The prison Pain Management Formulary-One Year On

5th Health and Justice Summit

Glasgow

28.11.17

Doctor George Ryan-Clinical Adviser Public Health England, Criminal Justice Team, Drugs, Alcohol and Tobacco Division

Denise Farmer-Pharmaceutical Adviser Health and Justice, Finance, Commercial and Specialised Commissioning Group NHS England

Neuropathic pain-diagnosis

Difficult to diagnose with certainty

Allodynia-pain due to a stimulus that does not normally cause pain

Hyperalgesia

Skin and/or sensory abnormalities on examination

Symptoms and signs neuroanatomically consistent with underlying cause

‘’Burning”, “stabbing” or ‘’shooting’’ pain

Neuropathic pain-approaches to management

People may ask for pregabalin especially-and plausibly

‘’If amitriptyline does not work-unlikely to be neuropathic pain”

Consider referral…….but might end up on high dose polypharmacy

Longer than five weeks waiting time to see specialist exacerbates symptoms

Use non-pharmacological approaches but services very variable and may be costly

BMJ 18.1.14 Drugs for neuropathic pain:

Duloxetine for DM neuropathy

Pregabalin for postherpetic neuralgia and central neuropathic pain

‘’For most off label drugs (..such as amitriptyline) little or no good evidence of efficacy’’

NICE guidance for pharmacological management of neuropathic pain

8.Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia)

If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.

Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use).

Consider capsaicin cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments

Consider referral to a pain specialist and/or a relevant clinical specialty (e.g. neurology, diabetology or oncology)

Offer carbamazepine for trigeminal neuralgia—consider referral if contra-indicated, not effective or not tolerated

NB Consider physical and psychological therapies or referral for surgery

NICE advises not to use

- cannabis sativa extract
- capsaicin patch
- lacosamide
- lamotrigine
- levetiracetam
- morphine
- oxcarbazepine
- topiramate
- tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use)
- venlafaxine.

Neuropathic pain-Non pharmacological management

Acupuncture to Zen

Cognitive behaviour therapy

Exercise

Manual therapy

Mutual aid

Mindfulness, meditation and acceptance and commitment therapy

Pain management solutions limited pmsltd.co.uk

The Pain Toolkit www.paintoolkit.org

Gabapentoid community Prescribing

Fig 13 Pregabalin and Gabapentin Prescribing (part of BNF 4.7.3 and 4.8.1): Quarterly Volume (Items) and Spend (NIC) in NHS Wolverhampton CCG

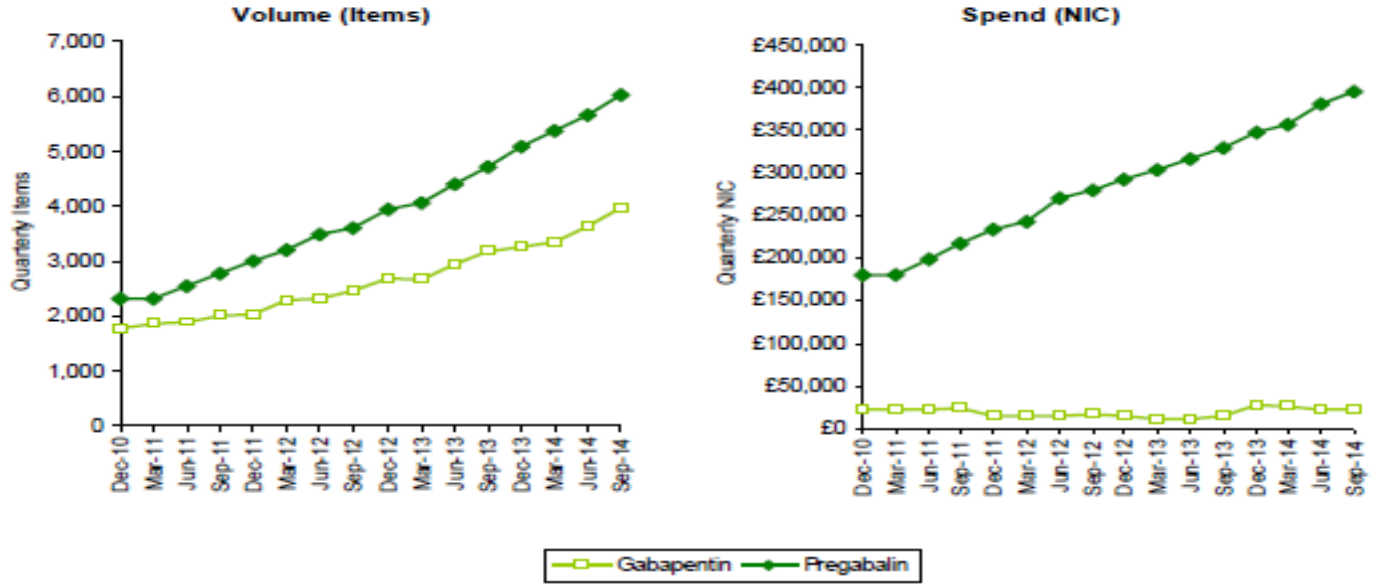
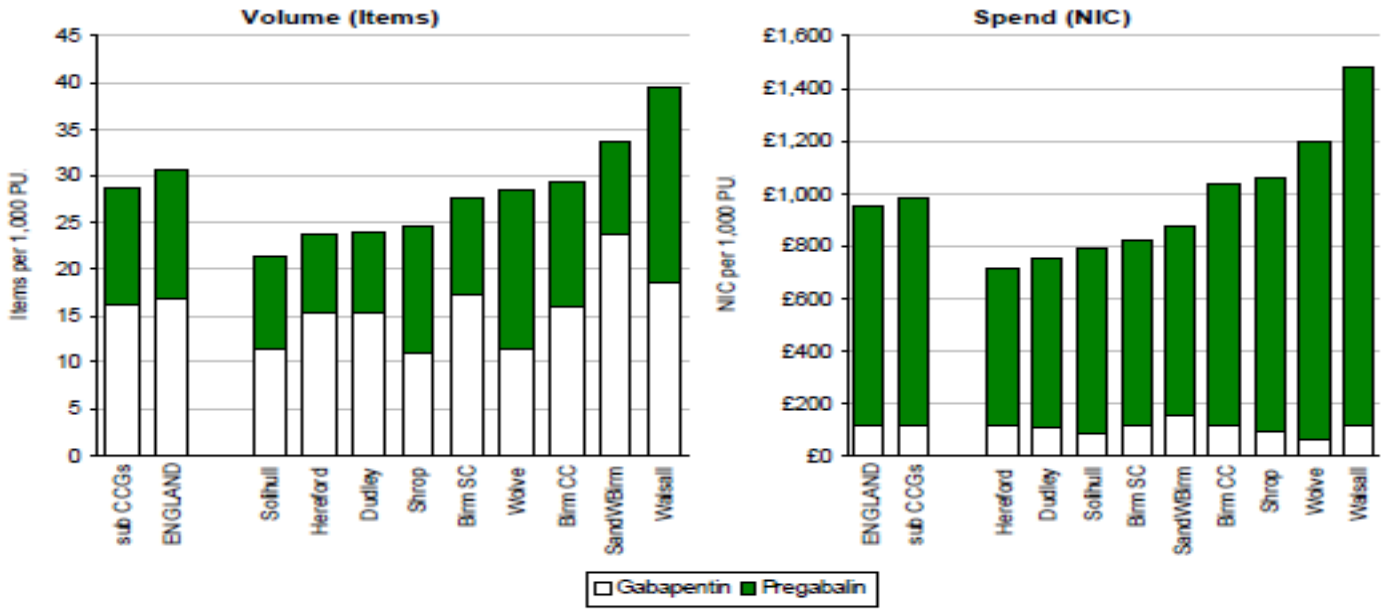


Fig 14 Comparative Data: Pregabalin and Gabapentin Prescribing (part of BNF 4.7.3 and 4.8.1) by Volume (Items) and Spend (NIC), for the period Jul-14 to Sep-14



Data: NHSBSA

Pregabalin

Structurally similar to GABA-gamma aminobutyric acid the predominant inhibitory neurotransmitter

Rapidly and highly [90%] absorbed—characteristic of a drug of misuse

Largely excreted unchanged in urine

Neuropathic pain 600mg daily in divided doses—b.d. or t.d.s.

Also licensed for post-herpetic neuralgia, generalised anxiety disorder, epilepsy

Used off license for migraine, mania, bipolar disorder

Reasons to choose pregabalin over gabapentin

The titration of pregabalin is easier

90% of pregabalin is absorbed through the gut, compared to only 27-60% of gabapentin

Pregabalin is more rapidly absorbed than gabapentin-reaching its peak effect one hour after ingestion

Pregabalin has a linear response between plasma concentration and dose, whereas gabapentin does not

Potential problems

Why is pregabalin a drug of abuse?

Pregabalin high-loss of inhibitions, euphoria, high energy, dissociation, improved sociability, relaxation, psychedelic effects and a sense of calm

-but may cause poor hand eye co-ordination, drowsiness, impaired balance

12% of people taking licensed dose experience euphoria

Tolerance-seems variable, some people may take massive doses

Potentiates effect of alcohol, benzodiazepines

Gabapentin-similar effects [similar street value]

‘’ Like alcohol without the hangover’ ’

Effects are dose-related

Can be taken orally [most common route], intranasally, i.v. or p.r.

Withdrawal symptoms-depression, anxiety, palpitations, agitation, sense of panic

Deaths involving pregabalin and gabapentin

	2012	2013	2014	2015	2016
Gabapentin	8	9	26	49	59
Pregabalin	4	33	38	90	111
Tramadol	175	220	240*	208	184

79% of these deaths involved opioids

Low dose of pregabalin reverses tolerance to morphine

High dose of pregabalin alone depresses respiration and has an additive effect if taken with opioids

Respiratory depression due to pregabalin cannot be reversed by naloxone

* Tramadol made Class C drug under Misuse of Drugs Act 1971and Schedule 3 under misuse of Drugs Regulations in June 2014

http://dx.doi.org/10.1111/add.13843

http://www.bmj.com/content/359/bmj.j4828/rr-2

NB 14.11.17 Proposal to make pregabalin/gabapentin Class C drug under Misuse of Drugs Act 1971 and Schedule 3 under Misuse of Drugs Regulations 2001.

Pain management

A serious challenge given the misuse potential of opioid analgesics, gabapentin and pregabalin

Take into account the context, risk of dependence and principles of underlying pain treatment

Refer to Clinical Guidelines 7.2 .4 on Pain management, Dependence on prescribed and over-the-counter opioids, Misuse of or dependence on gabapentoids

Use local protocols to inform prescribing in the context of multidisciplinary care

www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/12/Prsn-pain-mngmnt-formlry-pub.pdf

Key quotes from updated Clinical Guidelines

“Treatment and care for those with drug and alcohol problems in the criminal justice system should aim to be excellent, safe, effectively and broadly equivalent to that in the community”

“There should not normally be mandatory reduction regimes for dependence”

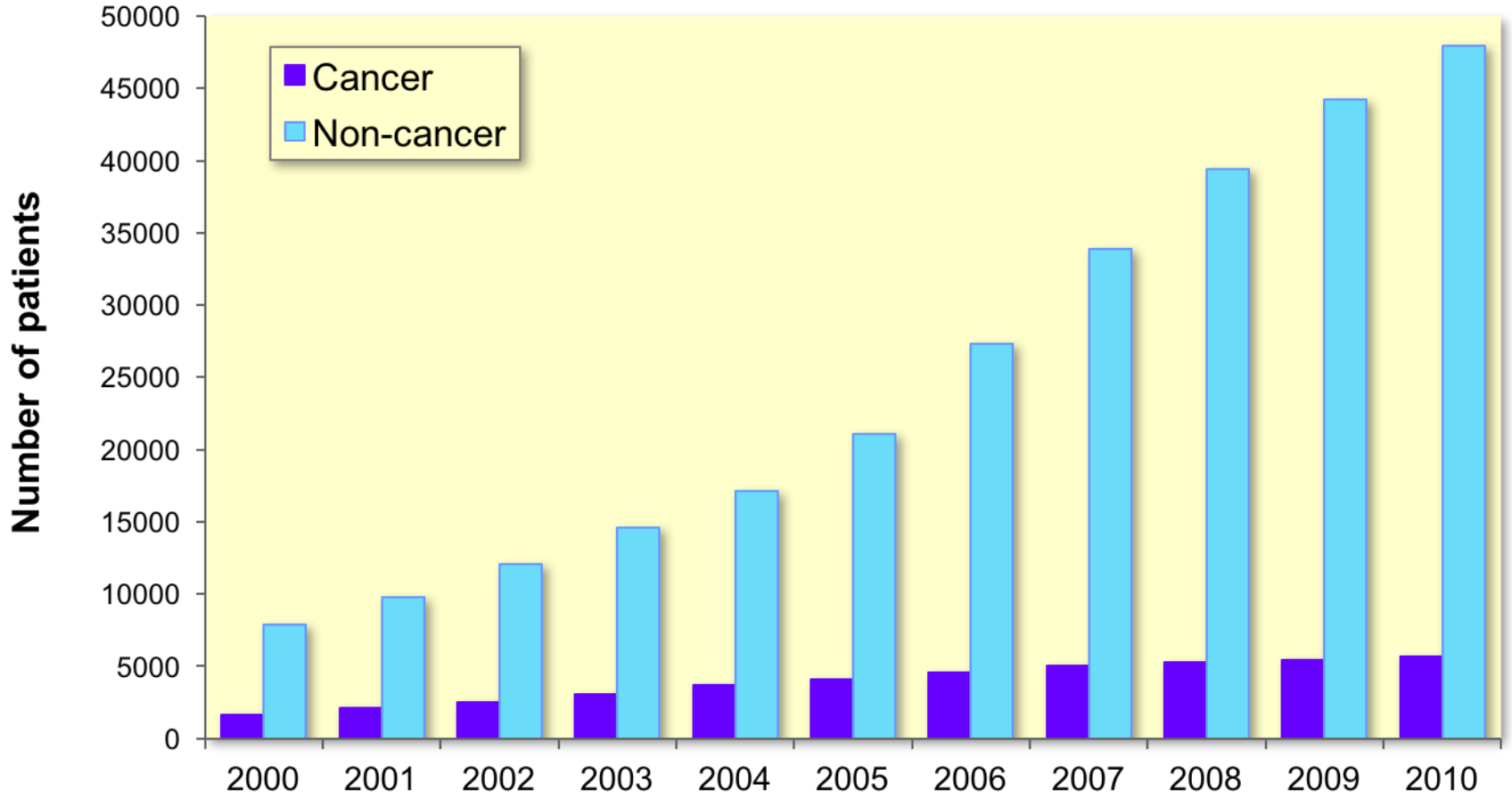
“Polypharmacy with two or more sedative or depressant medications should only be used with considerable caution on first night and for the first few days”

“Addressing veracity of ’self-reported’ high levels of community-led polypharmacy”

“The prescription of sedating antidepressants (e.g. mirtazapine or trazodone) for insomnia in the absence of depressive symptoms should be avoided”

“Re-induction could be considered for those who are about to leave prison, with a clearly identifiable risk of overdose and high likelihood of relapse”

Number of patients prescribed opioid analgesics for chronic non-cancer pain in UK primary care



Zin C et al. Eur J Pain 2014; 18**:** 1343 – 1351.