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Managing chronic pain in the non-specialist setting:

a new SIGN guideline

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CHRONIC PAIN AND THE NEED FOR A GUIDELINE

Chronic pain, defined as pain lasting beyond normal tissue healing time (taken to be 3 months),[1] is a syndrome that affects a large proportion of the primary care population. It is 'significant' in around 14% of UK adults, imposing a heavy burden on the physical and psychosocial health of sufferers, their families and society, at high cost to the healthcare services.[2] It was estimated in 2002 that people with chronic pain account for 4.6 million GP appointments in the UK, at an annual cost to the NHS of £69 million, equivalent to the employment of 793 GPs.[3] Although many clinical conditions can lead to chronic pain, there are common underlying neurobiological and psychosocial mechanisms, and the impact is generally independent of the clinical aetiology. Effective assessment and treatment of chronic pain therefore means that GPs should have:

- adequate education and knowledge;
- access to evidence-based effective management strategies; and
- agreed criteria for referral to specialist clinics.

Unfortunately, none of these requirements is generally in place.

Undergraduate training in management of pain is demonstrably minimal, accounting for <1% of programme hours,[4] despite its high prevalence and impact. Much of the available evidence for potential interventions is derived from specialist settings or in specific clinical conditions, making it difficult to apply to a general primary care population. Even standard treatments, such as drugs, often lack evidence for effectiveness beyond the short or medium term. However, in recent years, there have been some innovations in primary care, and a growing body of evidence for their feasibility and effectiveness. Partly on the strength of this, there are now standard guidelines to support non-specialist management of some chronic pain conditions, such as low back pain[5] and neuropathic pain.[6] There has not been a comprehensive guideline consolidating current knowledge of effectiveness of all interventions for all chronic pain, although this would be valuable in primary care. As Moore *et al* recently indicated, most people with pain do not respond well to any single intervention, but most will respond to at least one intervention.[7] Therefore ,the current challenges are to identify the correct intervention(s) for each patient, and to identify and stop ineffective treatments. These will be aided by easily-accessed clinical evidence, informed patient-centred review of our patients, and appropriate referral to colleagues in specialist services.

SIGN

For the past 20 years, the Scottish Intercollegiate Guidelines Network (SIGN) has produced evidence-based guidelines to optimally inform clinical practice, with the aims of reducing variation in service and improving patient outcomes. The methodology and objectivity of SIGN guidelines are internationally recognised and have an influence on healthcare worldwide. Recognising a large area of unmet need, a multidisciplinary SIGN guideline development group produced a new guideline on chronic pain, published in December 2013.[8] This guideline is specifically aimed at the non-specialist reviewing the assessment and management of adults with chronic non-malignant pain.

SUMMARY OF THE GUIDELINE

Following SIGN methodology,[9] the guideline development group identified 17 structured key questions about chronic pain, addressing the following areas:

- assessment;
- self-management;

Table 1. Summary of some of the Recommendations for chronic pain management included in the SIGN Guideline[a]

Area addressed by key question	Summary of key recommendations	Level of evidence[b]
Assessment and planning of care	To best direct treatment options, a comprehensive biopsychosocial assessment, including identification of pain type (for example neuropathic) should be carried out in any patient with chronic pain.	GPP
Supported self-management	Self-management can be used from an early stage in a pain condition, with patients being directed to self-help resources at any stage in the patient journey.	GPP
Pharmacological therapies	There should be at least annual assessment of patients on pharmacotherapy for chronic pain.	GPP
	Tricyclic antidepressants should not be used for the management of pain in patients with chronic low back pain.	A
	Amitriptyline (25 to 125 mg/day) should be considered for the treatment of patients with fibromyalgia and neuropathic pain (excluding HIV-related neuropathic pain).	A
	Strong opioids should be considered for chronic low back pain or osteoarthritis and only continued if there is ongoing pain relief.	B
	Specialist advice or referral should be considered if there are concerns about rapid opioid dose elevation or if >180mg/day morphine equivalent dose is needed.	D
Psychologically-based interventions	Consideration should be given for referral to a pain management programme for patients with chronic pain.	C
	There should be an awareness of the impact of healthcare behaviour, as well as the treatment environment, in reinforcing unhelpful responses.	GPP
Physical therapies	Any form of exercise or exercise is recommended for patients with chronic pain.	B
	In addition to exercise therapy, advice to stay active should be given to patients with chronic low back pain. This will improve disability in the long term. Advice alone is insufficient.	A
Complementary therapies	Acupuncture should be considered for short-term relief of pain in patients with chronic low back pain or osteoarthritis.	A

[a]This is not a comprehensive list. In total, 55 graded Recommendations are included in the Guideline. [b]The grade of recommendation relates to the strength of the supporting evidence on which the evidence is based. It does not reflect the clinical importance of the recommendation. Grade A is strongest; Grade D weakest; Good Practice Points (GPP) represent recommended best practice based on the clinical experience of the guideline development group.

- pharmacological therapies;
- psychologically-based interventions;
- physical therapies; and
- complementary therapies.

A systematic search was undertaken for the years 2007 to 2012, including MEDLINE, Embase, Cinahl, PsychINFO and the Cochrane Library for each key question. All relevant articles were critically appraised and rated using the SIGN Grading system.[9] The rated evidence was then graded[9] and summarised by the guideline development group. The primary output was a total of 55 graded recommendations relating to the predefined key questions, including but not restricted to those summarised in Table 1. They include helpful guidance on aspects of pharmacological and non-pharmacological approaches to chronic pain. Some of the best evidence was available for pharmacological management of neuropathic pain, resulting in several Grade A recommendations. In contrast, evidence for approaches to assessment and self-management was generally lacking. There was generally limited or absent high quality evidence for complementary therapies (excluding acupuncture) and dietary interventions.

Where good quality evidence was lacking, but a practical point could be made, the group used their clinical experience to produce 'Good practice points'. In addition, a number of patient pathways were developed

to address important areas for non-specialists, combining the evidence reviewed with existing high quality guidelines, clinical experience and consensus. These covered:

- assessment, early management, and care planning (from presentation to specialist referral);
- neuropathic pain; and
- the use of strong opioids.

These are intended to guide us practically, through a comprehensive biopsychosocial process of assessment and management, recognising the need for patient-centredness and safety.

The guideline concludes with recommended sources of further information and support, both for professionals and for patients. Finally, a patient version of the guideline is available, summarising the content and recommendations in lay language, aiming to facilitate engagement in a collaborative process towards optimal outcomes.

IMPLEMENTATION AND NEXT STEPS

This Guideline is relevant internationally, presenting the best available evidence for management of chronic pain by non-specialists. It is available freely online[6] and also in a quick reference guide and apps for Apple and Android systems. It therefore has the potential to inform all healthcare practitioners, and will be of particular interest to GPs and primary healthcare teams in the UK. Its implementation will be supported by the NHS in Scotland through linkage with SIGN to all NHS Boards, and through audit tools, linked to performance indicators, and targeted educational events.

This guideline will confirm and support much of the excellent practice that GPs are already providing for chronic pain in primary care. It will also provide a useful summary for those who are trying to find a way through the complex multimodal maze, which has so far been beset with conflicting evidence and advice. It will potentially highlight the importance of multidimensional and multi-discplinary approaches to chronic pain, and the need for continuing education and training in this area (as well as increased resource provision).

Finally, perhaps the most important finding in the guideline development process, of longer-term relevance, is the relative lack of good quality evidence available and applicable in primary care. This includes both standard approaches to treatment (for example, long-term opioids) and more innovative approaches (for example, self-management programmes). Therefore, there is an urgent need to commission and conduct primary care-based trials, recognising the need for psychological and physical therapy, considering the potential role of education, advice and complementary approaches, and the methodological complexities of identifying and measuring timely, relevant outcomes. This will allow an enhanced second edition of this Guideline when it is considered for review in 3 years' time.

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Competing interests

The authors have declared no competing interests.

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