GG&C Chronic Non Malignant Pain Opioid Prescribing Guideline
Background

Persistent pain is common, affecting around five million people in the UK. For many sufferers, pain can be frustrating and disabling, resulting in functional impairment - physically, emotionally and vocationally. Medications and other treatments that aim to reduce pain intensity play a role in the management of symptoms, but should be provided as part of a wider management plan focused on reducing disability and improving overall quality of life.

Opioids have been increasingly prescribed to treat chronic non-malignant pain. There is evidence from clinical trials that they can be effective, in the short and medium term, in providing symptomatic improvement in somatic, visceral and neuropathic pain. Complete relief of pain is rarely achieved. The goal should be to reduce pain sufficiently to facilitate engagement with rehabilitation and the restoration of useful function. The management of persistent pain focuses not only on reduction in pain intensity but also on improvement in sleep, mood, and physical, vocational, social and emotional wellbeing.

The safety and efficacy of opioids in the long term is uncertain, as is the propensity for these drugs to cause problems of tolerance, dependence and addiction. The benefits of opioid treatment for the patient must be balanced against burdens of long term use as therapy for persistent pain may need to be continued for months or years.

There is no good predictive factor of the analgesic effect of opioids in chronic non-malignant pain. If deemed appropriate, the individual should have a monitored opioid trial over a period of 6 weeks to determine the effectiveness of the treatment and the presence of side effects. If the clinical decision is made to continue the prescription of the opioid, there should be ongoing timely reassessment.

Recommendations are made on determining the suitability of an opioid trial, the choice of opioid, the conduct of an opioid trial and long term monitoring of the patient.

The guidelines reviewed included the following:

- The British Pain Society (2010)
- U.S. Department of Veterans Affairs/Department of Defence (2010)
- The Canadian Guidance (2010)
- Guidelines for South Australian GPs (2009)

A flowchart to support implementation of the Guideline for the prescribing of Opioids to patients with Chronic Non Malignant Pain can be found at the end of this document.
Suggestions for the Safe and Effective Prescribing of Opioids for the Management of Chronic Non-Malignant Pain: initiation, monitoring and tapering

Patients may be managed by the General Practitioner and/or the Pain Specialist. This guideline is to aid primary care and secondary care teams in managing patients, who have chronic pain, with opioids. This guidance should be used in conjunction with local and/or national guidance on the assessment of pain and with reference to British Pain Society Guidelines.

Key Points

- The aim of using opioids in the short to medium term is to support the rehabilitation and restoration of physical and mental function of patients.
- Clinical evidence has demonstrated that opioids can be useful in the management of chronic somatic, visceral and neuropathic pain.
- Opioids can also have untoward effects in terms of tolerance, dependence and addiction.

Before initiating opioids consider the following:

- What is the cause (diagnosis) of persistent pain in your patient?
- Has a biopsychosocial assessment been made?
- Have other appropriate methods of pain management been tried? (e.g. other medications, graded exercises, psychological methods)
- Does your patient have neuropathic pain? (Refer to local neuropathic pain guidelines)
- Would a trial of opioids be suitable for this patient? (see below)

1. There are no chronic pain conditions in which opioids are completely contraindicated, however the boxes to the right are situations where they are not recommended or where closer monitoring would be required. Consideration should be given to using the ‘Opioid Risk Tool’ (see Appendix 1) to assess for potential high risk/dependent patients. If patients are assessed as moderate to high risk closer monitoring will be required.

2. Initiation of Opioids

Prior to the commencement of opioid therapy, it is essential that appropriate informed consent is obtained from the patient and if necessary family/carers. The discussion should include:

A clear explanation of the advantages and disadvantages of opioid therapy, which should include short term and long term side effects, potential for tolerance and addiction, detrimental impact on quality of life and advice on driving and operating machinery as per the British Pain Society Information Leaflet.


- Agreeing achievable patient specific goals. This may include an agreed expected reduction in pain score (30%), improvement in sleep pattern and functional ability.
- An explanation of the concept of an Opioid Trial and what circumstances would surround the discontinuation of opioid medication.
- Complete the 1st page of the ‘Progress Note’ Pain Assessment & Documentation Tool (PADT) to record baseline levels of the pain score and functional ability.

http://www.healthinsight.org/Internal/assets/SMART/PADT.pdf

3. Opioid Trial : Anticipated length of trial would be 6 weeks.
Expectation: 30% improvement in pain and/or significant improvement in functional ability.

- Discontinue all Step 2 analgesia and replace with Step 3 during the trial however continue with Step 1 analgesia such as paracetamol/NSAIDs.

Step 2 and Step 3 Analgesia

Stop All STEP 2 Analgesia

Single or combination analgesics containing:
- Codeine
- Dihydrocodeine
- Tramadol
- Low Dose Buprenorphine Patches
  (This is Non SMC approved and its use is subject to approval via the Individual Patient Treatment Request Process)

Commence Step 3 Analgesia

<table>
<thead>
<tr>
<th>Line</th>
<th>Analgesic</th>
<th>Starting Dose</th>
<th>Titration</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Morphine Sulfate SR</td>
<td>10mg BD</td>
<td>Increase by 10-20mg BD every 2 weeks</td>
<td>60mg BD</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>Oxycodone SR</td>
<td>5mg BD</td>
<td>Increase by 5 – 10mg BD every 2 weeks</td>
<td>30mg BD</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>Fentanyl</td>
<td>12mcg/hr (Equivalent to 45mg morphine in 24 hours)</td>
<td>Increase by 12mcg/hr every 2 weeks</td>
<td>25mcg/hr (Equivalent to ~80mg morphine in 24 hours)</td>
</tr>
</tbody>
</table>

If there are issues with swallowing consider alternative oral slow release preparations e.g. suspension.

- Use a single agent by the oral route, using sustained release preparations. If no contraindication, first line choice is sustained release Morphine Sulfate SR 10mg BD in opioid naïve patients. For patients already on reasonable dose step 2 analgesics, convert using opioid conversion chart see Appendix 2, then reduce total daily dose by 25% as a safety precaution.

- If Morphine Sulfate SR is not tolerated despite treatment of side effects, recommence trial using sustained release Oxycodone SR.

- Oral route is preferred, however if the patient has problems with swallowing or GI absorption, Transdermal Fentanyl preparations should be used, recognizing that titration will take longer than oral preparations.

- Increase dose every 2 weeks until required pain relief has been achieved or side effects are intolerable or until 60mg BD Morphine Sulfate SR or equivalent is reached. Consider referral to the Pain Specialist Clinic.

- Reassess the patient 1-2 weekly.


- Ensure most cost effective brands are used as identified from local formularies

4. Regular Assessment
Use PADT tool for ongoing assessment (http://www.healthinsight.org/Internal/assets/SMART/PADT.pdf)

Assessment should include;

Ongoing Efficacy – carry out recordings of pain score and functional assessment.

If the opioid trial is not successful, discontinue opioid by tapering dose, reducing by 10-20mg of morphine/day or equivalent every 2 weeks.

There are no high quality randomized controlled trials to suggest that one opioid is more effective than another. If there is NO clinical benefit with a full trial of one opioid, we would not encourage further opioid trials in primary care – seek opinion of Pain Specialist If opioid trial is successful, continue with monitoring of dose, pain score, function and side effects every 3 months initially until does is stable, then every 6 months. Consider weaning opioids every 6 months to see if dose is still optimal.

• Avoid using short acting opioids for breakthrough pain.
• Keep daily dose of long acting opioid as low as possible.
• Measure sex hormones if patient reporting symptoms of hypogonadism and if abnormal seek advice from local endocrine clinic.

5. Treatment of Side Effects – further information

Constipation
The majority of patients taking opioids for moderate to severe pain will develop opioid induced constipation; tolerance does not develop to this side effect. Guidelines suggest that the best prophylactic treatment for opioid induced constipation is a combination of a stimulant laxative and a stool softener. Refer to local formularies

Nausea/Vomiting
Nausea and vomiting are common when starting on opioids but generally tolerance develops after 5-10 days. It is recommended that patients commencing on an opioid for moderate to severe pain should have access to prophylactic antiemetics to be taken if required. Refer to local formularies for treatment of choice.

Itch
Opioid induced itch occurs in around 1% of those who receive a systemic opioid. It is thought to be caused by a central mechanism rather than by histamine release, therefore in some cases antihistamines are not effective. Emollients should be used liberally if the patient has dry skin. Trial of a sedating antihistamine such as chlorphenamine or hydroxyzine is suggested, if this is not effective after a few days it should be stopped.

6. Renal Impaired patients
For those patients with renal impairment, the likelihood of opioid toxicity with any opioid increases and the following guiding principles should be followed when prescribing opioids:

- Use the smallest effective dose/frequency.
- Titrate carefully and monitor for adverse effects.
- It should be noted there is no advantage in using Oxydodone over Morphine in Stage 1-3 renal impaired patients.
- In patients with stage 4/5 kidney disease consult with the patients local renal specialist before commencing opioid treatment. General advice would be to avoid long acting preparations and where they are used, delay their introduction until the patient’s dose requirements are fully established.
- If there are clinical concerns consult local renal specialists.

NB: Treatment of very frail older people with chronic non cancer pain should be guided by individual circumstances and co-morbidities and need not follow guideline recommendations.

References

### Opioid Equivalent Doses*

<table>
<thead>
<tr>
<th>Oral morphine (mg/24 hrs)</th>
<th>10</th>
<th>15</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>60</th>
<th>80</th>
<th>120</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine/Dihydrocodeine (mg/24hrs)</td>
<td>120</td>
<td>240</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tramadol (mg/24hrs)</td>
<td>200</td>
<td>400</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxycontin(mg/24hrs)</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>30</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transdermal Buprenorphine (µg/hr)</td>
<td>5</td>
<td>10</td>
<td>20</td>
<td>20</td>
<td>35</td>
<td>35</td>
<td>52.5</td>
<td></td>
</tr>
<tr>
<td>Transdermal Fentanyl (µg/hr)</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td></td>
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</tbody>
</table>

*These figures are taken from a number of sources/dose ranges and are an approximation. See BNF for up-to-date equivalence charts for individual opioids. After an opioid conversion reduce the dose by 25% as a safety precaution.

You may also wish to use our online conversion tool: [http://www.jet5.com/pain/calculator.php](http://www.jet5.com/pain/calculator.php)

**APPENDIX 1**
# Opioid Risk Tool

<table>
<thead>
<tr>
<th>Item</th>
<th>Mark each box that applies</th>
<th>Item score if female</th>
<th>Item score if male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family History of Substance Abuse:</td>
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<tr>
<td>Alcohol</td>
<td>[ ]</td>
<td>1</td>
<td>3</td>
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<tr>
<td>Illegal Drugs</td>
<td>[ ]</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>[ ]</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal History of Substance Abuse:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>[ ]</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>[ ]</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>[ ]</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3. Age (mark box if 16-45)</td>
<td>[ ]</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. History of Preadolescent Sexual Abuse</td>
<td>[ ]</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5. Psychological Disease</td>
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<td></td>
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<tr>
<td>Attention Deficit Disorder, Obsessive-Compulsive Disorder, or Bipolar, Schizophrenia</td>
<td>[ ]</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>[ ]</td>
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<td>1</td>
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<tr>
<td>Total</td>
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<tr>
<td>Total Score Risk Category:</td>
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<tr>
<td>Low Risk:</td>
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<td>Moderate Risk:</td>
<td>4 to 7</td>
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<tr>
<td>High Risk:</td>
<td>8 and above</td>
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</tbody>
</table>

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Reference
APPENDIX 2
GG&C Chronic Non Malignant Pain Opioid Prescribing Guideline

**SUGGESTED AREAS WHERE OPIOIDS ARE NOT RECOMMENDED**
- No previous improvement with opioids
- Sleep Apnoea

**NO CLINICAL EVIDENCE OF LONG TERM EFFECTIVENESS IN:**
- Headache
- Non Specific Low Back Pain
- Fibromyalgia
- Unexplained Persistent Pain

**BEFORE INITIATING OPIOIDS CONSIDER**
- What is the cause of persistent pain?
- Biopsychosocial aspects considered?
- Have other appropriate methods of pain management been tried?
- Is there neuropathic pain?
- (Refer to local neuropathic pain guidelines)
- Is a trial of opioids appropriate for this patient?

**LONG TERM EFFECTS OF OPIOIDS**
- Immunosuppression.
- Suppression of pituitary hormones leading to hypogonadism, possible suppression of adrenal function, low bone mass.
- Possible effect on cognitive function

**CLOSER MONITORING REQUIRED FOR PATIENTS WITH:**
- Mental Health Disorders
- Depression and Anxiety Related to Pain
- Previous or Existing Addiction to Any Substance
- Serious Mental Health Issues or Addiction in the Family

**COMPLETE OPIOID RISK TOOL TO ASSESS RISK AND CONSIDER REFERRING TO LOCAL PAIN CLINIC**

**Commence Opioid Trial (Duration – 6 weeks)**

**AIM**
30% Improvement in Pain And/or Significant Improvement in Functional Ability see PADT tool – see PA

**PRIOR TO INITIATION**
- Explain advantages and disadvantages
- Explain the concept of the trial and reasons for discontinuation
- Agree patient specific goals
- Record baseline levels of pain score and functional ability using the PADT tool

**INITIATION**
- Discontinue all Step 2 Analgesia i.e.
  - Single or combination analgesics containing:
    - Codeine/Dihydrocodeine/Tramadol
    - Low Dose Buprenorphine Patches*
  *(Non SMC Approved)
- Commence Oral Morphine Sulfate SR
  - 10mg BD for Opioid Naïve patients & increase by 10-20mg BD every 2 weeks.
  - Alternatively use Opioid Conversion Chart to transfer from Step 2 analgesia minus 25% of total daily dose for safety.

**Assess patient every 1-2 weeks**
Increase dose every 2 weeks until pain relief achieved or other agreed objective or maximum dose of 60mg BD is reached. Treat side effects as per local formularies.

**REGULAR ASSESSMENT**
- Use PADT tool to regularly assess pain score and functional ability
- Measure sex hormones if patient reporting symptoms of hypogonadism e.g. impotence, oligoamenorrhea and if abnormal seek advice from local endocrine clinic.
- If trial is successful initially monitor every 3 months, then six monthly

**REVIEW: IF TRIAL UNSUCCESSFUL, REDUCE DOSE BY 10-20MG MORPHINE OR EQUIVALENT EVERY 2 WEEKS UNTIL DISCONTINUED**

**CONSIDER REFERRAL TO A PAIN SPECIALIST FOR:**
- Patients with previous mental health problems, dependency or addiction.
- Difficulty tapering or problem drug use
- Patients with opioid sensitive pain who require dose higher than 60mg Morphine Sulfate Tablets BD or equivalent.
- Opioid insensitive problematic pain
- Diagnostic difficulties