## Appendix 1. Conclusion to this module, written by a GP specialist in chronic pain

The following are the opinions of the GP expert reviewer of this module, who is involved with producing SIGN's new guideline on pain management, and looks at this topic from his viewpoint as a GPwSI.

1. 'First do no harm'. This is difficult to do in a 10-minute consultation. Instead, repeated short telephone reviews at two- to four-week intervals are a good way to assess response to treatment. Initial benefit (or lack of benefit) from most analgesics will be apparent within two weeks of reaching an optimal dose. This is probably about four weeks for TCAs, so timely review at two or four weeks is a key step.

2. Most patients either respond 'not at all' or 'very well' (i.e. more than 30-50% pain reduction) to most analgesics. As a very rough rule of thumb, it is reasonable to expect that any drug will produce a meaningful improvement of pain in ***less than 30%*** of our patients, and most patients will ***not*** achieve good long term pain control with analgesics. It is important for clinicians to set their own (and patients') expectations at an appropriate level at the outset, when deciding to prescribe.

3. There is a second module on non-pharmacological approaches to chronic pain (promoting self-management strategies, exercise, normal functioning, and addressing psychological yellow flags), and these approaches are often more likely to be beneficial than analgesic drugs. It is vital to offer non-pharmacological pain management strategies at the outset, usually in tandem with trials of analgesic drugs.

4. Many patients (and clinicians) need to exhaust drug options before they can seriously focus on non-drug strategies, which is a shame - as it can take a long time to logically go through every analgesic drug option!

5. A good principle is to trial drugs sequentially, one at a time, titrating to maximal effective dose as rapidly and safely as possible, allowing two to four weeks at each dose. The initial choice of drug should be based on all the usual parameters (drug interactions, co-morbidities, presence of neuropathic pain, severity of pain, patient experience of analgesics in past, cost, local formularies, etc.).

6. Use some kind of objective assessment to assess response - this may be as simple as "it works a lot, a bit or not at all" or "I can now get a full night's sleep" or a numerical score.

7. Document this assessment and ***stop any drugs that don't work or have only marginal benefit.*** A frequent comment from patients is 'I'm not sure if it helped,' and this can lead to the inappropriate continuation of the drug. Only continue those drugs that do actually make a significant difference.

8. Subsequent reviews may allow down titration of doses against symptoms to find the lowest effective dose. It is sometimes appropriate to do a planned trial of stopping drugs - and assessing the response - to try and gauge if there is any ongoing efficacy.

9. GP's are often in as good a position as pain specialists to do a lot of this work, and waiting times for pain clinics can be a real problem in practice. It requires investment of time initially by GPs, but saves effort in the long run if it

- reduces unnecessary prescriptions,
- reduces harm from iatrogenic dependence,
- reduces side effects from drugs like NSAIDs, and
- empowers patients, and encourages self-management.