

Q&A: Opioid Prescribing for Chronic Non-Malignant Pain

Why does there need to be a focus on opioid prescribing for chronic non-malignant pain?

There is a lack of evidence for opioids in chronic non-malignant pain, a significant risk of adverse effects, and a large prescribing cost to the healthcare economy. EHS and H&R CCGs are national outliers for opioid prescribing (2016).

What is the problem with opioid prescribing for chronic non-malignant pain?

There is little evidence of efficacy of opioids for chronic non-malignant pain. Prescribing opioids for this type of pain therefore puts patients at a potentially unnecessary risk of adverse effects and long-term risks. There are significant financial savings to be made locally in both oxycodone and opioid patches if prescribing were to move towards that of the best performing CCGs.

Are there patient groups prescribed opioids where change is most likely to be elicited following review?

- Patients taking a low total daily opioid dose.
- Patients prescribed one opioid preparation only.
- Patients that were initiated on their opioid for a short-term indication, but remained on it (e.g. post orthopaedic procedure).
- Patients prescribed BuTrans (low total daily opioid dose equivalent).

What type of pain are opioids most effective for?

Opioids provide good analgesia when used for acute and palliative pain. A minority of patients achieve good chronic pain relief with opioids when the dose is kept low and, if possible, used intermittently.

Why are opioids not very effective when used for chronic non-malignant pain?

Chronic non-malignant pain is a much more complex interaction of biological, psychological and social factors than acute pain. Once pain becomes persistent then huge changes are triggered in the spinal cord and brain, which probably explains why no drugs (or indeed other treatments) are particularly effective.

What is a realistic reduction in chronic pain when opioids are prescribed?

A reduction in pain of more than 30% is unlikely to be achieved with strong opioids when prescribed for chronic pain. Patients should not expect complete pain relief and other, non-pharmacological, methods are more effective.

What should happen if a patient prescribed an opioid remains in pain?

The opioid should be considered ineffective and stopped, even if there is no other drug treatment option. However pain relief should not be considered in isolation, improvement in functioning is also a beneficial outcome from opioids.

What are the alternatives to opioid prescribing for chronic pain?

The patient should be empowered to self-manage their pain, to enable them to function as well as possible. Non-pharmacological methods of managing chronic pain include increasing activity and physical fitness, physiotherapy, heat or cold pack application, transcutaneous electrical nerve stimulation (TENS), cognitive behavioural therapy (CBT) and meditation techniques such as mindfulness.

How common are side effects of opioids?

Side effects are very common with opioid therapy; up to 80% of patients report at least one side effect.

What are the commonly experienced side effects of opioids?

The most commonly experienced adverse effects are nausea, vomiting, constipation, pruritus, dizziness, dry mouth and sedation. *Constipation and sickness are not indications to change opioid choice; these side effects should be managed with laxatives and antiemetics.*

What are the long-term risks of opioids?

There is an increased incidence of falls (and fractures), endocrine abnormalities (amenorrhoea, erectile dysfunction, depression and fatigue), opioid induced hyperalgesia, cognitive decline, altered immune function, dependence and addiction.

How can opioid induced hyperalgesia be managed?

Opioid induced hyperalgesia occurs when opioid administration results in a decreased pain threshold. It manifests itself as apparent opioid tolerance, with pain increasing despite increasing opioid dosage. The only effective management for opioid induced hyperalgesia is to decrease the dose of opioid, preferably to a stop.

What is the strong opioid of choice?

Oral morphine (solid dosage form) is the first-line strong opioid of choice; there is little evidence that one opioid is more effective or associated with fewer adverse effects than others.

Is one strong opioid considered to be more effective than another?

There is no clear evidence that any particular opioid including morphine is better than any other in terms of efficacy for pain relief. Evidence suggests morphine sulphate is as effective as oxycodone; however the cost of oxycodone is significantly higher than morphine sulphate.

In patients with neuropathic / mixed features pain consider neuropathic agents.

What is considered to be a high dose of a strong opioid?

High opioid dosing is considered to be oral morphine equivalent of 120mg/day (oxycodone 60mg/day, fentanyl 25mcg/patch). The risk of harm increases substantially at doses above this, with no additional benefit and should therefore not be prescribed.

Can patients prescribed more than an oral morphine equivalent of 120mg/day be dose reduced?

Patients prescribed a high opioid dose can be dose reduced with careful titration and close monitoring. GPs can seek advice from the Medicines Management team about specific patients.

The focus should be on patients not having their opioid dose increase above an oral morphine equivalent of 120mg/day (except for in exceptional circumstances, with specialist input).

Why should doses above an oral morphine equivalent of 120mg/day not be prescribed when there is no ceiling effect of morphine [or other strong opioid]?

- Pain relief needs to be intrinsically linked to ability (and improvement) in patient function. The patient is more likely to experience adverse effects that impact on their function at high opioid doses.
- There is an increased risk of long-term adverse effects with high opioid doses.
- Opioid-induced hyperalgesia can be a problem with escalating opioid doses.

How should a strong opioid be initiated if it is thought to potentially be beneficial?

Realistic benefit, likely adverse effects and risks and various other management options should be discussed openly with the patient. Prescribe the strong opioid (solid dosage form immediate release oral morphine where possible) as a two week trial only, with patient documentation of pain intensity, improvement in function and side effects. Reduce and stop over one week if there is not a significant reduction in pain. In the instance of benefit, convert to an oral modified release formulation, with a four week review followed by a minimum of six monthly reviews.

When should an opioid be stopped?

Opioid analgesia should be reduced and stopped if it is not providing useful improvement in pain relief or function, the underlying condition resolves, the patient receives a definitive pain relieving intervention, development of intolerable side effects, or evidence of medication diversion.

When does a strong opioid need to be reduced gradually?

The total daily opioid dose should be reduced gradually when patients have been prescribed a strong opioid for longer than two weeks.

Which strong opioid should be prescribed when dose reducing?

Patients' prescribed oral oxycodone should be switched to the equivalent dose of oral morphine, assuming there are no contraindications to doing so.

Which dosage form should be prescribed when reducing an opioid in chronic pain?

Do not use liquid opioid preparations when reducing; round to the nearest available strength of solid dosage form. Do not use liquid opioid preparations at the end of a reduction regime, or for those patients on a long-term low dose of opioid that are stopping. Solid dosage form morphine 10mg twice daily can be reduced to solid dosage form 10mg once daily for five days and then stop.

Why should liquid opioid preparations be avoided in patients with chronic non-malignant pain?

Liquid opioid preparations should be avoided in patients with chronic pain as these preparations are associated with an increased risk of tolerance and dependence.

What is the dose equivalence of morphine and oxycodone?

Oral oxycodone is approximately twice as potent as oral morphine, i.e. a total daily oral oxycodone dose of 20mg is equivalent to a total daily oral morphine dose of 40mg. *When converting an oxycodone dose to an equivalent morphine dose in elderly or frail patients, or patients with renal impairment, caution should be exerted and a lower than usual morphine dose prescribed.*

Can morphine be prescribed for patients with renal impairment?

Morphine is the first line strong opioid in patients with stable mild to moderate renal impairment. A reduced dose of morphine (75% of normal dose) should be considered in patients with moderate renal impairment e.g. eGFR<50ml/min/1.73m². Patients with severe renal impairment or where the trend is that renal function is decreasing quickly/is unstable, should remain on oxycodone when reducing their opioid.

How should the opioid dose reduction be prescribed?

The total daily opioid dose can be reduced by approximately 10% of the original dose weekly or two weekly.

Transdermal Opioids

When is it appropriate for transdermal opioid preparations to be prescribed?

There are no transdermal opioids available for general prescribing on the local formulary, but it is accepted that opioid patches may have a limited role in patients with chronic non-malignant pain:

- Who cannot take or tolerate oral opioid preparations.
- Where a local pain management specialist has recommended their use.

Are there any transdermal specific considerations when reviewing an opioid?

It should be ascertained why the patient is being prescribed a transdermal opioid. The aim in patients prescribed an opioid for chronic pain remains to reduce and stop. *An oral opioid (solid dosage form morphine where possible) remains first-line in those patients that do have a true need for a strong opioid.*

What is the equivalent daily dose of oral morphine of transdermal opioids?

- BuTrans 5micrograms/hour is equivalent to just 10mg – 15mg oral morphine daily (codeine 60mg daily).
- Fentanyl (Fencino) 25micrograms/hour is equivalent to 90mg - 134mg oral morphine daily.

Why is it okay to stop from a fentanyl 12mcg/hour patch when it equates to a significant dose of oral morphine?

When a 12mcg/hour fentanyl patch is stopped there will still be drug in the tissues; the decline in plasma level will be more gradual and may prevent withdrawal.

What are the considerations when prescribing transdermal opioids?

- They lack flexibility required when treating patients with fluctuating or uncontrolled pain.
- They have a slow onset and prolonged duration of action.
- They need to be prescribed by brand; there are significant differences in bioavailability of some transdermal opioids.
- Heat exposure can cause increased opioid absorption.
- 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.

How should a transdermal opioid be dose reduced?

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

How can Transtec patches be dose reduced?

It is unlikely there will be many patients prescribed Transtec; patients prescribed BuTrans and fentanyl patches should be prioritised initially for a reduction. The lowest available Transtec patch strength is buprenorphine 35micrograms/hour, which is equivalent to oral morphine 60mg daily. ***It is advisable that GPs discuss patients prescribed Transtec who they wish to opioid reduce with a member of the medicines management team for guidance.***

A suggested method would be to switch the patient from Transtec 35mcg/hour to Butrans patches for the continued reduction. *Transtec patches are changed every four days; BuTrans patches are changed every seven days.*

Can patients prescribed an opioid patch be switched to an oral opioid where appropriate?

Patients that cannot reduce their transdermal opioid to a stop but can take oral opioids can be considered for careful conversion 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.*

In the instance of a patient with swallowing difficulties, would a patch be preferable to a liquid opioid?

Initially assess whether opioids are required / appropriate at all. In general, the advice in chronic pain is to avoid short acting opioids completely as they are more likely to be associated with tolerance and abuse. In light of this, patches would be the preferred option in this scenario (accepting that partial pain relief, with side effects, is usually all that is achievable).

Resources for Patients

ESH and H&R CCG Patient Information Leaflet, available in the Prescribing Support Scheme 2016-17 document 'Opioid Prescribing review for Chronic Non-Malignant Pain 2016-17', APPENDIX 7.

Opioids Aware Resources

'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>