Pain Theme

The following questions can be used as discussion points for peer groups or self-reflection of practice. The questions relate to topics within a pain theme. It is strongly recommended that the linked article is read before considering the questions. You may wish to cover only one discussion topic per session

Diagnosing and managing headache in adults in primary care

See: www.bpac.org.nz/2018/headache.aspx

A systematic approach is recommended when assessing patients with headache to rule out serious underlying conditions and to ensure an accurate diagnosis. Self-management and non-pharmacological treatments should be explored before prescribing medicines. Non-steroidal anti-inflammatory drugs (NSAIDs) are the first-line pharmacological treatment for patients with tension-type headache or migraine. Triptans are prescribed to patients with migraine if NSAIDs are ineffective or not tolerated. Beta-blockers or amitriptyline may be considered for prophylaxis in patients with frequent migraine, despite optimal acute management.

1. How easy is it in practice to determine if there could be a serious underlying cause for headache? At a minimum, fundoscopy, visual acuity, head and neck assessment, inspection of temporal arteries, a focused neurological examination and general observations should be done during an initial examination for headache; is this practical or do you have an alternative approach that works well in your practice?
2. Do you recommend the use of a headache diary? If so, do you find that patients comply with this? Do they provide information that is useful to identify triggers and management strategies for the headache?
3. What non-pharmacological strategies do you recommend to patients for managing headache? Is this advice generally well-received or are patients usually just wanting a prescription for a medicine?
4. What is your experience with patients using triptans for migraine? Do most patients with migraine end up trialling a triptan? How effective are they?
5. Do you often prescribe medicines for migraine prophylaxis? If so, what regimen do you find to be most effective? What about prophylaxis for tension-type headache?

Sometimes the use of analgesics for managing headaches can become the cause of the headache. Medicine overuse headache should be suspected in patients with persistent headache who are using simple analgesics, e.g. paracetamol, ibuprofen or aspirin, on ≥ 15 days a month, or patients using opioids, e.g. codeine-containing analgesics, tramadol, or triptans on ≥ 10 days a month.

6. How often, if at all, have you diagnosed medicine overuse headache? Are there any medicines in particular which are more likely to be implicated?
7. Do you feel more confident after reading the article on how to identify and manage this type of headache? What treatment strategies do you/would you use?

Managing pain in osteoarthritis: focus on the person and Celecoxib: the "need to know" for safe prescribing

See: www.bpac.org.nz/2018/osteoarthritis.aspx and www.bpac.org.nz/2018/celecoxib.aspx

The progression of osteoarthritis varies from person to person. Functional decline and worsening of symptoms is not inevitable, but people with osteoarthritis will often require ongoing management of pain. It is important that the pain is treated in the context of how it affects the person's day-to-day life and activities, with an overall goal of maintaining function.

1. There has been some recent debate in the literature about the effectiveness of paracetamol in patients with osteoarthritis. However, it remains appropriate and is still widely recommended. Do you prescribe paracetamol as your first-line option? If not, why not and what do you prescribe instead?
2. Do you often prescribe oral NSAIDs for osteoarthritis or do you find that many patients have contraindications to these medicines or are unable to tolerate them? If you do prescribe NSAIDs, what advice do you give to patients about how they should be used, i.e. "prn" or daily use?
3. Do you recommend topical treatments, such as capsaicin or NSAID gels or creams? If so, what is the general feedback from patients on the usefulness of these medicines?
4. There is no evidence that over-the-counter products, e.g. Anti-Flamme or Deep Heat, are any better than placebo, yet many patients with osteoarthritis find these treatments beneficial. In your experience do they appear to help? Are there any other products or supplements that patients seem to benefit from?
5. Weight loss can result in significant improvements in symptoms in people with osteoarthritis of weight-bearing joints. What strategies have you found to be successful in your practice for encouraging people with osteoarthritis to achieve and maintain weight loss?

Celecoxib is now fully subsidised without restriction and may be useful for the treatment of patients with osteoarthritis who are able to tolerate a NSAID. A significant advantage of celecoxib compared to other NSAIDs is that it is associated with less risk of gastrointestinal bleeding.

6. What has been your experience with prescribing celecoxib in the past? Now that it is fully subsidised, do you think that you will consider prescribing it for patients who require a NSAID?
7. There is no evidence that celecoxib is associated with any greater cardiovascular risk than non-selective NSAIDs, such as naproxen and ibuprofen. Are you satisfied with this evidence or are you still concerned about cardiovascular safety with celecoxib compared to other NSAIDs?
8. If you were going to prescribe celecoxib, or any NSAID, would you co-prescribe gastro-protection, i.e. a PPI?

Selected topics in acute pain management for primary care

See: www.bpac.org.nz/2018/pain-topics.aspx

The principles of managing acute pain in primary care

The primary aim of acute pain management is to provide treatment that reduces the patient's pain, with minimal adverse effects, while allowing them to maintain function. A secondary aim is to prevent acute pain from progressing to chronic pain. Use multi-modal analgesia, provide an analgesic plan and consider other treatments or techniques which will optimise resolution of pain.

1. When prescribing analgesics to a patient for acute pain, do you have a standard regimen that you use or does it vary? What factors do you use to decide which analgesic and dose to prescribe? Do you often have to alter a patient's analgesic regimen?
2. A written analgesic plan generally includes dosing instructions, potential adverse effects and how to manage these, the likely time frame for pain resolution and instructions on when and how to stop medicines as pain improves. Do you think that a written analgesic plan is likely to improve outcomes for patients in terms of their pain management? If you do not usually provide a written analgesic plan, is this something that you would now consider doing? Is there anything else that you think would be useful to include in the analgesic plan?
3. "Multi-modal" analgesia is the term used to refer to the concurrent use of analgesics with different modes of action, e.g. prescribing paracetamol with an opioid. In your experience does this approach to treatment improve acute pain management? Do you think that it results in lower doses of opioids being used?
4. Do you usually follow up patients to ensure that that their pain has resolved? What systems, if any, do you have in place in your practice to identify and monitor patients with acute pain that could become chronic?

Prescribing tramadol appropriately

Tramadol is an atypical opioid used for moderate pain when paracetamol and/or a NSAID is not adequate. There is no evidence that tramadol provides superior pain relief compared to other weak opioids, such as codeine. Tramadol is associated with less risk of respiratory depression and constipation than codeine, but has an increased risk of serotonin toxicity.

1. What factors do you take into account when choosing which Step two analgesic to prescribe, i.e. codeine, tramadol or dihydrocodeine?
2. In your experience have you found that tramadol is an effective analgesic medicine for patients or do many report adverse effects?
3. Do you find that patients are less likely to report constipation with tramadol than with codeine?
4. When tramadol is withdrawn do you usually advise the patient to stop abruptly or to taper the dose? What regimen would you use for tapering the dose? Have you found that some patients have difficulty stopping tramadol?

When to consider strong opioids for patients with acute pain

There are few indications for prescribing a strong opioid for acute pain in a primary care setting. If a strong opioid is required, morphine is first-line and treatment should ideally be prescribed for a few days only. An analgesic plan should be provided to the patient, and weaker opioids and/or paracetamol/NSAIDs prescribed to provide analgesic cover as the pain resolves and the strong opioid is withdrawn.

1. In the past few years, progress has been made in reducing the potentially inappropriate prescribing of oxycodone, which is often initiated in secondary care. Have you noticed a change in the analgesics patients are typically discharged on from secondary care, e.g. post-surgery? If a patient is discharged on oxycodone and they require a repeat prescription, would you usually: provide this for them, change them to morphine or change them to a weaker opioid?
2. If it is necessary to initiate a patient in primary care on a strong opioid, what do you prescribe? Do you usually prescribe short-acting or long-acting preparations, or both? How confident are you about adjusting the dose of a strong opioid in a patient with renal dysfunction?
3. In some cases, clinicians may be reluctant to prescribe strong opioids due to concern about potential misuse. In your experience are there particular red flags or patient characteristics that make you more cautious with prescribing an analgesic and in your advice to patients regarding their use?
4. If you do suspect that a patient is becoming dependent on opioids after they were initiated for acute pain, e.g. increasing or ongoing opioid requirements, what would be your next steps in terms of management?