The purpose of this guideline is to provide information to GPs about the medical treatment of chronic non-malignant pain using opioid drugs. Adherence to these guidelines will achieve a better balance in addressing the treatment of pain while minimising misuse, addiction and diversion of these medications.

While opioid therapy for chronic non-malignant pain may provide analgesic benefit for some patients, the evidence regarding improvement in function is limited. It is likely that only a minority of patients with chronic non-cancer pain will gain benefits from long term opioid medication, and the decision to prescribe opioids in these patients should only be made following these guidelines and may require consultation with a specialist (e.g. pain management clinic, alcohol and drug specialist, psychiatrist).

Key points when prescribing opioids:

When should opioids be prescribed?
Only after a full assessment process which includes: a pain diagnosis, mental health, alcohol and other drug dependency issues, a trial of non-opioid analgesia and non-drug treatments, and a corroborating history from other health professionals. A pain diagnosis should be made; opioids are usually only useful in defined nociceptive (mechanical) or neuropathic pain. Only then should a trial be initiated.

When should opioids not be prescribed?
Opioids should generally not be used to treat headaches including migraine and poorly or not defined general pain states such fibromyalgia, chronic visceral pain or non-specific lower back pain.

Counsel patients and their families regarding their beliefs about opioid therapy and its outcomes: Patients and family may have unrealistic expectations or fears about opioid medication. Clear explanation is needed about what can realistically be achieved, and that to be pain free and fully functional is not always possible.

Opioid Therapy should be trialled: If opioids are thought to be appropriate (i.e. anticipated improvements in function outweigh adverse effects and risks of dependence), then an initial four to six week trial of oral long-acting opioid analgesics should be undertaken to determine their suitability. Such a trial should have agreed goals that are realistic, achievable and measurable. A valid outcome of an opioid trial may be the decision not to proceed with treatment.

Single prescriber only: One medical practitioner should have responsibility for prescribing opioid medication. Patients should be encouraged to use a single pharmacist for dispensing.

Opioids as part of a pain management approach: If opioids are prescribed then it is vital that they are seen as only one part of the treatment (i.e. to provide analgesia to improve function) and that ongoing self-management and functional improvement is expected and desirable.

Regular review: Regularly review the pain diagnosis and comorbid conditions using the 4A's (Analgesia, Activity, Adverse effects, Aberrant behaviour).

Acute pain is pain of recent onset, usually a symptom of acute injury, surgery or disease, and its duration is limited to a few days to a few weeks and resolves with healing of the underlying condition.

Chronic pain persists for months to years, exceeds the healing process, is therefore no longer a symptom, but a disease in its own right and involves not only biological, but also psychological and social factors.
Has the cause of the chronic non-malignant pain been clearly established?

Patients under 45

Patients with a history of previous or existing alcohol/drug dependence.

Significant mental health issues such as conversion disorder, somatisation, borderline personality, PTSD, mood disorder.

Patients under 45 with poorly defined pathology (fibromyalgia, headaches, chronic low back pain).

Clinical pathway for an opioid trial in chronic non-malignant pain

Principle considerations:
The goals of pain management are to increase the ability to function, to reduce pain and suffering and enhance quality of life while minimising the risk of adverse effects. To accomplish these goals, pain management most often requires a broad array of interventions, only one of which is opioid prescription. In prescribing opioids the aim is to reduce pain without causing side effects thus the patient is then able to achieve their desired outcomes on treatment. These outcomes may require a team approach and the services of clinical psychology, graded activity, and a practice nurse with the focus on patient self-management rather than multiple visits to health practitioners.

Clinical decisions about the ongoing use of opioids require a careful assessment of all outcomes. Specific goals of opioid treatment will vary according to the patient’s circumstances, however these should be documented prior to an opioid trial. The goals of treatment may be as simple as ‘being able to hang out the washing’, or as significant as ‘being able to return to work full-time’. It is important that any goals of treatment are realistic, achievable, and are regularly reviewed by the patient and GP.

Patients ideally referred to other relevant specialists or a Multidisciplinary Pain Centre before prescribing opioids:

- Patients with a history of previous or existing alcohol/drug dependence.
- Patients whose previous use of opioids was problematic.
- Significant mental health issues such as conversion disorder, somatisation, borderline personality, PTSD, mood disorder.
- Patients under 45 with poorly defined pathology (fibromyalgia, headaches, chronic low back pain).

If a patient is considered drug dependent the treating doctor must apply for approval to treat prior to commencing opioids.

Has the cause of the chronic non-malignant pain been clearly established?

Yes

No

Has the cause of the chronic non-malignant pain been clearly established?

No

Yes

Identify causal pathology.

Full pain history.

Appropriate examination (including injection sites).

Supporting documents and corroborating history from other health professionals.

Check history of any alcohol/drug dependence.

Consultation with pain, mental health or drug and alcohol specialists if needed.

Informed consent by patient and care plan signed.

Baseline measure of patients functional ability established.

Goal of trial and endpoint clarified with patient.

Trial agreed in consultation with patient.

Contact 13 S8INFO (13 78 44) enquiry service for a full history of S8 drug prescribing.

Initiate four to six week trial of opioids (see overleaf for dosage details).

Trial successful if:

- Demonstrated improvement in function and/or pain control or achievement of goals without need for excessive doses or repeated dose increase.

Trial unsuccessful if:

- Lack of functional improvement.
- Lack of analgesia.
- Side effects.
- Repeated requests for increased dose or other problematic drug related behaviour.

Taper opioid dose (10 per cent/week) and cease. (This does not pose a health risk).

If needed consult with pain specialist regarding ongoing treatment options.

Long term use of opioids:

- Stable dose established.
- One prescriber—one pharmacy.
- Regular reviews assessing:
  - Analgesia
  - Activity
  - Aberrant behaviour
  - Adverse effects.
- Continuing review of non-pharmacological and non-opioid means of pain control.

Other relevant specialists:

- Behavioural Therapy and physiotherapy, Cognitive Behavioural Therapy and other pain management programmes, non-opioid analgesics and adjuvants.

Have all reasonable pain management alternatives been trialled, including physiotherapy, Cognitive Behavioural Therapy and other pain management programmes, non-opioid analgesics and adjuvants?

Yes

No

Trial of non-opioid analgesics/adjuvants and non pharmacological interventions.

Tritrate with 10-20mg morphine equivalent of a long-acting opioid per 24 hours.

Assess outcome at least weekly and titrate dose as required.

Review patient including (in order of importance) functioning, (both physical and psychosocial), pain relief, side effects, problematic drug-related behaviours.

Do not exceed 120mg morphine equivalent daily.

Encourage concurrent use of paracetamol, and nonpharmacological therapies.

One practitioner to implement and monitor the trial.

Document fully in the patients file.

This flowchart is intended to be a quick reference for general practitioners and is based on information taken from:


Graziotti PJ, Goucke CR. The use of oral opioids in patients with chronic non-cancer pain. MJA 1997; 167: 30-34
Dosing threshold for selected opioids

<table>
<thead>
<tr>
<th>Starting dose</th>
<th>Drug</th>
<th>Suggested maximum dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-20 mg twice daily</td>
<td>Kapanol</td>
<td>120mg per day</td>
</tr>
<tr>
<td>20 mg daily</td>
<td>MS Mono</td>
<td>120mg per day</td>
</tr>
<tr>
<td>10-20 mg twice daily</td>
<td>MS Contin</td>
<td>120mg per day</td>
</tr>
<tr>
<td>Oxycodeine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 mg twice daily</td>
<td>Oxycontin</td>
<td>80mg per day</td>
</tr>
<tr>
<td>Fentanyl</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 mcg/hr</td>
<td>Durogesic</td>
<td>25mcg/hr</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 mcg/hr</td>
<td>Norspan</td>
<td>20mcg/hr</td>
</tr>
</tbody>
</table>

These dosages are to be used as a guide only and are not intended to override clinical judgement in specific cases. Ongoing daily doses of more than 120mg morphine equivalent are usually only prescribed by GPs after specialist support or pain management clinic review; treatment with high opioid doses may paradoxically induce abnormal pain sensitivity, including hyperalgesia. Thus, increasing opioid doses beyond above dosing thresholds may not improve pain control and function. **Injectable opioids should never be used to treat chronic pain or acute breakthrough episodes of chronic pain.**

Managing behavioural issues

**If you observe any of the following:**
- Complaining about the need for more drugs, asking for early scripts or additional supply.
- Evidence of doctor shopping or multiple sources of medications.
- Requesting specific drugs.
- Unsanctioned dose escalation.
- Physical evidence of misuse, eg track marks.
- Multiple episodes of prescription loss (lost medication should not be replaced).
- Evidence of deterioration in function at work, in the family, or socially, that appears to be drug-related.
- Repeated resistance to therapy changes despite clear evidence of adverse physical or psychological effects from the drug.

**Then options to consider are:**
- Review care plan with patient.
- Do not prescribe additional medication to replace that used before the next prescription is due.
- Reassess medication, expectations and underlying nociceptive source.
- Reinforce previous discussions concerning restrictions of supply from other sources.
- Consider limited dispensing (weekly or daily).
- Consult with Monitored Medicines Unit via the 13 S8INFO (13 78 46) enquiry service.
- Random checks of remaining medications (tablet count).
- If evidence of inappropriate use e.g. injecting, refer to local Alcohol and Other Drug Services.

Contact numbers

**13 S8INFO** ........................................................................................................... 13 78 46
*(check the prescription history of new or existing patients)*

Requests to the Chief Executive .............................................................................. Fax 07 3708 5431

Email MMU@health.qld.gov.au

Medicare Australia Prescription Shopping Information Service .................................. 1800 631 181

Alcohol and Drug Information Service (ADIS) ............................................................ 1800 177 833

*(24 hours/7 days)*