ASSESSMENT

✓ A concise history, examination and biopsychosocial assessment, identifying pain type (neuropathic/nociceptive/mixed), severity, functional impact and context should be conducted in all patients with chronic pain. This will inform the selection of treatment options most likely to be effective.

✓ Referral should be considered when non-specialist management is failing, chronic pain is poorly controlled, there is significant distress, and/or where specific specialist intervention or assessment is considered.

✓ A compassionate, patient-centred approach to assessment and management of chronic pain is likely to optimise the therapeutic environment and improve the chances of successful outcome.

SUPPORTED SELF MANAGEMENT

C **Self management resources should be considered to complement other therapies in the treatment of patients with chronic pain.**

✓ Healthcare professionals should signpost patients to self help resources, identified and recommended by local pain services, as a useful aide at any point throughout the patient journey. Self management may be used from an early stage of a pain condition through to use as part of a long term management strategy.

PHARMACOLOGICAL THERAPIES

✓ Patients using analgesics to manage chronic pain should be reviewed at least annually, and more frequently if medication is being changed, or the pain syndrome and/or underlying comorbidities alter.

Non-opioid analgesics (simple and topical)

B **NSAIDs should be considered in the treatment of patients with chronic non-specific low back pain.**

B **Cardiovascular and gastrointestinal risk needs to be taken into account when prescribing any non-steroidal anti-inflammatory drug.**

C **Paracetamol** (1,000-4,000 mg/day) **should be considered alone or in combination with NSAIDs in the management of pain in patients with hip or knee osteoarthritis in addition to non-pharmacological treatments.**

A **Topical NSAIDs should be considered in the treatment of patients with chronic pain from musculoskeletal conditions, particularly in patients who cannot tolerate oral NSAIDs.**

A **Topical capsaicin patches** (8%) **should be considered in the treatment of patients with peripheral neuropathic pain when first line pharmacological therapies have been ineffective or not tolerated.**

B **Topical lidocaine should be considered for the treatment of patients with postherpetic neuralgia if first line pharmacological therapies have been ineffective.**

B **Topical rubifacients should be considered for the treatment of pain in patients with musculoskeletal conditions if other pharmacological therapies have been ineffective.**

Opioids

B **Strong opioids should be considered as an option for pain relief for patients with chronic low back pain or osteoarthritis, and only continued if there is ongoing pain relief. Regular review is required.**

B **Patients prescribed opioids should be advised of the likelihood of common side effects such as nausea and constipation.**

✓ All patients on strong opioids should be assessed regularly for changes in pain relief, side effects and quality of life, with consideration given to a gradual reduction to the lowest effective dose.

B **It may be necessary to trial more than one opioid sequentially, as both effectiveness and side effects vary between opioids.**

✓ Opioid rotation should be considered for chronic pain that is likely to respond to opioids, if there are problems with efficacy or side effects.

C **Signs of abuse and addiction should be sought at re-assessment of patients using strong opioids. Routine urine drug testing, pill counts or prescription monitoring should not be used to detect problem use.**

B **Currently available screening tools should not be relied upon to obtain an accurate prediction of patients at risk of developing problem opioid use before commencing treatment.**

✓ There should be careful assessment of pre-existing risk factors for developing opioid misuse. In patients where opioid therapy is indicated, but there is an increased risk of iatrogenic opioid misuse, specialist advice should be sought. The minimal effective dose should be used to avoid increased problems of fracture and overdose that may occur on higher doses.

D **Specialist referral or advice should be considered if there are concerns about rapid-dose escalation with continued unacceptable pain relief, or if >180 mg/day morphine equivalent dose is required.**

Anti-epilepsy drugs

A **Gabapentin** (titrated up to at least 1,200 mg daily) **should be considered for the treatment of patients with neuropathic pain.**

A **Pregabalin** (titrated up to at least 300 mg daily) **is recommended for the treatment of patients with neuropathic pain if other first and second line pharmacological treatments have failed.**

A **Pregabalin** (titrated up to at least 300 mg daily) **is recommended for the treatment of patients with fibromyalgia.**

B **Flexible dosing may improve tolerability. Failure to respond after an appropriate dose for several weeks should result in trial of a different compound.**

B **Carbamazepine should be considered for the treatment of patients with neuropathic pain. Potential risks of adverse events should be discussed.**

Antidepressants

✓ Patients with chronic pain conditions using antidepressants should be reviewed regularly and assessed for ongoing need and to ensure that the benefits outweigh the risks.

A **Tricyclic antidepressants should not be used for the management of pain in patients with chronic low back pain.**

A **Amitriptyline** (25-125 mg/day) **should be considered for the treatment of patients with fibromyalgia and neuropathic pain** (excluding HIV-related neuropathic pain)**.**

✓ It may be appropriate to try alternative tricyclic antidepressants to reduce the side effect profile.

A **Duloxetine** (60 mg/day) **should be considered for the treatment of patients with diabetic neuropathic pain if other first or second line pharmacological therapies have failed.**

A **Duloxetine** (60 mg/day) **should be considered for the treatment of patients with fibromyalgia or osteoarthritis.**

B **Fluoxetine** (20-80 mg/day) **should be considered for the treatment of patients with fibromyalgia.**

B **Optimised antidepressant therapy should be considered for the treatment of patients with chronic pain with moderate depression.**

✓ Depression is a common comorbidity with chronic pain. Patients should be monitored and treated for depression when necessary.

Combination therapies

A **Combination therapies should be considered for patients with neuropathic pain** (a pathway for patients with neuropathic pain can be found in Annex 3).

A **In patients with neuropathic pain who do not respond to gabapentinoid** (gabapentin/pregabalin) **alone, and who are unable to tolerate other combinations, consideration should be given to the addition of an opioid such as morphine or oxycodone. The risks and benefits of opioid use needs to be considered.**

PSYCHOLOGICALLY BASED INTERVENTIONS

✓ Healthcare professionals referring patients for psychological assessment should attempt to assess and address any concerns the patient may have about such a referral. It may be helpful to explicitly state that the aims of psychological interventions are to increase coping skills and improve quality of life when faced with the challenges of living with pain.

Pain management programmes

C **Referral to a pain management programme should be considered for patients with chronic pain.**

Unidisciplinary education

C **Brief education should be given to patients with chronic pain to help patients continue to work.**

Behavioural therapies

C **Progressive relaxation or EMG biofeedback should be considered for the treatment of patients with chronic pain.**

✓ Clinicians should be aware of the possibility that their own behaviour, and the clinical environment, can impact on reinforcement of unhelpful responses.

Cognitive behavioural therapy

C **Cognitive behavioural therapy should be considered for the treatment of patients with chronic pain.**

PHYSICAL THERAPIES

Manual therapy [Manual therapy includes massage]

B **Manual therapy should be considered for short term relief of pain for patients with chronic low back pain.**

B **Manual therapy, in combination with exercise, should be considered for the treatment of patients with chronic neck pain.**

Exercise

B **Exercise and exercise therapies, regardless of their form, are recommended in the management of patients with chronic pain.**

A **Advice to stay active should be given in addition to exercise therapy for patients with chronic low back pain to improve disability in the long term. Advice alone is insufficient.**

The following approaches should be used to improve adherence to exercise:

B • **supervised exercise sessions**

B • **individualised exercises in group settings**

C • **addition of supplementary material**

B • **Provision of a combined group and home exercise programme.**

Electrotherapy

B **Transcutaneous electrical nerve stimulation should be considered for the relief of chronic pain. Either low or high frequency TENS can be used.**

B **Low level laser therapy should be considered as a treatment option for patients with chronic low back pain.**

COMPLEMENTARY THERAPIES

Acupuncture

A **Acupuncture should be considered for short term relief of pain in patients with chronic low back pain or osteoarthritis.**

SOURCES OF FURTHER INFORMATION

National Chronic Pain Website for Scotland
www.chronicpainscotland.org

British Complementary Medicine Association
P.O. Box 5122, Bournemouth, BH8 0WG
Tel: 0845 345 5977
www.bcma.co.uk

British Pain Society
Third Floor, Churchill House, 35 Red Lion Square, London WC1R 4SG
Tel: 020 7269 7840
www.britishpainsociety.org • Email: info@britishpainsociety.org

Chronic Pain Policy Coalition
Policy Connect, CAN Mezzanine, 32-36 Loman Street, London, SE1 0EH
Tel: 020 7202 8580
www.policyconnect.org.uk/cppc • E-mail: rachel.downing@policyconnect.org.uk

Health and Social Care Alliance Scotland
Venlaw Building, 349 Bath Street, Glasgow, G2 4AA
Tel: 0141 404 0231 • Fax: 0141 246 0348
www.alliance-scotland.org.uk • E-mail: info@alliance-scotland.org.uk

Healthtalkonline Database
www.healthtalkonline.org

NHS Inform
www.nhsinform.co.uk

Pain Association Scotland
Suite D, Moncrieffe Business Centre, Friarton Road, Perth, PH2 8DG
Tel: 0800 783 6059
www.painassociation.com • Email: info@painassociation.com

Pain Concern
Unit 1-3, 62-66 Newcraighall Road, Fort Kinnaird, Edinburgh, EH15 3HS
Tel: 0131 669 5951 • Helpline: 0300 123 0789
www.painconcern.org.uk • Email: info@painconcern.org.uk

Pain Support
www.painsupport.co.uk

Pain UK
www.painuk.org

This Quick Reference Guide provides a summary of the main recommendations in **SIGN 136 Management of chronic pain.** Recommendations are graded A B C D to indicate the strength of the supporting evidence.

Good practice points ✓ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: www.sign.ac.uk. This Quick Reference Guide is also available as part of the SIGN Guidelines app.

Available on the App Store

Available from Android Market

Healthcare Improvement Scotland

SIGN 1993-2013

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Evidence