Quick Clinical Guideline

for the use of Opioids in Chronic Non-Malignant Pain

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.

Whilst 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 (eg. pain management clinic, alcohol and drug specialist, psychiatrist).

KEY POINTS
IN PRESCRIBING OPIOIDS FOR THE MANAGEMENT OF CHRONIC NON-MALIGNANT PAIN

- **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 family) 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 the 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'a (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.

Clinical pathway

Principle Considerations:

The goals of pain management are t
risk of adverse effects. To accomplis
prescription. In prescribing opioids t
on treatment. These outcomes may
focus on patient self-management r

Clinical decisions about the ongoing
to the patient's circumstances, howe
to hang out the washing', or as sign
and are regularly reviewed by the pa

Has the cause of the Chronic Non Malignant Pain been clearly established?

No

- 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

Yes

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

No

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

Yes

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

- Assess and address any mental health and/or substance abuse issues
- 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

Phone DDU enquiry service for full history of S8 prescribing
Ph 3328 9890

Initiate 4 to 6 week trial of opioids (see overleaf for dosage details)

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
- ✓ Younger patients (<45) with poorly defined pathology (fibromyalgia, headaches, chronic low back pain)

- Titrate 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.

for an opioid trial in chronic non-malignant pain

to increase the ability to function, to reduce pain and suffering and enhance quality of life while minimising the sh these goals, pain management most often requires a broad array of interventions, only one of which is opioid the aim is to reduce pain without causing side effects thus the patient is then able to achieve their desired outcomes require a team approach and the services of clinical psychology, graded activity, and a practice nurse with the ather than multiple visits to health practitioners.

g use of opioids require a careful assessment of all outcomes. Specific goals of opioid treatment will vary according ever these should be documented prior to an opioid trial. The goals of treatment may be as simple as 'being able ificant as 'being able to return to work full-time'. It is important that any goals of treatment are realistic, achievable, atient and GP.

Trial successful if:
Demonstrated improvement in function and/or pain control or achievement of goals without need for excessive doses or repeated dose increase

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
- For patients on S8 medication or anticipated to be on S8 medication for >8 weeks – treating doctor to complete a "Report to Chief Executive" forward to DDU

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%/week) and cease. *(This does not pose a health risk)*

If needed consult with Pain specialist regarding ongoing treatment options.

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

Trescot et al: Opioid Guidelines in the management of Chronic Non-cancer Pain. Pain Physician. 2006;9:1-40.
Schug SA, Large RG. Opioids for Chronic Non-Cancer Pain. IASP Clinical Updates. 2005. Vol 3; Issue 3.
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

Starting Dose	Drug	Suggested maximum dose
Morphine		
10-20 mg twice daily	Kapanol	120mg per day
20 mg daily	MS Mono	120mg per day
10-20 mg twice daily	MS Contin	120mg per day
Oxycodone		
5 mg twice daily	Oxycontin	80mg per day
Fentanyl		
12 mcg/hr	Durogesic	25mcg/hr
Buprenorphine		
5 mcg/hr	Norspan	20mcg/hr

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:	Then options to consider are:
• 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	• Review care plan with patient. • Do not prescribe additional medication to replace that used before the next prescription is due. • Reassess medication, expectations, underlying nociceptive source. • Reinforce previous discussions concerning restrictions of supply from other sources. • Consider limited dispensing (weekly or daily) • Consult with Drugs of Dependence (07 3328 9890) • Random checks of remaining medications (tablet count) • If evidence of inappropriate use e.g. injecting, refer to local ATODS.

Contact Numbers

Drugs of Dependence Unit – Enquiry Service **07 3328 9890**
(check the prescription history of new or existing patients).

Reports to the Chief Executive **07 3328 9890**

Fax **07 3328 9821**

Email ..... **ddu@health.qld.gov.au**

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

Royal Brisbane Hospital (RBH) **07 3636 1111**

Princess Alexandra Hospital (PA) **07 3240 2111**

Gold Coast Hospital **07 5519 8211**

Nambour Hospital **07 5470 6600**

Bundaberg Hospital **07 4152 1222**

Queensland Government

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