Colchester Hospital University NHS Foundation Trust
North East Essex Clinical Commissioning Group

Non-cancer chronic (≥ 3 months) pain pathway

Exclude serious pathology/red flags
Assess patient using appropriate assessment tools. Determine pain type, severity and functional impact.

Back pain see page 2 | Neuropathic pain see page 4 | Other pain

Establish patient expectations and agreed goals. Provide "Pain Toolkit" and give self-management advice.

Treatment step	Preferred option - suitable for majority of patients	Alternative if preferred option ineffective or patient intolerant.
Step 1 **Non-opioid analgesic**	• Regular paracetamol OR • NSAID (ibuprofen or naproxen) + PPI if necessary OR • Regular paracetamol + NSAID (ibuprofen or naproxen)	
Step 2 **Opioid for moderate pain**	Codeine or dihydrocodeine 30-60mg qds (max 240mg with or without paracetamol)	Preferred alternative - **GO TO STEP 3** **Under exceptional circumstances** • Tramadol 50mg – 100mg QDS Risk of serotonergic syndrome. Only prescribe if there is documented intolerance to codeine or dihydrocodeine or in patients experiencing side effects [CD sch. 3] • Buprenorphine patches where infrequent replacement of patches may be of benefit such as elderly patients who rely on others to help administer their medication [CD sch. 3]
	Co-prescribe laxatives as per formulary	
Step 3 **Opioid analgesics for severe pain.** **STOP weaker opioid** CD schedule 2	**Assess for mental health problems, alcohol abuse and addiction potential prior to treatment - see Opioid Risk Tool.** https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf **TRIAL STRONG OPIATE**. Review patient expectations and agreed goals.	
	Agree Tx goals. Trial Oramorph® 2.5mg – 5mg 4-6 hourly prn **for 2-4 weeks**	**Agree Tx goals. Trial** Oxycodone 1.25 – 5mg 4-6 hourly prn **for 2-4 weeks.** Check dose conversion if already on strong opiates. http://www.neessexccg.nhs.uk/uploads/files/opioid_conversion_chart_v2.pdf
	If ineffective withdraw opioid therapy even if no alternative drug. Refer to ACE. If effective: 30-50% reduction in pain convert as below.	
	Convert to a twice daily dose of morphine SR (Zomorph® capsules or MST® tablets). Titrate by no more than 10mg bd to a **maximum total daily dose of 120mg.**	• Convert to a twice daily dose of Oxycodone MR (Longtec® tablets). Titrate to a **maximum total daily dose of 60mg**. • Consider fentanyl patch (if unable to swallow). Fentanyl should not be started in opioid naïve patients. Initial dose should be based on the patient's current opioid use to a **maximum** of 25mcg/hr.
	Co-prescribe laxatives +/- anti-emetics (formulary). Consider written contract for opioid. If patient does not gain 30-50% pain relief within trial of 2-4 weeks, withdraw opioid.	

For more information refer to the full NEE "Guidelines for the management of Back pain, Neuropathic pain and Non-cancer pain in adults".

Approved by: North East Essex Medicines Management Committee October 2017 Review date: October 2019