Appendix 6 – Summary of NICE Guidance related to Pain Relief and Opioids

NICE Guidance	Non-pharmacological options	First choice medications	Alternative options
Chronic pain (primary and secondary) NG 193 (1) **o Not Do statements** Do not initiate any of the following medicines to manage chronic primary pain in people aged 16 years and over: • antiepileptic drugs including gabapentinoids, unless gabapentinoids are offered as part of a clinical trial for complex regional pain syndrome (see the recommendation for research on pharmacological interventions) • antipsychotic drugs • benzodiazepines • corticosteroid trigger point injections • ketamine • local anaesthetics (topical or intravenous), unless as part of a clinical trial for complex regional pain syndrome (see the recommendation for research on pharmacological interventions) • local anaesthetic/ corticosteroid combination trigger point injections • non-steroidal anti-inflammatory drugs	Offer a supervised group exercise programme. Encourage people with chronic primary pain to remain physically active for longer-term general health benefits. Consider acceptance and commitment therapy (ACT) or cognitive behavioural therapy (CBT) for chronic primary pain. Consider a single course of acupuncture or dry needling, within a traditional Chinese or Western acupuncture system, to manage chronic primary pain, but only if the course: is delivered in a community setting and • is delivered by a band 7 (equivalent or lower) healthcare professional with appropriate training and • is made up of no more than 5 hours of healthcare professional time (the number and length of sessions can be adapted within these boundaries) or • is delivered by another healthcare professional with appropriate training and/or in another setting for equivalent or lower cost.	Consider an antidepressant, either amitriptyline, citalopram, duloxetine, fluoxetine, paroxetine or sertraline, for people aged 18 years and over to manage chronic primary pain, after a full discussion of the benefits and harms. Seek specialist advice if pharmacological management with antidepressants is being considered for young people aged 16 to 17 years.	

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• opioids • paracetamol **Low back pain (NG59)** (11) **Do Not Do statements:** Do not offer paracetamol alone for managing low back pain. Do not routinely offer opioids for managing acute low back pain. Do not offer opioids for managing chronic low back pain. Do not offer selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors or tricyclic antidepressants for managing low back pain. Do not offer gabapentinoids or antiepileptics for managing low back pain. Do not offer gabapentinoids, other antiepileptics, oral corticosteroids or benzodiazepines for managing sciatica as there is no overall evidence of benefit and there is evidence of harm. Do not offer opioids for managing chronic sciatica.	**Self-management** Information on nature of low back pain and sciatica. Encouragement to continue with normal activities. **Non-pharmacological options** Exercise for people with a specific episode or flare-up of low back pain with or without sciatica. Manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy. Psychological therapies using a cognitive behavioural approach for managing low back pain with or without sciatica but only as part of a treatment package including exercise, with or without manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage). Combined physical and psychological programme, incorporating a cognitive behavioural approach (preferably in a group context that takes into account a person's specific needs and capabilities), for people with persistent low back pain or sciatica: • when they have significant psychosocial obstacles to recovery (for example, avoiding normal activities based on inappropriate beliefs about their condition) or • when previous treatments have not been effective. Promote and facilitate return to work or normal activities of daily living for people with low back pain with or without sciatica.	NSAIDs - lowest effective dose for the shortest possible period of time. Be aware of the risk of harms and limited evidence of benefit from the use of non-steroidal anti-inflammatory drugs (NSAIDs) in sciatica.	Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective.

NICE Guidance	Non-pharmacological options	First choice medications	Alternative options
Osteoarthritis (NG226) (12) **Do Not Do statements:** Do not routinely offer paracetamol or weak opioids unless: they are only used infrequently for short-term pain relief and all other pharmacological treatments are contraindicated, not tolerated or ineffective. Do not offer glucosamine or strong opioids to people to manage osteoarthritis. Do not offer intra-articular hyaluronan injections.	**Self-management** the core treatments for the condition are therapeutic exercise and weight management (if appropriate), along with information and support. **Non-pharmacological options** For all people with osteoarthritis, offer therapeutic exercise tailored to their needs (for example, local muscle strengthening, general aerobic fitness). For people with osteoarthritis who are living with overweight, or obesity advise them that weight loss will improve their quality of life and physical function, and reduce pain, support them to choose a weight loss goal, explain that any amount of weight loss is likely to be beneficial, but losing 10% of their body weight is likely to be better than 5%.	Topical non-steroidal anti-inflammatory drug (NSAID) to people with knee osteoarthritis. Consider a topical NSAID for people with osteoarthritis that affects other joints.	If topical medicines are ineffective or unsuitable, consider an oral NSAID for people with osteoarthritis. Consider intra-articular corticosteroid injections when other pharmacological treatments are ineffective or unsuitable, or to support therapeutic exercise. Explain to the person that these only provide short-term relief (2 to 10 weeks).
Neuropathic pain (CG173) (13) **Do Not Do statement:** Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so: • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol long-term • venlafaxine • sodium valproate		Amitriptyline, duloxetine, gabapentin or pregabalin. Trigeminal neuralgia. Carbamazepine.	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. Consider capsaicin cream for people with localised neuropathic pain (except trigeminal neuralgia) who wish to avoid, or who cannot tolerate, oral treatments.

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Tension headache (CG150) (14) **Do Not Do statement:** Do not offer opioids for the acute treatment of tension-type headache.		Aspirin (not if under 16), paracetamol or an NSAID.	
Migraine (CG150) (14) **Do Not Do statements:** Do not offer ergots or opioids for the acute treatment of migraine. Do not offer gabapentin for the prophylactic treatment of migraine.		Triptan together with either an NSAID or paracetamol.	For people who prefer to take only one drug, consider monotherapy with an oral triptan, NSAID, aspirin (900 mg) or paracetamol.
Cluster headache (CG150) (14) **Do Not Do statement:** Do not offer paracetamol, NSAIDS, opioids, ergots or oral triptans for the acute treatment of cluster headache.		Oxygen and/or a triptan	
Medication overuse headache (CG150) (14)		Advise people to stop taking all overused acute headache medications for at least 1 month and to stop abruptly rather than gradually.	
Rheumatoid arthritis (NG100) (15)	**Non-pharmacological options** • Physiotherapy • Occupational therapy • Hand exercising programmes • Podiatry • Psychological interventions	Conventional disease-modifying anti-rheumatic drugs (DMARDs)	Biological and targeted synthetic DMARDs. Short-term glucocorticoids for managing flares. Consider NSAIDs or COX-2 inhibitors when control of pain or stiffness is inadequate. Use the lowest effective dose fort the shortest possible time.