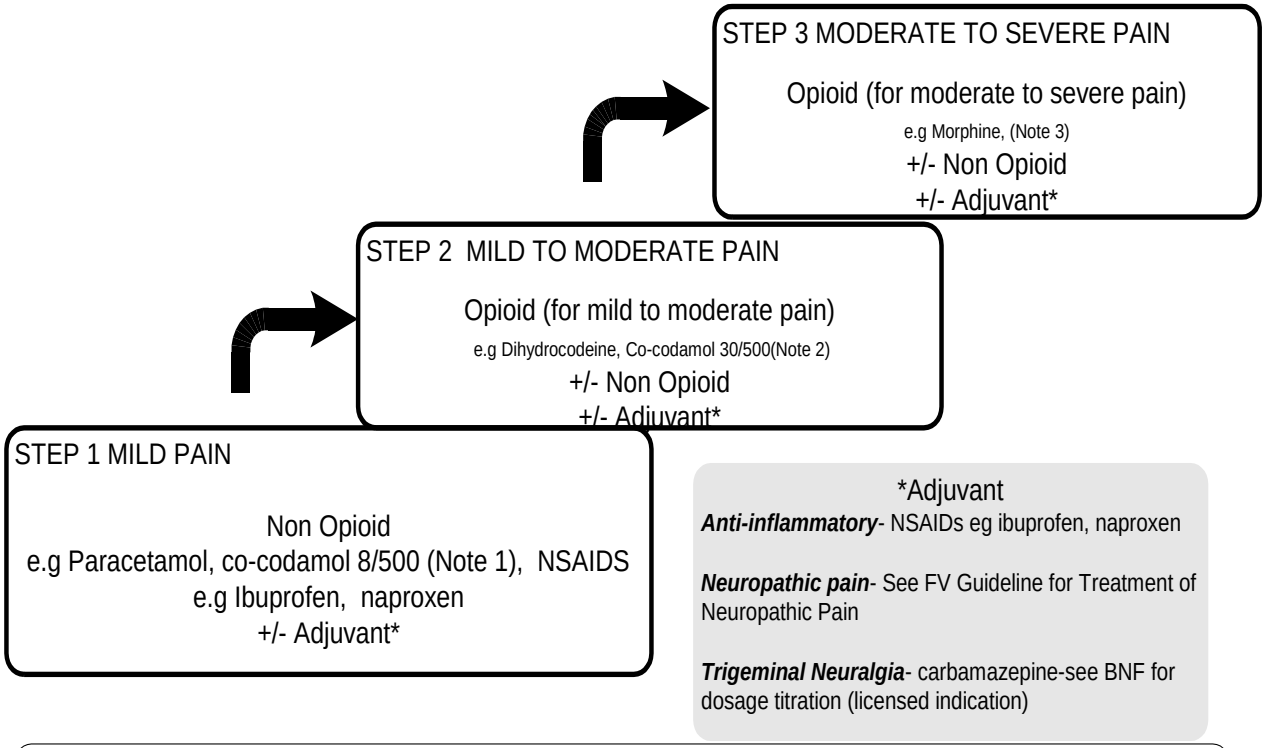
Appendix 4a

The Use of Oral Analgesics for Pain in Primary Care

The World Health Organisation's three-step analgesic ladder for cancer pain (see below) may also be used for non-malignant chronic or acute nociceptive pain. Analgesics should be started at the 'step' most appropriate to the patient's level of pain. Decision on analgesic choice depends on the type of pain, patient factors and supporting clinical evidence. For pain that is present constantly, analgesia should be prescribed regularly and not on an "as required" basis. For more detailed guidance on the management of chronic non malignant pain, please refer to **West of Scotland Chronic Non Malignant Pain Opioid Prescribing Guideline**.



*Adjuvant

Anti-inflammatory- NSAIDs eg ibuprofen, naproxen

Neuropathic pain- See FV Guideline for Treatment of Neuropathic Pain

Trigeminal Neuralgia- carbamazepine-see BNF for dosage titration (licensed indication)

NOTE 1:
Compound analgesics containing a low dose of opioid (e.g 8mg of codeine phosphate per tablet) are commonly used, but the advantages have not been substantiated. Effervescent preparations of compound analgesics may contain high levels of sodium. For patients requiring low sodium intake please refer to individual Summary of Product Characteristics.

NOTE 2:
Prescribe regular laxatives when opioids are being taken regularly

NOTE 3 : Advice regarding strong opioids
Distinguish between malignant and non malignant chronic pain and refer to guideline as appropriate. In non malignant chronic pain max recommended morphine equivalent dose is 60mg bd (or fentanyl 25mcg patch) before considering pain clinic referal. Avoid short acting opioids for breakthrough in non malignant chronic pain.
Malignant
Use oral route first, start with normal release oral morphine eg 5-10mg every 4 hours and as required for breakthrough pain.
A 2.5mg dose may be enough in the elderly or those with renal impairment. Consider alternative opioids ony if experiencing side effects to morphine or can no longer manage oral route
Every patient on regular opioid should have access to breakthrough analgesia (equivalent to 1/6th total dose oral morphine).
Start regular laxative and prophylactic ant-emetic as required for 7-10 days

NOTE 4: Consider self help booklets and pain assessment tools in non malignant pain.
e.g. PADT (http://www.healthinsight.org/Internal/assets/SMART/PADT.pdf) , NRS, VAS and opioid risk tools..

Appendix 4a

General Advice on Pain Management in Non Malignant Chronic Pain

Accurate assessment should be undertaken to determine the cause, type and severity of pain and effect on patient (anxiety/depression, neuropathic, mechanical, psychosocial).

Non-pharmacological interventions

Consideration should be given **at all stages** to utilising non-pharmacological interventions eg TENS, acupuncture, physiotherapy, weight loss, exercise, stress management counselling, pain management programmes, Pain Association Scotland and self management booklets available in practices.

Optimise non-opioid (ie paracetamol and/or NSAID) or opioid treatment

- Titrate doses to achieve optimal balance between analgesic benefit, side effects and functional improvement
- For continuous pain, ensure maximum **tolerated** dose is prescribed on a regular basis, by the clock, not 'prn'.

Add in adjuvant

- Consider adjuvant drugs (any drug that has a primary indication other than for pain management but is analgesic in some painful conditions) and choose the class of drug according to **your assessment** of type of pain (see shaded box on the WHO analgesic ladder)(1).
- Adjuvants can provide greater pain relief and less toxicity with lower doses of each drug given. **Start low and go slow (for TCA's and anticonvulsants)**
- Topical NSAIDs are recommended for short term usage (up to 6 weeks) for small joint pain – wrist, elbow, knees and ankles (2)

Give adequate length of trial

- neuropathic / inflammatory pain – 2-4 weeks to take effect and continue for 8 weeks, if tolerated, then assess
- non-opioid / opioid – 1 month at regular, maximal doses

Assess regularly using PADT or Numerical Rating Scale (ask the patient to rate their pain on a score of 1 to 10) or Visual Analogue Scale and consider stop if 30% improvement and / or significant improvement in functional ability is not achieved.

If pain treatment effective, **consider withdrawal of treatment after significant improvement every 6 months** with careful review (3)

If pain management still uncontrolled, refer to pain clinic or if non malignant pain if no/little pain relief on equivalent daily dose morphine 60mg bd

Tramadol in Non Malignant Pain

If co-codamol 30/500 + adjuvant drug therapies are ineffective or side-effects are not tolerated, tramadol could be considered. Tramadol should not be co-prescribed with co-codamol and should not be considered as first line therapy.

Tramadol is licensed for moderate to severe pain and is approximately twice as potent as codeine(3). It is promoted as between WHO step 2 analgesics for moderate pain (eg codeine) and WHO step 3 analgesics (morphine). Hallucinations, confusion and convulsions as well as drug dependence, abuse and withdrawal are reported at therapeutic doses. There is some evidence for Tramadol in the treatment of neuropathic pain.

Consultation is out whether to re classify as a schedule 3.

Ref

1.SIGN 106. Control of pain in adults with cancer November 2008

2.NICE Osteorthritis February 2008

3. MeReC Briefing. Issue 22, 2003.The use of strong opioids in palliative care

4. Cochrane Database Systematic Review 2006 July 19; (3):CD003726