NORTHERN IRELAND MEDICINES MANAGEMENT

Newsletter Supplement:
Chronic Pain Management – Important Messages

April 2025

This bulletin applies to chronic, non-malignant pain in individuals aged 16 years +

What is chronic pain?

Chronic (or persistent) pain, is pain that lasts for more than 3 months. Most people return to normal after an acute pain episode, e.g. after surgery or injury, however, sometimes the pain continues, or occurs without any such history. **Chronic pain is less about injury/damage and more about changes to sensitivity of the nervous system.**

Types of chronic pain

There are 2 types of chronic pain:

Chronic primary pain	No clear underlying condition, or pain impact is disproportionate to observable injury/disease, e.g. fibromyalgia, chronic primary headache/ musculoskeletal pain.
Chronic secondary pain	A symptom of an underlying condition, e.g. osteoarthritis, sciatica, neuropathic pain If medication is considered necessary, use alongside alternative strategies, and according to the relevant NICE guidance and Northern Ireland (NI) Formulary.

Note: both primary and secondary chronic pain can co-exist.

How should chronic pain be managed?

Factors such as personal beliefs, emotions and past experiences can turn the pain 'volume' up or down. **The most important aspect of chronic pain management is retraining the brain using a biopsychosocial approach.** This involves keeping active, mind-based activities and social connections. It is important to listen to the patient's pain story and use this to agree an individualised management plan.

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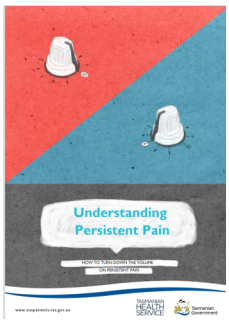
Patient education

Patient education on how chronic pain develops and is managed is key. This should include the role of medication and importance of alternative strategies in chronic pain management. The following explain these points well, and are useful for sharing with patients, and healthcare professionals (HCP).

- Understanding Persistent Pain – How to turn down the volume on persistent pain (leaflet)
- Understanding Pain in less than 5 minutes (video)



There has been a move away from the use of medication to manage chronic pain due to its limited benefit (estimated 30% pain reduction only). The primary purpose of medication should be to facilitate engagement in evidence-based pain management strategies, and improve functioning / quality of life. If medication is considered necessary this should be evidence-based in line with relevant NICE guidance and options within the NI Formulary.

Alternative strategies to manage chronic pain

At every opportunity, patients should be encouraged to utilise the many free resources available to educate and support them on their pain management journey.

Community pain support programmes — examples			
Programmes	**Location**	**Contact**	**Brief details**
Better Days	Regional	Improving Health - Pain Support (hlcalliance.org) – includes short video	• Open for self-referral or by HCP • 'In person' and online options available
Versus Arthritis	Regional (except WHSCT)	NI Versus Arthritis or email / phone northernireland@versusarthritis.org / 028 907 82 940	
Managing the Challenge	WHSCT only	https://www.amh.org.uk/services/managing-the-challenge/ Short video	

Pain support websites
(providing patient information leaflets, videos, tools, patient stories)

- NI Formulary Patient Area
- HSCNI Long term Pain Management
- My live well with Pain
- Flippin Pain
- The Pain Toolkit

Other resources

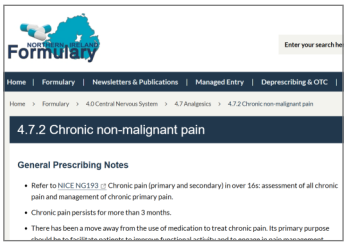
Physical Activity Referral Scheme (PARS) - electronic referral by GP Practice

Trust Recovery College Courses (check relevant Trust website)

For further information on alternative strategies to support chronic pain management, see relevant NICE guideline as per NICE Visual Summary.

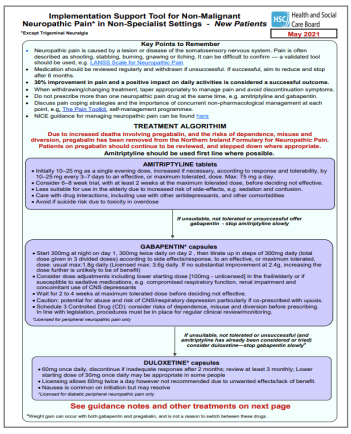
Reducing risks - Key points

Opioids



- All opioids are high risk medicines
- They are controlled drugs (CDs), governed by legislation
- Long-term use is associated with minimal benefit and potential harm, including dependence and addiction
- *Strong* opioids are not recommended for chronic non-cancer pain by NICE or the NI Formulary, and *weak* opioids have a limited role only (should be used **infrequently or short-term, when other treatments are unsuitable**)
- Tapentadol should be prescribed on pain specialist advice only

Gabapentinoids



- Pregabalin and gabapentin (gabapentinoids) are high risk medicines
- They are CDs, governed by legislation
- They have the potential to cause serious side-effects if used inappropriately, e.g. respiratory depression, cognitive impairment, dependence and addiction
- Gabapentinoids may have a role in the management of neuropathic pain (except trigeminal neuralgia)
- Gabapentinoids should not be offered for other types of chronic pain, e.g. fibromyalgia, low back pain, or sciatica. See Feb 2024 Newsletter
- Pregabalin is not a NI Formulary option
- After six months' maintenance, consideration should be given to reducing the dose. See NI Formulary Implementation Support Tool

Action:

- Follow NICE Guidance and NI Formulary
- Prioritise for review patients on higher doses. Aim to reduce slowly. See oral morphine equivalence (OME)
- Review regularly (as required by legislation) and document within the management plan
- Make all patients aware of:
  - ◊ risks and side-effects, providing appropriate written information where possible
  - ◊ alternative strategies/resources available
  - ◊ how to speak with their prescriber if they have queries/concerns or would like to reduce their dose.

Modified-release opioids – Increased dependence risk

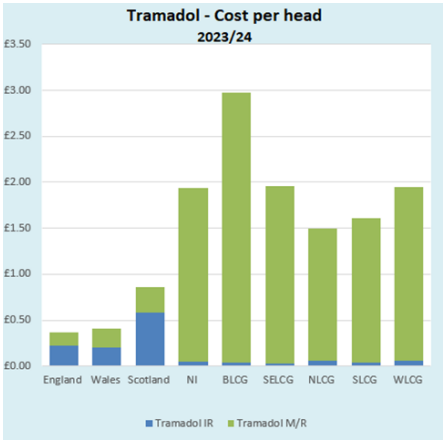
In NI, prescribing of tramadol MR preparations and buprenorphine patches is significantly higher than other parts of the UK.

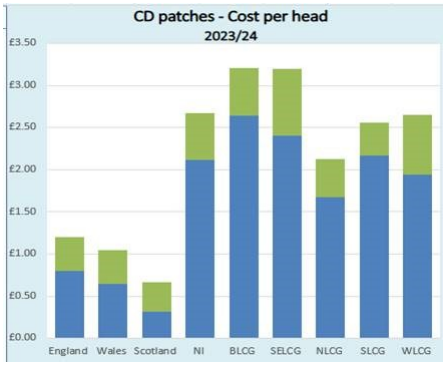
In March 2025, the MHRA removed the indication for relief of post-operative pain from the licences **of all MR opioids** due to the increased risk of persistent post-operative opioid use and opioid-induced ventilatory impairment.

In addition, in their guideline on *Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults*, NICE advise taking steps to reduce the risk of developing problems associated with dependence, for example starting at a low dose, and considering avoiding modified-release opioids (unless individual circumstances dictate otherwise).

Therefore, if an opioid is indicated, an IR preparation should be considered first where clinically suitable. MR preparations should be avoided where possible, unless clinically necessary for individual patient circumstances.

Note: tramadol and buprenorphine are classified as *strong* opioids by BNF.





Action

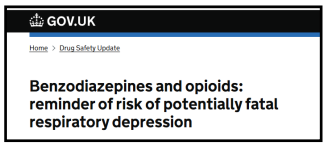
- Prioritise for review patients prescribed MR opioids, aiming to reduce the opioid (or other sedating medicine) slowly/carefully.

Risky opioid combinations

The risk of adverse effects, particularly respiratory depression, sedation and overdose, is increased when opioids are co-prescribed with some medications: **pregabalin, gabapentin, benzodiazepines, amitriptyline, and other sedating medicines, such as 'z drugs' and antihistamines**.

Note: more than one opioid should not be prescribed on a regular basis. See previous Newsletter article (July 2020) and MHRA alerts:

Benzodiazepines and opioids


GOV.UK

Home > Drug Safety Update

Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory depression

Pregabalin (including with opioids)


GOV.UK

Home > Drug Safety Update

Pregabalin (Lyrica): reports of severe respiratory depression

Gabapentin (including with opioids)

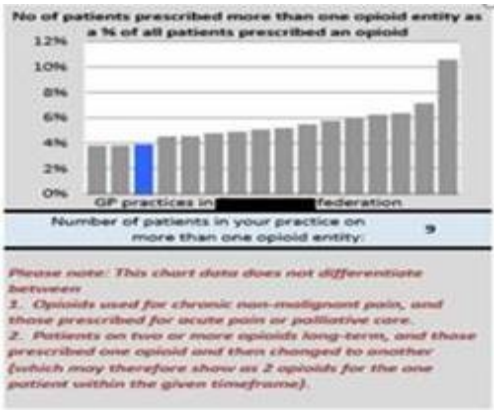

GOV.UK

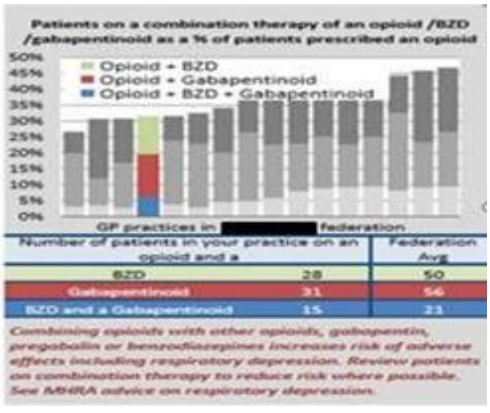
Home > Drug Safety Update

Gabapentin (Neurontin): risk of severe respiratory depression

Action:

- Prioritise for review patients prescribed risky opioid combinations, aiming to reduce the opioid (or other sedating medicine) slowly/carefully. Refer to the following graphs in the practice COMPASS report (Pg10) to support this work:
  - ◊ No of patients prescribed more than one opioid
  - ◊ No of patients on combination therapy of opioid / benzodiazepine / gabapentinoid





Lidocaine plasters

Lidocaine plasters are:

- **ONLY** licensed for symptomatic relief of neuropathic pain associated with post-herpetic neuralgia in adults. **Other use is off-license; i**nformed consent is needed if prescribing for unlicensed indications: see GMC advice
- Not on the NI Formulary; NICE CG173 does not make a recommendation on the use of lidocaine plasters as a treatment option for neuropathic pain **due to limited clinical evidence**. Lidocaine plasters are included in the HSC Limited evidence list. Note: lidocaine will diffuse to a maximal depth of 8 to 10 mm, so cannot reach deeper areas

If prescribing, counsel patient as follows:

- **Address treatment goals and expectations**: pain reduction / improved sleep / function / psychological well-being. Discuss importance of alternative pain management strategies as appropriate and provide HSC patient information leaflet
- **Explain how it works** (important for review later): ***Dual* mode of action:**
  - ⇒ Hydrogel plaster protects hypersensitive area (this is sometimes over looked)
  - ⇒ Lidocaine diffuses into the skin, providing a local analgesic effect resulting in pain reduction (not likely to reach beyond 10 mm deep)
- **How to use**: Skin must be intact, dry and non-irritated. Cover painful area with the plaster once daily for up to 12 hours within a 24 hours period. When needed, the plasters may be cut into smaller sizes with scissors prior to removal of the release liner (store the rest in the foil sachet until ready for use). In total, not more than three plasters should be used at the same time. Apply whenever pain is worst. If symptoms are intermittent, apply only when needed. Note: the effect is local (i.e. not like an opioid patch with systemic analgesic action)
- **Potential side-effects:** e.g. application site reactions
- **Time frame**: If goals are not met within 2 to 4 weeks, **then treatment must be stopped (no step-down is needed). Patient should not reorder** but instead contact their GP practice. It is important that patients are not left on the product if it is not working. If there is a response, the next step will be to trial a non-medicated barrier to confirm if response is due to the protective effect of the hydrogel plaster, or the lidocaine diffusing into the skin (see March 2025 newsletter article Review lidocaine plasters)
- It is sometimes possible to discontinue the plasters without pain recurring as the local effect on nerve endings persists after the plaster is removed. Prescribers may therefore wish to ask patients to try doing without the plaster for 24 hours before their next review
- The SPC notes that long-term use in clinical studies showed that the number of plasters used decreased over time. Therefore, reassess treatment regularly and consider the following strategies if continuing:
  - ⇒ Try to reduce the amount of plaster(s) needed to cover painful area (i.e. cut the plaster)
  - ⇒ Increase the interval between plasters, e.g. 11 hours on, 13 hours off. This plaster-free period can be extended until the patient may no longer need the product.

A local audit showed only 37% of new patients reviewed by practices within 4 weeks found lidocaine plasters effective and continued with treatment beyond 4 weeks.

Further resources

- Opioid Resource Pack
- Gabapentinoid Resource Pack
- Primary care intranet Pain management resources
- Pain | NI Formulary Patient Area
- Opioids Aware | Faculty of Pain Medicine
- PrescQIPP High dose opioid searches ≥120mg OME
- PrescQIPP bulletins:
  - ◊ Reducing opioid prescribing in chronic pain
  - ◊ Lidocaine plasters
  - ◊ NSAIDs
  - ◊ Dependence Forming Medicines

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