Management of nociceptive and neuropathic pain for adult patients in primary care

This guideline is intended to assist in the prescribing of drugs for nociceptive and neuropathic pain for adult patients in Sunderland. The underlying condition causing the pain should be managed in line with other relevant guidelines, the details of which are beyond the scope of this guideline. This guideline is confined to analgesic drug prescribing. Patients treated using this guideline should be prescribed these drugs as part of an overall management plan, incorporating all aspects of care and using shared decision making with the patient. The treatment of trigeminal neuralgia is outside of the scope of this guideline. The BNF/SPC of the relevant drugs should be referred to for further guidance and information.

Prescribers should be aware of the potential for medication diversion (when a patient obtains medication with the intention of sharing, swapping or selling medication). Medications should only be used by the patient for whom they are prescribed.

Resources for patient information:
http://www.nhs.uk/Livewell/Pain/Pages/Painhome.aspx
https://www.britishpainsociety.org/british-pain-society-publications/patient-publications/
http://www.paintoolkit.org/

Note: All medication dispensed from community pharmacies and all medications bought in the UK should contain a patient information leaflet.

Nociceptive pain:
Co-codamol is not included in the flow chart and its use is discouraged, due to inflexibility of dosing. Paracetamol and codeine should be prescribed separately. If cocodamol is used, this should be in tablet form, not the effervescent preparation which has a high salt content.

Codeine is preferred to dihydrocodeine, as dihydrocodeine is not recommend for regular use(either alone or when taken in combination with paracetamol as codydramol) has a shorter half life and the effects are more likely to lead to abuse. However, both codeine and dihydrocodeine are associated with the risk of developing physical and psychological dependency and there should be arrangements for review when being prescribed.

Initiation of strong opioids should only be considered when all other options have proved ineffective and after a review of concordance with other prescribed treatments. Morphine is first line and other agents such as oxycodone should only be considered in patients intolerant of morphine. If strong opioid use may be anything other than short term, patients should have had specialist review, unless there are good reasons not to do so. If there are concerns about the potential misuse of chronic pain drugs, a written and signed agreement with the patient should be considered.

Additional notes:
Patients prescribed analgesic drugs should receive appropriate advice about driving. Particular care should be taken when drugs are first initiated and or titrated. For further information refer to the DVLA website https://www.gov.uk/government/publications/at-a-glance.

Prescribing should take into account any co-morbidities and need for dose adjustments or if drugs are contra-indicated eg gabapentin and pregabalin require dose adjustment in renal impairment, duloxetine is contra-indicated in hepatic impairment. The BNF/SPC for individual drugs should always be referred to.

The rate at which drugs are titrated should be individualised, and particularly in the elderly, slower rates of titration should be considered. In general, drugs should not be overlapped if one is weaned down and another started. Treatment should be individualised.

Nociceptive pain treatment pathway:

Step	Drug	Dose (oral)	Comments
1	Paracetamol	1g QDS prn	
2	Paracetamol	1g QDS reg	
3	Add ibuprofen (NSAID)	200mg-400mg TDS	• Use the lowest possible NSAID dose for the shortest period necessary to control symptoms. • Consider risk of prescribing in high risk patients • Check for contraindications
4	Add codeine (weak opioid)	15mg to 60mg QDS	• Review past treatment • Consider potential for medication diversion (sharing,swapping/selling meds) • Use lowest effective dose • Do not use if contraindicated • Consider laxatives • Consider stopping NSAID if appropriate
5	Morphine (strong opioid)		• Stop codeine • Initiation of strong opioids should only be considered when all other options have proven ineffective. • If strong opioid use is anything other than short term patients should have specialist review, unless there are good reasons not to • Use Zomorph capsules • Do not prescribe more than 120mg morphine or equivalent per 24 hours (as per BPS guidelines). Refer to specialist.

Neuropathic pain* (excluding trigeminal neuralgia) treatment pathway:

**Do not prescribe more than one neuropathic pain drug at the same time. For example, do not prescribe amitriptyline concurrently with duloxetine, gabapentin, or pregabalin*

	Drug	Dose (oral)		Comments	Tapering
1	Amitriptyline	10 to 25mg ON		Titrate over 3 to 6 weeks to a maximum of 75mg ON	Gradually reduce dose and withdraw over 2 to 4 weeks
2	Switch to Gabapentin	Week 1	300mg ON	Where necessary, and if tolerated by patients, clinicians can prescribe a more rapid titration. See BNF for details.	Ideally reduce by 300mg every four days . However, it is possible to taper off faster, over <u>at least</u> one week. May need to taper over longer period if clinically indicated.
		Week 3	300mg OM, 300mg ON		
		Week 5	300mg OM, 300mg noon, 300mg ON		
		Week 7	300mg OM, 300mg noon, 600mg ON		
		Week 9	300mg OM, 600mg noon, 600mg ON		
		Week 11	600mg OM, 600mg noon, 600mg ON		
		Week 13 onwards	Increase according to up to max. 3.6g daily		
3	Switch to duloxetine	30mg OD. Can be increased to 60mg OD			Available strengths make tapering difficult. Reduce 60mg to 30mg for one week then stop. Stop if 30mg.
	OR				
	Switch to pregabalin	150mg daily in 2-3 divided doses, increased if necessary after 3-7 days to 300mg daily in 2-3 divided doses, increased further if necessary after 7 days to max 600mg daily in 2-3 divided doses		From 1st August 2017, pregabalin should be prescribed generically ie <u>NOT</u> as Lyrica or as any other branded generic.	Reduce by 50-100mg per week. However, it is possible to taper off faster, over <u>at least</u> one week. May need to taper over longer period if clinically indicated.
4	Refer to specialist. For people awaiting referral after initial treatments have failed, consider prescribing a short course of tramadol for pain relief. Prescribe tramadol cautiously, bearing in mind the potential for misuse. Tramadol is a Schedule 3 controlled drug and as such is subject to the legal hand writing requirements associated with controlled drugs				

Tapering: The advice regarding tapering should be treated as a guide only. Individuals may require a longer tapering period, or may tolerate a faster withdrawal. This will be dependent on multiple factors such as the individual, the length of treatment and the dose achieved.

Nefopam: Nefopam is a non formulary drug. Most of the studies assessing the efficacy of nefopam are either single dose or short term based; the majority of these involve parenteral administration which is not supported by the UK marketing authorisation. The evidence base for the efficacy of nefopam is weak, conflicting or absent in reducing pain in patients with RA or postoperative period. Further to this, the price has nefopam has recently increased by 456% (£10.59/90 tablets in Jan 16 to £58.88/90 tablets in July 16).

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