Pharmacological treatment of adult chronic pain and related pain conditions

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Written by BNSSG Medicines Optimisation Team in collaboration with Secondary Care Pain Specialists Oct 18, Jan 22, April 2025, V2.5d review April 2028. Approved at APMOC April 2025

Pharmacological treatment of adult chronic pain and related pain conditions

See BNSSG formulary for details https://remedy.bnssg.icb.nhs.uk/formulary-adult/local-guidelines/4-central-nervous-system-guidelines/

This guidance is designed to help primary care clinicians manage adult patients with chronic pain. Chronic pain (sometimes known as long-term pain or persistent pain) is defined as pain which persists beyond the normal healing time, which is assumed to be approximately three months (British Pain Society definition).

Pain can be secondary to (caused by) an underlying condition (for example, osteoarthritis, rheumatoid arthritis, ulcerative colitis, endometriosis). Chronic pain can also be primary. Chronic primary pain has no clear underlying condition, or the pain (or its impact) appears to be out of proportion to any observable injury or disease.

As chronic pain can be of mixed origin, patients should be assessed on an individual basis to identify the causes of the pain and its key features in order to support the patient in the most appropriate way. Clinicians are encouraged to use a holistic view of pain, taking into account patient circumstances, goals and values to ensure person centered approach in the management of their chronic pain.

Patients' expectations should be managed in terms of the degree to which likely pain relief will be obtained. The aim of treatment of pain is to reduce and/or manage pain sufficiently to enable engagement with rehabilitation, restore function and improve sleep, mood and wellbeing.

Particular attention should be paid to psychosocial factors such as work, attitude to recovery or avoidance of movement which can influence an individual's response to pain. Mental health issues can also be both risk factors and consequences of pain.

This guideline is aimed at those patients with chronic pain whose key feature of pain is **not chronic primary or cancer pain** – in these situations refer to the following guidelines: -

- **Chronic Primary Pain - NICE NG193** (https://www.nice.org.uk/guidance/ng193/resources/chronic-pain-primary-and-secondary-in-over-16s-assessment-of-all-chronic-pain-and-management-of-chronic-primary-pain-pdf-66142080468421)
- **Cancer Pain** – https://www.stpetershospice.org/for-professionals/resources-for-professionals/clinical-guidelines/

Medicines play only a minor role in the management of persistent pain. Maintaining fitness, pacing activities and a healthy lifestyle using non-pharmacological methods of pain relief that include physical and psychological techniques, are far more important. Medicines should be prescribed on a trial basis only and should only be continued if there is significant improvement in pain, or an agreed objective is achieved (e.g. reduction in pain of a certain amount, or patient can now manage a particular activity).

Consideration should be given to specific groups of patients, e.g. renal or hepatic dysfunction, frail elderly, as drug side effects may be more pronounced, such as anticholinergic effect of tricyclic antidepressants can result in confusion and falls. Cross sector working with local substance misuse services should be considered when prescribing for patients currently taking medicines for dependency.

In situations where a patient is in the process of being diagnosed, **paracetamol** should always be considered as an initial treatment option (if appropriate) in a time limited trial until the diagnosis has been confirmed. Please also consider the BNSSG Paracetamol Dosing in Adult Patients clinical guidance when prescribing paracetamol.

General Prescribing Principals

- Use minimum effective dose.
- If pain settles, consider stepwise reduction to evaluate continued effectiveness.
- If no significant benefit, stop medication.
- All patients on pain medication **must be reviewed every 3-6 months**.
- Patient record to include why medication continued ("Chronic pain" is not sufficient information)
- Always consider whether there have been changes in renal or hepatic function which may affect drug choice or dosing.
- Prescribers may be asked to prescribe cost effectively and in line with local formulary.

BNSSG Prescribing Guidelines for Adult Chronic Pain and related pain conditions

Table intended to be followed in stepwise manner.
Please refer to the BNF/NICE CKS for dosages, cautions and contraindications and the renal drug handbook for renal impairment dosing.

<table>
<tr><td>Step 1</td><td colspan="2">Non-opioid analgesia
If appropriate, consider stepping down to self-care whereby patients can purchase painkillers over-the-counter (OTC) as per BNSSG self-care guidance</td></tr>
<tr><td></td><td>Paracetamol</td><td>• Paracetamol should always be considered as an initial treatment option (if appropriate) in a time limited trial until the diagnosis has been confirmed.
• Caution if body weight <50kg or risk factors for hepatotoxicity, see information on BNSSG Formulary: BNSSG Oral Paracetamol Dosing in Adults</td></tr>
<tr><td></td><td>+/- NSAID
Ibuprofen
or
Naproxen</td><td>• Consider adding NSAID, the choice of NSAID should consider patient co-morbidities.
• Consider need for gastroprotection (e.g. omeprazole) if prescribing an NSAID. See NICE CKS for information on risk factors for NSAID induced gastrointestinal adverse effects. Consider stopping gastroprotection if NSAID is stopped. Proton Pump Inhibitors (PPIs) are associated with long term risks e.g. risk of fractures. See: local deprescribing guidance.
• Discuss cardiovascular risk factors if ≥1.2g/day ibuprofen or ≥1g naproxen; renal issues or hepatic disease. See NICE Clinical Knowledge Summaries for further information on cautions or contraindications.
• Please note ibuprofen is available to purchase from pharmacies over the counter (where appropriate).
• For patients at high risk of GI adverse events, a COX-2 inhibitor e.g. celecoxib and etoricoxib could be considered with a PPI. However, note COX-2 inhibitors are contraindicated in people with ischaemic heart disease, cerebrovascular disease, or peripheral arterial disease.
• Please see separate information section regarding use of analgesia in diverticular disease.</td></tr>
<tr><td></td><td>Topical NSAID or capsaicin cream</td><td>• If oral NSAID is inappropriate or not tolerated, then consider a topical preparation as per BNSSG Formulary.
• Note topical preparations should be used in localised pain.
• For capsaicin (TLS green): Maximum use 8 weeks (no clinical trial evidence of efficacy for treatment of more than 8 weeks duration). After this time, it is recommended that the patient's condition should be fully clinically assessed prior to continuation of treatment, and regularly re-evaluated thereafter, by the supervising consultant. Please note, there are supply issues with Capsaicin cream which are likely to not resolve until 2026.</td></tr>
<tr><td>Step 2</td><td colspan="2">Opioid analgesia (for moderate to severe pain)
• NICE NG193 highlights that there is a lack of evidence for the use of opioids in chronic primary pain. Please carefully consider the risks vs benefits before contemplating opioids and include rationale for and against prescribing in shared decision-making discussions with patients.
• In general, concomitant opioids should be avoided.
• Consider regular laxatives, if required (see ‘Considerations when prescribing opioids’ section of this guidance).
• Continue regular paracetamol (increased efficacy compared to opioid alone) Also can continue NSAIDs if effective.
• Patients should always receive the lowest dose that provides effective pain control.
• Prescribers to supply “Opioids aware” information to patients where opioids are prescribed.
• Prescribers to record in patient record that dependence risks discussed.
• See BNSSG guidance on opioid conversion to support conversions
• Please see separate information section regarding use of opioids in diverticular disease</td></tr>
</table>

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<table>
<tr><td></td><td colspan="2">Weak opioids</td></tr>
<tr><td></td><td>Codeine</td><td>• Codeine metabolism varies widely among patients, so conversion to morphine may occur to a greater or lesser extent, with a varying degree of pain relief and side effects.
• Codeine is converted to morphine in the body to achieve an analgesic effect (100 mg of codeine is approximately equivalent to 10 mg of oral morphine).
• Codeine should be used at the lowest effective dose for the shortest period of time.
• Mild to moderate pain: 15mg to 60 mg up to 4 times a day at intervals of not less than 6 hours.
• Lower doses of weak opioids (for example codeine 15 mg or the codeine 8mg combination with 500mg paracetamol) are recommended for: elderly and/or debilitated people, people with hypothyroidism and adrenocorticoid insufficiency, people with moderate-to-severe chronic kidney disease (CKD).
• Maximum daily dose of codeine should not exceed 240mg.
• Codeine should not be co-prescribed with other opioids/ opioid combination products.
• Consider co-prescribing laxatives to avoid constipation from codeine.
• Small quantities of low dose co-codamol can be purchased from community pharmacies as part of self-care.</td></tr>
<tr><td></td><td>Dihydrocodeine</td><td>• Dihydrocodeine should only be used as a second line option when codeine is not appropriate (e.g. it is often preferred opioid in breastfeeding mothers)
• Dihydrocodeine is derived from codeine and has similar mu-opioid agonist activity. The Faculty of Pain Medicine guidance highlights that 100mg dihydrocodeine is equivalent to 10mg oral morphine.
• For moderate to severe pain: the usual dose 30mg every 4 to 6 hours as required by mouth using immediate release preparation.
• Lower doses should be considered for frail, elderly patients.
• 6-10% of Caucasians lack CYP2D6 to metabolise codeine to morphine. Therefore, they obtain limited pain relief while experiencing all the adverse effects. Dihydrocodeine does not rely on this process and so can be considered in this situation.
• Dihydrocodeine should not be co-prescribed with other opioids/ opioid combination products.
• Please note the misuse potential of this medication.</td></tr>
<tr><td>Step 3</td><td colspan="2">Strong opioids
• NICE NG193 highlights that there is a lack of evidence for the use of opioids in chronic primary pain.

• Where a prescriber wishes to consider opioids in the management of a patient's pain, the usefulness of opioids should be explored by prescribing a short trial of 1-3 weeks to assess effectiveness and impact on agreed patient outcomes. Consider patient medical history (e.g. if there is a history of dependence or if the patient is co-prescribed methadone or buprenorphine) and interaction potential with other prescribed medicines when initiating opioids.
• If opioids from step 2 are not having any analgesic effect, do not progress to step 3 as this indicates pain unresponsive to opioids.
• If there is benefit from weak opioids at step 2, stop the weak opioids before progressing to step 3.

• Use the dose equivalents and changing opioids table on the Faculty of Pain Medicine Website for the equivalent dose to oral morphine.
• Daily doses ≥120mg/day morphine or equivalent <u>should not</u> be used in primary care unless patient under specialist review e.g. oxycodone 60mg/day is equivalent to 90 mg oral morphine or fentanyl 50mcg/hour patches is equivalent to 120mg oral morphine).
• Agree goals of therapy with patient i.e. complete pain relief unlikely; success measured by patient being able to complete tasks pain currently prevents.
• Aim to taper dose intermittently to confirm continued benefit.</td></tr>
</table>

	• Patients with non-cancer pain do not normally experience breakthrough pain. Do not prescribe immediate relief "breakthrough" medication unless there is considerable variation in pain intensity, or those variations are predictable, then a short-term trial of an immediate release product may be considered for a maximum of 7 days. Review after 1 week and discontinue if no benefit reported or consider alternative slow-release dosing schedule. • In the cases of shared care prescribing between specialist pain service and GP practice, be clear on who is responsible for prescribing and any related monitoring requirements (e.g. side effects, effectiveness of treatment). • The March 2025 drug safety update advised 'The indication for the treatment of post-operative pain has been removed from the licences of all prolonged release opioids due to the increased risk of persistent post-operative opioid use (PPOU) and opioid-induced ventilatory impairment (OIVI).'	
	Tramadol	• Tramadol has mixed opioid/SNRI activity, which may be useful in mixed or neuropathic pain. • Tramadol has been associated with withdrawal symptoms even after short-term use. • Start at 50mg daily and titrate according to effect; may be followed by 50-100mg every 4-6 hours. • **Maximum dose 400mg daily** (equivalent to approximately 40-80mg morphine, but conversion rates vary) – the dose equivalents and changing opioids table on the Faculty of Pain Medicine Website can be used to calculate the equivalent dose to oral morphine. • Due to tramadol's' complex pharmacology caution is required. If converting from maximum dose of tramadol to morphine, start with 10mg morphine MR twice daily and titrate according to response. • Please note tramadol is contraindicated in people with uncontrolled epilepsy. • Use with caution in patients taking other interacting drugs e.g. warfarin, SSRIs, TCAs, MAOIs (including linezolid), mirtazapine, venlafaxine, antipsychotics, epilepsy medications and other medications that can lower the seizure threshold. In June 2024, the MHRA issued an alert advising on the risk of tramadol interactions with warfarin. • Tramadol **should not be** co-prescribed with other opioids/ opioid combination products which includes codeine and dihydrocodeine. • Vigilance needed: patients requesting extra or interim prescriptions of tramadol, as this may indicate that the patient's pain is not being managed appropriately, or that the patient is stockpiling or diverting supplies. • Avoid abrupt withdrawal after long-term treatment. The dose must be reduced slowly to ensure patient safety and to minimise the risk of withdrawal symptoms and/or adverse reactions. • Tramadol is a **Schedule 3 controlled drug** and as such is subject to the legal prescription requirements associated with controlled drugs.
	Morphine MR Review dose at least monthly, do not increase without seeing patient	• Usual starting dose is 10mg MR twice-daily with 12-hourly preparation. • Increase by no more than 10mg twice daily at a time, titrating according to analgesic effect and side-effects. • Lower doses may be required in those with limited renal function e.g. consider a reduced dose in those with an eGFR below 50ml/min and avoid in those with an eGFR below 30ml/min. (The Renal Drug Database) • Review at 30mg twice daily (or equivalent). • If pain is not settled consider tapering dose, then stop (unlikely alternative opioids effective if morphine ineffective). • **Do not exceed maximum dose of 60mg twice daily** before referral to specialist pain management team. Consider an earlier referral if patient's pain is uncontrolled and pain requirements are escalating. • **Only change opioid if adequate analgesia achieved but intolerable side effects with morphine.** • **Do not escalate total doses of morphine above 120mg daily; the risk of harm increases substantially with no increases in benefits.**
	Oxycodone MR	• Oxycodone should only be prescribed where morphine is not tolerated or

	tablets Review dose at least monthly, do not increase without seeing patient	contraindicated, e.g. patients that are allergic to sulphates and need a strong oral opioid. It can sometimes be tolerated when morphine is causing excess sedation, nausea, and / or hallucinations. • Initially 5-10 mg Oxycodone MR every 12 hours (**max. 30mg twice daily of oxycodone in primary care prior to secondary care advice**). Note. 60mg of oxycodone is equivalent to 90mg oral morphine. • Lower doses may be required in those with limited renal function There is no robust evidence that oxycodone has fewer side effects compared to morphine. • Despite many claims and a perception of oxycodone's superiority to morphine, available data does not provide any evidence to support this (NICE CG140). • Ensure that adverse effects such as constipation and nausea have been managed with adjunctive treatments before switching to oxycodone. • Oxycodone (oral) is approximately1.5 times as potent as morphine. • Targinact (oxycodone/naloxone) is **not recommended** for use and is not included on the BNSSG formulary.
Other oral formulary options		
	Tapentadol	• On recommendation of pain team only with a shared-care protocol in place. • Modified release is amber on joint formulary and should be reserved for severe chronic pain in adults who cannot tolerate other strong opioids. • In patients not currently taking opioids: initially 50 mg MR tablets every 12 hours, adjusted according to response, titrated slowly, **maximum 500mg per day.** At cessation of treatment dose must be tapered gradually. • Immediate release is red and **should not** be prescribed in primary care.
Transdermal formulary options		
Transdermal drugs: See BNSSG Joint Formulary for details, including cost- effective branded generics		• **Not for use in opioid naïve patients.** • Patches should be reserved for patients with stable pain who cannot tolerate oral medication, where there are compliance issues or if recommended by a specialist pain clinic. • Transdermal patches lack the flexibility required when treating patients with fluctuating or uncontrolled pain but may give better 24-hour coverage than morphine modified-release. • Patches can take a long time (up to 72 hours with buprenorphine) following a dose change to reach a stable blood level. If treatment is discontinued, patients and clinicians should be aware of this long duration of action. • Patients should avoid hot baths, heat pads and hot water bottles as heat accelerates drug release. • New patches must not be applied to the same site for several days. • When prescribing always considering equivalent dose to oral morphine – see the Faculty of Pain Medicine website guidance: https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/dose-equivalents-and-changing-opioids • Prescribe opioid patches by brand name for continuity of supply and to avoid confusion for patients and carers.
		• Fentanyl is a strong pain killer. Fentanyl patches are highly addictive and have limited value in non-malignant chronic pain therefore should **only be used on the recommendation of a pain specialist or palliative care** and not increased without specialist advice and regular review by a pain specialist. To put into context Fentanyl 50 microgram/hour patches are equivalent to 120mg oral morphine/day. For those patients already prescribed fentanyl patches as part of their pain management they may be supplied with the MHRA's Fentanyl patches safety leaflet for information.
Buprenorphine		• Buprenorphine patches should be prescribed by brand as they are available as 3 day, 4 day & 7 day release versions so prescribers and dispensers must ensure that the correct preparation is prescribed. • They are broadly as effective as codeine or (twice daily) tramadol but more expensive and

continued

should only be used on the recommendation of a pain specialist or palliative care.

- Lower strength patches (5, 10, 15, 20 micrograms/hour patches) usually have a patch application frequency of 7 days.
  - The dose of ***7-day patches*** may be titrated upwards as indicated after 3 days, when the maximum effect of a given dose is established.

- Please note the BNF/Faculty of Pain Medicine highlights transdermal buprenorphine 7-day patch dose equivalence to oral morphine as follows:

Buprenorphine 7-day patch (micrograms/hour)	5 micrograms/hour	10micrograms/hour	20 micrograms/hour
24-hour oral Morphine sulphate dose (mg/day)	12mg	24mg	48mg

- Higher strength patches (35, 52.5, 70 micrograms/hour patches) will either have a patch application frequency of 3 days (72 hours) or 4 days (96 hours) **depending on brand**.
  - For ***4 day patches*** (96 hours), doses should be titrated after 4 days, at the point when the patch would usually be changed.
  - For ***3 day patches*** (72 hour patch), doses should be titrated after 3 days, at the point when the patch would usually be changed.
- Patients should be counselled on frequency of patch removal and renewal.

- Please note the BNF/ Faculty of Pain Medicine highlights transdermal buprenorphine three or four days (twice weekly) patch dose equivalence to oral morphine as follows:

Buprenorphine three or four days (twice weekly) patch (micrograms/hr)	35 micrograms/hour	52.5 micrograms/hour	70 micrograms/hour
24-hour oral Morphine sulphate dose (mg/day)	84mg	126mg	168mg

Low Back Pain and Sciatica	
• NICE NG59 Lower Back Pain and Sciatica in under 16 years guidance highlights that paracetamol should not be offered alone for managing low back pain. • **This NICE guidance also highlights that prescriber should not offer** gabapentinoids, other antiepileptics, oral corticosteroids or benzodiazepines for managing sciatica as there is no overall evidence of benefit and there is evidence of harm. • **Do not offer opioids** for managing **chronic sciatica.** • If a person is already taking opioids, gabapentinoids or benzodiazepines for sciatica, explain the risks of continuing these medicines.	
NSAIDs **Ibuprofen** **or** **Naproxen**	• Ibuprofen 400mg Three time a day or Naproxen 250-500mg Twice a day. • Prescribe oral NSAIDs at the lowest effective dose for the shortest period of time. • Consider need for gastroprotection (e.g. omeprazole) if prescribing an NSAID. See NICE CKS for more information on risk factors for NSAID induced gastrointestinal adverse effects. • PPIs can increase risk of fractures, particularly at high doses for over 12months in the elderly. • Discuss Cardiovascular risk factors if ≥1.2g/day ibuprofen or ≥1g naproxen; renal issues or hepatic disease. • See NICE Clinical Knowledge Summaries for further information: https://cks.nice.org.uk/nsaids-prescribing-issues#!scenario • Consider weak opioids with/without paracetamol only if NSAID alone has been considered ineffective.

Trigeminal neuralgia	
Carbamazepine CKS revised January 2024: https://cks.nice.org.uk/topics/trigeminal-neuralgia/ Follow the MHRA safety advice on antiepileptic drugs in pregnancy: Antiepileptic drugs in pregnancy: updated advice following comprehensive safety review - GOV.UK (www.gov.uk)	• Start with 100mg Immediate Release up to twice-daily and titrate in steps of 100-200mg every two weeks until pain is relieved. • In most people 600-800mg daily (in three to four divided doses) is sufficient. • **Maximum daily dose 1600mg.** • Modified release preparations may be useful if pain is experienced at night. • Once pain is controlled, consider reducing the dose to the lowest effective dose, or the drug can be tapered slowly and withdrawn until the next attack. • Do not offer alternatives if ineffective or not tolerated, unless advised by a specialist. • NICE recommends only one drug at a time, but neurologists may recommend combinations.

Neuropathic Pain Guidance (excluding trigeminal neuralgia and painful diabetic neuropathy)

Patient presents with neuropathic pain. Discuss symptoms, patient concerns and expectations including:

- The severity of the pain, and its impact on lifestyle, daily activities (including sleep disturbance) and participation
- The underlying cause of the pain and whether this condition has deteriorated
- Why a particular pharmacological treatment is being offered, benefits and possible adverse effects of pharmacological treatments, considering any physical or psychological problems, and concurrent medications
- Coping strategies for pain and for possible adverse effects of treatment
- Non-pharmacological treatments, for example, physical and psychological therapies and surgery.

Consider early specialist referral if:

- There is diagnostic uncertainty
- Patient has severe pain
- Pain significantly limits daily activities including sleep disturbances
- The underlying health condition has deteriorated
- Continue to work through the medication recommendations whilst waiting for an appointment ensuring the need for regular reviews

NICE CG173 highlights that a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia) should be offered. Locally, amitriptyline is the preferred first line treatment choice, unless clinically inappropriate. If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated. When considering drug choice, please be aware of pregabalin and gabapentin's potential for dependence. Consider capsaicin cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.

Step 1 Non-opioid Analgesic / baseline analgesia	Step 2 Tricyclic Antidepressant (TCAs) (usually first choice)	Step 3 Anticonvulsant (First choice if TCAs are contraindicated)	Step 4: Duloxetine (For resistant neuropathic pain or those also prescribed methadone/ buprenorphine)
•Consider **Paracetamol** 1g four times a day **•Only continue if patient finds it beneficial.** •Simple analgesics are usually ineffective in pure neuropathic pain but may help with a coexisting nociceptive condition. This can be considered at any treatment stage. **If not effective move to step 2.**	•Be aware of anticholinergic and sedative effects of TCAs, especially in older, frail patients. Monitor for cardiac or psychiatric side effects. Also see Prescqipp anticholinergic drugs guidance for further information. •Amitriptyline, start at 10mg daily and increase by 10mg every 1-2 weeks. Slowly titrate to reduce side effects. Ensure titration occurs even if dose is later reduced. •10mg is usually the minimum effective dose, but up to 75mg can be used if effective and patient is not experiencing side effects (higher doses should only be given under specialist supervision). •The dose can be taken once daily or be divided into two doses. •Side effect profile of TCAs are similar but alternative TCAs e.g. Nortriptyline can be used if amitriptyline is not tolerated. Note nortriptyline is not licensed for this indication. •Review after 4-6 weeks at maximum tolerated dose. **•Stop if not effective and go to step 3.** **•If partial benefit at maximum tolerated dose, consider addition of anticonvulsant/ gabapentinoids as per step 3**	•**Gabapentin** - titrate dose weekly according to table overleaf. • If dose increases are tolerated, consider daily dose titration; however, consider titrating slowly if patient is elderly or frail as gabapentin has a sedative effect. Continue to titrate in a stepwise manner to a maximum of 900mg three times a day, as determined by efficacy and side effects. •A further increase to a **maximum of 1200mg three times a day** can be made if tolerated. • Review after 4-6 weeks at maximum tolerated dose. Should be used for at least an 8-week trial period •Taper and stop if no benefit. PHE recommend reduce the daily dose at a maximum rate of 300mg every four days then stop. •If this does not produce a benefit or is not suitable see other possible options below. Alternatively, **Pregabalin** could be used if gabapentin is **not tolerated due to side effects** or if there are contraindications. See table overleaf. • The starting dose as recommended by local specialists is 50mg bd, however a lower starting dose may be appropriate for some patients (e.g. elderly patients or those susceptible to side effects. •Review after 7 days at this dose and increase stepwise as needed. Continue to titrate in a stepwise manner to a **maximum of 300mg twice daily**, as determined by efficacy and side effects. Review after 4-6 weeks at maximum tolerated dose. **If no benefit obtained, PHE recommend reduce the daily dose at a maximum of 50-100mg/week then stop. Consider seeking specialist advice after second agent failure.** • It is more cost effective to prescribe pregabalin twice daily and improves patient compliance. •Consider trialing pregabalin for 4 weeks before deciding it is not effective. If not effective or not tolerated, discontinue treatment gradually over a minimum of 1 week. •Consider the misuse potential and risk of interaction with these gabapentinoid medications as well as consider the side effect profile of these medications.	•Can be used for treatment **resistant** neuropathic pain or as first line option for patients with neuropathic pain who are also **prescribed methadone or buprenorphine.** •Usual dose is 60mg daily. Review at 2 months and discontinue if inadequate response; review treatment at least every 3 months thereafter. **Maximum 120mg/day in divided doses.** •Note Duloxetine (Cymbalta®) is only licensed for the treatment of diabetic peripheral neuropathic pain. •Duloxetine has been associated with an increase in blood pressure, and clinically significant hypertension in some patients. Cases of hypertensive crisis have been reported, especially in patients with pre-existing hypertension. Blood pressure monitoring is recommended in these patients, especially during the first month of treatment. Use with caution in patients whose conditions could be compromised by an increased heart rate or by an increase in blood pressure. **•If duloxetine is not effective or not tolerated, discontinue treatment gradually over a minimum of 1 to 2 weeks to reduce the risk of withdrawal reactions and seek advice.**

Reassess patients every two weeks until pain is well controlled. Refer if there is no significant improvement, the underlying health condition has deteriorated and to clarify the diagnosis.

Dose Titration examples

Amitriptyline

Week 1	Week 2	Week 3	Week 4	Week 5	**Max**
10mg ON	20mg ON	30mg ON	40mg ON	50mg ON	75mg/day

CNS side-effects are common with **amitriptyline** particularly in the elderly, therefore low doses should beused for initial treatment in this group.

Gabapentin

	Week 1	Week 2	Week 3	Week 4	**Max**
Morning		300mg	300mg	300mg	3600mg/day in divided doses
Midday			300mg	300mg	
Night	300mg	300mg	300mg	600mg	

Depending on your reference source e.g. BNF titration schedules may differ. Patients should be maintained on the lowest effective dose and monitored for any emerging side effects e.g. cognitive effects and risk of dependence. Please see the BNSSG Gabapentinoid position statement for more information.
Slower titration may be required in the elderly, starting at 100mg and increasing by 100mg increments.
Elderly patients may require dosage adjustment because of declining renal function with age. Somnolence, peripheral oedema and asthenia may be more frequent in elderly patients.

Pregabalin

	Week 1	Week 2	Week 3	**Max**
Morning	50mg	100mg	150mg	600mg/day in divided doses
Night	50mg	100mg	150mg	

Pregabalin is more cost effective if prescribed twice daily and can support patient compliance. Depending on your reference source e.g. BNF titration schedules may differ, this is a slower titration based on local specialist recommendation. Patients should be maintained on the lowest effective dose and monitored for any emerging side effects e.g. cognitive effects and risk of dependence. Please see the BNSSG Gabapentinoid position statement for more information.
Lower dosing is recommended in the elderly, frail, those with renal impairment or low BMI. Consider an initial dose of 25 mg PO twice daily. If CrCl <30 ml/min, it may be appropriate to give this as a single daily dose of 25 mg as per table below:

Pregabalin doses according to renal function

Creatinine clearance (crcl) (mL/min)	Total pregabalin daily dose *		Dose regimen
	Starting dose (mg/day)	Maximum dose (mg/day)	
≥ 60	150	600	BID or TID
≥30 - <60	75	300	BID or TID
≥15 - <30	25 – 50	150	Once Daily or BID
< 15	25	75	Once Daily

* Total daily dose (mg/day) should be divided as indicated by dose regimen to provide mg/dose

Ref: SPC Alzain 100 mg Capsules, Hard

Switching between gabapentinoids

A useful resource for switching between pregabalin and gabapentin for neuropathic pain can be found on the Specialist Pharmacy Service website. See: Switching between gabapentin and pregabalin for neuropathic pain – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

Other medication options:

- **Tramadol**- Oral, 50-100mg 4-hourly, max dose in 24 hours is 400mg. **Only use if acute rescue therapy required and not on other opioid whilst awaiting specialist assessment. Long-term use only on advice of Specialist Pain Team.** The combination of tramadol with Amitriptyline, Imipramine or Duloxetine is associated with a risk of serotonin syndrome.
- **Opioids** – Only to be used on recommendation from a **specialist pain service**. Not usually effective for chronic pain.
- **Capsaicin cream 0.075%**: Localized areas of neuropathic pain may respond to topical capsaicin (e.g. 0.075% cream 3-4 times a day, 4 hours between applications), especially for those who wish to avoid or cannot tolerate oral treatments. This is licensed for treatment of post-herpetic neuralgia, after lesions have healed. Maximum use 8 weeks (no clinical trial evidence of efficacy for treatment of more than **8 weeks** duration). After that time, it is recommended that the patient's condition is clinically assessed prior to continuation of treatment and regularly re-evaluated thereafter. This could be prescribed whilst waiting referral to the pain clinic if referral required.
  Please note there is ease note, there are supply issues with Capsaicin cream which are likely to not resolve until 2026.

<table>
<tr><th colspan="3">Diabetic painful neuropathy (DPN)
Local expert opinion
*Do not prescribe these medicines in combination</th></tr>
<tr><td>Step 1</td><td>Duloxetine</td><td>• 60 mg once daily, discontinue if inadequate response after 2 months; review treatment at least every 3 months, maximum dose 120mg/day to be given in divided doses.</td></tr>
<tr><td>Step 2</td><td>Amitriptyline</td><td>• Be aware of anticholinergic and sedative effects of TCAs, especially in older, frail patients. Monitor for cardiac or psychiatric side effects. See https://www.prescqipp.info/resources/category/294-anticholinergic-drugs for more information on anticholinergic burden.
• Take in the evening to reduce “hangover effect” (drowsiness) in morning e.g. 6-8pm.
• Slowly titrate to reduce side effects.
• 10mg is usually the minimum effective dose, but up to 75mg can be used if effective and patient is not experiencing side effects (higher doses should only be given under specialist supervision).
• Review after 4-6 weeks at maximum tolerated dose. Stop if no benefit.
• If partial benefit at maximum tolerated dose, consider addition of gabapentinoids (please note: may be increased risk of adverse effects e.g. hyponatraemia)
• Side effect profiles of tricyclics are similar, but alternative may be used if amitriptyline is not well tolerated, such as nortriptyline (removed from NICE CG173 due to lack of evidence of greater clinical efficacy over other licensed treatments)

Amitriptyline (TLS green for neuropathic pain) and Nortriptyline (TLS blue) have the same dosing schedule:

<table>
<tr><th></th><th>Week 1</th><th>Week 2</th><th>Week 3</th><th>Week 4</th><th>Week 5</th><th>Max</th></tr>
<tr><td>Daily dose to be taken at night</td><td>10mg</td><td>20mg</td><td>30mg</td><td>40mg</td><td>50mg</td><td>75mg daily</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Step 3</td><td>Gabapentinoids</td><td></td></tr>
<tr><td></td><td>Gabapentin</td><td>
<table>
<tr><th></th><th>Week 1</th><th>Week 2</th><th>Week 3</th><th>Week 4</th></tr>
<tr><td>Morning</td><td></td><td>300mg</td><td>300mg</td><td>300mg</td></tr>
<tr><td>Noon</td><td></td><td></td><td>300mg</td><td>300mg</td></tr>
<tr><td>Night</td><td>300mg</td><td>300mg</td><td>300mg</td><td>600mg</td></tr>
</table>

Depending on your reference source e.g. BNF titration schedules may differ. A weekly titration is commonly seen in a chronic pain setting but quicker titrations may be seen in an acute pain inpatient setting.
If dose increases are tolerated, consider daily dose titration; however, consider titrating slowly if patient is elderly or frail as gabapentin has a sedative effect.
Continue to titrate as above in a stepwise manner to a maximum of 900mg tds, as determined by efficacy and side effects. Review after 4-6 weeks at maximum tolerated dose.
If no benefit obtained UKHSA (previously PHE) recommend reduce the daily dose at a maximum rate of 300mg every four days, then stop.
If gabapentin does not produce pain relief, gradually reduce and stop. Do not prescribe pregabalin.

</td></tr>
<tr><td></td><td>Pregabalin</td><td>

Use only if gabapentin is not tolerated due to side effects.
The starting dose as recommended by local specialists is 50mg bd, however a lower starting dose may be appropriate for some patients (e.g. elderly patients or those susceptible to side effects e.g. 25mg nocte). Monitor for side effects and risk of dependence.
Review after 7 days at this dose and increase stepwise as needed Continue to titrate in a stepwise manner to a maximum of 300mg bd, as determined by efficacy and side effects.
Review after 4-6 weeks at maximum tolerated dose.
If no benefit obtained, PHE recommend reduce the daily dose at a maximum of 50-100mg/week then stop.
If pregabalin does not produce pain relief, reduce and stop. Do not prescribe gabapentin.
If changing from gabapentin to pregabalin for neuropathic pain see SPS resource: https://www.sps.nhs.uk/articles/switching-between-gabapentin-and-pregabalin-for-neuropathic-pain/

</td></tr>
<tr><td>If oral treatments not tolerated.</td><td>Capsaicin cream 0.075% (Axsain cream)</td><td>

Apply pea size cream to the affected area 3 or 4 times daily (4 hours between applications).
Maximum use 8 weeks (no clinical trial evidence of efficacy for treatment of more than 8 weeks duration). After this time, the patient's condition should be clinically assessed prior to continuation of treatment and regularly re-evaluated thereafter. https://www.medicines.org.uk/emc/product/887
Please note, there are supply issues with Capsaicin cream which are likely to not resolve until 2026.

</td></tr>
<tr><td colspan="3">If no benefit, consider referral to secondary care pain specialist</td></tr>
<tr><td>Step 4</td><td>Tramadol</td><td>

Tramadol should only be considered as a rescue medication when people are awaiting referral to specialist pain services after initial treatment has failed [NICE CG173].
NICE does not give a recommended duration of treatment with tramadol but states that it should be considered for short-term use only.
CKS recommends that tramadol should be prescribed cautiously because of the potential for dependence.
Start at 50mg immediate release daily then titrate dose according to pain severity. The initial dose may be followed, if

</td></tr>
</table>

	Tramadol continued	necessary, by 50-100mg every 4-6 hours. • Patients should always receive the lowest dose that provides effective pain control. • **Maximum dose 400mg daily**. • Caution - tramadol is associated with drug induced deaths, may induce convulsions and increase potential for SSRIs, SNRIs, TCAs, anti- psychotics and other seizure lowering drugs to cause convulsions. • Mixed opioid/SNRI activity, may be useful in mixed or neuropathic pain. Has been associated with withdrawal symptoms even after short-term use.

Fibromyalgia Fibromyalgia (chronic widespread pain) is a type of chronic primary pain For more information see: https://remedy.bnssg.icb.nhs.uk/adults/pain-management-and-cfs/fibromyalgia/	
Amitriptyline	• Local pain teams are now only advising use of amitriptyline in fibromyalgia and that other medications should be avoided. • Local clinicians suggest start at 10mg at 8pm and titrate up every 2 weeks to a maximum of 50mg daily. The aim is a full, refreshing night's sleep, with no hang-over effect. • If Amitriptyline is too sedating, Nortriptyline (10-50mg) or Lofepramine (70mg) could be considered as alternatives.

Osteoarthritis (NICE guideline NG226 – Osteoarthritis in over 16s: diagnose and management)
• Offer a topical NSAID such as ibuprofen 5% gel to people with knee osteoarthritis and consider a topical NSAID for people with osteoarthritis that affects other joints. Review after 14 days. • If topical is unsuitable or ineffective, consider an oral NSAID such as ibuprofen or naproxen, considering potential gastrointestinal, renal, liver and cardiovascular toxicity and any risk factors. Consider prescribing gastroprotective treatment such as a PPI, whilst on the NSAID. • Paracetamol or weak opioids are not recommended unless they are only used infrequently for short-term pain relief and all other pharmacological treatments are contraindicated, not tolerated or ineffective.

Common Headaches

For further information see: https://remedy.bnssg.icb.nhs.uk/adults/neurology/headache-adults/

Diagnosis	Acute treatment	Prophylaxis
Trigeminal neuralgia	**Carbamazepine** (TLS Blue)	Carbamazepine first line: Note slow titration, enzyme induction and interactions. **See specific section on trigeminal neuralgia above**
Cluster headache	See CKS for advice including: • **Subcutaneous sumatriptan** (TLS Green) • Intranasal sumatriptan (TLS Blue) (off-label) For use when subcutaneous sumatriptan is unsuitable. • High Flow oxygen	Avoid triggers and medication overuse. Verapamil for cluster headache has two traffic light statuses depending on the patient cohort. **Verapamil (immediate release tablets) (TLS Amber 3 months)** • Cluster headache for patients <75 years old without a history of hypertension. See shared care protocol here. **Verapamil (immediate release tablets) (TLS Red)** • Cluster headache for patients ≥75 years old or have longstanding hypertension • ECG monitoring required for this higher risk cohort of patients i.e. repeat ECG 10 days after each dose titration. Repeat ECGs required on completing a course and on restarting subsequent courses of verapamil immediate release.
Migraine	Analgesia, antiemetic or triptans Recommended: (TLS Green) **Sumatriptan** Initially 50-100mg for one dose, followed by 50-100mg after at least 2 hours if required, to be taken only if migraine recurs (patient not responding to initial dose should not take second dose for same attack). **Max 300mg/day**. (BNF) Alternatives: (TLS Blue) **Almotriptan** 12.5mg, dose to be taken as soon as possible after onset, followed by 12.5mg after 2 hours if required, dose to be taken only if migraine recurs (patients not responding to initial dose should not take second dose for same attack); **maximum 25mg/day**. (BNF) **Naratriptan** 2.5mg, followed by 2.5mg after at least 4 hours if required, to be taken only if	Recommended: **Propranolol** (TLS Green) 80-240mg daily in divided doses (BNF) Alternatives: **Amitriptyline** (TLS Blue) Initially 10-25mg daily, dose to be taken in the evening, then increased if tolerated, in steps of 10-25mg every 3-7days in one to two divided doses; usual dose 25-75mg daily, doses above 100mg should be used with caution (doses above 75mg should be used with caution in the elderly and with cardiovascular disease) **Max 75mg/ day**. (BNF) **Topiramate** (TLS Blue) Initially 25mg once daily for 1 week, dose to be taken at night, then increased in steps of 25mg every week; usual dose 50-100mg daily in two divided doses; **max 200mg/day**.(BNF) Topiramate should be used with **caution in women of child-bearing potential and not**

Migraine continued	migraine recurs (patient not responding to initial doses should not take second dose for same attack); **max 5mg per day**. (BNF) **Rizatriptan** 10mg, dose to be taken as soon as possible after onset, followed by 10mg after 2 hours if required, dose to be taken only if migraine recurs (patient not responding to initial dose should not take second dose for same attack); **max 20mg/day**. (BNF) **Rimegepant** (if at least 2 triptans failed) (See NICE TA919 and BNF) 75mg once daily if required for treatment of acute migraine.	**be used in pregnancy** and there is a pregnancy prevention programme for this medication **Candesartan** (TLS Blue) Titrate as tolerated up to 16mg, by mouth, once daily or until headaches resolve. Note unlicensed use. (BNF) Riboflavin (400 mg once a day) may be effective in reducing migraine frequency and intensity for some people and can be purchased OTC (Note: This is **not** on the BNSSG formulary). Other drugs for migraine prophylaxis should only be initiated by a neurologist - see migraine prevention pathway in BNSSG formulary Consider non-pharmacological therapies as an adjunct or alternative to pharmacological therapy depending on the specific clinical situation. See CKS for further information.
Tension type headache (TTH)	If there is suspected **frequent episodic** or **chronic** tension-type headache: • Advise to avoid the frequent and excessive use of acute analgesia due to the risk of developing medication overuse headache.	Management of **episodic** tension-type headache includes: • Simple analgesia such as paracetamol, aspirin or nonsteroidal anti-inflammatories considering comorbidities and risk of adverse effects. • Avoidance of opioids. • Identification and appropriate management of associated co-morbidities such as mood disorders, chronic pain and sleep disorders. Preventative treatments that may be considered for chronic tension-type headache include: • A course of up to 10 sessions of acupuncture over 5–8 weeks. (Please note that acupuncture for TTH is **not available in BNSSG**) • Low dose amitriptyline (**off-label** indication). See Headache - tension-type | Health topics A to Z | CKS | NICE for further advice on management. Also see Remedy Headache page.

Drug Driving and Analgesia

- It remains illegal in England and Wales to drive when taking prescription medicines if the medication impairs a patient's ability to drive.
- Prescribers should discuss with the patient the risks associated in relation to analgesic drugs and driving and this should be clearly documented in the medical notes.
- Patients should be advised that it is their responsibility to decide not to drive if their driving may be impaired. If they do so they may be in breach of drug driving law and unable to use the statutory "medical defense".

- Further details of the drug driving law can be found in this Department of Transport guide: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/325275/healthcare-profs-drug-driving.pdf
- Gov.uk website: https://www.gov.uk/drug-driving-law
- DVLA guidance is available on drug or alcohol misuse and dependence.
- GMC guidance is available on how to speak to a patient about driving, what to do if you're unsure about their fitness to drive, and the steps to take if a patient continues to drive after you've advised them to stop.

Diverticular disease and Analgesia

Paracetamol is the preferred analgesia in diverticular disease. NSAIDs and opioids are best avoided, due to constipation and perforation risks. If their pain is due to diverticular disease, and paracetamol and/or antispasmodics are not helping their pain, they may need referral to secondary care for management. Dietary advice is essential to help avoid need for analgesia escalation.
If the pain is not related to a patient's diverticular disease, then may be necessary to use NSAIDs/opioids if all other options have been exhausted, and with measures taken to help reduce their use e.g. laxatives, with the risks versus benefits considered. Analgesia should be reviewed regularly, and if appropriate, opioids with less constipation effects should be considered.

Additional information on red and yellow flags in pain management

1	Red flags are clinical indicators of possible serious underlying conditions requiring further medical intervention. From patient history • *Possible fracture*: ○ significant trauma ○ minor trauma in elderly/osteoporosis • *Possible tumour or infection* ○ Age <20 or >50 years ○ History of cancer ○ Fever, chills, weight loss ○ Recent bacterial infection ○ IV drug use ○ Immunosuppressed patients ○ Pain worse at night or when lying down. • *Possible significant neurological deficit* ○ Severe or progressive sensory alteration or weakness e.g.; sudden onset footdrop. ○ Bladder or bowel dysfunction including saddle anaesthesia or paraesthesia. ○ Bilateral limb pain or altered sensations. From examination • Evidence of neurological deficit (e.g. in legs or perineum in lower back pain) Ref: https://cks.nice.org.uk/topics/back-pain-low-without-radiculopathy/diagnosis/assessment/
2	It is estimated that only 1 in 6 patients take their medication as intended by the prescriber. Improving a patient's compliance with a prescribed regimen can help to maximise the benefit of the drug prescribed. • Use simple language and avoid medical terms. • Discuss reasons for treatment and consequences of not treating. • Ensure information is tailored, clear, accessible and sufficiently detailed. • Seek patient's view on their condition and agree on a course of action. • Explain the drug, its function and mechanism of action if necessary. • Explain why slow dose titration is essential and is likely to help reduce the impact of side-effects on non-compliance and thus efficacy. • Keep the prescribed regimen as simple as possible. • Seek the patients views on how they will manage the regimen with their schedule and try to tie the regimen in with their routine

3	Prescribers should be aware of the existence of "yellow flags" early in the management of chronic pain. Yellow flags are psychosocial indicators suggesting increased risk of progression to long term distress, disability and pain. Identification and management of these yellow flags will improve the overall management of pain. ❖ **Attitude** towards the current problem. Does the patient feel that with appropriate help and self-management they will be able to return to normal activities? As above, the patient's expectation of response to treatments is critical as to whether they fully engage with the advice they receive. ❖ **Belief**. The most common belief is that the patient feels that something serious is causing their problem (such as cancer). These "faulty" beliefs can lead to "catastrophisation." ❖ **Compensation**. Are they awaiting payment for an accident or injury at work? ❖ **Diagnosis** or **iatrogenesis**. Poor communication can lead to patients misunderstanding what is meant. ❖ **Emotions**. Patients with other emotional difficulties (e.g. anxiety or depression) are at higher risk of developing chronic pain. ❖ **Family** may be overbearing or under-supportive. ❖ **Work**. Is the person currently off sick or have a history of significant work absence as a result of their pain, are they in a physically demanding job, are they supported at work, do they receive sick pay, and are they out of work as a result of their problem?

For further Information on the different types of pain included in this guidance, please refer to the relevant national or local guidance as below:

- **Low Back Pain and Sciatica**

NICE pathway Low back pain and sciatica in over 16s: assessment and management (NG59)

- BNSSG Remedy - https://remedy.bnssg.icb.nhs.uk/adults/pain-management-and-cfs/back-pack/

  MSK Physio services https://remedy.bnssg.icb.nhs.uk/adults/physiotherapy/msk-physio-services/
- To support discussions with patients about the benefits and harms of opioid treatment, and safe withdrawal management, see:
  - the NICE guideline on shared decision making
  - the NICE guideline on medicines optimisation for recommendations on structured medication reviews
  - the key therapeutic topic on medicines optimisation in chronic pain, the opioids aware website and the section in the BNF on controlled drugs and drug dependence.

- **Fibromyalgia**

See BNSSG Remedy**: https://remedy.bnssgccg.nhs.uk/adults/pain-management-and-mecfs/fibromyalgia/**

Another reference source for clinicians is the EULAR revised recommendations for the management of fibromyalgia 2016: https://ard.bmj.com/content/76/2/318

- **Neuropathic Pain**

NICE CG173 - Neuropathic pain in adults: pharmacological management in non-specialist settings

Trigeminal Neuralgia – CKS guidance: https://cks.nice.org.uk/topics/trigeminal-neuralgia/

- **Osteoarthritis**

NICE NG226 Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE

Overview of Opioids for Chronic Pain

Key Messages

- Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain. Long-term opioid use may worsen or prolong symptoms of pain.
- A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).
- Ensure the patient is given realistic expectations. Opioids are unlikely to give complete pain relief and effectiveness may be demonstrated by other means, such as functional improvement.
- Agree objectives for opioid treatment; if pain is not reduced by (for example) 30-50% (or other agreed objective), the opioid has not been effective and should be discontinued.
- The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit: tapering or stopping high dose opioids needs careful planning and collaboration.
- If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped and do not increase the dose, even if no other treatment is available. Seek specialist advice.
- Seek specialist advice early on in the patient's management rather than later.
- Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.
- **Do not** use injectable opioids or pethidine in chronic pain.
- Opioids are not usually helpful in the management of mechanical back pain, fibromyalgia, pelvic or abdominal pain or non-specific visceral pain.

Reference: https://www.fpm.ac.uk/opioids-aware

Considerations when prescribing opioids:

1. **Assess the patient before commencing a trial of opioids**, including indicators of anxiety or other psychiatric co-morbidities. These patients will require additional support and monitoring if trialing opioids. Agree specific function of goals that may be achieved. These could include:
    - Improvement of sleep in those whose sleep is impaired due to their pain.
    - Weight management to maintain mobility which has been impaired by their pain.

2. **Cautions**
    - Opioids should not be used in pregnant women without specialist advice and should be used with caution in older people (particularly those with co-morbidities).
    - Involve Substance Misuse Services in discussions around pain management in patients with a history of dependence to opioids or other drugs (including alcohol) to ensure good cross working to best support the patient.
    - Patients should not drive when starting opioids or adjusting dose or if they feel unfit to drive. Resources to inform patients about drugs and driving.

3. **Adverse Effects**
    - Most common side effects are predictable consequences of opioid pharmacological actions and include nausea, vomiting, constipation, pruritus, dizziness, dry mouth and sedation.
    - Side effects are extremely common with opioid therapy.
    - Constipation is a common side effect of opioids and should be considered when prescribing

opioids in any patients. Constipation (and itching) tend to persist throughout treatment and may require long-term management. NICE CKS and the local guideline for the use of laxatives in the management of constipation in adults recommend:

- An osmotic laxative (e.g. macrogol first line, or lactulose second line) and a stimulant laxative (e.g. bisacodyl or senna) should be considered.
- Docusate may be an alternative, which has both stimulant and stool-softening properties.
- Titrate the dose up and down to achieve soft-formed stools without straining at least three times per week.
- Naloxegol is blue on the BNSSG formulary for opioid induced constipation, in line with NICE TA345 for those who have not adequately responded to laxatives.
- Naldemedine is blue on the BNSSG formulary for opioid-induced constipation in line with NICE TA651 in adults who have had laxative treatment.
- Bulk forming laxatives (e.g. ispaghula husk) **should not be prescribed** for opioid-induced constipation.

- Opioid toxicity (sedation, respiratory depression, cyanosis) is more common with increasing age, co-morbidity or if opioids taken with alcohol or illicit drugs. Opioids have long-term endocrine and immunological effects.
- Withdrawal effects can occur if the opioid is stopped or if the dose is reduced abruptly.
- Increased absorption may occur from transdermal opioid formulations with a fever or other intercurrent illness, and if the patient is exposed to external heat, for example a hot bath or sauna. If concerns arise, closer patient monitoring will be required.
- Dependence is characterised by impaired control over use, craving and continued use despite harm. It is related to, but distinct from physiological dependence.
- Opioid-induced hyperalgesia may occur pain becomes more diffuse and different from pre-existing pain. Specialist advice is needed.

4. Documentation

- All stages of the opioid trial should be clearly documented and if appropriate, a copy of the agreed aims of therapy and how these may be monitored should be given to the patient.
- Documentation should also include the agreed starting dose and formulation of drug and details of planned dose escalation.
- If the opioid treatment has not been helpful (lack of efficacy/intolerable adverse effects), reasons for this should be clearly documented.

Referral to Pain Clinic

The Pain Clinic offers a joined up, multi-professional patient specific assessment of pain and put in place an individual management plan, enabling a more normal life with reduced disability.

Please see **BNSSG Remedy** for full information on referring to the Pain Clinic at Southmead and BRI hospitals.

Prescribing opioids on discharge from hospital

Patient who are discharged following surgery:

The finding of similar rates of use between the minor and major surgery groups suggests new persistent opioid use after surgery may be less related to pain than individual risk factors such as preoperative pain and mood disorders, substance abuse, and preoperative tobacco use.

Patients are often discharged after an operation when they still require analgesia, and they may be prescribed a few days of strong opioid medication (morphine or oxycodone) to help them manage their pain. This opioid therapy should **not be continued for longer than 7 days after discharge**, and maximum quantity for tramadol at discharge should be 28/30 (original pack sizes vary).
Further medication should not be prescribed by the GP unless there is a clear instruction on the discharge letter or there has been a discussion with the discharge team.

Please also be aware of the March 2025 drug safety update advice about against the routine use of prolonged release opioids post-surgery

Patients who are admitted to hospital already on continuous opioid therapy:

Where patients arrive in hospital already on opioid therapy consider dose before and afterwards, before prescribing further courses. Include specific instructions for GPs regarding dose, indication, review timescale and whether opiates should be continued long-term in the discharge letter.

Patients who are newly initiated on opioid therapy in hospital for non-surgical reasons:

Clinicians should include specific instructions for GPs regarding dose, indication, review timescale and whether opiates should be continued in the discharge letter.

For further information for patients and healthcare professionals to support prescribing of opioid medicines for pain see the Opioids Aware website: http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

In general, it is recommended to communicate the pain management plan with the primary care practice taking over care in the community and document in patient clinical notes and discharge summary.

Resources

Helpful resources to share with **patients** on chronic pain:	
'Opioids Aware' – information for patients	https://fpm.ac.uk/opioids-aware/information-patients
An Introduction to Opioid Medication by Health and Care Videos.uk	https://www.healthandcarevideos.uk/pain?videoId=3454
Risks, side effects and misuse of opioids by Health and Care Videos.uk	https://www.healthandcarevideos.uk/pain?videoId=3455
NHS England and Improvement – Sean's story – There is another way	https://www.youtube.com/watch?v=l17SjDth4pU
Management of chronic pain	https://livewellwithpain.co.uk/ https://www.paintoolkit.org/
NHS Choices back pain	https://www.nhs.uk/ (use search engine to look for back pain information)
Pain Concern	https://painconcern.org.uk/
BNSSG Chronic Pain Self-Help Resources Summary	https://remedy.bnssgccg.nhs.uk/formulary-adult/local-guidelines/4-nervous-system-guidelines/
Guidance on Opioids and Risk of Addiction	https://www.gov.uk/guidance/opioid-medicines-and-the-risk-of-addiction
BNSSG Mental Wellbeing Leaflet	https://bnssgccg.nhs.uk/library/mental-wellbeing-leaflet/
Shared decision-making tool for osteoarthritis of knee	Making a decision about knee osteoarthritis (england.nhs.uk)

Helpful resources for **Clinicians** on chronic pain:	
"Opioids aware" resources	https://fpm.ac.uk/opioids-aware
The Pain Toolkit	www.paintoolkit.org (available to download or as a book for a small fee)
STarT Back Screening Tool (Keele University) - a brief validated tool (Hill et al 2008), designed to screen primary care patients with low back pain for prognostic indicators that are relevant to initial decision making	https://www.keele.ac.uk/sbst/startbacktool/sbtoolonline/
Live Well with Pain: resources for patients and clinicians	http://livewellwithpain.co.uk/
British Pain Society, pain scales in multiple languages	https://www.britishpainsociety.org/british-pain-society-publications/pain-scales-in-multiple-languages/
Pain assessment in advanced dementia tool (PAINAD)	http://dementiapathways.ie/_filecache/04a/ddd/98-painad.pdf
BNSSG Chronic Pain Self-Help Resources Summary (this contains a wide range of patient resources)	https://remedy.bnssgccg.nhs.uk/formulary-adult/local-guidelines/4-nervous-system-guidelines/
NICE NG193 'Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain'	https://www.nice.org.uk/guidance/ng193

NICE CG173 'Neuropathic pain in adults: pharmacological management in non-specialist settings'	https://www.nice.org.uk/guidance/cg173
NICE NG59 'Low back pain and sciatica in over 16s: assessment and management'	https://www.nice.org.uk/guidance/ng59
NICE NG226 'Osteoarthritis in over 16s: diagnosis and management'	Recommendations | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE
Opioid calculator from Faculty of Pain Medicine for Australia and New Zealand	http://www.opioidcalculator.com.au/
Faculty of Pain Medicine of the Royal College of Anaesthetists – Dose equivalents and changing opioids	https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/dose-equivalents-and-changing-opioids
Patient Health Questionnaire (PHQ-9)	https://patient.info/doctor/patient-health-questionnaire-phq-9
General Medical Council: Good practice in prescribing and managing medicines and devices	https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices
A practice by practice review of the data comparing prescribing to other GP practices in England and Bristol, North Somerset and South Gloucestershire CCG can be found on OpenPrescribing. To help with the review of patients who may be taking > 120mg equivalent of morphine per day, find your practice then click on the link below the chart to see the preparations prescribed.	https://openprescribing.net/ccg/15C/opioidper1000/
BNSSG Remedy: which includes a number of resources for clinicians such as information on specific conditions, referral processes and formulary treatments.	https://remedy.bnssg.icb.nhs.uk/
Oxford University Hospitals Resources for GPs regarding Opioids and Chronic Pain.	https://www.ouh.nhs.uk/services/referrals/pain/opioids-chronic-pain.aspx
Prescqipp Bulletin 284 – Chronic Pain	https://www.prescqipp.info/our-resources/bulletins/bulletin-284-chronic-pain/