
Chronic pain
virtual workshop
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PrescQIPP
Community Interest Company

About me

- Pharmacist 20+ years in primary care (practice and CCG)
- Head of Education at PrescQIPP
- NICE Medicines and Prescribing Associate
- Trainer in therapeutics for the former National Prescribing Centre

About PrescQIPP

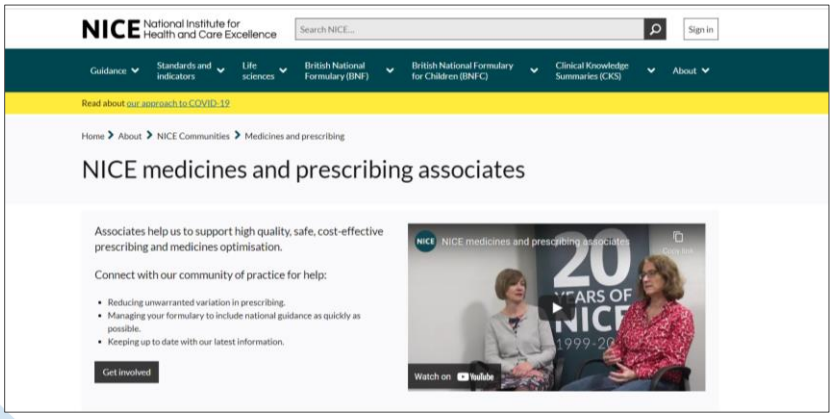
- **Community Interest Company, funded by the NHS for the NHS**
- Our aims are to:
- Help NHS commissioners **to improve patient outcomes** and manage medicines budgets effectively
- **Reduce duplication** and support collaboration across the NHS
- Highlight and spread prescribing **good practice and innovation**

PrescQIPP resources

- Clinical resources which include bulletins, briefings, data, audit tools, patient information and clinical system searches
- Non-clinical resources covering system changes or national strategy
- Prescribing data analytics
- Training courses such as leadership, clinical systems
- E-learning courses and face to face/virtual courses in therapeutics
- Virtual professional groups
- Annual event and awards/ shared good practice

NICE Medicines and Prescribing Associates

"Associates act as an ambassadors for excellence in prescribing and medicines optimisation"



5

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https://www.nice.org.uk/about/nice-communities/medicines-and-prescribing/nice-medicines-and-prescribing-associates

- **Part 1 – Chronic pain management guidelines**
- **Part 2 – Reducing opioid use in chronic pain**

Format

- Presentations
- Polls
- Plenary discussion
- Slides (with references) will be shared

Poll

Which professional group do you belong to?

a. GP
b. Nurse
c. Pharmacist
d. Pharmacy technician
e. Paramedic
f. Physiotherapist
g. Practice Manager
h. Social prescriber
i. Mental health practitioner
j. Other

Poll

What % of your workload do you estimate is involved in seeing/reviewing patients with chronic pain?

a. <20%

b. 20-40%

c. 40-60%

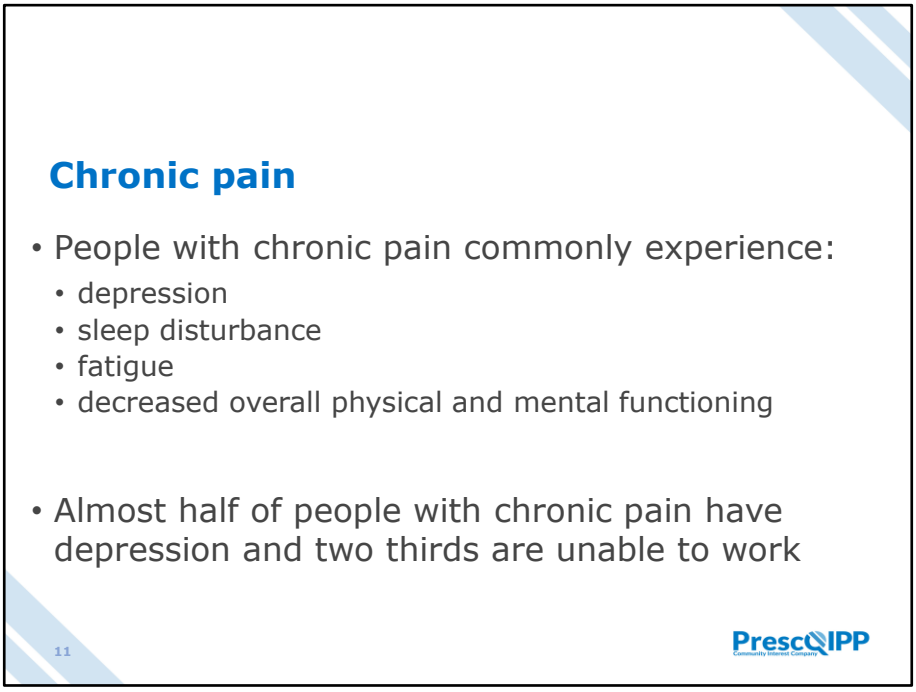
d. 60-80%

e. >80%

Chronic pain

- The British Pain Society defines chronic pain as persistent pain beyond the time that tissue healing would normally be expected, often stated as > three months
- A common, complex, sensory, emotional, cognitive and behavioural long term health condition which occurs when pain cannot be resolved by available medical or other treatments

https://www.britishpainsociety.org/



high economic burden with absence from work and poor productivity

Prevalence of chronic pain

- Affects between one-third and one-half of the population of the UK - just under 28 million adults
- 10-14% report disabling chronic pain that is moderate or severe
- Trend towards increasing prevalence with increasing age - 62% in the over 75 age group
- More common in women than in men

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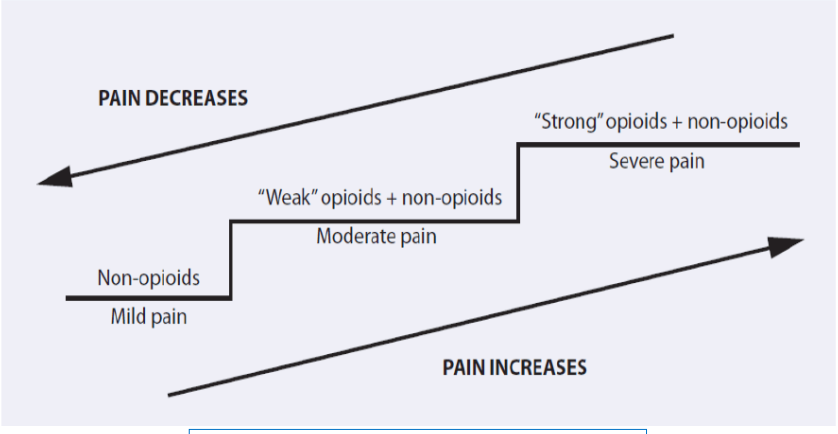
http://bmjopen.bmj.com/content/6/6/e010364

Chronic primary pain (CPP)

The prevalence of CPP is unknown but is estimated to be between 1% and 6% in England.

The analgesic ladder



WHO 1986

Developed and validated specifically for the treatment of *cancer* pain.
The Faculty of Pain Medicine states that the analgesic ladder is unhelpful in chronic pain as it has an unpredictable course and may continue for many years.
SIGN also states that there is little good quality evidence for use of the ladder in chronic pain.

Poll

The WHO pain ladder is useful to guide treatment in chronic pain.

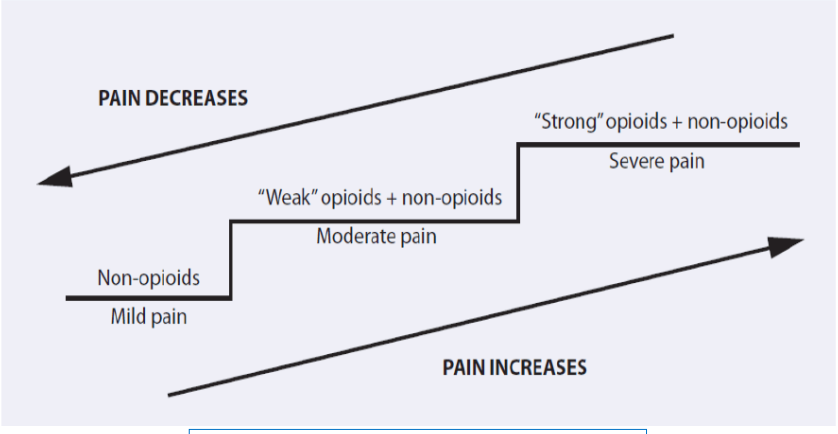
True

False

WHO analgesic ladder

- The WHO analgesic ladder was developed and validated specifically for the treatment of *cancer* pain
- Faculty of Pain Medicine - the analgesic ladder is unhelpful in chronic pain as it has an unpredictable course and may continue for many years
- The Scottish Intercollegiate Guidelines Network (SIGN) - little good quality evidence for use of the ladder in chronic pain

The analgesic ladder



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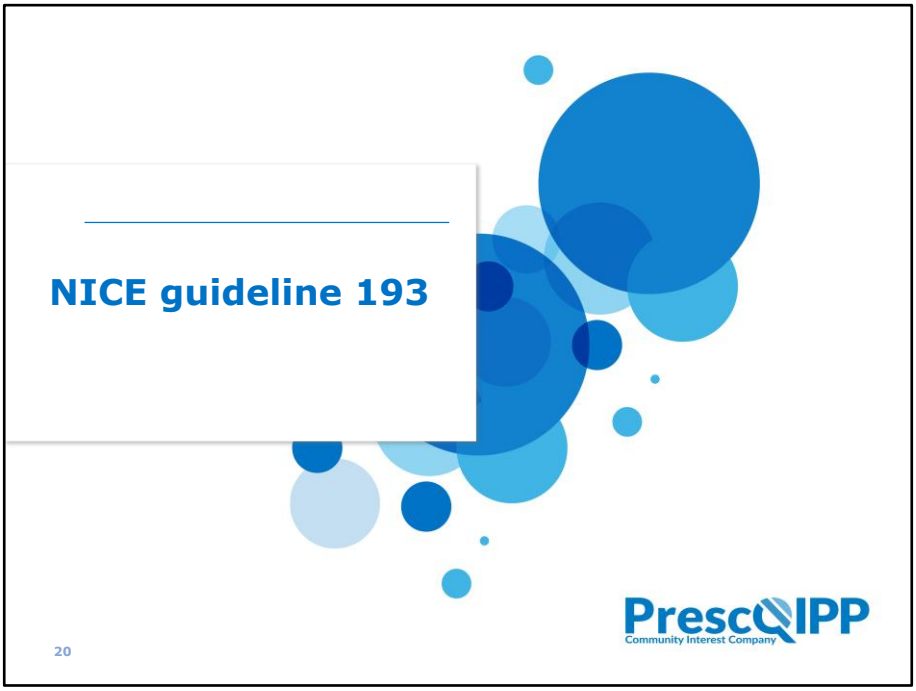
Chronic pain management

- Substantial reduction in pain intensity in chronic pain is rarely an achievable goal
- Pain may be resistant to medication and complete relief of symptoms is not a realistic goal of therapy; 30-50% pain relief may only be achieved
- Reductions in pain intensity for any treatment are very modest
- Maintaining fitness, weight loss, normal activities and a generally healthy lifestyle are important

PrescQIPP

The principal aims of pain management are to enable people with chronic pain to achieve as normal a life as possible by reducing physical disability and emotional distress.



Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain
NICE guideline [NG193]Published: 07 April 2021
https://www.nice.org.uk/guidance/ng193

NG193; Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain (April 2021)

- Defines chronic pain (long-term or persistent pain) as pain that lasts for > 3 months
- Pain can be secondary to an underlying condition
- CPP has no clear underlying condition or the pain or its impact is out of proportion to any observable injury or disease

21

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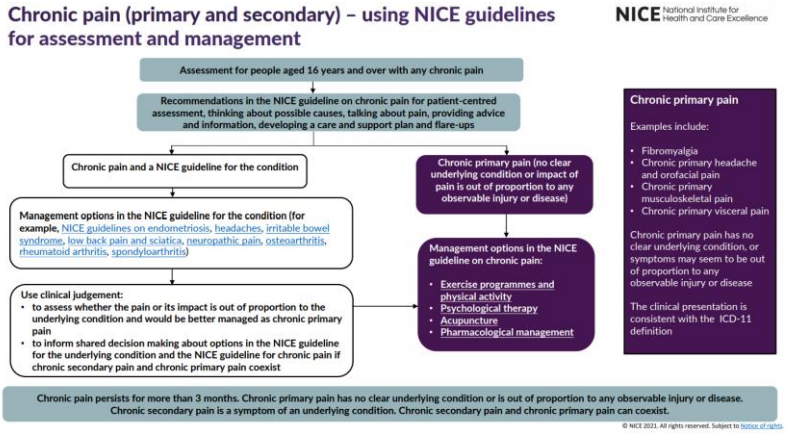
https://www.nice.org.uk/guidance/ng193

Visual summary



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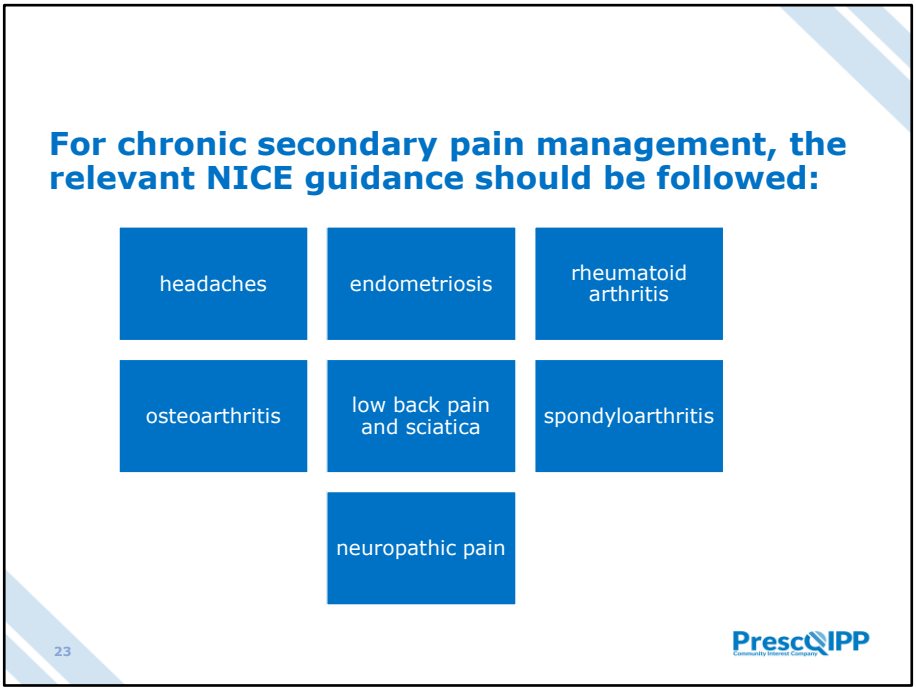
https://www.nice.org.uk/guidance/ng193



Osteoarthritis: care and management
Clinical guideline [CG177]Published: 12 February 2014 Last updated: 11 December 2020 https://www.nice.org.uk/guidance/cg177

Rheumatoid arthritis in adults: management
NICE guideline [NG100]Published: 11 July 2018 Last updated: 12 October 2020
https://www.nice.org.uk/guidance/ng100

Endometriosis: diagnosis and management
NICE guideline [NG73]Published: 06 September 2017
https://www.nice.org.uk/guidance/ng73

Headaches in over 12s: diagnosis and management
Clinical guideline [CG150]Published: 19 September 2012 Last updated: 17 December 2021
https://www.nice.org.uk/guidance/cg150

Low back pain and sciatica in over 16s: assessment and management
NICE guideline [NG59]Published: 30 November 2016 Last updated: 11

December 2020
https://www.nice.org.uk/guidance/ng59

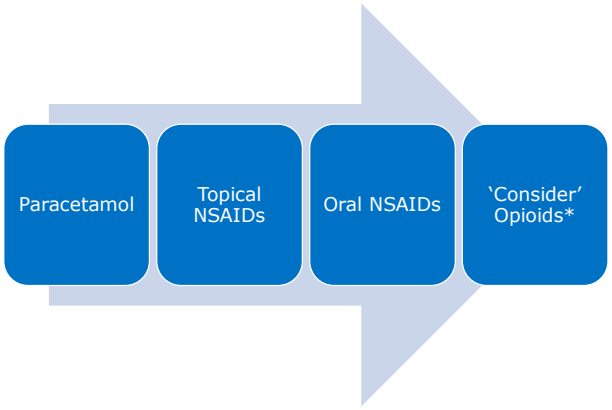
Neuropathic pain in adults: pharmacological management in non-specialist settings
Clinical guideline [CG173]Published: 20 November 2013 Last updated: 22 September 2020
https://www.nice.org.uk/guidance/cg173
Spondyloarthritis in over 16s: diagnosis and management
NICE guideline [NG65]Published: 28 February 2017 Last updated: 02 June 2017
https://www.nice.org.uk/guidance/ng65

Poll

Which of the following NICE guidelines recommend opioids as a treatment option? (Tick all that apply)

- Osteoarthritis
- Headache
- Low back pain and sciatica
- Neuropathic pain

CG177 Osteoarthritis (update due Oct 22)



*Risks and benefits should be considered, particularly in older people.

CG150 Headache

No recommendations for opioids for any type of headache.

NG59 Low back pain and sciatica

- Do not offer opioids for managing chronic sciatica
- Do not offer gabapentinoids, oral corticosteroids or benzodiazepines for managing sciatica as there is no overall evidence of benefit and there is evidence of harm

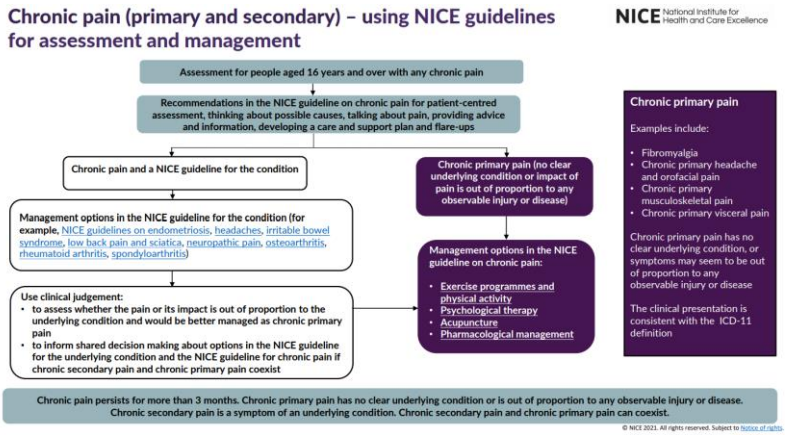
- Consider oral NSAIDs for managing low back pain
- Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective
- Do not offer paracetamol alone for managing low back pain

- Do not routinely offer opioids for managing acute low back pain
- Do not offer opioids for managing chronic low back pain
- Do not offer SSRIs, SNRIs or TCAs for managing low back pain
- Do not offer gabapentinoids for managing low back pain

CG173 Neuropathic pain

- Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain
- Consider tramadol only if acute rescue therapy is needed
- Do not start morphine to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so

Visual summary



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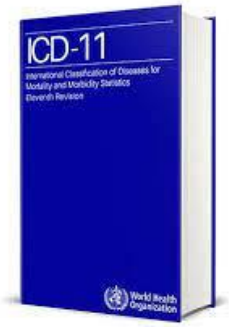
31

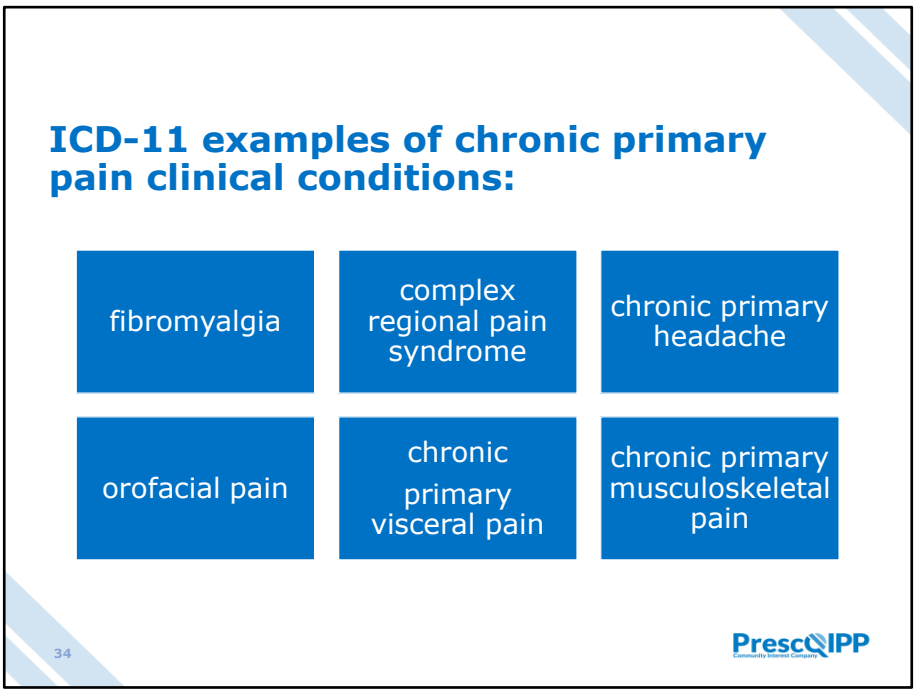
https://www.nice.org.uk/guidance/ng193

Chronic primary pain

- No clear underlying condition or the pain (or its impact) appears to be out of proportion to any observable injury or disease
- Mechanisms underlying CPP are only partially understood and the definitions are fairly new

- All forms of pain can cause distress and disability, but these features are particularly prominent in presentations of CPP
- NG193 is consistent with the ICD-11 definition of CPP





https://icd.who.int/en

Poll

Which of the following does NICE recommend for CPP?

a. acupuncture

b. supervised group exercise

c. antidepressants

d. paracetamol

e. acceptance and commitment therapy

What does NICE recommend?

NICE National Institute for Health and Care Excellence

The Daily Telegraph Tuesday 4 August 2020

Acupuncture or exercise is better than drugs for chronic pain, doctors told

New guidelines to GPs urge them to prescribe alternative therapies rather than medicinal treatment

By Lizzie Roberts

ing disability in daily tasks. It is estimated to affect between one third and one half of the population.

The Nice guidance, which is open for public consultation until Sept 16, recommends that some antidepressants should be considered as treatment, after a review of evidence found advise against anti-epileptic drugs, such as local anaesthetics and ketamine, as there was also little evidence that they work, but they could cause harm.

Instead, treatments such as a group exercise programme or cognitive behavioural therapy are recommended. The committee also said "a

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Exercise programmes and physical activity for CPP

- Recommendations 1.2.1 and 1.2.2

- **Offer** a supervised group exercise programme to people aged ≥ 16 to manage CPP
- Take people's specific needs, preferences and abilities into account
- Encourage people with chronic primary pain to remain physically active for longer-term general health benefits

Non-pharmacological management of chronic primary pain
Exercise programmes and physical activity for chronic primary pain
1.2.1 Offer a supervised group exercise programme to people aged 16 years and over to manage chronic primary pain. Take people's specific needs, preferences and abilities into account.
1.2.2 Encourage people with chronic primary pain to remain physically active for longer-term general health benefits (also see NICE guidelines on physical activity and behaviour change: individual approaches).

Physical activity: https://www.nice.org.uk/guidance/ph54
Behaviour change: https://www.nice.org.uk/guidance/ph49

Rationale for exercise and physical activity

- Evidence showed that exercise reduced pain (23 studies) and improved quality of life (22 studies) compared with usual care
- No evidence suggesting effectiveness differed for types of CPP
- Limited evidence comparing different types of exercise and minimal differences between the types

Exercise programmes and physical activity for chronic primary pain
Recommendations 1.2.1 and 1.2.2
Why the committee made the recommendations
Evidence from many studies showed that exercise reduced pain (23 studies) and improved quality of life (22 studies) compared with usual care in people with chronic primary pain. Benefit was seen for both short- and long-term follow up and was consistent across different types of exercise. Most of the evidence was for professionally led supervised group exercise and for women with fibromyalgia or people with chronic neck pain. As there was no evidence to suggest that effectiveness differed for types of chronic primary pain it was agreed there was no reason this evidence could not apply for the whole review population. There was limited evidence comparing different types of exercise with each other although, from what was available, there was minimal difference between the types. The committee agreed the most appropriate type of exercise may depend on the type of pain. For these reasons, the committee did not specify what type of exercise should be used, and agreed it could be any of the types included in the studies reviewed (cardiovascular, mind–body, strength, or a combination of approaches). An economic model comparing exercise (all types) with no exercise was developed for this guideline and showed that exercise was likely to be cost effective (both if using only the time horizon of the trials and also when extrapolating the quality of life gain beyond the trials). The analysis used studies in which exercise was predominantly group based. The committee considered

the results to be robust, and agreed that the studies used in the model were representative of the whole evidence review. Exercise remained cost effective when the assumed benefits and costs were varied (sensitivity analysis). There were no negative effects demonstrated except for more people discontinuing from exercise programmes. The committee agreed that people are more likely to continue with exercise if the programme offered suits their lifestyle and physical ability and addresses their individual health needs. They agreed that the choice of programme as well as the content should take into account people's abilities and preferences. This might include providing individual exercise advice for different members of a group. The committee's experience was that many people with chronic primary pain find it difficult to be physically active. The committee agreed that it is important for these people to continue to be physically active after a formal exercise programme ends, but the type of physical activity should be sustainable for the person.

Psychological therapy for CPP

- Recommendations 1.2.3 and 1.2.4

- **Consider** acceptance and commitment therapy (ACT) or cognitive behavioural therapy (CBT) for pain for people aged ≥ 16 with CPP
- PrescQIPP webinar (June 2020) on ACT in relation to opioid reduction

Psychological therapy for chronic primary pain

1.2.3 Consider acceptance and commitment therapy (ACT) or cognitive behavioural therapy (CBT) for pain for people aged 16 years and over with chronic primary pain, delivered by healthcare professionals with appropriate training.

1.2.4 Do not offer biofeedback to people aged 16 years and over to manage chronic primary pain.

PrescQIPP webinar (June 2020) on Acceptance and commitment therapy (ACT) in relation to opioid reduction

https://www.prescqipp.info/our-resources/clinical-webinars/opioid-reduction-motivational-interviewing-blended-with-acceptance-and-commitment-therapy-act-to-achieve-lasting-change/

Rationale for psychological therapies

- Most of the evidence showed that ACT improved quality of life and sleep, and reduced pain and psychological distress
- Evidence from a small number of studies, 1 economic evaluation also showed ACT to be cost effective

ACT = acceptance and commitment therapy
CBT = cognitive behavioural therapy

Psychological therapy for chronic primary pain
Recommendations 1.2.3 and 1.2.4
Why the committee made the recommendations
ACT for chronic primary pain
Most of the evidence showed that acceptance and commitment therapy (ACT) improved quality of life and sleep, and reduced pain and psychological distress. Although clinical evidence was from a fairly small number of studies, 1 economic evaluation also showed ACT to be cost effective. The committee agreed that ACT was likely to offer a good balance of benefits and costs and so recommended that it should be considered as a psychological therapy for chronic primary pain. There was not enough evidence to support a preference for ACT over cognitive–behavioural therapy (CBT) or CBT over ACT.

CBT for chronic primary pain
Most of the evidence showed that CBT for pain improved quality of life for people with chronic primary pain. A consistent benefit was not demonstrated in other outcomes, but the committee considered that the evidence may have underestimated the benefits because the studies varied in terms of the level of training of the therapists and the way

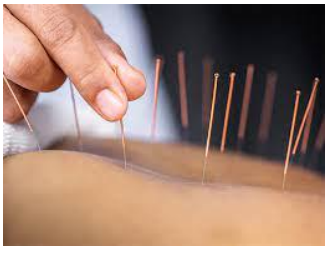
the therapy was delivered. There was no strong evidence of harm. Two economic evaluations also showed CBT to be cost effective. The committee agreed that the evidence was not of high quality so they decided to recommend that CBT (for pain) is considered, rather than making a stronger recommendation to offer CBT (for pain). Although there was some benefit of CBT for insomnia (CBT-I), particularly for quality of life and sleep, the amount of evidence was smaller and did not include economic evidence, so was insufficient to justify a practice recommendation. The committee agreed to make a research recommendation for CBT-I to inform future guidance (see research recommendation 2).

- Most of the evidence (not high quality) showed that CBT for pain improved quality of life for people with CPP
  - Consistent benefit was not demonstrated for other outcomes but no strong evidence of harm
  - Some benefit of CBT for insomnia but smaller amount of evidence
- Insufficient evidence to recommend biofeedback, relaxation, mindfulness, psychotherapy, pain education, sleep hygiene or hypnosis for CPP

Acupuncture for CPP

- Recommendations 1.2.5

- **Consider** a single course of acupuncture or dry needling, within a traditional Chinese or Western acupuncture system, for people aged ≥ 16 to manage CPP, but only if the course:



- is delivered in a community setting and
- is delivered by a band 7 (equivalent or lower) HCP with appropriate training and
- is made up of no more than 5 hours of healthcare professional time or
- is delivered by another healthcare professional and/or in another setting for equivalent or lower cost

Rationale for acupuncture

- Evidence (27 studies) - acupuncture reduced pain and improved quality of life in the short term (up to 3 months) compared with usual care or sham acupuncture
- Not enough evidence to determine longer term benefits
- Wide variation among the studies in the type and intensity of the intervention used, and the studies were from many different countries

Acupuncture for chronic primary pain

Recommendation 1.2.5

Why the committee made the recommendation

Many studies (27 in total) showed that acupuncture reduced pain and improved quality of life in the short term (up to 3 months) compared with usual care or sham acupuncture. There was not enough evidence to determine longer term benefits. The committee acknowledged the difficulty in blinding for sham procedures, but agreed that the benefit compared with a sham procedure indicated a specific treatment effect of acupuncture. There was a wide variation among the studies in the type and intensity of the intervention used, and the studies were from many different countries. The committee agreed that the type of acupuncture or dry needling should depend on the individual needs of the person with pain. Two economic evaluations (1 in the UK) showed that acupuncture offered a good balance of benefits and costs for people with chronic neck pain. However, both studies had limitations; a notable limitation being that the costs of acupuncture seemed low. Threshold analysis based on these studies indicated the maximum number of hours of a band 6 and 7 healthcare professional's time that would make the intervention cost effective. An original economic model was developed for this guideline, which compared acupuncture with no acupuncture. The model used data from studies with usual care comparisons, not comparisons with sham acupuncture, because the committee agreed that a usual care comparison in an economic model better reflects the real world benefit of the intervention.

The model showed that acupuncture was likely to be cost effective. The committee considered the results to be robust, and agreed that the studies used in the model were representative of the whole evidence review. Acupuncture remained cost effective when the assumed benefits and costs were varied (sensitivity analysis). Overall, the committee agreed that there was a large evidence base showing acupuncture to be clinically effective in the short term (3 months); the original economic modelling also showed it is likely to be cost effective. However, they were uncertain whether the beneficial effects would be sustained long term and were aware of the high resource impact of implementation. Taking these factors into account, the committee made a recommendation to consider acupuncture or dry needling for chronic primary pain, caveated by the factors likely to make the intervention cost effective. These were: only if delivered in the community, and with a maximum of 5 treatment hours (based on the average resource use in the trials in the model and on the threshold analysis), and from a band 7 (equivalent cost or lower) healthcare professional (based on the threshold analysis). It was agreed there may be different ways of delivering the service that enable acupuncture to be delivered for the same costs, which would equally be appropriate. The committee agreed that discontinuing before this total amount of course time would be an option if the person finds that the first few sessions are not effective. No evidence was found to inform a recommendation for repeat courses of acupuncture. The committee agreed that further research would help to inform future practice (see research recommendation 4). How the recommendation might affect practice There is variation in the availability and use of acupuncture for chronic primary pain.

- 2 economic evaluations (1 in the UK) with some limitations, showed that acupuncture offered a good balance of benefits and costs for people with chronic neck pain
- No evidence was found to inform a recommendation for repeat courses of acupuncture

Pharmacological management of CPP - antidepressants

- Recommendations 1.2.7 to 1.2.9

- **Consider** an antidepressant, for people aged ≥ 18 to manage CPP, after a full discussion of the benefits and harms
- Consider amitriptyline, citalopram, duloxetine, fluoxetine, paroxetine or sertraline (off-label)
- Seek specialist advice if antidepressants being considered for young people aged 16 to 17

Explain that these medicines may help with quality of life, pain, sleep and psychological distress, even in the absence of a diagnosis of depression.

Rationale for antidepressants

Evidence showed antidepressants improved quality of life, pain, sleep and psychological distress compared with placebo:

- Some limitations in the quality and amount of the evidence
- Most of the evidence was for women with fibromyalgia but no evidence demonstrating a different response to treatment in other conditions
- Efficacy of antidepressants should be reviewed at 4 to 6 weeks

SSRI = selective serotonin reuptake inhibitors
SNRI = serotonin and noradrenaline reuptake inhibitors

Pharmacological management for chronic primary pain
Recommendations 1.2.7 to 1.2.15
Why the committee made the recommendations
Antidepressants for chronic primary pain
Evidence indicated that antidepressants (amitriptyline, citalopram, duloxetine, fluoxetine, paroxetine and sertraline) improved quality of life, pain, sleep and psychological distress compared with placebo. But there were some limitations in the quality and amount of the evidence. Most of the evidence was for women with fibromyalgia. However, included evidence from other types of chronic primary pain was consistent with these findings. The committee agreed that there was no evidence demonstrating a different response to treatment in other chronic primary pain conditions, and therefore it was agreed there was no reason this recommendation could not apply to all chronic primary pain conditions. The antidepressants were considered by class, but evidence was only available for certain drugs within each class. The committee agreed these should be stated in the recommendation. No evidence was identified that compared antidepressant classes with each other, and the committee agreed that although there were some inconsistencies in benefits observed between classes, they could not assume one class to be more or less effective than

another. Duloxetine (the only SNRI with evidence for chronic primary pain) had a larger amount of long-term evidence of effectiveness. However, due to the lack of head-to-head comparisons between the antidepressant classes, the committee could not recommend duloxetine in preference to the other antidepressants for which there was evidence. The committee agreed to recommend considering any of the antidepressants for which there was evidence of benefit. The decision of which antidepressant to try should be based on a fully informed discussion with the person with chronic primary pain, taking into account the risks and benefits. Although none of the antidepressants have marketing authorisations for chronic primary pain, there are no licensed alternatives for this indication and these medications are already used in practice for this purpose. The committee agreed that doses of SSRIs and SNRIs should be in line with BNF recommendations for depression. For amitriptyline, the evidence indicating benefit included very low doses of 5 mg per day. The committee therefore agreed it was appropriate to start amitriptyline at the lowest possible dose and titrate up to no more than 100 mg per day. Efficacy of antidepressants should be reviewed at 4 to 6 weeks. No evidence was identified for people aged 16 to 17 years. The committee agreed that if pharmacological management was being considered for people of this age, specialist advice should be sought. The committee agreed that the risk of withdrawal symptoms should be considered when prescribing antidepressants and these should not be continued if they were not effective. They recommended that the recommendations in the NICE guideline on depression in adults should be followed if stopping or reducing antidepressants.

- No evidence comparing antidepressant classes with each other or for young people
- Evidence was only available for certain drugs within each class and these are listed in the recommendation
- Doses of SSRIs and SNRIs should be in line with BNF recommendations for depression
- For amitriptyline, very low doses of 5 mg per day showed benefit, so start at the lowest possible dose and titrate up to no more than 100 mg per day

Poll

Which of the following does NICE **not** recommend for CPP? (Tick all that apply)

a. gabapentinoids

b. opioids

c. NSAIDs

d. benzodiazepines

e. paracetamol

Pharmacological management of chronic primary pain - do not initiate

- Recommendation 1.2.10

- antiepileptic drugs including gabapentinoids
  - unless as part of a clinical trial for complex regional pain syndrome
- antipsychotic drugs
- benzodiazepines
- corticosteroid trigger point injections
- ketamine
- local anaesthetics (topical or intravenous)
  - unless as part of a clinical trial for complex regional pain syndrome
- local anaesthetic/corticosteroid combination trigger point injections
- NSAIDs
- opioids
- paracetamol

Pregabalin and gabapentin (gabapentinoids) are Class C controlled substances (under the Misuse of Drugs Act 1971) and scheduled under the Misuse of Drugs Regulations 2001 as Schedule 3. Evaluate patients carefully for a history of drug misuse before prescribing and observe patients for development of signs of misuse and dependence (MHRA Drug Safety Update April 2019).

Pharmacological management of CPP – review of existing treatments

- Recommendations 1.2.11 and 1.2.12
- If a person with CPP is already taking any of these medicines, review the prescribing as part of shared decision making:
  - explain the lack of evidence
  - agree a shared plan for continuing safely if they report benefit or
  - explain the risks of continuing if they report little benefit or significant harm
  - …encouraging and supporting them to reduce and stop the medicine, if possible

Possible implementation issues

- Recommendations reflect best practice but variation across NHS
- Implementation is challenging where recommendations vary from other national bodies
- Commissioning of new services maybe required
- Potential disinvestment in other interventions or services
- Education and training around key messages and support for change

How the recommendations might affect practice

The recommendations reflect best practice, but are currently implemented to varying degrees across NHS settings and will involve a change of practice for some providers. To fully implement these recommendations for people with chronic pain, longer consultations or additional follow-up may be needed to discuss self-management and treatment options.

The types of exercise programmes currently offered vary from place to place, often determined by the needs of the local population. In areas where supervised group exercise is currently not provided, implementing the recommendation will lead to increased resource use, The committee discussed that if costs are incurred by engaging in physical activity after a formal exercise programme ends, this would be a personal cost for people with chronic primary pain, and would not fall to the NHS.

There is variation in the availability and use of acupuncture for chronic primary pain, with a recent reduction in these services. The recommendation is expected to lead to increased use and need for acupuncture services and therefore to have a resource impact. This is due to the number of people with chronic primary pain, and acupuncture usually being an individual patient intervention and so staff intensive.

There is currently variation in the use of drugs to treat chronic primary pain. The

recommendations are likely to have a resource impact in the short term because there may be increased resource use from helping people to stop treatments, particularly opioids and gabapentinoids. SNRI antidepressants are also slightly more expensive than other types of antidepressant such as tricyclics, but this does depend on dose. In the longer term, the recommendations should reduce the use of drugs for managing chronic primary pain, with a consequent reduction in harms and cost savings.

Consultation comments (see https://www.nice.org.uk/guidance/ng193/history), relevant themes:
Redesign of care pathways e.g. ACT/CBT often accessed through pain management services
Availability of withdrawal services
Applicability of recommendations to specific populations e.g. health and justice system
Availability of recommended interventions

British Pain Society:

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

https://www.britishpainsociety.org/mediacentre/news/bps-statement-on-new-nice-chronic-pain-guidelines/

"This guidance could encourage busy non-specialist clinicians to withdraw existing medication other than antidepressants in an overzealous fashion. While NICE wrote back reassuringly to concerned stakeholders that "The committee agree that the guideline should not be interpreted to mean all medicines should be withdrawn", no such caveat was given in the final guidance".

Faculty of Pain Medicine:

https://fpm.ac.uk/fpm-concerns-regarding-new-nice-chronic-pain-guidelines

"Potential withdrawal of useful medications from patients by GPs"

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

Discussion

How straightforward is NG193 to implement?

What access do you have locally to non-pharmacological interventions e.g. exercise, psychological therapies, acupuncture?

How will you engage patients with CPP taking medicines other than antidepressants?


Public Health England
Prescribed Medicines Review
September 2019
PrescQIPP
Community Interest Company
57

PHE Prescribed Medicines Review

Public Health England (PHE) was commissioned to identify the scale, distribution and causes of prescription drug dependence, and what might be done to address it.

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58

https://www.gov.uk/government/publications/prescribed-medicines-review-report

The review covered adults (aged 18 and over) and 5 classes of medicines:

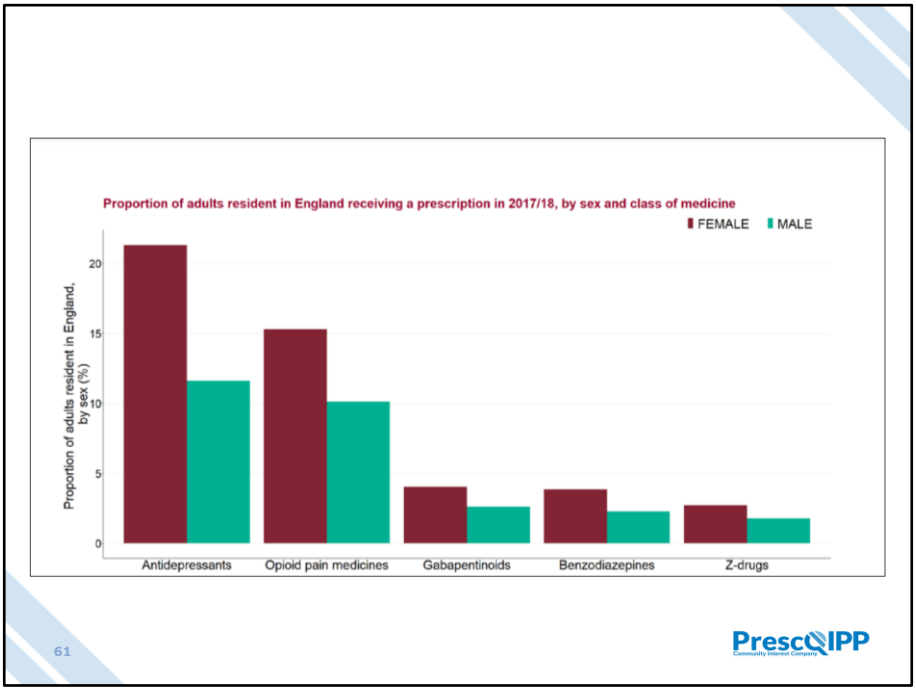
- benzodiazepines
- z-drugs
- gabapentin and pregabalin
- opioids for chronic non-cancer pain
- antidepressants

NB Antidepressants, although historically not classified as dependence-forming medicines, can cause withdrawal symptoms when they are stopped.

Prevalence

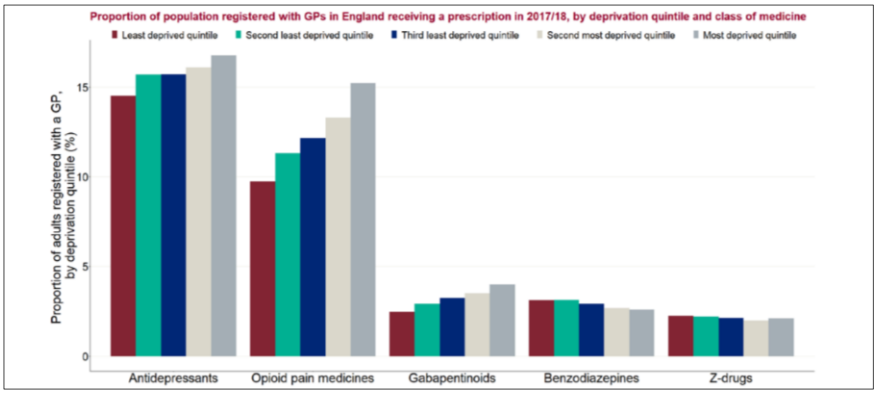
- antidepressants 7.3 million people (17% of the adult population)
- opioid pain medicines 5.6 million (13%)
- gabapentinoids 1.5 million (3%)
- benzodiazepines 1.4 million (3%)
- z-drugs 1.0 million (2%)

Large variations in the standardised rates of prescribing across CCGs.



Rates of prescribing were higher for women (1.5 times those of men), and the rates generally increased with age

Associations with deprivation



62

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Prescribing rates for opioids and gabapentinoids had a strong association with deprivation, being higher in areas of greater deprivation

For all medicine classes the proportion of patients who had at least a year of prescriptions increased with higher deprivation

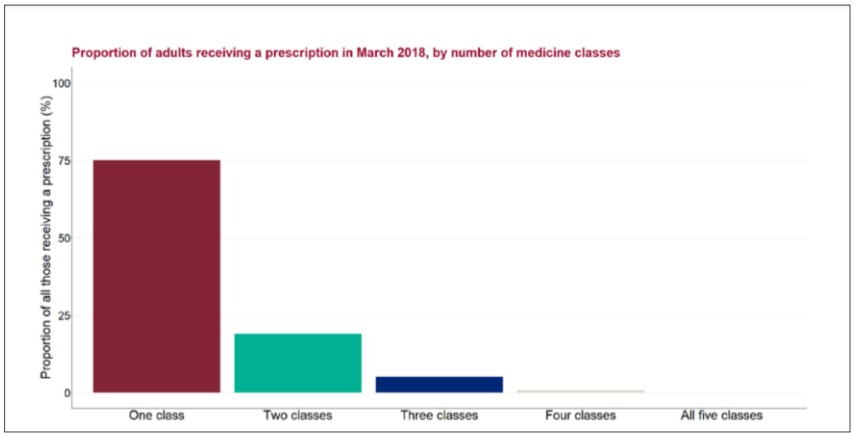
Trends and demographics

- Between 2015/16 and 2017/18 the rate of prescribing for antidepressants increased from 15.8% of the adult population to 16.6% and for gabapentinoids from 2.9% to 3.3%
- There was a small decrease in prescribing rates for the other 3 medicine classes

Trends and demographics

- After a long increasing trend, the annual number of prescriptions for opioid pain medicines has slightly decreased since 2016
- There is a continuing longer-term fall in prescription numbers for benzodiazepines
- A longer-term increase in annual prescription numbers for z-drugs started to reverse in 2014

Co-prescribing



Time receiving prescriptions

Around half of patients in each medicine class were estimated to have been receiving a prescription continuously for at least 12 months.

Time receiving prescriptions

The number of patients who received a prescription continuously between April 2015 (and perhaps earlier) and March 2018 was as follows:

- antidepressants 930,000 people
- opioid pain medicines 540,000
- gabapentinoids 160,000
- benzodiazepines 120,000
- z-drugs 100,000

Patients' experiences

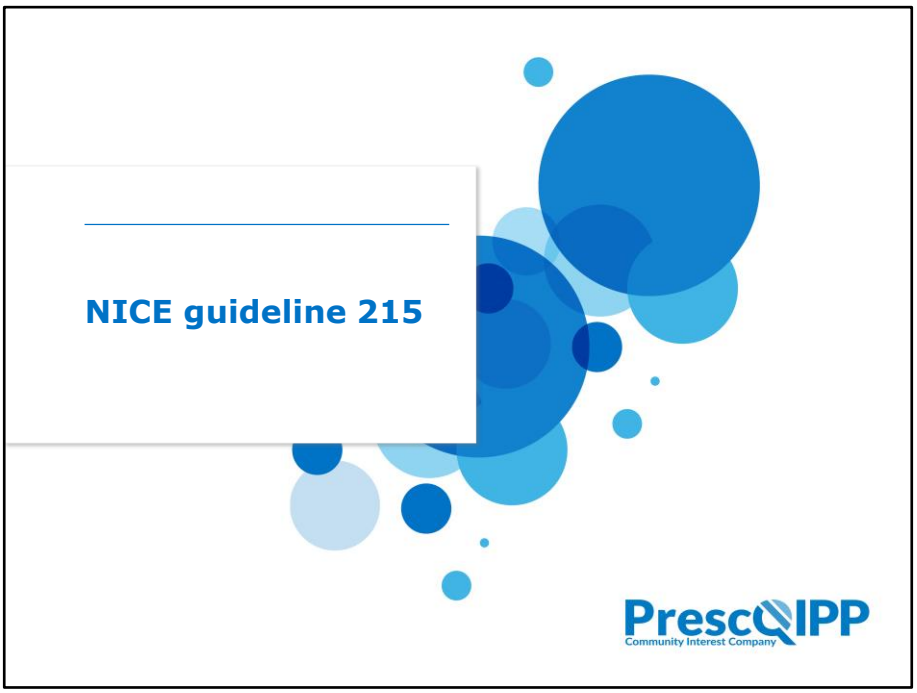
Some patients reported harmful effects and withdrawal symptoms on stopping benzodiazepines, z-drugs, opioids and antidepressants which affected their well-being, personal, social and occupational functioning. These effects and symptoms could last many months.

Patients' experiences

- Higher initial opioid doses and prior mental health problems were associated with long-term use of opioids and opioid dependence, respectively
- Prescribing opioid pain medicines for longer than 90 days was associated with opioid overdose and dependence

Patients' experiences

- Patients experienced barriers to accessing and engaging in treatment services
- They felt there was a lack of information on the risks of medication and that doctors did not acknowledge or recognise withdrawal symptoms
- Patients described not being offered any non-medicinal treatment options, their treatment not being reviewed sufficiently and a lack of access to effective management and NHS support services



https://www.nice.org.uk/guidance/ng215/chapter/Recommendations

Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults: April 2022

- Covers prescribing and managing withdrawal from opioids, benzodiazepines, gabapentinoids, Z-drugs and antidepressants
- Assumes non-pharmacological treatment options have been discussed and offered where appropriate before these medicines are prescribed

Does not cover use of opioids prescribed for acute pain, cancer pain or at the end of life.

Contents:

- Supporting people taking a DFM or antidepressant
- Making decisions about prescribing a DFM or antidepressant
- Starting a DFM or antidepressant
- Reviewing a DFM or antidepressant
- Withdrawing a DFM or antidepressant

Any questions / comments?
Break

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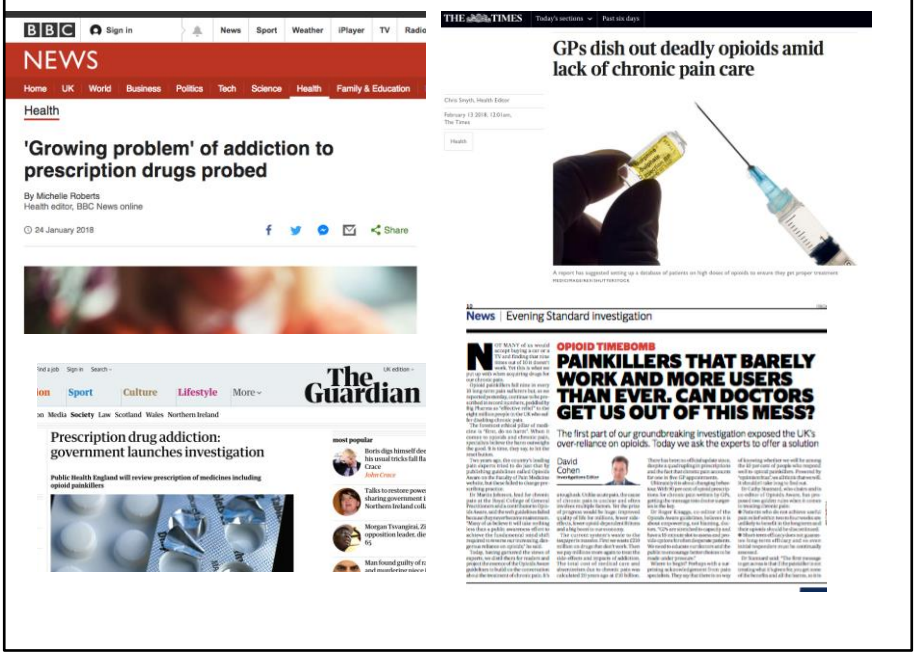
Reducing opioid prescribing in chronic pain
PrescQIPP
Community Interest Company



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Health

'Growing problem' of addiction to prescription drugs probed

By Michelle Roberts
Health editor, BBC News online

24 January 2018 Share

THE TIMES Today's sections Past six days

GPs dish out deadly opioids amid lack of chronic pain care

Chris Smyth, Health Editor

February 13 2018, 12:01am, The Times

Health

A report has suggested setting up a database of patients on high doses of opioids to ensure they get proper treatment

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Prescription drug addiction: government launches investigation

Public Health England will review prescription of medicines including opioid painkillers

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Morgan Tsvangirai, Zi opposition leader, die 65

Man found guilty of r and murdering niece

News | Evening Standard investigation

OPIOID TIMEBOMB

PAINKILLERS THAT BARELY WORK AND MORE USERS THAN EVER. CAN DOCTORS GET US OUT OF THIS MESS?

The first part of our groundbreaking investigation exposed the UK's over-reliance on opioids. Today we ask the experts to offer a solution

David Cohen
Investigations Editor

Levels of consumption of narcotic drugs in defined daily doses for statistical purposes per million inhabitants per day (excluding preparations in schedule III)

Global Ranking	Country	Total DDD
1	United States	46 090
2	Canada	30 570
3	Germany	28 842
4	Austria	21 279
5	Denmark	21 055
6	Switzerland	19 668
7	Belgium	19 199
8	Australia	15 713
10	Netherlands	14 882
12	United Kingdom	14 648
16	Ireland	11 592

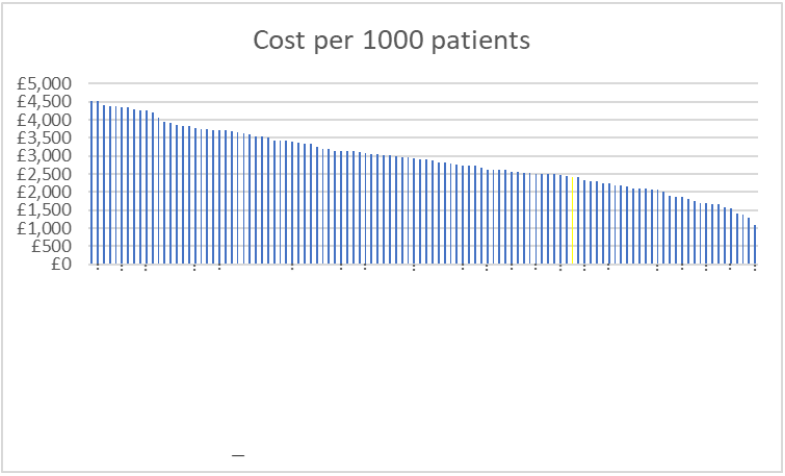
Data extracted from
International Narcotics Control Board Narcotic Drugs report 2018 Estimated World Requirements for 2018 - Statistics for 2016 (United Nations)

Poll

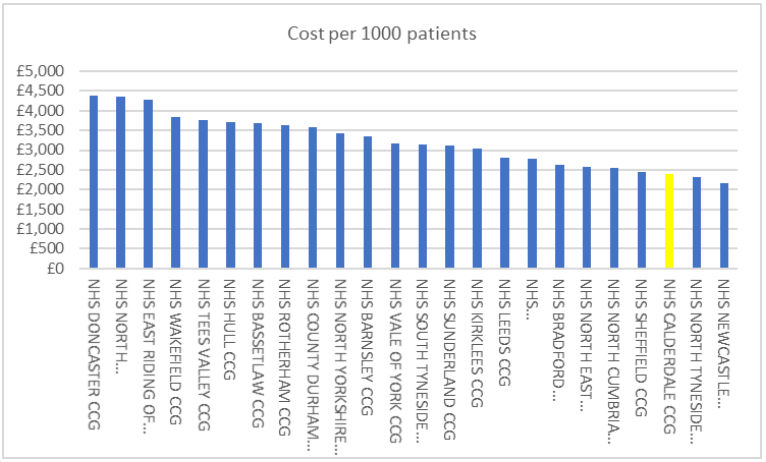
Do you think that over-prescribing of opioids *might* be a problem in your practice?

- Yes
- No
- Don’t know

Calderdale CCG versus national
Strong opioids Feb 21-Jan 22



Calderdale CCG versus region
Strong opioids Feb 21-Jan 22



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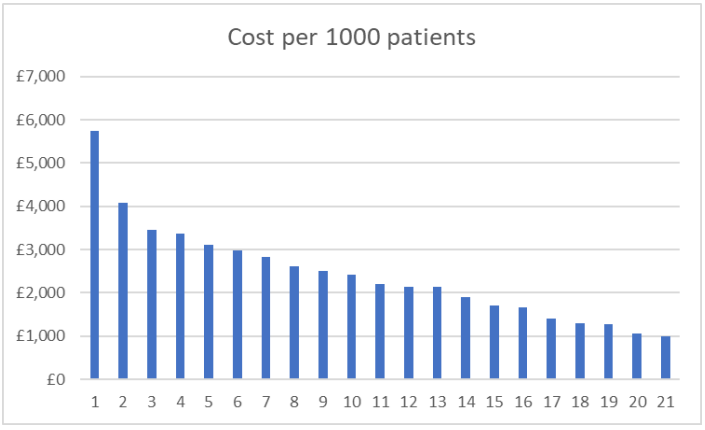
Calderdale CCG – by practice
Strong opioids Feb 21-Jan 22



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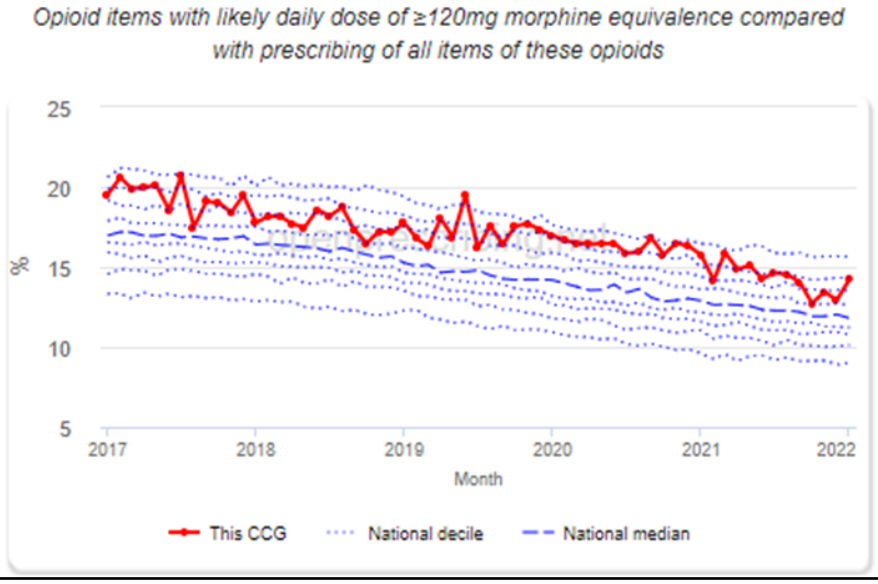
January 2022 – 79th percentile



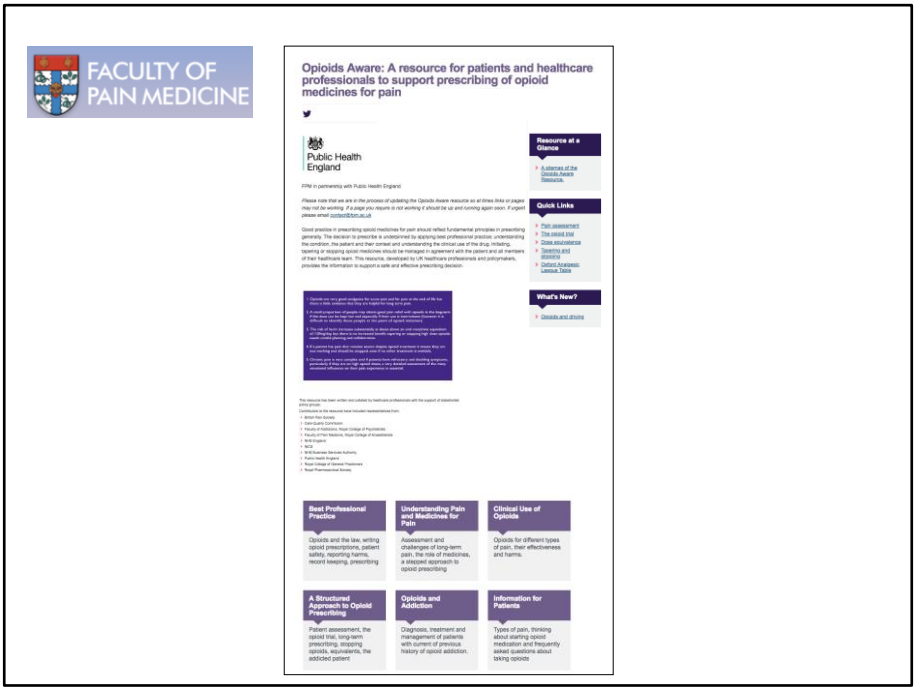
Why are opioids prescribed?

Because…

- they are strong analgesics
- persistent pain is hard to treat so something strong is a tempting idea
- pain sufferers exhibit distress
- distress makes clinicians want to do something
- we know there are risks but think we can handle them

- There are concerns that patients are being moved up the opioid ladder towards potent opioids inappropriately and without considering other drug and non-drug aspects of care
- The potential social and medical harms of opioids have been significantly underestimated

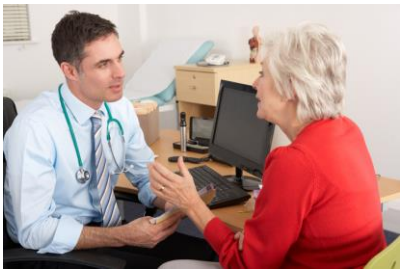

Opioid efficacy and trial of treatment
PrescQIPP
Community Interest Company



https://www.fpm.ac.uk/opioids-aware

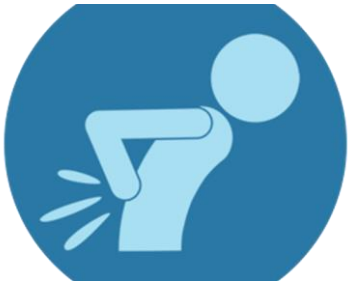
NICE NG215

Before starting or continuing treatment with an opioid, ensure that all relevant management options, including non-pharmacological treatment and watchful waiting, have been discussed with and offered to the person.



Opioid efficacy in chronic pain

Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.



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Limitations in clinical trials

- Most opioid trials 12 weeks or less
- Patients have discrete pain diagnoses
- Lack the physical and emotional co-morbidities of patients seen in clinical practice
- High drop-out due to adverse events
- Use of "Last observation carried forward"

Opioids aware

"If trial data are interpreted such that treatment success should include BOTH pain relief at 12 weeks AND ability to keep taking the tablets, then opioids are no better than placebo.

EVERY single RCT in chronic pain using this interpretation comes to this same result".

What about > 12 weeks?

- Open-label extension data suggest that a small proportion of patients may derive continuing benefit from opioids in the long term
- Relevance to clinical practice is uncertain as patients with co-morbidities that may predispose to problematic opioid use are generally excluded from clinical trials

Observational data

- Prospective cohort studies suggest that opioids delay return to work after injury and may prolong or worsen functional recovery
- Opioid use appears to be associated with poorer quality of life and employment status, increased healthcare use, and worse pain

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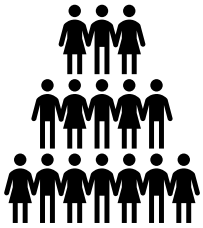
- There are likely to be patients for whom drugs that cannot be shown to be efficacious in RCTs ‘work’ for them
- Opioids *may* reasonably be included in the repertoire of *cautious* attempts to find some therapy that works when all the obvious ones have been tried

A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and use is intermittent, but it is difficult to identify these people at the start of treatment.



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NG215

Factors that might increase the person's risk of developing problems associated with dependence:

- comorbid mental health diagnosis
- history of drug misuse
- not having a clear, defined diagnosis to support the prescription
- taking an opioid together with a benzodiazepine

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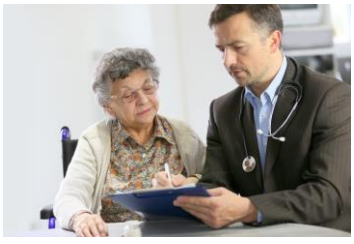
Shared decision making

At the first appointment, give the person information and advice to help them balance the potential benefit of the medicine and other treatment options in treating their current symptoms with the risk of long-term consequences.



- Recognise and acknowledge that decisions about medicines can be difficult for a person who is in distress
- Consider delaying prescribing until after the first appointment to allow time for the person to think about their options, and for you to consult with other members of the healthcare team if needed

If a shared decision about starting (or continuing) a medicine cannot be reached and the medicine is not in the person's best interests, follow the GMC advice on 'handling patient requests for medicines you don't think will benefit them'.


General Medical Council

Good practice in prescribing and managing medicines and devices

99

GMC Good practice in prescribing and managing medicines and devices https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices

You should:

- not prescribe a medicine if you believe it is not in the person's best interests
- explain the reasons for your decision to the person
- document all discussions carefully and give a copy to the person
- offer the person a second opinion.

- Before starting treatment with an opioid, give the person verbal and written information
- Evidence-based and understandable

Explain:

- the potential side effects
- the additional implications if the person is pregnant or planning pregnancy, if appropriate
- what the options might be if the medicine does not work
- how difficult it might be to stop the medicine later
  - the risk of developing dependence
  - the symptoms and signs of dependence
  - the risk of developing tolerance

Poll

If I initiate a strong opioid I use a short trial of treatment initially.

- Always
- Mostly
- Sometimes
- Not applicable

Trial of treatment

- 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 opioid trial establishes whether the patient achieves any reduction in pain with use of opioids

The opioid trial

Patients who do not achieve useful pain relief from opioids within 2-4 weeks are unlikely to gain benefit in the long term.

PrescQIPP

Agree a management plan:

- what the medicine has been prescribed for, the intended outcomes of treatment and how these might be assessed
- the starting dose and intervals between dose adjustments or titrations
- who to contact if problems occur
- information about how long the medicine will take to work and how long they might be taking it for
- the plans for review

106

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Agree a management plan – copy to the patient:

Duration of the trial

- If the patient has constant pain, the opioid trial may be concluded in one or two weeks
- If the patient has intermittent disabling flare ups of pain on a background of more manageable symptoms, the trial should be long enough to observe the effect of opioids on 2-3 episodes of increased pain

NG215

Take steps to reduce the risk of developing problems associated with dependence, for example starting at a low dose, and consider avoiding modified-release opioids.

Opioids aware

- Prescribe a short (1-2 week supply) of immediate-release morphine tablets or liquid
- The patient may be advised to try different doses within a specified range e.g. morphine 5-10mg
- If reduction in pain is not achieved following a single dose of IR morphine 20mg, opioids are unlikely to be beneficial in the long term

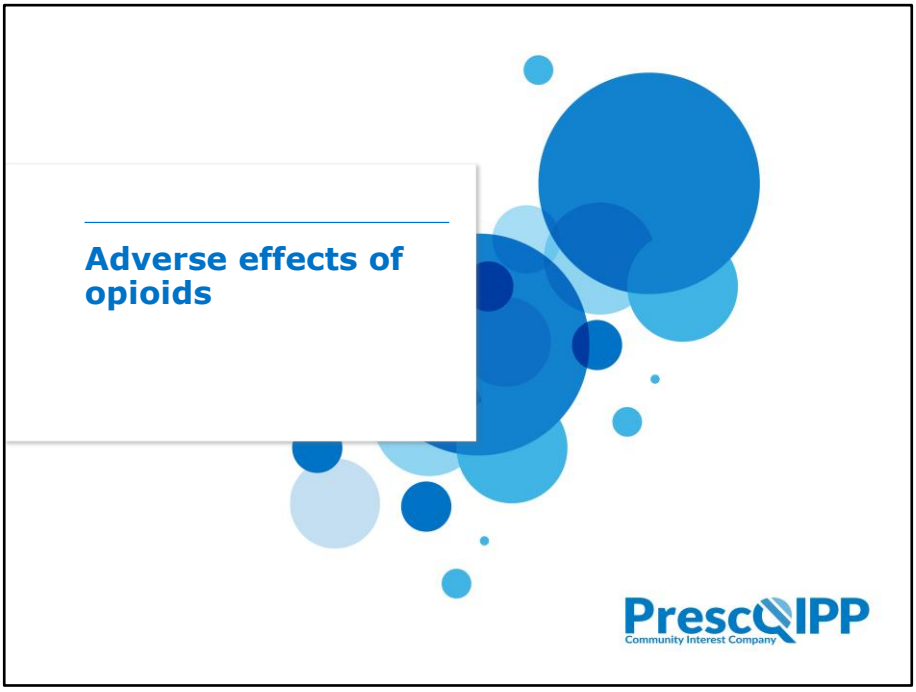
Assessing success

- Patient should keep a diary during the opioid trial
- Twice-daily report of pain intensity, sleep, activity levels
- All doses of opioid should be recorded in the diary with a comment on side effects

- If the opioid trial is not successful (for example pain is not reduced by 30-50% or other, pre-agreed objective), the drug should be tapered and stopped within one week
- If the patient reports no improvement in symptoms following the trial it is very unlikely that long-term opioid therapy will be helpful

A successful short-term opioid trial does not predict long-term efficacy, which may be limited by adverse effects or declining efficacy.

Increasing the opioid dose above 120mg/day oral morphine equivalent is unlikely to yield further benefits but exposes the patient to increased harm.


Adverse effects of opioids
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Community Interest Company

Poll

Up to what % of patients will experience at least one adverse effect from opioids?

- 20%
- 40%
- 60%
- 80%
- 100%

Adverse effects of opioids

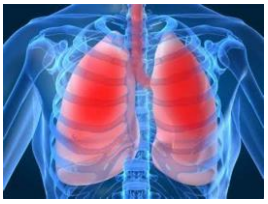
- 80% of patients taking opioids will experience at least one adverse effect
- Patients should be advised about side effects and the likelihood of their occurrence before starting opioid therapy
- Most common - constipation, nausea, somnolence, itching, dizziness and vomiting
- Should be managed actively with antiemetics, laxatives and antihistamines, or by dose reduction

Tolerance

- Tolerance to some side effects usually occurs within the first few days of initiating treatment; pruritis and constipation tend to persist
- Patients using intermittent dosing schedules may not become tolerant to side effects

Respiratory depression

- Only likely to be a potential problem if there have been major changes in dose, formulation or route of administration or if the person's general health deteriorates
- Accidental overdose is likely to be the commonest cause of respiratory depression



Respiratory depression

Particular caution is necessary for patients taking more than one class of sedative medication, such as benzodiazepines, gabapentin or pregabalin, and in those with pre-existing disorders of respiratory control, such as obstructive sleep apnoea.

Long term effects of opioids

- Opioids increase the risk and incidence of falls
- Of particular importance in elderly patients
- In a systematic review of six observational studies, the relative risk of any fracture in patients on opioids compared to non-users was 1.38 (95% CI 1.15 to 1.66)

Endocrine effects

Endocrine effects are probably dose related:

- amenorrhoea in women
- reduced libido in both sexes
- erectile dysfunction in men
- infertility
- depression
- fatigue

Immunomodulating effect

- Mediated via opioid receptors both on immune effector cells and in the central nervous system
- Patients on long-term opioids may be more susceptible to infection

Opioid induced hyperalgesia

- Clinically, the patient on long term opioid therapy presents with increased pain
- This might be qualitatively distinct from pain related to disease progression or to breakthrough pain resulting from development of opioid tolerance

Opioid induced hyperalgesia

- Pain associated with hyperalgesia is more diffuse than the pre-existing pain and less defined in quality
- The management of opioid induced hyperalgesia is opioid dose reduction or changing to an alternative opioid preparation
- Consider referral to specialist pain services

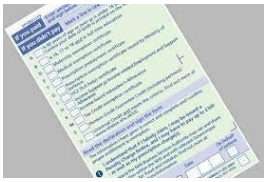
Withdrawal symptoms

- Occur if an opioid is stopped or the dose reduced abruptly, e.g. sweating, yawning, abdominal cramps, vomiting and diarrhoea
- This is common with opioids even after a short course


Duration of opioid therapy and review
PrescQIPP
Community Interest Company

Repeat prescriptions

- The ability to create computer-generated prescriptions for Controlled Drugs has made the actual process of prescribing opioids much easier and opioids may be entered onto repeat prescribing systems
- However, this practice is discouraged!



Coroner's report – Mrs A

- Mrs A, a 40 year old woman transferred to the GP practice. She had symptoms of fibromyalgia and was taking tramadol for the pain. Her prescription was for tramadol 200mg MR twice daily (quantity 112 tablets) every two months, on repeat prescription.
- Her prescription was due every 2 months, but over a 10 month period she was becoming more reliant on the drug, and started ordering her tramadol early.
- By month 10, Mrs A was ordering her tramadol nearly one month early and had received three additional prescriptions for tramadol. She had told reception staff she was going on holiday, as an excuse
- Mrs A had a seizure and tramadol toxicity caused by unintentionally taking too much tramadol.

PrescQIPP

https://www.judiciary.uk/wp-content/uploads/2017/12/Hayley-SHEEHAN-2017-0324_Redacted.pdf

Tramadol was on repeat rather than acute and therefore the patient was able to re-order without each script being checked. Every so often she called in to request early and the staff tried to be helpful.

Since this incident the practice has been physically reviewed regularly (6-monthly) by CQC to ensure everything, not just the CDs is in strict order.
All CDs in this practice are now on acute. Every Monday morning each GP reviews all their own patients receiving CDs.

Coroner's report – Mrs B

- Mrs B, 71 year old partially sighted lady, fell and had a wrist fracture which required admission to hospital. She was prescribed 100ml Oramorph for pain relief on discharge.
- Her repeat medicines were ordered for her by the local community pharmacy, including Oramorph.
- For a further 5 months, Mrs B continued to received 300 ml Oramorph monthly along with her other repeat medicines without review.
- After 5 months Mrs B's GP advised that she should stop taking the Oramorph. Sadly 7 days later she was found collapsed and unresponsive due to morphine toxicity

PrescQIPP

https://www.judiciary.uk/wp-content/uploads/2019/12/Brenda-Drew-2019-0421_Redacted.pdf

https://www.bournemouthecho.co.uk/news/18141723.morphine-overdose-woman-71-broke-wrist/

Think about a strategy for regular reviews and include in the management plan.

- ensure that the benefits of the medicine continue to outweigh the potential harms
- factors that might indicate a need for frequent reviews, such as:
  - whether the person is taking the medicine for the first time
  - potential for adverse effects
  - problems associated with dependence
  - potential for misuse

Where practicable, review of long-term opioid therapy should be carried out by the initial prescriber.

Taper and then, if possible, stop the opioid regimen if:

- the medication is not providing useful pain relief
- the dose is > 120mg oral morphine equivalent per day, at which point harms are likely to outweigh benefits
- the underlying painful condition resolves

- the patient receives a definitive pain-relieving intervention (e.g. joint replacement)
- the patient develops intolerable side effects
- there is strong evidence that the patient is diverting his/her medications to others


Tapering and stopping opioids
PrescQIPP
Community Interest Company

Poll

What best describes your experience of tapering and stopping opioids?

- It's too time consuming
- It's too difficult to convince patients
- There aren't enough non-drug options
- I've done it successfully a few times
- I do it successfully on a regular basis

Challenges when stopping opioid treatment

- Prescribers can face significant challenges in stopping opioid treatment for patients in whom these medications have not provided effective pain relief
- This may result in patients being prescribed opioids despite the fact that they are receiving no benefit from them

Be prepared for queries about prescribing decisions made previously.

Preparation for dose tapering

The decision needs to be discussed carefully with the patient including:

- rationale for stopping opioids
- potential benefits
- agreed tapering schedule
- outcomes of taper
- monitoring of pain

Dose tapering

- The Faculty of Pain Medicine states that the dose of drug can be tapered by 10% weekly or two weekly
- Tapers reducing weekly dosage by 10%–50% of the original dosage have been recommended by other clinical guidelines

- Tapers slower than 10% per week (for example, 10% per month) also might be appropriate and better tolerated than more rapid tapers, particularly when patients have been taking opioids for longer durations
- A taper slow enough to minimise symptoms and signs of opioid withdrawal should be used

NG215

- Less specific
- Suggests a slow, stepwise rate of reduction proportionate to the existing dose, so that decrements become smaller as the dose is lowered

PrescQIPP Community Interest Company

Conversion to oral morphine

- It may sometimes be necessary to convert to oral morphine and then wean down
- Careful monitoring during conversion is always necessary, especially when high doses are used, as conversion ratios are only an approximate guide

Dose tapering

- Tapering plans should be individualised based on patient goals and concerns
- Might have to be paused and restarted
- Might have to be slowed once patients reach low dosages

- Tapers may be considered successful as long as the patient is making progress
- Once the smallest available dose is reached, the interval between doses can be extended
- Opioids may be stopped when taken less frequently than once a day
- In people taking very high doses of opioids, total cessation may be difficult to achieve

Consultations and review

- Initial consultation should be face-to-face (ideally) to explain why the opioid is being reduced
- Subsequent consultations may be fortnightly, weekly or twice-weekly telephone calls
- Ensure continuity of care with the same healthcare professional where possible


Helping it happen
PrescQIPP
Community Interest Company
146

- Opportunistic reviews?
- Planned reviews?
- IIF 22/23 SMR-01C: Percentage of patients using potentially addictive medicines who received a Structured Medication Review

147

https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357-investment-and-impact-fund-2022-23-updated-guidance-march-2022.pdf

SMR-01C:

Cohort 1: Patients with 2 or more prescriptions over a 3-month period for any of the following four classes of medicine:

a. Gabapentinoids.

b. Benzodiazepines.

c. Z-drugs.

d. Any oral or transdermal opioid other than:

i. Weak opioids (Codeine, Dihydrocodeine, Meptazinol).
ii. Heroin substitutes (including Methadone, Buprenorphine).

Cohort 2: Patients with a single prescription for an oral or transdermal opioid with > 120 mg oral morphine equivalent

The practice team

- Everyone needs to be involved
- Receptionists, admin staff, prescription clerical staff
- Practice protocols/SOPs in relation to opioids/DFMs
  - Requests
  - Reviews
  - Problems
  - In-house training, all staff know what to do before a problem arises

PrescQIPP Community Interest Company

Community pharmacy

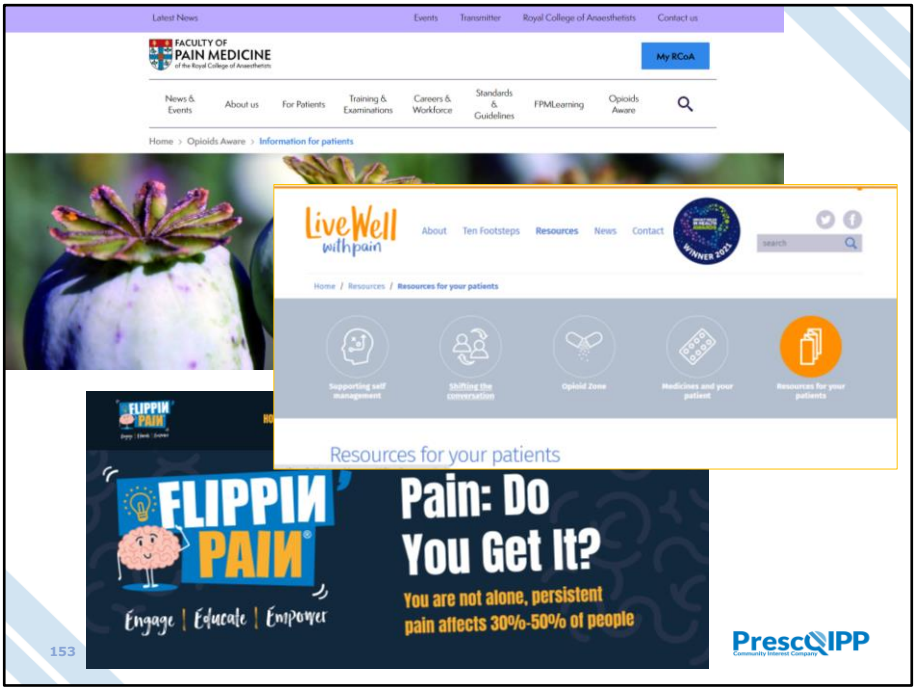
- Very well placed to observe patient behaviour
- May be the first to recognise over-use
- Well placed to recognise polypharmacy (multiple opioids being prescribed, co-prescribing of DFMs)

PrescQIPP Community Interest Company

- MDT approach – GPs, nurses, pharmacists, physios, social prescribers
- Training for all staff, not only clinicians
- Know the national guidance e.g. NICE

Consultation skills

- Empathy and building rapport
- Supportive, empathetic approach
- Shared decision making
- Build trust



https://www.flippinpain.co.uk/
https://livewellwithpain.co.uk/resources/resources-for-your-patients/

Discussion

How will you help this to happen?

Are you doing it already? Share!

What else do you need?

Final thoughts about pain relief

- Yes, we should try to treat pain but…
- Pain can't always be treated
- Inability to reduce a patient's pain intensity is neither a reflection of lack of effort nor a sign of incompetence
- Trying hard to treat pain and making the patient worse is not a result