

## NICE chronic primary pain guidelines:

what the busy GP needs to know

### ASSESSING CHRONIC PAIN

Chronic primary pain occurs without a clear underlying condition or when the pain — including associated emotional distress and functional disability — is disproportionate to observable injury or condition. These conditions, including fibromyalgia, chronic primary headache, and chronic primary pelvic pain, affect between 1% and 6% of people in England.<sup>1</sup> The underlying pathophysiology is poorly understood.

Patients can experience both primary and secondary pain concomitantly with significant overlap of symptoms. It is important to acknowledge this to the patient and where possible address them separately. National Institute for Health and Care Excellence (NICE) guidance<sup>1</sup> focuses particularly on the management of chronic primary pain and not chronic secondary pain, for which condition-specific guidance should be followed.

### NON-PHARMACOLOGICAL OPTIONS

NICE recommends three types of non-pharmacological intervention for chronic primary pain: exercise, psychological therapies, and acupuncture.

Supervised exercise programmes and encouraging physical activity are beneficial for patients with chronic primary pain.<sup>1</sup> There was no evidence that one type of exercise provided a greater benefit than another.

Psychological therapies in the form of cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT) are recommended. While CBT is well recognised, ACT may be less familiar to clinicians: it is a mindfulness and behaviour change approach that emphasises psychological flexibility to enable acceptance of pain. One systematic review and meta-analysis found ACT led to significant improvements in functioning with reduced anxiety and depression.<sup>2</sup>

A single course of acupuncture delivered by a trained professional is recommended as evidence showed an improved quality of life for up to 3 months. The evidence is unclear whether this benefit is sustained, and

repeated courses are not recommended. For cost-effectiveness, the acupuncture should be delivered in the community, consisting of no more than five sessions.<sup>1</sup>

NICE recommendations are neither for nor against pain management programmes. Due to variation in their content and delivery, the evidence was felt to be insufficiently robust to demonstrate consistent clinical or cost-effectiveness. The Faculty of Pain Medicine has raised concerns that this may lead to the decommissioning of pain-management programmes, potentially depriving patients who benefit from their services.<sup>3</sup> Social prescribing is not recommended due to lack of evidence, but further research is suggested.

There is inconsistency between interventions included or excluded in this chronic primary pain guidance and those in specific guidelines for other pain syndromes. For example, the recommendation in favour of acupuncture for chronic primary pain contrasts with its recommendation against it for low back pain.<sup>4</sup> The guideline states that it should be used alongside existing NICE guidance for 'specific conditions' but does not advise what to do when they directly contradict each other. This could be interpreted as leaving it to the clinician's discretion as to whether they aim to treat a patient's primary or secondary pain.

### NO ANALGESICS

The most significant change to chronic primary pain management is the guidance to not prescribe any conventional analgesic medications. This includes prescribing neither simple analgesia, paracetamol and non-steroidal anti-inflammatory drugs [NSAIDs], nor complex 'pain' medications including opiates, benzodiazepines, gabapentinoids, corticosteroids, local anaesthetics, ketamine, and cannabis-based products. Even short-term use was not recommended, with little or no evidence that they improve pain, psychological distress, or quality of life, and significant

**A Harvey-Sullivan**, MA, MSc, MBBS, GP ST, Tower Hamlets Training Scheme, London; academic clinical fellow, Queen Mary University of London, London. **S Higginbottom**, MA, MRCP, DRCOG, DFSRH, GP and e-learning author, Royal College of General Practitioners, London. **T Round**, MRCP, GP academic, King's College London, London; e-learning clinical lead, Royal College of General Practitioners, London.

#### Address for correspondence

Adam Harvey-Sullivan, Barts and The London NHS Trust, Royal London Hospital, Whitechapel Road, London E1 1RD, UK.

**Email:** adam.sullivan@nhs.net

**Submitted:** 6 December 2021; **Editor's response:** 25 January 2022; **final acceptance:** 7 March 2022.

©British Journal of General Practice 2022; **72:** 240–241.

**DOI:** <https://doi.org/10.3399/bjgp22X719453>

## Box 1. Summary of NICE guidelines 2021 on the assessment of all chronic pain and the management of chronic primary pain

- Assessment of chronic pain should be holistic including consideration of wider factors that could contribute to and/or be impacted by the chronic pain. It should aim to differentiate between chronic primary and secondary pain, recognising that they can coexist.
- Exercise, psychological therapy, and a single course of acupuncture are recommended.
- No analgesic medication is recommended.
- Patients already on these medications should be involved in a shared decision-making process including discussion about potential staged reduction and deprescribing.
- Antidepressants should be considered, even for those without concomitant depression.

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## Competing interests

Thomas Round is *BJGP* Associate Editor and Clinical Lead for the RCGP Essential Knowledge Updates (EKU) programme. Sally Higginbottom writes for RCGP EKU e-learning and wrote the EKU module on chronic pain.

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evidence of long-term harm. For example, a multicentre, randomised, double-blind, placebo-controlled trial found gabapentin was ineffective in women with chronic pelvic pain and resulted in a significant increase in serious adverse effects.<sup>5</sup>

This recommendation against analgesic medications goes further than the Scottish Intercollegiate Guidelines Network (SIGN) update in 2019 to their chronic pain guidelines from 2013. SIGN introduced new restrictions for opioid prescriptions for chronic pain considering the increasing evidence of harm but did not recommend against them nor change their recommendations for other analgesics.

## MEDICATION REVIEW AND DEPRESCRIBING

What does this mean for patients who are already taking one if not several analgesic agents to manage their pain and may have done so for many years?

The UK is developing an analgesic prescribing crisis. In 2017–2018, 11.5 million adults in England (26% of the adult population) received one or more prescription for opioids, gabapentinoids, benzodiazepines, z-drugs, and antidepressants.<sup>6</sup> Prescribing rates of these medications are strongly linked with areas of socioeconomic deprivation. These drugs are associated with well-recognised harms including overdose, dependence, and withdrawal. A 2020 *BJGP* editorial argues that adversity and distress has been medicalised, risking mass iatrogenic harm.<sup>7</sup> As such, this guidance may be welcomed by some clinicians as providing the evidence base to support honest dialogue with patients about the harms and limitations of these drugs, and to enable therapeutic deprescribing.

Yet while this guidance encourages deprescribing it does not provide any guidance about how to do this in the context of potentially prolonged polypharmacy of analgesics for ongoing chronic pain. As noted, there have been concerns that the guidance could result in deprescribing of potentially beneficial medications.<sup>3</sup> A joint statement advised that a medication review should be

a shared decision-making process including discussion of the patient's experience, as well as the risks and current evidence.<sup>8</sup>

## ANTIDEPRESSANTS

NICE has recommended the use of antidepressants for chronic primary pain. There is evidence of benefit in improving quality of life, pain, sleep, and psychological distress compared with placebo. This includes those without a concomitant diagnosis of depression, although this is an off-label use.

Duloxetine has the greatest body of long-term evidence of effectiveness. A systematic review estimated the number needed to treat (NNT) in fibromyalgia to get 50% pain relief from duloxetine was 5.8.<sup>9</sup> However, there are insufficient head-to-head comparative data to recommend duloxetine over other antidepressants; as such, the choice should be tailored to the patient.

## CONCLUSION

This NICE guideline (see Box 1) could be a 'paradigm shift' in the management of chronic pain away from habitual analgesic prescribing towards doctor and patient developing a shared understanding of the complex experience of pain and collaboratively constructing an informed management plan.<sup>10</sup> Yet there is likely to be a significant implementation gap between the guidance and what is deliverable in day-to-day primary care. Clinicians may welcome the evidence-based guidance encouraging non-pharmacological interventions, yet these services are often lacking, under-resourced, or inaccessible for patients. Patients are likely to continue to expect analgesics to manage their pain, leaving clinicians in the difficult position of refusing a prescription in the face of their patient's suffering.

An important gap in the guidance relates to flare-ups of chronic pain. While NICE emphasises the importance of recognition and reassessment of flares, it provides no specific prescribing guidance. Whether the recommendation against the use of analgesics would apply is unclear. In reality, it may be worth considering a trial of analgesic with a shared plan about the acute prescription duration.

Management of chronic primary pain remains a challenge in primary care, but GPs can have honest discussions about its psychosocial determinants and should feel empowered to review patients' usage of potentially harmful drugs.

## Provenance

Freely submitted; externally peer reviewed.