General Practice Guidelines for the initial management of patients with Chronic Pain in North Central London

Key Points

This guideline provides recommendations in three key areas:

1. Practical guidance for the initial management of Chronic Pain
2. Guidance for the involvement of Specialist Palliative Care in patients with Chronic pain, including referral recommendations
3. Information regarding the Pain services available across North Central London, referral pathways, and waiting times

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Background

Chronic pain can be difficult to manage in the community setting, and patients can wait many weeks/months following referral to access dedicated Pain services. Non-pharmacological and pharmacological management can be complex, and Chronic Pain can be distressing to patients.

This guideline aims to clarify the involvement of Specialist Palliative Care Services in the management of chronic and complex pain, and to provide some practical advice for initial management of pain whilst awaiting referral to Pain services.

Definitions[1]

Chronic pain is pain that persists for more than 3 months.

Chronic primary pain is pain with no clear underlying cause, or pain that is out of proportion to any observable injury or disease. Chronic primary pain includes conditions such as fibromyalgia (chronic widespread pain), complex regional pain syndrome, chronic primary headache and orofacial pain, chronic primary visceral pain, and chronic primary musculoskeletal pain.

Chronic secondary pain is a symptom of an underlying condition, such as osteoarthritis, rheumatoid arthritis, ulcerative colitis, endometriosis, or irritable bowel syndrome.

Chronic primary pain and chronic secondary pain can coexist.

Practical guidance for initial management of Chronic Pain

Principles of Pain Assessment

These recommendations are reconfigured from: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain [NG193] - Published: 07 April 2021

An individual, person-centred approach should be taken in order to:

1. Understand the factors contributing to and affected by pain, including:
   - lifestyle, day-to-day activities, work, and sleep
   - physical and psychological wellbeing, social interaction, and relationships
   - stressful life events, including previous or current physical or emotional trauma
   - current or past history of substance misuse
   - difficulties with employment, housing, income, and other social concerns

2. Understand and acknowledge the effect of pain on a person's life, and those of their relatives:
   - acknowledging that living with pain can be distressing
   - discussing likelihood that symptoms will fluctuate over time and that they may have flare-ups
   - discussing the possibility that a reason for the pain (or flare-up) may not be identified
   - discussing the possibility that the pain may not improve, or may get worse
   - acknowledging there can be improvements in quality of life even if the pain is unchanged

3. Explore a person's strengths, which may include talking about:
   - their views on living well
   - the skills they have for managing their pain
   - what helps when their pain is difficult to control

4. Explore patients' and relatives' understanding of their condition:
   - understanding of the causes of their pain
   - expectations of what might happen in the future in relation to their pain
   - understanding of the outcome of possible treatments

5. Consider that a person's socioeconomic, cultural and ethnic background, and faith group, might influence their symptoms, understanding, and choice of management

6. Consider the impact of chronic pain on younger adults (aged 16-25 years), taking into account:
   - possible age-related differences in presentation of symptoms
   - impact of pain on family interactions and dynamics
   - impact of pain on education and social and emotional development

Discussing the following will also aid future management plans:

- a person's priorities, abilities, and goals
- what they are already doing that is helpful
- their preferred approach to treatment, and balance of treatments for multiple conditions
- any support needed for young adults (aged 16-25) to continue with their education or training, if appropriate

Principles of Pain Management

Chronic primary pain

- Physical activity, psychological therapy, and acupuncture are non-pharmacological management options for chronic primary pain.
- Anti-depressants may improve quality of life, pain, sleep, and psychological distress. They are **the only** medications recommended by NICE.

Please see: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain [NG193] - *Published: 07 April 2021* for more details.

Chronic Secondary pain

There are multiple non-pharmacological, pharmacological, and surgical interventions recommended by NICE for certain conditions which can commonly cause pain. Please see the relevant guidelines hyperlinked below for further information.

Musculoskeletal and Joint Pain

- Low back pain and sciatica in over 16s: assessment and management [NG59] - *Published: 30 November 2016, Last updated: 11 December 2020*
- Osteoarthritis in over 16s: diagnosis and management [NG226] - *Published: 19 October 2022*
- Rheumatoid arthritis in adults: management [NG100] - *Published: 11 July 2018, Last updated: 12 October 2020*
- Spondyloarthritis in over 16s: diagnosis and management [NG65] - *Published: 28 February 2017, Last updated: 02 June 2017*
    - Please note symptoms from Rheumatological disease should be managed in conjunction with Rheumatology Services

Headaches

- Headaches in over 12s: diagnosis and management [CG150] - *Published: 19 September 2012, Last updated: 17 December 2021*

Neuropathic Pain

- Neuropathic pain in adults: pharmacological management in non-specialist settings [CG173] - *Published: 20 November 2013, Last updated: 22 September 2020*

Endometriosis

- Endometriosis: diagnosis and management [NG73] - *Published: 06 September 2017*

Irritable Bowel Syndrome

- Irritable bowel syndrome in adults: diagnosis and management [CG61] - *Published: 23 February 2008, Last updated: 04 April 2017*

Pharmacological Management of Chronic Pain

Patients may have been started on any of the following medications/interventions since their symptoms began, through the NHS or private means.

TENS	**Anti-epileptics (including gabapentinoids)**
NSAIDs	**Anti-depressants**
Paracetamol	**Benzodiazepines**
Local anaesthetics (topical and injection)	**Anti-psychotics**
Corticosteroid injections	**Ketamine**
Opioids	**Medical Cannabis**

Patients may be buying medications over the counter, or accessing illicit medications to help with their pain. A single prescriber is recommended when possible, and is usually the GP.

Discussion should include whether existing prescription medications are providing benefit, and if patients are experiencing side effects.

Neuropathic agents specifically prescribed for neuropathic pain can be up-titrated if providing benefit. Medications that are *not* recommended for use in the NICE guidance referenced above can be continued if providing benefit, with little evidence of harm. If not providing benefit, medications should be reduced and stopped if possible, if the patient is willing to do so.

- This should be considered for patients reporting little benefit, and medication side effects
- Of primary importance is creating a weaning regime that is acceptable to patients so that they wish to continue
- Possible withdrawal symptoms must be discussed prior to attempting weaning
- De-prescribing may not be possible until patients have developed alternative skills to manage their pain

Opioids are not recommended for the treatment of chronic pain.[2]

In addition to the common side effects of opioids, chronic use of opioids has been associated with:[3]

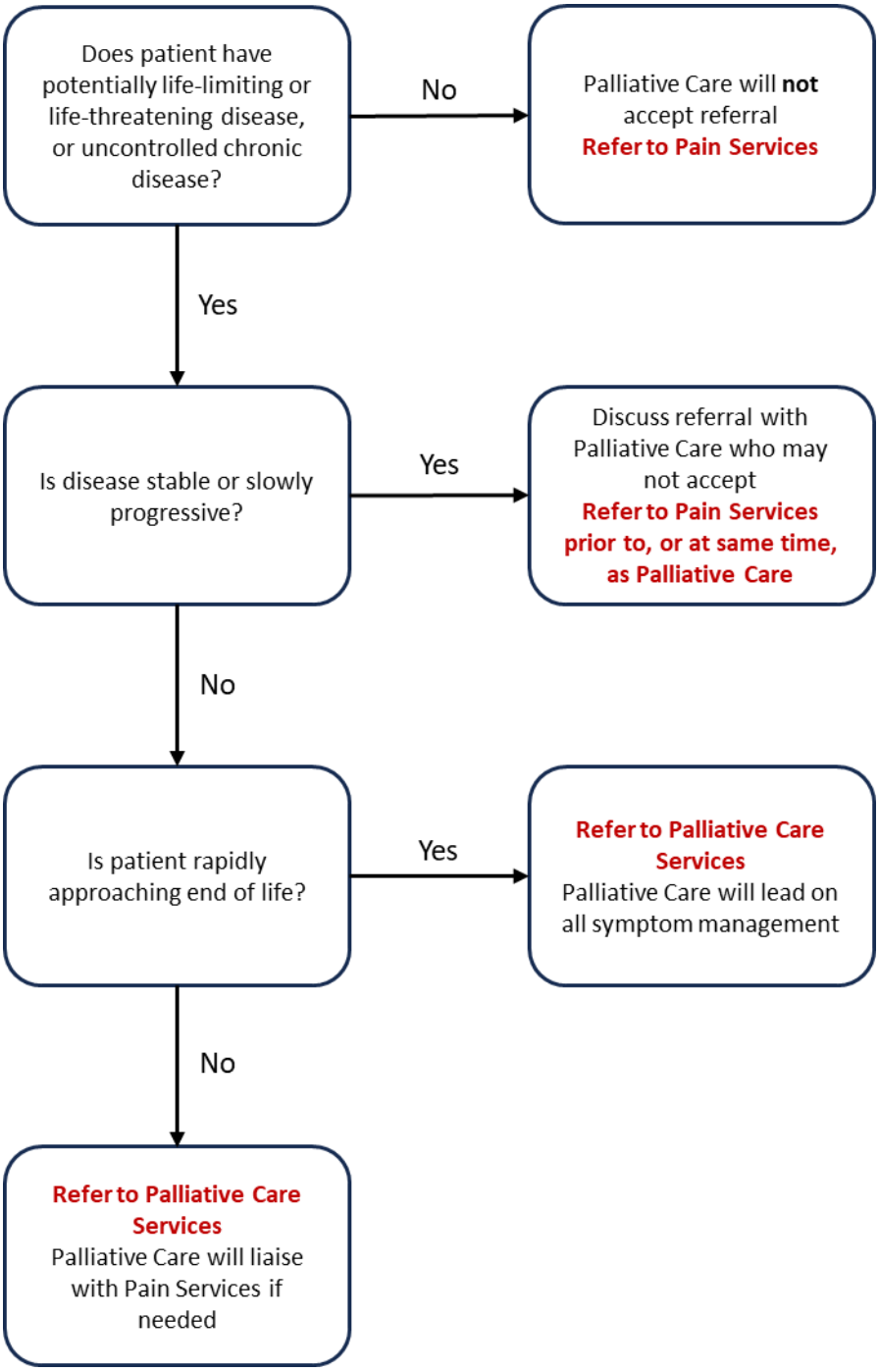
- Increased risk of falls
- Hypogonadism and adrenal insufficiency
- Immunosuppression
- Opioid-induced hyperalgesia

In general, the prescription of opioids for chronic pain should be avoided. If prescribed, this should be at the *lowest dose possible*, and concurrent use of benzodiazepines should be avoided. Injectable opioids should be avoided. If opioids are started for acute pain, only a short course of 7 days or fewer should be prescribed,[2] and prescriptions should be reviewed after 2 weeks.[4]

If possible, patients established on opioids for chronic pain should have these weaned slowly, with the aim to stop. Up to a 10% reduction in total dose every 1-2 weeks is reasonable.[5] The Faculty of Pain Medicine provides further information and advice on the use of opioids, including tapering and stopping.

Specialist Palliative Care involvement in patients with chronic pain

There are four main categories of patients with chronic pain where a query about referral to specialist palliative care services may arise. The flow chart and notes clarify these:



1. **Patients without potentially life-limiting or life-threatening disease, or with well-controlled chronic disease.**

Specialist Palliative Care Teams will not accept referrals for patients without potentially life-limiting or life-threatening disease, or for patients with well controlled chronic disease, since the approach to their care is outside the remit of Specialist Palliative Care.

- Examples might include:
    - A patient with well controlled COPD with chronic back pain secondary to spinal stenosis
    - A patient with well controlled T2DM with pain secondary to peripheral neuropathy

Please refer these patients to local Pain services.

2. **Patients with stable or slowly progressive life-limiting or life-threatening disease**

This includes patients with stable or very slowly progressive malignancy, organ failure, or multi-morbidity, who have concurrent chronic pain. Patients' chronic pain may be due to long-term sequelae of their disease, or be unrelated to the illness causing their deterioration.

For these patients, it is unlikely that Specialist Palliative Care is the correct service to successfully manage these patients' pain. However, there may be a role for our services, for example in establishing Specialist Palliative Care needs, conducting Advance Care Planning discussions, or signposting to other services.

- Examples might include:
    - A patient with stable metastatic breast cancer with chest wall pain as a result of her initial radiotherapy treatment, who remains on treatment and has a prognosis of years.
    - A patient with multi-morbidity and frailty, with an uncertain prognosis, with pain due to osteoarthritis.

Please discuss these referrals with your local Palliative Care Team. If accepted by Palliative Care, *it is very likely these patients will ultimately be discharged*, and Palliative Care services may not give any advice regarding the management of their chronic pain.

Please refer these patients to local Pain services at the same time, or prior to, referral to Palliative Care.

3. **Patients with progressive deterioration from life-limiting or life-threatening disease**

This includes patients with steady or rapid functional deterioration from their advanced malignancy, organ failure or multi-morbidity, who have concurrent chronic pain.

- Patients may also have acute pain related to their disease.
- Patients' chronic pain may be due to long-term sequelae of their disease, or be unrelated to the illness causing their deterioration.

It is likely that these patients will benefit from Specialist Palliative Care services. Please refer in the usual way.

- Palliative Care services will take the lead in liaising with Chronic Pain and Interventional Pain Services where necessary.

4. Patients approaching the last days to weeks of life

This includes any patient with rapid deterioration who is clearly approaching the end of their life, regardless of which disorder may be the cause of their pain.

Please refer these patients to Specialist Palliative Care Services in the usual way.

- Palliative Care services will take the lead in managing symptoms.

North Central London Pain Services

Please find below details of the Chronic Pain Services available in North Central London, including referral pathways.
Waiting times across NCL are currently anywhere between 20-52 weeks.

What patients can expect from pain clinic

- A multi-disciplinary approach to pain management from healthcare and allied healthcare professionals
- A holistic assessment of their pain and the impact of this on their lives, and the lives of their loved ones
- Advice and support in developing skills to manage and cope with their pain, and to continue activities that are important to them
- Advice and support in managing the impact of pain on sleep, relationships, and emotions
- Advice and support with starting, uptitrating, maintaining, downtitrating, or stopping analgesic medications as appropriate

Available Services

Service	Catchment area / boroughs covered	Professionals within Pain Service	Referral criteria	Referral method
Community Pain Services:				
Camden Pain Service (run from Royal Free Grove Centre)	Camden	Consultant Pain Specialists Psychology Clinical Nurse Specialists Physiotherapy	MSK pain	General Practice NHS e-referrals system
Enfield Pain Service (run from Chase Farm Hospital)	Enfield	Consultant Pain Specialists Psychology Clinical Nurse Specialists Physiotherapy	MSK pain	General Practice NHS e-referrals system
Haringey Pain Service	Haringey	Consultant Pain Specialists Psychology Clinical Nurse Specialists Physiotherapy	MSK pain	General Practice NHS e-referrals system

Hospital Pain Services:				
Royal Free Hospital Trust (run from Edgware community Hospital)	Barnet, Brent and Harrow, South Hertfordshire	Consultant Pain Specialists Clinical Nurse Specialists Physiotherapy Psychology		General Practice NHS e-referrals system
North Middlesex University Hospital	Haringey, Islington, Barnet	Consultant Pain Specialists Clinical Nurse Specialists Pharmacist		General Practice NHS e-referrals system
The Whittington Hospital	Islington	Consultant Pain Specialists Physiotherapy Psychology		General Practice NHS e-referrals system
Tertiary Hospital Pain Services:				
Royal National Orthopaedic Hospital		Consultant Pain Specialists Clinical Nurse Specialists Physiotherapy Occupational Therapy Psychology Pharmacist Acupuncture	Chronic neuropathic or spinal pain only	General Practice NHS e-referrals system
University College London Hospital		Consultant Pain Specialists Clinical Nurse Specialists Physiotherapy Acupuncture Psychology		General Practice NHS e-referrals system***

***Referrals to UCLH pain services:

- Referrals for facial pain should be made to the facial pain clinic at the Royal National ENT and Eastman Dental hospitals by calling 020 3456 2300, or emailing uclh.referrals.edhappts@nhs.net.
- Referrals for headache should be made to the National Hospital for Neurology and Neurosurgery by calling 020 3448 3664/3371.

Alternatives to Pain Services Referral

Nuffield Health offers a free Joint Pain Programme, run from their gyms, which patients can apply for themselves. This includes pain checks, group workshops and exercise sessions, and access to their gyms. Applications are assessed by a Rehabilitation Specialist and suitability is based on current exercise and activity levels.

References

1. National Institute for Health Clinical Excellence. Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain [NICE Guideline 193]. *Chronic Pain*. Published online April 7, 2021.

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3. Long term harms of opioids | Faculty of Pain Medicine. Accessed August 21, 2023. https://fpm.ac.uk/opioids-aware-clinical-use-opioids/long-term-harms-opioids

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