A practical guide to the provision of Chronic Pain Services for adults in Primary Care

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Section 1

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Introduction, foreword, acknowledgements and background information

Introduction

Pain is a universal human experience. It is the third most common reason why people visit their General Practitioner.

Treating the disease or condition that causes pain often resolves the problem. However, on other occasions treatment is not totally successful (e.g. diabetic neuropathy) and sometimes the cause of the pain is not entirely clear (e.g. pain following surgery, low back pain). Pain then persists.

Chronic pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.[1] Statistics show that nearly one in seven people suffer from chronic pain and 20% have suffered for more than 20 years.[2] It is hardly surprising that people suffering from chronic pain consult their doctor up to five times more frequently than others and that this results in nearly 5 million GP appointments a year.[3]

Two-thirds of chronic pain sufferers surveyed in the UK reported inadequate pain control with only 16% saying they had seen a pain specialist. Despite the fact that many patients want more effective management and better understanding of their pain, 70% were very satisfied with the doctor who treats their pain.[2]

88% of cancer patients in the last year of their life are in pain.[4] 47% of those treated for pain by their GPs said their treatment only partially controlled their pain.[4]

Pain is poorly addressed during undergraduate and postgraduate medical and nursing education and many healthcare professionals find the management of chronic pain a challenge. The Clinical Standards Advisory Group (CSAG) report on pain management services has been distributed to all Primary Care Organisations (PCOs). A summary of the recommendations from this report is available in the Appendices.

Introduction

There is growing pressure from patients and politicians to ensure that patients have effective pain management. This document is designed to help all members of primary healthcare teams achieve that aim. It contains background information, practical methods of assessing and treating chronic pain and advice on how to set up a nurse-led chronic pain management clinic. The management of chronic diseases is increasingly an area where nurses are taking a lead role and many are keen to develop their skills by taking on new challenges in the workplace. Nurse-led management of chronic conditions can allow a more appropriate distribution of work-loads within the practice. This document also highlights resource in secondary care which may be pivotal in managing patients in pain. Improved liaison between primary care and secondary care will enhance the management of pain and quality of life for patients.

We hope you will find this document useful and flexible enough to suit the individual needs of your practice. We believe that everybody wants to treat chronic pain effectively and the rewards both on a personal level and to the practice can be significant.

References:

1. IASP Pain Terminology. International Association for the Study of Pain: http://www.iasp-pain.org/terms-p.html, 2001
2. Pain in Europe. A 2003 Report. Research project by NFO Worldgroup. Funded by an educational grant from Mundipharma International Limited., Cambridge, England. October 2003
3. Elliott AM, Smith BH, Penny KI, et al. The epidemiology of chronic pain in the community. Lancet 1999; 354: 1248 – 1252
4. Addington-Hall J, McCarthy M. Dying from cancer: results of a national population-based investigation: Ann Oncol 1995, 9: 295-305

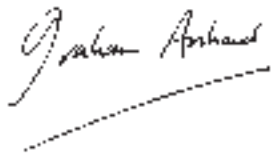
Foreword

It has been a privilege to be asked to produce this important document on the provision of chronic pain services in primary care. The document is the culmination of the thoughts of many multidisciplinary pain professionals and has been designed to help you, the practitioner, deal with pain as you see the problem in your practice.

Pain can be successfully managed in many patients by the use of simple assessment scales of the pain itself, assessment of both physical and psychological functional impairment and medication and non-medication treatments, coupled with an idea of the patient's goals for the end of treatment. Some patients with complex pain and psychosocial problems may require much more in-depth assessment and treatment and will need to be referred to secondary care. It is hoped that this document will inform you about treatments that are available. The art of medicine is in differentiating those patients who can be managed very successfully in primary care and those who require the more complex involvement of healthcare professionals in secondary care.

This document hopes to support you in improving the provision of chronic pain management services in primary care and has been produced with support from the Royal College of General Practitioners and The British Pain Society with an educational grant from Napp Pharmaceuticals Limited.

We hope you find the following information useful and we welcome any feedback you may have. Please e-mail the Royal College of General Practitioners at info@rcgp.org.uk



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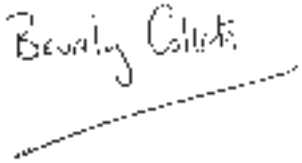

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Acknowledgements

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The facts about chronic pain in the UK

- 1 in 7 (13%) of the UK population suffer from chronic pain;[1]
- studies of chronic pain show that it is often persistent and that it seldom totally resolves even with treatment.[2] This does not mean that management is not worth pursuing;
- at least 7 million adults in the UK suffer from painful musculoskeletal conditions;[3]
- over half a million people in the UK suffer neuropathic pain. It is estimated that 25% of people with diabetes suffer from chronic pain, including neuropathic pain;[4]
- chronic pain can also arise from underlying disease such as multiple sclerosis, sickle cell disease, connective disease disorders etc;
- pain can arise after apparently uncomplicated surgery[5] and on many occasions no structural reason can be found to explain the pain. This does not mean that it is imagined or exaggerated;
- chronic pain can also arise in children from a variety of causes. It can be a significant problem and needs to be tackled jointly by primary care, paediatric services and specialised pain management services;
- untreated pain can affect quality of life for sufferers and carers resulting in helplessness, isolation, depression and family breakdown;[6]
- musculoskeletal conditions have a more negative effect on quality of life than cardiovascular, chronic respiratory and gastrointestinal disease and visual impairment;[7]
- two thirds of people with chronic pain surveyed across Europe reported inadequate pain control with only 16% saying they had seen a pain specialist;[1]

The facts about chronic pain in the UK

- poorly managed chronic pain accounts for 208 million days off work equating to £18 billion a year;[3]
- currently nearly 4.2% of the working population is on incapacity benefit, 24% of which are due to diseases of the musculoskeletal system and connective tissue, almost two thirds of whom are male.[8] This equates to a cost of £6.7 billion;[9]
- provision of chronic pain services in the UK is under- and variably- resourced with clinics providing a variety of treatments and with only half of reported pain clinics being able to offer Pain Management Programmes;[10]
- the prevalence of cancer pain is approximately 30-50% among patients with cancer who are undergoing active treatment for a solid tumour and 70-90% among those with advanced disease.[11]

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Assessing the current status of pain management in your practice

Section 2

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Assessing the current status of pain management in your practice

Should we have a primary care pain clinic?

There is a need to improve the management offered to patients with pain. Too often patients in pain are denied the treatment that they deserve. This document hopes to address this problem.

In the CSAG report 'Services for Patients with Pain', commissioners of care were urged to:

- review the provision of local pain services in relation to local need;
- commission a range of specialist services across a number of centres;
- set and monitor waiting time targets for chronic pain clinics, ensuring that no-one waits more than three months for a first appointment;
- specify pain relief quality standards for surgical intervention (i.e. pain relief measures after surgery).

Among the recommendations NHS Trusts were also urged to:

- improve GP access to investigations and to prompt opinion from specialists;
- ensure that patients have access where appropriate to a multi-disciplinary chronic pain team, which will also educate other professionals;
- ensure that patients undergoing painful procedures have access to an acute pain team led by a doctor and at least one specialist nurse, working closely with pharmacists and physiotherapists;
- ensure reasonable access to a pain management programme for patients with high levels of distress or disability as a result of chronic pain.

This sets a standard that should be attained, and it is important that there are specialist centres which have access to multidisciplinary teams.

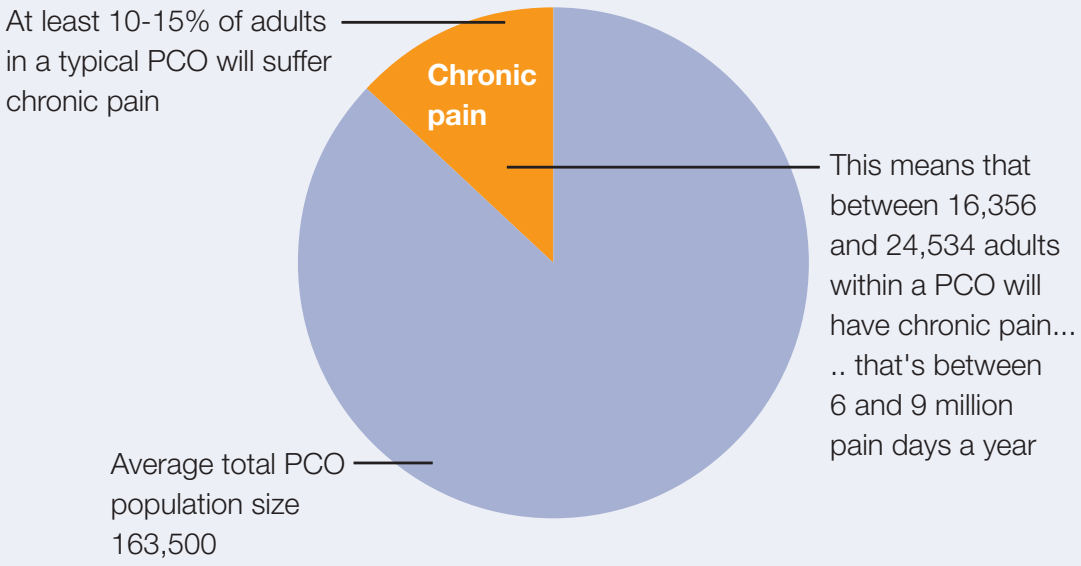
The need to improve the management offered to people with pain extends to the primary care sector, as much can be done there to ensure that people with pain are not denied the treatments they deserve.

Should we have a primary care pain clinic?

The diagram below demonstrates the burden of chronic pain to an average PCO.

It is important that primary and secondary care services work together to develop a seamless service for people with pain that acknowledges the multifaceted dimensions of the chronic pain experience and recognises that for some individuals, secondary care services with their multi-disciplinary perspective may be able to assist. For some patients, total relief of their pain is an unrealistic expectation and attention needs to be focused on minimising the adverse impact of chronic pain on the patient's life.

The burden of chronic pain to an average Primary Care Organisation



Why audit?

We all try to deliver the best healthcare to our patients. Sometimes we experience an unpleasant realisation that our practice is not as good as we hoped it might be. This may occur as a result of a clinical incident or complaint, or simply because of a sense of discomfort in the effectiveness of our care in a particular clinical area.

Pain is one of the most common reasons that patients present to primary care.[1] Many chronic pain sufferers are dissatisfied with the services that they receive from their GP or primary healthcare team, and also that their pain is inadequately controlled.[2]

So how do you know that your services for patients with chronic pain meet the standards that both you and your patients expect? The simplest way is to undertake an audit of your care. To do this you need to look at some of your basic data that is readily available and ask your patients about their perceptions.

In this section is an audit designed to be used by your practice for monitoring chronic pain management. For example:

- do all clinicians in your practice use the same medications for treating pain? If not, why is this so?
- would it be beneficial to use the same care pathway for those with chronic pain so that a patient will pass through an algorithm in the same direction no matter who in the practice the patient consults?

Your referral data also need to be assessed. For example:

- do some clinicians in your practice refer to secondary care more than others and for what painful conditions?
- should the team consider who best to refer to and why one clinician has a preference to refer to one rather than another secondary care consultant?

It is then worth asking your patients if they suffer from chronic pain. This will indicate the size of the problem and the effectiveness of your care. You may be very pleased with your performance, or you may be disappointed. Whatever the findings, this is a good talking point both for appraisal, Personal and Practice Development Plans (PPDPs) and clinical governance reviews.

Why audit?

You should ask every patient who attends the surgery on a particular day (when all the clinicians are present) to complete a pre-consultation questionnaire while waiting to be seen. A suitable form to use is suggested in Section 3.

Those patients who suffer chronic pain should be offered the post-consultation questionnaire in order to establish how well they feel you have treated their pain. This can be an unpleasant exercise but results should be considered constructively since patient feedback is a requirement of the GP contract. A suitable form to use is again suggested in Section 3.

The results of both these forms can then be entered easily into a spreadsheet and the figures analysed to see if your practice population is similar to others that have been reporting, and also if your management of chronic pain is favourable. Annual auditing will enable you to see the progress the practice is making in effective chronic pain management (through reduction of patient visits, time and cost-effectiveness).

References:
1. Elliott AM, Smith BH, Penny KI, et al. The epidemiology of chronic pain in the community. Lancet 1999; 354: 1248 – 1252
2. Pain in Europe. A 2003 Report. Research project by NFO Worldgroup. Funded by an educational grant from Mundipharma International Limited., Cambridge, England. October 2003

What to audit

In order to audit properly it is important that we first identify standards for the quality of care we plan to provide for patients suffering from chronic pain. We should then make our measurements and compare our performance against that care. Parts of the audit can be carried out in this way – but much of it is a survey of practice – this is because it is not always possible to decide what standards should be applied – for example – how many referrals should be made.

The list of data requirements suggested below will provide a good background for discussion to see what your practice is doing and how it might change for the better. Alternatively it might show that you do not need to change anything because your practice is already at a standard you are proud of. Whatever the result, it can be presented as part of your PPDP and appraisal documentation.

STEP 1 Examine your Prescribing Analysis and Cost (PACT) data for analgesia use

- section 4.7.1 Non-opioid analgesics
- section 4.7.2 Opioid analgesics
- section 10.1.1. Non-steroidal anti-inflammatory drugs (NSAIDs)
- section 4.3.1 Tricyclics for pain management
- section 4.8.1 Anticonvulsants for pain management

Determine whether all prescribers in the practice appear to use the same analgesics, or if there is no particular policy. If there is no consistency it is worth proposing a practice formulary – possibly with the local secondary care pain clinic or Pharmaceutical Advisor. Discuss and agree a policy concerning which medications to use for which condition, including the use of opioids in non-cancer pain.

What to audit

STEP 2 Determine how many patients are registered with painful diagnoses and are on repeat medication for analgesics

Examples include those with:

- back pain
- osteoarthritis
- rheumatoid arthritis
- cancer
- diabetic neuropathy
- post herpetic neuralgia
- multiple sclerosis
- post-surgical pain
- others who you consider may have chronic pain.

This audit may also help you to identify the different Read Codes that are used by members of the practice which may then present an opportunity to rationalise.

STEP 3 Record your demographic details

- determine the total number of patients in the practice
- determine the population in the following age bands:
  0 to 21 years
  22 to 65 years
  66 to 75 years
  over 75 years
- determine which medications are used for which age groups. Identify any variations and, where present, consider discussing with your local secondary care pain clinic or Pharmaceutical Advisor whether these are valid and useful.

STEP 4 Determine the number of referrals to secondary care for pain management:

Referral to:

• pain specialist	8H69 (9N1k)
• palliative care	8H7g
• orthopaedic surgeon	8H54
• rheumatologist	8H4B
• neurologist	8H46

What next?

Armed with this information it is now worth meeting as a practice to look at what you consider you are doing well and what areas you might like to improve. So far you have had no patient input into the proceedings. Patient feedback is highlighted not only in the GMS contract, but also in many GP documents. The involvement of patients in audit and care processes in general practice is very revealing. The next section will offer advice on how this might be done.

The questions you might ask at the practice meeting may include:

- when was pain control last reviewed in the practice PPDP meeting?
- is pain control included in all clinical professionals' Personal Development Plans (PDPs)? If not, is this because you have adequate data to prove that your practice manages chronic pain effectively?
- ensure all pain management contacts are discussed and included in the pain team members contact details sheet (Section 5).

These data should give an indication of how many patients in the practice are being seen for chronic pain and if pain management is being addressed as well as you would like it to be.

Patient survey and audit of pain

Pre-consultation audit of 100 patients who come to the surgery

Having considered surveys to determine how you, as a practice or an individual, manage patients suffering chronic pain, the next part of this audit is to ask patients about their pain and its management.

You should ask every patient who attends the surgery on a particular day (when all the clinicians are present) to complete a pre-consultation questionnaire while waiting to be seen (a suggestion for this questionnaire is included in Section 3). It does not matter why they are attending or who they intend to see. By asking every patient to complete a questionnaire you will be able to ascertain the prevalence of chronic pain in your practice.

It is also worthwhile having a simple poster in your waiting room or on the reception desk explaining why you are doing this audit.

Post-consultation audit of patients in pain

Those patients who have come in to the surgery for a consultation in which pain plays a part in their management, should be asked to complete the post-consultation questionnaire before leaving the surgery (a suggestion for this questionnaire is also included in Section 3).

If a patient volunteers their name then it is worth marrying up the pre- and post-audit surveys.

Patient assessment

Section 3

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Patient assessment

On the following pages of this section are questionnaires which are designed to assist you in obtaining the appropriate information from the patient as quickly as possible. There are also tables provided to enable you to record this information which can then be used for future audit.

Pre-consultation patient questionnaire

The following questionnaire gives many examples of the type of information that would be useful for the doctor whose care the patient is under and also as audit data for the practice or PCO. As a suggestion it may also be useful to cross reference age with the high risk of gastro-intestinal effects of prescribed NSAIDs.

Dear Patient

The doctors and nurses at this practice are very keen to ensure that you are being treated to the very best standards. Taking a few moments to answer the following questions will help us to understand what's needed to improve the services we offer to patients who are in chronic pain. If you are not suffering pain regularly there is no need to fill out this questionnaire.

Otherwise, thank you for taking the time to answer the following questions.

Please circle the appropriate response or add your comments

1. I am …… years old

2. I am female/male

3. Ethnic group

.....

4. Do you know the cause of your pain? Yes/No

5. If 'Yes' what is the cause of your pain?

.....

6. What do you believe is the cause of your pain?

.....

7. Do you have pain on most days? Yes/No

8. Where is your pain?

.....

Pre-consultation patient questionnaire

9. Do you have pain in more than one place? Yes/No

10. If so, where else is your pain?

.....

11. How long has your pain lasted?

A few days
A few weeks
Between 1 and 2 months
Between 2 and 4 months
Between 4 and 6 months
More than 6 months
2 years or more
5 years or more
More than 10 years

12. What pain-relieving medication do you take that has been prescribed by a doctor or nurse?

.....

13. What pain-relieving medication do you take when you feel you need it?
(that has not been prescribed by a doctor or nurse)

.....

14. What other medication do you take (prescribed or self-medicated)

.....

15. How would you describe your pain? (for office use only)

Burning	1DC1
Aching	1DC2
Stabbing	1DC3
Cutting	1CD4
Griping	1CD5
Tightening	1CD6
Pricking	1CD7
Shooting	1CD9
Pain at rest	1DCA
Pain on movement	

Pre-consultation patient questionnaire

16. How well is your pain controlled? Put a mark along this line to show how severe your pain is:

no pain _____ worst pain imaginable

17. Does pain regularly stop you getting to sleep? Yes/No

18. Does pain regularly wake you from your sleep? Yes/No

19. What else does your pain stop you from doing?

.....

20. Has the pain affected your mood?

.....

21. Have you had any of the following to improve your pain? .....(numbers for office use only)

TENS (Nerve Stimulation)	Yes/No	If 'yes' did it help? 8643
Acupuncture	Yes/No	If 'yes' did it help? 856
Surgery	Yes/No	If 'yes' did it help? .....
Counselling/ support	Yes/No	If 'yes' did it help? .....
Nerve blocks	Yes/No	If 'yes' did it help? .....
Medication	Yes/No	If 'yes' did it help? .....
Pain Management Programme	Yes/No	If 'yes' did it help? .....
Other (specify)	Yes/No	If 'yes' did it help? .....

22. Have you seen the following other people to help control your pain? (numbers for office use only)

Chiropractor	Yes/No	If 'yes' did it help? 9N2X
Osteopath	Yes/No	If 'yes' did it help? 82D3
Physiotherapist	Yes/No	If 'yes' did it help? 9N28
Psychologist	Yes/No	If 'yes' did it help? 9N2W
Occupational Therapist	Yes/No	If 'yes' did it help? 9N2A
Pain Management Services	Yes/No	If 'yes' did it help? .....

Pre-consultation patient questionnaire

23. Do you think your doctor or nurse understands how much pain you are in? Yes/No

24. Do you feel more could be done to control or manage your pain? Yes/No

25. If you feel more could be done, in what way do you think your pain control could be improved?

.....

.....

26. What do you hope to get out of your appointment with the doctor or nurse today?

.....

.....

If you are happy to give your name and which doctor or nurse you see or are about to see, please enter these details here:

Your name

.....

Doctor you usually see or are about to see

.....

Nurse you usually see or are about to see

.....

Please give your completed questionnaire to your doctor.

Thank you for your time.

Post-consultation patient questionnaire

Dear Patient

You have discussed your pain today with the doctor/nurse. We would be very grateful if you could take a little time to complete the questionnaire below.

This will help us to ensure that your questions were answered and worries eased.

Please circle the appropriate response or add your comments

1. Did you complete a pain questionnaire before your appointment? Yes/No

2. Was your pain poorly controlled before this appointment? Yes/No

3. Did you have enough time with the doctor/nurse to talk about what you wanted to? Yes/No

4. Do you think you understand the reasons or explanations given to you? Yes/No

5. Do you think your questions and worries were answered? Yes/No

6. Did the doctor/nurse examine you in a way you would have expected them to? Yes/No

If not, what else would you have liked them to have done?

.....

.....

7. Do you understand what you need to do next? Yes/No

8. Do you agree with the plan that the doctor/nurse has suggested? Yes/No

Post-consultation patient questionnaire

9. Could you explain what is going to happen to improve your pain? Yes/No

If you are happy to give your name and which doctor/nurse you saw, please enter these details below:

Your name

.....

Doctor's name

.....

Nurse's name

.....

Please give your completed questionnaire to the receptionist.

Thank you for your time.

Pre-consultation practice data collection form for chronic pain

Consultation Number	Patient 1	Patient 2	Patient 3	Patient 4	
Patient Number					
Does the patient know the cause of the pain? (Y/N)					
Is the pain present on most days? (Y/N)					
Has the pain been present for at least 6 months? (Y/N)					
What pain killing medication does the patient take regularly?					
What pain killing medication is taken as required?					
Visual analogue score (cm)					
Does the pain wake the patient from sleep? (Y/N)					
TENS (Y/N)					
Acupuncture (Y/N)					
Surgery (Y/N)					
Counselling / Support (Y/N)					
Nerve Blocks (Y/N)					
Pain Management Programme (Y/N)					

Pre-consultation practice data collection form for chronic pain

	Patient 1	Patient 2	Patient 3	Patient 4	
Chiropractor (Y/N)					
Osteopath (Y/N)					
Physiotherapist (Y/N)					
Psychologist (Y/N)					
Pain Management Services (Y/N)					
Occupational Therapist (Y/N)					
Does the patient feel that the doctor/nurse understands how much pain the patient is in? (Y/N)					
Does the patient feel more could be done to control their pain? (Y/N)					

Comments .....

.....

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.....

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..... Date .....

Post-consultation practice questionnaire data collection form for chronic pain

Consultation Number	Patient 1	Patient 2	Patient 3	Patient 4	
Patient Number					
Did the patient complete a pre-consultation questionnaire? (Y/N)					
Was the patient's pain poorly controlled before the consultation? (Y/N)					
Did the patient have enough time with the doctor/nurse to discuss their problems? (Y/N)					
Did the patient feel that the doctor/nurse answered their questions and worries? (Y/N)					
Did the patient feel that the doctor /nurse examined them in a way they would have expected? (Y/N)					
Did the patient understand the next steps? (Y/N)					
Did the patient agree with the suggested plan? (Y/N)					
Could the patient explain what was going to happen to improve their pain? (Y/N)					

Comments .....

.....

.....

.....

.....

.....

.....

.....

..... Date .....

Invitation to attend a primary care Chronic Pain Clinic

Dear

We are aware that you have been experiencing pain for some time now and therefore we would like to invite you to attend a Chronic Pain Clinic in your practice. We hope that we will be better able to assess your pain and then plan a treatment or management programme for you. We will be able to provide some of this programme in the practice but you may need referral to the local hospital Pain Management Service for more specialised treatment.

An appointment has been made for you:

On (date) .....

At (time) .....

Location (surgery address) .....

If you cannot attend this appointment please notify the practice in advance so that we can arrange a more convenient time for you to attend.

What to do before your appointment

Please complete the enclosed questionnaire and bring it with you when you come to the clinic. Do not worry if there are parts of the questionnaire you cannot complete; we will be able to help you when you come to the clinic. Write down any worries or concerns you may have regarding your pain so that we can discuss them at the clinic.

What will happen at the clinic?

Your appointment will last about 45 minutes. During this time, we will ask you about your pain and how it affects your day-to-day life, and about the medications that you are taking for your pain. We will discuss any worries you may have identified and try to find ways to resolve any problems you may have.

Invitation to attend a primary care Chronic Pain Clinic

What will happen as a result of my appointment?

We will discuss the results of the assessment with your doctor and give you an action plan. This might involve seeing your doctor, a change in your medication, recommendations for lifestyle changes or referral to a specialist. You will then have follow-up visits at the Chronic Pain Clinic to see whether the action plan is helping to improve your pain control.

We look forward to meeting you when you come to the clinic. In the meantime, if you have any queries or concerns please do not hesitate to contact our practice nurse on the number below.

Yours sincerely

.....

Practice nurse

.....

Address

.....

.....

.....

Contact details

.....

.....

.....

Aims and liaisons in primary care

Section 4

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Aims and liaisons in primary care

Some patients with chronic pain can be effectively managed in primary care. Some will need referral to multidisciplinary pain management services in secondary care. This section gives advice about setting up services for these patients using resources available in primary care. Remember that effective healthcare models exist when boundaries between primary and secondary care activity are broken down. Primary care physicians and hospital specialists should work together to manage patients in the most appropriate environment.

Setting up and managing a Chronic Pain Clinic in primary care

If a practice decision is taken to set up and run a Chronic Pain Clinic in primary care the following points may be useful:

What are the objectives of a primary care practice Pain Management Team?

The objectives of such a team need to be clearly identified. For example, the objective may be to identify those patients who have pain that is difficult to manage. e.g. leg ulcers, chronic back pain, fibromyalgia, chronic pelvic pain. What are the causes of these pain problems? How do psychosocial factors contribute to these problems? How can they be managed better and by whom?

Develop an effective team

Decide who the members of the team will be (e.g. doctor, nurse, physiotherapist, psychologist, occupational therapist) and what training they will need (expertise in patient care pathways will be essential). Ensure that the objectives are developed together and that there is an understanding of each other's job roles. Ensure liaison with your local hospital Pain Management Service so that care pathways are developed together. Your local hospital Pain Management Service may be willing and able to develop sessions within a primary care locality, to see difficult pain problems, and to be an educational resource as well as seeing patients within secondary care. Care pathways are a two-way process between secondary care and primary care.

It is important for members of the team to have a shared understanding of chronic pain. This may be promoted initially by reviewing research on the key areas of chronic pain. In this way it is possible to raise awareness of the conditions which can result in chronic pain, and the basis of protocols can be constructed and action plans developed.

Setting up and managing a Chronic Pain Clinic in primary care

Arrange initial and follow-up meetings to discuss practicalities

For example:

- obtain agreement from the PCO that setting up a Chronic Pain Clinic is a service priority;
- obtain agreement from the practice for funding extra work that may be generated and for personnel required;
- approve a lead clinician for the project;
- approve the membership of the team;
- determine the clinic time, frequency and start date;
- produce a timetable of training for team members;
- produce a timetable of meetings with subjects to be presented and list of presenters;
- agree on a level of advertising of the facility within the practice;
- decide whether this is for in-house use only or should be made available to other local practices;
- determine how to set up good lines of communication with colleagues in secondary care.

Audit

As discussed earlier in this document, audit activity needs to be simple and focused on specific terms of reference (example questionnaires and templates are shown in Section 3). This is a way of ensuring that the best possible care is being provided to patients. Feedback and re-audit are necessary to ensure any agreed recommendations are implemented and effective. Staff performing the audit should be members of the team.

Protocols

It is important to define clearly what information is to be recorded and where. This keeps the clinic focused, the staff interested and motivated and facilitates the audit process and subsequent report. Such a protocol will allow prompt recognition of trends. It is important to ensure that, at each attendance, the minimum data set per patient is recorded and that, at regular defined intervals, a collation of these data occurs by a defined individual and the audit cycle is completed. Local Care Pathways also need to be considered.

Examples of data to include:

- personal data;
- health problems including stress/depresion;
- therapy history;
- examination data;
- investigation data;
- current concerns.

Managing pain effectively

Pain is a complex sensory and emotional experience. The way in which we perceive pain is a complicated and dynamic interplay of inhibitory and excitatory neural events involving many parts of the peripheral and central nervous system. The relationship between pain and tissue injury is not straightforward.

Pain Management Services provide a multidisciplinary approach that not only addresses the biomedical component of the pain experience but also the social, emotional and economic context of the experience for both patients and their carers. The focus is on symptom management rather than diagnosis of the cause of pain (as in many instances no cause is found or the cause is untreatable).

The following steps are helpful when managing chronic pain:

- accurate assessment of pain;
- explanation of the cause of the pain to the patient if this is possible;
- discussion of possible treatment options available in primary care;
- appropriate selection of self-help techniques, simple pain management modalities and analgesia;
- consideration of referral to secondary care pain management for further assessment, complex pain modifying interventions and pain management programmes.

Accurate assessment of pain

This is the first step in improving pain management. Regional guidelines recommend a comprehensive assessment of the type of pain and its severity coupled with a basic psychosocial assessment and an assessment of mood and function.[1]

Pain should be routinely assessed just like other measures, such as blood pressure, and pain scores should be entered on a patient's records along with heart rate, blood pressure and other information.

There is no simple, direct measure of pain but it is generally recommended that pain should be assessed by the patient.[1] It has been suggested that, 'because pain is inherently subjective, a patient's self-report is the gold standard for assessment'.[2]

Managing pain effectively

Pain assessment should include the following:

- site: primary sites and patterns of radiation;
- quality e.g. stabbing, burning;
- temporal features: how long the pain has been present; what pattern it follows, diurnal variation;
- factors that exacerbate or relieve the pain;
- impact of pain on sleep;
- emotional impact e.g. anxiety, depression etc;
- severity: mild, moderate or severe or as indicated on a numerical rating scale or visual analogue scale;
- impact on quality of life: activities that are difficult to carry out or the patient has stopped doing or avoids, or manages but at a high cost to their pain.

Several tools have been developed for people to assess their pain. The simplest pain measurement techniques require patients to rate their pain on visual scales – such as lines ranging from 'no pain' to 'worst pain imaginable' – or on verbal or numerical scales. A simple verbal rating scale with the patient rating pain as 'none', 'mild', 'moderate' or 'severe' has been shown to correlate well with a visual analogue scale.[3]

Scales are also used that record pain experience and the effect that pain has on functioning and quality of life.

It may be useful to differentiate between neuropathic, inflammatory or nociceptive components of the pain as this may help define the analgesic medication that is needed.

Psychosocial 'Yellow Flags'

These are factors that may increase the risk of developing or perpetuating long-term disability and work loss associated with low back pain. Identification of risk factors can inform appropriate cognitive and behavioural management strategies to achieve functional outcome gains. Keeping active and maintaining social, work and family activities is important.

Communication with the patient at this stage is vital. Pain management will only succeed in collaboration with the patient. It is important for healthcare professionals to understand pain from the patient's perspective to give them information to help them understand their pain. Sometimes referral to hospital for further investigation is necessary. Unfortunately, chronic pain is complex and we do not understand the mechanisms for all pains. Regrettably, this also means that we are not always successful at controlling a person's pain.

Myths about pain

The amount of pain is proportional to the injury or pathology identified

This is not true for the simplest of experimental pains, nor in Accident & Emergency and certainly not in chronic pain where, in addition to the variable relationship between the painful stimulus and the pain experienced, there are many complex modulating processes in the nervous system which influence the pain experience.

If no cause is identified for the pain, then the complaint of pain is due to psychological causes

There are many causes of pain which are not evident on imaging technology, from headaches to neuropathic and phantom pains. Functional changes in the central nervous system are important in some of these. In addition, the distress which often accompanies chronic pain is generally a consequence of the pain and its impact rather than causative, and the theories proposing mechanisms by which psychological distress becomes pain, lack empirical support.

A patient who describes pain as severe or rates it high on numerical or visual analogue scales, and who does not look ill, writhe and grimace, is exaggerating their pain

Pain is detectable in subtle ways even when people with pain try not to show it. Many patients try to minimise their pain by guarding and careful movement, or by keeping still. In addition, they are often aware that their pain may be disbelieved by some people if they show their distress, and by others if they present in a calm way.

Patients who do not take analgesics but continue to complain of pain are not cooperating with treatment

Not all pain is treatable by every analgesic and some pains do not reduce significantly with any. That is not the patient's fault. Additionally, sometimes for the patient the benefits in terms of 'some' pain reduction are outweighed by the adverse effects, particularly those, like sedation, which interfere with daily life.

Treatment options

Primary care professionals need to identify what the problems are, what outcomes are wanted by the healthcare professional and the patient, and what is the best treatment route to try to achieve those outcomes in this particular case. A selection of non-pharmacological or pharmacological treatment options may be offered.

Non-pharmacological options for pain management

Physical therapies

Healthcare professionals may refer patients to a physiotherapist who will assess the patient, suggest exercises to increase mobility and educate the patient to take control of the pain. For patients with arthritis or osteoporosis, gentle, frequent muscle-strengthening exercises can help to maintain joint mobility. The application of heat or cold packs may also help in some cases. The use of graduated exercise programmes has been shown to be of benefit in the management of fibromyalgia syndrome and chronic fatigue syndrome although the efficacy of conventional physiotherapy in the management of back pain needs to be clarified.

Transcutaneous electrical nerve stimulation (TENS)

Often used to treat patients with chronic pain, including those with neuropathic pain (such as post-herpetic neuralgia), TENS involves a small, battery-powered instrument that delivers an electrical current to pairs of electrodes applied to the skin.

Patients will usually need to have a period of continuous stimulation for 90 minutes or more to achieve pain relief.

Non-pharmacological options for pain management

Psychological treatments

Cognitive behavioural treatment (CBT) and a psychologically-based rehabilitation programme have shown good evidence for clear benefits across pain, mood, activity and reduced healthcare use. It can be extended to incorporate return to work. It is often delivered in a group programme format with exercise, education and other rehabilitative initiatives by a team including physiotherapists, doctors, occupational therapists and nurses. A clinical psychologist is central to providing cognitive behavioural treatment.

Referral to general clinical psychology, mental health services, or psychiatry, will not necessarily result in appropriate diagnosis or help, although it is essential that clinical depression is appropriately treated.

Patient support groups

Patient support groups exist, are centrally encouraged and may be of benefit to some patients with chronic pain. However their content and style vary considerably and they rarely bring about improved function, although they may help mood.

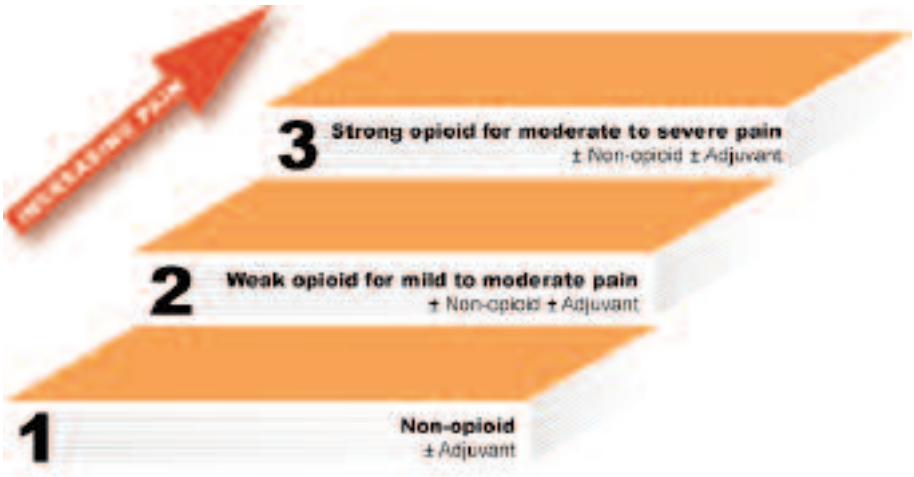
Complementary therapies

Several complementary therapies are available, including acupuncture, reflexology, massage therapy, therapeutic touch, and aromatherapy. The evidence-base to support the use of these interventions is sparse.

Pharmacological pain management

Appropriate selection of analgesia

In general, the World Health Organisation (WHO) three-step 'analgesic ladder',[4] originally developed for cancer pain, is accepted as a model approach for the management of other forms of chronic nociceptive pain. However this approach needs to be implemented in this group of patients with care.



* Adjuvant – secondary remedy assisting the action of another

Treatment should be started at the bottom of the ladder and the ladder ascended in accordance to the response to medication with regards to both efficacy and side effect profile. Although ascending the ladder may be deemed appropriate, in some patients this is prevented by increasing side effects.

Paracetamol

For people with mild or moderate pain, paracetamol may prove sufficient for pain control. Often undervalued, paracetamol is an effective analgesic, with no gastrointestinal adverse effects, and is available in a variety of formulations. Care should be taken to avoid overdosing, because this may cause liver damage.

Pharmacological pain management

Non-steroidal anti-inflammatory drugs (NSAIDs)

NSAIDs have a threefold action: relieving pain, reducing inflammation and reducing fever. They can be particularly useful in conditions where the pain is accompanied by inflammation, such as rheumatoid arthritis. NSAIDs may have no advantage over simple analgesics in back pain.[6]

First-generation NSAIDs, such as diclofenac and naproxen, may be associated with gastrointestinal problems, such as stomach ulcers. The newer NSAIDs (COX-2 inhibitors or coxibs) appear to have fewer gastrointestinal side effects in some people and thus may offer an important option in the treatment of chronic pain in disorders such as arthritis.[5] However, all NSAIDs and Coxibs have the potential to cause renal dysfunction and should be used with caution in patients with cardiac disease.

Weak opioids

Weak opioids include drugs such as codeine, dihydrocodeine, and propoxyphene. They are effective analgesics, but may cause drowsiness, constipation and other side-effects.

Strong opioids

It may be appropriate to use strong opioids as part of the patient's overall pain management strategy. Strong opioids may be considered when other options have failed to control a patient's pain.

The choice of opioid and method of administration depends on clinical circumstances and it may be necessary to try different opioids before the best balance of efficacy and adverse effects is achieved for a particular patient.

The treatment of chronic non-malignant pain, in particular, requires the consideration of many factors (such as causative disease, previous analgesic history and extent of disability), before choosing whether to start a strong opioid and which opioid to start treatment with.[7,8]

Pharmacological pain management

Side effects with opioids

All opioid analgesics can have a range of side effects. These include:

Sedation – sedation can occur in the first few days of regular opioid treatment. This is exacerbated by concomitant use of other medication that depresses the central nervous system. Patients should be warned about the possibility of sedation and be advised not to drive or use machinery until on a stable dose.

Constipation – most patients who take opioids develop constipation. The best prophylactic treatment for preventing opioid-induced constipation is a combination of stimulant and softening laxatives.

Nausea and vomiting – 30 to 60 per cent of patients taking opioids for the first time will develop nausea and/or vomiting. This usually settles within five to ten days. It is generally recommended that patients starting opioids should have access to antiemetics. If patients continue to suffer nausea and vomiting, parenteral or transdermal preparations should be used.

Dry mouth – this problem is common. Patients should be encouraged to take regular sips of cool water.

Itching – This is an intrusive symptom which may settle with time but occasionally persists and necessitates trial of an alternative preparation or cessation of opioid treatment.

Less common side-effects of strong opioids include hypotension, confusion, and urinary hesitancy or retention. Respiratory depression is uncommon in this context. In addition, effects on fertility, sexual function and the immune system have been described. There is also a possibility that opioids can sometimes causes hyperalgesia i.e. increased sensitivity to pain. Further work in these areas needs to be undertaken. However, it is important to monitor patients who take opioids regularly and if difficulties are encountered in these patients, then expert advice MUST be sought.

'Co-analgesics' are drugs which have been found to have an analgesic effect although their primary use is to treat other conditions. These drugs are mainly used in the treatment of neuropathic pain, and fall into two main groups: the tricyclic antidepressants and anticonvulsants.

Pharmacological pain management

Tricyclic antidepressants (TCAs) and serotonin-noradrenergic reuptake inhibitors (SNRIs)

Tricyclic antidepressants have been extensively used for neuropathic pain and more recently for fibromyalgia. They work by increasing the levels of chemicals involved in endogenous pain control and their action is independent of the antidepressant activity. Evidence suggests that drugs that increase the levels of both noradrenaline and serotonin are most effective. The first generation of tricyclic antidepressants (amitriptyline, dosulepin, imipramine) are probably the best studied and most effective. Onset of analgesia is more rapid than onset of the antidepressant effect and there is a dose-response relationship for analgesia – although generally a lower dose is required for pain than for depression. A low dose is prescribed initially and gradually increased according to effect and side-effects. Constipation, dry mouth, urinary hesitancy and, occasionally, postural hypotension in the elderly, may occur.

Anticonvulsants

Drugs used in the treatment of epilepsy have a number of actions which make them a logical choice for the treatment of neuropathic pain. Carbamazepine and gabapentin are most commonly used. Again, it is important to start with a low daily dose and gradually increase, according to response.

In order to ensure concordance with the treatment regime, it is essential that the patient is given a full explanation of the rationale for the use of both these classes of drugs and also of the side effects to expect. Although some of these drugs have product licences for treating neuropathic pain (e.g. gabapentin, pregabalin), many do not (e.g. amitriptyline) and are used outside their product licence. The British Pain Society booklet on The Use of Drugs Beyond Licence in Palliative Care and Pain Management (2002) offers valuable advice on this subject.

There are other groups of drugs which have some degree of analgesic efficacy but are less frequently used, such as corticosteroids, hormone therapy and bisphosphonates.

Pharmacological pain management

Nerve blocks

Nerve blocks with local anaesthetic may temporarily modify a patient's pain experience. They are rarely useful in management of ongoing pain.

Steroids can be added to these local anaesthetic blocks. Steroids reduce nerve conduction in C nociceptive fibres and may reduce inflammation in inflamed nerves.

Epidural steroid injections are used for radicular leg pain with relief in some cases.

When pain cannot be controlled by any other means, the nerves may be irreversibly disrupted by chemical or surgical processes to block the pain. With peripheral nerve blocks it is normally not possible to block sensory nerves without blocking motor nerves as well. Phenol and alcohol can be used to block sympathetic nerves and can be helpful in pain due to cancer, such as pancreatic cancer and other cases of pelvic malignancy. This often gives good short-term pain relief and may be useful for the patient with reduced life expectancy.

For patients with chronic non-cancer pain, destroying nerves seems to produce only short-term relief.[8]

Joint replacement

For patients with rheumatoid arthritis and severe osteoarthritis, surgical replacement of the affected joints may be a possibility in advanced cases of the disease, where there is severe pain and disability.[9] On occasions there may not be any reduction in the pain from the affected joint, other pains related to the scar or to other nerves in which pain may manifest.

References:

1. Scottish Intercollegiate Guidelines Network, Scottish Cancer Therapy Network. Control of Pain in Patients With Cancer. Edinburgh: SIGN, 2000
2. Portenoy RK, Lesage P. Management of cancer pain. Lancet 1999; 353: 1695-1700
3. Working Party on Pain After Surgery. Commission on the Provision of Surgical Services. Report of the Working Party on Pain After Surgery. London: The Royal College of Surgeons of England – College of Anaesthetists, 1990
4. Cancer Pain Relief: With a Guide to Opioid Availability. Geneva: World Health Organisation, 1996
5. Association of the British Pharmaceutical Industry. Target pain. London: ABPI, 2003
6. Non-steroidal anti-inflammatory drugs for low back pain http://www.jr2.ox.ac.uk/bandolier/booth/painpag/Chronrev/muscskel/CP107.HTML.2000 (last accessed 23 April 2003)
7. Breivik H. Treatment protocols for chronic non-malignant pain. In: Breivik H, Campbell W, Eccleston C, editors. Clinical Pain Management – Practical Applications and Procedures. London: Arnold, 2002: 77-83
8. Recommendations for the appropriate use of opioids for persistent non-cancer pain. The Pain Society March 2004
9. McQuay H. Pain and its Control http://www.jr2.ox.ac.uk/bandolier/booth/painpag/wisdom/C13.html, 1999 (last accessed 23 April 2003)
10. Hip replacement: needs and risks. http://www.jr2.ox.ac.uk/bandolier/band103/b103-2.html, 2003 (last accessed 22 May 2003)

Older people

Advancing age is known to be associated with a greater prevalence of pain ranging from 25%-65% in community dwelling older people and up to 80% for those in residential or nursing home care.[1] There is no doubt that older people may present particular problems such as co-morbidity and polypharmacy, along with special considerations when carrying out pain assessment. For example this group may be unable to comprehend or see the assessment scales.

There is much evidence to support the need for education of staff to enable them to understand the specific needs of the older person. Furthermore, there are a range of specialised pain assessment tools available such as the one developed by Abbey [2] or the Doloplus[3] scale. These tools have been developed specifically for this group, however many older people can still cope with the traditional verbal descriptors or visual analogue scales.[4] As with all patients with chronic pain, it is necessary to carry out a multidimensional assessment, since issues associated with mobility and quality of life can be important to this group who can easily experience social isolation as a result of pain.

If pharmacological management is required, it should be used with caution and monitored closely.[5] Older people may prefer self-help strategies over which they have control as opposed to drug interventions which can often cause unpleasant effects. As such, self-help techniques may be more appropriate as long as the information given is understandable and in a written format. Where pharmacological approaches are used, the ideal setting for monitoring these approaches is within the nurse-led clinic.

Finally, the provision of self-help groups is another option, but consideration should be given as to where the groups are facilitated and to ensure that they are tailored specifically for the older person in terms of activity, pacing and relaxation. The ideal venue for such programmes would be in the community setting or within secondary care to negate the need for travelling to acute trusts.

References:

1. Helme RD, Gibson SJ, The epidemiology of pain in elderly people. Clinical Geriatric Medicine 2001; 17: 417-431
2. Abbey J, Piller N, DeBellis A et al (2004) The Abbey Pain Scale: a 1 minute numerical indicator for people with end stage dementia. International Journal of Palliative Nursing 10.1.6-13
3. Chapiro S (2001) The DOLOPLUS2 scale - evaluating pain in the elderly. European Journal of Palliative Care 8.5 191-194
4. Closs SJ (2004) Assessment of pain in the nursing home population. Unpublished Report & Verbal Communication
5. Popp B, Portenoy RK, Management of chronic pain in the elderly: pharmacology of opioids and other analgesic drugs. In Ferrell BR, Ferrell BA (eds) Pain in the elderly IASP Seattle. 1996; 21-34

When to refer

Section 5

Supported by an educational grant from Napp Pharmaceuticals Limited

When to refer

The Pain in Europe survey report has shown that most people with chronic pain do not feel that their pain is adequately controlled.[1]

A large number of pain management techniques and complex pharmacological therapies available in secondary care are not usually available in the primary care setting.

Patients should be given comprehensive instructions on how to self-manage their pain in the first instance. Non-pharmaceutical options, such as TENS and physiotherapy can be considered.

Mild analgesic therapies may be offered with good effect. Most acute pain will resolve. However, for those in whom pain continues and becomes chronic, the decision needs to be made on whether or not the pain can be managed in primary care or whether the patient needs to be referred to a specialist unit. It is very important for patients and doctors to understand that not all pains can be treated.

It is important to refer early rather than late. All patients whose diagnosis is in doubt must be referred to the appropriate hospital specialist. All patients whose pain is not well controlled or those whose pain is likely to deteriorate – for example those with cancer pain – should be considered for referral early rather than late. This enables the patient and pain/palliative care specialist to develop a rapport before the situation is particularly bad and have rapid access to this care when the time comes.

An early return to work is to be encouraged and the employers should be involved in this part of the process, as changes to the work place environment may be needed. Although pain may be present this should not prevent a return to work, and this needs to be discussed with the patient.

Secondary Care Pain Management Services will be available in your local hospital or in a hospital near to you. You should have the facility to refer a patient to these services. Waiting times for specialist pain services may be several months, but it is important to continue to see patients waiting for specialist referral and to modify treatment where appropriate.

Reference:

1. Pain in Europe. A 2003 Report. Research project by NFO Worldgroup. Funded by an educational grant from Mundipharma International Limited., Cambridge, England. October 2003

Pain scales in multiple languages

The British Pain Society has produced a series of pain scales to assist in the assessment of pain in people for whom English is not their first language. It is thought that a translator may quite easily be found for the more commonly spoken languages.

The following pain scale translations are available via The British Pain Society's website, www.painsociety.org

- English (for reference)
- Albanian
- Arabic
- Bengali
- Traditional Chinese
- Greek
- Gujarati
- Hindi
- Simplified Chinese
- Polish
- Punjabi
- Somali
- Swahili
- Turkish
- Urdu
- Vietnamese
- Welsh

Pain Management Services: contact details

It is worth completing the contact details sheet below so that all (including locums) know what services are available in your area for the management of chronic pain, who to contact and where to find them. This can be adapted for your own particular practice or PCO.

Role	Name	Work address	Telephone / Fax / email
Consultant in Pain Management & Anaesthesia			
Consultant in Palliative Care			
Palliative Care Clinical Nurse Specialist			
Pain Clinical Nurse Specialist(s) – Acute/Post-operative			
Pain Clinical Nurse Specialist(s) – Chronic (if not Palliative Care)			
General Practitioner			
General Practitioner with a special interest in pain			
Practice Nurse			
Occupational Therapist			
Physiotherapist			
Clinical Psychologist			
Pain Management Programme contact			

Date .....

Important documents

Appendix 1

Supported by an educational grant from Napp Pharmaceuticals Limited

Important documents

- Clinical Standards Advisory Group report: Services for Patients with Pain. March 2000
- RCGP Clinical Guidelines for the Management of Acute Low Back Pain. December 2001
- Recommendations for the appropriate use of opioids for persistent non-cancer pain. The British Pain Society. March 2004
- Pain and Pain Services in the NHS. November 2002
- Morphine and alternative opioids in cancer pain: European Association for Palliative Care (EAPC) recommendations. January 2001
- The Oxford Pain Internet Site including:
  Moore A, Edwards J, Barden J and McQuay H, Bandolier's Little Book of Pain, Oxford University Press 2003. Oxford University Press. (www.oup.com)
- NICE Guidance on Coxibs. 2003
- Five Pledges for People Living with Persistent Pain
  Endorsed by The British Pain Society and the Royal College of General Practitioners

Clinical Standards Advisory Group report: Services for Patients with Pain *March 2000*

Summary

- pain is a common consequence of ill-health and long-term pain can have a devastating effect on the lives of sufferers and families;
- the subjective nature of pain makes it difficult to evaluate interventions and professional differences lead to a wide range of treatments;
- specialist services for acute and chronic pain exist in the majority of general hospitals, but there is marked variation in their level and nature. Some services were poorly organised and lacked dedicated time from consultants and an agreed role for specialist nurses;
- specialist palliative care services were usually better organised, with clearer policies and better funding than those for chronic cancer pain;
- specialist acute pain services concentrated on post-operative pain: the same priority was not given in Accident & Emergency departments;
- a total of 20 recommendations are made to Health Authorities, Primary Care Groups, Trusts, Commissioners of Research and Development and to professional bodies. These recommendations seek to ensure that services are more equitably provided, better organised and managed, and that they are based on the best clinical evidence for effectiveness.

Clinical Standards Advisory Group report: Services for Patients with Pain *March 2000*

Points from the report

- long standing pain can have devastating effects on the lives of sufferers and families;
- untreated pain can cause helplessness, depression, isolation, family breakdown and inappropriate disability, but there is a great deal that can be done to treat pain and alleviate its effects;
- acute pain teams have been established at the majority of Trusts, and this can now be considered to be normal practice in the UK;
- expertise in treating chronic pain is scarce; typically, there is under-provision of services and significant unexpressed demand;
- many specialist pain services are too poorly resourced to meet local need and there are unacceptable waiting times for many participants. There is a significant lack of specialised and general nursing care;
- psychologically based approaches can be effective but are offered to only a few patients;
- there was minimal formal joint working between chronic pain and other medical specialities;
- services discharged far fewer patients than they took on each year. This is unsustainable;
- professionals felt poorly supported within their Trusts. Service heads frequently reported unsuccessful attempts to increase funding;
- GPs are more satisfied with palliative care than with pain management services;
- there is a demand from patients and healthcare professionals for access to complementary therapies. More research is needed to evaluate the outcomes;
- many patients felt that healthcare professionals had not believed that their symptoms were genuine.

Clinical Standards Advisory Group report: Services for Patients with Pain *March 2000*

Recommendations to:

Health Authorities

- review provision of local pain services in relation to local need;
- commission a range of specialist services across a number of centres;
- set and monitor waiting time targets for chronic pain clinics, ensuring that no one waits more than three months for a first appointment;
- specify pain relief quality standards for surgical agreements;
- ensure that cancer patients have access to palliative care pain services;
- encourage evaluation of complementary therapies and develop referral guidelines to ensure that funding is directed towards effective treatments.

NHS Trusts

- improve GP access to investigations and to prompt opinion from specialists;
- ensure that patients have access where appropriate to a multi-disciplinary chronic pain team, which will also educate other professionals;
- ensure that patients undergoing painful procedures have access to an acute pain team led by a doctor and at least one specialist nurse, working closely with pharmacists and physiotherapists;
- ensure reasonable access to a pain management programme for patients with high levels of distress or disability as a result of chronic pain;
- give a higher priority to effective pain management in Accident & Emergency departments;
- ensure that staff who provide pain services for children are trained and experienced in paediatric and family care;
- ensure that staff who manage patients with pain are adequately trained.

Clinical Standards Advisory Group report: Services for Patients with Pain *March 2000*

Commissioners of Research and Development

- assess guidelines centrally for the NHS and disseminate the best examples;
- develop evidence-based guidelines for some conditions and therapies;
- support research into the epidemiology and impact of unrelieved pain;
- support research into the effectiveness of therapies, particularly those that may prevent acute pain becoming chronic pain, and reviewing the existing research;
- review the value and appropriate use of pain assessment tools for children.

Professional bodies

- ensure that teaching and training at all levels covers pain management adequately;
- make available to GPs good quality guidelines on the management of pain and the referral of patients.

Further information:
ISBN 0-11-1 84182 157 8:
Department of Health, PO Box 777, London SE1 6XH
http://www.doh.gov.uk/pointh.hkm

The Royal College of General Practitioners: Clinical Guidelines for the Management of Acute Low Back Pain *December 2001*

Diagnostic triage

Diagnostic triage is the differential diagnosis between:

- Simple backache (non-specific low back pain)
- Nerve root pain
- Possible serious spinal pathology

- **Simple backache:** *specialist referral not required*

Presentation 20-55 years
Lumbosacral, buttocks and thighs
'Mechanical' pain
Patient well

- **Nerve root pain:** *specialist referral not generally required within first 4 weeks, provided resolving:*

Unilateral leg pain worse than low back pain
Radiates to foot or toes
Numbness and paraesthesia in same direction
Straight Leg Raising (SLR) reproduces leg pain
Localised neurological signs

- **Red flags for possible serious spinal pathology:** *consider prompt referral (less than 4 weeks)*

Presentation under age 20 or onset over 55
Non-mechanical pain
Thoracic pain
Past history – carcinoma, steroids, HIV
Unwell, weight loss
Widespread neurological symptoms or signs
Structural deformity

Cauda equina syndrome: *immediate referral*
Sphincter disturbance
Gait disturbance
Saddle anaesthesia

The Royal College of General Practitioners: Clinical Guidelines for the Management of Acute Low Back Pain *December 2001*

Principal recommendations

The evidence is weighted as follows:

*** Generally consistent finding in a majority of acceptable studies
** Either based on a single acceptable study or a weak or inconsistent finding in some of multiple acceptable studies
* Limited scientific evidence which does not meet all the criteria of 'acceptable' studies

Assessment	Evidence
Carry out diagnostic triage	* Diagnostic triage forms basis for referral, investigation and management
X-rays are not routinely indicated in simple backache	* Royal College of Radiologists Guidelines
Consider psychosocial 'yellow flags'	*** Psychosocial factors play an important role in low back pain and disability and influence the patients response to treatment and rehabilitation

Simple backache

Drug therapy

Prescribe analgesics at regular intervals not p.r.n	** Paracetamol effectively reduces low back pain
Start with paracetamol. If inadequate substitute NSAIDs (e.g. ibuprofen or diclofenac) and then paracetamol-weak opioid compound (e.g. codydramol or coproxamol). Finally, consider adding a short course of muscle relaxant (e.g. diazepam or baclofen)	*** NSAIDs effectively reduce pain. Ibuprofen and diclofenac have lower risks of gastro-intestinal complications
	** Paracetamol-weak opioid compounds may be effective when NSAIDs or paracetamol alone are inadequate
Avoid strong opioids if possible	*** Muscle relaxants effectively reduce low back pain

The Royal College of General Practitioners: Clinical Guidelines for the Management of Acute Low Back Pain *December 2001*

Bed rest

Do not recommend or use bed rest as a treatment

*** Bed rest for 2-7 days is worse than placebo or ordinary activity and is not as effective as alternative treatments for relief of pain, rate of recovery, return to daily activities and work

Some patients may be confined to bed for a few days as a consequence of their pain but this should not be considered a treatment

Advice on staying active

Advise patients to stay as active as possible and to continue normal daily activities

*** Advice to continue ordinary activity can give equivalent or faster symptomatic recovery from the acute attack and lead to less chronic disability and less time off work

Advise patients to increase their physical activities progressively over a few days or weeks

If a patient is working, then advice to stay at work or return to work as soon as possible is probably beneficial

The Royal College of General Practitioners: Clinical Guidelines for the Management of Acute Low Back Pain *December 2001*

Manipulation

Consider manipulative treatment for patients who need additional help with pain relief or who are failing to return to normal activities

*** Manipulation can provide short-term improvement in pain and activity levels and higher patient satisfaction

** The optimum timing for this intervention is unclear

** The risks of manipulation are very low in skilled hands

Back exercises

Referral for reactivation / rehabilitation should be considered for patients who have not returned to ordinary activities and work by 6 weeks

*** It is doubtful that specific back exercises produce clinically significant improvement in acute low back pain

** There is some evidence that exercise programmes and physical reconditioning can improve pain and functional levels in patients with chronic low back pain. There are theoretical arguments for starting this at around 6 weeks

The Royal College of General Practitioners: Clinical Guidelines for the Management of Acute Low Back Pain *December 2001*

Key patient information points

Simple backache – give positive messages

There is nothing to worry about. Backache is very common
No sign of any serious damage or disease. Full recovery in days or weeks – but may vary
No permanent weakness. Recurrence possible – but does not mean re-injury
Activity is helpful, too much rest is not. Hurting does not mean harm

Nerve root pain – give guarded positive messages

No cause for alarm. No sign of disease
Conservative treatment should suffice – but may take a month or two
Full recovery expected – but recurrence possible

Possible serious spinal pathology – avoid negative messages

Some tests are needed to make the diagnosis
Often these tests are negative
The specialist will advise on the best treatment
Rest or activity avoidance until appointment to see specialist

Patient booklet

The above messages can be enhanced by an educational booklet given at consultation
The Back Book is an evidence-based booklet developed for use with these guidelines and is available from The Stationery Office (ISBN 011 702 0788)

The Royal College of General Practitioners: Clinical Guidelines for the Management of Acute Low Back Pain *December 2001*

Psychosocial 'Yellow Flags'

When conducting assessment, it may be useful to consider psychosocial 'yellow flags' (beliefs or behaviours on the part of the patient which may predict poor outcomes)

The following factors are important and consistently predict poor outcomes:

- a belief that back pain is harmful or potentially severely disabling;
- fear-avoidance behaviour and reduced activity levels;
- tendency to low mood and withdrawal from social interaction;
- expectation of passive treatment(s) rather than a belief that active participation will help.

Further information:
ISBN Number 0 85084 229 8
Royal College of General Practitioners
14 Princes Gate, Hyde Park, London SW7 1PU
http://www.rcgp.org.uk

Recommendations for the appropriate use of opioids for persistent non-cancer pain *March 2004*

Executive summary

- the document makes recommendations about the appropriate use of opioids in persistent non-cancer related pain;
- these recommendations pertain to all opioids available in the UK. The recommendations do not concern spinally delivered opioids;
- these recommendations were not developed for those patients who chronically use 'weak opioids' within the British National Formulary dosage range. The recommendations refer to patients who use 'weak' opioids outside the British National Formulary range, and to patients who use, or might benefit from using 'strong' opioids;
- it is the opinion of the working group that injectable opioids should not be used in the management of persistent non-malignant pain;
- there is a lack of good quality research about the benefits and risks of opioids for patients with persistent non-cancer pain;
- there is a need for closer working relationships and good communication between primary and secondary care services with regard to the management of patients who are prescribed opioids;
- the primary outcome of treatment should be analgesia. Demonstrable improvements in physical, psychological and social function are important secondary aims. Opioids should not be used as primary anxiolytics or sedatives;
- the presence of psychological co-morbidity or a history of alcohol/problem drug use does not preclude the use of opioids. Advice from or referral to a specialised service with experience of managing these patients (e.g multidisciplinary pain management service or specialised addiction service) is recommended in these circumstances;
- only a registered medical practitioner should make the initial prescription of strong opioids for persistent non-cancer pain. Thereafter, other healthcare professionals may assist with monitoring and maintaining opioid therapy. Healthcare professionals who prescribe or maintain opioid treatment for persistent non-cancer pain should develop an individualised treatment plan in discussion with the patient;

Recommendations for the appropriate use of opioids for persistent non-cancer pain *March 2004*

- patients who are prescribed opioids for persistent non cancer-related pain should be regularly assessed at intervals determined by clinical need. Initially it is expected that this assessment would be at least monthly. The assessment should include documented evaluation of: pain relief, physical, psychological and social function, sleep, side effects and signs of problem drug use. It is important to regularly discuss any concerns that patients have about their opioid use;
- evidence of developing tolerance should prompt referral to a multidisciplinary pain management service (or specialised addiction service);
- evidence of problem drug use should initiate prompt consultation with and /or referral to a specialised addiction service;
- it is envisaged that this document will stimulate the development of local clinical networks using defined care pathways, such that early referral will lead to prompt specialist intervention.

Further information:
The British Pain Society
21 Portland Place
London W1B 1PY
Tel: 020 7631 8870
www.britishpainsociety.org

Pain and pain services in the NHS – An overview of current thinking and provision in the UK

November 2002

Report aims

- to provide a brief review of current management practices in chronic severe pain, national guidance and policy directives;
- the report aims to capture the financial burden of pain and its inadequate management in order to highlight pain management opportunities for commissioners and pain management advocates.

Key messages

- the burden of chronic pain remains significant;
- older people suffer unnecessary chronic pain;
- doctors and nurses believe cancer pain is poorly controlled.

Summary

- chronic pain is common and affects almost half of the population to some extent;
- as well as causing a great deal of personal suffering, chronic pain has major economic implications for health service expenditure and for society as a whole;
- there are many effective pain relief interventions available; pain clinics are considered to be economically worthwhile;
- the NHS fails to resource pain relief services adequately;
- investment in pain relief services by health service commissioners is likely to benefit individuals, the health service and society as a whole.

For copies please contact:
Medical Information
Napp Pharmaceuticals
Cambridge Science Park
Milton Road
Cambridge
CB4 0GW
Tel: 01223 424444

Morphine and alternative opioids in cancer pain: the EAPC recommendations *January 2001*

Summary

These recommendations give guidance on the use of morphine and alternative strong opioids in the management of cancer pain.

An expert working group of the European Association for Palliative Care (EAPC) has revised and updated its guidelines on the use of morphine in the management of cancer pain. The revised recommendations presented here give guidance on the use of morphine and the alternative strong opioid analgesics which have been introduced in many parts of the world in recent years.

A summary of the highlighted points is presented here with information on where to obtain the complete document given at the end.

- the opioid of first choice for moderate to severe cancer pain is morphine;
- the optimal route of administration of morphine is by mouth. Ideally, two types of formulation are required: normal release (for dose titration) and modified release (for maintenance treatment);
- the simplest method of dose titration is with a dose of normal release morphine given every 4 hours and the same dose for breakthrough pain. This 'rescue' dose may be given as often as required (up to hourly) and the total daily dose of morphine should be reviewed daily. The regular dose can then be adjusted to take into account the total amount of rescue morphine;
- if pain returns consistently before the next regular dose is due the regular dose should be increased. In general, normal release morphine does not need to be given more often than every 4 hours and modified release morphine more often than 12 or 24 hours (according to the intended duration of the formulation). Patients stabilised on regular oral morphine require continued access to a rescue dose to treat 'breakthrough' pain;
- several countries do not have a normal release formulation of morphine, though such a formulation is necessary for optimal pain management. A different strategy is needed if treatment is started with modified release morphine. Changes to the regular dose should not be made more frequently than every 48 hours, which means that the dose titration phase will be prolonged;
- for patients receiving normal release morphine every 4 hours, a double dose at bedtime is a simple and effective way of avoiding being woken by pain;

Morphine and alternative opioids in cancer pain: the EAPC recommendations *January 2001*

- several modified release formulations are available. There is no evidence that the 12-hourly formulations (tablets, capsules or liquids) are substantially different in their duration of effect and relative analgesic potency. The same is true for the 24-hour formulations though there is less evidence to draw on;
- if patients are unable to take morphine orally the preferred alternative route is subcutaneous. There is generally no indication for giving morphine intramuscularly for chronic cancer pain because subcutaneous administration is simpler and less painful;
- the average relative potency ratio of oral morphine to subcutaneous morphine is between 1:2 and 1:3 (i.e. 20-30mg of morphine by mouth is equianalgesic to 10mg by subcutaneous injection);
- in patients requiring continuous parenteral morphine, the preferred method of administration is by subcutaneous infusion;
- intravenous infusion of morphine may be preferred in patients: a. who already have an indwelling intravenous line; b. with generalised oedema; c. who develop erythema, soreness or sterile abscesses with subcutaneous administration; d. with coagulation disorders; e. with poor peripheral circulation;
- the average relative potency ratio of oral to intravenous morphine is between 1:2 and 1:3;
- the buccal, sublingual and nebulised routes of administration of morphine are not recommended because at the present time there is no evidence of clinical advantage over the conventional routes;
- oral transmucosal fentanyl citrate (OTFC) is an effective treatment for 'breakthrough pain' in patients stabilised on regular oral morphine or an alternative step 3 opioid;
- successful pain management with opioids requires that adequate analgesia be achieved without excessive adverse effects. By these criteria the application of the WHO and the EAPC guidelines (using morphine as the preferred step 3 opioid) permit effective control of chronic cancer pain in the majority of patients. In a minority of patients adequate relief without excessive adverse effects may depend on the use of alternative opioids, spinal administration of analgesics or non-drug methods of pain control;

Morphine and alternative opioids in cancer pain: the EAPC recommendations *January 2001*

- a small proportion of patients develop intolerable adverse effects with oral morphine (in conjunction with a non-opioid and adjuvant analgesic as appropriate) before achieving adequate pain relief. In such patients a change to an alternative opioid or a change in the route of administration should be considered;
- hydromorphone or oxycodone, if available in both normal release and modified release formulations for oral administration, are effective alternatives to oral morphine;
- methadone is an effective alternative but may be more complicated to use compared with other opioids because of pronounced interindividual differences in its plasma half-life, relative analgesic potency and duration of action. Its use by non-specialist practitioners is not recommended;
- transdermal fentanyl is an effective alternative to oral morphine but is best reserved for patients whose opioid requirements are stable. It may have particular advantages for such patients if they are unable to take oral morphine, as an alternative to subcutaneous infusion;
- spinal (epidural or intrathecal) administration of opioid analgesics in combination with local anaesthetics or clonidine should be considered in patients who derive inadequate analgesia or suffer intolerable adverse effects despite the optimal use of systemic opioids and non-opioids.

Ref: GW Hanks et al. British Journal of Cancer. 2001: 84(5), 587-593

Further information:
http:/www.bjcancer.com

The Oxford Pain Internet Site

Last accessed September 2004

Cancer pain:

Intracerebroventricular opioids
Neurolytic coeliac plexus block
Nilutamide plus orchidectomy for metastatic prostatic cancer
NSAIDs for cancer pain
Radiotherapy for bone metastases
Strontium for bone metastases

Chronic pain:

Neuropathic pain

Antidepressants for diabetic neuropathy and postherpetic neuralgia
Antidepressants
Anticonvulsants for diabetic neuropathy and postherpetic neuralgia
Anticonvulsants
Chronic pain after surgery
Postherpetic neuralgia and acute herpes zoster
Postherpetic neuralgia
Systemic local anaesthetic type drugs

Dysmenorrhoea

Analgesics for dysmenorrhoea
COXIBs for dysmenorrhoea

The Oxford Pain Internet Site

Last accessed September 2004

Chronic pain – other interventions or conditions

Fibromyalgia: diagnosis and treatment
Acupuncture for fibromyalgia
Cannabis for pain relief
Arnica efficacy
CBT for chronic pain
Group education for low back pain
Homeopathy versus Standard Treatments
Ionised wrist bracelets for musculoskeletal pain
IRSB in RSD (CRPS)
Magnetic insoles for foot pain
Pancreatitis
Peppermint oil for irritable bowel syndrome
Relaxation
Quinine for nocturnal leg cramp in the elderly
Quinine for nocturnal leg cramp in the elderly update
Temporomandibular Joint Dysfunction and acupuncture
Topical agents or dressings for pain in venous leg ulcers
Treatments for plantar heel pain
TENS – chronic pain

Further information:
Bandolier Office
Pain Research
The Churchill
Oxford OX3 7LJ
Tel: 01865 226132
Email: Bandolier@pru.ox.ac.uk
www.jr2.ox.ac.uk/bandolier/booth/painpag/

Five pledges to help people living with persistent pain

Endorsed by The British Pain Society and the Royal College of General Practitioners

Further information:
Medical Information, Napp Pharmaceuticals, Cambridge Science Park,
Milton Road, Cambridge CB4 0GW Tel: 01223 424444

Five pledges to help people living with persistent pain

Endorsed by The British Pain Society and the Royal College of General Practitioners

Five pledges to help people living with persistent pain

Action plan

Parliamentarians should

- Ensure that effective management of persistent pain is prioritised by the government
- Ask local NHS trusts about the provision and funding of health services for people living with persistent pain
- Liaise with constituents in the voluntary sector and self-help groups to improve services for people living with persistent pain
- Commit to adequate funding for research in basic and clinical science

NHS service providers and commissioners should

- Ensure that the management of chronic pain is a priority issue and provide adequate resourcing
- Work to adopt care pathways for people living with persistent pain across the primary, community and secondary care sectors
- Commit to training in effective pain management for all healthcare professionals within the health economy
- Encourage the development of self-help groups
- Commit to audit and research

People living with persistent pain should be prepared to play an active role in the management of their pain and should

- Be listened to and treated with respect
- Be assessed by an appropriately trained healthcare professional
- Be treated as a partner with healthcare professionals and kept fully informed of diagnosis and treatment options
- Be made aware of pain management clinics, self-management or expert-patient programmes and relevant voluntary organisations

Healthcare professionals should

- Listen to and respect patients' personal experience of pain
- Use appropriate assessment tools to measure pain
- Identify remediable causes for the pain
- Use evidence-based pain management and best clinical practice
- Recognise when a person living with persistent pain needs to be referred to colleagues who specialise in pain management

Those who educate healthcare professionals should

- Ensure that assessment and management of pain is in the core curriculum of doctors, nurses, allied and other healthcare professionals
- Provide training in pain management for support staff working with healthcare professionals

For further information on pain management, visit www.painsociety.org

Sponsored by an educational grant from Napp Pharmaceuticals

Further information:
Medical Information, Napp Pharmaceuticals, Cambridge Science Park,
Milton Road, Cambridge CB4 0GW Tel: 01223 424444

Courses in pain management

Appendix 2

Supported by an educational grant from Napp Pharmaceuticals Limited

Courses in pain management

There are a number of courses developed to meet the needs of healthcare professionals working in pain management. They range from 2-3 day courses providing basic skills on specific areas of pain management to more comprehensive programmes offering education regarding theoretical components of pain, such as anatomy and physiology and assessment and management of pain. Some of these courses are available as a multidisciplinary MSc, whilst others are designed to meet the specific needs of one profession. Information regarding these courses is available from your local university or from the internet. Some of the courses available are mentioned overleaf.

MSc Courses in Pain Management

MSc in Pain Management

University Hospitals of Leicester
MSc Course Administrator
University Division of Anaesthesia
Critical Care and Pain Management
Leicester Royal Infirmary
Clinical Sciences Building
Leicester LE2 7LX

Tel: 0116 258 5735
Email: mscpain@le.ac.uk
www.le.ac.uk/anaesthesia/mscpain.html

MSc in Pain Science and Management

Keele University
Faculty of Health
Department of Physiotherapy Studies
MacKay Building
Keele University
Keele, Staffordshire ST5 5BG

Tel: 01782 584191
Email: pta13@cc.keele.ac.uk
www.keele.ac.uk/depts/pt/

MSc in Pain

King's College London
School Postgraduate Office

Tel: 020 7848 6363

MSc in Pain Management

University of Central Lancashire
Customer Services
Faculty of Health
University of Central Lancashire
Preston PR1 2HE

Tel: 01772 893805
Email: cservices@uclan.ac.uk
www.uclan.ac.uk/courses/

MSc in Pain

Queen Margaret University College
Edinburgh
Department of Physiotherapy
Queen Margaret University College
Edinburgh EH6 8HF

Tel: 0131 317 3655

BSc Courses in Pain Management

BSc (Hons) Managing Pain (distance learning)

University of Glamorgan

Tel 0800 716 925
Email: enquiries@glam.ac.uk

Other Courses in Pain Management

King's College London

Pain Management & Pain Management Strategies
ENB N53 Principles of Effective Pain Management Level 2
ENB D07 Care and Management of Clients Requiring Pain Management Level 2
ENB N53 Principles of Effective Pain Management Level 3
ENB D07 Care and Management of Clients Requiring Pain Management Level 3

Tel: 020 7848 6363

University of Abertay Dundee

Pain Management Research Centre
Distance Learning Course in Chronic Pain Management
Pain II Communication and Counselling in Chronic Pain

Tel: 01382 308080
Email: iro@abertay.ac.uk

Institute of Child Health and Great Ormond Street Hospital for Children NHS Trust

The Children's Pain Assessment Project

Tel: 0207 242 9789
www.ich.ucl.ac.uk/contact/

The Royal Marsden Hospital London

Caring for the Patient with Pain
The Central School of Anaesthesia

Tel: 020 7380 9013
www.schoolofanaesthesia.co.uk

The British Medical Acupuncture Society

Foundation Course

Tel: 01606 786782
Email: admin@medical-acupuncture.org.uk

Physiotherapy Pain Association

www.ppaonline.co.uk/courses.html

MSc Courses in Palliative Care

MSc in Palliative Medicine

MSc Administrator
Department of Palliative Care and Policy
Guy's, King's and St. Thomas' School of Medicine
Weston Education Centre
Cutcombe Road, London SE5 9RJ

Tel: 020 7848 5584

MSc in Palliative Medicine

Diploma/MSc Administrator
University of Wales College of Medicine
Velindre NHS Trust
Whitchurch
Cardiff CF14 2TL

Tel: 029 201 96111
Email: dippallmed@velindre-tr.wales.nhs.uk

Diploma Courses in Palliative Care

Diploma in Palliative Care

The Programmes Secretary,
Institute of Health Studies,
School of Community and Health Studies,
Wilberforce Building,
The University of Hull
Cottingham Road
Hull HU6 7RX

Tel: 01482 466226
www.hull.ac.uk

Diploma in Palliative Care

School of Nursing and Midwifery
Faculty of Health and Social Medicine
The Robert Gordon University
Garthdee Road
Garthdee
Aberdeen AB10 7QS

Tel: 01224 262632

Diploma in Palliative Nursing

University of Wales College of Medicine
Velindre NHS Trust
Whitchurch
Cardiff CF14 2TL

Tel: 029 201 96111
Email: dippallmed@velindre-tr.wales.nhs.uk

Useful definitions and glossary

Appendix 3

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Useful definitions and glossary

Useful definitions

Pain

An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage[1]

Acute pain

Pain in association with acute disease or injury (including surgery). The pain is of recent onset and limited duration. It reduces over time and can be brief, lasting a few minutes, or may persist for several months

Chronic pain

Pain that either persists beyond the point that healing would be expected to be complete (usually taken as 3-6 months) or that occurs in disease processes in which healing does not take place. The pain may be continuous or intermittent. Chronic pain can be experienced by those who do not have evidence of tissue damage[1]

Nociceptive pain

Pain that occurs due to tissue damage or inflammation. It can be somatic or visceral, for example, ischaemia, infection, burn, abscess, incision, pelvic pain[2]

Neuropathic pain

Pain that is initiated or caused by a primary lesion or dysfunction in peripheral or central nervous system.[1] (e.g. postherpetic neuralgia, sciatica, phantom limb pain)

Central pain

Pain associated with disease or injury to the central nervous system (e.g. pain associated with stroke/multiple sclerosis)

Episodic pain

Spontaneous episodes of recurrent severe pain. The patient may be pain free between episodes (e.g. pain associated with sickle cell disease, haemophilia, angina)

Breakthrough pain

Transient exacerbations of pain occurring on a background of pain that is otherwise well controlled.[3]

Glossary

CBT Cognitive Behavioural Treatment

CRPS Complex Regional Pain Syndrome

CSAG Clinical Standards Advisory Group

EAPC European Association for Palliative Care

GMS General Medical Services

IRSB Intravenous Regional Sympathetic Block

LHB Local Health Board

NHS National Health Service

NICE National Institute of Clinical Excellence

PACT Prescribing Analysis and Cost Data

PCT Primary Care Trust

PDP Personal Development Plan

PHCT Primary Healthcare Trust

PPDP Personal and Practice Development Plans

PCO Primary Care Organisation

RCGP Royal College of General Practitioners

RSD Reflex Sympathetic Dystrophy

SLR Straight Leg Raising

SNRI Serotonin-noradrenergic reuptake inhibitors

TCA Tricyclic antidepressant

TENS Transcutaneous Electrical Nerve Stimulation

WHO World Health Organisation

References:
1. IASP Pain Terminology. International Association for the Study of Pain: http://www.iasp-pain.org/terms-p.html, 2001
2. http://www.neuro.wustl.edu/neuromuscular/mother/mpain.html#paincat
3. Portenoy RK, Hagen NA (1990) Breakthrough pain: definition, prevalence and characteristics. Pain: 41(3); 273-281

Examples of leaflets available for patients

The British Pain Society

- Understanding and Managing Pain: Information for Patients

The Back Book

- The Best Way to deal with Back Pain. Available through the Royal College of General Practitioners

Action on Pain

- About living with chronic pain
- About Pain Management
- Have Pain will Travel
- Plan to Start Exercising
- Pacing
- Relaxation

Endorsed by the Pain Association Scotland

- A guide for patients with chronic pain

Pain Concern

- A guide to Managing Pain
- Understanding your Pain – The Good, the Bad and The Not-So-Ugly

Neuropathy Trust

- Peripheral Neuropathy & Neuropathic Pain Under the Spotlight
- Diabetic Neuropathy Under the Spotlight

A copy of some of these leaflets can be found at the back of this binder and contact information for further leaflets is listed in the next section.

Sources of useful information

Appendix 5

Supported by an educational grant from Napp Pharmaceuticals Limited

Sources of useful information

Action on Pain

20 Necton Road
Little Dunham
Norfolk
PE32 2DN

Tel: Painline 0845 603 1593
Website: www.action-on-pain.co.uk

Arthritis Care

18 Stephenson Way
London NW1 2HD

Tel: 020 7380 6500
www.arthritiscare.org.uk

Association for Palliative Medicine of Great Britain and Ireland (APM)

Bellis House
11 Westwood Road
Southampton
SO17 1DL

Tel: 023 8067 2888
www.palliative-medicine.org

BackCare

16 Elmtree Road
Teddington, Middlesex
TW11 8ST

Tel; 020 8977 5474
www.backcare.org.uk

Bath Pain Management Unit

University of Bath
Bath BA2 7AY

Tel: 01225 384225
www.bath.ac.uk/psychology/PMU.html

British Medical Journal

BMJ Publishing Group
BMA House
Tavistock Square, London

Tel: 0207 387 4499
www.bmj.com

British Pain Society

21 Portland Place
London W1B 1PY

Tel: 020 7631 8870
www.britishpainsociety.org

Cancer BACUP

3 Bath Place
Rivington Street
London EC2A 3JR

Tel: 020 7696 9003
www.cancerbacup.org.uk

Cancer Macmillan Relief

89 Albert Embankment
London SE1 7UQ

Tel: 020 7840 7840
www.macmillan.org.uk

Carers UK

Ruth Pitter House
20-25 Glasshouse Yard
London EC1A 4JT

Tel: 020 7490 8818
www.infoukcarers.org

Department of Health

www.doh.gov.uk

Diabetes UK

10 Queen Anne Street
London W1G 9LH

Tel: 020 7323 1531
www.diabetes.org.uk

Fibromyalgia Association UK

PO Box 206
Stourbridge DY9 8YL

Tel: 0870 220 1232
www.fibromyalgia-associationuk.org

Health Development Agency

www.had-online.org.uk

Long-term Medical Conditions Alliance (LMCA)

Tel: 020 7813 3637
Email: info@lmca.org.uk

Marie Curie Cancer Care

89 Albert Embankment
London SE1 7TP
Tel: 020 7599 7777
www.mariecurie.org.uk

MS Society

MS National Centre
372 Edgware Road
London NW2 6ND

Tel: 020 8438 0700

Neurological Alliance

Southbank House
Black Prince Road
London SE1 7SJ

Tel: 0207 463 2074
Email: admin@neural.org.uk

Neuropathy Trust

PO Box 26
Nantwich
Cheshire CW5 5FP

Tel; 01270 611 828
www.neurocentre.com

NHS Direct

Tel: 0845 4647
Website: nhsdirect.nhs.uk

Nursing Standard

Email: nursing.standard@rcnpublishing.co.uk
www.nursing-standard.co.uk

Pain Association Scotland

Cramond House
Cramond Glebe Road
Edinburgh

Tel: 0800 783 6059
www.painassociation.com

Pain Concern

PO Box 13256
Haddington EH41 4YD

Tel: 01620 822572
Email: painconcern@btinternet.com
www.painconcern.fsnet.co.uk

Pain Relief Foundation

Clinical Sciences Centre
University Hospital Aintree
Lower Lane
Liverpool L9 7AL

Tel: 0151 529 5820
Email: pri@liv.ac.uk
www.painrelieffoundation.org.uk

Patients' Association

PO Box 935
Harrow
Middlesex HA1 3YJ

Tel: 0208 423 9111
www.patients-association.com

Physiotherapy Pain Association

Barnet General Hospital
Wellhouse Lane
Barnet
Herts EN5 3DJ

www.ppaonline.co.uk

Royal College of General Practitioners

14 Princes Gate
Hyde Park
London SW7 1PU

Tel: 020 7581 3232
Email: info@rcgp.org.uk

Royal College of Nursing

www.rcn.org.uk

Scottish Network for Chronic Pain Research (SNCPR)

Tel: 01786 466338 or 0131 554 8160

Sickle Cell Society

54 Station Road
London NW10 4UA

Tel: 020 8961 7795
www.sicklecellsociety.org

Sue Ryder Care

2nd Floor
114–118 Southampton Row
London
WC1B 5AA

Tel: 020 7400 0440
www.suerydercare.org.uk

Trigeminal Neuralgia Self Help

27 St Keyna Avenue
Hove BN3 4NP

Tel: 01273 410 565

Welsh Pain Society

University Hospital of Wales
Heath Park
Cardiff CF14 4XW

Tel: 01978 725956

Feedback form

Appendix 6

Supported by an educational grant from Napp Pharmaceuticals Limited

A practical guide to the provision of Chronic Pain Services for adults in Primary Care

Feedback form

We will always seek to ensure that materials such as this binder are beneficial to you and your practice or PCO. Therefore we would very much like to hear your comments, which will then be considered when reviewing the document. If you would like to comment please complete the form and return by post or alternatively send an email to the address below:

Royal College of General Practitioners

14 Princes Gate
Hyde Park
London SW17 1PU

Tel: 020 7581 3232
Email: info@rcgp.org.uk

Do you find the document of use to you and your practice or PCO?

- ☐ Very
- ☐ Fairly
- ☐ Not at all

If very or fairly, which sections do you find to be of most use?

- ☐ Section 2 Assessing the current status of pain management in your practice
- ☐ Section 3 Patient assessment
- ☐ Section 4 Aims and liaisons in primary care
- ☐ Section 5 When to refer
- ☐ Appendix 1 Important documents
- ☐ Appendix 2 Courses in pain management
- ☐ Appendix 3 Useful definitions and glossary
- ☐ Appendix 4 Examples of leaflets available for patients
- ☐ Appendix 5 Sources of useful Information

If not at all, please explain why .....

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We would value any comments you may have .....

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Copies of this document are available on CD ROM and will shortly appear on the websites of the Royal College of General Practitioners and The British Pain Society

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