Annex 1

ADVICE ON ANALGESIC OPTIONS IN TREATMENT OF MILD TO MODERATE PAIN IN ADULTS

Introduction

The CSM Pain Management Working Group reviewed alternative pain management strategies excluding co-proxamol (paracetamol and dextropropoxyphene) for acute and chronic mild to moderate pain.

The group considered supporting evidence in currently available guidelines on pain management in adults noting in particular the very limited role for co-proxamol.

General Principles

The group reinforced the need for prescribers to adopt general principles of pain management advised by current guidelines. These principles include:

1. **Diagnosis** Adequate assessment and accurate diagnosis of the cause of acute or chronic pain is essential for specific treatment options to be pursued.

2. **Acute on chronic pain** Acute pain may arise on a background of chronic pain, for example due to superimposition of osteoporotic vertebral collapse or nerve entrapment upon other pre-existing conditions. Pain management strategy as for an acute episode is advised.

3. **Progressive conditions** In a proportion of patients the underlying disease will be expected to deteriorate, in both malignant and non-malignant conditions, and the pain management strategy will require continual adjustment.

4. **Psychosocial factors** may contribute to pain severity, and should be treated and/or referred if necessary.

5. **Non-drug interventions** should be considered. Topical rubifacients or other therapies, for example, Trans-Epidermal Nerve Stimulation (TENS) may be beneficial to some patients.

6. **Pharmacological interventions** should be increased to full therapeutic and tolerated doses before switching to a different agent.

7. **Patient requirements** All treatment strategies need to be individualised to specific patient requirements and tolerance. Particular formulations may meet individual patient needs such as modified release or skin patch presentations.

8. **Combination analgesics** Individual patient treatment strategies should be worked out on the basis of single constituent analgesics where each component can be titrated independently. Fixed combination analgesics have a limited role in pain management, but may be convenient for patients so as to reduce the overall quantity of tablets. If
combination preparations are used, prescribers are encouraged to give therapeutic doses e.g. codeine 30mg and paracetamol 500mg per tablet.

9. Guidelines Additional sources of data on analgesics and published pain management guidelines should be consulted for detailed information. These include the Summary of Product Characteristics and patient information leaflets for specific products, the British National Formulary (BNF), the National Prescribing Centre (NPC), Scottish Intercollegiate Guidelines Network (SIGN), Prodigy NHS, the Pain Society and the World Health Organisation (WHO)\(^1\). This is not a comprehensive list.

Pain Management Strategies for Acute and Chronic Mild to Moderate Pain in Adults

Treatment strategies are considered in the following clinical settings where pharmacological agents can be introduced in a step-wise manner.

1. Acute pain either as a self-limiting episode or upon a background of chronic pain

2. Chronic pain due either to stable or progressive conditions.

Class I – Acute pain either as acute self-limiting episode or on a background of chronic pain: e.g. soft tissue injuries, post-operative pain, osteoarthritis, low back pain, dysmenorrhoea.

Step I: Paracetamol

Step II: Substitute ibuprofen

Step III: Add Paracetamol to Ibuprofen

Step IV: Continue paracetamol and replace ibuprofen with an alternative NSAID

An alternative approach where NSAIDs are contraindicated or not recommended (see product information) is to substitute a low potency opioid e.g. codeine or dihydrocodeine for the NSAID in place of, or in addition to full dose of paracetamol at steps II and III.

Where pain is not controlled on Step IV, a low potency opioid e.g. codeine or dihydrocodeine may be added.

Class IIa – Chronic stable pain requiring long-term regular analgesic use e.g. in osteoarthritis

Steps I to IV above may be effective for many patients.

Where chronic pain is not controlled after Step IV, the addition of a low potency opioid at therapeutic doses should be considered early in the management of chronic pain:

\(^1\) http://www.bnf.org/
http://www.npc.co.uk/
http://www.sign.ac.uk/
http://www.prodigy.nhs.uk/
http://www.painsociety.org/
Step V: Full therapeutic dose of low potency opioid e.g. codeine or dihydrocodeine in addition to full dose of NSAID or paracetamol.

Most patients will respond to this regimen, but for the small minority who do not:

Step VI: Therapeutic trial of a tricyclic antidepressant (e.g. amitriptyline) or an anti-convulsant (e.g. carbamazepine or gabapentin) for pain which is more complex or difficult to control. Note that the prescriber should check the licensed indications for individual products in these classes.

Class IIb – Chronic long-term pain of a progressive nature

This group includes cancer patients and some patients with neuropathic pain e.g. diabetic patients.

Treatment should follow the guidance for Class IIa chronic pain in relatively stable conditions (see above). If there is a possibility of neuropathic pain an early trial of a tricyclic antidepressant (e.g. amitriptyline) or anti-convulsants (e.g. carbamazepine or gabapentin) should be considered at the outset. In addition, the patient should be reviewed regularly and more potent opioids, eg morphine, oxycodone or fentanyl, should be considered as soon as pain fails to respond to lower potency opioids. This is particularly likely to happen in the case of cancer pain or some severe complex pain syndromes, where there may be a neuropathic component.

[Treatment of severe progressive cancer pain is not within the scope of this advice.]

Medicines and Healthcare products Regulatory Agency

October 2004