Treatment of Adult Chronic (Non-Cancer and Non-Chronic Primary) Pain 2022. Abridged version

Full guideline https://remedy.bnssgccg.nhs.uk/formulary-adult/local-guidelines/4-nervous-system-guidelines/
Prescribers may be asked to prescribe by brand based on drug acquisition cost, which may change. ScriptSwitch will prompt best value. Use minimum effective dose. If pain settles, consider reduction to evaluate continued effectiveness. If no significant benefit, stop medication. Patient record to include why medication continued, "Chronic pain" is not sufficient. Clinical records should include sufficient relevant documentation e.g. agreed outcomes of opioid therapy. All patients on pain medication **should be reviewed every 3-6 months**.
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, considering patient circumstances, goals and values to ensure person centered approach in the management of their chronic pain.
For those with chronic primary pain refer to NICE NG 193 and cancer pain refer to local hospice information.

Non-opioid analgesia **If appropriate,** consider stepping down to self-care i.e. purchase over the counter (OTC) https://bit.ly/3vqbGRm	Paracetamol	Caution if body weight <50kg or risk of hepatotoxicity, for further information see BNSSG Oral Paracetamol Dosing in Adults
	+/- NSAID Ibuprofen or Naproxen	Consider need for gastroprotection (e.g. omeprazole) but stop if no longer required when NSAID stopped (See local deprescribing guidance). Discuss cardiovascular risk factors if ≥1.2g/day ibuprofen or ≥1g naproxen; renal issues or hepatic disease. See NICE CKS for more information.
	Topical NSAID or capsaicin cream	Consider if oral NSAID inappropriate or not tolerated, as per BNSSG Formulary
Weak opioid analgesia*	Codeine Dihydrocodeine	For moderate to severe pain; avoid multiple opioids; consider regular laxatives, and continue regular paracetamol (increased efficacy compared to opioid alone). Can continue NSAIDs if effective. Do not progress to strong opioids if weak ones not helping as indicates pain unresponsive to opioids. Dihydrocodeine should only be used as a second line option when codeine is not appropriate.
Strong opioids* **Do not** prescribe immediate relief "breakthrough" medication	Tramadol Morphine MR (10mg bd; 12hourly preparation) Oxycodone MR tablets	Caution when converting tramadol dose to morphine (see separate guidance on opiate conversion doses). Do not increase dose without seeing patient. Daily doses ≥120mg/day morphine or equivalent (e.g. fentanyl 50micrograms/hour patches) should not be used in primary care unless patient under specialist review. Oxycodone should only be prescribed where morphine is not tolerated or contraindicated. Review monthly - taper then stop if no benefit.
	Buprenorphine patches	Reserved for stable pain and patients who cannot tolerate oral medication, compliance issues due to cognitive or physical cause or recommended by a specialist pain clinic. Prescribe by brand. Vary patch application site.
Low back pain and sciatica	NSAIDs - Ibuprofen or Naproxen	Do not use paracetamol alone. Do not offer gabapentinoids, other antiepileptics, oral corticosteroids or benzodiazepines for sciatica. Do not offer opioids for chronic sciatica. Consider need for gastroprotection (e.g. omeprazole) with NSAIDs, but stop if no longer required when NSAID stopped. Discuss cardiovascular risk factors if ≥1.2g/day ibuprofen or ≥1g naproxen; renal issues or hepatic disease. See NICE CKS for more information.
Trigeminal neuralgia CKS 2018: https://bit.ly/2MF0axd	Carbamazepine	Once pain controlled reduce dose to lowest effective dose or taper slowly and withdraw until 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. Also be aware of MHRA safety advice on antiepileptic drugs in pregnancy.
Neuropathic pain (excluding Diabetic Painful Neuropathy (DPN) and trigeminal neuralgia)	Step 1: Regular paracetamol (this can be used at each step) Step 2: Tricyclic Antidepressants (TCAs) e.g. Amitriptyline Step 3: Gabapentinoids Gabapentin / Pregabalin Step 4: Duloxetine	NICE CG 173 Neuropathic pain in adults: amitriptyline, gabapentin or pregabalin, or duloxetine (licensed in DPN only), as initial treatment. If one treatment is not effective or not tolerated, offer alternative/move to next step. Be aware of anticholinergic and sedative effects of TCAs, especially in older, frail patients. Monitor for cardiac or psychiatric side effects. Titrate dose – gabapentinoids according to SPC or BNF. Review after **4-6 weeks,** taper and stop if no benefit. **If one gabapentinoid does not produce pain relief do not prescribe the other.** A useful resource for switching between pregabalin and gabapentin for neuropathic pain can be found on the Specialist Pharmacy Service website. Duloxetine - Consider for those with resistant neuropathic pain or those also prescribed methadone/ buprenorphine

	If oral treatment not tolerated: Capsaicin cream 0.075% (Axsain® cream)	If oral treatments not tolerated. Maximum use 8 weeks.
Diabetic Painful Neuropathy (DPN)	Step 1: Duloxetine Step 2: Amitriptyline Step 3: Gabapentinoids Gabapentin / Pregabalin If oral treatments not tolerated: Capsaicin cream 0.075% (Axsain cream)	NICE CG 173 Neuropathic pain in adults: duloxetine, amitriptyline, gabapentin or pregabalin as initial treatment. If one treatment is not effective or not tolerated offer alternative/move to next step. Be aware of anticholinergic and sedative effects of TCAs, especially in older, frail patients. Monitor for cardiac or psychiatric side effects. Titrate dose – gabapentinoids according to SPC or BNF. Review after **4-6 weeks,** taper and stop if no benefit. **If one gabapentinoid does not produce pain relief do not prescribe the other.** Duloxetine - discontinue if inadequate response after 2 months; review treatment at least every 3 months
Common Headaches	**Trigeminal neuralgia** Acute: Carbamazepine Prophylaxis: Carbamazepine **Cluster Headache** Acute: Subcutaneous sumatriptan Prophylaxis: oral Verapamil (TLS Red) **Migraine** Acute: Sumatriptan, or alternatives include Almotriptan, Naratriptan, Rizatriptan Prophylaxis: Propranolol,or alternatives include Amitriptyline, Topiramate, Candesartan **Tension type headache (TTH)** Acute: Analgesic withdrawal Prophylaxis: Simple analgesia e.g. paracetamol, aspirin or NSAID. A course of up to 10 sessions of acupuncture over 5–8 weeks or low dose amitriptyline (off-label indication)	Consider non-pharmacological therapies as an adjunct or alternative to pharmacological therapy depending on the specific clinical situation. See CKS for further information. In tension type headache (TTH) avoid the use of opioids, identify and manage associated co-morbidities such as mood disorders, chronic pain and sleep disorders. (Please note that acupuncture for TTH is not available in BNSSG)
Fibromyalgia	Amitryptyline	If Amitriptyline is too sedating, Nortriptyline (10-50mg) or Lofepramine (70mg) could be considered as alternatives. Also see helpful information on the BNSSG Remedy page.

*GPs to supply “Opioids aware” information http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware; record addiction risks discussed, along with information on potential for driving impairment

Useful local resources include:

- BNSSG Paracetamol dosing in adult patients
- Opioid conversion chart guidance
- BNSSG Chronic pain guideline
- Chronic Pain self-help resource summary
- BNSSG Reducing and Stopping Opioids, Information for Patients leaflet
- Remedy information page on persistent (chronic) pain

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