Persistent Pain Resources
Educational Slide Set

October 2016
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This document has been prepared by multiprofessional collaborative group, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC). This document has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

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Management of Persistent Pain

Aims

Highlight the issues surrounding the management of persistent pain conditions and support patients, carers and healthcare teams in understanding the potential benefits and harms of medicines used in pain management.

Provide prescribers with the information needed to support the appropriate management of persistent pain conditions.

Highlight the risks associated with inappropriate prescribing of medicines in pain management.

Definitions

Pain

“Pain is an emotion experienced in the brain, it is not like touch, taste, sight, smell or hearing. It is categorised into Acute pain - less than twelve weeks duration and Chronic pain - of more than twelve weeks.

Pain can be perceived as a warning of potential damage, but can also be present when no actual harm is being done to the body.”

British Pain Society
www.britishpainsociety.org/people-with-pain/useful-definitions-and-glossary/#pain

Neuropathic pain

“Neuropathic pain is pain initiated or caused by a primary lesion or dysfunction in the peripheral or central nervous system. For example, pain following shingles, or an amputation, or spinal cord trauma. Pain that occurs in diabetics or in patients with multiple sclerosis can also be neuropathic.”

British Pain Society
www.britishpainsociety.org/people-with-pain/useful-definitions-and-glossary/#pain

Persistent Pain

• Persistent pain is complex and can be described as having both sensory and emotional components

• The only way of deciding whether someone has pain is by asking them or picking up clues from the way they behave

• There must be a patient-centred holistic approach to persistent pain management
Persistent Pain

Medicines in general and opioids in particular are often not very effective for persistent pain

Prescribers must consider the benefits for the patient balanced against the burdens and risks of long-term use

The position of opioid treatment must be considered within a wider social context, and issues such as diversion must be addressed

Different treatments work for different people

Managing expectations

Not likely to be cured

Not likely to be pain-free

Need to self-manage as with any other chronic condition

Patient needs to be party to the treatment and to take control/responsibility for some of their care

Background

Persistent pain is complex

Opioids are increasingly being used to treat persistent pain

Opioids have a well-established role in the management of acute pain and in the management of pain in terminal illness

However, the safety and efficacy of opioids in the long-term, as well as the risks of tolerance, dependence and addiction, is uncertain.

Healthcare professionals should discuss the risks and features of tolerance, dependence, and addiction with patients, and agree together a treatment strategy and plan for end of treatment.

Prescribers must consider the benefits for the patient balanced against the burdens and risks of long-term use

The position of opioid treatment must also be considered within a wider social context and issues such as diversion and misuse must be addressed

Non-pharmacological management of persistent pain

Non-pharmacological therapies and medicines with proven efficacy for persistent pain syndromes should always be tried before starting opioids
Self-management of persistent pain

It has been estimated that people with health conditions (including pain) may spend less than 3 hours a year on average in contact with members of their healthcare team; therefore, the need to reinforce self-management skills, as well as seeking the help of healthcare professionals, is very important. Patients often feel helpless and unable to cope with pain themselves.

The Pain Toolkit is a very useful resource to set the scene with patients:

- Acceptance of the pain and recognition of the need to take control is an important part of self-management.
- Goal setting, pacing, planning and prioritising daily activities help patients maintain motivation and increase their activity without causing significant fluctuations in pain levels.
- Relaxation and mindfulness can help ease tension in the muscles and mind.
- In some cases, lack of activity scenarios deconditioning to the point where any movement becomes painful; patients should be encouraged to maintain a level of activity.

Prescribing in persistent pain

Complete pain relief is rarely achieved with opioids; the goal of pain management should be to reduce symptoms sufficiently to support improvement in physical, social and emotional functioning.

The decision to start long-term opioid therapy should be considered carefully by the patient and the prescriber, and arrangements for long-term monitoring must be in place.

The prescribing of opioids can result in problem drug use and the likelihood of this occurring can be influenced by social, psychological and health related factors.

Any concerns about problem drug use should prompt referral to specialised pain and addiction services.

Resources should be available to prescribers in non-specialist settings to empower clinicians by supporting the evidence-based decisions they make within the complex context of multidisciplinary pain management.

MHRA drug safety update September 2020

Advice for healthcare professionals:

- Opioid medicines (opioids) provide relief from serious short-term pain; however long-term use in non-cancer pain (longer than 3 months) carries an increased risk of dependence and addiction.
- Discuss with patients that prolonged use of opioids may lead to drug dependence and addiction, even at therapeutic doses; warnings have been added to the labels (packaging) of UK opioid medicines to support patient awareness.
- Before starting treatment with opioids, agree with the patient a treatment strategy and plan for end of treatment.
- Explain the risks of tolerance and potentially fatal unintentional overdose, and obtain patient and carer agreement that symptoms of opioid overdose be aware of per opioid safety information booklet and PDF.
- Provide regular monitoring and support especially to individuals at increased risk, such as those with current or past history of substance use disorder (including alcohol misuse or mental health disorder).
- At the end of treatment, taper dosage slowly to reduce the risk of withdrawal effects associated with sudden cessation of opioids, even from a high dose, may take weeks or months.
- Consider the possibility of hyperalgesia if a patient on long-term opioid therapy presents with increased sensitivity to pain.
- Consult the latest advice and warnings for opioids during pregnancy in the product information and clinical resources.
- Report suspected dependence or addiction to any medicine, including an opioid, via the Yellow Card scheme.

Dose equivalences

The following slides provide examples from the BNF of dose equivalence tables of some commonly prescribed opioids.

Equivalence tables may differ locally.

Refer to local guidelines when appropriate.
Equivalent doses of opioid analgesics

<table>
<thead>
<tr>
<th>Analgesic</th>
<th>Route</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>PO</td>
<td>100 mg</td>
</tr>
<tr>
<td>Diamorphine</td>
<td>IM, IV, SC</td>
<td>3 mg</td>
</tr>
<tr>
<td>Dihydrocodeine</td>
<td>PO</td>
<td>100 mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>PO</td>
<td>2 mg</td>
</tr>
<tr>
<td>Morphine</td>
<td>PO</td>
<td>10 mg</td>
</tr>
<tr>
<td>Morphine</td>
<td>IM, IV, SC</td>
<td>5 mg</td>
</tr>
<tr>
<td>Codeine</td>
<td>PO</td>
<td>6.6 mg</td>
</tr>
<tr>
<td>Tramadol</td>
<td>PO</td>
<td>100 mg</td>
</tr>
</tbody>
</table>

Fentanyl patch equivalences

72-hour fentanyl patches are approximately equivalent to the following 24-hour dose of oral morphine.*

- morphine salt 30 mg daily ≡ fentanyl 12 patch
- morphine salt 60 mg daily ≡ fentanyl 25 patch
- morphine salt 120 mg daily ≡ fentanyl 50 patch
- morphine salt 180 mg daily ≡ fentanyl 75 patch
- morphine salt 240 mg daily = fentanyl 100 patch

*An MHRA drug safety update highlighted in September 2020 that, following a review of the risks associated with use of opioid medicines for non-cancer pain, the Commission on Human Medicines (CHM) has recommended that fentanyl transdermal patches are contraindicated in opioid-naive patients in the UK.

Buprenorphine patch equivalences

Buprenorphine patches are approximately equivalent to the following 24-hour dose of oral morphine.*

- morphine salt 12 mg daily ≡ BuTrans® 5 patch 7-day patches
- morphine salt 24 mg daily ≡ BuTrans® 10 patch 7-day patches
- morphine salt 48 mg daily ≡ BuTrans® 20 patch 7-day patches
- morphine salt 96 mg daily ≡ Transact® 35 patch 4-day patches
- morphine salt 120 mg daily ≡ Transact® 52.5 patch 4-day patches
- morphine salt 168 mg daily ≡ Transact® 70 patch 4-day patches

*Conversion ratios vary and these figures are a guide only. Morphine equivalences for transdermal opioid preparations have been approximated to allow comparison with available preparations of oral morphine.

Strong Opioid Prescribing

Strong opioid use a whole is increasing within NHS Wales

The number of prescription items of strong opioids in Wales has increased by 48%* over the last few years

The number of prescription items for strong opioids increased by 11% over the last year**
Strong opioid prescribing trends for Wales, England and NE England*
Quarter ending December 2009–Quarter ending March 2016

Strong opioid prescribing trends for Welsh health boards*
Quarter ending December 2009–Quarter ending March 2016

Strong Opioids – Items per 1,000 PUs

Morphine as a percentage of strong opioid prescribing

Tramadol prescribing trends for Welsh health boards.*
Quarter ending December 2009–Quarter ending March 2016

*The data displayed was correct at the time of original publication (October 2016) and has not been updated as part of the December 2020 update that was made to include information from MHRA Drug Safety Updates published in September 2020. The data will be updated as part of a full review due to be carried out in 2021.
Tramadol – DDDs per 1,000 patients

Neuropathic agents

Gabapentin and pregabalin prescribing trend for Welsh health boards*
Quarter ending December 2009–Quarter ending March 2016

Aneurin Bevan  Cardif And Vale  Hywel Dda  Betsi Cadwaladr
ABMU  Powys  Cwm Taf

* The data displayed was correct at the time of original publication (October 2016), and has not been updated as part of the December 2020 update that was made to include information from MHRA Drug Safety Updates published in September 2020.

This data will be updated as part of a full review due to be carried out in 2021.

National Prescribing Indicators

NPIS
There are a number of National Prescribing indicators (NPIS) related to the use of medicines in persistent pain.

Details of these can be found on the NPI pages on the awmsg website:

Deaths related to drug poisoning in England and Wales 2014

3,346 drug poisoning deaths were registered in 2014 in England and Wales, the highest since comparable records began in 1993.

Deaths involving heroin and/or morphine increased by almost two-thirds between 2012 and 2014, from 579 to 952 deaths.

Deaths involving tramadol have continued to rise, with 240 deaths in 2014.

In England there was a 17% rise in the drug misuse mortality rate in 2014 to 39.7 per million population, while in Wales the rate fell by 16% to 39.0 deaths per million, the lowest since 2006.

Number of drug-related deaths in England and Wales by substance*

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>All drug poisoning deaths</td>
<td>2,747</td>
<td>2,552</td>
<td>2,507</td>
<td>2,955</td>
<td>3,346</td>
</tr>
<tr>
<td>Heroin and morphine</td>
<td>761</td>
<td>536</td>
<td>519</td>
<td>765</td>
<td>942</td>
</tr>
<tr>
<td>Methadone</td>
<td>355</td>
<td>486</td>
<td>414</td>
<td>429</td>
<td>394</td>
</tr>
<tr>
<td>All amphetamines</td>
<td>56</td>
<td>63</td>
<td>97</td>
<td>120</td>
<td>157</td>
</tr>
<tr>
<td>MDMA/ECstasy</td>
<td>8</td>
<td>13</td>
<td>31</td>
<td>43</td>
<td>50</td>
</tr>
<tr>
<td>PMA/PHPA</td>
<td>0</td>
<td>1</td>
<td>20</td>
<td>29</td>
<td>24</td>
</tr>
<tr>
<td>Novel psychotropic substances</td>
<td>22</td>
<td>20</td>
<td>52</td>
<td>60</td>
<td>67</td>
</tr>
<tr>
<td>All benzodiazepines</td>
<td>337</td>
<td>353</td>
<td>284</td>
<td>342</td>
<td>353</td>
</tr>
<tr>
<td>Diazepam</td>
<td>188</td>
<td>179</td>
<td>267</td>
<td>238</td>
<td>258</td>
</tr>
<tr>
<td>Zopiclone/azidopine</td>
<td>67</td>
<td>71</td>
<td>83</td>
<td>88</td>
<td>130</td>
</tr>
<tr>
<td>All antidepressants</td>
<td>381</td>
<td>363</td>
<td>408</td>
<td>458</td>
<td>517</td>
</tr>
<tr>
<td>Tricyclic antidepressants (BNF 4.3.1)</td>
<td>194</td>
<td>205</td>
<td>253</td>
<td>258</td>
<td>257</td>
</tr>
<tr>
<td>Selective serotonin re-uptake inhibitors (SSRIs) (BNF 4.3.3)</td>
<td>138</td>
<td>127</td>
<td>150</td>
<td>150</td>
<td>159</td>
</tr>
<tr>
<td>Other antidepressants (BNF 4.3.2 and 4.3.4)</td>
<td>74</td>
<td>84</td>
<td>104</td>
<td>123</td>
<td>155</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>199</td>
<td>207</td>
<td>192</td>
<td>238</td>
<td>255</td>
</tr>
<tr>
<td>Tramadol</td>
<td>132</td>
<td>154</td>
<td>175</td>
<td>220</td>
<td>240</td>
</tr>
<tr>
<td>Codeine</td>
<td>91</td>
<td>88</td>
<td>73</td>
<td>130</td>
<td>136</td>
</tr>
<tr>
<td>Diethylpropion</td>
<td>90</td>
<td>109</td>
<td>103</td>
<td>102</td>
<td>96</td>
</tr>
<tr>
<td>Other specified opiates</td>
<td>56</td>
<td>80</td>
<td>90</td>
<td>52</td>
<td>129</td>
</tr>
<tr>
<td>Unspecified opiate</td>
<td>172</td>
<td>131</td>
<td>92</td>
<td>145</td>
<td>169</td>
</tr>
</tbody>
</table>

Telephone enquiries to the National Poisons Information Service (NPIS) 2014–2015

<table>
<thead>
<tr>
<th>Substance</th>
<th>Number of telephone enquiries</th>
<th>Ranked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tramadol</td>
<td>690</td>
<td>8</td>
</tr>
<tr>
<td>Morphine</td>
<td>246</td>
<td>20</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>278</td>
<td>31</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>435</td>
<td>18</td>
</tr>
<tr>
<td>Methadone</td>
<td>74</td>
<td>N/A</td>
</tr>
</tbody>
</table>