Kent and Medway

Kent and Medway Guidance to Support the Safe and Effective, Initiation and Review of Opioids

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Please note

NICE guidance [NG193] *Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain* recommends that non-pharmacological management of chronic primary pain (*defined as pain with no clear underlying cause or impact of pain is out of proportion to any observable injury or disease*) should be managed with exercise, psychological therapy and acupuncture.[1]

The guidance states that opioids should not be initiated for the pharmacological management of chronic primary pain and should be reviewed if the patient is already taking these.[1] Please see the Kent and Medway position statement on opioid prescribing for further information on the prescribing of opioids for non-cancer, chronic pain in adults.

NICE guidance [NG215] *Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults* contains further information and useful visual summaries.

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1. Before starting An Opioid

1.1 Patient Assessment

- Undertake a full patient assessment and pain history.[1]
- Consider and optimise non opioid interventions (paracetamol +/-NSAIDs) and ensure non-pharmacological interventions, including watchful waiting have been discussed and offered before opioid therapy.[3][4]
- Determine whether there are any factors that might increase the person's risk of developing problems associated with dependence.[5] This may include but is not limited to:
  - Co-morbid mental health diagnosis
  - History of drug or alcohol misuse
  - No clear defined diagnosis to support the prescription
  - Concurrent use of a benzodiazepine or gabapentinoid
- Refer patients with a history of addiction (to opioids or other drugs) to specialist services with expertise in pain medicine and addiction management.[3]

1.2 Managing patient expectation, counsel patient on:

- Treatment **aim** to use medication for pain **only** as part of a wider management plan aimed at reducing disability and improving quality of life.[3]
- In trials most medicines for long-term pain only benefit around one in every four or five people and on average only provide 30 % reduction in pain.[2]
- Medicines work best if you combine them with other ways of managing symptoms such as regular activity and doing things that are satisfying or enjoyable, such as work or study, and social activities.[1]
- **Note:** if a patient is in pain that restricts their movement phrasing exercise as 'regular movement' and 'increasing activity' may help prevent patient disengagement.
- Stress that short term response to opioid therapy does not predict long term therapy which may be limited by adverse effects or declining efficacy.[2]

1.3 Patient Education

Consider providing the following leaflets and information:

- About Pain and Thinking about Opioid Treatment for Pain
- Direct patients to the information about driving and opioid use in the following leaflet Taking Opioids for pain
- Inform patient of the potential side effects, whether these are likely to be short term or permanent and whether they may improve or worsen over time and how their use may impact any existing conditions they have.[5]
- Any additional implications of taking the medicine if the person is pregnant or planning pregnancy[5]
- Explain how difficult it may be to stop the medicine later, the risk of developing dependence, symptoms and signs of dependence, risk of developing tolerance.[4] Please see Appendix 1.
- Consider delaying prescribing until after the initial appointment to give the patient time to think about their options, discuss with family or allow the prescriber to consult with other healthcare members.[4]

- Provide the patient with information about storing the medication safely

1.4 Shared agreement

- Encourage the patient to sign the Kent and Medway patient treatment agreement available here.
- If a shared decision about starting an opioid cannot be reached and the medicine is not in the person's best interests follow GMC guidance on '*handling patient requests for medicines you don't think will benefit them*'. Do not initiate an opioid if you believe it is not in the person's best interest.[4]
- **If** the prescriber and patient **both** agree that opioid therapy may play a role in further management of the patient's pain, a trial of opioid therapy should be planned[1]

NICE have produced a visual summary, available here, of recommendations to support prescribers before starting treatment with an opioid, and for discussing and agreeing a plan. Please note this is not an exhaustive list.

2. Initial Prescribing of an Opioid

If the prescriber and patient both agree that opioid therapy may play a role in further management of the patient's pain, a trial of opioid therapy should be planned.

Both prescriber and patient should be clear on the aim of the trial which is to determine whether opioids are helpful for the patient. Optimal doses and managing side effects of opioids can be explored once it has been shown whether opioids are helpful for the patient.**[2]**

2.1 Starting the opioid trial

- Agree some readily assessable outcomes e.g. reduction in pain intensity, ability to achieve specific functional improvement[2]
- Prescribe initially on acute medication records[3]
- Use with caution in older people, particularly those with medical co-morbidity[3]

2.2 Duration of the trial[2]

This will depend on the periodicity of the patient's pain.

- For constant pain - consider a trial of one or two weeks
- For intermittent disabling flare ups of pain on a background of more manageable symptoms- the trial should be long enough to observe the effect of opioids on two or three episodes of increased pain.

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2.3 Choice of opioid formulation and dose[2]

- Prescribe a **short** (1-2 week supply) of immediate release morphine tablets or liquid. **Tablets are preferred** where possible due to easier more precise dosage measurements.
- The patient may be advised to explore different doses within a specified range e.g. morphine 5-10mg.

2.4 Documentation: the opioid trial[2,5]

All stages of the opioid trial should be clearly documented in the patients notes, the patient may be given a copy **where appropriate**. It should include:

What the medicine has been prescribed for
Intended outcomes and their assessment
The agreed formulation
The agreed starting dose
Any intervals between dose adjustments
Duration of each prescription
Details of any planned dose escalation
Date of next review
Who the patient should contact if there are any problems/the patients designated prescriber
How long it is anticipated the patient may be taking the opioid for
Risks that were discussed and agreed with the patient including taking more than the prescribed dose
Safety netting advice for symptoms and signs of overdose or side effects

2.5 Assessing the opioid trial[2]

Advise the patient to keep a pain diary throughout the trial that reports at least:

- Twice-daily report of pain intensity
- Impact on sleep and quality of sleep
- Activity levels and whether this changes following a dose of opioid.
- Recording all doses of opioid and the timings
- Any side effects experienced

2.6 Decision & Documentation[2]

- **If the opioid trial is not successful, the drugs should be tapered and stopped within one week**.
- If the patient reports reduction in pain but at the cost of side effects that impede functional goals consider exploring different dose regimes alongside active management of side effects to see if a balance between benefits and harms can be achieved.[1]
- If the opioid trial demonstrates some benefit from opioids, further exploration of opioid treatment may be helpful. However a successful short-term opioid trial does not predict long-term efficacy.[1]
- Document reasons why/why not the opioid trial demonstrates that the medicines are helpful or unhelpful. E.g. lack of efficacy, intolerable side-effects.
- Document rationale for continuing or discontinuing use.

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3. Long term prescribing and ongoing Review

3.1 Choice of Drug and Formulation

- Choice of opioid depends on clinical circumstance, local formularies and guidance and individual knowledge and competence.[2] Drugs should be used for their licensed indication only
- The oral route is the preferred route of administration.[2]
- There is little evidence that one opioid is more effective and associated with fewer side effects than others.[2] **It is easier to manage opioid prescribing if a single opioid is used rather than combining several opioids.**[5]
- When prescribing at the suggestion of or deciding whether to continue a prescription made by another healthcare professional take the same level of care you would take if you were the original prescriber.
- Use of opioid formulations with a rapid onset, such as fentanyl for transmucosal or sublingual administration are **inappropriate** for the management of persistent pain[1]
- Injectable opioids should not be used in the management of patients with chronic non-cancer pain[5]

Consider Immediate release if:	Consider Modified release at regular intervals if
• The pain is intermittent and short-lived.[1] • The pain intensity varies significantly: use of regimens including immediate release preparations allows flexibility to reduce dose on days when pain is or is expected to be less severe; or background pain is well controlled with modified release preparations but the patient has infrequent, short-lived episodes of increased pain.[1]	• Patients with persistent pain throughout the day and night.

3.2 Frequency of review

- Where practicable, reviews should be carried out by the patients designated prescriber.
- The patient should ideally be reviewed within one to two weeks of initiation of opioid treatment or at least within four weeks and reviewed regularly to ensure the dose is adjusted to determine the lowest effective dose in a reasonable time[2][5]
- The frequency of review once the opioid regimen has been established will depend on:
    - Patient preferences and circumstances
    - The early effectiveness of treatment
    - The timing of additional interventions to control pain (eg, surgery)
    - The presence of concerns e.g. side effects, problems associated with dependence
- In the first six months, review at least monthly after stable dosing has been achieved.[3]
- After the first six months: review the continuing benefit of opioid therapy and potential harms at least twice each year.[2]
- If opioids have been started in secondary care, clear communication regarding the indication, treatment plan and review of medication should be provided to the patient's GP. For further information please see the Kent and Medway position statement on opioid prescribing.

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3.3 Content of Reviews:

- Discuss the benefits and risks of continuing at current dose, adjusting the dose or stopping the medicine[5]
- Discuss any signs of the person developing problems associated with dependence e.g. running out of medication, frequent medication requests, or dose increases, loss of efficacy where medication previously working well. Understand that the person might be reluctant or anxious about discussing problems associated with dependence.[5]
- Discuss the benefits gained and whether the initial improvements have subsided.
- Discuss any harms the patient is experiencing from continuing the medicine.
- Discuss lowering the dose to determine whether a lower dose can effectively manage symptoms.[4]
- Whether patient has any preferences for continuing, adjusting the dose or stopping the medicine.
- If decision taken to taper down or stop opioid please see Kent and Medway Tapering Resource Pack.

NICE guidance [NG215] includes a visual summary for reviewing medicines associated with dependence or withdrawal.

3.4 Repeat prescribing and rational prescribing

- Keep pain relief simple and effective. Follow these S.T.E.P.S. to answer the following questions:[5]
  - Is it **Safe** for the patient to continue on this medication long term?
  - Can they **Tolerate** this medication with its side effects?
  - Is the medication **Effective**? Some patients can't tell one way or another.
  - Are they on the best **Priced** treatment? (Expensive treatment is acceptable if it works.)
  - Is the taking of analgesics as **Simple** as possible? Would a long-acting preparation be preferable to frequent doses of short-acting analgesics?
- The minimum effective dose should always be used.
- In general it is not recommended for opioids to be added to the repeat prescribing system, particularly following initiation of an opioid, but should be generated as acute prescriptions.
- If an opioid has a demonstrable positive benefit for an individual patient and there is a robust system for monitoring use then consideration may be given for short-term authorisation of repeat prescriptions.

3.5 Documentation in patient notes for each review

- Relevant clinical findings that support the decision to prescribe opioids.
- Agreed outcomes of opioid therapy.
- The choice of drug, formulation, dose and duration of treatment. A maximum dose of drug should be defined at initiation and this should not exceed oral morphine equivalent 120mg/day.
- The circumstances under which opioid therapy should be discontinued.
- Arrangements for review.
- The information given to patients.

Appendix 1.

SAFER OPIOID MANAGEMENT
KNOW THE RISKS

Opioids are effective pain killers especially for acute pain, but there is little evidence that they help in long-term pain.

Various opioids may be prescribed for the same purpose.
Oral morphine equivalent daily dose (OMEDD) has been used to make their strength comparison easier.

ORAL MORPHINE EQUIVALENT DAILY DOOSE (OMEDD)

Codeine
30mg - 8 tabs a day = 30 mg (OMEDD)

Sevredol
20mg - 3 tabs a day = 60mg (OMEDD)

Tramadol
50mg - 8 caps daily = 80mg (OMEDD)

Tapentadol
200mg - 2 caps daily = 120 mg (OMEDD)

Oxycodone
60mg - 2 caps daily = 180mg (OMEDD)

Morphgesic SR
100mg - 2 caps daily = 200mg (OMEDD)

Fentanyl
75mcg/hrs patch = 225mg (OMEDD)

Fentanyl
100mcg/hrs patch= 300mg (OMEDD)

Burprenorphine (sublingual tablets)
8mg - 1 tabs daily= 320mg (OMEDD)

As the oral morphine equivalent daily dose increases, the risk of serious harm due to side effects increases as well.

Long-term use of opioids is associated with endocrine abnormalities such as:
- absence of period in women
- erectile dysfunction (impotence)
- low sex drive
- infertility
- low mood and fatigue

Recent studies demonstrated that prolonged use of opioids can lead to abnormal pain sensitivity called 'hyperalgesia'.

Opioids can cause sleep apnoea, breathing problems, respiratory depression and even death.

Tame the Beast

Information source:
Faculty of Pain Medicine UK
ANZCA Opioid Calculator
GOV.UK Opioids: risk of dependence and addiction

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References

[1] Chronic pain (primary and secondary in over 16s: assessment of all chronic pain and management of chronic primary pain Available here
[2]Opioids Aware. Faculty of Pain Medicine
[3] PrescQIPP Bulletin 149 Management of non-neuropathic pain. Available here
[4] West Suffolk CCG. Opioid prescribing for acute pain- Key recommendations . Available here
[5] NICE Guidance. Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults. Available here
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Initiating Opioids Appropriately

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