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A planned approach to prescribing opioids

Opioids have a role in managing chronic (persistent) non-cancer pain; however their long-term benefits and harms in this context are not well understood. Current guidelines recommend a cautious approach to prescribing and emphasise strategies to optimise the benefits of opioids while minimising potential harms.^{1,2} Strategies include careful patient selection, clear communication between health professionals and patients about the goals of opioid therapy, instructions about proper use and close patient monitoring.

When to consider opioids for chronic non-cancer pain

Managing chronic pain involves a combination of non-pharmacological and pharmacological approaches. Guidelines consistently recommend opioids as an option when other analgesics (including paracetamol, at adequate doses, or NSAIDs) are unsuitable or provide inadequate pain relief.²⁻⁶ In the absence of good quality evidence to guide choices, recommendations about opioids are frequently based on expert consensus and clinical experience.

Before considering an opioid for chronic pain, perform a thorough history and physical examination to consider whether further diagnostic tests are required.⁴

Weigh up the potential risks and benefits of opioids for individual patients and consider seeking advice from a specialist pain service, or experienced colleague before prescribing.² A list of specialist pain services in your state or territory can be found under the menu item "Facility directory" on the Australian Pain Society website (www.apsoc.org.au; see also a direct link via www.nps.org.au/news_69).

Make sure you understand the legislative controls on the opioid prescribing in your state or territory, and Pharmaceutical Benefits Scheme prescribing requirements.

Opioids as part of a pain management plan

The goals of opioid therapy in chronic pain are to reduce pain and improve function and quality of life.^{2,4,6,7} Opioids should only be prescribed as part of a comprehensive pain management plan (see Box 1). Written pain management plans support a structured approach to care and a continuity of care regardless of the setting.⁸ Actively involve patients in developing a pain management plan tailored to their specific treatment goals.^{7,9} You can find the *My pain management plan* template at: www.nps.org.au/opioids

Plans should be reviewed regularly, and used to document response to treatment and management decisions.⁸ Patients eligible for a GP management plan and Team Care Arrangements may be able to access other treatments for chronic pain under the Medicare Benefits Scheme. For more details see the chronic disease management Medicare items on www.health.gov.au (or go to www.nps.org.au/news_69 for a direct link).



Thinking differently about medicines

Box 1: Issues to discuss when developing a pain management plan including an opioid^{2-6,8,10,11}

- Agreed treatment goals (e.g. specific targets for physical, psychological or social functioning, use of drug and non-drug strategies)
- Duration of opioid therapy (e.g. timeline for meeting treatment goals, alternative strategies if treatment goals are not met, conditions under which an opioid may be stopped [for example, lack of pain relief, unsanctioned use], and that opioids should ideally be used for a limited time)
- Safe use, storage and disposal of the opioid (e.g. names, doses and frequency of prescribed opioid medication and other analgesics; how to manage breakthrough pain/pain flares, especially 'after hours'; how to avoid and manage adverse effects, especially constipation; clearly written instructions about storage and disposal)
- Follow-up appointments to review progress
- Patient's obligations regarding opioid therapy (e.g. only one prescriber, no early repeats or replacements of lost prescriptions).

Start an opioid on a trial basis

Before starting a trial of opioid therapy, agree on realistic treatment goals with the patient (for example, walk to the shops, improved sleep or return to part-time work) along with an evaluation timeframe.^{2-5,9,10} The recommended duration of an opioid trial ranges from 2–6 weeks, to several months.^{3,6,10,12-14} Assess progress at appropriate intervals (for example, weekly in the first month, then monthly thereafter).^{3,5} Talk about adverse effects as these are a common reason for early discontinuation of opioids.^{5,15} Encourage patients to have realistic expectations of treatment — for example, complete pain relief is unlikely, but some improvement in function and increased activity is expected.⁶

A more formal opioid agreement ('contract') between the patient and doctor outlining the terms and conditions for opioid prescribing is often suggested as a way of preventing unsanctioned use, particularly for patients unlikely to follow an agreed treatment plan.^{1-3,6,7,10,16,17} There is no clear evidence, however, that opioid agreements improve clinical outcomes or reduce harms such as problematic opioid use.¹⁸

Which opioid?

The choice of opioid, initial dose and titration schedule should be individualised according to the patient's health, age, past experience with opioids and response.^{10,19} Consider also your familiarity with an opioid, its availability, range of strengths and cost

when choosing between different opioids.¹⁴ Long-acting opioids are recommended for chronic pain.^{2-6,14} Some guidelines^{4,10} recommend using a short-acting opioid to establish total daily requirements, but starting with a low dose of a long-acting opioid appears to be increasingly accepted for most patients.

Guidelines recommend starting with a low dose (for example, modified-release morphine 5–20 mg twice daily, or modified-release oxycodone 5–10 mg twice daily) and titrating slowly. Choose a dose at the lower end of the range for opioid-naïve or elderly patients.^{5-7,10,14} Lower starting doses and slower dose titration are recommended for frail patients.^{5,10} It may be necessary to titrate upwards if tolerated two or three times before measurable pain relief is achieved.⁵ Specialist advice should be sought for patients requiring repeated dose escalations or higher doses (for example, doses exceeding morphine 100–120 mg daily or oxycodone 80 mg daily).^{2,3,6}

Suggested maximum opioid doses that should not be exceeded without specialist advice can be found on the Hunter New England Area Health Service website (www.hnehealth.nsw.gov.au), or access a direct link via www.nps.org.au/news_69.

Codeine and codeine containing products have a limited role in the treatment of chronic pain.³ Codeine is a short-acting opioid suitable only for mild to moderate pain.¹⁴ Avoid injectable opioids in managing chronic pain.

Appropriate use of opioid patches

Opioid patches are an alternative to long-acting oral opioids for relatively stable chronic pain, especially for patients unable to take oral medicines. However the range of available oral opioid preparations offers greater dose flexibility and choice. Patches are unsuitable for acute pain and fluctuating analgesic needs because they have a slow onset of action and long duration of effect. After initial patch application, it may take a few days for serum opioid concentrations to reach a steady state.¹⁴ The 2 currently available opioid patches (fentanyl and buprenorphine) have characteristics that make them unsuitable for many patients (see below).

Make sure that patients prescribed an opioid patch and their carers know how to use, store and dispose of patches safely to prevent accidental or intentional misuse (see Box 2).

Box 2: Important safety advice for a patient wearing an opioid patch^{14,20,21}

- Do not cut or divide opioid patches; do not use a damaged patch.
- Apply the patch to an area of dry, cool, hairless non-irritated skin on the upper chest or outer arm.
- Write the date and time of application on the patch with a permanent pen/marker.
- Remove the old patch before applying the new one and rotate skin application site.
- Avoid wearing more than 2 patches at the same time.
- Avoid excessive body heat while wearing a patch. Do not apply heat to patches (for example, electric blankets, heat lamps, hot baths, saunas, intensive sunbathing).
- After use, fold patch over on itself (sticky sides together) and dispose of out of reach of children — used patches may still contain a significant amount of drug.
- Remind health professionals that you are wearing a patch (especially if you are admitted to hospital or aged care home).

Buprenorphine patches – for moderate pain only?

Buprenorphine is a partial opioid agonist available in a 7-day patch formulation.

The highest strength patch (releasing buprenorphine 20 micrograms/hour) is approximately equivalent to 100–150 mg/day of oral tramadol. Buprenorphine patches may therefore be suitable for people who require low doses of opioids.¹⁴ For some patients, starting on a low dose of an oral opioid with a wider

range of available strengths will provide greater flexibility to titrate to effect.

Like other opioids, buprenorphine produces a range of typical opioid adverse effects (including nausea, vomiting constipation, somnolence, dizziness).²¹ Respiratory depression seems less likely with buprenorphine than with full opioid agonists (in the absence of other concomitantly administered CNS depressants), but cannot be ruled out.²¹

Because buprenorphine is a partial agonist, there is a possibility that it may precipitate withdrawal symptoms including pain in those on regular maintenance with other opioids.¹⁴ It is thought that this is unlikely to occur at the low doses of buprenorphine found in patches, compared with doses of buprenorphine in sublingual formulations used in the treatment of opioid dependence, but evidence for this is lacking.

Fentanyl patches not for opioid-naïve patients

Fentanyl patches are an option for people with stable severe chronic pain and established opioid needs. They are not appropriate for opioid-naïve patients because of the risk of toxicity including fatal respiratory depression.^{14,20}

Fentanyl is a highly potent opioid. Start with the lowest possible strength fentanyl patch based on the patient's current 24-hour opioid requirements and clinical status and titrate to response. Fentanyl patches are usually changed every 72 hours. If required, increase the dose at 3-day intervals using the 12 microgram/hour or 25 microgram/hour patch. Some sources however caution against exceeding fentanyl 25 microgram/hour (applied every three days) in chronic pain without seeking specialist advice.^{3,6} Only one patch should usually be worn at a time; however more than one patch may be required to reach a dose that cannot be achieved using a single patch.²⁰

GPs should refer to a reliable resource (for example Australian Medicines Handbook, Therapeutic Guidelines) for equianalgesic doses before switching from one opioid to another. It is generally recommended to switch to approximately one-half of the calculated equianalgesic dose to allow for incomplete cross-tolerance.¹⁴

For more information about fentanyl and buprenorphine patches for see the full NPS RADAR reviews www.nps.org.au/nps_radar/fentanyl_patches and www.nps.org.au/nps_radar/buprenorphine.

Managing breakthrough pain

Breakthrough pain (pain flares) is an exacerbation of chronic pain otherwise stabilised on round-the-clock analgesia.⁴

Consider the possible causes of breakthrough pain, including inadequate medication or poor adherence.⁴ Patients reporting repeated episodes of breakthrough pain should have a thorough review of their medicines and treatment plan. It may be necessary to address breakthrough pain by adjusting regular baseline opioid doses. However, also ensure that patients are realistic about the goals of treatment (complete pain relief is rare). Encourage them to consider non-pharmacological and

non-opioid options (for example, paracetamol) for relieving breakthrough pain.^{4,10,14}

As a general rule, and in contrast to the recommendations for cancer pain, short-acting opioids should not be used 'as-needed' for breakthrough pain.^{1,6,10,19} Minimal use of short-acting opioids may be necessary if all other approaches are unsuitable or provide inadequate pain relief. Frequent follow up of these patients is required.¹⁰

For links to online materials go to www.nps.org.au/news_69

Expert reviewers

Dr Chris Hayes
Director of Hunter Integrated Pain Service (HIPS), John Hunter Hospital, Newcastle NSW

Assoc Prof Roger Goucke
Head, Department of Pain Management
Sir Charles Gairdner Hospital
Clinical Associate Professor
School of Medicine and Pharmacology,
University of Western Australia

Other reviewers are listed
at www.nps.org.au/news_69

Any correspondence regarding content should be directed to NPS. Declarations of conflicts of interest have been sought from all reviewers. The opinions expressed do not necessarily represent those of the reviewers.

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National Prescribing Service Limited (NPS) is an independent, not-for-profit organisation for quality use of medicines.
NPS is funded by the Australian Government Department of Health and Ageing.

ABN 61 082 034 393 | Level 7/418A Elizabeth Street Surry Hills NSW 2010 | PO Box 1147 Strawberry Hills NSW 2012
Phone: 02 8217 8700 | Fax: 02 9211 7578 | email: info@nps.org.au | web: www.nps.org.au