PAIN MANAGEMENT & REFERRAL GUIDELINES - TARANAKI

PROBLEM		ACTION	LIKELY PRIORITY
CHRONIC / PERSISTENT PAIN			
Persistent pain	Diagnostic uncertainty	Refer to relevant speciality to assess for treatable underlying condition.	Not seen
All persistent pain >3/12	**Non-drug measures** and s**imple analgesics** (see **Box 1&/or 3** below) Consider P.E.P. for all (see Box 1)	Refer **early** to pain clinic if lack of response *include 'SF Orebro'* • Other options: • ACC eligible: refer ACC • Private physiotherapy /psychology • Private pain specialist (nil local)	Semi-urgent
Low back pain (LBP) without leg pain & with no red flags	Activity/exercise. (Refer ACC Back Pain guidelines if relevant) No role for opioids Use NSAIDs, Tramadol or Venlafaxine	Exercise/Green prescription +/- community physiotherapy +/- psychologist +/- P.E.P.	Routine
LBP with 'sciatica' –severe, persisting, extending below knee, neurological deficit,+/- other red flags.	Refer ACC Back Pain guidelines Orthopaedic referral	• Orthopaedic referral (under ACC if relevant) +/-PEP • ? epidural steroid option (see ACC website*)	Urgent or Semi-urgent
Local pain syndromes: e.g. shoulder capsulitis, epicondylitis, CTS.	Refer to physiotherapy or orthopaedic specialist.	GP management or referral	Routine
Persistent pain patient on long term opioids	Opioids no longer recommended for persistent non cancer pain, long term harms outweigh benefit. Youtube; Brainman reduces his opioids	Wean at 5-10% reduction per 28 day script. Use opioid contract +/- RUDT Refer for PEP If patient will not consider reduction option refer to CADs or persistent pain clinic.	Routine/semi-urgent
Patients known to persistent pain service			
PUEA graduate with flare up and no new pain problem	Refer for PEP		Not accepted for FSA
Persistent Pain & presenting to ED	Follow Pain Management Plan Manage as per boxes 1-3	+/- referral to PEP	Semi-urgent/routine
INPATIENT PAIN			
Acute pain	Optimise analgesia, boxes, 1, 2, 3.	• APS automatically see PCA, epidural and pain infusion patients on surgical wards only. • Written referral required from medical wards, and Page 475.(No fax)	Within 24 hours.
Inpatient with persistent pain *not* interfering with discharge	No inpatient persistent pain service	Refer to outpatients as per these guidelines	Semi-urgent or routine O/P appointment
Inpatient with complex pain interfering with discharge.	Optimise analgesia as per boxes 2 & 3. Discuss with Acute Pain Service (APS)	• Refer to APS (page 475) • Put written referral in notes.(No fax) • Consider inpatient psychology now available	Within 48 -72 hours

CANCER PAIN			
Community Cancer pain	• **First line management -** Analgesia including opioids as indicated. (Box 1&3) • &Trial of **adjuvant Rx** (Box 2)	Refer hospice and/or oncology Currently no opioid maximum	Pain clinic no longer taking GP referrals
Cancer survivor with persistent pain	• **First line management - Analgesia. (Box 1&3)** • **&Trial of adjuvant Rx (Box 2)**	Refer pain service with SFOrebro • +/- PEP Maximum opioids 60mg MEQ /day	Semi-urgent
NEUROPATHIC PAIN			
Recent onset neuropathic pain	• **Simple measures** (Box 1 & 3) • Trial of **adjuvant Rx** (Box 2)	Refer **early** to pain clinic if lack of response *SF Orebro.* • +/- PEP	Semiurgent
Longstanding neuropathic pain	As above (box 1/2/3) (response less likely)	GP management +/- PEP ?refer pain clinic *include "SF OMPSQ"*	Routine
COMPLEX REGIONAL PAIN SYNDROME (CRPS) (causalgia/RSD)			
Recent onset (<1 yr) CRPS or exacerbation	• **Encourage movement of affected limb** • **Simple measures** (Box 1 & 3) • Trial of **adjuvant Rx** (Box 2) • Pamidronate infusion early Refer **early** to pain clinic if lack of response	• **Avoid immobilisation of affected limb.** • Urgent physiotherapist management. • 2 x 500mg Vitamin C (S) for 3months Refer pain clinic *include "OMPSQ" please*	Urgent to Semiurgent
Longstanding CRPS	As above (Box1/2/3) (response less likely)	? Private spec. referral ? refer pain clinic/specialist	Routine

* ACC website for Interventional Pain Management: ACC4246 Interventional Pain Management

\# **Gabapentin** is licensed for neuropathic pain (special authority criteria apply), **carbamazepine** for diabetic neuropathy and trigeminal neuralgia, the others are unlicensed for this indication – although widely used and recommended

SF Orebro = " Short Form Orebro Musculo-skeletal Pain Screening Questionnaire"

- Canadian opioid prescribing guidelines 2017 http://nationalpaincentre.mcmaster.ca/guidelines.html
- CDC guidelines 2016 https://www.cdc.gov/drugoverdose/prescribing/guideline.html
- MEQ calculator from ANZCA http://fpm.anzca.edu.au/documents/opioid-dose-equivalence.pdf

BOX 1 NON-PHARMACOLOGICAL
- Comfort measures, relaxation, distraction.
- *Physical modalities*: active physiotherapy, exercise (green Rx), acupuncture, ice, heat, TENS
- *Psychology* referral for anxiety/depression or pain management skills.
- PEP Pain Education Programme – contact persistent pain service. Self referrals accepted 7536139 x 7532 Lara Blundell.

BOX 2 ADJUVANT ANALGESICS

May benefit from continued Box 1&3, e.g. if mixed nociceptive & neuropathic pain.
1. Tricyclic antidepressant –up to 75mg –especially if night sedation needed (eg Ami/Nortriptyline)
2. Gabapentinoids; Gabapentin # /Pregabalin (NS)
3. Venlafaxine up to 225mg.
4. Anti-epileptics eg. carbamazepine #, Sodium valproate.)

BOX 3 SIMPLE ANALGESICS
- Regular paracetamol (4g /day or less)
- +/- NSAID or Cox2 inhibitor
- +/- Opioid – but avoid MEQ more than 40-50mg/day