Drugs for chronic pain:

we still need them

We note the concerns expressed by Abdel Shaheed *et al* in their recent editorial 'Drugs for Chronic Pain'.[1] They expressed important anxieties about the availability of pharmacological options for GPs treating chronic pain, which will be restricted if the current draft National Institute for Health and Care Excellence (NICE) guideline is implemented.[2] Their concerns include:

- conclusions, drawn by NICE, based on inconsistent application of the International Classification of Diseases eleventh revision (ICD-11) definition of 'chronic primary pain'; and
- failure to apply this definition at all to the evidence they reviewed.

As clinicians treating chronic pain, people living with chronic pain, and advisors on relevant national policy, we share these concerns, and add the following observations:

1. Lack of evidence of effectiveness at population level does not equate to lack of effectiveness for all individuals. As Andrew Moore *et al* argued, *'we need to move away from a focus on average response and seek out what works for each patient'*.[3] In general, people in pain do not want to have to take medication, but, in the absence of other effective options, still want to live their life.

Failure to offer a trial of potentially effective drugs to all patients means that many will be denied the opportunity of relief from pain and distress. The key is in shared decision making, which includes a range of options to meet the biopsychosocial needs of the individual, early review, and adjustment or cessation of any prescribing according to response and side effects. Although there are recognised potential harms from many analgesics, poorly controlled chronic pain itself has a significant detrimental impact.

2. 'Chronic primary pain', as a formal entity, is a new concept, defined by the World Health Organization and the International Association for the Study of Pain (IASP) for ICD-11.[4] It can refer to conditions in which pain is the primary disease; importantly, however, it can change to one of the six 'chronic secondary pain' diagnoses available in ICD-11 (for example, chronic cancer pain and chronic neuropathic pain) as more information comes to light from investigations. In primary care especially, it may therefore be a 'holding diagnosis', evolving eventually into one for which standard analgesic medications are recommended by NICE. These drugs would be withheld from a patient awaiting or declining these investigations.

3. In Scotland, the standard for this clinical area is the Scottish Intercollegiate Guidelines Network (SIGN) guideline *Management of Chronic Pain*.[5] Updated in 2019, this is not consistent with the draft NICE guideline, in that it recommends the use of analgesics in specific circumstances. For example, SIGN recommends that: *'Opioids should be considered for short- to medium-term treatment of carefully selected patients with chronic non-malignant pain, for whom other therapies have been insufficient, and the benefits may outweigh the risks of serious harms such as addiction, overdose and death.'* A detailed algorithm is provided to guide its safe and effective use, in the context of shared agreement, early and frequent review, and appropriate cessation. Non-pharmacological approaches are also encouraged. These recommendations will not change following publication of the NICE guideline.

4. Similarly, while emphasising the need for caution and the use of non-pharmacological treatments, the IASP states that, *'There may be a role for medium-term, low-dose opioid therapy in carefully selected patients with chronic pain who can be managed in a monitored setting.'*[6]

The Scottish Government responded to NICE during the consultation phase of their draft guideline, noting the above potential deleterious impact the draft recommendations could have on people living with chronic pain, and on clinicians helping them to manage it. Chronic pain has such an important impact on the lives of people who live with it that we need every tool available in our toolbox to help in its management. Now is not the time to reduce our options.

> *"The key is in shared decision making, which includes a range of options to meet the biopsychosocial needs of the individual ..."*

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Competing interests
All authors are members of the National Advisory Committee for Chronic Pain (Scottish Government). Blair H Smith and Lesley A Colvin led the revision of the 2019 SIGN guideline, noted in this article, focusing on opioids. There are no other conflicts of interest.

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