

# Persistent Pain Resources

## Ten Key Messages

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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# Ten Key Messages - Managing Persistent Pain

1. Ongoing pain is often due to changes in the processing of pain information rather than a symptom of an underlying pathology.



2. **Red flags** MUST be excluded before any treatment commenced.



3. Further investigations may be appropriate, but be aware that findings may not always be related to the pain.

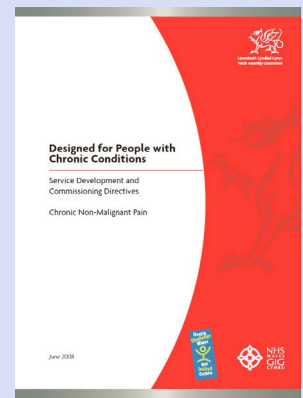
4. The **World Health Organization (WHO) pain ladder** was devised for cancer pain and, whilst it is a useful tool, it must be remembered it was not developed for ongoing pain. If using the ladder, weak opiates should be **stopped** before a strong opiate started.

5. Establishing whether or not the pain has a **neuropathic** component may help when deciding on a management plan.

6. Managing persistent pain is about effective management and not about finding a cure, as with any other chronic condition. All treatments are aiming to help a patient cope with their pain better. The British Pain Society provides useful [information for patients](#).

7. The **Education Programmes for Patients** and exercise on referral schemes may be useful to help patients to self-manage.

8. **Being active is very important;** the less active a patient is, the more painful it is to move, and a vicious cycle ensues.



9. **Goal setting, pacing and planning** are useful strategies for managing a pain problem.



10. It is OK to say that nothing more can be **given** to the patient in terms of medical treatment. It may not be helpful to give the patient false hope with further treatments and referrals, looking for an elusive cure. However, continued support with self-management strategies is essential.

# Ten Key Messages - Non-pharmacological Management

1. Referral to a multidisciplinary team (including professionals such as clinical psychologists, physiotherapists, occupational therapists and nurses) experienced in managing pain can contribute to the non-medical management of persistent pain (e.g. through pain management and functional restoration programmes)<sup>1,2</sup>.



2. Persistent pain should be assessed and managed using a biopsychosocial model<sup>3</sup>. Psychosocial factors have a significant impact on disability and outcome<sup>4</sup>.

3. Biomedical factors often do not explain the severity of symptoms or disability.

4. Supporting self-management is a central component. Informing and educating people that treating persistent pain is about management and not about finding a cure.



5. Graded exercise and keeping active is effective at helping to manage persistent pain.

6. Evidence has found that self-management support can be more effective in a group versus individual settings<sup>5</sup>: for example, exercise referral schemes and [Education Programmes for Patients](#).

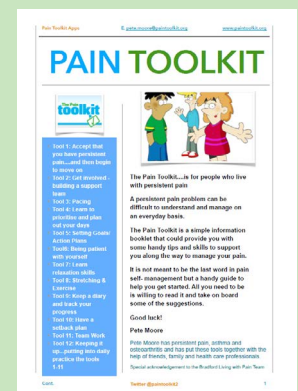
7. Cognitive Behavioural Therapy (CBT) can be effective in helping to manage persistent pain<sup>6</sup>. It is important to note that these therapies should be delivered by appropriately trained and skilled practitioners.



8. Acceptance of their situation can be a challenge for people with persistent pain. Mindfulness and Acceptance and Commitment Therapy (ACT) can help with this. Consider referral to a psychologist or other appropriately accredited professional.

9. Consider referral to a physiotherapist who can offer individualised management that may include manual therapy, which can be beneficial.

10. Promote self-efficiency behaviours and quality of life by encouraging patients to explore and maintain meaningful activities and interests through goal setting and activity planning.



# Ten Key Messages - Treatment of Neuropathic Pain

1. Neuropathic pain is caused by dysfunctional, damaged or injured nerves sending incorrect signals to the brain. It can have a metabolic, infective, traumatic, toxic, inflammatory/autoimmune, vascular, malignancy or musculoskeletal cause.

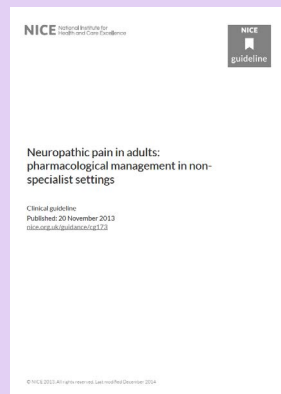
2. The pain can be spontaneous, continuous, intermittent, superficial or evoked. It can be made worse by temperature or touch.



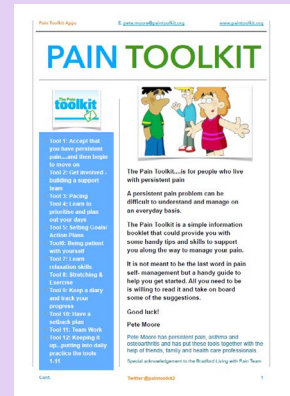
3. It can be described as burning, sharp, shooting, lancinating, itching, pins and needles, or indescribable in terms of normal reference.

4. Assessment tools such as the [LANSS scoring tool](#) or the [Pain Detect tool](#) can be used to assist diagnosis<sup>1,2</sup>. See Appendix 3 in the main document for other examples.

5. [NICE](#) has provided guidance with regards to management of neuropathic pain. Drug choices are amitriptyline, gabapentin, pregabalin or duloxetine for generalised neuropathic pain. Capsaicin cream should be considered for focal pain (check that your health board does not have any local guidance).



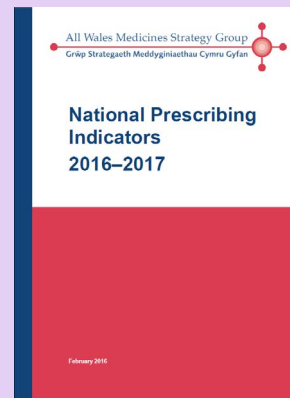
6. General pain management advice can be given as per the [Pain Toolkit](#).



7. If in any doubt as to the underlying disease process, the following investigations should be undertaken: urine (glucose and protein), ESR/c-reactive protein, folate, fasting glucose, U&Es, FBC, vitamin B12, LFT, TFT, HbA1C, appropriate radiology.

8. Pain may not be sensitive to opiates – so if pain persists despite increasing doses of opiates, it is NOT opiate sensitive.

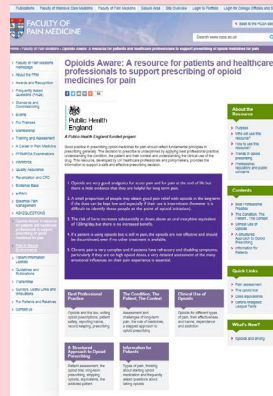
9. Drugs should be titrated (dose changes and speed of titration should be dictated by the patient's tolerance of the medication). If they are not helping, they should be weaned and discontinued and another drug tried. It is about regular review.



10. NICE also provides some [Do Not Dos](#) – do not use the following medicines to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so (see local advice for referral criteria to specialist services): tramadol for long-term use, morphine, cannabis sativa extract, capsaicin patch, lacosamide, lamotrigine, levetiracetam, oxcarbazepine, topiramate, venlafaxine.

# Ten Key Messages - Strong Opioids

1. Opioid medicines 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, even at therapeutic doses<sup>1</sup>.



2. Persistent pain may not be opiate sensitive, so increasing the dose may have no benefit on the pain.



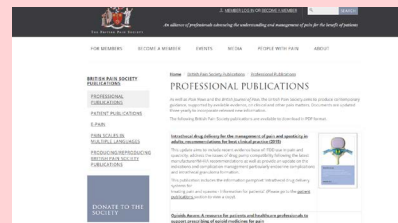
3. Complete pain relief is rarely achieved; the goal of therapy should be to reduce symptoms enough to support improvement in physical, social and emotional functioning.

4. 80% of patients taking opioids will have at least one adverse effect<sup>2</sup> and these should be discussed before prescribing such medications. Also explain the risks of tolerance and potentially fatal unintentional overdose, and counsel patients and caregivers on signs and symptoms of opioid overdose to be aware of.

5. Driving advice – the patient should be advised not to drive at the start of therapy, and when doses are increased. They should only then drive if they feel fit to do so. It is their responsibility to inform the DVLA that they are taking such medications (see [Department for Transport Guidance](#)).

6. Report suspected dependence or addiction to any medicine, including to an opioid, via the [Yellow Card scheme](#).

7. If possible, consider using modified release preparations<sup>3</sup>. Due to the wide range of modified release preparations available, caution should be exercised to ensure the correct product is selected, and the product should be prescribed by brand where appropriate\*.



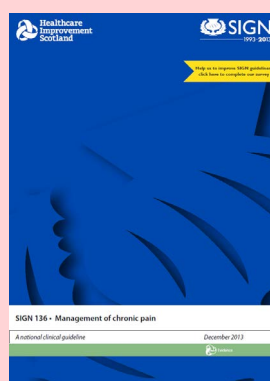
8. Injectable formulations should NOT be used to manage persistent pain<sup>3</sup>; immediate-release preparations should only be used for short periods if clinically relevant, and should be stopped as soon as possible as they have a higher incidence of addiction<sup>4</sup>.

9. If patients have been titrated to 120 mg or more oral morphine equivalent per 24 hours with no benefit, specialist referral or advice is recommended<sup>3</sup>.

Consider the possibility of hyperalgesia if a patient on long-term opioid therapy presents with increased sensitivity to pain<sup>1</sup>.

10. Fentanyl and buprenorphine patches can be difficult to titrate and so should be avoided in persistent pain unless there is a good clinical indication to use them, e.g. patient unable to swallow.

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-naïve patients in the UK<sup>5</sup>.



\* Refer to specific product literature and local guidance.

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