

# Coping with persistent pain

*A guide for patients, partners, family & carers*

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# Introduction

## Pain is no evil, unless it conquers us.

*Charles Kingsley*

Pain is a highly personal experience. How much it interferes with your quality of life is also a very personal thing. Pain can make it difficult to do many day to day activities and can cause worry and emotional distress.

When pain persists for weeks or months (i.e. becomes chronic or persistent), it can have a significant impact on your well-being. You may find that it affects your social relationships, your ability to function at work and home, and your mental health.

The idea that pain is imaginary is a myth. It is true however that attitudes and expectations about treatment can make a difference to your quality-of-life. Even though it may not be possible to 'cure' the pain, or take it away, there are treatments that can help improve your quality-of-life.

The treatment of pain can be broadly divided into three categories:

1. Physical (e.g. physiotherapy)
2. Psychological (e.g. relaxation training)
3. Pharmacological (i.e. medicines)

The treatment of persistent pain may involve one, two or all three of these categories.

Because pain is a 'subjective' sensation, treatment can be different from one person to another, even though the diagnosis may be the same. It is best to discuss your treatment with your doctor or healthcare professional rather than just trying something your friend suggests. Your overall pain management plan will usually consist of several different types of treatment that will complement each other.

This booklet has been designed to help you understand persistent pain and some current treatments which may help reduce the pain, improve your ability to function and improve your quality-of-life.

# What is pain?

“Pain is what the person says it is, existing whenever the person says it does”.<sup>1</sup> *Pain 1999 (quoting McCaffery & Beebe)*

## The International Association for the Study of Pain (IASP) definition is widely used.

“Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage... Pain is always subjective. Each individual learns the application of the word through experience related to injury in early life... It is unquestionably a sensation in a part or parts of the body, but it is also always unpleasant and therefore an emotional experience”.<sup>2</sup>

*International Association for the Study of Pain, 1979*

**Importantly, this definition indicates that pain can occur without a recognised or obvious cause and may also be influenced by our emotions.**

There are other ways of defining pain.

## Acute pain

Acute pain is pain that lasts a short time and is clearly caused by tissue damage. This includes minor and major injuries, burns and surgery related pain. Acute pain usually improves within three months. If pain lasts longer than three months it is considered to be persistent.

## Persistent pain

Persistent pain (also referred to as chronic pain) is pain that lasts longer than 3 months<sup>3,4</sup>.

It includes:

- pain that has an identifiable or obvious cause (an injury), *and*
- pain that no longer has an identifiable cause (i.e. the original injury has healed)

Persistent pain with an obvious cause includes conditions like arthritis, spinal stenosis, degenerative disc disease, or persistent leg ulcers. In persistent pain with no obvious cause, pain continues longer than you would expect (e.g. fibromyalgia, which is generalised muscle soreness and stiffness). In these cases the nervous system misfires and continues to send pain signals even though there may be no damage.

Persistent pain can also be made worse by a lack of exercise that causes physical weakening.

Our thoughts and emotions can also affect how we respond to persistent pain.

Acute pain can usually be resolved by treating the underlying cause or by using analgesics (pain relieving medicines). Persistent pain is more difficult to manage than acute pain. Usually, the underlying cause cannot be cured, as is the case in osteoarthritis. However, most forms of persistent pain can be relieved by using medicines including analgesics.

	Acute pain	Persistent pain
<b>Diagnosis</b>	Usually clear	Not always clear
<b>Duration</b>	Temporary, may last a few days (or weeks)	Persists for an indefinite length of time
<b>Examples of pain descriptors</b>	Sharp, stabbing	Aching, burning but can also be sharp and of longer duration
<b>Appearance of person</b>	Anxious, afraid	Anxious and afraid and possibly withdrawn and depressed
<b>Examples</b>	Traumatic injury, post-operative pain, burns	Low back pain, cancer, osteoarthritis, migraine

There are two basic types of pain; nociceptive pain and neuropathic pain.

**Nociceptive (no-si-sep-tiv) pain<sup>5</sup>**  
*is caused by an injury to body tissues.*

Nociceptive pain is the pain caused by an injury such as a cut, burn or broken bones. The pain resulting from surgery (post-operative pain) and cancer pain is also nociceptive pain. This type of pain can be constant or intermittent (come and go) and, depending on the injury, may be made worse by movement.

Nociceptive pain can be divided into somatic and visceral pain.

- **Somatic pain** refers to pain that originates from muscles, bones and tendons and tends to be localised and sharp
- **Visceral pain** refers to pain felt in the organs of your body, such as your stomach or gall bladder. This pain is more of an aching type and can be difficult to pin point. Visceral pain can often cause **referred pain**, which is pain that is felt somewhere other than where it originates

**Neuropathic (noo r-uh-path-ik) pain<sup>5</sup>**

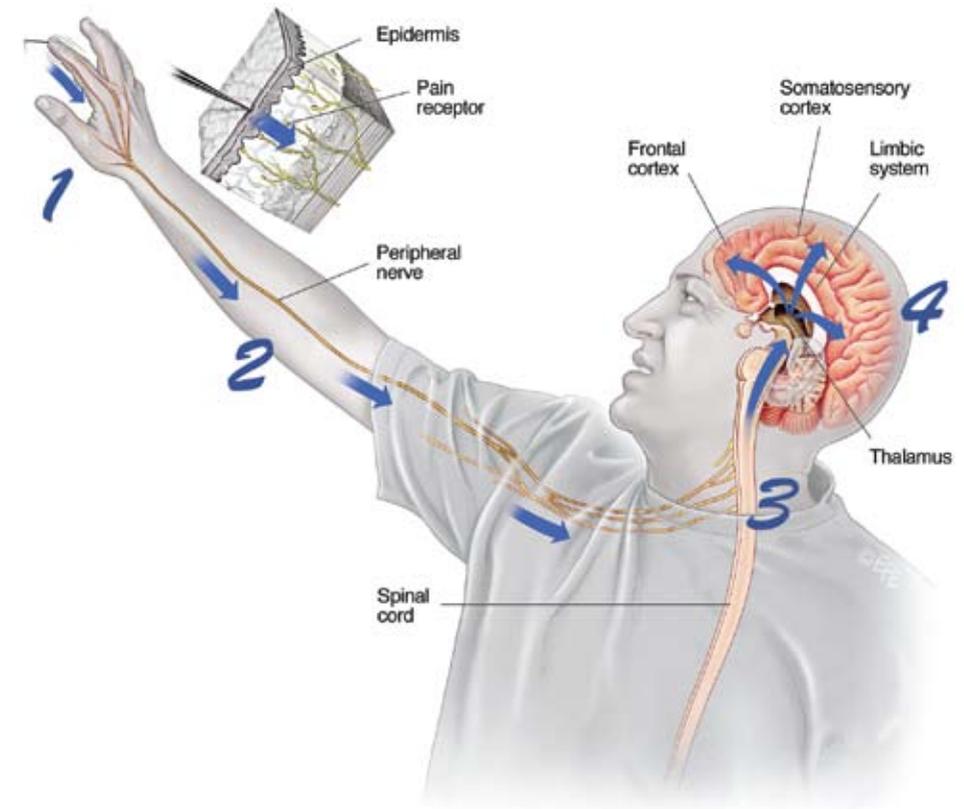
*is caused by abnormalities in the nerves, spinal cord, or brain.*

Neuropathic pain (which is also called nerve damage pain) occurs when there is damage to part of the pain pathway. In some cases there may be no real tissue damage; instead the pain pathway is 'misfiring', causing the experience of pain without actual injury

Neuropathic pain is often severe and is classically described as tingling, burning or having an electric-shock type quality. It may be associated with allodynia (severe pain on very light touch). Neuropathic pain can be highly resistant to standard pain treatments and other medicines may be needed to help control pain.

Sometimes people can experience mixed pain such as in low back pain (i.e. both nociceptive and neuropathic pain mechanisms are involved). In this type of pain, the back itself may hurt with a constant aching (i.e. nociceptive pain) in addition there may be sudden burning and hurting sensations extending into the legs, called sciatica (sahy-at-i-ka), which may be neuropathic in origin.

The explanation for this may be that a bulging disc is causing pain but is also pressing on a nerve at the same time causing neuropathic pain.



# Persistent pain in Australia

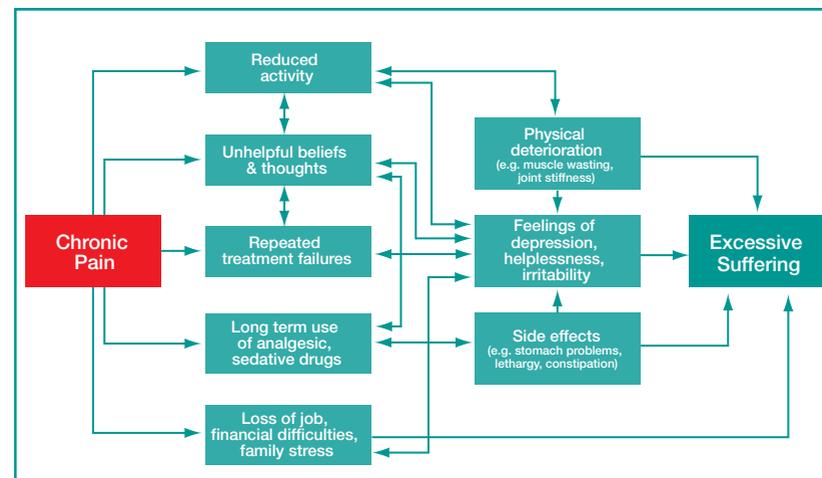
Chronic, persistent or long-lasting pain affects up to one in five Australians.<sup>6</sup>



Studies have shown:

- In New South Wales alone, 17.1% of men and 20.0% of women aged 16 years or more, suffer from persistent pain  
If you compare these numbers with information from the Australian Institute of Health and Welfare, we see that more Australians have persistent pain than many other common long-term conditions, including high blood pressure, asthma, and high cholesterol<sup>7</sup>
- The cause and treatment of persistent pain can be complex. This can impact greatly on a person's family life, social life and ability to function at work. It is estimated that 9.9 million workdays are lost due to persistent pain in Australia every year<sup>8</sup>
- Persistent pain interferes with the daily activities of 6.8% of the general adult population and is associated with increased hospitalisation and GP visits<sup>9</sup>

## When persistent pain becomes a problem





## The importance of communication

If you suffer from persistent pain, it is vital to have good communication with your doctor and other healthcare professionals so that you can get the help you need to live well in spite of your pain. It is often good to have your partner, family member or a close friend accompany you when you visit the doctor so they will have an understanding of your problems.

### **Tools which can help you talk more productively with your doctor are:**

- Body Pain Chart
- Pain Log

These tools can help you find patterns in your day to day activities that have an impact on your pain. When you and your doctor understand your personal pain triggers, it will be easier to deal with them more proactively.

### **If your doctor has prescribed medicines for your pain, it is important to understand:**

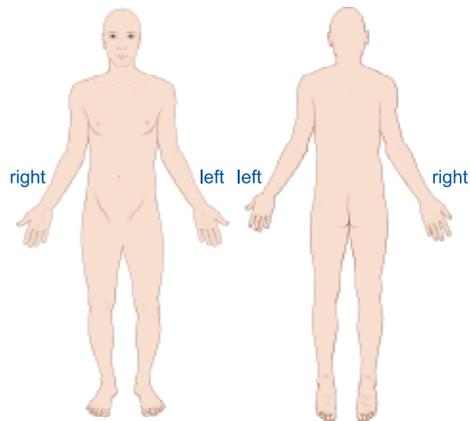
- What medicines you are taking
- Any allergies or intolerances to medicines you may have
- Why you are taking it
- When to take it
- How much to take
- Whether it should be taken with food, or on an empty stomach
- If there are things you should avoid while taking the medicines (e.g. driving, alcohol, sun, dairy products, vitamins, etc.)

Medicines can cause side effects. It is important to talk to your doctor or pharmacist if you experience side effects.

# Body pain assessment chart<sup>10</sup>

Make a photocopy of this page and, using the symbols below, mark all the areas on your body where you feel pain or abnormal sensations. You may wish to show this to your doctor.

- Numbness ○
- Pins & Needles ●
- Aches ×
- Cramping □
- Burning ▲
- Stabbing +



### Circle the words below that fit the description of your pain:

- |           |            |                   |           |         |             |
|-----------|------------|-------------------|-----------|---------|-------------|
| Shooting  | Stabbing   | Sharp             | Cramping  | Gnawing | Hot/burning |
| Throbbing | Aching     | Pulling           | Dull      | Heavy   | Tender      |
| Tight     | Splitting  | Tiring/exhausting | Sickening | Fearful | Punishing   |
| Cruel     | Terrifying | Nauseating        | Agonising |         |             |

### Tick the box that best describes your situation:

- How long have you had this pain?  Days  Months  Years
- Is it constant?  Yes  No
- When is your pain at its worst?  Morning  Noon  Night

### Which of the following activities makes your pain worse?

- Lying down  Sitting  Getting up off a chair  Standing
- Walking  Climbing stairs  Walking down stairs
- Other (specify) .....

### What makes your pain feel better?

- Pills  Lotions  Thinking strategies  Rest
- Exercise  Diversionary tactics  Potions  Heat
- Going for a walk  Changing posture/position  Other  Nothing

# Live better with Pain Log

You may find there are certain things which can 'trigger' your pain. These could be stress, lack of sleep, money worries, and even the weather. Understanding what makes your pain worse means that you and your doctor can begin working together to find the best ways to reduce or deal with your pain 'triggers'.

Using the Live Better with Pain Log<sup>11</sup> below, circle the number that closely matches your experience over the last few weeks.

### For example:

- (i) If you have experienced very little pain circle a low number (1–5); if you have experienced a lot of pain circle a high number (6–10)
- (ii) If you have exercised on a daily basis circle a low number (1–5); if you have done no exercise circle a high number (6–10)

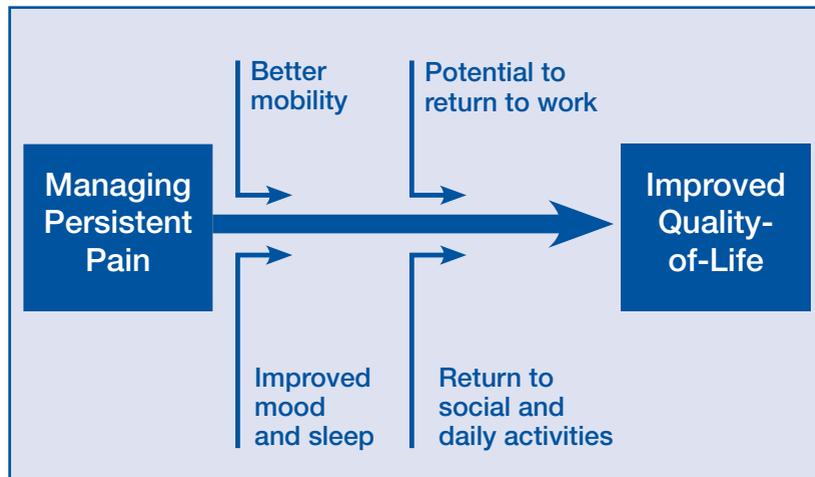
<b>Pain Level</b>										
No Pain										Worst Pain
1	2	3	4	5	6	7	8	9	10	
<b>Stress</b>										
No Stress										Very Stressed
1	2	3	4	5	6	7	8	9	10	
<b>Exercise</b>										
Exercise Daily										No Exercise
1	2	3	4	5	6	7	8	9	10	
<b>Activity</b>										
Normally Active										No Activity
1	2	3	4	5	6	7	8	9	10	
<b>Sleep</b>										
Fully Rested										Poor-Quality Sleep
1	2	3	4	5	6	7	8	9	10	

# Managing persistent pain

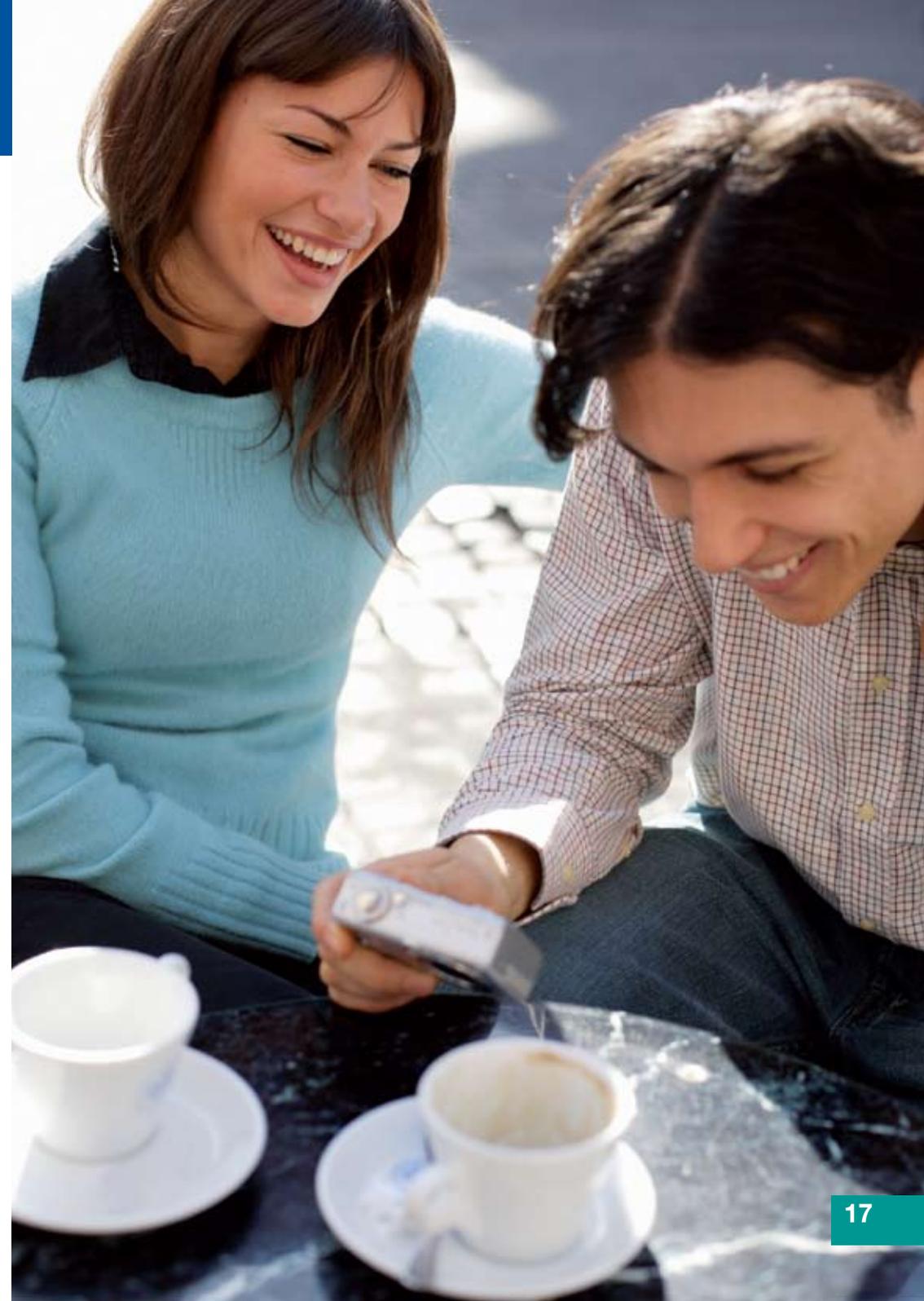
It is important to start managing your persistent pain as soon as possible. This should start whether or not the cause of the pain can be found.

It is important not to try and 'tough it out', because your condition could worsen if left untreated. See a doctor or healthcare professional as early as possible, follow their treatment recommendations and set up a regular follow-up program to monitor your progress.

Even though there may not be a 'cure' for persistent pain, there are many ways to help suppress the pain and improve your quality-of-life.



The primary goal of pain management is to reduce any disability caused by the pain. The aim is to achieve or maintain your fitness, movement and function and continue doing normal everyday activities. The use of analgesics (pain relievers) and other medicines are the most common method of treating persistent pain. However, there are many non-drug treatments which also form part of the overall treatment plan.



# Non-drug treatment and management strategies

Because relieving persistent pain can be difficult, it can take time to get back to a fuller, more rewarding life. Managing persistent pain is about much more than just medicine. By being actively involved in a multidisciplinary approach to pain management, you can help your recovery and improve the quality of your life and how you live it, even though your pain persists.

A multidisciplinary approach means you consult a number of healthcare professionals, including your GP and possibly a physiotherapist, pain specialist, social worker, nurse, occupational therapist and psychologist or counsellor to develop a range of strategies for you to use in managing your pain.

It is important to follow your healthcare professional's advice. Management strategies are always individualised, because pain varies so much from person to person. Someone with arthritis may do well with occasional use of an over-the-counter pain reliever, whereas someone else with arthritis may need a prescription pain reliever and regular appropriate exercise to feel good.

When pain persists your role in managing it becomes really important. Remember, there are ways to take some control over your pain. A good way to start is to understand that what you think, feel and do on a day-to-day basis will have an affect on your pain.

## Accepting Pain

Most people who are successful pain managers have learned to accept their pain. This means accepting that although you may not have caused it in the first place, it is now your pain. Pain may bring about feelings of anger, sadness, frustration and grief, and that is normal.

However, if these negative emotions go on for long periods, they tend to make pain worse (see section on *recognising emotions*, page 21). Whilst you and your healthcare team may be involved in exploring strategies which help you with your pain, at the end of the day it is you who experiences it.

Successful pain managers say that they choose a team (for example partner, doctor, counsellor, other healthcare professional) which helps them decide on the strategies that work for them, and they develop a tool kit which they use to manage their pain and which allows them to participate fully in important everyday activities.

Some examples of various tools you might choose are discussed in this booklet. Many people report they are helped by using exercise strategies, special relaxation techniques, choosing enjoyable activities that they pace well, and organising their lives so that there is less stress and worry.

## Exercise

Before commencing any exercise program it is best to discuss what exercise is appropriate for your condition with your healthcare professional e.g. GP or physiotherapist.

Australian health authorities recommend that everyone, regardless of whether or not they have persistent pain, should aim to do at least 30 minutes of moderate intensity physical activity everyday. This doesn't mean however, that you would necessarily start on 30 minutes. Many successful pain managers start on levels of 5 minutes or less, then gradually build up over time. Examples of moderate exercise activity could include a brisk walk, cycling or hydrotherapy (exercise in warm water usually under supervision).

Some people with persistent pain may fear exercise because it has caused them pain in the past or because they fear that they may be causing further injury. With reassurance and support from your doctor and a healthcare professional (e.g. physiotherapist) you can develop an individual exercise program that is more suitable for you. As you build strength, your pain can decrease.

It is important not to overdo your activities, especially on the days you feel 'good', as this may make the pain worse the following day. Here is a tip that may help you improve your mobility without making the pain worse: reduce your average daily activity by 20% and start a more balanced activity program.

*For example:* If you exercise 30 minutes on a good day and only 10 minutes on a bad day, you could try to spread your activity more evenly by doing 16 minutes on your good days and bad days. This may be broken into smaller intervals and accumulated (or added up) at the end of the day. For example two (2) sessions of eight (8) minutes or four (4) sessions of four (4) minutes.

Work out your own recommended daily activity time based on your own exercise experience. By slowly increasing your activity time you should be able to exercise for longer without making your pain worse. But if exercise makes your pain worse, you should tell your doctor and appropriate members of your healthcare team (i.e. physiotherapist, pain specialist, psychologist, etc.).

Remember if you flare up you might not have started at a realistic level or there may be a particular movement not right for you. Successful pain managers often start small and build up over time.

# Non-drug treatment and management strategies

## Ask for help

It is OK to ask for help. It is estimated that nearly one person in five suffers with some form of persistent pain.<sup>6</sup>

Once you have begun to find ways to manage the pain, reach out and share what you know. Living with persistent pain is an ongoing learning experience. We all support and learn from each other.

One way you can do this is to look for self-help organisations in the community who have a special interest in your condition, such as Arthritis NSW (**1800 011 041**), Diabetes Australia (**1300 136 588**) or Chronic Pain Australia (**02 9481 0189**). These are organisations that provide excellent support and understanding for people living with persistent pain.

## Learn to relax

While it is important to relax, it is also important to learn relaxation techniques, which is different to just relaxing. Relaxation techniques operate on the principle of learning how to calm the mind which in turn calms the pain. Finding a technique that suits you and using it regularly can make a very real difference to pain.

Pain increases in times of stress. Muscles tighten up when you are stressed and this can increase your pain. Deep breathing, visualisation, meditation and other relaxation techniques can help you to better manage the pain you live with. As not all relaxation techniques suit everyone, discuss this with an appropriate healthcare professional, such as a counsellor, a psychologist, a doctor, or a physiotherapist to find out which type suits you best.

## Set realistic goals

Focus on your abilities not your disabilities. Set goals that are within your power to accomplish or break a larger goal down into manageable steps. And take time to enjoy your successes.

People living with persistent pain can sometimes aim too high. Some are 'people pleasers'. You don't have to please everyone, it is OK to do as much as you consider is possible for you at any particular time so that you don't go into a flare up.

It is also recommended that you choose *what is important for you* amongst the various activities available. What is helpful is that you start to listen to

what is right for you right now, and learn how to do the right level of activity for *you*. The challenge is in keeping your body as active and healthy as possible while at the same time being aware of what is too much. Remember, you do not want to end up in a negative pattern of doing too much, having a flare up and then needing to rest which results in doing too little.

## Understand your pain

Learn all you can about your physical condition. Understand that there may be no current cure but by getting involved in your own recovery you can improve functioning.

Knowing that pain does not mean further injury or damage is really important. If you think that every time you feel an increase in pain you are injuring yourself, then you will be afraid to move. However, if your doctor or healthcare professional has investigated your pain and told you not to worry, you can continue doing what you can. Remember, enjoying what you choose to do is one of the keys to managing your pain.

## Recognise your emotions

Our physical wellbeing can be directly influenced by our emotions. By acknowledging and dealing with your feelings, you can reduce stress and decrease the pain you feel.

We have mentioned that the nervous system can misfire when you are living with persistent pain. You might have already noticed that when you have a very stressful time your pain is worse. This is because there are chemicals inside your body which are produced in times of stress and these can actually make pain worse.

On the other hand, there are natural chemicals you produce in your body which relieve pain. These are released when you do things you enjoy such as talking with friends, laughing, feeling loved and loving, watching a good movie, listening to your favourite music or just going for a walk and enjoying your neighbourhood. People in pain sometimes forget how important the simple things in life are to their wellbeing.

Living with pain can contribute to mood changes or depression. Please be aware of any mood swings or changes and discuss these with your healthcare team or visit [www.beyondblue.org.au](http://www.beyondblue.org.au) for assistance.

# Non-drug treatment and management strategies

## Good sleeping habits

Proper sleep is essential but if you suffer from persistent pain, it can be hard to achieve. Below are just a few simple, common sense tips that might increase the chance of getting a good sleep.

- Try to go to bed and wake up around the same time everyday. Your body has a natural clock that makes you get sleepy when you're ready for bed. Getting up at the same time will help to keep your body clock synchronized
- Try to get regular exercise everyday
- Try to spend some time outside or in natural sunlight everyday. Sunlight is needed to make melatonin, a natural chemical inside your body which promotes sleep
- Take your medicines as directed
- Try to make your bedroom as restful as possible. Keep it dark and quiet (leave beeping watches and noisy or bright clocks in another room)
- Make sure you are comfortable and relaxed. Warm hands and feet are particularly important. You spend around eight hours a day sleeping so it is also important to have a comfortable pillow and mattress
- Avoid drinking tea or coffee before bed and avoid using alcohol to try to get to sleep
- Avoid exercise just before bed
- Avoid relying on sleeping tablets to help you sleep

## Other options

Some people may find relief via other treatments such as acupuncture or TENS (transcutaneous electrical nerve simulation). A TENS unit is a small battery operated device that stimulates nerves in the painful area by low-level electrical impulses. These electrical impulses block the pain signals and alter the perception of pain. The use of TENS can result in periods of pain relief although it does not 'cure' pain. Consult your doctor and/or physiotherapist before using or buying one.

Doctors and other practitioners use acupuncture for many reasons including pain relief. It is thought to relieve pain by stimulating the release of endorphins. Again, although it may provide some relief, these treatments are not 'cures' for pain.

Talk to your doctor, physiotherapist or other qualified healthcare professional about what other options may be available to you.



# Medicines for persistent pain

How you cope best with persistent pain is highly personal. Many people with persistent pain are able to manage adequately without medicines. Others find that they function better, are more comfortable and have a better overall quality-of-life, when they take medicines.

Medicines include prescription medicines, medicines bought over-the-counter in pharmacies (chemists) or supermarkets and herbal and natural medicines.

The role of medicines is not to 'cure' the pain, but to lessen the pain and improve your functionality and quality-of-life. Even the strongest medicines for pain will not always completely eliminate it, but they can reduce the severity of pain. In this way, it is important to view medicines as part of a comprehensive approach to pain management and functional improvement.

By making you comfortable, medicines can make it easier for you to resume normal activities or activities you may have been avoiding. They can help improve your quality-of-life by minimising your suffering *and* maximising function.

It is however important to understand that while all medicines can help relieve and cure symptoms, they can sometimes have unpleasant side effects. Often these side effects can be avoided or at least managed with the help of your doctor.

Beware that alcohol is also a drug and can increase the potential toxic side effects of certain prescription drugs.

All medicine, whether it is prescription, over-the-counter, herbal or vitamins/supplements, should be used carefully and appropriately because they can interact with each other and cause side effects. It is essential to always tell your doctor about everything you are taking for pain and other conditions. You should always take your medicines as prescribed by your doctor and if you have any concerns discuss them with your doctor before changing the medicines or dose.

## Oral pain relievers

### Non-prescription or over-the-counter (OTC) products

OTC pain relievers are medicines which are available without a prescription – usually from your pharmacy or supermarket. You may be familiar with traditional OTCs such as aspirin, paracetamol, ibuprofen, naproxen and various combinations.

Although OTC medicines are considered safe enough to be dispensed without a prescription, they are real medicines and can be dangerous in certain situations:

- Paracetamol is widely recommended for all types of pain and should be used according to the dosing instructions. It is commonly used for headache, muscle ache, backache, fever and arthritis pain (especially osteoarthritis). Paracetamol can be toxic to the liver and caution is recommended in people with liver problems, even at low doses
- Nonsteroidal anti-inflammatory drugs, or NSAIDs (aspirin, ibuprofen and others) are commonly used to treat headache, muscle ache, fever, menstrual cramps, arthritis pain and inflammation. NSAIDs can cause an increase in stomach acid and reduce the stomach's protective mucous layer. NSAIDs have been associated with bleeding from the stomach, and this risk increases with dose and duration of use. They may increase your blood pressure. They may also cause kidney failure in people with damaged kidneys, liver disease and other certain conditions

For many people, a gastrointestinal (GI) protective medication (such as proton pump inhibitors) taken in addition to an NSAID can help prevent associated ulcers (but may not prevent long-term serious GI problems).

### Weak opioids and combinations

Weak opioids such as codeine and dextropropoxyphene are often combined with other drugs.

The effects and side effects of these are dealt with in the section on opioids (see page 30). Some of these combinations are OTC and some are prescription only. (Please see table on page 27).

### Doxylamine

This is a sedative drug which is contained in some OTC and prescription only combination products (such as Mersyndol®).

# Medicines for persistent pain

To safely and effectively use OTC medicines it is essential to understand what you are taking and how much you should take. **Always read the label** and discuss with your doctor any OTC medicines you use (or are considering), especially if you also take prescription medicines.

## Prescription medicines (non-opioid, weak opioid and combinations)

**Prescription medicines are legally available only from a general practitioner (GP) or specialist. Do not use them unless prescribed for you by your doctor.**

Your doctor will know which medicine is best suited to you.

## Common non-opioids and their uses

Opioids are morphine-like drugs used to treat moderate to severe pain. A non-opioid drug contains no morphine or morphine-like substances (such as codeine).

Below is a table that shows some commonly used non-opioid medicines and combination products (i.e. non-opioid combined with weak opioid). This table shows some examples of the medicines used to treat a range of painful conditions such as:

- Headache
- Muscle aches and strains
- Back aches
- Pain from colds and flu
- Fever
- Menstrual cramps
- Arthritis pain
- Inflammation

Please note: This is not a complete list of all the medicines used to treat pain.

Medicines (chemical name)	Over the counter medicines (brand name)	Prescription only medicines (brand name)
Acetylsalicylic acid	Aspro® Tablets Aspro® Clear Aspirin® Disprin® Ecotrin®	
Paracetamol and Paracetamol-codeine phosphates	Dymadon® Mersyndol® (also contains doxylamine) Panadol® Panadeine™ Panamax	Dymadon® Forte Panadeine® Forte
Ibuprofen	Advil® Bugesic Nurofen® ProVen™	Brufen® Rafen
Ibuprofen and codeine	Nurofen® Plus Panafen® Plus	
Ketoprofen		Orudis™
Naproxen sodium	Aleve® Naprogesic® Naprosyn®	Naprosyn SR® Proxen SR®
Meloxicam		Mobic®
COX-2 inhibitors		Celebrex®

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**Always refer to the Consumer Medical Information (CMI) for the facts to know before, during and after using your medicines. CMI's are available from the pharmacist or online at [www.nps.org.au/consumers](http://www.nps.org.au/consumers). Alternatively you can telephone Medicines Line 1300 888 763 for medicines information.**

# Medicines for persistent pain

## Topical pain relievers

Creams, gels, sprays, liquids, patches, or rubs applied on the skin over a painful muscle or joint are called topical pain relievers or topical analgesics and generally only have a local effect. Many of these are available without a prescription.

Many of the over-the-counter topical agents contain salicylates (sali-si-lates), a family of drugs known to reduce inflammation and pain. Salicylates work by decreasing the ability of the nerve endings in the skin to sense pain. Small amounts relieve mild pain. Larger amounts may reduce both pain and inflammation.

Capsaicin (kap-se-i-sin) cream can help relieve pain because the capsaicin is absorbed into the nerves and is confused with the usual chemical transmitter for pain, reducing the pain. As it is extracted from chillies it can cause a burning sensation in some people.

Counter-irritants (e.g. menthol, camphor, eucalyptus oil, turpentine oil, methyl salicylate, histamine dihydrochloride and methyl nicotinate) are another group of topical agents which can treat minor aches and pains of muscles and joints. They stimulate nerve endings in the skin to cause feelings of cold, warmth or itching. These topical agents produce a mild skin irritation which causes tingling. This may create a soothing effect by diverting attention away from the existing pain.

Taping can often help support a painful area while the muscles are being retrained to support the area. See your physiotherapist for advice on correct strapping and to make sure you have no adverse reactions from the tape.

*Topical medicines are different to transdermal medicines.*

*Transdermal medicines are applied directly to the skin in a patch and the medicine is absorbed through the skin by the bloodstream over a period of time. The drug may have effects throughout the body and work away from the area of pain.*

## Other medicines

You may have other symptoms or conditions such as sleeplessness, depression or anxiety that may affect your pain. Your doctor may choose to treat these conditions with medicines not described in this booklet. It is best to discuss these conditions and treatment with your doctor.



## Opioid analgesics

When a non-opioid medicine no longer adequately controls the pain, your doctor may decide to prescribe an opioid analgesic.<sup>12</sup> Opioids are morphine-like substances which have been used for centuries to relieve pain.

There are a number of opioids available by prescription. Some are short-acting, while others are long-acting. Your doctor will discuss the treatment options with you and together you can decide if the benefits of using an opioid outweigh the risks and side effects.

An opioid may be prescribed if your doctor feels it can increase your level of functioning, reduce or eliminate pain and if it enables you to feel more positive and hopeful. Your doctor will also help you to minimise or manage any side effects.

Common side effects with opioids, particularly at higher doses, include, but are not limited to:

- **Constipation**
  - Almost all people taking opioids will get some degree of constipation initially
  - The best strategy is to expect this and take steps to prevent it
  - Increased physical activity, high-fibre diet and fluids may be helpful
  - Talk to your doctor about the use of a laxative if necessary
- **Nausea**
  - Occurs in about 50% of patients
  - It usually passes in 1–2 weeks
  - If necessary, your doctor may prescribe a medicine to help with nausea
  - Speak to your doctor if nausea persists or worsens
- **Drowsiness**
  - Mild drowsiness occurs in most people taking opioids when they first start, or when doses are increased
  - It usually decreases within 7–14 days. Driving or using dangerous machinery during this time should / must be avoided
  - If drowsiness still persists your doctor may lower the dose or switch you to another opioid medicine

- **Dry mouth**
  - This is a common side effect with stronger opioids
  - Speak to your doctor about the use of oral fluids, sugarless gum or sweets and good oral hygiene
- **Increased sweating**
  - This is common with higher doses of opioids especially with exertion
- **Effects in women**
  - Periods may temporarily stop on higher dose opioid therapy
  - The long term use of opioids may increase the risk of osteoporosis
- **Effects in men**
  - Opioids may cause a decrease in testosterone resulting in a loss of libido and an increased risk of osteoporosis
- **Itchy skin**
  - Occurs in a small number of patients
  - Speak to your doctor or pharmacist about treatment
  - If symptoms become increasingly uncomfortable, speak to your doctor about alternative therapy/options

### Other side effects may include:

- Vomiting
- Thought and memory impairment
- Hypotension (low blood pressure)
- Headache
- Confusion
- Hallucinations
- Euphoria
- Pruritus (e.g. rash)
- Urinary retention

The majority of these side effects can be treated with dose adjustments, while others may ease over time or can be managed with other medicines.

Mild nausea can be treated with medicines, but if it does not get better within a few days your doctor may want to try a different opioid.

# Medicines for persistent pain

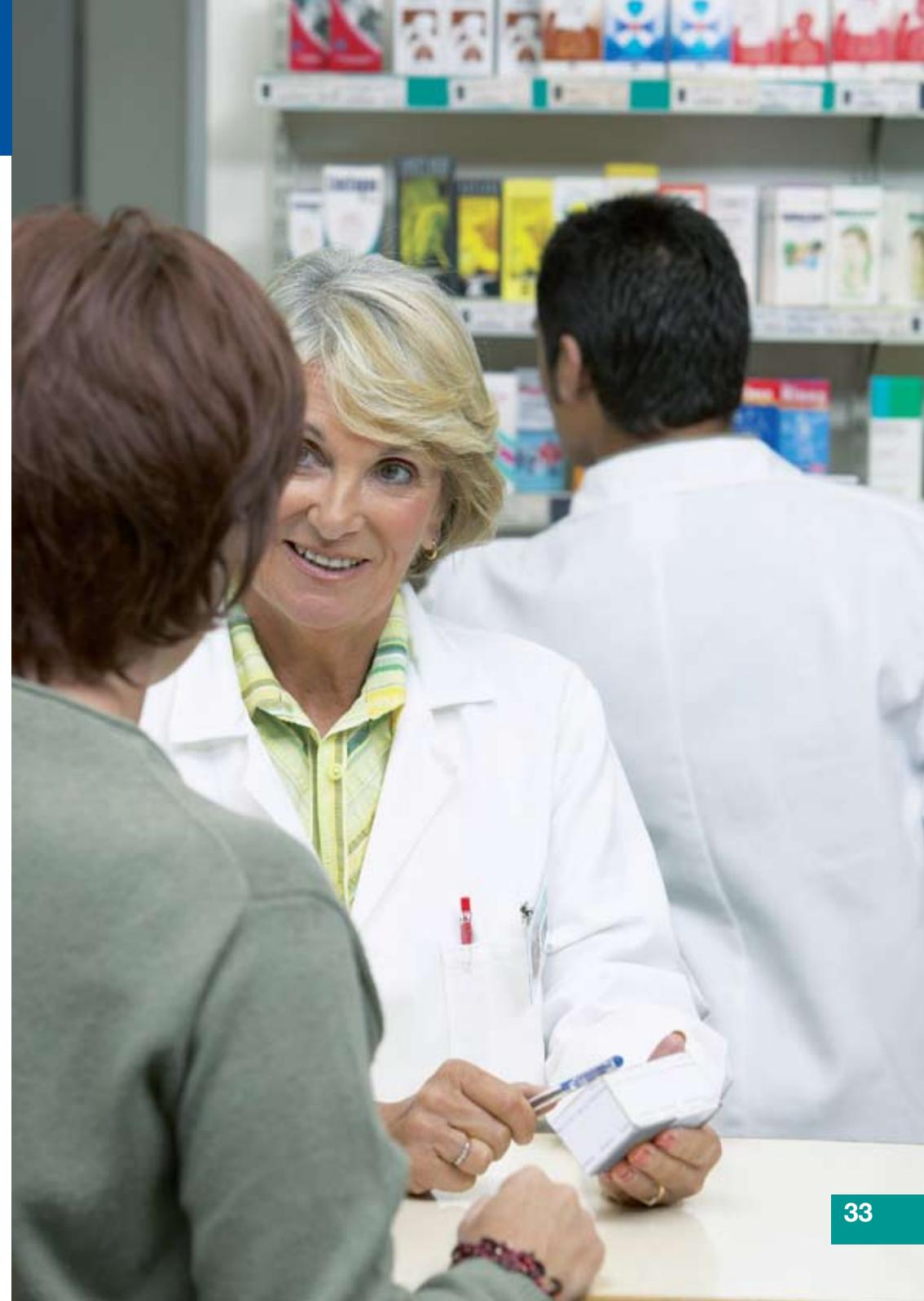
More serious side effects can include respiratory depression (i.e. a slowed rate of breathing or loss of urge to breathe). For this reason, directions for use must always be exactly followed. If you experience difficulties in breathing you should stop taking your medicines immediately and contact your doctor for advice.

When your doctor first prescribes an opioid, it is usual to trial the medicine over 4–6 weeks before a decision is made to prescribe the medicine long term. During this time, your doctor may adjust the dose to suit your body's response. If, at the end of the trial period, the expected outcome has not been achieved the dose of your medicines will be slowly reduced over a few days and then stopped.<sup>12</sup>

It is important that you don't stop taking your medicines suddenly, unless you experience serious side effects. Opioid doses should always be adjusted gradually to avoid symptoms of withdrawal. Symptoms of withdrawal include sweating, goose flesh, runny nose, abdominal cramping, diarrhoea, nervousness, agitation, hallucinations and a fast heartbeat. Tell your doctor or pharmacist if you experience these or any other side effects. Your doctor is in the best position to determine if the benefits of opioids (or any other medicine) outweigh the risks and side effects.

## Examples of medical opioids are:

- Codeine
- Hydromorphone
- Oxycodone
- Morphine
- Buprenorphine
- Fentanyl



## Ways of taking opioids

There are several routes of administration for analgesics. The choice of route usually depends on the nature of the drug, the condition of the patient, and the nature and urgency of the pain. For the majority of people, the preferred route is oral (by mouth), however, other options are available.

Suppositories are available for administration by the rectal route, but patients may not find this acceptable.

Besides oral medicines (i.e. tablets, capsules and liquids) another easy non-invasive way of taking medicines is by a transdermal patch delivery system (fentanyl and buprenorphine are the only opioids available in this form).

The delivery of a drug across the skin may vary and can be affected by several factors. Heat can affect the amount of medicine released from the transdermal patch. Patients **should not** expose the patch to direct heat from hot water bottles, heating pads, electric blankets, heat lamps, hot spa baths, saunas, etc.<sup>13</sup> Normal physical activity is generally OK. If you have any questions discuss them with your doctor or healthcare professional.

A further problem may arise in patients with sensitive skin, who may suffer reactions on the skin at the patch application site. If this happens, speak to your GP, pharmacist or pain specialist.

## Concerns relating to opioid therapy

Opioid therapy may be used when the benefits of treatment outweigh the possible harm they may do. However, it is important to set treatment goals, which include setting a maximum (or ceiling) dose to be used. Treatment should be reviewed by the doctor if the maximum dose does not provide adequate pain relief.

The body's normal response to the continued use of opioids is **physical dependence** and **tolerance**.<sup>14</sup>

**Physical dependence** occurs when a person's body adapts to a medicine. If someone has become physically dependent on a medicine and suddenly stops taking it, withdrawal may occur. These symptoms can include muscle aches, watery nose and eyes, irritability, sweating, and diarrhoea. Physical dependence is a normal response when opioids are used for more than 7–10 days. Physical dependence is different to psychological dependence (or addiction). Your doctor will provide advice on how to minimise or manage any side effects.

**Tolerance** is when one or more effects of a medicine become less with repeated use at the same dose (many people say it is like becoming 'immune' to the medicine). For example the first time you take the medicine, you might feel quite drowsy with just one pill, but with continued use you might need several pills to feel anything. With opioids most people quickly become tolerant to the sedating effects, but will not develop tolerance to constipation.

**Addiction (or psychological dependence)** is an overwhelming need to use a particular medicine or drug. People with a drug addiction develop an uncontrollable need to use the drug. Opioids may produce psychological dependence if used for the wrong reason by people who have the potential to develop a drug addiction. Opioids should always be used with caution especially in these individuals.

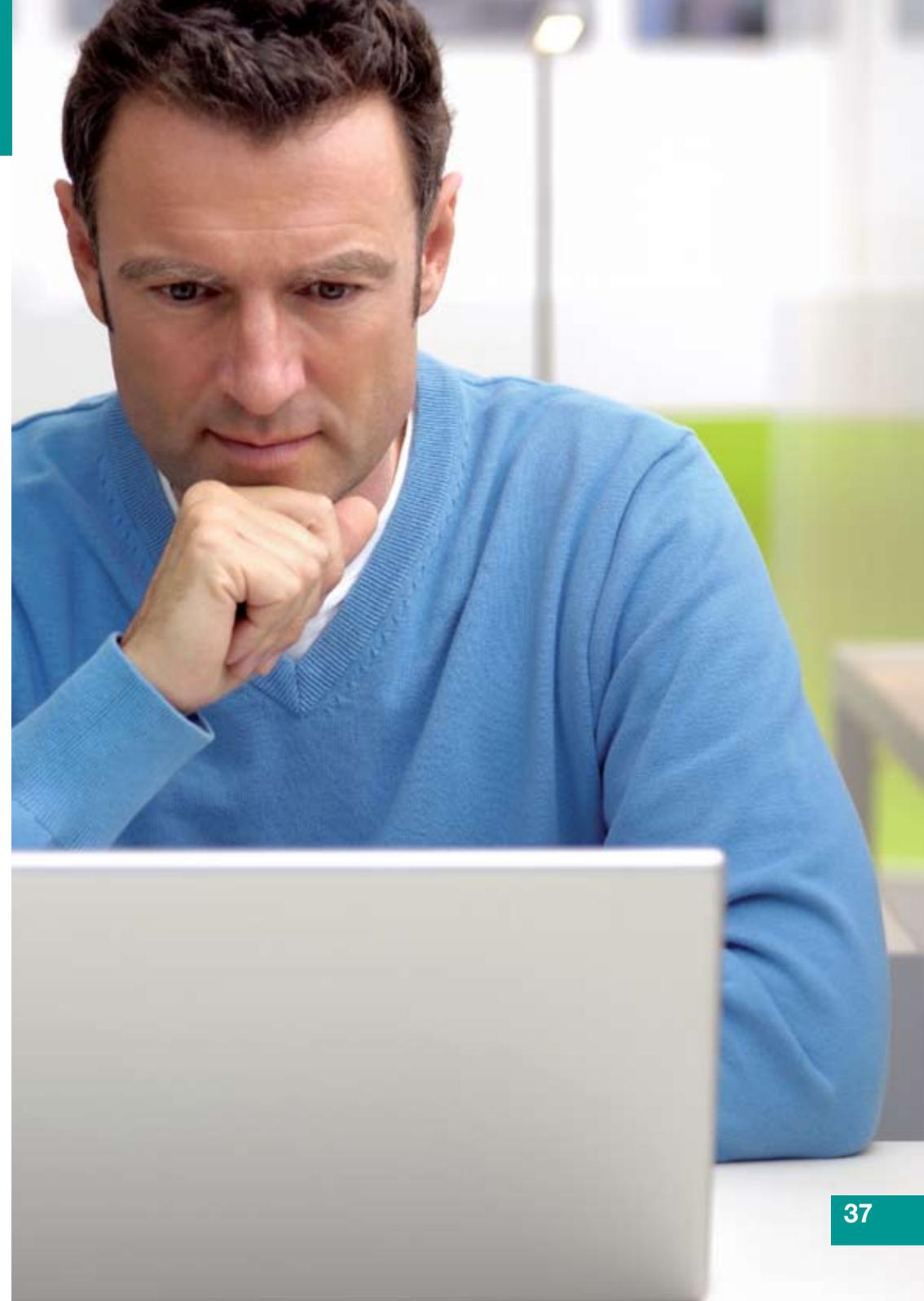
If opioids are prescribed for your pain, you are not abusing drugs if you are taking the medicine as prescribed. Taking doses of opioid medicine to relieve pain is not the same as taking them to get high.

Remember, if you have any questions about your condition or the medicines you are taking talk to your healthcare professional.

## Useful links

Below are some links to websites that may provide some additional information.

Arthritis NSW	<a href="http://www.arthritisnsw.org.au">www.arthritisnsw.org.au</a>
Anxiety Australia	<a href="http://www.anxietyaustralia.com.au">www.anxietyaustralia.com.au</a>
Australian Pain Society	<a href="http://www.apsoc.org.au">www.apsoc.org.au</a>
Beyond Blue	<a href="http://www.beyondblue.org.au">www.beyondblue.org.au</a>
Chronic Pain Association of Australia	<a href="http://www.chronicpainassociation.org.au">www.chronicpainassociation.org.au</a>
Diabetes Australia	<a href="http://www.diabetesaustralia.com.au">www.diabetesaustralia.com.au</a>
Health Institute	<a href="http://www.healthinsite.gov.au">www.healthinsite.gov.au</a>
myDr	<a href="http://www.mydr.com.au">www.mydr.com.au</a>
Pain Management Research Institute	<a href="http://www.pmri.med.usyd.edu.au">www.pmri.med.usyd.edu.au</a>
Pain World	<a href="http://www.painworld.zip.com.au/index.html">www.painworld.zip.com.au/index.html</a>
Virtual Medical Centre	<a href="http://www.virtualmedicalcentre.com">www.virtualmedicalcentre.com</a>



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# References

- <sup>1</sup> McCaffery M & Beebe A (1999). *Pain: Clinical Manual for Nursing Practice (2nd ed.)*; St Louis: Mosby.
- <sup>2</sup> International Association for the Study of Pain (IASP). Pain Terms: a list of definitions and notes on usage. *Pain* 1979; 6:249-252.
- <sup>3</sup> Analgesic Expert Group. Therapeutic Guidelines; analgesic. Version 5. Melbourne: Therapeutic Guidelines Limited 2007.
- <sup>4</sup> <http://www.thewellingtonpainunit.com/what-is-pain.asp>. Accessed 2 Nov 2007.
- <sup>5</sup> Adapted from <http://www.clevelandclinic.org/health/health-info/docs/3600/3687.asp?index=12094>. Accessed 11 Jan 2008 and <http://www.virtualcancercentre.com/anatomy.asp?sid=25>. Accessed 25 Jan 2008.
- <sup>6</sup> Blyth FM *et al.* Chronic pain in Australia: a prevalence study. *Pain* 2001; 89:127-134.
- <sup>7</sup> Australian Institute of Health and Welfare 2006. Australia's health 2006. AIHW cat. No. AUS 73. Canberra: AIHW.
- <sup>8</sup> Van Leeuwen MT *et al.* Chronic pain and reduced work effectiveness: the hidden cost to Australian employers. *European Journal of Pain* 2006; 10:161-166.
- <sup>9</sup> Blyth FM *et al.* Chronic pain and frequent use of health care. *Pain* 2004; 111:51-58.
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- <sup>12</sup> Graziotti PJ, Goucke CR. The use of oral opioids in patients with chronic non-cancer pain. *MJA* 1997; 167:30-34.
- <sup>13</sup> <http://www.npsradar.org.au/npsradar/content/fentanyl.pdf>. Accessed 18 Feb 2008.
- <sup>14</sup> Adapted from: Analgesic Expert Group. Therapeutic Guidelines; analgesic. Version 5. Melbourne: Therapeutic Guidelines Limited 2007.



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