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Are we doing enough for our OTC patients with acute pain?

Given the panic buying and stocking up of paracetamol and ibuprofen in March in anticipation of COVID-19, you would be forgiven for thinking you may not have to sell another packet for the rest of the year. Yet requests for analgesia remain a common feature in the workday of the pharmacy team. In this article, pharmacist Fearghal O'Nia aims to start a conversation between pharmacists and their teams about the approach to patients requesting advice and products for the relief of acute pain, especially in the context of living with COVID-19.

Acute pain

Acute pain is defined as pain lasting less than 12 weeks. Chronic pain persists beyond this period. Acute pain is usually a warning to alert the body to a problem, with the aim of preventing further tissue injury. It is often proportional to the severity of the injury, typically resolving when tissue healing is complete. Pharmacological OTC treatment options include paracetamol, ibuprofen, aspirin, codeine and topical NSAIDs. Non-pharmacological treatment options include heat patches, RICE (Rest, Ice, Compression, Elevation), exercise, physio-therapy, massage, sleep hygiene and acupuncture.

What we know or what we think we know

Not much has changed in the selection of OTC medicines available for the treatment of acute pain in the 20 years since I qualified as a pharmacist. Because of this, we may be tempted to skip over yet another article about pain. We already know all about paracetamol, ibuprofen and codeine don't we? A recent review found that pharmacists in the UK were very confident when it came to questions on doses of these products but very few had any formal education on pain since their undergraduate training. Does this familiarity lull us into complacency? Are we offering our patients advice based on best practice and the most up-to-date guidelines or do we just reach for the same few products we are familiar with?

The customer is not always right!

Do we presume that the patient asking for a product by name knows what they want so it is not as important to figure out what kind of symptoms they have? How often has this happened to you? A patient comes into the pharmacy and asks for a product by name. In the course of a chat with them, you discover that they believe that this product will treat something different than it actually does. Other times they come in asking for a product because a friend recommended it to them even though they may not have the exact same symptoms or perhaps it is the product that they always use.

The customers requesting a product by name tend to be the ones that get most irritated about being asked further questions. Here, good communication is important in explaining that the questions are to ensure they receive the most appropriate and effective treatment for their pain.

It is also important not to presume that because someone has had a medication before that they know how to take it correctly. A study in a London emergency department found that half of the patients thought ibuprofen contained paracetamol. In the UK, about one in four people frequently exceed the maximum daily dose of 4,000mg for paracetamol. In the US half did not know the maximum dose, and one in 20 thought it as high as 10,000mg.

The consultation process – what questions should we be asking?

Before asking the presenting patient questions, we should first ask ourselves if we have created an environment to make the patient comfortable discussing their symptoms. Are we in a quiet area or should we use the consultation area?

The goal of asking the patient questions is to gather enough information to help decide on the most appropriate treatment for the condition for that specific patient. In my experience, I find patients respond better when my approach is more of a conversational one rather than just rolling off a list of questions, but it is important to gather all the relevant information.

There are a number of ways to help remember which questions to ask. All pharmacy staff are probably familiar with the WWHAM mnemonic but there are other useful ones as well *(See Figure 1 below)*.

Another useful memory aid when dealing with queries about acute pain is LESSPAIN *(see next page)*.

Figure 1: **Useful Mnemonics**

WWHAM

- **W** Who is it for?
- **W** What are the symptoms?
- **H** How long have the symptoms been present?
- **A** Action taken?
- **M** Medication being taken

ASMETHOD

- **A** Age & appearance
- **S** Self or someone else
- **M** Medication
- **E** Extra medicines
- **T** Time persisting
- **H** History
- **O** Other symptoms
- **D** Danger symptoms

TED

(Probing questions)

Tell
You mentioned you have pain when getting out of bed. Can you tell me more about that?

Explain
Can you explain to me why you are worried about taking tablets?

Describe
Can you describe the symptoms?

ICE

(to establish patient's perspective)

- **I** Ideas
- **C** Concerns
- **E** Expectations

Source www.consultationskillsforpharmacy.com/docs/docb.pdf

Figure 2: **Less Pain**

L	LENGTH	How long has the pain been troubling you?
E	EVENT	Is the pain linked with a specific event or illness?
S	SEVERITY	How strong is the pain on a scale of 1 (no pain) to 10 (worst pain imaginable)? The pain scale can help here (see below).
S	SENSATION	Can you describe the pain? e.g. sharp, searing, dull.
P	PRESCRIPTION/ OTC MEDICINES	What medicines have you tried to relieve your pain? (and are you taking any other medication).
A	ACTIVITY	Is the pain affecting your ability to do your normal activities?
I	INTERVENTIONS	Have you tried any non-pharmaceutical treatments to help relieve your pain? e.g. RICE(Rest, Ice, Compression, Elevation), physiotherapy.
N	NOT MENTIONED ISSUES	Is there anything else concerning you about your pain?

Pain scales are also a useful tool to use to help benchmark a person's individual experience of pain *(see below)*.

Reasons to refer

It is important that all staff are aware of red flag symptoms that could indicate a more serious condition. Other things to consider are comorbidities that could affect choice of treatment or medication. Overuse headache and inflammatory back pain are examples of conditions to rule out.

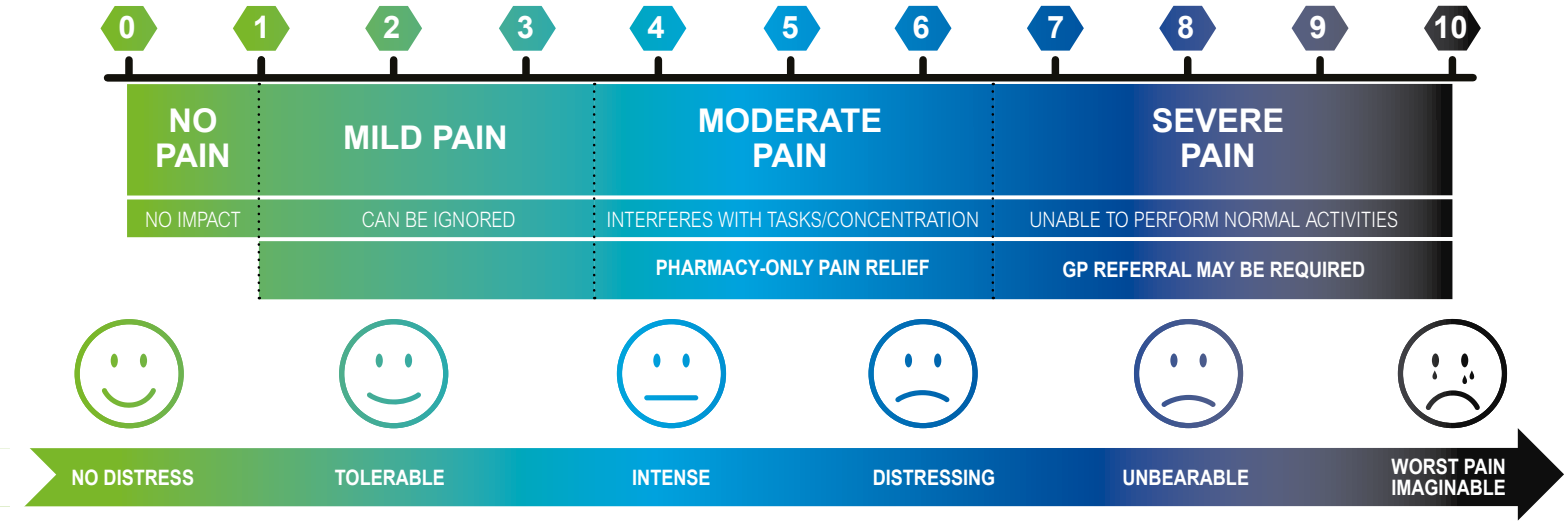
Involving the patient in the choice of treatment

While we may be the experts on the medicines available to treat acute pain, the patient is the expert on themselves. If we involve them in the decision-making process, we can find a patient-centred treatment option that suits them better and leads to improved adherence.

Are you Getting the Right Level

# of Pain Relief?

This scale provides a way to benchmark individual experience of pain.



When discussing treatment options, **BRAN** is a useful mnemonic to use:

Benefits – what are the benefits of the treatment?

Risks – what are the risks of the treatment?

Alternatives – what are the alternative treatments available?

Nothing – what might happen if the patient does nothing?

Management of acute pain: treatment choices

The underlying cause of pain should be treated wherever possible. The Pain Ladder is a useful resource in deciding what analgesic to use. The analgesia ladder was developed by the WHO for treatment of cancer pain but it can be adapted for the OTC treatment of acute pain with a stepwise approach. It is important that the full therapeutic dose of an analgesic is used before switching to a different analgesic or adding an additional one.

Evidence-based advice

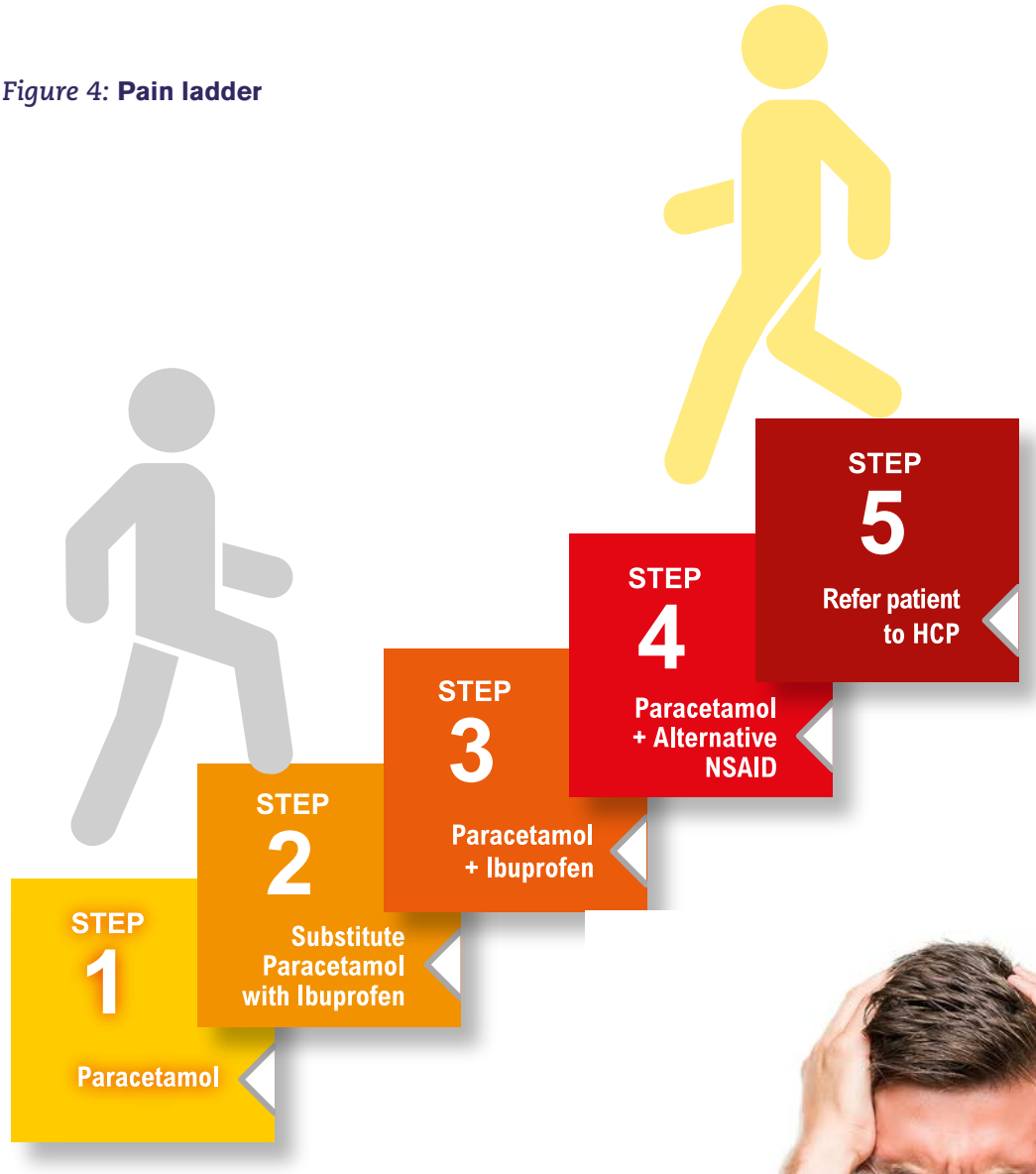
Another issue we experienced in March was conflicting advice, especially on social media, on the safety of ibuprofen in patients with COVID-19. It served as a good reminder of the importance of encouraging patients to get their information from reputable sources like their local community pharmacy. There is currently no scientific evidence that shows ibuprofen worsens the symptoms of COVID-19.

Pharmacists are not immune from failing to follow guidelines. A UK survey of pharmacists revealed that more than 20% of respondents would recommend co-codamol (paracetamol and codeine) as first-line treatment of migraine, which goes against the British Association for the Study of Headaches guidelines.

Having the knowledge of up-to-date guidelines and recommendations can also assist when having to have the difficult conversations with people about suspected codeine misuse and medicine overuse headaches.

While codeine has a use in the treatment of pain, it is important that it is used in a structured stepwise way, following the pain ladder guidelines. Opioids have been shown to be effective for acute pain but to have minimal effect in the treatment of chronic pain.

Figure 4: **Pain ladder**



Ibuprofen with food?

We often give patients advice to take ibuprofen with food with the aim of reducing adverse effects in the gastrointestinal tract. It is suggested that when used short term, OTC, eating food can delay drug absorption and impair the time to optimum efficacy and that we should recommend that OTC ibuprofen is taken with water.

Table 1: **Evidence-based guidelines on choice of analgesia for acute pain**

Tension-type headache
Consider aspirin, paracetamol or ibuprofen for the acute treatment of tension-type headache, taking into account the person's preference, comorbidities and risk of adverse events. Do not offer opioids for the acute treatment of tension-type headache.
Migraine (must be previously medically diagnosed)
Offer combination therapy with sumatriptan and an NSAID or sumatriptan and paracetamol taking into account the person's preference, comorbidities and risk of adverse events. Monotherapy with sumatriptan, NSAID or paracetamol can be considered for people who only want to take one drug. Opioids should not be used for the acute treatment of migraine.
Lower back pain
Consider NSAIDs for managing low back pain, taking into account potential differences in gastrointestinal, liver and cardio-renal toxicity and the person's risk factors, including age. Oral NSAIDs should be used at the lowest effective dose for the shortest appropriate time. 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. Do not offer paracetamol alone for managing low back pain.
Period pain
Consider NSAID (e.g. ibuprofen) unless contraindicated. Paracetamol can be used if a NSAID is contraindicated or provides insufficient pain relief.
Sprains and Strains
Paracetamol four times per day or topical NSAID are recommended as first line. Consider oral NSAID 48 hours after the initial injury if needed.
Dental pain
A visit to a dentist will usually be required to deal with underlying cause. Consider ibuprofen unless contraindicated. Ibuprofen and paracetamol can be used together for more severe pain. This combination has been found to have a greater effect than opioid-containing combination products.

Conclusion

With all the misinformation going around on social media, it has never been more important for healthcare professionals to offer up-to-date, evidence-based advice. Given that many households may now also have a medicine cabinet full of stockpiled OTC medicines, perhaps we should also encourage them to seek advice from us if they have any queries about them.

With all the pressures in community pharmacy, finding the time to keep up to date on guidelines and evidence seems to be getting even more difficult. One solution could be to divide this task up, e.g. a member of staff is assigned pain as their subject to monitor for updates and they share any updated information with the rest of the pharmacy team.

References available on request.

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