Prescribing opioids for chronic non-cancer pain

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Opioids are now widely used to treat chronic non-cancer pain (CNCP) in Australia but they frequently cause concern for patients, doctors, regulators and society in general. Despite guidelines and regulations it can be difficult to use opioids safely and effectively. Opioids are a high risk medication and best used as part of a comprehensive pain management plan. They are not a "set and forget" medication and require active management, including a willingness to cease them. With careful selection and management, opioids can benefit many patients with CNCP. These brief key points may help.

Opioids behave differently when used acutely; they are very effective for many types of pain and have well known side effects (e.g. nausea, respiratory depression, sedation etc). Chronically, they become less effective, typically providing only 30% reduction in pain intensity, and have new adverse effects including hormonal suppression, immune modulation, opioid-induced hyperalgesia, and addiction.

Some people are not suitable for opioid therapy – their pain is not opioid-sensitive, so do not feel pressured to prescribe opioids because it is "the only thing left". When contemplating an opioid for CNCP, consider these factors:

- Fully evaluate the pain problem, especially psychosocial factors; opioids may not be best for neuropathic pain or psychologically unstable patients.
- Maximise non-pharmacological and non-opioid therapy.
- Evaluate the risk of opioid misuse
  - Quick screening tools can be useful, such as the Opioid Risk Tool (see www.partnersagainstpain.com/printouts/Opioid_Risk_Tool.pdf) and the DIRE score (see www.hpime.org/Pain/D.I.R.E. Score - Patient Selection for Chronic Opioid Analgesia.pdf)
  - Ring Pharmaceutical Services Branch of the DoH (9222 4424) to check opioid script use and if they are a notified drug addict.
  - High risk patients should NOT have opioids commenced in general practice. They need specialist referral and management.

Having completed these things, a 1-2 month TRIAL of opioid therapy can be considered:

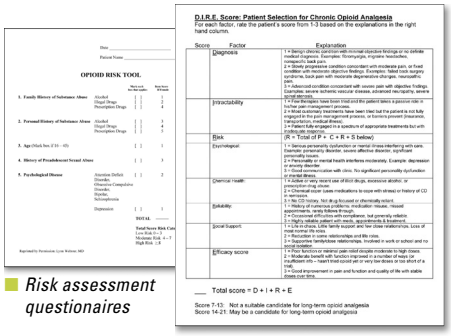
- Get *informed consent*: explain the risks, benefits, goals and alternatives.
- Give the patient *realistic expectations*: "This drug may reduce your pain by about 1/3 and is only a part of the overall treatment plan."
- Agree on a *functional* goal to be achieved during the trial (e.g. walking for 10 minutes every day); improved analgesia and reduction of other analgesics are mandatory goals.
- Explain the "rules" regarding opioids and sign a "contract" with the patient; WADoH has these available (see http://www.health.wa.gov.au/pharmacy/home/)
- Choose an opioid:
  - Use oral morphine or hydromorphone initially.
  - Start with short acting formulations to assess dose requirements.
  - After 1-2 weeks convert to long acting formulations.
  - Avoid oxycodone (it has unique properties that seem to make it more prone to abuse).
  - Do not use injectable opioids.
- Review frequently (see below)
- Titrate opioid to *maximum* of 120mg oral morphine equivalent per day (Table 1); aim for optimal balance between function and adverse effects.
- At the end of the trial, if goals are achieved without significant adverse effects then opioid therapy can continue. Otherwise, the trial has failed and opioids should be gradually withdrawn (see below).
- If ongoing therapy is to occur, apply for authority to prescribe from the Department of Health, and consider referral to a pain management specialist.

When reviewing patients on opioid therapy, consider the "4 A's":

- *Analgesia*: is it effective?
- *Activities* of daily living: Is the patient's function adequate or improving?
- *Adverse* events: ask about constipation, cognition, sexual function etc
- *Aberrant* drug-taking behaviours: these can point to potential misuse or abuse (see Table 2)

How to handle common problems:

- *Poor analgesia*: re-evaluate the diagnosis (?neuropathic pain, ?new pain, ?disease progression). Are psychosocial factors exacerbating the pain? Consider increasing the dose but not beyond 120mg oral morphine equivalents per day.
- *Breakthrough pain*: use non-opioid or non-drug treatments (do not give a supply of short acting opioids)
- *Poor function*: try reducing or increasing the dose (within the maximum)
- *Adverse effects*: laxatives for constipation; reduce opiod dose; rotate to another opioid (seek advice when doing this).
- *Rapid dose escalation above "maximum" doses*: often indicates patient is unsuitable (i.e. aberrant behaviour).
- *Aberrant behaviour*: highlight opioid contract "rules"; reduce dispensing interval (e.g. to weekly or daily); cease prescriptions and refer to pain management or addiction specialist.
- *Withdrawal symptoms*: reduce dose by 10% per fortnight to minimise symptoms; use clonidine, buscopan and diazepam as needed; seek specialist advice.



Risk assessment questionaires

Table 1. Suggested maximum daily doses of opioids

Morphine 120mg PO
Hydromorphone 24mg PO
Oxycodone 80mg PO
Fentanyl Patch 25 mcg/hr changed every 3 days
Buprenorphine Patch 40 mcg/hr changed every 3 days

Table 2. Aberrant drug related behaviours

More predictive features of addiction
• Selling prescription drugs
• Prescription forgery
• Stealing or borrowing drugs from others
• Injecting oral formulations
• Obtaining prescription drugs from non medical sources
• Concurrent abuse of alcohol or illicit drugs
• Multiple non sanctioned dose escalations
• Multiple episodes of prescription loss
• Repeatedly seeking prescriptions from other physicians or emergency departments without informing the prescriber or after warnings to desist
• Evidence of deterioration in function, at work, in the family, or socially that appear to be drug related
• Repeated resistance to therapy changes despite clear evidence of adverse physical or psychological effects from the drug
Less predictive features
• Aggressive complaining about the need for more drug
• Drug hoarding during periods of reduced symptoms
• Requesting specific drugs
• Openly acquiring similar drugs from other medical sources
• Unsanctioned dose escalation
• Unapproved use of the drug to treat other symptoms

Recommended reading

Graziotti PJ, Goucke CR. The use of oral opioids in patients with chronic non-malignant pain: management strategies. Available from The Australian Pain Society www.apsoc.org.au/public_position_papers.php

Chou R, Fanciullo GJ, Fine PG et al. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. The Journal of Pain 10(2):113-130, 2009. Available at www.ampainsoc.org/pub/cp_guidelines.htm