Government of **Western Australia**
Department of **Health**

Enhanced Access Community Pharmacy Pilot

Mild, acute musculoskeletal pain

Clinical practice guideline

Service restricted to patients aged 18 years or over.

Ineligibility for treatment as part of a prescribing service does not preclude a patient from accessing services provided as part of usual pharmacy care.

The information and content in this clinical practice guideline do not constitute medical advice, diagnosis, or treatment recommendations for individual patients. Pharmacists must exercise professional discretion and judgement consistent with their qualifications and legislative authority. This guideline does not override the responsibility of the pharmacist to undertake clinical assessments and to make decisions appropriate to the circumstances of the individual and the relevant standards of care, in consultation with the patient and/or their parent/caregiver. This clinical practice guideline may only be used by pharmacists who have been approved by the Department of Health to participate in the Enhanced Access Community Pharmacy Pilot (EACPP) and are authorised to prescribe under the *Medicines and Poisons Regulations 2016* (WA). This document alone does not provide an authorisation for a pharmacist to prescribe.

Contents

Guideline overview

Meet service and professional obligations

- Initial patient eligibility and suitability for management within the scope of the service
- Patient informed consent (including consent for communication with other health practitioners if relevant)

Patient history and assessment

- Patient history:
  - pain history and assessment
- Examination:
  - vital signs
  - examine area

Develop management plan

- Non-pharmacological measures
- Pharmacotherapy:
  - oral analgesia

Confirm management is appropriate

- Contraindications, precautions, and interactions
- Pregnancy and lactation

Communicate agreed management plan

- Medication counselling
- General advice and patient information
- When to seek further care and/or treatment
- Communication with other health practitioners

Clinical review

- Response to treatment
- Communication with other health practitioners

Refer when

- The patient is aged below 18 years (does not preclude a patient from accessing usual pharmacy care)
- Acute swelling, erythema, and significant reduction in range of motion of a joint
- Headache and acute onset of visual or auditory disturbances
- Digital ischaemia
- Suspected nerve damage or mononeuropathy
- Neurological signs including altered bladder or bowel function
- Systemic symptoms suggestive of serious pathology including fever, malaise, weight loss, nausea, and vomiting
- Pain cannot be attributed to acute mechanical musculoskeletal (MSK) pain (chronic pain or inflammatory pain)
- History of chronic inflammatory MSK pain or complex underlying rheumatological conditions (including acute flares of these conditions)
- The patient is at high risk of acute rheumatic fever
- The patient rates their pain as moderate to severe
- The patient is unable to accurately rate their pain due to cognitive impairment or other special needs
- The patient requests treatment with an opioid
- The patient is opioid-tolerant or recovering from an opioid use disorder
- Inadequate response to optimal treatment.

Treat and concurrently refer

- Nil criteria.

Key points

- Acute MSK pain is generally mechanical, caused by damage to tissue or structural changes to joints, vertebrae, and muscles/soft tissue[1-3].

While mechanical pain can lead to inflammation, it is different to inflammatory pain caused by an underlying chronic inflammatory disease such as arthritis, that results in chronic pain and is treated differently[1]. Refer to Table 1.

- Injury is the most common cause of acute mechanical MSK pain. Acute MSK pain is expected to be self-limiting (last less than 3 months), with a return to usual function as the underlying injury resolves[2,4].
- Non-pharmacological therapies and lifestyle measures (where there is a proven benefit) and pharmacotherapy (paracetamol and non-steroidal anti-inflammatory drugs (NSAIDs)) should be considered in the overall management plan for acute, mild MSK pain[5-8].
- Opioids are not required for the management of acute, mild MSK pain and cannot be prescribed by pharmacists[9].

Refer when

Refer the patient to an appropriate healthcare provider (including emergency services if required) in the following situations:

- the patient is aged below 18 years (does not preclude a patient from accessing usual pharmacy care)
- acute swelling, erythema, and significant reduction in range of motion of a joint
- headache and acute onset of visual or auditory disturbances
- digital ischaemia
- suspected nerve damage or mononeuropathy (e.g. loss of feeling, weakness, pain, burning and/or paraesthesia ('pins and needles'))
- neurological signs including altered bladder or bowel function
- systemic symptoms suggestive of serious pathology including fever, malaise, weight loss, nausea, and vomiting
- pain that cannot be attributed to acute mechanical MSK pain (chronic pain or inflammatory pain)
- history of chronic inflammatory MSK pain or complex underlying rheumatological conditions (including acute flares of these conditions)
- the patient is at high risk of acute rheumatic fever
- the patient rates their pain as moderate to severe
- the patient is unable to accurately rate their pain due to cognitive impairment or other special needs
- the patient requests treatment with an opioid
- the patient is opioid-tolerant or recovering from an opioid use disorder
- inadequate response to optimal treatment.

Treat (if clinically appropriate) and concurrently refer

Nil criteria.

Patient history and assessment

Patient history

Obtain sufficient information from the patient to assess the safety and appropriateness of any recommendations and medicines provided.

The patient history should consider:

- age
- pregnancy and lactation status (if applicable)
- underlying or co-existing medical conditions, including rheumatological and autoimmune conditions such as inflammatory arthritis and psoriasis
- family history of inflammatory pain, rheumatological and/or autoimmune conditions e.g. ankylosing spondylitis or inflammatory arthritis
- non-musculoskeletal symptoms that may indicate serious pathology, including weight-loss or gain, fever, malaise, nausea, vomiting, and sweating
- risk factors for developing acute rheumatic fever as per the Therapeutic Guidelines: Antibiotic (Acute rheumatic fever)[11]
- alerting symptoms and features as per the Therapeutic Guidelines: Rheumatology (Clinical assessment of musculoskeletal symptoms in adults)[12]
- response to any previous treatments
- impacts on quality of life including sleep, ability to self-care, mobility, work, leisure, emotional health, and relationships
- precipitating, aggravating and relieving/alleviating factors
- current and recently ceased treatments (including prescribed medicines, vitamins, herbs, other supplements, and over-the-counter medicines)
- weight, dietary patterns, levels of physical activity
- allergies/adverse drug reactions
- alcohol, tobacco, and other drug history/status
- mechanism of injury if injury involved
- if the injury occurred in a workplace
- if the patient has been, or suspected to have been, subject to domestic abuse
- other psychosocial factors.

Pain history and assessment

Where appropriate, conduct assessment of vital signs.

Pain history and assessment should be conducted in accordance with the Therapeutic Guidelines: Pain and analgesia (General principles of acute pain management) and Therapeutic Guidelines: Pain and analgesia (Assessing a patient with pain)[4,13].

Pain severity is subjective and should be interpreted in the context of the patient's presentation as well as additional information gained through the pain history[14].

The Therapeutic Guidelines: Pain and analgesia (General principles of acute pain management) includes information to assist with determining pain severity[4].

If the patient's self-reported pain severity is not consistent with other assessment findings e.g. physical function or examination findings, the patient should be referred to an appropriate healthcare provider for comprehensive assessment including socio-psycho-biomedical factors[4,14].

Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies, and current medical conditions.

Examination

Examine the area of pain in accordance with the Therapeutic Guidelines: Rheumatology (Clinical assessment of musculoskeletal symptoms in adults)[12].

To determine appropriate management or referral, it is important to identify the aetiology of the pain (nociceptive, neuropathic, nociplastic, or a combination (mixed pain)) and to distinguish pain associated with inflammation from mechanical pain. See Therapeutic Guidelines: Pain and analgesia (Understanding Pain)[14].

MSK pain is predominantly nociceptive, with a superficial or deep origin and localisation of pain from the bone, joint, or muscles (somatic)[14].

Acute pain is defined by a duration of less than 3 months, usually with a nociceptive pain component arising from actual or threatened tissue damage[4,14].

Table 1: Clinical features/characteristics of mechanical versus inflammatory pain[1,15]

Inflammatory pain	Mechanical pain (musculoskeletal)
• Improves with exercise/movement • Does not improve with rest • Lasts more than 3 months • Patient may experience morning stiffness (for greater than 30 minutes) • Pain waking patient during second half of the night with improvement on getting up.	• May worsen with movement/exercise • Often improves with rest • Most cases have acute onset lasting less than 3 months • Precipitating physical injury may be identifiable.

Investigations

Referral to an appropriate healthcare provider for further investigation is required for acute pain that does not respond to treatment, or if indicated by patient history and/or pain history e.g. patients presenting with traumatic injuries that may require radiological examination.

Develop management plan

Pharmacists must ensure that they are prescribing medicines according to the specified sections of the current online version of the Therapeutic Guidelines.

Pharmacist management of acute mild MSK pain involves:

- **non-pharmacological measures:**
  - advice regarding non-pharmacological pain management strategies for all patients in accordance with the Therapeutic Guidelines: Pain and analgesia (Nonpharmacological management of acute pain)[6]
- **pharmacotherapy:**
  - oral analgesia in accordance with the:
    - Therapeutic Guidelines: Pain and Analgesia (Pharmacological management of acute pain – Mild, acute nociceptive pain)[16]
    - Therapeutic Guidelines: Rheumatology (Overview of limb conditions – Analgesia for acute soft-tissue limb conditions)[17].

Confirm management is appropriate

Consult the *Therapeutic Guidelines, Australian Medicines Handbook* and other resources to confirm that management is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) should be provided to the patient regarding:

- management options and expectations for resolution
- individual product and medicine use e.g. treatment regimens with paracetamol and NSAIDS and application instructions for topical NSAIDs
- non-pharmacological measures
- how to manage adverse effects
- when to seek further care and/or treatment.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients (and/or parents/caregivers if applicable), and to ensure compliance with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

General advice

General advice to be provided to the patient regarding strategies to manage acute MSK pain includes:

- physical interventions that may provide adequate pain relief on their own e.g. hot and cold therapy
- other interventions based on the reported injury e.g. ice, immobilisation, and compression therapy[6,10]
- evidence for the use of complementary medicines and possible adverse effects and interactions with conventional medicines.

At the time of initial consultation, patients (and/or parents/caregivers) should be advised to see an appropriate healthcare provider if:

- the pain relief provided is not adequate
- symptoms do not improve with recommended treatment
- the pain or other symptoms worsen
- new pain or symptoms develop.

Advise patients that analgesia (NSAIDs or paracetamol) should be discontinued if there is no benefit, or treatment causes adverse effects[7,8]. Patients prescribed NSAIDs should be advised to use the minimum effective dose for the shortest duration possible[7].

Clinical review

Clinical review is generally not required unless the condition does not improve or resolve. Pharmacists should prescribe a quantity of medicine that aligns with the expected duration of therapy. Advise patients (and/or parents/caregivers, if applicable) to see an appropriate healthcare provider if the condition does not improve or resolve (see Refer when and General advice).

Patient resource

- HealthyWA: Sprain

Pharmacist resources

- Therapeutic Guidelines: Rheumatology
  - Clinical assessment of musculoskeletal symptoms in adults
  - Principles of NSAID use for musculoskeletal pain
  - Principles of paracetamol use for musculoskeletal pain
  - Overview of limb conditions
- Therapeutic Guidelines: Pain and analgesia
  - Understanding pain
  - Assessing a patient with pain
  - General principles of acute pain management
  - Nonpharmacological management of acute pain
  - Pharmacological management of acute pain
  - Mild, acute nociceptive pain
- Australian Medicines Handbook:
  - Drugs for pain relief
  - NSAIDs
- Australian Pharmaceutical Formulary and Handbook (APF): Treatment guideline for pharmacists (Musculoskeletal pain)
- Queensland Ambulance Service: Pain assessment
- National Centre for Complementary and Integrative Health:
  - Pain information for Health Professionals
  - Herbs at a glance

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