Guidelines for pharmacological management of Chronic non-cancer pain

- Give advice and support for staying active and self-management
- Consider referral to: physiotherapy, manual therapy, acupuncture, TENS etc.
- Provide support to stay at work
- Exclude red flags
- Determine use of over the counter (OTC) treatments
- Determine pain type: i.e. nociceptive, neuropathic pain (NeP) or mixed (nonciceptive & NeP)
- Assess for depression, alcohol abuse and abuse potential prior to treatment and seek pain specialist input as appropriate

Red Flags

Complaints of new pain:	History of:
❖ In patients under 20 years or over 55 years old ❖ Following violent trauma ❖ Constant progressive, non mechanical pain (no relief with bed rest) ❖ Thoracic pain ❖ Widespread neurological symptoms (including cauda equina syndrome) ❖ Structural deformity	❖ Malignant tumour: lung, breast, prostate, and multiple myeloma ❖ Prolonged use of corticosteroids ❖ Drug abuse, immunosuppression, HIV ❖ Systematically unwell, fever ❖ Unexplained weight loss

Yellow Flags

Biomedical	Psychological	Social
❖ **Severe pain and disability at presentation** ❖ Previous significant pain episodes ❖ Multiple pain problems ❖ Non-organic signs	❖ **Belief that pain indicates harm, fear avoidance** ❖ Passive expectations ❖ **Catastrophic thinking** ❖ High level of distress ❖ Atypical beliefs, lack of problem solving ability	❖ Lack of confidence in performing work related activities ❖ **Poor work relationships** ❖ Social dysfunction ❖ **Ongoing Medico-legal issues**

Prior to prescribing strong opioids:

- Prescriber and patients should establish clear and assessable treatment goals when prescribing Step III opioids: 30% reduction in pain intensity with ability to achieve specific functional improvement/improvement in sleep
- Do not increase opioid to >120 mg/day of oral morphine or equivalent. Consider prophylactic laxatives and also may need anti-emetic when initiating strong opioids
- Discuss potential harm of opioid therapy and impairment of driving skills

If pain settles consider a step wise reduction of analgesia - check compliance at each stage

Nociceptive Pain

	Preferred	Second line
Step 1 : Non-opioid analgesics for mild pain pain score: <4/10	**Regular paracetamol** 1g four times daily check compliance +/- NSAIDs **naproxen or ibuprofen + PPI** if necessary NSAIDs not for long term use in patients over 45 years old	
Step 2: Weak opioids for moderate pain pain score: >4/10 <7/10	**Codeine (cocodamol) 30/500** (prescribe by cost effective brand) **or dihydrocodeine 30 mg** every 4-6 hours *Consider **modified release dihydrocodeine** 60 to 90 mg twice a day once daily requirement is calculated*	**Tramadol 50 mg** up to four times daily. Increase to a maximum of 100 mg four times daily [CD schedule 3] Consider **tramadol modified release** for early morning pain (prescribe by cost effective brand) **Buprenorphine patch** [CD schedule 3] **consider only if unable to swallow** Start at 5 micrograms/hour increased to a maxImum of 20 micrograms/hour Increase only if beneficial. Higher doses associated with QTc prolongation **Avoid use in young, may be beneficial in elderly**
	• **Consider referral to Chronic Pain Management prior to initiating on strong opioids** • **Exclude neuropathic pain and yellow flags**	
Step 3: Opioid analgesics for severe pain (STOP/convert weak opioid) pain score: > 7/10	**Morphine modified release** (prescribe by cost effective brand) 10 mg – 20 mg twice daily [CD schedule 2] Titrate by no more than 10 mg twice daily to a maximum of 120 mg daily Consider early **referral to chronic pain clinic** if there is rapid dose escalation with inadequate response or development of rapid tolerance.	**Zomorph® capsules may be opened and contents mixed with soft food and water if swallowing difficulties** **Fentanyl patch** (if unable to swallow) [CD schedule 2] **Buprenorphine patch** [CD schedule 3] Start at 10 micrograms/hour, maximum 35 micrograms/hour Increase only if beneficial. Doses over 20 micrograms/hour are associated with QTc prolongation. **Tapentadol SR** [CD schedule 2] (only with secondary care initiation and completed SIDC) 50 mg twice daily and titrate to 150 mg twice daily, increase only if beneficial to maximum 250 mg twice daily, usual dose 150 mg twice daily

Neuropathic Pain

	Preferred	Second line
Step 1 : Mild pain pain score: <4/10	**Amitriptyline:** 10 mg/day titrate up to maximum 50 mg /day or imipramine, (nortriptyline) **Carbamazepine:** For trigeminal neuralgia only 200 – 400 mg daily titrated up to 200 mg four times a day (maximum 1200 mg daily)	**Gabapentin:** Titrate from 100 mg three times a day to maximum 600 mg three times a day Can be used in combination with preferred choice or on its own
Step 2: Moderate pain pain score: >4/10 <7/10 Confirm NeP	**Duloxetine (SNRI):** **30 mg once a day –** 60 mg twice a day May be considered first line for diabetic peripheral neuropathy	**Pregabalin: 50 – 75 mg twice daily** and increase to maximum 300 mg twice daily (prescribe generically) **Stop gabapentin when starting pregabalin** It should only be considered when patients have not achieved adequate benefit with conventional preferred and second line drugs or their combination

- **Consider referral to Chronic Pain Management prior to initiating on strong opioids**
- **Consider topical treatments in peripheral neuropathic pain:**
  NSAIDS/ rubifacients (Ibuprofen gel)/ salicylate cream) for musculoskeletal pain topical lidocaine in post herpetic neuralgia capsaicin cream 0.025% and 0.075% useful in osteoarthritis knee pain

Step 3: Opioid analgesics for severe neuropathic pain pain score: > 7/10 Strong conventional opioids are usually not beneficial in neuropathic pain states	**Tramadol** 50 mg up to four times daily, increase to a maximum of 100 mg four times daily **Should only be considered for acute rescue therapy in neuropathic pain** **Opioids should only be used after careful consideration, ideally with secondary care input**	**Buprenorphine patch** [CD schedule 3] Start at 5 micrograms/hour maximum 20 micrograms/hour Increase only if beneficial, higher doses associated with QTc prolongation **Tapentadol MR** [CD schedule 2] (only with secondary care initiation and completed SIDC) 50 mg twice daily and titrate up to maximum 250 mg twice daily, usual dose 150 mg twice daily

Tramadol, tapentadol and transdermal buprenorphine are useful in mixed pain states (when nociceptive and NeP present)
Be aware of serotonergic syndrome when tramadol, SSRIs, tricyclic antidepresssants and/or SNRIs are combined
May require dose adjustment or stopping a medication

Avoid combinations of different opioids

Dose equivalence from Faculty of Pain (RcOA)

Transdermal buprenorphine						
Patch strength (micrograms/hour)	5	10	20	35	52	70
Codeine phosphate mg/day	120	240				
Tramadol mg/day	100	200	400			
Morphine oral mg/day	12	24	48	84	126	168

Transdermal fentanyl				
Patch strength (micrograms/hour)	12	25	50	75
Morphine oral mg/day	45	90	180	270

Opioid conversion table for common opioids		
	Potency ratio with oral morphine	Equivalent dose to 10 mg oral morphine
Codeine phosphate	0.1	100 mg
Dihydrocodeine	0.1	100 mg
Tramadol	0.15	0.67 mg
Morphine	1	10 mg
Tapentadol	0.4	25 mg
Oxycodone	2	5 mg

[1] *Faculty of Pain Medicine. Supported by Public Health England. Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain. Available at http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware*