

Moving away from medicines: an overview of chronic pain management.

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Nursing Standard

evidence & practice medicines

Why you should read this article:

- To update your knowledge of the latest guidance on managing chronic pain
- To recognise the importance of reducing medicines use in chronic primary pain management
- To consider which non-pharmacological interventions could be effective for people experiencing chronic pain

Moving away from medicines: an overview of chronic pain management

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Abstract

Chronic pain can be debilitating and affects an increasing number of people in the UK due to an ageing population and the rising prevalence of comorbidities. Chronic pain can be primary, where it is not accounted for by another condition, or secondary, where it results from an underlying condition or injury. The National Institute for Health and Care Excellence has published updated guidance on the assessment and management of chronic pain in adults. This article explores the latest recommendations regarding medicines use in chronic primary pain and outlines appropriate non-pharmacological management strategies. It also discusses some of the barriers to implementing chronic pain management interventions, and provides advice for nurses caring for patients who are experiencing this type of pain.

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Keywords

analgesics, anti-inflammatories, chronic pain, clinical, clinical guidelines, medicines, nursing care, pain, pain assessment, pain management, professional

Key points

- *Chronic pain is that which has lasted for three months or longer, and it is managed as a long-term condition*
- *Chronic primary pain is not accounted for by another condition and is associated with emotional distress and/or functional disability, whereas chronic secondary pain results from an underlying condition or injury*
- *Various medicines that have been used in chronic primary pain management are associated with risks and harmful side effects*
- *Non-pharmacological pain management strategies include structured programmes, physical activity, relaxation, mindfulness and psychological interventions*

Chronic pain is defined as pain that has lasted for three months or longer, and is classed as a long-term condition; this contrasts with acute pain, which resolves within six months (Fayaz et al 2016, International Association for the Study of Pain 2019, National Institute for Health and Care Excellence (NICE) 2021a, World Health Organization (WHO) 2022). There is no curative treatment for chronic pain, so it is managed as a long-term condition by healthcare professionals (Howarth and Poole 2019). Chronic pain affects between one third and one half of the UK population, with this figure likely to increase due to an ageing population and a related rise in comorbidities (Fayaz et al 2016).

Chronic pain can be categorised as (Nicholas et al 2019, WHO 2022):

Chronic primary pain – this is pain not accounted for by another condition and is associated with emotional distress and/or functional disability. Chronic primary pain is caused by a change in the nervous system and may be classified as a condition rather than a symptom (Melzack 1999). Because there is no tissue injury or damage, analgesics such as opioids are often ineffective. Chronic secondary pain – this is pain secondary to an underlying condition or injury, for example arthritis or spinal injury.

This article details the latest NICE (2021a) guidance on the management of chronic primary pain, at the time of writing, with a focus on the recommendations to reduce medicines use. The injuries or conditions that can result in chronic secondary pain will have their own medicines guidelines, and people with this type of pain will be prescribed analgesics according to their diagnosis, for example non-steroidal anti-inflammatory drugs or corticosteroids for arthritis, and antiepileptic medicines for neuropathic pain. This article also provides information on the use of non-pharmacological pain management interventions in people with chronic primary and secondary pain, and examines some of the common barriers to pain management.

Medicines use in chronic primary pain

In the initial stages of chronic primary pain, it is common for people to seek a cure (Clarke and Iphofen 2007), which can lead to them requesting a prescription for pain relief medicines. However, since the 1980s there have been reports of misuse of and dependency on prescribed medicines, as well as increasing issues with over-the-counter medicines, opioids and gabapentinoids (antiepileptic medicines that are used for their side effects in minimising the symptoms of nerve pain) (Public Health England 2017). The psychological burden of chronic primary pain can lead to medicines dependency and addiction, alongside associated risks and harmful side effects such as personality changes, weight changes and kidney damage (Dillie et al 2008, Halbert et al 2016, Kaiser 2020, NICE 2021a). There is also a significant link between mood and anxiety disorders and long-term opioid use (Halbert et al 2016).

It is concerning that between 2006 and 2017 there was a 30-fold increase in oxycodone hydrochloride prescriptions for acute and chronic pain, which may increase the risk of long-term opioid use (Jani et al 2020). Furthermore, research shows that people on long-term opioids have lower quality of life and self-efficacy scores, demonstrating a lack of confidence in undertaking activities (Dillie et al 2008, Quinlan et al 2020). However, although the issue of harm associated with long-term opioid use has been at the forefront of prescribing discussions in recent years, a qualitative study of 564 hospital nurses detailed that fewer than 70% of them accurately identified the risk factors associated with opioids (Kaiser 2020). Opioids are not recommended for the management of chronic pain (NICE 2021b), but strong opioids are still recommended in the management of palliative and cancer-related pain (NICE 2016).

NICE (2021b) conducted an evidence review into the pharmacological management of chronic primary pain. The review included 33 studies, which investigated antiepileptics, antidepressants, benzodiazepines, non-steroidal anti-inflammatory drugs and cannabinoids (cannabis-based medicines); all medicines that have been regarded as alternatives to opioids. Antiepileptics such as gabapentin and pregabalin have become common prescriptions for people with chronic pain. However, seven of the 33 studies in the NICE (2021b) review demonstrated no clinically significant difference between these medicines and placebo in relation to pain reduction, physical function, quality of life and psychological distress. Furthermore, the evidence indicated a significant risk of clinical harm due to adverse events and side effects such as anxiety, depression, dizziness and hypertension, which often led to discontinuation of these medicines within three months (NICE 2021a). Therefore, neither pregabalin nor gabapentin should be prescribed in cases of chronic primary pain.

There has been an increase in requests for cannabinoids from patients with chronic pain, possibly due to their use in other countries or media coverage (The British Pain Society 2019, Schlag et al 2020). NICE (2021b) reported that there is a lack of evidence to inform a recommendation for or against the use of cannabinoids in the NHS for people with chronic pain and that further research was required.

The NICE (2021a) guideline on chronic pain advises considering the use of antidepressants to manage chronic primary pain for adults, once a full discussion of the benefits and risks has taken place. The rationale for using antidepressants in chronic primary pain is not only to manage the patient's pain, but also to improve their sleep, enhance their quality of life and reduce their distress (NICE 2021a).

Medicines tapering

Since there was minimal official guidance on the use of medicines for chronic primary pain before 2021, some patients will have been previously prescribed, and continue to take, medicines that are no longer recommended by NICE for chronic primary pain. Therefore, education for nurses and support for patients is required to facilitate discussions about medicines tapering, which is the process of slowly decreasing a medicine to prevent withdrawal symptoms. Negative responses to tapering opioids – such as immediate withdrawal from treatment plans and negative emotional reactions – are common among patients because many of them are anxious about experiencing an increase in pain, withdrawal symptoms such as tremors and headaches, and negative effects on their quality of life (Quinlan et al 2020). Nurses can increase the likelihood of effective medicines tapering by identifying an individual's concerns, explaining the lack of evidence for the use of opioids in chronic primary pain and the risks associated with these medicines, while also ensuring compassionate person-centred care plans are put in place (NICE 2021a).

Chronic pain clinics commonly introduce non-pharmacological pain management strategies as a way to increase the likelihood of a patient reducing their medicines use and therefore reducing the risk of harmful side effects.

Non-pharmacological pain management strategies

People who experience chronic pain may experience a 'pain cycle', whereby they avoid activities and movement due to the pain, which can lead to increased muscle tension, decreased activity and low mood or depression. Subsequently, these factors can lead to reduced motivation and increased pain symptoms (Moore 2022). As part of pain management, people need to adopt new or established strategies to self-manage their chronic primary or secondary pain, which can 'break' the pain cycle and enhance their quality of life (Moore 2022).

Once the nurse has undertaken thorough assessment of an individual's chronic pain, considering the biological, psychological and social factors, an individualised pain management plan can be collaboratively formulated with the patient to include (NICE 2021a, 2021c, 2021d, 2021e):

Nurse-led interventions to minimise or distract from painful sensations. A rehabilitative approach using physiotherapy and occupational therapy to reduce challenges in undertaking daily activities. A psychological approach to reduce distress, anxiety and depression. Attending a structured pain management programme.

» The strategies outlined in this section incorporate some or all of these elements, and all can be nurse-led initially before the patient learns to self-manage their pain.

Structured pain management programmes

Pain management programmes are designed to reduce disability, distress and medicines use, rather than to provide curative relief (Howarth and Poole 2019). People referred to pain management programmes have been in pain for at least ten years on average and will have explored many other interventions first (Dopson 2010).

Pain management programmes are recommended by The British Pain Society (2013) and can be offered by multidisciplinary professionals, including nurses, physiotherapists, occupational therapists, psychologists and doctors. They generally consist of weekly group sessions that take place over 6-10 weeks and explore gentle exercise, relaxation, discussion of topics related to pain education and medicines, mental well-being and physical activity (Dopson 2010, The British Pain Society 2013). Pain management programmes may also include advice on explaining chronic pain to other people such as friends and family members, as well as strategies to assist with improving sleep – both of which are areas that Hurley-Wallace et al (2020) found to be of interest to adolescents experiencing chronic pain. Such programmes not only enable pain management strategies to be attempted and evaluated, but also offer people with chronic pain peer support from others with similar experiences. This peer support has been shown to be a valuable strategy in the management of any long-term condition (Dopson 2010, Nees et al 2020, NICE 2021a, 2021c, Moore 2022).

Physical activity and goal setting

Physical activity is an important part of a healthy lifestyle; however, it can be highly challenging for individuals with chronic pain to identify the amount and type of physical activity required, as well as to remain motivated to undertake this (NICE 2021a). Nees et al's (2020) study of 276 patients with chronic back pain who had attended pain management programmes reported that 75% found physiotherapy and physical activity to be the most useful strategies for them.

The NICE (2021d) evidence review of exercise for chronic primary pain included 91 studies and three Cochrane reviews that examined a broad range of exercise programmes. NICE (2021a, 2021d) concluded that the effect of physical activity overall was positive. Therefore, nurses should encourage physical activity and independence in people experiencing chronic pain because this can have a significant positive effect on their overall quality of life and pain management.

Acupuncture

Acupuncture is one of the most common alternative therapies accessed by people with chronic pain (Howarth and Poole 2019). It involves the insertion of fine needles into certain sites of the body and can assist with muscle relaxation, natural endorphin release and stress reduction (The British Medical Acupuncture Society 2022).

Acupuncture has been seen as a controversial management strategy for chronic pain due to the lack of quality research in its evidence base (Howarth and Poole 2019). However, a NICE (2021f) evidence review of acupuncture in chronic primary pain, which included 32 studies, found that although the research was of low quality, there was a sufficient evidence base to recommend acupuncture. As such, the use of acupuncture can reduce the amount of medicines an individual is prescribed for chronic pain (NICE 2021a, 2021f).

Breathing, relaxation and mindfulness

Chronic pain can lead to an activation of the body's sympathetic nervous system response, releasing hormones such as adrenaline (epinephrine) and cortisol. These hormones act on the sympathetic nervous system, triggering the response to life-threatening emergencies known as 'fight or flight' (Melzack 1999). However, using techniques such as relaxation and controlled breathing can alter this response by decreasing elevated metabolism, heart rate, blood pressure and respiratory rate, as well as 'calming' brain activity (Benson and Proctor 2011, Brown and Jones 2013). Cusens et al (2010) reviewed the Breathworks mindfulness-based pain management programme, which incorporates the use of breathing strategies in which an individual becomes aware of, or controls, their breath. The researchers found improvements in attendees' self-reported scores for depression and catastrophising following the use of such breathing strategies.

As well as breathing strategies, other mindfulness techniques can also be effective in managing pain (NICE 2021e). Mindfulness is the practice of the individual 'being in the present moment' and paying attention to their internal and external environment, thereby aiming to control the cognitive and emotional aspects of pain (Brown and Jones 2013). It is a skill that requires practice and takes time to develop, which has led to inconsistent research outcomes regarding its effectiveness (NICE 2021a, 2021e).

Brown and Jones (2013) used self-reporting questionnaires and electroencephalograms (EEGs) of neural activity to measure the effects on people experiencing chronic musculoskeletal pain who attended an eight-week mindfulness programme. The researchers found that the 15 patients who had attended the programme experienced improvements in their mental health and greater perceived control over their pain compared with a control group of 13 patients who did not attend the programme. Similarly, Cassidy et al (2012) examined 87 patients with chronic lower back pain before and three months after mindfulness education during a pain management programme and found that those who regularly practised mindfulness reported lower levels of disability, anxiety and depression, as well as less reliance on medicines.

Psychological interventions

Psychological factors such as stress and anxiety levels have a significant effect on people's experience of chronic pain and how they perceive their pain (Veehof et al 2016, Hughes et al 2017, NICE 2021e). Psychological interventions for chronic pain have improved, becoming more accessible and person-centred than in the past, but there is still variability in access to these interventions across the UK (NICE 2021e).

Current psychological interventions include cognitive behavioural therapy (CBT), which focuses on changing people's unhelpful or distorted beliefs and automatic thoughts, and acceptance and commitment therapy (ACT), which aims to increase people's psychological flexibility by enabling them to move towards living in accordance with their values alongside the pain (Hughes et al 2017, NICE 2021e). People can also learn to stop avoiding, denying or struggling with their inner emotions and pain experiences.

The NICE (2021e) evidence review of psychological therapies for chronic pain, which included 47 studies, concluded that ACT enhanced people's short-term and long-term quality of life, while also improving psychological measures for distress associated with pain. There was conflicting evidence for the benefits of CBT, although some studies showed a positive effect on sleep (Hedman-Lagerlöf et al 2018). Additional research has been recommended to further measure the effects of CBT on chronic pain (NICE 2021a, 2021e).

Nurses should have conversations with patients experiencing chronic pain about their psychological well-being as part of a holistic approach. Since the emotional distress associated with chronic pain can place a further burden on people already experiencing

physical discomfort, managing the psychological aspects of pain should be seen as equally as important as managing the physical aspects. However, people with chronic pain may be less willing to talk about the psychological factors that affect their pain and how their pain affects their emotions. This can be due to factors such as previous unsympathetic experiences with healthcare professionals or cultural beliefs such as taboos around discussing mental health (NICE 2021a, 2021g).

Barriers to effective chronic pain management

Engagement with pain management

During the person-centred assessment of an individual with chronic pain, the nurse should assess the level of engagement a patient has with any non-pharmacological management interventions. Kerns and Habib (2004) found that any form of preparation – such as questionnaire-led assessments or simply a discussion between the patient and the nurse before the intervention – increased the likelihood of patients adhering to that intervention compared with those who did not experience similar preparation. Similarly, managing a patient's expectations by asking whether they are ready to change how they manage their pain if it does not resolve can form part of a chronic pain management strategy (Kerns and Habib 2004, Clarke and Iphofen 2007).

Staff attitudes towards chronic pain

In 1968 McCaffrey provided a simple and person-centred definition of pain, stating it is: 'Whatever the experiencing person says it is, existing whenever and wherever the person says it does' (McCaffery 1968). McCaffery's definition is frequently quoted and remains relevant as healthcare moves away from a predominantly biomedical model to a person-centred and holistic model of care. Rather than making assumptions about a patient's experience of their pain based on medical knowledge, nurses should focus on identifying how the pain is experienced by the individual (Clarke and Iphofen 2008).

Nurses have an important role in identifying and supporting people with chronic pain. However, it has been identified that many healthcare professionals often do not accept patients' reports of pain, in part due to a lack of knowledge and training (Clarke and Iphofen 2008). Waterhouse's (1996) case study of a surgical patient found that suboptimal post-operative pain management was often due to nurses not believing the patient's self-report of pain. de Rond et al (2000) implemented a pain monitoring programme on three hospital wards, which included education for nurses on pain assessment and management. Before the education programme was implemented the researchers found deficits in nurses' knowledge and attitudes towards pain, which led to inadequate pain management. After completing the programme, a higher proportion of nurses believed they had sufficient skills and knowledge to assess and manage patients' pain (de Rond et al 2000).

Jacques (1992) stated that accurate pain assessment depended on whether patients feel they are believed by nurses. Therefore, the validation of patients' pain is an important part of any pain management intervention.

Pain management advice for nurses

It is essential that nurses use person-centred communication and active listening to support patients' well-being (NICE 2021h). However, it may be challenging for nurses to use these skills in practice for various reasons, such as time constraints and high-pressure work environments. The following general advice may support nurses in providing advice and education to anyone experiencing chronic pain, and in signposting them to relevant services.

Listening and validating

The labelling of patients is not uncommon in healthcare, particularly on wards or units that have a quick turnaround, where patients might be referred to as a number or a diagnosis (Clarke and Iphofen 2008). However, the labelling of patients with chronic pain is particularly prevalent, with them sometimes being referred to as 'moaners', 'problems' or even 'liars', which can add to their feelings of frustration (Clarke and Iphofen 2008). By actively listening to people's experiences and demonstrating compassion, nurses can ensure that patients feel believed, which is a first step towards effective pain management.

Promoting self-management

Self-management of long-term health conditions can have several benefits, such as enabling people to be less reliant on healthcare professionals, reducing the number of appointments that people require and their frustration with long waiting times, reducing the number of medicines prescribed and enhancing quality of life (Moore 2022).

The use of social media can support self-management by providing a means for peer support. Many adolescents with chronic pain frequently use social media platforms such as Instagram to identify and increase their support networks, thereby reducing feelings of isolation (Hurley-Wallace et al 2020).

Nurses can also support patients' self-management of chronic pain by:

Advising them to practise square breathing (Figure 1) – this technique can assist in distracting people and reducing the stress associated with chronic pain almost immediately, and it can be taught and learned quickly (Rakel and Mercado 2007).

Encouraging them to undertake daily stretching – this can assist patients with chronic pain to improve muscle stiffness, blood flow and general movement (NICE 2021c). Using a five-minute daily stretching routine can assist many people with chronic pain.

Signposting and referring them to appropriate services, charities and resources – for example local chronic pain clinics and resources such as Versus Arthritis ([versusarthritis.org](https://www.versusarthritis.org)), The Pain Toolkit (paintoolkit.org) and Living Well with Pain (livingwellpain.net).

Figure 1. Square breathing technique

(© Charlotte Bacchus)

Conclusion

Chronic pain can be debilitating and significantly reduce an individual's quality of life. It is important that nurses are aware of the risks and harmful side effects associated with various medicines that have been used in chronic primary pain management. Non-pharmacological strategies such as physical activity, breathing, relaxation and psychological interventions have all demonstrated improvements in the quality of life of people with chronic pain, and resulted in reduced medicines use.

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