FPM & BPS Joint Guidance on Pain Interventions during the COVID-19 Recovery Phase

8 June 2020

Summary of Recommendations

- **The decision to resume injections should be based on a balance of risks and benefits for individual patients**
- **The decision to resume injections should take into account the current COVID-19 situation in that region**
- **Injections should be prioritised according to the level of urgency suggested by the FPM guidance on recovery of services**
- **An individualised treatment plan for difficult cases should be supported by the MDT with a minimum of two clinicians involved**
- **All reasonable non-injection pain management measures should be explored before injections are started or resumed**
- **Protective measures should be taken by local protocol to minimise the risks to patients and staff**
- **Pain services must aim for the resumption of fully commissioned services when safe to deliver**

Introduction

The Coronavirus Disease 2019 pandemic (COVID-19) has led to significant changes in the delivery of pain medicine services nationally. A survey by the Faculty of Pain Medicine (FPM)[1], showed that the majority of the services currently have reduced staffing, rest redeployed to help with the acute services. Additionally, the majority of elective work has been postponed to create capacity to deal with the pandemic. The NHS is now entering a COVID-19 recovery phase, with some non COVID services resuming. Planning for the recovery phase will depend on the ongoing impact of COVID-19 locally and the resources that are available both to hospitals and community services.

Pain interventions form an important part of a range of evidence based multi-disciplinary therapies offered to appropriate patients. Interventions are usually offered alongside conservative methods such as pharmacological, physical and supportive therapies. Balancing the risk of interventional and non-interventional treatment options for patients is of paramount importance.

This guidance aims to support FPM fellows and other appropriately trained pain clinicians in safely resuming interventional services during all phases of the COVID-19 pandemic. These are unprecedented times; we would expect services will only return to fully commissioned activity levels, when it is safe to do so. Time frame might vary between different regions. Temporary restrictions are placed on pain interventions during the pandemic because of safety and resource concerns, with acknowledgement that some patients will not receive optimal care. The pandemic must not be used as an opportunity to decommission interventions or pain services.

Factors to consider when resuming pain interventions

1. **Local COVID-19 situation**

    a. It is likely that geographical differences in infection rates will occur. The decision to resume injections should be cognisant of this fact, considering the demand on healthcare resources and risk to staff and patients in your region

2. **Prioritising injections**

    a. The FPM has published guidance on time dependent pain procedures, and this should be considered when prioritising the resumption of interventional services[1]
    b. Local pain services may wish to prioritise the resumption of lower risk aspects of their service first
    c. Pain interventions that do not fall within the categorisation should be assessed on an individual basis and a collaborative approach should be taken with other clinicians to guide prioritisation
    d. It is important that the reasons for decision making in difficult cases are carefully documented, with at least two clinicians involved in the decision making process

3. **Reducing the risk to patients**

    a. All appropriate and available non-invasive treatments should be explored and discussed with the patients, before injection treatments are considered
    b. Where an injection treatment is considered as an alternative or a precursor to a more major surgical procedure e.g. selective nerve root block in place of lumbar decompression, the injection should be prioritised[2]
    c. In order to minimise visits to hospital for high risk patients, consider proceeding directly to a definitive procedure rather than first performing diagnostic injections. The risks and benefits of this should be discussed
    d. Services should follow local policy on the routine testing of patients for coronavirus prior to elective procedures and develop guidance on post-procedural isolation if a steroid injection is to be considered
    e. Risks posed by steroid injections particularly in high risk patients should be thoroughly discussed with a pain clinician. They should be aware of current evidence in assessing the mortality and morbidity of COVID-19 and its risk factors
    f. Patients must understand their risks are greater if they are in an 'at risk' group[3], and very high risk patients should only undergo injections with appropriate MDT support with a minimum of two clinician involvement
    g. Follow British Pain Society and FPM guidance on good medical practice while performing pain interventions[4–6]

4. Use of Steroids in Pain interventions

a. Faculty of Pain Medicine released a statement on safety of steroid use in pain interventions and this should be followed[7]
b. Steroid injections may cause immunosuppression, and steroid use should only be considered where there is suspected acute inflammation involved in the pathophysiology of the pain
c. The minimum effective steroid dose should be used. Water soluble steroids may have a shorter duration of systemic effect compared to other steroid preparations[8]
d. As with all pain management interventions, a risk benefit balance has to be reached in discussion with the patient. Each case is unique and no guidance will cover all eventualities
e. Records of all patients treated should be maintained and an audit system developed to report any morbidity or mortality secondary to COVID-19 infection after steroid injections. Any steroid related incident should be reported using the MHRA yellow card system[9]
f. Steroids are not indicated in diagnostic blocks, nor following ablation for low back pain[10]

5. Reducing risk to staff

a. Patients having active symptoms of COVID-19 infection should have their procedure deferred unless there is an overriding clinical priority
b. Appropriate PPE must be available and social distancing protocols to be maintained except during actively imparting clinical care or monitoring
c. Deep sedation requiring the potential need for airway support and subsequent aerosol generation should be avoided[11]
d. Appropriate time for interventions should be allowed (to allow social distancing for patients and staff, and the cleaning procedures after each case). This will mean fewer patients in a 'list' to be factored into any return to activity

6. Consent

a. It is recognised that face to face appointments to discuss the risks and benefits of treatment may not be in the best interests of patients and staff. However, it is important that the same principles of consent are followed, whether patient are spoken to on the telephone or by video call or in person
b. It is vital that patients understand the additional risks of attending hospital, and receiving an injection during the COVID-19 pandemic
c. Written patient information on the additional risks of injection treatment during the COVID-19 pandemic should be available to patients to aid the consent process
d. The guidance in the General Medical Council (GMC) publication 'Consent: patients and doctors making decisions together' must be followed[12]
e. It is vital that the person discussing the risks of a procedure with the patient is not only familiar with the risks/benefit of the procedure but also remains current on the risks and mortality from COVID-19

References

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12. GMC. Consent: patients and doctors making decisions together. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent

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APPENDIX: Relevant NICE Publications

Back pain and Sciatica	
Low back pain and sciatica in over 16s	QS155
Low back pain and sciatica in over 16s: assessment and management	NG59

Neuromodulation	
Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin	TA159
Senza spinal cord stimulation system for delivering HF10 therapy to treat chronic neuropathic pain	MTG41
Occipital nerve stimulation for intractable chronic migraine	IPG452
Percutaneous electrical nerve stimulation for refractory neuropathic pain	IPG450
Peripheral nerve-field stimulation for chronic low back pain	IPG451

Uncommon Pain Medicine interventions	
Percutaneous intradiscal laser ablation in the lumbar spine	IPG357
Percutaneous interlaminar endoscopic lumbar discectomy for sciatica	IPG555
Percutaneous transforaminal endoscopic lumbar discectomy for sciatica	IPG556
Percutaneous coblation of the intervertebral disc for low back pain and sciatica	IPG543
Percutaneous electrothermal treatment of the intervertebral disc annulus for low back pain and sciatica	IPG544
Percutaneous intradiscal radiofrequency treatment of the intervertebral disc nucleus for low back pain	IPG545
Percutaneous vertebroplasty and percutaneous balloon kyphoplasty for treating osteoporotic vertebral compression fractures	TA279

Cancer Pain and Vascular pain	
Pancreatic cancer in adults: diagnosis and management	NG85
Peripheral arterial disease: diagnosis and management	CG147

Drugs in Pain Medicine	
COVID-19 rapid guideline: rheumatological autoimmune, inflammatory and metabolic bone disorders	NG167
Cannabis-based medicinal products	NG144
Neuropathic pain in adults: pharmacological management in non-specialist settings	CG173
Methadone and buprenorphine for the management of opioid dependence	TA114
Naltrexone for the management of opioid dependence	TA115