National Institute for Health and Clinical Excellence

CHEST PAIN

Scope consultation 14th September – 12th October 2007
Email: chestpain@nice.org.uk

Stakeholder Comments

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Name:	**J Goddard**
Organisation:	**British Pain Society**
General	The scope document itself recognises that *"Chest pain is caused by CHD in only a minority of cases, and guidance on the assessment of chest pain will aid in making an accurate diagnosis, avoiding inappropriate diagnoses and treatment, and reducing unnecessary referral and admission to secondary care."* This differentiation is largely a matter of proper history taking and examination. For the proposed guideline to have any relevance chest pain of cardiac origin must have already been ruled in. Thus there seems little point in having a separate ACS guideline unless this guideline focuses on risk assessment and the need for referring to specialist care. (see below Chronic Refractory Angina Guidelines)
4.3.1b	**Working diagnosis**. Emphasis must be given to the importance of making clear the difference between a 'working' diagnosis and a final diagnosis. Later management is much more difficult when patients are told there is only a minor problem or that there is 'nothing wrong' after they have been given the clear impression that they have a potentially life threatening cardiac condition during the early diagnostic stage.
4.3.1 c	**Analgesia and Pain management**. It should be understood that modern pain management involves optimising the psychological status of the patient and carer by dealing with misconceptions and offering alternative explanations for the symptoms as well as providing analgesia. Specific symptomatic treatment with analgesia should be mentioned with reference to current pain management guidelines.
4.3.1.d	**Psychological factors**. It should be acknowledged that the psychological status of the pain has a huge influence on the pain experience. Similarly the pain experience has a feedback effecting on psychological status. Patients with chest pain are easily frightened and this impairs their cognitive function. In turn, this impairs their capacity to give consent and advice should be given to ensure that patients are given time to properly consider medical advice before giving consent to procedures.

4.3.1e	**Education**. This section mentions education. It is important to note that whilst extant angina guidelines mention the critical importance of education/rehabilitation at the outset of care they leave the reader to track down the relevant guidelines. In this regard the Cheshire and Merseyside and North Wales Cardiac Network Stable Angina Guidelines are to be recommended (link http://www.cmcn.nhs.uk/guidelines/stable_angina.html) This guideline should not repeat the mistake of assuming that colleagues will read and implement the relevant guidance on education. Harmful misconceptions are extremely common and there is good evidence that patient education (as opposed to giving patients information) is amongst the most neglected areas of clinical care.
4.3.1.e	How is education to be delivered-by whom and in what form? How is consistency to be assured?
4.3.1.e	Behavioural and lifestyle advice should be defined. Otherwise practitioners are likely to default to non-evidence based prejudices such as advising patients to give up work and risky activities. Without clear explanations this often leads to excessive anxiety and harmful behaviours.
General	The scope ignores patients with chest pain of cardiac origin for whom revascularisation is not an option either because it is not clinically appropriate or the patient refuses. The British Pain Society sponsored UK National Refractory Angina guideline was introduced for such a situation in 1998. The guideline has been endorsed by the British Pain Society angina special interest group (SIG), our parent body (IASP) angina SIG and the British Cardiovascular Intervention Society. We urge NICE to take account of these longstanding and widely used guidelines when considering how to manage this complex and difficult clinical problem. Contact Prof M Chester, guideline chairman, for further details: NRAC, RLBUHT, Thomas Drive, Liverpool 14 3PE. Tel 0151 600 1244/1448 email chester@angina.org