In association with VERSUS ARTHRITIS

Chronic pain: NICE guideline

NICE issued its DRAFT guidance on chronic pain in August 2020 and it received substantial media interest. It has not changed significantly in its final form, released April 2021.

We think this guidance offers a real opportunity for change and to build more appropriate pathways of care for people with chronic pain, but it will take time for these pathways to emerge. We also cannot fail to acknowledge that the distress of chronic pain is commonly embedded in a web of social and societal issues, many of which are not directly in our control as primary care clinicians. This is difficult.

In this series of 3 articles, we aim to focus on what we **can control** and what is in our circle of influence while we wait for (or influence) care pathways to catch up.

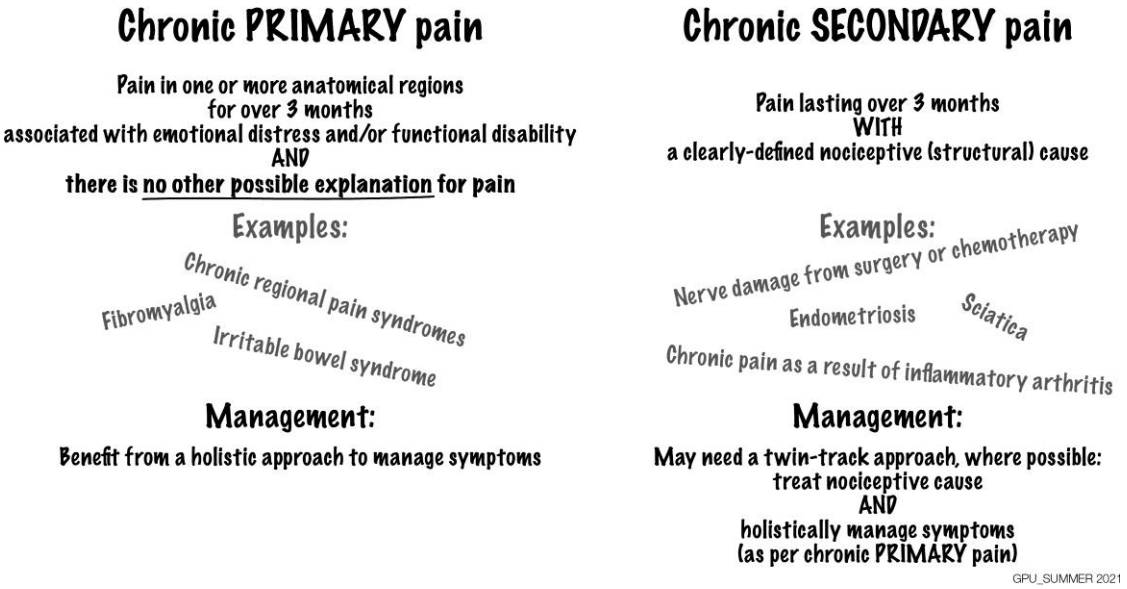
- This article covers the nuts and bolts of the new NICE guidance.
- *Chronic pain: communication skills and self-management* will help to change the conversation, and offers lots of ideas for creating care plans).
- Finally, *Chronic pain: opiates and dependence-forming medication* offers some ideas as to how to avoid prescribing where it does not help, how to prescribe safely and effectively when it does help, and how to de-prescribe where necessary.

This article is based on 'Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain, NG193 April 2021'.

What do we mean by chronic pain?

Pain becomes chronic when it has been present for over 3 months.

Typically, chronic pain can be divided into:



And, of course, chronic primary pain AND chronic secondary pain can co-exist:

However, NICE does not quite follow these traditional definitions: NICE defines chronic secondary pain as any painful condition for which there is an underlying diagnosis with pre-existing NICE guidance – thus, irritable bowel syndrome becomes chronic secondary pain, alongside those with chronic pain with osteoarthritis or rheumatoid arthritis. The bottom line: **it wants us to follow the condition-specific guidance first**.

Why does this matter?

- NICE sets out an holistic assessment process for ALL types of chronic pain (whether primary or secondary). One could argue that this assessment process is in itself therapeutic as it offers the opportunity for excellent communication, collaboration and coaching towards approaching self-management with confidence.
- NICE then defines treatments, and makes specific recommendations for drugs that should not be initiated, which only apply to those with chronic PRIMARY pain.

Having said all that, NICE then reminds us that chronic primary and secondary pain can co-exist.

So, our dilemma is which treatments can you offer to which people, in line with NICE guidance? More on this in the section on management!

NICE on the assessment of chronic pain

At Red Whale, we think this assessment is crucial. Of course, it is important to rule out other conditions. But critically, people need to feel heard and understood, and in doing so, it begins to change the conversation from "I need stronger painkillers" or "I need another scan" to acknowledging that distress may be affected by psychosocial factors, and that 'treatment' is more than pills or tests.

Doing this well may change the course of the illness…

Assessing primary AND secondary chronic pain

- **Acknowledge that living with pain chronic pain can be distressing**.
- **Consider each person as an individual and take a holistic, collaborative approach.** Encourage and enable the person with chronic pain to actively participate in their care.
- **Think about the *cause* of the pain and make a proactive diagnosis**. Is this:
  - Chronic primary pain?
  - Pain secondary to another condition?
  - Co-existing chronic primary AND chronic secondary pain *(particularly consider this if the pain is disproportionate in its impact and the distress and disability it causes).*
- **Adopt a biopsychosocial approach**: explore the relationship between how pain affects the person's life and how life affects the person's pain, including:
  - Day-to-day activities, work and sleep.
  - Physical and psychological wellbeing.
  - Stressful life events, including emotional and physical trauma.
  - Social interaction and relationships.
- **Take a positive approach:**
  - What matters to this person (what does living well look like)?
  - What are their strengths (skills they have already to manage pain; what helps when their pain is difficult to control)?
- **Provide advice and information** in a format relevant to the individual (this may be written, verbal, video-based, etc. See useful resources, below).
- **Explicitly discuss that:**
  - Symptoms will likely fluctuate over time and flare-ups may occur.
  - It is possible that the *cause* of the flare-up may not be identifiable.
  - Pain may not improve or may get worse and need ongoing management.
  - **Quality of life CAN improve even if the pain remains unchanged.**
- **Develop a care and support plan, exploring with the person their preferences, strengths, priorities, interests and abilities** *(think: which primary care team members can contribute to this?)*. This should include:
  - Priorities, abilities and goals.
  - What they are doing already that helps.
  - Preferred approach to treatment.
  - Additional support needed for young people age 16–25y to continue with education and training.

NICE on managing chronic pain

We think 3 questions can help us unpack how to use the NICE guideline on chronic pain, shown in the flowchart below. **In particular, note that in chronic SECONDARY pain, we should manage the underlying condition as optimally as possible AND we should consider whether it would also be helpful to manage it as chronic PRIMARY pain too.**

Download a high-res version of this GEMS at https://gpcpd.com/SM4/Mutable/Uploads/medialibrary/Chronic-pain-GEMS.pdf

Chronic Pain

NICE NG 193, 2021

More details can be found in the full article

Red Whale

GEMS

Guidelines & Evidence Made Simple

How to use the NICE guideline on chronic pain: start with 3 questions

QUESTION 1

Does this person have chronic pain?

(defined as constant or intermittent pain lasting 3 months or more with significant emotional distress or functional impact)

No → **This guideline does not apply!**

Yes ↓

Assess holistically using a biopsychosocial approach (see later)

QUESTION 2

Is there an underlying condition (for which there is a NICE guideline) that is thought to be the main underlying cause of the chronic pain?

Yes → **NICE considers all these as 'chronic SECONDARY pain'**

No → **This is 'chronic PRIMARY pain'**

(no clear underlying cause, or the impact of the pain is out of proportion to the injury or disease)

Examples from NICE: fibromyalgia, complex regional pain syndrome, chronic primary headaches and orofacial pain, chronic visceral pain, chronic MSK pain

FIRST:

Manage in accordance with the relevant NICE guidance for the underlying condition

Remember, there are NICE guidelines on many conditions that can cause chronic pain, including:

IBS
Headaches
Low back pain and sciatica
Neuropathic pain
Osteoarthritis/rheumatoid arthritis/spondyloarthritis
Endometriosis

AND ALSO ask...

QUESTION 3

Is the pain, or its impact, disproportionate to the underlying condition, and would it be more helpful to ALSO manage as chronic PRIMARY pain *alongside the management of the disease itself? Use clinical judgement to determine this*

Yes ↓

Manage as chronic PRIMARY pain

Options include:

- **Exercise programmes/physical activity**
- **Psychological therapy (ACT or CBT)**
- **Acupuncture** *(up to 5 hours in community delivered by band 7 clinician or lower or cost equivalent)*
- Consider an **antidepressant** even in the absence of depression *(off-label use)*
- **Do NOT offer** (to new patients): *opioids, NSAIDs, paracetamol, antiepileptics (including gabapentinoids), antipsychotics, benzodiazepines, steroid+/- local anaesthetic trigger point injections, ketamine, local anaesthetics, TENS, ultrasound, biofeedback*

  If ***already taking*** these drugs:
  - Explain lack of evidence in chronic pain
  - Agree a plan to continue safely if they report benefit/few harms and are on a safe dose **or**
  - If little benefit or significant harm, encourage and support them to reduce and stop

Managing chronic SECONDARY pain: summary of ANALGESIA interventions recommended by NICE

Here we summarise the ANALGESIA recommendations in each of the NICE/SIGN guidelines for the conditions listed. **IMPORTANT!** There are many non-analgesia treatments for all these conditions (see relevant articles in the online handbook for all of these). Where a box is blank, NICE makes no specific recommendation.

Chronic primary pain (NICE NG193, 2021)	
Opioids	Do not offer.
NSAIDs	
Paracetamol	
Antidepressants	*Consider* an antidepressant from: duloxetine, fluoxetine, paroxetine, citalopram, sertraline, amitriptyline.
Antiepileptics	Do not offer.
Low back pain/sciatica (NICE NG59, 2020)	
Opioids	Do not offer opiates for: • Chronic low back pain. • Chronic (>12 weeks) sciatica. *Consider* for acute low back pain or acute sciatica <12 weeks: • Intermittent weak opiate if necessary if NSAIDs are not tolerated/ineffective *(NICE says further research is needed).*
NSAIDs	Consider oral NSAIDs for low back pain and sciatica.
Paracetamol	Do not offer paracetamol alone (ineffective) for low back pain or sciatica.
Antidepressants	• Do not offer SSRIs, SNRIs or tricyclics for low back pain. • Do not offer benzodiazepines for low back pain or sciatica. • NICE acknowledges that amitriptyline and duloxetine seem to help some people with sciatica but more research is needed.
Antiepileptics	Do not offer gabapentinoids or any other anticonvulsant for low back pain or sciatica.
Headache and migraine (NICE CG150, 2015; SIGN 155: Migraine 2018)	
Opioids	• Avoid opiates for acute management of migraine (SIGN). • Do not offer opiates for tension or cluster headaches. • Be aware of role in medication-overuse headache if used >10 days per month.
NSAIDs	• Use NSAIDs for acute treatment of migraine. If cannot take NSAIDs, paracetamol can be used. • Both can be used for tension headaches. • **Do not use** either in cluster headache. • Be aware of their role in medication-overuse headache if used for >15 days per month.
Paracetamol	
Antidepressants	• Consider amitriptyline for migraine prophylaxis. • *(SIGN also says we can consider as prophylaxis for tension headache).* • Do not use SSRIs or SNRIs as prophylaxis.
Antiepileptics	For migraine prophylaxis: • Consider topiramate or sodium valproate ***except*** in women of childbearing age when they should be avoided. • Do not use gabapentinoids or any other anticonvulsants.
Irritable bowel syndrome (NICE CG61, 2017)	
Opioids	No specific recommendation *(but this could be considered a chronic primary pain so we would interpret as don't use opiates!).*
Antidepressants	Consider TCAs as ***second-line*** treatment; consider SSRIs only if TCAs are ineffective. *See IBS article for more options.*
Osteoarthritis (NICE CG177, 2014, updated 2020)	
Opioids	If NSAID/paracetamol insufficient, consider a weak opiate (ideally for flares – short duration with specific goals in mind).
NSAIDs	Try topical NSAIDs first for knee/hand osteoarthritis. If paracetamol/topical NSAIDs are insufficient, consider an oral NSAID if not contraindicated.
Paracetamol	Consider paracetamol in addition to core treatments (information/education, exercise, weight loss).
Neuropathic pain (excluding sciatica)	

Opioids	Consider tramadol ONLY as acute rescue therapy, not for long-term use. Avoid all other opiates outside specialist settings.
Antidepressants **Antiepileptics**	• For trigeminal neuralgia: offer carbamazepine as an initial treatment. • For other types of neuropathic pain: offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as an initial treatment. • No other agents should be considered outside specialist settings (including capsaicin patch, other antidepressants/anticonvulsants).

Managing chronic PRIMARY pain

Managing chronic PRIMARY pain		
Things we can offer…	**Things we should not offer…**	**Things that need more research**
• Supervised group exercise programmes. • Encouragement for people to stay active. • Acceptance and commitment therapy (ACT). • Cognitive behaviour therapy (CBT). • Acupuncture (*single course delivered in the community by band 7 or lower or equivalent/lower cost trained provider for no more than 5 hours).* • Consider offering an antidepressant (OFF LABEL). Seek specialist advice if considering this in 16–17-year-olds. Choose from: o Amitriptyline, citalopram, duloxetine, fluoxetine, paroxetine, sertraline.	Electrical physical treatments: TENS, ultrasound, inferential therapy. **<u>Do not start any other pharmacological intervention,</u> including:** • Opioids. • NSAIDs. • Paracetamol. • Antiepileptics, including gabapentinoids (*unless part of a trial for chronic regional pain syndrome*). • Corticosteroids. • Local anaesthetics (unless part of a trial for chronic regional pain syndrome). • Corticosteroid +/- local anaesthetic trigger point injections. • Ketamine. • Antipsychotics.	Mindfulness. CBT-Insomnia *(needs economic evaluation).* Manual therapy. Pain management programmes.
What to do with people with chronic primary pain who are taking medications that are no longer recommended?		
Review prescribing as 'part of shared decision-making': • Explain the lack of evidence for these medications for chronic primary pain AND • Agree a plan to continue **safely** if they report benefit at a **safe** dose and with **few harms** OR • Explain the risks of continuing if they report little benefit/significant harm, and encourage and support them to reduce or stop the medication if possible (see article on *Chronic pain: opiates and other dependence-forming medication*).		

Frequently-asked questions on the NICE guideline

Why are all painkillers out for chronic primary pain?

In simple terms, because of an absence of evidence of long-term benefits and a body of evidence of short and long-term harms. NICE concludes that benefits do not outweigh the risks at population level. However, importantly, it **does** make provision for continued prescribing for the individual who is already taking one of these medications at safe, stable dose, and who is gaining benefit and experiencing no side-effects.

Our challenge is to work with people to identify the best options for them – the next 2 articles offer lots of suggestions.

Why offer antidepressants and which one?

Remember: this is off-label if being used purely for the management of chronic primary pain in the hope that the antidepressant may improve sleep and quality of life (*though we may well be treating a mood disorder as well, and should assess people with chronic pain specifically for anxiety and depression as both are more common than in the background population).*

We should explicitly discuss the reason(s) for prescribing, *and avoid people leaving feeling that we believe they are 'just depressed' or 'making it up'.*

NICE acknowledges that the evidence base is imperfect here, and the included studies predominantly relate to women with fibromyalgia where antidepressants have been shown to improve quality of life, pain and psychological distress.

Duloxetine had a larger amount of evidence of long-term effectiveness in this setting than other drugs. However, there were no studies that compared different classes of antidepressant head to head, and while the effect size varies in placebo-controlled studies, NICE did not feel it could assume one class to be more or less beneficial than another.

In making prescribing decisions, we need to weigh up the person's preferences, comorbidities and other medication in making our choice. We should discuss that this is off-label use, and not be afraid to stop and reconsider/try an alternative if no emotional or functional improvement is seen.

What is acceptance and commitment therapy (ACT) and can we access it?

Acceptance and commitment therapy (ACT) is recommended by NICE alongside CBT as options for psychological therapy for chronic primary pain.

ACT is based on the idea of instead of fighting and reframing distressing thoughts and feelings, the alternative is to accept it but without giving up, being defeated or agreeing to the suffering. It uses mindfulness and values-based strategies to help manage and diffuse these thoughts and feelings.

Both ACT and CBT have been shown to improve quality of life, and ACT has also been shown to improve sleep, pain and psychological distress (in small studies). There was insufficient evidence for NICE to recommend one over another, and, while we *may* have access to both through IAPT, what is available locally is more likely to determine which we pick.

What is the evidence for acupuncture?

NICE identified 27 studies that demonstrated reduced pain and improved quality of life when compared with 'usual care' or sham acupuncture in the short term (up to 3 months). There was insufficient evidence to determine longer-term benefits. Economic evaluation was taken into account in suggesting the maximum number of hours and band of healthcare professional who could deliver the intervention in a cost-effective way.

In practice, this means it is unlikely to be cost effective for a GP to deliver the intervention, but it may be cost effective for community-based physiotherapy or first-contact physiotherapy in primary care.

How do we create a personalised care plan for this?

You may well be screaming at this article right now, or feeling somewhat despondent. Don't.

We cannot do all of this alone as individual clinicians working in our consulting rooms.

While we wait for commissioned services to catch up, we need to work together as primary care teams and, where possible, use multi-professional team resources; for example, clinical pharmacists may be able to support the tapering and deprescribing work; social prescribing link workers may be able to support self-management and access to third-sector resources, e.g. the Live Well With Pain Festival (see link below); first-contact physiotherapists may be able to support a plan for exercise, pacing and grading; and together, we can adopt a more holistic approach. The following articles focus on these areas.

NICE Chronic pain guidelines

- Acknowledge that chronic pain is distressing. Aim to form a collaborative relationship.
- Assess all people with constant or intermittent pain lasting more than 3 months in a holistic, biopsychosocial manner – develop a care plan that supports self-management.
- What matters to this person? What skills do they already have? Use this to create a care plan.
- What is the cause of the pain? If identifiable AND a NICE guideline exists, use this to guide treating the chronic secondary pain first, and assess whether they would ALSO benefit from co-treatment of chronic PRIMARY pain.
- For people with chronic PRIMARY pain, discuss treatment options from a menu of:
  - Supervised exercise programmes and keeping active.
  - Psychological treatment: CBT or ACT.
  - A single course of acupuncture.
  - Consider an antidepressant to help sleep and quality of life (*also assess for anxiety and mood disorder!).*
- Adjust this menu depending on what you have access to locally!
- Do not start ANY OTHER pharmacological treatment for chronic primary pain, including opiates, paracetamol, gabapentinoids, NSAIDs, benzodiazepines, antipsychotics and antiepileptics.

	• For people ALREADY taking these drugs: Do they help? Do they cause side-effects? Are they safe? If minimal benefits or significant harms or unsafe levels, create a plan to reduce and stop.
	Discuss this guidance as a practice team, or even a PCN. How can different roles in the team best support people with chronic pain? Does your social prescribing link worker have access to good local resources, and are they aware of sites like Live Well With Pain? You may want to audit people with chronic primary pain (*perhaps start with those with fibromyalgia).* Compare their current treatment with these recommendations, and make a plan to flag the notes and discuss at their next review. If you have a clinical pharmacist, they may be able to help with this?
	Live Well With Pain: For people living with pain: https://my.livewellwithpain.co.uk For clinicians: https://livewellwithpain.co.uk Goal-setting information leaflet and templates to use with people with chronic pain in care planning: https://my.livewellwithpain.co.uk/resources/self-management/goal-setting/