid use, if specialist support is required for this or in confirming diagnosis or cause of pain; consider contacting pain team via CRS Advice and Guidance (MEHT) or via Consultant Connect (CHUFT)

Patient is currently opioid naïve or has only used occasional PRN codeine or OTC low dose codeine preparations (if so, start at equivalent place in pathway below after implementing non-pharmaceutical measures)

May be undertaken by community pharmacists or non-medical clinical staff in the GP practice

- Give patient Faculty of Pain Patient Information Leaflets: "About Pain" and "Thinking about Opioid Treatment for Pain"
- Ensure patient is self-caring with prn paracetamol (and/or a non-steroidal anti-inflammatory if lower back pain)
- Try to avoid initiating opioids at the first appointment, explain that opioids are not often very effective for chronic pain and may be harmful
- Some people find relief from non-medicine treatments such as electrical stimulating techniques (TENS machine), acupuncture, advice about activity and increasing physical fitness, and psychological treatments such as Cognitive Behaviour Therapy and meditation techniques such as mindfulness.
- Explain that *Staying active and continuing usual activities, even though there may be initial pain and discomfort, usually results in a faster recovery from symptoms, less chronic disability and less time off work*
- Re-iterate that prolonged bed rest is now known to be harmful
- Refer for social prescribing https://connectwellessex.org.uk/connect-well-mid-essex-partners/#modal
- Start a pain management plan with the patient, recording their current activity levels and baseline pain score and review patient in 1-2 weeks

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After 1-2 weeks of self-care and non-pharmacological strategies, if **pain has not reduced by at least 30% from baseline and** pt wishes to try stronger analgesics

Is there a suspicion of neuropathic pain?
If patients use words like burning, stinging, shooting, crawling insects, stabbing refer to neuropathic pain guidelines and assess using the LANSS score or PainDETECT tool.

Neuropathy likely (LANSS ≥ 12)

Continue self-care and non-pharmacological strategies AND

Follow neuropathic pain guidelines

Neuropathy unlikely (LANSS < 12)

Continue self-care and non-pharmacological strategies AND

Codeine phosphate 15-30mg FOUR times daily when required

May be increased by patient to 30-60mg in 2-3 days if insufficient response. Ensure OTC or prescribed stimulant laxative

Do NOT prescribe combination tablets while establishing dose. Record pre-opioid pain score & pt goals.

Review outcomes 1 – 4 weeks later [IF starting opioid, refer also to box on page 3]

Non-responder (<30% reduction in pain score) - STOP codeine

May be a poor metaboliser of codeine (4-10% of population). **Do not use** tramadol, hydrocodone, oxycodone in codeine non-responders as unlikely to be effective.

Morphine immediate release at **age appropriate dose** (pg 2) not more than 6 times daily)

If renal impairt, poor swallow or intolerant of morphine:

buprenorphine: **Butec® 5 mcg/hour patch.** Increase dose to not more than 15mcg/hr aiming to achieve 30-50% reduction in pain score. Do not increase more than every 2-4 weeks

Refer to "Prescribing opioids" box on pg3

Typical responder (30-50% reduction in pain score)

Explain to patient this is an excellent response. It is unlikely that further increasing dose or strength of opioid will produce further response.

Exit Strategy

Consider exercise programme (Essex Lifestyle Service or Mid Essex Exercise Referral Scheme) to strengthen and improve flexibility and tone; aiding long-term recovery. As soon as able, step down opioids over a period of several weeks. If used for 4 weeks or less, stop without wean

Hyper-response (>50% reduction in pain score)

May be a rapid metabliser of codeine and more susceptible to adverse effects. Try to manage at lower dose (15-30mg FOUR times daily when required).

Adverse effects limit efficacy – STOP codeine

May be a rapid metabliser of codeine and susceptible to adverse effects. It would be advisable to also **avoid** tramadol and oxycodone if suspected.

Morphine immediate release at **age appropriate dose** (pg 2) not more than 6 times daily)

If renal impairt, poor swallow or intolerant of morphine:

buprenorphine: **Butec® 5 mcg/hour patch.** Increase dose to not more than 15mcg/hr aiming to achieve 30-50% reduction in pain score. Do not increase more than every 2-4 weeks

Refer to "Prescribing opioids" box on pg3

Review patient every 2-4 weeks until either:

30-50% reduction in pain score

Explain to patient this is an excellent response. It is unlikely that further increasing dose or strength of opioid will produce further response.

Troublesome adverse effects or max dose of 2nd line opioid reached

STOP 2nd line opioid. Further opioid trial unlikely to be beneficial. Proceed to EXIT Strategy. Ensure patient accessing CBT – eg through iAPT

Review patient every 2-4 weeks until either: