Freedom of Information Request: Our Reference CTHB_331_17

You asked:
I would be grateful if you would answer the following questions in relation to Chronic Pain Management Services provided by Cwm Taf Health Board.

1) Could you please tell me whether the Health Board has a Chronic Pain Management Service?

I can confirm that the Health Board does have a chronic pain management service.

2) Could you please tell me whether the Health Board has a Chronic Pain Management pathway?

Please find the Chronic pain management pathway attached.

3) Could you please tell me what the current referral criteria is, to the Chronic Pain Management Service?

The referral criteria is included as an appendix in the pathway (attached).

4) Could you please tell me what the current Chronic Pain Management Services provide?

The service provides an Out Patient Department, Day Case treatments with Consultants, GP & Nurse Specialists as well as medication reviews, acupuncture, TENS & Interventional procedures.

5) Could you please tell me how long the current referral to treatment waiting times are for those patients classed as routine at point of referral?

Summary of the current reported Anaesthetic/Pain Management RTT:

Anaesthetic Pain Management (Spec: 190*)			
RTT September 2017	**Routine**	**Urgent**	**Total**
Stage 1 Patients Waiting	604	37	641
Longest Wait	32 weeks	29 weeks	32 weeks
Average Wait	14.8 weeks	8.3 weeks	14.4 weeks
RTT: Referral to Treatment, the standard waiting list submission to WG			
Stage 1: Awaiting an initial consultation			
M:\Adhoc\Results\Q6500-6599\6556 series			

6) **Could you please tell me how long the current referral to treatment waiting times are for those patients classed as urgent at point of referral?**

As above.

Ref:

Guidelines for the Pharmacological Treatment of Chronic Non-Malignant Pain in Adults

INITIATED BY:	Medicines Management Directorate Chronic Pain Specialists
APPROVED BY:	Cwm Taf Medicines Management and Expenditure Committee
DATE APPROVED:	17-05-13
VERSION:	1
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DISTRIBUTION:	All Clinical Directorates, Medicines Management Directorate and GPs

FREEDOM OF INFORMATION STATUS: Open

CONTENTS

1. Introduction

Chronic non-malignant pain (CNMP) can be defined as persistant pain that exists beyond the expected period of healing.[1,2] It is pain that serves no inherent biological function. CNMP can occur because of conditions involving ongoing nociception such as inflammation of various arthritic conditions or as a result of damage/dysfunction of pain pathways resulting in neuropathic pain. Chronic pain can have multiple causes and a myriad of perpetuating factors and so approaches to management of CNMP should be individualised. In recent years the treatment of chronic pain has escalated, resulting in inappropriate use of analgesia in patients causing an increase in adverse events, and rising costs resulting from adherence monitoring and inappropriate therapies[3].

To tackle these issues many Health Boards have begun to develop guidelines for the prescribing of analgesia in CNMP. The aim is to use these guidelines as a way to rationalise prescribing, and provde prescribers with easy to follow advice regarding appropriate use of analgesic therapy in CNMP.

2. Scope

This guidance is directed at all clinicians involved in the management of CNMP irrespective of primary or secondary healthcare setting.

3. Aims

The aim of this guideline is to provide a reference tool for primary and secondary care prescribers when trying to manage patients with CNMP. The guideline should provide prescribers with appropriate options for analgesia based on the cause of pain (Nociceptive and Neuropathic pain), and detail approaches to specialist groups of patients such as the elderly.

4. Responsibilities

This guideline has been developed as an aid for prescribing of analgesic therapies in the management of CNMP. The clinician may refer to this guideline, however clinical judgment may also be used in the prescribing process. Adherence to the guideline is not mandatory, but the guideline does outline the safest, most evidence based and cost-effective pharmacological therapies for use in CNMP and the order in which they should be used.

5. Assessment of Chronic Non-Malignant Pain

Even though pain is a common presenting complaint, lack of regular and appropriate assessment of pain remains widespread and can contribute to undertreatment. When assessing patients for pain the prescriber should consider the following[3]:

- General physical condition
- Musculoskeletal and neurological systems
- Range of motion
- Effect of physical factors on pain and performance measures.
- Psychosocial factors associated with CNMP
- Screening for Addiction
- Identifying co- morbid psychiatric disorders

Identifying the source of pain through objective and subjective evaluation is key. This allows identification of nociceptive and/or neuropathic elements of the pain patients experience, and it is this identification that can allow prescribers to select the most appropriate therapies.

There are several assessment tools for distinguishing between neuropathic pain and nociceptive pain, however the most effective tools combine self-reporting of symptoms with physical examination. The Leeds Assessment of Neuropathic Signs and Symptoms (LANSS)[4] is a questionnaire consisting of seven items, (5 symptoms and 2 clincial examinations) and is regarded as one of the best assessment tools due to its sensitivity (85%) and specificity (80%). The LANSS assessement tool (Appendix 1) is scored out of 24 with a score of 0-12 indicating nociceptive pain, and 12-24 indicating presence of neuropathic pain.

6. Treatment of Chronic Non-Malignant Pain

The experience of CNMP can affect the whole patient and result in a variety of physical and psychological symptoms. Consequently the treatment of CNMP requires a multimodal approach to address the multiple issues of patient suffering including physical, psychological and behavioral manifestations.

The goals of treatment should be established with the patient before the initiation of pharmacological treatment. A useful model for goals of treatment is **PAIN** (Sakhuja, R, 2012) **-** Pain symptoms improvement, reduction in **A**ssociated psychological symptoms, **A**dverse events & **A**berrant behaviours, **I**mprovement in function and **N**o dependence. Prevention, reduction, or elimination of pain should be discussed. [3] The patient should be involved in the establishment of these goals so that outcomes important to the patient should be incorporated into the management plan, and also so the patient has a realistic expectation.[5] This is important in patients with CNMP, particularly as in these patients pain is more difficult to eliminate but can be made more tolerable.

Cwm Taf Health Board recognises and supports the Royal College of Psychiatrists in Wales- Faculty of Addictions position on Over-the-counter (OTC) and Prescribed Medication (POM) dependence, which states

- There is an increasing trend of Over-the-counter and Prescribed Medication Dependence in UK

- Royal College of Psychiatrists in Wales- Faculty of Addictions- support and emphasise use of tools for

    - Early Screening for Vulnerable Individuals along with early involvement of Pain Teams and Addiction Specialists to avoid dependence.

    - More robust monitoring of people with long term pain medication needs.

7. Choice of Analgesia for Chronic Non-Malignant Pain

Prescribers are presented with a large range of medications to choose from when prescribing for patients with CNMP. There are many pharmacological classes of drugs that all have evidence supporting their use; however the quality of the evidence behind their use can vary from randomised control trials to peer reviewed anecdotal evidence. Identification of any nociceptive, neuropathic component of patients pain can aid in selection of appropriate therapies.

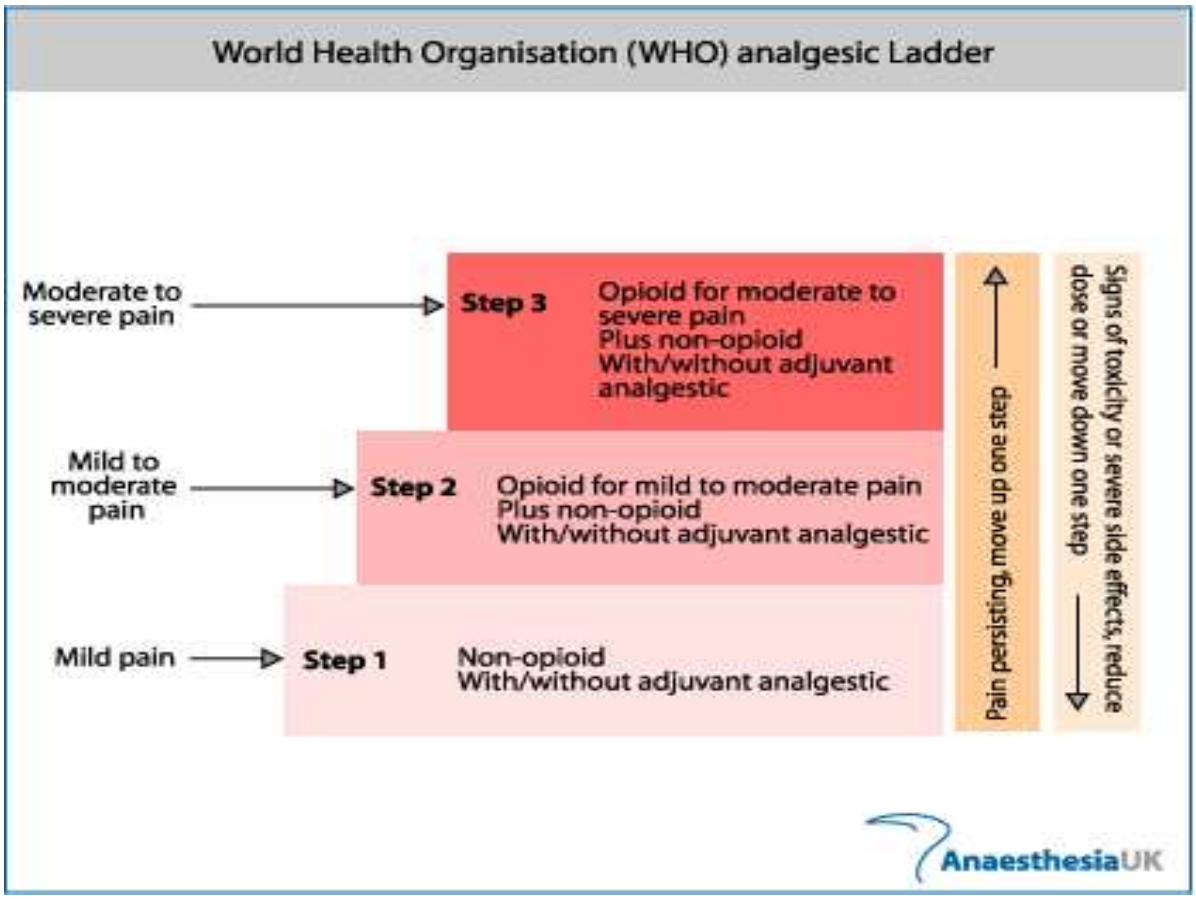
The pathophysiology of pain is such that therapeutic targets for pharmacological management depend on the type of pain patients are experiencing. As such patients with nociceptive pain may require drugs that target different pain pathways to those who require analgesia for neuropathic pain.

The use of benzodiazepines for the therapeutic management of CNMP is not supported by clinical evidence, and as such should not be used.

8. Chronic Non-Malignant Pain – Nociceptive Pain

The pharmacological elements required to treat CNMP of a nociceptive origin can be located on the World Health Organisation Pain Ladder (Fig 1)[6]. Despite the development of this ladder to treat cancer pain, it also provides a general guideline for selection of medication based on varying degrees of pain. As such, patients can be initiated at any step on the ladder that is deemed appropriate for the pain the patient is experiencing.

Fig 1 – WHO Analgesic Ladder



Where patients are assessed for their pain, the LANSS assessment tool should be used to determine any nociceptive element that is present. Patients with a nociceptive element of pain should then be considered for initation of a medication from the Nociceptive Pain algorithm (Appendix 2), at a stage of the WHO ladder that best represents the severity of pain the patient is experiencing.

9. Chronic Non-Malignant Pain – Neuropathic Pain

The treatment options for neuropathic pain are many, owing to the diverse modes of action of the drugs available. Patients who are diagnosed with neuropathic pain should be initiated on the Neuropathic Pain Algorithm (Appendix 3).

This algorithm demonstrates the stepwise approach to prescribing for neuropathic pain. The algorithm begins with amitriptyline, the first line drug for patients with a neuropathic element of pain, and where this is not tolerated or ineffective progresses to include other neuropathic pain medications. These treatment options and their priority in the algortithm are supported by high quality clinical evidence, namely Cochrane reviews and NICE guidelines.[8,9,10,11] All primary and secondary care

clinicians, should follow this algorithm where patients are diagnosed with neuropathic pain. Deviation from this guideline should only be undertaken by a chronic pain specialist, and only when patients have exhausted the options currently identified in the neuropathic pain algorithm.

10. Chronic Non-Malignant Pain – Use of NSAIDs

Patients may frequently present with CNMP that has an inflammatory element, or pain that is currently uncontrolled with paracetamol +/- weak opioids and as such may require treatment with medication that provides both an analgesic and anti-inflammatory response. Where these criteria are met, prescribers should consider addition of a Non-Steroidal Anti-inflammatory Drug (NSAID) to current therapy.

Recent advice by the National Prescribing Committee (NPC) and the Medicines and Health Regulatory Authority (MHRA) has highlighted the gastrointestinal and cardiovascular risks associated with particular NSAIDs. The LHB has recently published guidance with regard to the treatment options available when considering addition of an NSAID[12]. Current evidence recommends ibuprofen up to 1200mg/day or naproxen up to 1000mg/day (Appendix 4). It is also recommended that diclofenac is avoided due to cardiovascular risks associated with its use. Use of Ibuprofen and Naproxen have substantial evidence supporting both their gastrointestinal and cardiovascular safety, and so are the choice drugs where NSAIDs are required.

11. Referral to Cwm Taf Chronic Pain Service

Where clinicians have followed the CNMP pathways and patients have not achieved satisfactory pain relief, or where adherence/tolerance is difficult to manage, referral to the Cwm Taf Chronic Pain service is recommended. Referrals to the service will only be accepted if the appropriate documentation is completed (Appendix 5).

12. References

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17. Joint Formulary Committee. British National Formulary 64. London: BMJ Group and Pharmaceutical Press. Section 4.3.4 – Other Anti-depressant Drugs: Duloxetine. Page 249.
18. Joint Formulary Committee. British National Formulary 64. London: BMJ Group and Pharmaceutical Press. Section 15.2 – Local Anaesthesia – Lidocaine Hydrochloride. Page 825-6.
19. Joint Formulary Committee. British National Formulary 64. London: BMJ Group and Pharmaceutical Press. Section 10.3.2 – Capsaicin. Page 690

Appendix 1 – LANSS Pain Scale[4]

Patient Name:

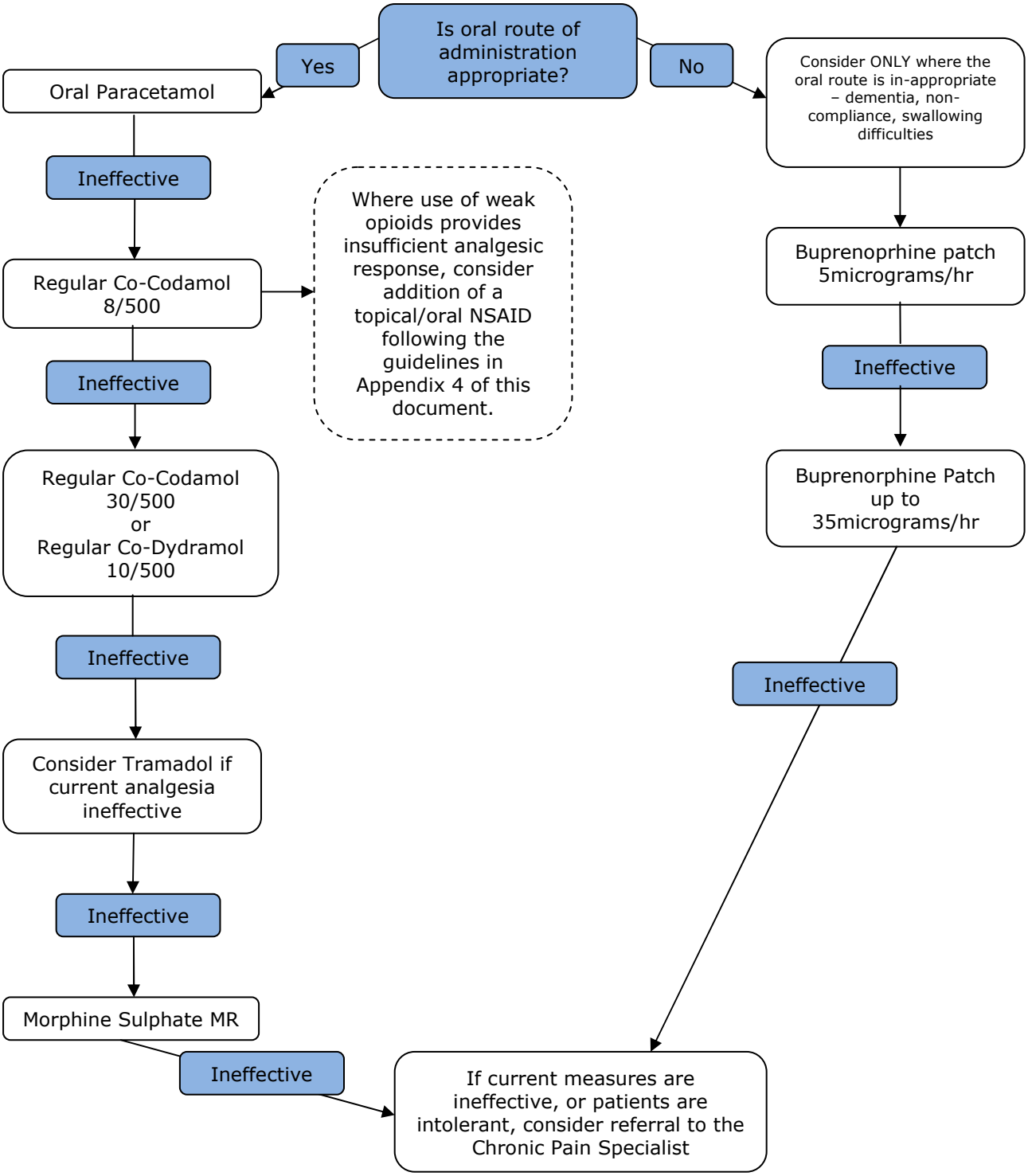
Date of Birth:

Date of Pain Review:

Date of Last Review:

Symptom / Sign	Score for YES
Question Patient: Does the pain feel like strange, unpleasant sensations? (e.g. pricking, tingling pins and needles)	**5**
Question Patient: Do the painful areas look different? (e.g. mottled, red/pink)	**5**
Question Patient: Is the area abnormally sensitive to touch? (e.g. lightly stroked, tight clothes)	**3**
Question Patient: Do you have sudden unexplained bursts of pain? (e.g. electric shock, "jumping")	**2**
Question Patient: Does the skin temperature in the painful area feel abnormal? (e.g. hot, burning)	**1**
Exam: Does stroking the affected area of skin with cotton produce pain?	**5**
Exam: Does a pinprick at the affected area feel sharper or duller when compared to an unaffected area of skin?	**3**
0-12 = likely nociceptive >12 = likely neuropathic	**Total:**

Appendix 2 – Treatment Algorithm & Prescribing Points for Nociceptive Chronic Non-Malignant Pain



Prescribing Points for Nociceptive Chronic Non-Malignant Pain Guideline

General

1. Prescribers should assess patients to determine the type of pain experienced, and use the appropriate treatment algorithm.

2. Patients experiencing nociceptive pain should be initiated at the point in the algorithm that best represents the severity of pain experienced as indicated by the W.H.O Pain Ladder.

3. Patients prescribed opioids should be considered for concomitant anti-emetics and laxatives to reduce incidence of adverse effects.

4. Any anti-emetic may be appropriate, but consideration must be given to the side effect profiles of some classes of anti-emetics, particularly in the elderly.

5. Drugs with a demonstrated efficacy for persistent pain syndromes (such as tricyclic antidepressants for neuropathic pain) should always be prescribed for neuropathic pain before initiation of opioid therapy.

6. Appropriate laxatives include stimulant, and softening agents such as:
    - Senna 15mg twice daily
    - Docusate Sodium 100mg twice daily
    - Bisacodyl 10mg at Night
    - Lactulose 5 – 15mL twice daily

Weak Opioids – Mild to Moderate Pain

1. Where weak opioids are prescribed patients should be encouraged to take them as regularly as required and tolerated. Doses for weak opioids are detailed below:

    - Co-codamol 8/500 1-2 tablets four to six hourly
    - Co-codamol 30/500 1-2 tablets four to six hourly
    - Codydramol 10/500 1-2 tablets four to six hourly

2. Patients should be counseled on the common side effects of regular opioid use such as nausea and vomiting (particularly on initiation of opioids, drowsiness, constipation and dry mouth.

3. Patients should be informed that drowsiness may affect performance of skilled tasks, and this effect may be enhanced by

alcohol consumption. Patients should consider the impact this may have on their driving.

4. Prescribers should also counsel patients on the use of paracetamol with combination medications such as co-codamol and co-dydramol to ensure maximum doses of paracetamol are not exceeded.

5. Where use of paracetamol and weak opioids does not provide sufficient analgesia, prescibers should consider addition of a NSAID to current therapy before escalation to stonger opioids. Prescribing points for use of NSAIDs can be found in Appendix 4.

Tramadol[13]

1. Tramadol produces analgesia by two mechanisms: an opioid and an enhancement of serotonergic and adrenergic pathways.

2. This mode of action results in fewer "opioid-type" side effects such as respiratory depression, constipation and addiction potential.

3. Psychiatric reactions such as hallucinations, anxiety and mood disturbances may occur in patients.

4. Common side-effects include dizziness, drowsiness and headaches.

5. The dose of Tramadol is 50-100mg up to four times daily.

6. Use in caution in the elderly where incidence and experience of these side effects can be increased.

7. Caution should also be taken in patients who take serotonergic medications such as selective serotonin reuptake inhibitors (SSRI's). Comcomitant administration of tramadol and serotonergic drugs can rarely cause serotonergic syndrome.

8. Use of tramadol in epilepsy is condra-indicated only in when the condition is uncontrolled.

Strong Opioids – Moderate to Severe Pain[5,13]

1. Where patients experience moderate to severe pain that is not relieved by weak opioids, the drug of choice is Morphine Sulphate.

2. Where Morphine is required for persistent pain, modified release morphine should be prescribed at 12 hourly intervals.

3. A closely monitored trial of opioid therapy is recommended before deciding to prescibe long term opioids.

4. When transferring from weak opioids the starting dose of Morphine Sulphate MR should be 5-10mg every 12 hours. The analgesic effect, as well as patient experience of adverse effects, should be assessed at regular intervals.

5. Consider smaller incremental increases in dose in elderly patients, where the incidence of adverse effects may be higher.

6. Where patients have dementia, non-compliance issues or swallowing difficulties, use of burenorphine transdermal patches may be considered where stong opioids are required. However this route of administration should be routinely revieved for appropriatness.

7. Where buprenorphine patches are required, the total daily dose of any oral weak opioid currently being taken should be incorporated into the patch strength to improve efficacy of therapy. The table below indicates total daily doses of morphine and equivalent preparations of transdermal buprenophine patches.

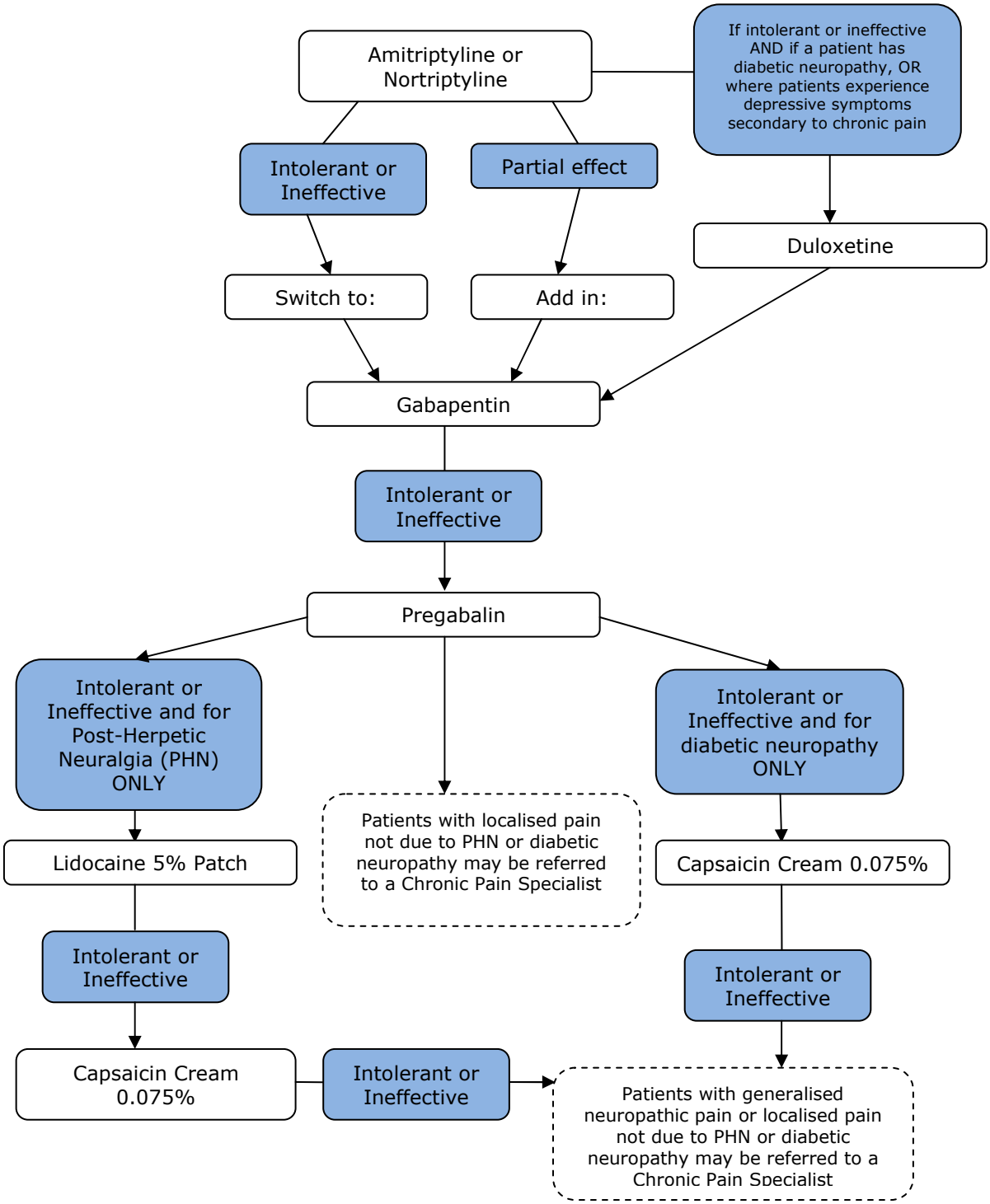
Oral Morphine (Total dose in 24 hours)	**Transdermal Buprenorphine**
5 – 10mg	BuTrans 5mcg/hr 7day patch
10 – 20mg	BuTrans 10mcg/hr 7day patch
20 – 40mg	BuTrans 20mcg/hr 7day patch
40 – 60mg	BuTrans 35mcg/hr 7day patch

8. A patient may require two to three upward adjustments of opioid dose before effectiveness can be evaluated. If acceptable pain relief/control is not achieved, or side effects occur, opioid therapy should be considered ineffective. If opioids are to be stopped they should be withdrawn gradually.

9. Where opioid therapy shows benefit, patients may be prescribed opioids up to an equivalent total daily Morphine dose of 60mg/24hrs. If patients do not experience benefit at this dose alone or in combination with adjuvant therapies, then referral to a Chronic Pain Specialist should be considered.

10. Patients with a current or past history of substance misuse, or with a comorbid non-substance misuse psychiatric diagnosis are more likely to develop issues with opioid use. Treatment in these individuals should be closely and collaboratively monitored by specialists in pain management and/or addiction medicine.

Appendix 3 – Treatment Algorithm & Prescribing Points for Neuropathic Chronic Non-Malignant Pain[8-19]



Prescribing Points for Neuropathic Chronic Non-Malignant Pain Guideline

General

1. Prescribers should assess the patient to determine the type of pain experienced, and use the the appropriate treatment algorithm.

2. Patients who, after assessment, are found to be experiencing a neuropathic element to their pain should be initiated onto the neuropathic treatment algorithm.

3. Patients started on new medications for neuropathic pain should be initiated on doses that consider age, co-morbidities and other medications.

4. Where patients experience neuropathic and nociceptive elements of chronic pain, the initiation of strong opioids should be delayed until the introduction of neuropathic analgesia, and assessment of analgesic effect has occurred[5].

Amitriptyline[15]

1. Patients initiated on amitriptyline should be started on a dose of 10mg at night, and increased according to response and tolerability up to a maximum dose of 100mg at night.

2. Amitriptyline is used in caution in patients with cardiovascular disease due to the risk of arrhythmias, however this does not exclude use in these patients.

3. Patients should receive counseling on common side effects of tricyclic antidepressants such as dry mouth, constipation, blurred vision and urinary retention.

4. Patients should be informed that side effects are less likely with the low doses used for initiation, and encouraged to persist if side effects do occur as some tolerance does seem to develop.

5. Elderly patients are more susceptible to side-effects and so small incremental increases in doses and close monitoring for psychiatric and cardiac side effects is encouraged.

6. Where patients are intolerant of Amitriptyline or find the drug ineffective withdrawal, where possible, should be undertaken slowly and cautiously.

Gabapentin[16]

1. Gabapentin may be used alone in patients where amitriptyline is not tolerated, ineffective, or in combination with amitriptyline where a partial effect is seen but increases in amitriptyline doses precipitate side-effects.

2. Gabapentin can be initiated at a dose of 100-300mg once daily, and increased in frequency weekly to achieve three times daily dosing as tolerated. The maximum recommended total daily dose is 3.6g/24hours.

3. In primary care, the initial titration stage of treatment may be acheivied by issue of a single prescription. However patients should be assessed for effectiveness and tolerance.

4. The patient should be informed of the common side effects which include nausea, diarrhoea, abdominal pain and drowsiness. These can be avoided by slowly titrating the dose upwards.

5. Caution should be used in the elderly and patients with renal impairment/disease. Gabapentin dosing and frequency should be adjusted as per the British National Formulary in patients with renal insufficiency to avoid accumulation, and thus increased risk of side effects.

6. In patients intolerant of Gabapentin, abrupt cessation should be avoided where possible. Withdrawal should occur over 1-2 weeks.

Pregabalin[16]

1. In patients intolerant to gabapentin, pregablin may be introduced due to its lower incidence of adverse effects.

2. Pregabalin should be initiated at a dose of 25mg twice daily, increased at weekly intervals as tolerated or until therapeutic benefit is achieved up to a maximum dose of 300mg twice daily.

3. The side effect profile of pregabalin is similar to that of gabapentin. However it should be used with caution in patients with severe congestive heart failure.

4. Caution should be expressed in the elderly and patients with renal impairment/disease. Pregabalin dosing and frequency should be adjusted as per the British National Formulary in patients with renal insufficiency to avoid accumulation.

Duloxetine[17]

1. Duloxetine is a re-uptake inhibitor of both serotonin and noradrenaline licensed for use in major depressive illness and diabetic neuropathy.

2. Where patients have chronic non-malignant neuropathic pain resulting from diabetes, or where patients have symptoms of depression secondary to a generalised neuropathy, Duloxetine is an appropriate agent due to its dual effect.

3. Duloxetine should be initiated at a dose of 30-60mg once daily and can be increased to a maximum of 120mg/24hrs in divided doses. The maximum single dose is 60mg.

4. Duloxetine should be prescribed as *Cymbalta*®, the licensed preparation for diabetic neuropathy and depression.

5. Duloxetine should be used in caution in the elderly, those with cardiac disease, uncontrolled hypertension, bleeding disorders and anticoagulants.

6. Duloxetine should be avoided in patients with hepatic impairment and those with a eGFR of less than 30mL/minute/1.73m^2.

7. Where the use of Duloxetine is not tolerated or ineffective the dose should be reduced over a period of 1-2 weeks.

Lidocaine 5% Patches[18]

1. Lidocaine 5% patches are licensed for use in Post-herpetic neuralgia **ONLY;** and only then in patients who have experienced ineffective analgesia or intolerance with first and second line systemic therapies.

2. Lidocaine 5% patches should only be used in patients without Post-herpetic neuralgia by a specialist in chronic pain management.

3. Patients should be counselled to apply the Lidocaine 5% patch once daily for 12 hours followed by a 12 hour plaster free period.

4. Where large areas are effected up to 3 plasters may be used in any 12 hour period.

5. If the patient has had no response after 4 weeks of therapy, Lidocaine 5% treatment must be discontinued.

Capsaicin 0.075% Cream[19]

1. Capsaicin cream is licensed for use in painful diabetic neuropathy, or in post-herpetic neuralgia but only after lesions have healed.

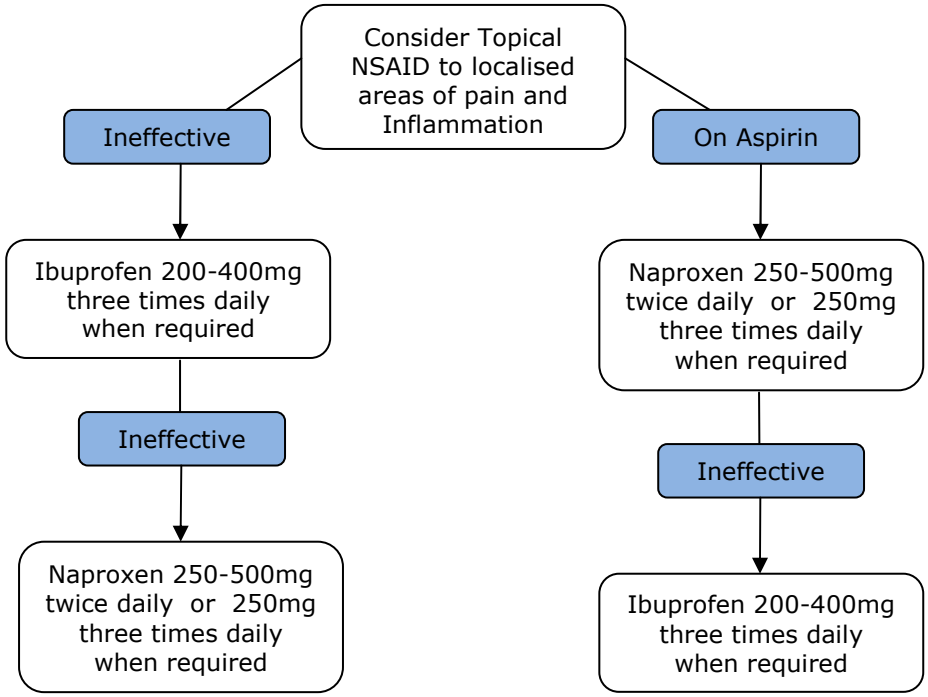
2. The cream is applied 3-4 times daily to the affected area.

3. Patients should be informed that side effects include a burning sensation at site of application, along with rare incidences of sneezing, eye irritation and dyspnoea.

4. Patients should be instructed to wash their hands immediately after use (or within 30minutes if hands being treated), not to use under tight bandages and to avoid hot showers immediately before and after administration.

5. When used for painful diabetic neuropathy Capsaicin 0.075% should be used for 8 weeks, or as tolerated, and then reviewed.

Appendix 4 – Treatment Algorithm and Prescribing Points for use of NSAIDs in Chronic Non-Malignant Pain[12]



Prescribing Points for NSAIDs use in Chronic Non-Malignant Pain

1. NSAIDs may be prescribed for any pain condition where analgesic effect of current therapy is insufficient. However prescribers should consider initiation of NSAIDs in combination with paracetamol +/- weak opioids prior to escalation to stong opioids.

2. Where oral NSAIDs are required, patients should be prescribed the lowest effective dose, and encouraged to take only when required, although regular use may commonly be required in chronic pain conditions.

3. Exceeding the doses started above, will increase the cardiovascular risk to patients, and is not recommended.

4. **NSAIDs should be used with cation in patients with renal impairment/disease, congestive heart failure, history of cardiovascular disease, and asthma.**

5. Patients at an increased risk of upper gastrointestinal bleeding should be co-prescribed a PPI to minimise the risk. Concomittant

use of NSAIDs with aspirin or anticoagulants should always result in prescribing of prophylactic gastroprotection.

Ref:

Appendix 6

CWM TAF HEALTH BOARD COMMUNITY CHRONIC NON MALIGNANT PAIN SERVICE REFERRAL FORM

Inclusion Criteria:	**Exclusion Criteria:**
• Pain > 6 months duration • Fully Investigated Symptoms • Known Pathologies • Failure of initial treatments after Algorithm followed	• Pain < 6 months • Non Diagnosed Pain • Presence of "red flags". • Non treated symptoms

Name:	**DOB:**
Address:	**Post Code:**
Telephone:	

GP:	**Practice Address:**
Post Code:	**Practice Telephone**:

Patient Height:	**Patient Weight:**

Diagnosis:

Duration of symptoms:

Relevant Investigation Results:

Ref:

CWM TAF HEALTH BOARD COMMUNITY CHRONIC NON MALIGNANT PAIN SERVICE REFERRAL FORM

Name:	**DOB:**
Address:	**Post Code:**

Other Relevant Medical History:

Current Medication:

Allergies / Intolerances:

Previous Therapies (include treatment duration and reason for cessation):

Outstanding Treatment Plans: