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 pain medicines.

Whilst opioid therapy for chronic non-malignant pain may provide analgesic benefit for some patients, the evidence regarding improvement of 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 often require consultation with a specialist pain management centre.

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 is 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
effects. To accomplish these goals,
prescribing opioids the aim is to red
to achieve outcomes and specific g
graded physiotherapy, and a practic

Clinical decisions about the ongoing
to the patient's circumstances, how
to hang out the washing', or as sign
and are regularly reviewed by the pa
starts and each time goals of treatm

Has a diagnoses of 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

- Assess and address any mental health and/or substance abuse issues.
- Consultation with pain specialist or other specialist if needed
- Informed consent by patient and treatment contract signed.
- Baseline measure of patients functional ability established.
- Goal of trial and endpoint clarified with patient.
- Trial agreed in consultation with at least one other medical practitioner.
- Check patients prescribing history with Pharmaceutical Services Branch

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

- Titrate with 10-50mg morphine equivalent of a long-acting opioid.
- Assess outcome at least weekly and titrate dose as required. Relevant categories, 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, NSAIDS and adjuvants.
- One practitioner to implement and monitor the trial.

***Patients registered as Drug Addicts under the Poisons (Notification) Regulations must receive authority before prescribing commences.**

Patients ideally referred to a multidisciplinary pain management center or other relevant specialist ***before*** prescribing opioids:

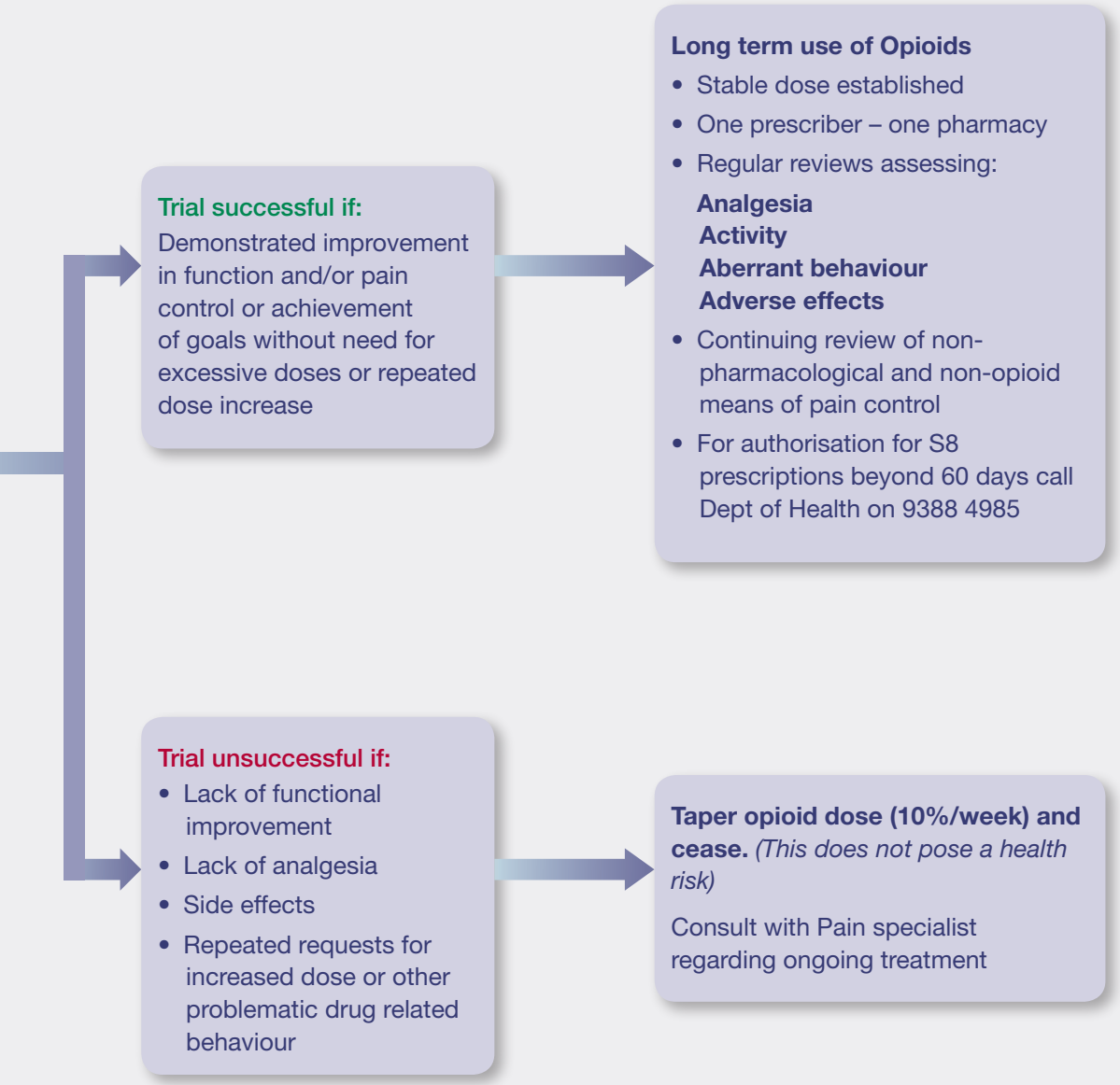
- ✓ Patients with a history of previous or existing alcohol/drug dependence*
- ✓ Patients whose previous use of opioids was problematic
- ✓ Significant psychological issues such as conversion disorder, somatisation, borderline personality, PTSD, mood disorder
- ✓ Younger patients (<50) with poorly defined pathology (fibromyalgia, headaches, chronic low back pain)
- ✓ Complex compensable patients

See overleaf for contact details of specialist services

for an opioid trial in chronic non-malignant pain

to increase the ability to function, reduce pain and suffering, enhance quality of life, and minimise the risk of adverse pain management most often requires a broad array of interventions, only one of which is opioid prescription. In uce pain without causing distressing side effects thus enabling functional restoration in the patient who is then able oals on treatment. These latter outcomes may require a team approach and the services of clinical psychology, ce nurse with the focus on patient self-management rather than endless 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. Goals should be identified, documented and agreed between GP and patient before opioid treatment ent are modified.



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
20-60 mg daily	MS Mono	120mg per day
10-30 mg twice daily	MS Contin	120mg per day
	Oxycodone	
10 mg twice daily	Oxycontin	80mg per day
	Methadone	
5mg up to 3 times daily	Physeptone	30mg 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 unit review; treatment with high opioid doses may paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. 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 abuse, 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 contract 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 Next Step (Alcohol and Drug Authority) • Random checks of remaining medications (tablet count) • Wean and cease opioid if evidence of inappropriate use; if necessary refer to Next Step

Contact Numbers

Department of Health Pharmaceutical services Branch (for Authorisation of S8 Prescriptions beyond 60 days, or to check the prescription history of new or existing patients) **9388 4985**

Next Step Clinical Advisory Service (for 24 hour consultation on Alcohol and Drug related issues) **9442 5042**

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

Royal Perth Hospital Pain Management Unit **9382 7574**

Sir Charles Gairdner Hospital Pain Management Unit **9346 3263**

Fremantle Hospital Pain Medicine Unit **9431 3296**

Government of **Western Australia**
Department of **Health**

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