

Clinical audit: Review of opioid prescribing in chronic pain

Improving clinical practice for better patient health

How are you managing your patients prescribed an opioid for chronic non-cancer pain?

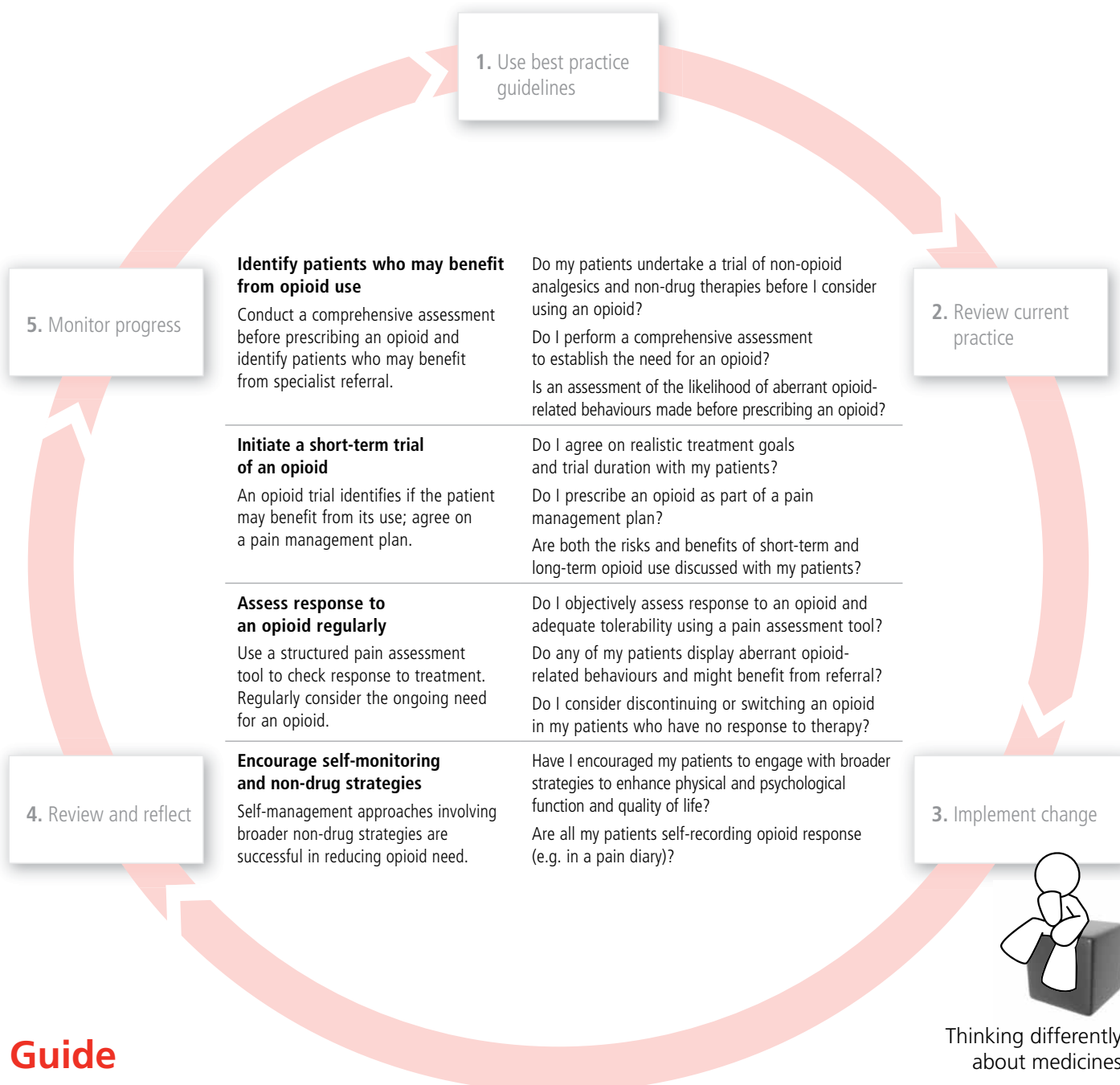
Include 15 adult patients (>18 years) who are prescribed an opioid (excluding tramadol), including codeine-containing analgesics, for chronic non-cancer pain (either an initial prescription or ongoing supply).

Exclude patients receiving palliative care, with migraine only, with a history of substance misuse or addiction, or prescribed tramadol.

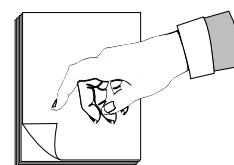
This clinical audit activity has been approved by the RACGP QA&CPD Program, total points for steps 1-5: 40 (Category 1), and by the ACRRM PD Program for 30 points (extended skills) for the 2008-2010 triennium. Points are awarded only to participants who complete the review phase.

This audit is recognised for the Quality Prescribing Initiative of the Practice Incentives Program (May 2010 to April 2011).

Best practice for the use of an opioid for chronic non-cancer pain



Notes for the clinical audit



Additional information to assist you to review your management.

Identify 15 patients prospectively as they present or retrospectively from a search of your medical records who:

- are older than 18 years
- have chronic (≥ 3 months) non-cancer pain
- are prescribed an opioid (either an initial prescription or ongoing supply), including codeine-containing analgesics, for ongoing management of chronic non-cancer pain.

Exclude patients:

- receiving palliative care
- with migraine pain alone
- with a history of substance misuse or addiction
- prescribed tramadol.

Patients should be aware that your practice participates in quality assurance activities; display the poster *Quality assurance in this practice and your privacy* and make available the patient information leaflet *Your health records and NPS clinical audits*.

Complete one double-sided audit form for each patient.

It is estimated that between 10% to 20% of Australians experience chronic (persistent) non-cancer pain, with an increasing number of people being prescribed opioids for this condition.^{1,2} Opioids should be reserved for chronic pain unresponsive to other drug and non-drug therapies, coupled with clear treatment goals and regular review to determine response to therapy and continued need.²⁻⁸

Identify patients who may benefit from opioid use

Perform a thorough history and physical examination

A formal assessment before considering opioid use helps in deciding whether an imaging test is indicated, and identifying patients at risk of aberrant opioid-related behaviours.

Conduct a comprehensive assessment before opioid use

Undertake and document a comprehensive assessment that includes a history and physical examination. This establishes the need for opioid therapy and the likely balance of benefit and harm^{2,5-7,9} and whether investigations such as imaging tests are indicated.¹⁰ In some cases imaging is unnecessary and contrary to recommendations in well-established guidelines.^{11,12}

Do not prescribe opioids unless the patient is known to you and there is an understanding of the patient's psychosocial situation.⁶

A thorough physical, psychological and social assessment of the patient should also include:

- pain history and assessment, including impact on quality of life
- current level of function
- mental health diagnoses
- social interactions.^{2,5,6}

A structured pain assessment tool (e.g. Brief Pain Inventory see www.nps.org.au/opioids) can be useful to consistently measure progress over time (see section – *Ongoing review for opioid use*) and should consider pain assessment as well as functioning levels.^{2,5}

Don't use imaging in routine evaluation of patients with non-specific low back pain

Check for 'red flag' indicators of potentially serious underlying conditions (Table 1) based on patient history and physical examination in patients with non-specific low back pain.¹⁰ Imaging in the absence of these features is not routinely recommended in Australian guidelines for **acute** (< 6 weeks) and **sub-acute** (6–12 weeks) non-specific low back pain as it is unlikely to improve patient outcomes or alter clinical decision making.^{10,13,14} Evidence suggest that this advice is also true in the early management of chronic non-specific low back pain of less than 12 months duration.^{15,16} There may be a poor correlation between symptoms, pathology and radiological appearances.^{2,13,17}

Discuss with patients their concerns about the possible cause of their low back pain, and the likely risks and benefits of imaging. Unnecessary X-ray and CT scans expose patients to unnecessary radiation doses (e.g. a lumbar spine CT scan may deliver a dose of radiation equivalent to 165 chest X-rays).¹⁷

Reduce risk of aberrant opioid-related behaviours

Screen patients to predict aberrant opioid-related behaviours before beginning long-term opioids to reduce this risk.^{2,5}

Consider any social, psychological or work-related factors that may indicate increased potential for misuse, addiction or diversion of opioids ('unsanctioned use') including:

- personal or family history of alcohol and/or drug dependence
- young age (< 35 years)
- non-specific long-standing chronic pain syndromes
- comorbid psychiatric or psychological disorders.^{2,6,9}

Contact the Australian Prescription Shopping Information Service¹⁸ and seek specialist advice in those with a high risk of aberrant opioid-related behaviours.⁹

Ensure previous adequate trial of non-opioid and non-drug therapies

Use an opioid only after the failure of established drug and non-drug therapies in patients with chronic pain that interferes with their function and quality of life.^{2,5-7,9}

Managing chronic pain involves a combination of drug and non-drug strategies. Before trialling opioid therapy ensure an adequate trial of:

- non-drug therapy, either physical and/or psychological
- non-opioid analgesics (e.g. 2–4 weeks of optimal dose paracetamol ± NSAID)
- other appropriate drug therapies (e.g. antidepressants and anticonvulsants in neuropathic pain).^{6,9}

Recognise those patients that may benefit from specialist referral

Consider seeking advice from a specialist or an experienced colleague when treatment is outside your expertise. See Box 1 for other circumstances under which specialist advice should be sought.^{5,6}

Box 1: Considerations for specialist referral^{5,6}

- relatively young patient (e.g. < 35 years old)
- indeterminate pathology
- comorbid psychiatric or psychological disorder
- previous or current opioid or other substance use disorder
- no improvement in pain or functioning despite high doses of opioid prescribed (e.g. > 100–120 mg/day of morphine or equivalent)
- large increases in opioid dose over a short period of time
- regular use of both short- and long-acting opioids
- regular use of injectable or short-acting opioids alone
- aberrant opioid-related behaviours (See Box 3)

Table 1: 'Red flags'—indicators of potential serious conditions associated with acute low back pain¹⁰

Serious condition	Alerting feature or risk factor ('red flag') associated with condition
Infection	Symptoms of infection (e.g. fever) Risk factors for spinal infection (e.g. underlying disease, immunosuppression, penetrating wound, intravenous drug use)
Fracture	Major trauma Minor trauma (if age > 50 years, history of osteoporosis and/or taking corticosteroids)
Malignancy	History of malignancy Age > 50 years Unexplained weight loss (e.g. > 4.5 kg in < 6 months) Pain at multiple sites Pain at rest
Aortic aneurysm, leak or rupture	Sudden onset Associated collapse/hypotension Pain not aggravated by spinal movement Abdominal pain radiating to back
Cauda equina syndrome	Saddle anaesthesia Urinary and/or faecal incontinence or retention of recent onset Widespread motor and/or sensory weakness

Initiate a short-term trial of an opioid

Evidence for longer-term use of opioids in chronic pain is currently lacking. Opioids offer modest efficacy in the short-term treatment (up to 3–6 months) of chronic pain^{3,4}, although patient selection and outcome measures are not clearly defined in the literature.

Initiate an opioid as part of a pain management plan

The main goals of opioid therapy in chronic pain are to improve function and quality of life.^{5,6,8,19} Opioids should always be prescribed as part of a comprehensive pain management plan tailored to agreed treatment goals.

Involve the patient in the development and implementation of a pain management plan.^{19,20} Documented pain management plans (Box 2) support a consistent approach to care and should include patient education, self management and physical and psychological therapies.²¹ You can find the *My pain management plan* template at: www.nps.org.au/opioids

Start an opioid on a trial basis

Gain agreement from the patient for the use an opioid and a suitable trial duration.

Trial opioids for 2–6 weeks to establish the effectiveness and tolerability and the appropriate drug and dose as some pain types are poorly responsive or non-responsive to opioids (e.g. neuropathic pain) and it is impossible to predict individual responses to opioids.^{6,8,9,22,23}

Discuss with the patient and agree realistic treatment goals (e.g. walking to the shops, improved sleep, returning to work) and criteria for continued opioid use from the outset.^{2,5-7,20,24} Check that the patient understands that this is a trial and unless there is evidence of improved function, pain relief or quality of life, without undue adverse effects, the medication may be discontinued.⁶

A more formal opioid agreement ('contract') outlining the terms and conditions for continued opioid prescribing is often suggested in those patients unlikely to follow an agreed treatment plan for whom you consider an upfront exit strategy to be useful.^{1-3,5,24}

Only one doctor should routinely prescribe and assess the patient's response to opioid therapy.^{2,5}

Box 2: Components of a pain management plan^{2,5,7,8,20,24}

- agreed treatment goals
 - specific targets for physical, psychological or social functioning
 - use of drug and non-drug strategies
- a timeline for achieving treatment goals
- an alternative strategy if treatment goals are not achieved
- names, doses and frequency of prescribed opioids and other analgesics
 - include any 'prn' doses or strategies for managing 'breakthrough' pain
- follow-up appointments to review progress.

Opioid drug therapy

Use long-acting opioids at regular intervals, rather than short-acting opioids for the treatment of chronic pain (Table 2).^{2,5,6,8,21}

Starting opioid treatment

Some guidelines^{6,24} recommend using a short-acting opioid to establish daily requirements, but starting with a low dose of a long-acting opioid appears to be increasingly accepted for most patients.

Begin with a low-dose (e.g. modified-release morphine 5–20 mg twice daily or modified-release oxycodone 5–10 mg twice daily).^{5-9,24} Titrate slowly to minimise adverse effects.^{5-9,24} Use lower doses for opioid naïve or older patients.^{5-9,24} Slower dose titration is also recommended for frail patients.^{7,24}

Review response to dose and therapy weekly at first and then monthly in the trial and maintenance periods.⁹ Final dose should provide adequate analgesia and satisfactory functioning without undue adverse effects.²⁴

Which opioid?

Use long-acting opioids wherever possible.²¹ Modified-release morphine and oxycodone are suitable options.

Morphine and oxycodone

If suitable, use the range of modified-release formulations of morphine or oxycodone to allow for flexible dosing.⁹ Oxycodone (with dose modification) may be more suited in those with mild-to-moderate renal impairment e.g. in older patients.⁹

Transdermal opioids ('patches')

Patches are suitable for patients with relatively stable chronic pain, who are unable to take oral medicines.⁹

Patches are unsuitable for acute pain and fluctuating analgesic needs due to their slow onset of action, long duration of effect and relatively inflexible dosage.⁹

Do not use **fentanyl patches** in opioid naïve patients because there is an increased risk of toxicity including fatal respiratory depression.⁹ They have a role in those who are unable to take or are intolerant of other opioids or have severe renal impairment.

Buprenorphine patches may be a suitable option for patients who require low doses of opioids (the highest strength patch [20 microgram/hour] is equivalent to 100–150 mg/day oral tramadol, with a maximum recommended dose of 40 microgram/hour i.e. 2 patches), especially in those with swallowing difficulties.⁹

Methadone

Prescribe for methadone patients with chronic pain only if you are experienced in its use as it has a variable and long elimination half-life (15–60 hrs), potential drug interactions (especially with drugs that prolong the QT interval) and can take up to 2 weeks to reach steady state levels.^{6,9}

Table 2: Comparison of short- and long-acting opioids preparations^{2,6,8,9}

Drug	Formulation*	Brand	Duration of action	Suggested recommended ceiling dosage
Short-acting opioids				
codeine	liquid, tablet	Actacode	3–4 hrs	240 mg daily
dextropropoxyphene	capsule	Doloxene	4–6 hrs	600 mg daily
hydromorphone	liquid, tablet	Dilaudid	2–4 hrs	16 mg daily
morphine	liquid, tablet	Anamorph, Ordine, Sevredol	2–3 hrs	100–120 mg daily
oxycodone	capsule, liquid, tablet	Endone, Oxynorm	3–4 hrs	80 mg daily
	suppository	Proladone	uncertain	
tramadol [†]	oral drops, capsule	Lodam, Tramal, Tramedo, Zydol	3–6 hrs	400 mg daily 300 mg daily, if age > 75 years
Long-acting opioids				
buprenorphine	patch	Norspan	7 days	40 microgram/hr weekly
fentanyl	patch	Durogesic	72 hrs	25 microgram/hr every three days
hydromorphone	modified-release tablet	Jurnista	24 hrs	16 mg daily
methadone	liquid, tablet	Biodone Forte, Physeptone	6–8 hrs initially, then increases with chronic dosing up to > 24 hrs	40 mg daily
morphine	modified-release: capsule, suspension, tablet	Kapanol, Momex, MS Contin, MS Mono	12–24 hrs	100–120 mg daily
oxycodone	modified-release tablet	Oxycontin	12–24 hrs	80 mg daily
tramadol [†]	modified-release tablet	Durotram, Tramal, Tramahexal, Tramedo, Zydol	12–24 hrs	400 mg daily

* Modified-release products are either controlled-release or sustained-release (slow-release) preparations.

† Patients prescribed tramadol are excluded from this audit.

Opioid drug therapy (continued...)

Codeine

Codeine is short-acting and has a limited role in the management of chronic pain.^{8,20,21} Codeine is an ineffective analgesic in patients who are poor metabolisers of codeine to morphine but can still cause adverse effects.⁹ Whereas ultra-rapid metabolisers may achieve higher morphine concentrations, increasing their risk of toxicity.⁹

Doses of at least 30 mg of codeine are usually given at 4–6 hours if used regularly and combination products containing lower doses are unlikely to be more effective than paracetamol alone.^{9,21}

Pethidine

Do not prescribe pethidine for chronic pain as it has a short duration of action, greater misuse potential and is no more effective than other opioids.^{6,9,22} Pethidine metabolises to norpethidine, which can cause seizures especially in renal impairment.⁶

Dextropropoxyphene

Avoid using dextropropoxyphene alone (Doloxene) or in combination with paracetamol (Capadex, Di-Gesic, Paradex) as this is no more effective than paracetamol alone and has a greater risk of adverse effects.^{25,26}

Patient advice

Explain to the patient all the possible benefits and harms of opioid therapy. Advise the patient on:

- planned duration of opioid therapy
- realistic expectation of benefit (usually 20% to 30% pain reduction, some improvement in function)
- reasons an opioid may be ceased
 - lack of pain relief, intolerable adverse effects, aberrant opioid-related behaviours
- safe use, storage and disposal of opioids
- likely adverse effects (Table 3)
- risk of tolerance and dependence over time, misuse and addiction
- risks associated with driving or operating machinery after initiation and dose titration.^{2,6,9,20}

Available patient leaflets include:

- *Chronic pain – what can I do?* at: www.nps.org.au/factsheets
- *Using opioid medicines for your chronic pain* at: www.nps.org.au/opioids

Ongoing review of opioid use

Continue in patients who benefit from use and limit duration

Determine a positive response to an opioid trial before progressing to maintenance therapy.^{2,6,9} Limit the maintenance opioid therapy to 3–6 months, with the expectation that the opioid will be gradually tapered.⁹ The limited time period should encourage the patient to develop their own self-management strategies and engage with broader therapeutic strategies.⁹

Involve other members of the multidisciplinary team such as physical therapist, occupational therapist, psychologist, social worker and rehabilitation counsellor in any pain management plan.^{8,20}

Patients may be eligible for a GP management plan (including a pain management plan) or a Team Care Arrangement under the Medicare Benefits Scheme. Also consider a Home Medicines Review.

Regularly reassess ongoing need

Use a structured pain assessment tool, such as the Brief Pain Inventory (see www.nps.org.au/opioids), which considers both pain assessment and functioning levels.^{2,6,9} Review at least monthly in the first instance until the patient is either stabilised on an opioid dose or has discontinued treatment.^{2,9}

Expect that many patients may choose to cease therapy due to lack of response or adverse effects.⁸ Consider the 6 A's at each review.

Analgesia

Pain is subjective and cannot be measured directly; self-report is the gold standard.^{6,9} Assess pain location, radiation, quality, what makes the pain better or worse, severity, timing and how the patient understands their pain.⁶ Using a pain rating scale (e.g. the visual-analogue scale, numerical scale) facilitates a way of monitoring pain intensity and treatment response.⁶

Activity

Consider both physical and psychological function measures such as interference of pain with daily activity, mood, sleep patterns, relationships with others, and physical ability in order to assess the patient's quality of life.^{2,5,6,9}

Adverse effects

Discuss likely adverse effects (Table 3) with patients and how they can be managed. Adverse effects with opioids are common and sometimes persistent. Other adverse effects are transient such as dizziness, nausea and vomiting, drowsiness and confusion.^{6,7,9}

Table 3: Adverse effects of opioids^{6,7,9}

Common adverse effects	Adverse effects with long-term use
constipation	erectile dysfunction
dizziness	fluid retention
drowsiness	hyperalgesia
dry mouth	immunosuppression
dyspepsia	irregular periods
headache	low sex drive
itch	reduced fertility
nausea and vomiting	weight gain
orthostatic hypotension	
urinary retention	

Aberrant opioid-related behaviours

Check for actions that demonstrate aberrant opioid-related behaviours at every visit (Box 3).⁵ Discuss patient management with a pain specialist or the drug and alcohol service if needed.

Affect

Check on the mood of the patient at every visit and manage any mental health issues, including depression.^{5,8,20}

Accurate records

Document all medicines used, as well as adherence and response to therapy.⁸ Only one doctor should routinely prescribe and assess the patient's response to opioid therapy.^{2,5} Remain vigilant for requests for the replacement of lost prescriptions and other signs of aberrant opioid-related behaviours.^{5,8}

Encourage patient self-report of response to opioid therapy

Encourage patients to keep a pain diary to help them better understand possible causes of pain and response to therapy and what they can do to help manage their pain.²¹ This can provide valuable information to clinicians, assist patients to monitor their response to therapy and allow patients to be actively engaged in their management.²¹ You can find *My pain diary* at: www.nps.org.au/opioids

Box 3: Aberrant opioid-related behaviours⁵

- deterioration in functioning at work, in the family, or socially
- concurrent misuse of alcohol or illicit drugs
- illegal activities e.g. selling medicine, forging prescriptions, stealing drugs from other patients, buying prescription drugs from non-medical sources
- injecting or snorting of medicine
- crushing modified-release preparations
- multiple episodes of "lost" or "stolen" prescriptions
- resistance to changes in treatment, regardless of adverse effects
- refusal to comply with random urine drug screens or referral to pain management specialists
- use of multiple GPs and pharmacists.

Consider discontinuation or switching of opioid therapy

Always consider discontinuing or reducing the opioid therapy as there is some evidence for self-management approaches for chronic pain typically involving opioid reduction, and there is no good evidence for long-term opioid use.^{2,4,27}

Discontinue the opioid if there is no improvement in functionality, pain reduction and/or intolerable adverse effects.^{2,5,6,9}

Taper the dose slowly to avoid withdrawal symptoms.^{6,9} Approaches to tapering range from a slow 10% reduction in dose every week, to a more rapid 25% to 50% reduction every few days.^{2,24}

If tolerance to an opioid is suspected, consider switching to another opioid.^{2,5}

Refer those patients identified as requiring specialist input or advice

Check for any aberrant opioid-related behaviours (Box 3)⁵ and consider having 'ceiling' doses for opioids (Table 2) which necessitates reassessment and probably specialist advice.^{2,5,8}

Consider other circumstances where specialist referral may be useful (Box 1).

Refer to specialist pain team or local drug and alcohol services, where possible, for the independent 12 month review of Schedule 8 opioids if long-term therapy is to be considered.⁵

Confidentiality and privacy

You must sign and date the **Submission cover sheet** to participate in this audit. By participating you agree to aggregation of your de-identified patient data and use of your personal data. Individual results of your clinical audit are kept confidential by NPS.

What will happen to your patient data

- Your de-identified patient data forms are scanned and returned to you.
- Your individual results are provided to you only.
- Your data are aggregated with those of other participants and the de-identified aggregate results:
 - are provided to all participants
 - may be used in NPS evaluation and reports
 - are provided to the RACGP and ACRRM.

The RACGP has advised that program information may be shared with researchers and interested general practitioners for the purpose of continuing education coordination at the discretion of the QA&CPD Program.

What will happen to your personal details

Your personal details:

- are provided to the mail house for processing
- are provided to the RACGP QA&CPD Program and/or ACRRM Professional Development Program for point allocation (if applicable)
- are recorded for the purpose of the PIP and NPS evaluation
- can be obtained from NPS by request in writing.

Individual clinical audit results will not be available after potentially identifying data are removed from NPS records at the close of the clinical audit cycle.

Please note: You are responsible for advising NPS of any changes of address during the audit cycle.

Further information

Contact NPS customer service (02) 8217 8700

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Using opioid medicines for your chronic pain

What is chronic pain?

Chronic pain is when pain occurs most days of the week, for at least three months. It is not always possible to completely relieve chronic pain, however it should be possible to reduce your pain to an acceptable level, improve your quality of life and increase your activity levels.

How do I assess my pain?

Many things can increase or decrease your pain levels. A pain diary can help you keep track of your pain and remember how things like medicines, your mood, stress and sleep patterns affect your pain levels. This information will help you and your healthcare team manage your pain better. See *My pain diary* at www.nps.org.au/opioids



What are opioid medicines?

Opioid medicines provide pain relief by imitating the body's natural pain reliever. They come in many forms including tablets, capsules, patches and liquids. Examples include: codeine (found in Panadeine and Nurofen Plus), fentanyl (Durogesic), morphine (MS Contin) and oxycodone (Oxycontin).

Opioid medicines are used to manage moderate to severe pain when other pain medicines are not suitable or do not provide enough pain relief.

Opioid medicines do not work for everyone or for all types of pain. To start with, your doctor may prescribe an opioid for 2–6 weeks to see if an opioid is suitable for you.

Are there side effects from opioid medicines?

Like all medicines, opioids have side effects. The side effects you experience may vary and will depend on the type of opioid and the dose you take.

Some side effects get better after a short time, but others last longer or can appear after long-term use. Talk to your doctor or pharmacist about how to manage side effects of opioid medicines.

Common side effects of opioid medicines

- confusion
- constipation
- dizziness
- drowsiness
- itching
- nausea
- sweating
- vomiting

What is a pain management plan?

A pain management plan is a written 'plan' developed by you and your healthcare team. It details your treatment goals to help manage your pain. Opioid medicines should be used as part of your pain management plan.



Talk to your healthcare team about developing a pain management plan for you. See *My pain management plan* at www.nps.org.au/opioids

Set achievable goals like...

- walking four times a week for half an hour
- hanging out the washing
- returning to work within the next two months.

Using opioid medicines for your chronic pain continued...

What else can I do to help manage my pain?

- Lead a healthy lifestyle (exercise regularly, get adequate sleep, eat a balanced diet).
- Arrange a support network that you can access when you need help (this may include family, friends or fellow pain sufferers).
- Learn skills to help cope with your pain (set priorities or use relaxation therapies).
- Take your medicines only as prescribed. Never try anyone else's medicine or give yours to them: it can be dangerous.
- Reward yourself for each positive step in the management of your pain.

Things to discuss with your doctor or pharmacist

- The details in the consumer medicines information (CMI) leaflet for your opioid medicine.
- An up-to-date list of any medicines that you are taking, including over-the-counter and herbal medicines.
- Any new medicines that you are going to take, to avoid interactions or overdose.
- If your opioid medicine is not working for you.
- Any problems that you experience with your opioid medicine (eg. side effects).

For more information

Visit our website (www.nps.org.au/consumers) for the following:

- Fact sheet, Chronic pain – what can I do?



- Medicines list, a sheet for you to record your medicines



- Medimate, to help you find, understand and use information about medicines (in 5 languages)



- Consumer medicines information (CMI), important facts about your medicines.

Record below any questions to ask your doctor or pharmacist at your next visit:

This leaflet has been provided to you by your doctor or pharmacist to help discuss the use of your medicines, and has been designed to be used with the consumer medicine information leaflet for your medicine.



Think differently about medicines

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My pain management plan



National Prescribing Service Limited

Patient name:	Initial pain assessment completed: / /
GP name:	Diagnosis:
GP contact details:	
After hours details:	

Goals of my pain management plan

Goals (e.g. walk three times a week for half an hour)	Review date	Comments (including date and progress)
1.		
2.		
3.		
4.		
5.		

Other health professionals assisting my pain management (e.g. physiotherapist)

Professional (type and details)	Goals of treatment	Action	Review date	Comments (including date and progress)

This leaflet may be printed for patient use.

May 2010

Pain medicines See Medicines List at www.nps.org.au/medicines_list

Name of medicine (prescription and over-the-counter)	Strength	What is the medicine for?	How much do I use and when?	Special instructions or comments (including date and progress)
1.				
2.				
3.				
4.				
5.				

Other ways to help manage my pain (non-medicine strategies)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

If my pain gets worse my doctor recommends

Non-medicine strategies

- _____
- _____

Medicines (include details as in the table above)

- _____
- _____

To help me manage my pain better (patient to fill out)

What makes my pain worse:

What makes my pain better:

Your patient code: Do not use patient name.
Use this to identify your patients for the Review Phase.

Use a **black biro** to mark a **cross (X)** in the box beside your response. If you make a mistake, use white correction fluid.



NPS office use only

Patient details

1. **Gender:** female male 2. **Age (years):** 18–34 35–50 51–65 ≥ 66

Diagnosis and assessment

3. **Does the patient have:** (Mark all that apply)

- | | |
|---|--|
| <input type="checkbox"/> neuropathic pain | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> visceral/organ pain |
| <input type="checkbox"/> other bone, hip, neck or spinal pain | <input type="checkbox"/> uncertain diagnosis |
| <input type="checkbox"/> post-operative pain | <input type="checkbox"/> not known |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> other _____ |

4. **How long has the patient had this episode of chronic pain?**

- 3–6 months > 6–12 months > 12 months not known

5. **Was a comprehensive assessment undertaken prior to initiating an opioid (see Guide p2)?**

- yes no not known

During the first 3 months of the acute presentation did the patient have any...

...‘red flags’ for serious conditions associated with acute back pain (see Guide p3)?

- yes no not known

...investigations? (Mark all that apply)

- none plain X-ray
 CT scan not known
 MRI other _____

i Check whether a patient has any ‘red flags’ (alerting features or risk factors) associated with a serious condition whenever presenting with acute low back pain to determine if further investigation is warranted.

Drug and non-drug management

6. **Did initiation of an opioid follow an adequate trial of non-drug therapy (i.e. physical or psychological therapy)?**

- yes no not known

7. **Current non-drug therapies:**

- | | |
|--|---|
| <input type="checkbox"/> none | <input type="checkbox"/> psychological therapies e.g. cognitive behavioural therapy |
| <input type="checkbox"/> physical therapies e.g. exercise, physiotherapy | |
| <input type="checkbox"/> not known | |
| <input type="checkbox"/> not possible | |

i Consider optimising or recommending non-drug therapies.

8. **Did initiation of an opioid follow an adequate trial of a non-opioid analgesic (i.e. optimal doses of regular paracetamol ± NSAID for 2–4 weeks)?**

- yes no not known

9. **Previous and current non-opioid drug(s) and tramadol used for ANALGESIA:** (Mark all that apply)

Which drug(s) are used? (include OTC, prescription and combination use)	Previous use	Current use
<input type="checkbox"/> none	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> paracetamol	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> conventional NSAID	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> COX-2 selective NSAID	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tramadol	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/> anticonvulsant	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tricyclic antidepressant	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> not known	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____	<input type="checkbox"/>	<input type="checkbox"/>

* Patients currently prescribed tramadol are excluded from this audit.

10. **Current opioid(s) used for ANALGESIA (including fixed-dose combinations):** (Mark all that apply)

Which opioids(s) are used? (include OTC, prescription and combination use)	Route					Current dosing schedule		
	oral IR	oral MR	rectal	patch	injection	regularly each day	as needed	not known
<input type="checkbox"/> codeine ± non-opioid <input type="checkbox"/> codeine ≥ 30 mg/dose <input type="checkbox"/> codeine < 30 mg/dose	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> dextropropoxyphene ± paracetamol	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> buprenorphine	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fentanyl	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> hydromorphone	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> methadone	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> morphine	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> oxycodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> pethidine	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If using a patch, has the patient previously been prescribed or used an oral opioid?

- yes no
 not known

Abbreviations: IR = immediate release (includes buccal, lozenge and liquid preparations), MR = modified release (includes controlled- and sustained-release preparations).

11. **Current opioid initiated by:**

- myself another GP pain specialist / pain clinic rheumatologist other specialist not known other _____

Patient review and planned actions

12. Which of the following aspects of opioid treatment have been discussed with your patient? (Mark all that apply)

- none physical dependence with long-term use expected benefits not known
 adverse effects tolerance with long-term use misuse other _____
 addiction driving risk storage and disposal

13. Was the prescription:

a new prescription
(i.e. initial supply)

OR

ongoing supply
(i.e. maintenance therapy)

What duration of therapy was prescribed?

- ≤ 2 weeks > 4 weeks
 > 2–4 weeks

How long has the patient been using an opioid for this current condition?

- ≤ 1 month > 3–6 months > 12 months
 > 1–3 months > 6–12 months not known

Consider discontinuing or decreasing dose of opioid.

Did you and the patient agree to realistic treatment goals?

- yes no not known

Is there an agreed documented pain management plan outlining realistic treatment goals and timeframe?

- yes no not known

Initiate a pain management plan.

What duration of an opioid trial was agreed with the patient?

- none > 2–4 weeks > 6 weeks
 ≤ 2 weeks > 4–6 weeks not known

Was an initial opioid trial undertaken to assess response to opioid use before agreeing to maintenance therapy?

- yes no not known

When is the next review date?

- not set > 1–2 weeks > 4 weeks
 ≤ 1 week > 2–4 weeks

How often do you review response to opioid use?

- ≤ 1 month > 1–3 months > 3–6 months > 6 months not known

Did you assess patient risk for aberrant opioid behaviours (see Guide p7)?

- yes no not known

What regular objective assessments are made to determine response to opioid use?

- none function and activities social well being
 aberrant opioid behaviours mental health issues not known
 adverse effects pain control other _____

Use a pain assessment tool to assess response.

Does the patient regularly self-record response to opioid use (e.g. a pain diary)?

- yes no not known

Recommend a pain diary.

Has the patient been assessed for adverse effects (see Guide p6)?

- yes no not known

Has there been adequate tolerability and response (i.e. improvement in function and pain control) to an opioid?

- yes no not known

Consider discontinuing, decreasing or switching opioid.

Planned action(s) for opioid use:

- assess for aberrant opioid behaviours
 assess response to opioid use and determine whether to continue therapy
 other _____

Planned action(s) for opioid use:

- none decrease opioid dose switch opioid
 continue current opioid discontinue opioid slowly assess for aberrant opioid behaviours
 change route/formulation of opioid increase opioid dose other _____

Further planned action(s):

- none recommend non-drug therapies initiate pain management plan refer for Home Medicines Review (HMR)
 continue current therapy treat mood/anxiety disorder recommend a pain diary other _____
 optimise non-drug therapies add analgesic use a pain assessment tool

14. Patient factors that may require specialist advice or referral (see Guide p3): (Mark all that apply)

- none patient aged < 35 years treated only with injectable or short-acting opioid
 aberrant opioid behaviours previous/current opioid or substance abuse waiting for surgery
 co-prescribed regular short- and long-acting opioids psychiatric/psychological disorder not known
 high dose of opioid recent large increases in opioid dose other _____
 indeterminate pathology

Patient referral for specialist review?

- completed
 planned
 no referral
 not known