NPS
National Prescribing Service Limited

Opioids and chronic pain

PRESCRIBING PRACTICE REVIEW: PPR51

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Opioids in chronic non-cancer pain: use a planned approach

KEY MESSAGES

- Perform a thorough history and physical examination to determine if investigations are necessary
- Prescribe an opioid only as part of an agreed pain management plan
- Initiate an opioid as a short-term therapeutic trial
- Continue an opioid only in those who demonstrate benefit from a trial and reassess regularly the need for ongoing therapy
- Discuss options for managing breakthrough pain

Determine if investigations are necessary

Managing chronic (persistent) non-cancer pain involves a combination of non-pharmacological and pharmacological approaches. Opioids are an option for chronic pain as part of an overall management strategy when other treatments (including paracetamol at adequate doses, or NSAIDs) are unsuitable or provide inadequate pain relief.[1-4]

Conduct a comprehensive patient assessment that includes a thorough history and physical examination before deciding whether investigations such as imaging tests are indicated.[5] In some cases imaging is unnecessary and contrary to recommendations in guidelines.[6,7]

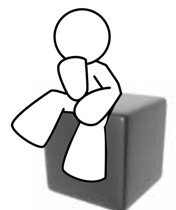
Multidimensional assessment, including a thorough history, physical, psychological and social assessment assists in the development of a comprehensive pain management plan which may or may not include an opioid.[3] Pain assessment can help identify patients likely to benefit from non-drug approaches such as physical therapies or cognitive and behavioural strategies to help manage their pain.

Avoid imaging in routine evaluation of patients with non-specific low back pain

Check for 'red flag' indicators of potentially serious underlying conditions (for example, signs of infection, fracture, malignancy, cauda equina syndrome) based on history and physical examination.[5] Imaging in the absence of these features is not routinely recommended in non-specific low back pain (lasting up to 12 months) and there is no clear evidence that it improves patient outcomes or alters clinical-decision-making.[5,8-12] Reasons for inappropriate use of diagnostic imaging for low back pain may include real and perceived patient expectations, misconceptions by both health professionals and patients about the usefulness of imaging tests, and fear of litigation.[7]

There may be a poor correlation between structural changes found on diagnostic imaging and the experience of pain.[3,10,12] Discuss with patients their concerns about the possible cause of their back pain, and the likely benefits and risks of imaging. Unnecessary X-ray and CT scanning exposes patients to unnecessary doses of ionising radiation.[12] For example, a lumbar spine CT scan may deliver a dose of radiation equivalent to 165 chest X-rays.[12]

A clinical decision support tool that includes diagnostic imaging pathways for health professionals and consumer information is available at www.imagingpathways.health.wa.gov.au



Thinking differently about medicines

Prescribe as part of an agreed pain management plan

Encourage patients to take an active role in developing a pain management plan (see Box 1) tailored to their specific treatment goals. Help patients set realistic, measurable treatment goals (for example, walking to the shops, returning to part-time work or sleeping better) and an evaluation timeframe.[3,13,14] A pain management plan template ('My pain management plan') can be found at www.nps.org.au/opioids

Keeping a pain diary may help some patients to better understand their pain, how it affects their lifestyle and what they can do to improve its management.[15] A pain diary can be a tool for communicating with health professionals the effects of pain, its daily fluctuations and the effectiveness of pain-relieving strategies. A pain diary ('My pain diary') can be found at www.nps.org.au/opioids

Important information for patients starting an opioid

Inform patients about the goals, possible risks and benefits of opioids before prescribing.[3,13,14,16] Explain that complete pain relief is unlikely, but that some improvement in function is expected.[1,3] It is important to discuss with patients the possible adverse effects of opioids and how they can be managed. In trials, adverse effects were a common cause of early discontinuation of opioids.[17]

Explain circumstances for which opioid prescribing may be withdrawn—for example, inadequate pain relief, intolerable adverse effects, worsening of the patient's condition, or unsanctioned (problematic or illicit) use. A written treatment agreement ('contract') outlining the terms and conditions for continued opioid prescribing may be considered, particularly for patients unlikely to follow an agreed treatment plan.[1,3,13,14]

Consider seeking advice from a specialist pain service or experienced colleague before prescribing an opioid, especially for patients who lack a defined diagnosis or basis for pain, or where there is a high risk of unsanctioned use.[1,3] Where indicated, refer to an appropriate specialist for advice on managing identified underlying causes of pain (for example rheumatoid arthritis).

Box 1: Details to include in a pain management plan[3,13,14,18]

- agreed treatment goals (including specific targets for physical, psychological or social functioning), an evaluation timeframe and alternative strategies if goals are not met
- names, doses and frequency of prescribed opioid and other analgesics
- clearly written instructions about how to manage breakthrough pain/pain flares, especially 'after hours'
- expectations about non-drug strategies for improving physical, psychological and social functioning
- follow-up appointments to review progress.

Trial opioids short-term initially

Start an opioid as a short-term therapeutic trial (for example, 2–6 weeks) including regular review (for example, weekly) to assess response and adverse effects.[3,14,19] The decision to proceed with ongoing prescribing is contingent on the outcomes of the trial and pre-set treatment goals.

Individualise the choice of opioid, initial dose and titration schedule

Choose between different opioids, initial dose and titration schedule based on the patient's health, age, past experience with opioids and response. Consider also your familiarity with an opioid, its availability, range of strengths and cost.[14,19] A long-acting/modified-release opioid administered at regular intervals is usually recommended for chronic pain.[1-4,13,19] In some cases it may be appropriate to start with a short-acting opioid preparation to establish total daily requirements[2,14], but many patients can start with a low-dose long-acting opioid.

Codeine is a short-acting weak opioid and has a limited role in managing chronic pain.[3,20] Transdermal opioids (patches) are an alternative to oral opioids for stable chronic pain, especially for people unable to take oral medications. Avoid fentanyl patches in opioid-naïve patients because there is a risk of toxicity including fatal respiratory depression.[19,21] Avoid injectable opioids in managing chronic pain.[16]

Start with a low dose and titrate slowly

Start with a low dose (for example, modified-release morphine 5–20 mg twice daily or modified-release oxycodone 5–10 mg twice daily) and titrate slowly to reduce the risk of adverse effects.[14,16,22-24] Choose a dose at the lower end of the range for opioid naïve and elderly patients.[22] Lower starting doses and slower dose titration are recommended for frail patients.[14,24]

The dose of a long-acting opioid may need to be titrated upwards 2 or 3 times if tolerated before measureable pain relief is achieved.[16] If useful pain relief is not achieved despite reasonable dose titration, or if adverse effects are intolerable, consider gradually withdrawing the opioid (over 1–2 weeks) to minimise withdrawal symptoms, and seek specialist advice.[3,16,19]

Seek specialist advice for patients requiring ongoing escalation of opioid doses

Do not exceed suggested maximum daily doses of long-acting opioids in chronic non-cancer pain (for example, morphine 100–120 mg, oxycodone 80 mg) without specialist advice.[1,3,4] Suggested maximum daily doses of opioids that GPs should not exceed without specialist advice are available from several sources. See an example on the Hunter New England Area Health Service site (link available through www.nps.org.au/ppr_51).

If continuing opioids — reassess regularly

Consider an opioid for chronic pain as an interim measure. For patients who benefit from a trial and wish to continue, agree on a time limit for ongoing prescribing (3–6 months is suggested) and encourage use of non-drug strategies to improve pain and function.[3] Assess progress at regular intervals (for example, monthly) for patients on a stable dose of an opioid.[3,16] Use a structured pain assessment tool (such as the Brief Pain Inventory [BPI]) at baseline, and regularly during treatment to document pain intensity, the impact of pain on the patient's functioning, and response to treatment.[1,3] You can access a copy of the BPI at www.nps.org.au/opioids

Have a plan in place to stop the opioid if the underlying condition resolves or receives definitive treatment, if the patient no longer benefits from an opioid or has intolerable adverse effects, or if there is evidence of unsanctioned use. Periodic dose tapering or stopping may be useful to confirm ongoing effectiveness of an opioid.[16]

Review by a second doctor is required for Pharmaceutical Benefits Scheme prescription of an opioid beyond 12 months.[3]

Options for managing breakthrough pain

Use a pain management plan to discuss and document strategies for dealing with short-lived exacerbations of chronic pain otherwise stabilised by 'round-the-clock' analgesia (often known as breakthrough pain or pain flares).[18] Encourage patients to be realistic about the goals of treatment and to use non-opioid drug and non-drug approaches for managing breakthrough pain (for example, pacing their activities, taking regular short breaks during activities likely to cause incident pain, practicing relaxation techniques rather than taking more medicines). Assess possible causes of breakthrough pain including inadequate medication or poor adherence.[2,14] Conduct a thorough review of their medicines and treatment plan for patients who are experiencing repeated episodes of breakthrough pain; regular baseline doses of the long-acting opioid may need to be adjusted.[2,14]

If analgesia is required for breakthrough pain, use a non-opioid option where possible (for example, paracetamol or an NSAID). If all other approaches are unsuitable or provide inadequate relief, minimal use of a short-acting opioid may be warranted.[14]

Links to online citations available at www.nps.org.au/ppr_51

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References

1. Drug and Alcohol Services South Australia. Opioid prescription in chronic pain conditions - Guidelines for South Australian general practitioners (GP's). 2008. http://www.dassa.sa.gov.au/webdata/resources/files/Opioid_prescription_chronic_pain_guidelines_for_SA_GPs.pdf (accessed 3 May 2010).
2. Therapeutic Guidelines: Analgesics, 2007.
3. Hunter New England NSW Health. Pain matters: opioids in persistent pain. March 2010. http://www.hnehealth.nsw.gov.au/pain/health_professionals/medical_practice_guidelines (accessed 3 May 2010).
4. Cohen M L, Wodak A D. MedicineToday 2010;11:10–8.
5. National Health and Medical Research Council (NHMRC) National Institute of Clinical Studies (NICS) Emergency Care Community of Practice. Lumbar imaging in acute non-specific low back pain. A summary of best available evidence and information on current clinical practice. Emergency Care Evidence in Practice Series, 2008. http://www.nhmrc.gov.au/nics/material_resources/resources/emergency_care_lumbar.htm (accessed 3 May 2010).
6. Williams CM, et al. Arch Intern Med 2010;170:271–7.
7. National Institute of Clinical Studies. The Royal Australian and New Zealand College of Radiologists Quality Use of Diagnostic Imaging Program Project ES2 - Phase 1 Promoting public awareness of the appropriate use of diagnostic imaging. Melbourne, National Institute of Clinical Studies (NICS): March 2006. http://www.ranzcr.edu.au/documents/detail.cfm?ophileEntry=1025&ophileLibrary=29&ophileReturnpage=&llLetter=All (accessed 31 May 2010).
8. Kendrick D, et al. Health Technol Assess 2001;5:1–69.
9. Chou R, et al. Lancet 2009;373:463–72.
10. Goucke R, Schutze M. MedicineToday 2009;10:51–60.
11. National Institute for Health and Clinical Excellence. CG88 Low back pain: NICE guideline. May 2009. http://guidance.nice.org.uk/CG88/NiceGuidance/pdf/English (accessed 3 May 2010).
12. Government of Western Australia Department of Health. Diagnostic imaging pathways: A clinical decision support tool and educational resource for diagnostic imaging. 2009. http://www.imagingpathways.health.wa.gov.au/includes/index.html (accessed 3 May 2010).
13. Royal Australasian College of Physicians. Prescription opioid policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use. 2009. http://www.racp.edu.au/page/policy-and-advocacy/public-health-and-social-policy (accessed 3 May 2010).
14. Chou R, et al. J Pain 2009;10:113–30.
15. NSW Therapeutic Assessment Group. Migraine, what you can do? http://www.ciap.health.nsw.gov.au/nswtag/publications/guidelines/MigrainePt.pdf (accessed 3 May 2010).
16. British Pain Society. Opioids for persistent pain: Good practice. January 2010. http://www.britishpainsociety.org/pub_professional.htm#opioids (accessed 3 May 2010).
17. Noble M, et al. J Pain Symptom Manage 2008;35:214–28.
18. NSW Therapeutic Assessment Group. Rational use of opioids in chronic or recurrent non-malignant pain. General principles. 2002. http://www.ciap.health.nsw.gov.au/nswtag/guidelines.html (accessed 3 May 2010).
19. Australian Medicines Handbook, 2010.
20. Graziotti PJ, Goucke CR. Med J Aust 1997;167:30–4.
21. Janssen-Cilag Pty Ltd. Durogesic transdermal system product information. 6 January 2010.
22. Australian Medicines Handbook Pty Ltd. Personal communication. 13 May 2010.
23. Mundipharma Pty Limited. OxyContin tablets product information. 15 February 2010.
24. National Opioid Use Guideline Group. Canadian guideline for safe and effective use of opioids for chronic non-cancer pain. 2010. http://nationalpaincentre.mcmaster.ca/opioid/ (accessed 10 May 2010).

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