Appendices

Appendix A: Pathway for chronic pain assessment, early management and care planning in non-specialist settings

Pathway for chronic pain assessment, early management and care planning in non-specialist settings

This pathway is drawn from evidence identified in the guideline, information extrapolated in the research for the guideline and the clinical experience and consensus of the guideline development group. More detailed pathways on pain assessment and management are available from the British Pain Society.[195]

Chronic pain management should focus on non-pharmacological strategies just as much as the use of analgesic drugs. The prescription of medication is the most convenient element of care but is potentially the most harmful and sometimes the least effective.

<table>
<tr><td rowspan="10">Step 1
Initial
assessment</td><td colspan="2">Divide assessment and initial management over multiple consultations
Investing time at the initial presentation may improve outcomes for patients and minimise unhelpful use of resources in future.</td></tr>
<tr><td colspan="2">Use a patient-centred, culturally sensitive approach
• Explain the treatment options.
• Encourage patients' involvement in decision making.</td></tr>
<tr><td colspan="2">Consider red flags
• Consider serious pathology and investigate and refer if necessary.
• Avoid further investigations unless serious pathology is suspected.
• Identify the stage at which no more investigations are planned and explain this clearly to the patient.</td></tr>
<tr><td colspan="2">Identify the duration of pain
• Make a clear diagnosis of chronic pain where appropriate.
Pain that has been present for more than 12 weeks.
• Record the diagnosis and code it electronically in the patient record.</td></tr>
<tr><td colspan="2">Identify if there may be an element of neuropathic pain
Typical features: character of pain (burning, shooting), allodynia (pain due to a stimulus that does not normally provoke pain), hyperalgesia (exaggerated response to a painful stimulus) unpredictable pain, other abnormal sensations, sensory abnormalities and/or skin changes on clinical examination; symptoms and signs neuroanatomocally consistent with underlying cause.
Brief validated tools are available to aid diagnosis (eg LANSS, DN4, painDETECT)[196] but there is insufficient evidence to support a recommendation for their routine use.</td></tr>
<tr><td colspan="2">Assess the severity of pain at different sites
• Use a narrative clinical history to clarify the complexity and intensity of pain.
• Consider using a visual analogue scale or numerical score to help gauge the response to treatment.</td></tr>
<tr><td colspan="2">Assess functional impact as part of a biopsychosocial assessment
• Consider work, relationships, sleep, mood, disability etc.
The depth of the assessment will depend on the severity of the problem and it may be completed over multiple consultations.</td></tr>
<tr><td colspan="2">Identify patients at increased risk of poor outcomes
• Use clinical judgement.
• Consider the use of evidence-based tools (eg Keele STarT Back Tool).
• Be aware of the presence of significant comorbidities.
Mental health problems (including depression, anxiety, personality disorder, post-traumatic stress disorder), cognitive impairment, substance misuse, pregnancy, polypharmacy, significant renal or hepatic impairment
• Be aware of the presence of yellow flags.</td></tr>
<tr><td>Biomedical yellow flags</td><td>Severe pain or increased disability at presentation, previous significant pain episodes, multiple site pain, non-organic signs, iatrogenic factors.</td></tr>
<tr><td>Psychological yellow flags</td><td>Belief that pain indicates harm, an expectation that passive rather than active treatments are most helpful, fear avoidance behaviour, catastrophic thinking, poor problem solving ability, passive coping strategies, atypical health beliefs, psychosomatic perceptions, high levels of distress.</td></tr>
<tr><td>Social yellow flags</td><td>Low expectation of return to work, lack of confidence in performing work activities, heavier work, low levels of control over rate of work, poor work relationships, social dysfunction, medico-legal issues.</td></tr>
</table>

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Appendix B: Self-Management Resources

- 'Flipping Pain': Patient leaflets, webinars and workbooks on chronic pain, written in accessible, engaging style and endorsed by NHS Scotland, are available on the website. Available at: Flipping Pain.

- 'Flippin Pain' also have a section on 'Flippin Fibromyalgia' with leaflets and webinars on fibromyalgia. Available at: Flippin Fibromyalgia

- Leaflet on Persistent Pain: a guide to self-management (produced by NHS GGC): self-management-persistent pain english.pdf (paindata.org)

- PainData website produced by the Chronic Pain Education Group with resources for patients and clinicians: Pain Management Home (paindata.org)

- Pain Association Scotland: patient information: Pain Association

- Versus Arthritis have useful advice about symptom management in osteoarthritis, for patient, on their website. Available at: Versus Arthritis | All of us pushing to defy arthritis

Appendix C: High risk factors in oral NSAID prescribing[34]

Risk Factors	Recommendations
Heart Failure	• Severe heart failure-avoid NSAID • Mild or moderate heart failure ○ Do not prescribe a COX-2 inhibitor, aceclofenac, diclofenac, or high-dose ibuprofen >2400 mg/day. Prescribe a standard NSAID and monitor. • Ibuprofen up to 1200 mg daily, or naproxen up to 1000 mg daily are first-line options
Ischaemic heart disease, cerebrovascular disease, or peripheral arterial disease	• Ibuprofen up to 1200 mg/day, or naproxen up to 1000 mg/day, are first line. Consider monitoring. • COX-2 inhibitors, aceclofenac, diclofenac, and high-dose ibuprofen are contraindicated.
For people with severe renal impairment (eGFR less than 30 mL/minute/1.73 m^2)	• Ideally, avoid prescribing NSAIDs. • If an NSAID is used, monitor closely
Risk factors for cardiovascular (CV) disease or the elderly	• Ibuprofen up to 1200 mg/day or naproxen 1000 mg daily are first-line options • Only prescribe diclofenac after careful consideration of its risks in this group • If a COX-2 inhibitor is required (e.g. in those with risk factors for gastrointestinal adverse effects) consider celecoxib 100 mg twice daily, if benefits are expected to outweigh the risks. • There are insufficient CV safety data to permit the use of higher doses of celecoxib. • Regularly review ongoing need for, and response to therapy, and monitor closely.
Hypertension	• Avoid prescribing etoricoxib or high-dose ibuprofen in people with blood pressure persistently above 140/90 mmHg. • Consider whether monitoring is needed.
Gastrointestinal bleed risk	• **High risk** of GI adverse events: prescribe a COX-2 selective NSAID (for example etoricoxib or celecoxib) instead of a standard NSAID and co-prescribe a PPI. • **Moderate risk** of GI adverse events — prescribe a COX-2 inhibitor alone, or an NSAID plus a PPI. • **Low risk** of GI events — prescribe a non-selective NSAID.

Appendix D: Neuropathic Pain Scoring Tool DN4[70]

(Bouhassira D, Attal N, Alchaar H et al. "Comparison of pain syndromes associated with nervous or somatic lesions and development of a new neuropathic pain diagnostic questionnaire (DN4)" Pain 114.1-2 (2005): 29-36.)

DN4 – QUESTIONNAIRE

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions.

INTERVIEW OF THE PATIENT

QUESTION 1:

Does the pain have one or more of the following characteristics? YES NO

Burning . . . . . ❑ ❑

Painful cold . . . . . ❑ ❑

Electric shocks . . . . . ❑ ❑

QUESTION 2:

Is the pain associated with one or more of the following symptoms in the same area? YES NO

Tingling . . . . . ❑ ❑

Pins and needles . . . . . ❑ ❑

Numbness . . . . . ❑ ❑

Itching . . . . . ❑ ❑

EXAMINATION OF THE PATIENT

QUESTION 3:

Is the pain located in an area where the physical examination may reveal one or more of the following characteristics? YES NO

Hypoesthesia to touch . . . . . ❑ ❑

Hypoesthesia to pinprick . . . . . ❑ ❑

QUESTION 4:

In the painful area, can the pain be caused or increased by: YES NO

Brushing? . . . . . ❑ ❑

YES = 1 point

NO = 0 points

Patient's Score: /10

A score of 4 or more out of 10 suggests neuropathic pain