Lincolnshire Primary Care— Managing Non-malignant Chronic/Persistent Pain One-Page Guide

FIRST LINE TREATMENT OPTIONS

1.Address common psychological comorbidities (anxiety/depression)
2.Cognitive behavioural strategies
3.Sleep restoration strategies
4. Physiotherapy
5. Paracetamol 1g QDS or appropriate lower doses
6. +/ - NSAID Ibuprofen 400 mg TDS or Naproxen 500 mg BD unless contraindicated (Consider PPI if clinically indicated—see https://cks.nice.org.uk/nsaids-prescribing-issues)

Key

= 1st line medication(s) (green)

= 2nd line medication(s) (orange)

Determine whether nociceptive or neuropathic pain (patients may experience both and should be treated accordingly)

NOCICEPTIVE PAIN

If no improvement with simple analgesia consider adding
Codeine phosphate 30- 60mg QDS PRN as a preferred first option or
Tramadol 50-l00mg QDS PRN (*Caution in elderly, epileptics, and those on antidepressants)*

Are there symptoms of Neuropathic Pain?
Burning pain, stabbing pain, shooting pain, pins and needles and numbness? ***If YES treat for Neuropathic pain***

If NO, review diagnosis*. If insufficient pain relief with weak opioids (see opioid prescribing in appendix) obtained consider using a stronger opioid in place of codeine or tramadol.*

NEUROPATHIC SYMPTOMS

Strong opioids are **ONLY** recommended in the following scenarios
1.Acute pain (less than 3 months) of known aetiology
2.Chronic cancer related pain
3.Palliative care

1st line if strong opioids indicated

Morphine Sulfate M/R 10mg BD as starting dose
Swallowing difficulties: Zomorph® capsules can be opened.

Where compliance is an issue consider
Buprenorphine weekly patch *(e.g. Butec®)*
Starting from 5 mcg/hr patch every 7 days, titrating up after 2 weeks if need be.

At all steps counsel patients appropriately on the side effects of their medications including drowsiness and ability to perform skilled tasks and/or driving. Caution should be exercised regarding multiple medications with sedative effects.

NEUROPATHIC PAIN*

AMITRIPTYLINE trial
Start with low dose (10mg - 25mg) at night and titrate to 75mg at night if tolerated (consider anticholinergic load and side effects). Review after 6-8 weeks

If NO *decrease in pain or substantial increase in physical function,* ***stop amitriptyline*** *and consider gabapentin*

GABAPENTIN trial
Follow BNF titration or slower. (Aim for 600mg TDS, if creatinine clearance <50ml/min see BNF for dosing information). Review after 6-8 week trial. Max 1.2g TDS.

If NO *decrease in pain or substantial increase in physical function,* ***stop gabapentin*** *and consider other pharmacological treatment options*

Duloxetine (Cymbalta®) - 30mg each morning increased to 60mg daily after 2 weeks. Review after 8 week trial. Avoid if CrCl<30ml/min. Caution hypertension/ CVD, avoid abrupt withdrawal.
Pregabalin capsules- consider only if gabapentin provided some analgesic benefit but intolerable side effects. 75mg BD increased to max. 300mg BD as per BNF titration or slower.
Tramadol capsules - reserved for short periods only (less than 3 months), dose 50-100mg QDS.
Capsaicin 0.075% cream - for post herpetic neuralgia or those patients wishing to avoid or intolerant of oral therapy.

***For trigeminal neuralgia—**consider carbamazepine first line. Dose = 100mg BD increasing to 200mg QDS. Refer to specialist if carbamazepine ineffective