Non-neuropathic pain

These resources are aimed at reviewing pain pathways and facilitating the appropriate primary care management of pain in all patients aged 18 years and over suffering from chronic pain. This document does not cover the specific management of pain associated with cancer.

Recommendations

- Use medication for pain only as part of a wider management plan aimed at reducing disability and improving quality of life. Patients should be informed that complete pain relief may not be possible and analgesia may only offer a 30-50% reduction in pain relief.[1,2]
- Consider non opioid interventions (paracetamol +/-NSAIDs and non-pharmacological) before opioid therapy.[1-3] See attachment 1: Treatment pathway for non cancer pain in adults.
- When initiating prescribing, always consider a one to two week opioid trial (or long enough to observe the effect of opioids on two or three episodes of increased pain) to establish if the patient achieves a reduction in pain intensity and ability to achieve specific functional improvements (including sleep).[1,2]
- Use with caution in older people (particularly those with medical co-morbidity).[1,2]
- There is little evidence that opioids are helpful long term. During long term treatment, review at least monthly in the first six months after stable dosing has been achieved.[1,2]
- If ineffective, the opioid should be slowly tapered down and discontinued.[2]

Background

Pharmacological management for pain should be used only as part of a wider management plan aimed at reducing disability and improving quality of life. Opioids should not usually be used as first line therapy for pain. The WHO analgesic ladder advises oral administration of drugs in a stepwise approach.

The safety and efficacy of long term opioid use is uncertain although use may be appropriate in some cases of persistent pain. Treatment success is demonstrated by the patient becoming able to do tasks that the pain currently prevents. Improved sleep would also be a reasonable outcome. 80% of patients taking opioids will experience at least one adverse effect, e.g. constipation, nausea, itching and dizziness. If the prescriber and patient agree that opioid therapy may play a role in further management of the patient's pain, a trial of opioid therapy should be planned. The risk of harm with opioids increases substantially at doses above oral morphine equivalent to 120mg/day, but there is no increased benefit.[1,2]

There is little evidence that one opioid is more effective and associated with fewer side effects than another. Oral morphine is the preferred choice. Non-morphine opioids, such as fentanyl, buprenorphine and oxycodone are significantly more expensive than oral morphine. There is no consistent evidence to suggest that non-morphine opioids are any more effective or show improved tolerability. However, there is a theoretical rationale for trying an alternative opioid if the first drug is helpful but causes intolerable side effects.[1,2]

Table 1: Cost comparison for strong oral opiates for 30 days (NB. Doses do not imply equivalence or an equianalgesic effect.)[4,5]

	Doses	Drug Tariff cost[4]	Most cost effective brand[5]
Tramadol SR capsules	100-200mg bd	£14.47 - £28.93	£6.94 - £14.19 (Marol)
Morphine SR (Zomorph)	30mg-60mg bd	£8.30 - £16.20	£8.30 - £16.20 (Zomorph)
Oxycodone MR	20mg-40mg bd	£53.66 - £107.35	£26.83 - £53.66 (Longtec, Reltebon)
Tapentadol prolonged release tablets	100-250mg bd	£49.82 - £124.55	£49.82 – £124.55 (Palexia SR)

Cost savings (ePACT April to June 2016)

The annual cost of analgesics across England and Wales is over £546 million. If reviewing prescribing and discontinuing treatment no longer needed resulted in a 20% reduction, **this would lead to over £109 million worth of savings across England and Wales. This equates to £179,494 per 100,000 patients.**

Use of opioid formulations with a rapid onset, such as fentanyl for transmucosal or sublingual administration are inappropriate for the management of persistent pain and should be reviewed, The current annual cost of these formulations across England and Wales is over £10.4 million.

Opioid injections, or pethidine in any form, for the management of persistent non cancer pain (unless on the advice of a specialist pain management team) should not be prescribed. The current annual cost of pethidine across England and Wales is over £1.9 million.

Review existing patients on nefopam. If ineffective and patients cannot tolerate side effects, reduce slowly and discontinue. The current annual cost of nefopam across England and Wales is over £24.4 million.

If a review of prescribing led to a 50% reduction in fentanyl, nefopam or pethidine formulations then this would lead to annual savings across England and Wales of over £19.4 million. This equates to £31,887 per 100,000 patients.

References

1. The British Pain Society. Opioids for persistent pain. A consensus statement prepared on behalf of the British Pain Society, Faculty of Pain Medicine of the Royal College of Anaesthetists, Royal College of General Practitioners and the Faculty of Addictions of the Royal College of Psychiatrists. Accessed via http://www.rcoa.ac.uk/news-and-bulletin/rcoa-news-and-statements/opioids-persistent-pain-good-practice
2. Faculty of Pain Medicine. Supported by Public Health England. Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain. Accessed via http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware on 09/12/16
3. Best Practice Advocacy Centre New Zealand (BPAC) WHO Analgesic Ladder: which opioid to use at step two. BPJ 2008:18 Accessed via http://www.bpac.org.nz/BPJ/2008/December/ladder2.aspx on 21/03/16.
4. Prescription Pricing Division (PPD). NHS Business Services Authority. Drug Tariff March 2016. Accessed via http://www.drugtariff.nhsbsa.nhs.uk on 21/03/16.
5. MIMS. Haymarket Publishing, London. March 2016. Accessed via www.mims.co.uk on 21/03/16.

Additional resources available: https://www.prescqipp.info/resources/category/349-non-neuropathic-pain

Bulletin Data pack Audit, patient letter, pathway

PrescQIPP Community Interest Company