

Opioid Prescribing for Chronic Non-Malignant Pain Guidance for GPs on Opioid Prescribing in Primary Care

Local CCGs are outliers from the national average for strong opioid prescribing; EHS CCG is above the national average and H&R CCG is significantly above it. Opioid prescribing has been identified as a priority area for quality improvement.

Opioids provide good analgesia when used for acute and palliative pain, but there is little evidence of benefit in chronic pain. Patients with chronic pain prescribed a strong opioid should not expect complete pain relief; a reduction in pain of more than 30% is unlikely to be achieved. There needs to be a rational approach to analgesic prescribing, with realistic assessment of potential efficacy when considering medication. Efficacy should be considered to **comprise both improved pain and function**.

Chronic pain is difficult to treat with medication; opioids in particular are not very effective. The aim of management is empowerment of patients to self-manage pain **and increase function**. Chronic pain is complex; there should be an assessment of emotional and social influences (yellow flags; **APPENDIX 2**).

Non-pharmacological methods of managing chronic pain include increasing activity and physical fitness, physiotherapy, hot or cold pack application, transcutaneous electrical nerve stimulation (TENS), cognitive behavioural therapy (CBT) and meditation techniques such as mindfulness.

If patients taking opioids remain in pain and do not show improved function, they are not effective and should be stopped, even if there is no other drug treatment option. A small number of patients show significant functional improvement with an opioid when the dose is kept low and used intermittently.

Side effects are very common with opioid therapy; up to 80% of patients report at least one side effect. The most commonly experienced side effects include nausea, vomiting, constipation, pruritus, dizziness, dry mouth and sedation.

Constipation and sickness are not indications to switch to a different opioid; these side effects should be managed with laxatives and antiemetics. All patients prescribed regular strong opioids should be prescribed regular laxatives as tolerance to constipation does not develop with long-term use. Most patients will require a stimulant, such as bisacodyl (5–10 mg at night, increased if necessary to max. 20 mg at night), plus lactulose. Nausea and vomiting is most commonly experienced at initiation, with an antiemetic such as metoclopramide (10mg three times a day) usually only necessary for the first 4 or 5 days.

Long-term risks of opioid therapy include increased incidence of falls and fractures, daytime drowsiness, cognitive decline, endocrine abnormalities (amenorrhoea, erectile dysfunction, depression and fatigue), impaired immune response, opioid induced hyperalgesia, dependence, addiction, and social risks such as diversion.

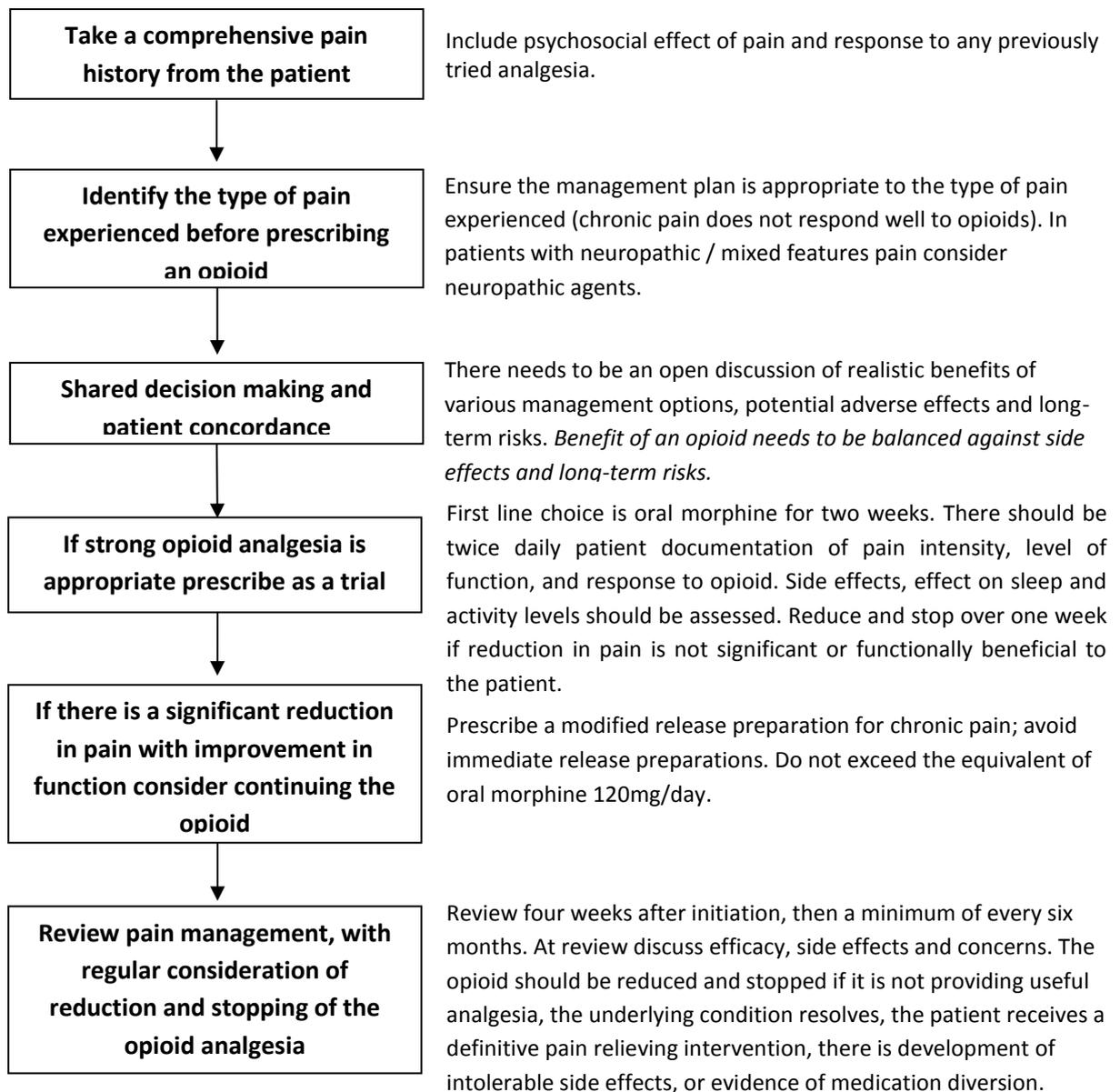
Oral morphine is the first-line strong opioid of choice; there is little evidence that one opioid is more effective and associated with fewer adverse effects than others.

The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, with no additional analgesic benefit; doses above this should not be prescribed. ***Patients on doses higher than this still require a slow reduction of opioid.***

Avoid liquid opioid preparations in patients with chronic pain; they are rapidly absorbed and metabolised, which can lead to tolerance and addiction.

A Structured Approach to Opioid Prescribing

<https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/structured-approach-to-prescribing>



Reducing and Stopping an Opioid

There needs to be an agreed outcome of opioid reduction, with an explanation of benefits of stopping an opioid. Patients and carers should be involved in decision making, with plans made for follow up. The patient needs to be monitored for pain, level of function, and signs of withdrawal while reducing their opioid.

Opioid induced hyperalgesia is a problem for some patients prescribed an opioid long-term. The only effective management is to decrease the dose of opioid, preferably to a stop.

Key Points

- Total daily opioid dose should be reduced gradually when patients have been prescribed a strong opioid for longer than two weeks.
- Patients prescribed oral oxycodone should be switched to the equivalent dose of oral morphine (when there are no contraindications to doing so).

- Patients should be reviewed after switching from oxycodone to morphine, to check tolerability. *Review can be via telephone.*
- Oxycodone is approximately twice as potent as morphine. When converting oxycodone to an equivalent morphine dose in elderly, frail, or renally impaired patients a lower than usual morphine dose should be prescribed.
- Oxycodone can be switched to a cautious equivalent (75% of usual equivalent) dose of morphine for reducing in patients with mild and stable renal impairment. Patients with severe renal impairment, a trend showing renal function is decreasing quickly, or when renal function is unstable should remain on oxycodone for opioid reduction.
- The total daily opioid dose can be reduced by 10% of the original dose weekly or two weekly.
- Patients should be reviewed every two weeks when reducing their opioid. *Review can be via telephone.*
- Do not use liquid opioid preparations when reducing; round to the nearest available strength of solid dosage form.
- Liquid opioid preparations are not to be used at the end of a reduction regime or for patients on a long-term low dose of opioid that are stopping. *Solid dosage form morphine 10mg MR twice daily can be reduced to solid dosage form 10mg MR once daily for five days and then stop.*

Transdermal Opioids

There is a trend of increased prescribing of transdermal opioids in both EHS and H&R CCGs despite there being no transdermal opioids available for general prescribing on the local formulary. It is accepted that opioid patches may have a limited role in patients with chronic pain who cannot take or tolerate oral opioid preparations, and there may be some very limited situations where local pain management specialist recommend their use. These prescribing scenarios do not however account for all of the current local transdermal opioid prescribing.

As with all long-term opioid prescribing it is recommended regular reviews of efficacy, appropriateness and adverse effects are undertaken. It is clinically appropriate to propose a trial withdrawal of transdermal opioids when these reviews are undertaken.

Considerations when Prescribing Transdermal Opioids

- Transdermal opioids lack the flexibility required when treating patients with fluctuating or uncontrolled pain.
- Prescribe by brand; there are significant differences in bioavailability of some transdermal opioids.
- Transdermal opioids have a slow onset and prolonged duration of action; drowsiness can be a problem.
- Heat exposure can cause increased opioid absorption, e.g. in febrile patients, when using electric blankets or heat pads, or with a warm bath.
- There is a risk of multiple patch application.
- Skin reactions occur in approximately 9% of patients prescribed transdermal opioids.
- Used patches contain significant residual opioid and require careful disposal.

Reducing Transdermal Opioid Dose

- Opioid patches should be dose reduced as a patch. There should not be a switch to morphine or other strong opioid for the purpose of reducing.
- Patients can be stopped from transdermal fentanyl 12micrograms/hour; it does not necessitate a switch to morphine.

In patients that cannot reduce their transdermal opioid to a stop but can take oral opioids, care should be taken if switching to an oral opioid equivalent. There needs to be consideration of individual patient variability when switching from one opioid to another, what other opioids they are taking, and the residual action of the opioid after the patch has been removed.

Information for Patients

Every opportunity should be taken to highlight the risks of long-term opioid treatment and encourage patients to consider opioid withdrawal. Providing the patient with additional educational resources is more likely to result in successful withdrawal.

'Thinking About Opioid Treatment for Pain', a patient information sheet:

<https://www.rcoa.ac.uk/system/files/FPM-OA-opioid-treatment.pdf>

Patient friendly information about various types of pain, describing the effects of chronic pain and the importance of self-management: <https://www.rcoa.ac.uk/node/21134>

FAQs for patients regularly taking opioids; it provides useful information to support discussions with patients regarding issues such as likely side effects and stopping taking an opioid: <https://www.rcoa.ac.uk/node/21136>

Barriers to opioid reduction should be addressed, with the patient being given the opportunity to raise any concerns they may have. Social issues can be referred to Hastings Advice and Representation Centre (HARC): <http://www.harcuk.com/>

References

The Royal College of Anaesthetists, Faculty of Pain Medicine, Opioids Aware; a resource for patients and healthcare professionals to support prescribing of opioid medicines for pain: <http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware>

SIGN 136: Management of Chronic Pain: <http://sign.ac.uk/guidelines/fulltext/136/index.html>

MHRA Transdermal Fentanyl Safety Update: <https://www.gov.uk/drug-safety-update/serious-and-fatal-overdose-of-fentanyl-patches>