Pathway for the pharmaceutical management of chronic pain in adults

(To be used as part of a wider management plan with the patient)

Step 1 - Initial management

Regular Paracetamol

+ (if suitable) NSAID (consider GI protection if >60yrs and CVS assessment)

- Ist line choice Ibuprofen or Naproxen
- Use short course and lowest effective dose

Step 2 – Moderate pain

Continue paracetamol (+/- NSAID)

Add in weak opioid – codeine, dihydrocodeine or tramadol (do not combine weak opioids)

- Titrate as needed to reach max dose of weak opioid before moving to step 3.
- Use plain tramadol capsules, if MR tramadol is required use a low cost brand such as **Marol**
- Review and add laxatives if indicated
- Consider risk of abuse of weak and strong opiates

Step 3 – Severe pain

Continue paracetamol (+/- NSAID)

Replace weak opioid with strong opioid

- Do not give more than one opioid drug simultaneously unless directed by pain specialist
- Use laxative to prevent constipation and anti-emetic (e.g.cyclizine)

Option 1
Oral Morphine MR 10mg - 20mg bd
(Use low cost brand such as **Zomorph**)

Assess in 2 weeks

Follow up assessment – increase dose as needed in increments of **not more than** half the previous prescribed dose. Remember to include the PRN doses (e.g. 20mg bd increases to 30mg bd)

Assess in 2 weeks

Follow up assessment- increase doses in increments **of not more than** half the previous prescribed dose

Assess every 2 weeks

Follow up assessment – (if patient not achieved useful pain relief at 120-180mg morphine equivalent in 24hrs, referral to pain specialist recommended.
If no significant improvement in pain relief in 6 weeks STOP opioid, reduce slowly. Support may be required to manage both physical and psychological withdrawal

or

Option 2
Oramorph oral solution 10mg/5ml.
5mg every four hours

Assess in 1 week

Follow up assessment – include change in function, QoL, activity, pain score, usage of drug, adverse effects etc

Switch to equivalent MR bd (twice/day) dose

Only consider a switch of opioid/route if oral route not appropriate or un-acceptable adverse effects despite pre-emptive use of laxatives and anti-emetics

Consider: oxycodone, fentanyl patch (prescribe low cost brand such as **Mezolar**, useful if renal impairment) or buprenorphine patch.

Patches should only be used if:

- opioid requirement is stable
- unable to take oral medication

Based on the Sheffield pathway: Use of opiates in persistent pain. Further information can be found at www.sheffieldpersistentpain.com, including assessment tools and conversion charts.

Other resources:

The British Pain Society. Opioids for persistent pain: Information for patients. 2010.
http://www.britishpainsociety.org/pub_patient.htm#opioidpatient

The British Pain Society. Opioids for persistent pain: Good practice. London: The British Pain Society; 2010. http://www.britishpainsociety.org/pub_professional.htm

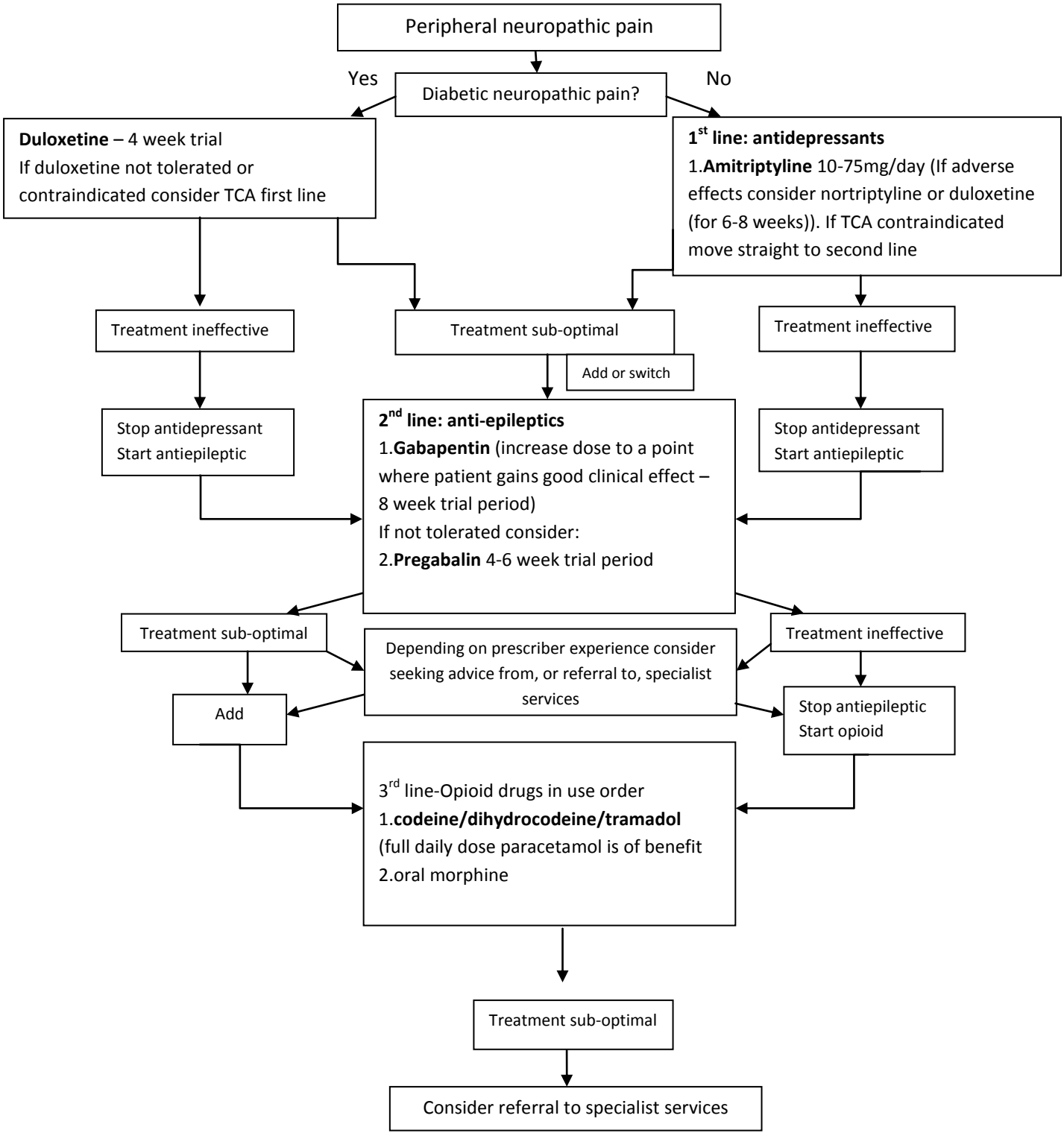
General points

- Analgesics should be titrated to full therapeutic and tolerated doses before switching to a different agent
- Regular review of effect should be performed during titration with a focus on measured benefit in terms of function, quality of life as well as pain. Specific review of side-effects is also important, including, mood, sleep, memory, constipation.
- The British Pain Society recommends if patients do not achieve useful relief of pain symptoms at doses between 120-180mg morphine equivalent in 24 hours, referral to a specialist in pain medicine is strongly recommended.
- Do not prescribe more than one agent from the same class together
- Single constituent analgesics should be used where possible to allow independent dose titration. If fixed combination analgesics are used, prescribers are encouraged to give therapeutic doses e.g. codeine 30mg and paracetamol 500mg per tablet.
- Avoid the use of soluble preparations due to the high salt content and high costs.
- More information on fentanyl patches can be found in the MMT protocol 'Review of Opioid Prescribing - Fentanyl Patches'
- Fentanyl is considered a second-line option for moderate to severe opioid responsive pain in patients unable to tolerate morphine due to persistent side effects. Side effects are classed as persistent if the patient does not develop tolerance to the side effects or the side effects cannot be managed with the appropriate concomitant drugs – antiemetics, laxatives, antihistamines etc.

For full prescribing information please refer to the BNF or to the Summary of Product Characteristics (available on-line on the electronic Medicines Compendium www.emc.medicines.org.uk)

Pathway for the pharmaceutical management of neuropathic pain

To be used as part of a wider management plan with the patient



Based on the Sheffield Neuropathic pain pathway. See www.sheffieldpersistentpain.com for more information, including assessment tools and patient information leaflets. Please refer to NICE clinical guideline 96 (2010) for more details on the pharmacological management of neuropathic pain in adults in non-specialist setting.

General Points

- Give each drug adequate trial at max tolerated dose before considering moving to the next step
- Doses should be increased gradually to reduce the incidence of side effects.
- When stopping a drug, doses should be reduced gradually.

NICE CG 96 recommends referral to specialist pain service and/or a condition-specific service if:

- They have severe pain
- Pain significantly limits their daily activities and participation
- Their underlying health condition has deteriorated