THE PAIN PATHWAY

Treatment Algorithm for Non Palliative Pain in Adults – Primary Care
TREATMENT ALGORITHM FOR NON PALLIATIVE PAIN IN ADULTS – Primary Care
At whatever stage you are on and the patient is stable – review at 6 months

**NOCICEPTIVE PAIN**
Regular paracetamol, simple analgesia (+/- NSAIDs where appropriate) should be used as first line

If insufficient

**WEAK OPIOIDS**
Add in codeine or tramadol
Use **buprenorphine patches (5-10mcg/hour)** if unable to take oral tramadol and or codeine
*Tritrate up to maximum tolerable dose.*

If ineffective or experiencing unmanageable side effects

**MORPHINE (SLOW RELEASE) +/- MORPHINE (IMMEDIATE RELEASE) (start 10mg bd)**
*Tritrate up to maximum tolerable dose*

If ineffective or experiencing unmanageable side effects

**ADDICTION**
If history of substance misuse, pain team to contact specialist substance misuse team at ELFT

**ADDITION 1ST LINE FOR DIABETIC**

**FOCAL NEUROPATHIC PAIN**

**AMITRIPTYLINE***
Tritrate up to max of 75mg/day

If ineffective, add

**GABAPENTIN 2nd line**
Tritrate up to a max of 3600mg/day

**PREGABALIN 3rd line**
Tritrate up to a max of 600mg/day

**TRAMADOL**
If ineffective seek specialist advice

**1ST LINE FOR DIABETIC**

**DULOXETINE**
Tritrate up to 60mg/day – above 60mg/day refer to a specialist unless used for depression

**Specialist Advice**

**FOR HERPETIC NEURALGIA OR FOCAL NEUROPATHIC PAIN**

**LIDOCAINE PATCH** *(1st line)*
Discontinue if no response after 4 weeks

**CAPSAICIN PATCH** *
Discontinue if no response after 1 patch

**Exclusion criteria**
- History of intolerance to patches
- Misuse potential
- Myasthenia gravis & delirium tremens
- Conditions in which the respiratory centre & function are severely impaired or may become so
- Patients who are receiving MAO inhibitors or have in the last 2 weeks

**Inclusion criteria**
- Difficulty tolerating/swallowing tablets
- On tramadol patient intolerant of or experiences sedation / unsteadiness

****Restricted to use in Homerton only – GP/Phv / specialist
- Specify which tablet formulation : slow/modified release (SR/MR) or immediate release
- Refer to summary of product characteristics or the BNF for dosage adjustments in renal or hepatic impairment
- Review analgesic requirements regularly, adjust doses as appropriate
- Ensure adequate laxatives are co-prescribed with opioids to minimise side effects

**(exclusion criteria)

(CVD, contraindicated in AF

Refer for specialist advice

***caution in anyone with history of opioid drug abuse, CVD, contraindicated in AF

*Reserved to use in Homerton only – GP/Phv / specialist
- Specify which tablet formulation: slow/modified release (SR/MR) or immediate release
- Refer to summary of product characteristics or the BNF for dosage adjustments in renal or hepatic impairment
- Review analgesic requirements regularly, adjust doses as appropriate
- Ensure adequate laxatives are co-prescribed with opioids to minimise side effects

If non-compliant or unable to take oral formulation

Severe constipation despite regular laxatives
Opioid prescription agreement form

Date

PATIENT NAME

PRESCRIBER NAME

I understand that -----insert prescriber name----- intends to give me a potent pain medication (Opioid) as part of the management plan for my pain symptoms. It is only one item amongst a range of options for my care.

This medicine is intended to:

1) Improve my level of routine function/ mobility.
2) Improve my quality of life.
3) Reduce (not eliminate) my intensity of pain.

I have read and understand the potential side effects (overleaf).

I understand that this medication if misused can cause grave harm to myself or any other individual who may have access to it.

I will therefore;

1) Keep the medicine in a safe place and not share with others.
2) Take the medicine as prescribed.
3) If I require potent medication from another source I will inform my GP.
4) Agree to not take/use illegal drugs during this treatment.
5) I understand that this medicine may be withdrawn if the intended benefits are not realised.

Patient Name

Patient Signature and Date

Prescriber Name

Prescriber Signature and Date
# Adverse effects of opioid use – Patient information

<table>
<thead>
<tr>
<th>Adverse effects</th>
<th>How common?</th>
<th>Description of effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory depression (caused by overdose).</td>
<td>1% per year</td>
<td>Slowing of your breathing especially while asleep. Can worsen obstructive sleep apnea. Can cause death.</td>
</tr>
<tr>
<td>Constipation and nausea</td>
<td>40-50%</td>
<td>Severe cases can cause blockage of the intestine. This may need hospital treatment</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>15-40%</td>
<td>Sedation, dizziness (can cause falls and injuries) depression, anxiety and apathy. Impaired concentration (driving). Certain people are prone to misuse of opioids specifically if they have a history of depression or mental health issues.</td>
</tr>
<tr>
<td>Addiction, misuse.</td>
<td>5-30%</td>
<td>Misuse can occur if other people have access to your medication. It can result in overdoses.</td>
</tr>
<tr>
<td>Hormonal effects</td>
<td>&gt;25%</td>
<td>Reduced production of hormones controlling fertility and sexual function, osteoporosis, infertility &amp; impotence.</td>
</tr>
<tr>
<td>Immunosuppression</td>
<td></td>
<td>You may become prone to catching infections. Pneumonia in the elderly.</td>
</tr>
<tr>
<td>Cardiac effects</td>
<td></td>
<td>Non specific cardiac symptoms, myocardial infarctions, heart failure, death.</td>
</tr>
<tr>
<td>Tolerance and withdrawal</td>
<td></td>
<td>Medication will need to be reduced slowly to prevent withdrawal symptoms such as insomnia.</td>
</tr>
</tbody>
</table>
Protocol for opioid prescribing

This protocol is intended for GPs and other specialists working in City & Hackney. It provides guidance on how to manage patients who have inadequately controlled pain where there may be the need for initiation, maintenance or cessation of opioids. Management includes consideration of pain, function and psychological distress.

PATIENT WITH INADEQUATELY CONTROLLED PAIN

ASSESSMENT
- Medical History – include cause, description and impact of pain; history of depression or suicide
- Drug history – medications, alcohol, other drugs, include questions of dependence (see box over)
- Examination – area of pain & associated system, check injection sites
- Supporting evidence – imaging, reports
- Pain – type/cause. Identify pathology
- Co-morbidities e.g. mental health, medical
- Drug dependency
- Be aware of safeguarding issues

Management
- Physical education
- Physical therapies
- Non drug approaches

MONITORING
1. Assess function and pain status routinely. This could include an assessment of maintained effect at annual review e.g. consider a 10% dose reduction or nearest equivalent lower dose.
2. Monitor for medication misuse and drug seeking behaviours (see warning flags overleaf)
3. Consider checking compliance with random urine checks for opioid & other drugs – make patient aware of this possibility

Early referral or advice
- Pain service
- Referral made by pain service
  - Alcohol and drug service
  - Mental health services (including community psychologists, psychiatrist
  - Psychiatrist, pain medicine
- Rheumatologist

Care when crossing the line

Opioid prescribing (check the 7 Cs)
1. Clinical Indication – right pathology vs. right drug
2. Clinical risks – drug & disease interactions, adverse effects
3. Consider warning flags (see box over)
4. Control dose – Use lowest effective dose & don’t exceed max
5. Contract to be signed by patient and prescriber as and when appropriate
6. Contain prescription – by single prescriber & single pharmacy where possible
7. Consensus between parties about outcomes (function, goals)
Points to be discussed with the patient before a trial of oral opioids

- Stress that oral opioids are only part of the treatment plan
- Warn of the potential for cognitive impairment e.g. driving, falls
- Explain the indications for ceasing treatment with opioids:
  - Lack of improvement in function, or evidence of deterioration in function
  - Unsanctioned dose escalation and requests for early repeat prescriptions
  - Losing prescriptions
  - Unapproved use of the drug to treat other symptoms
- Set realistic functional goals (e.g. to commence or maintain an exercise program, improving self-care ability, get out to the shops etc.)
- Explain that the aim is for controlling pain rather than no pain
- Explain that dependence is a physiological effect of opioids and that withdrawal symptoms occur if the drug is stopped. (This should not be a problem with medically prescribed opioids)
- Stress that patients must accept the responsibility for:
  - Ensuring their supply of medication does not run out after hours
  - Security of their medication
  - Keeping review appointments
  - Using only one doctor to supply this medication
- Discuss side effects and their management (e.g. constipation, nausea, sedation, dry mouth, urinary hesitancy, and depression of sex hormones, with associated risk of osteoporosis with long term use)
- After 6-8 weeks opioids often cease to be effective and can lead to Hyperalgesia

Warning flags for opioid prescribing

- Deterioration in functioning at work, in the family or socially
- Illegal activities e.g. selling medicine, forging prescriptions, stealing drugs from other patients, buying prescription drugs from non-medical sources
- Previous treatment on an opioid pharmacotherapy program
- Mental health problems
- Indeterminate cause of pain
- Previous or current opioid or other substance abuse disorder
- Resistance to changes in treatment & requesting increases in treatment doses
- Refusal to comply with random drug screens
- Multiple episodes of lost or stolen prescriptions

Exit strategies
Consider weaning off opioids if
1. Completion of time limited maintenance phase
2. Inadequate analgesia or excessive adverse effects
3. Evidence of aberrant drug related behaviour
4. Development of predominance or psychological issues

Get advice from substance misuse or pain specialist

Sources of advice (as of January 2013):
ELFT substance misuse services:
Specialist Addiction Services
City & Hackney Centre for Mental Health, Homerton Row, Hackney, London, E9 6SR
020 8510 8629
020 8510 8270

Reference:
1. Goucke, R. MJA Vol 178 5 May 2003
   http://www.britishpainsociety.org/book_opiod_main.pdf (accessed 01/05/13)
Prescription drugs and addiction: the interface

Introduction
This material has been produced to cover the potential harms associated with prescription drugs (especially opioids), including potential drug interactions, the risk of “addiction” to prescription drugs, and sources of support for patients who may be becoming dependent on prescription drugs. Many of the concerns that apply to uses of prescription drugs also apply to commonly available over the counter medications (especially those containing codeine).

At risk groups
The risk of developing Prescription only Medicines (POM) and over the counter (OTC) dependency appears to be low in the population as a whole, but higher in service users with risk factors such as:

- depression and other psychiatric illnesses previous substance misuse or dependency and especially where both problems co-exist

Clinically, polypharmacy may be a marker for the development of POM/OTC problems and patients taking multiple medication are at higher risk of overdose and drug related death (see appendix below).

Reference:


Ghodse H, Corkery J et al. Drug–related deaths in the UK 11th Annual report. National programme on Substance Abuse deaths (np_SAD). International Centre for Drug Policy, St. Georges Hospital Medical School, University of London; 2010


National Treatment Agency. Addiction to medicine An investigation into the configuration and commissioning of treatment services to support those who develop problems with prescription only or over-the-counter medicine. NTA, DoH, London; 2011


<table>
<thead>
<tr>
<th>System</th>
<th>Licit / OTC drug</th>
<th>Prescription only Medicine (POM)</th>
<th>Illicit drug (or POM used illicitly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serotonin / noradrenalin</td>
<td>St Johns Wort, Khat, Pseudoephedrine</td>
<td>Fluoxetine, Methylphenidate</td>
<td>Amphetamine, Ecstasy, Many “legal highs”* e.g. Methcathinone</td>
</tr>
<tr>
<td>Dopamine</td>
<td>Salvia Divinorum</td>
<td>Chlorpromazine, ropinirole</td>
<td>Cocaine, Methamphetamine</td>
</tr>
<tr>
<td>GABA</td>
<td>Alcohol</td>
<td>Zopiclone, Baclofen</td>
<td>Diazepam, GHB / GBL</td>
</tr>
<tr>
<td>Opioid</td>
<td>Nurofen Plus, Kratom</td>
<td>Dihydrocodeine, Tramadol</td>
<td>Heroin, Methadone, Buprenorphine, Tramadol, Oxycontin</td>
</tr>
<tr>
<td>Glutamate/NMDA</td>
<td>Alcohol, Dextromethorphan, Nitrous oxide, Ibogaine</td>
<td>Methadone, tramadol, acamprosate, memantine</td>
<td>Ketamine, Pencyclidine, Methoxetamine</td>
</tr>
<tr>
<td>Acetylcholine</td>
<td>Nicotine</td>
<td>Clomipramine, donepezil</td>
<td>Pro cyclidine</td>
</tr>
<tr>
<td>Histamine</td>
<td>OTC sedatives</td>
<td>Clozapine, Imipramine</td>
<td>Amitriptyline</td>
</tr>
<tr>
<td>Voltage gated ion channels</td>
<td>Sodium Valproate, Carbamazepine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>Caffeine</td>
<td></td>
<td>Cannabis / synthetic cannabinoids(e.g. Mary Joy)</td>
</tr>
</tbody>
</table>

**Acknowledgement**
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