OP30 PHARMACIST-LED MANAGEMENT OF CHRONIC PAIN IN PRIMARY CARE: THE PIPPC STUDY

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Background Chronic pain, (lasting >3 months) affects nearly half the adult population. Most are managed in primary care but prescribing is often suboptimal. Practice pharmacists are

ideally placed to improve prescribing. Following the Medical Research Council (MRC) framework for development of complex interventions, we are developing a randomised controlled trial (RCT) to compare pharmacist medication-review, with or without prescribing, with standard care. This paper reports the six month results of the pilot RCT.

Aims To test acceptability and feasibility of the intervention(s); obtain estimates of patient recruitment and attrition rates; select outcome measures; estimate effect size and optimise the intervention.

Design We recruited six general practices with prescribing pharmacists in Grampian and East Anglia. Pharmacists were trained in pharmaceutical management of chronic pain.

Participants Patients with chronic (>3 months) pain were identified by a computerised search of prescribed medication. General Practitioners (GP) screened patients and mailed invitations to a random subsample.

Interventions Three arms: (i) pharmacist medication-review with pharmacist prescribing; or (ii) pharmacist medication-review with feedback to GP; or (iii) treatment as usual. Outcome measures: 12-Item Short Form Health Survey (SF-12), Chronic pain grade (CPG: range I-IV, higher grade indicates higher pain intensity and pain-related disability), Health Utility Index, ICEpop CAPability measure for Older people (ICECAP-O), and Hospital Anxiety and Depression Scale (HADS). Follow-up questionnaires were collected after three and six months. Audio-taped interviews with GPs and pharmacists were transcribed and content analysed.

Results 1397 patients were contacted and 289 consented and were sent baseline questionnaires. 251 returned questionnaires (87%): of these 232 were randomised (36 used as 'training patients'), and 19 were excluded (questionnaires arrived after sample size achieved). Of those randomised who were not training patients (196 patients), 40 had pain for <3 years, 77 for 3–10 years, and 78 for >10 years. Chronic Pain Grade could be calculated for 180 (Grade IV: n=67; III: n=45; II: n=49; and I: n=19). There was an 82% (160) response rate to the 3-month follow-up questionnaire, and 78% (152) at 6 months. By 6 months, changes in Mental Component SF-12 scores favoured the prescribing arm (p=0.04), but not physical component scores (p=0.75); CPG pain intensity was reduced most in the prescribing arm (p=0.02), as was HADS depression (p=0.02) and anxiety scores (p=0.05). Furthermore, 48% of those in prescribing arm had improved their Chronic Pain Grade, compared with 39% in the review arm and 31% of controls, but this was not statistically significant (p=0.16). Interviews showed that pharmacists were positive about the intervention. There was some ambivalence among GPs.

Conclusion The pilot trial confirmed recruitment was possible, response rate reasonable and outcomes were appropriate. This pilot suggests that pharmacist prescribing has the potential to confer additional benefit over medication-review alone or usual care and should now be tested in a definitive trial.