Chronic Non-Malignant Pain Opioid Guideline

This guideline should be used in conjunction with local and/or national guidance on the assessment and treatment of chronic pain.

This guideline includes text taken from The West of Scotland (WoS) Chronic Non-Malignant Pain Opioid Prescribing Group Guideline and NHS GGC's (Greater Glasgow and Clyde) Chronic Non Malignant Pain Opioid Guideline. The WoS and NHS GGC guidance have been used and adapted for use in NHS Lanarkshire.

Introduction

Chronic pain is common, affecting around five million people in the UK. It is defined as pain which persists or reoccurs for more than three months[1]. Opioids have been increasingly prescribed to treat chronic non-malignant pain. Despite this increase in prescribing, there is little evidence in the long-term use of opioids in chronic pain management.

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 chronic pain should focus 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.

This guideline is intended to provide health care professionals with a practical framework to enable potent opioids to be prescribed in the most effective, safe and consistent way for chronic non-malignant pain. Whilst this guideline is suitable for most patients, clinical judgement should always be applied, taking into consideration of individual patient characteristics.

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NHS Lanarkshire Chronic Non-Malignant Pain Opioid Prescribing Flow Chart

Before Prescribing Opioids:

Initial consultation:

- Assess diagnosis, pain and function. The Brief pain inventory (BPI) may be used click here
- Conduct a biopsychosocial assessment
- Consider non-opioid, non-pharmacological therapies, or neuropathic pain medication where appropriate
- Assess risk of harm or misuse (use Opioid Risk Tool)
- **Talk to patient about treatment plan: expectations, goals and when to stop**

Do be aware that:

- the evidence for use of opioids is mainly from use in acute pain and end of life pain
- there is little evidence of benefit in long term use for chronic pain regardless of diagnosis
- the risk of harm increases substantially at doses above oral Morphine equivalent of 90mg/day

Do not prescribe to:

- patients with concurrent significant mental health problems, drug dependency or addiction
- patients with opioid insensitive pain
- patients with pain associated with diagnostic difficulties, mechanical back pain, headache and fibromyalgia
- patients currently taking benzodiazepines and other sedative medication

Initiation

'Start Low, Go Slow' trial period should be limited to 2 weeks

Aim of therapy is to achieve a 30% improvement in pain and/or a significant improvement in functional ability

- **Continue with analgesia such as NSAIDs or/and Paracetamol if appropriate.**
- **Establish baseline pain and function.**
- **Don't base assessment on WHO Pain ladder.**

Use *immediate release* oral Morphine

- **For opioid naïve patients use lowest effective dose e.g. 5-10mg (max 4 hourly); max 50mg/24 hours**
- **For patients currently on analgesia such as dihydrocodeine (DHC) and co-codamol, discontinue these and treat as opioid naïve**
- **For patients currently on Tramadol, wean this medication and treat as opioid naïve as above**
- **In patients with significant renal dysfunction, refer to appendix 2 for dose adjustments**
- **In frail or elderly patients, dosage should be guided by individual circumstances and co-morbidities, and not by guideline recommendations**

Assess pain and function within 1-2 weeks

- **If intolerable side effects despite treatment, try alternative opioid, refer to 'Opioid Switch'**
- **If no clinically meaningful response, trial is unsuccessful. Wean and DISCONTINUE opioid medication; trial of alternative opioid unlikely to help**
- **If clinically meaningful response, refer to 'Continuing Opioid Prescribing'**

Continuing Opioid Prescribing

- **Use oral route**
- **Convert to MODIFIED or SUSTAINED release opioids**
- **Do not use immediate acting opioids**
- **Use lowest possible dose: avoid >90mg/day Morphine equivalent**

- **Review regularly e.g. 3 – 6 monthly**
- **Maintain lowest dose**
- **Consider weaning every 6 months: is there still need to continue with opioid therapy?**

Wean and discontinue opioid therapy in patients who are no longer suitable- refer to 'Tapering/Weaning and Stopping Guide' – page 6

Side Effects

Common side effects:

- Constipation
- Nausea and vomiting
- itch and sweating

High doses of morphine can impair driving ability. See Appendix 1

Some long-term effects of opioids

- Tolerance, dependence, addiction
- Immunosuppression
- Hyperalgesia
- Hypogonadism, sexual dysfunction, osteoporosis
- Effect on mood, weight, fertility and cognitive function

If Morphine is not tolerated despite treatment of side effects

- Recommence trial using an alternative **immediate release oral morphine** equivalent as per local formulary
- Refer to 'Opioid Switch'.

Indications for discontinuing opioids

- No benefit
- Pain resolves
- Patient receives definitive treatment for pain
- Intolerable side effects
- Aberrant behaviour with opioids

Consider referral to a Pain Specialist for advice:

(please note that these patients should also fulfil the criteria for referral to the Pain service in the first instance)

- Patients with problematic prescribed-opioid drug use, and the patients are willing to engage in drug reduction.
- Patients already in the process of weaning off opioid medication but are having difficulty doing so.

1. Before prescribing opioids

Do be aware that:

- Chronic non-malignant pain can be managed using non-pharmacologic therapy and non-opioid therapy. Examples of this includes:

    - self-referral physiotherapy
    - use of a TENS machine
    - physical exercise and activity
    - cognitive behavioural therapy (CBT)
    - providing patients with a self-help leaflet (Pain Self-Management Prescription)
    - Websites such as Pain Toolkit and Scottish Moodjuice (useful for patients whose mood is affected by their chronic pain)

- There is little evidence of the benefit of opioids in long term persistent pain, regardless of diagnosis. Most evidence for opioid prescribing is mainly in relation to acute and malignant pain.

- The risk of harm increases significantly at doses that are above an oral Morphine equivalent dose of 90mg/day (oral Oxycodone 45mg/day and transdermal Fentanyl patch 25mcg/hour).

- Opioids are associated with common side effects such as nausea, vomiting, constipation, pruritus, dizziness, dry mouth and sedation.

- Opioids are also associated with sleep apnoea, (which can be worsened with concurrent benzodiazepine prescribing). Therefore, opioids are contraindicated in patients with respiratory depression.

- If it is appropriate to prescribe opioids, they should be used in addition to non-pharmacological therapies.

Do not prescribe strong opioids to patients with:

- Opioid insensitive pain.

- Active illicit drug abuse. Refer to addiction services.

- Concurrent significant health problems, drug dependency or drug addiction.

- Patients currently also taking benzodiazepines and other sedative medication.

- Pain associated with diagnostic difficulties, mechanical back pain, headache and fibromyalgia.

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Initial consultation

- **Asses diagnosis, pain and function**

  - What is the cause of the persistent pain?
  - Assess baseline pain and function, (e.g. using Brief Pain Inventory or PADT)
  - Avoid strong opioids for treating mechanical back pain, headaches and fibromyalgia

- **Conduct a biopsychosocial assessment**

  - This includes screening for major medical, psychological and social issues

- **Consider non-opioid pain management treatments**

  - Non-opioid medications
  - Non-pharmacological therapies such as physiotherapy and psychological methods
  - If neuropathic pain is present, consider neuropathic medication (refer to NHS Lanarkshire Neuropathic Pain Guidelines)

- **Assess risk of harm or misuse from using opioids**

  - Consider using The Opioid Risk Tool

- **Talk to patient about opioid treatment plan**

  - Set realistic goals for pain reduction. Typically, a 30% reduction in pain reduction with functional improvement is a useful example.
  - Discuss benefits, side effects and risks of opioids.
  - Give advice on driving and operating machinery (appendix 1).
  - Explain the opioid trial.
  - Set criteria for stopping or continuing opioid therapy.
  - Plan review appointments, initial review should be within 1-2 weeks from commencing treatment.
  - Make patient aware opioids may impair patients' ability to drive.
  - Consider the using a "written agreement action plan" in potentially problematic patients.
  - Check patients understanding of their treatment plan.

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2. Initiation of opioids: Start low, go slow

Aim for a 30% improvement in pain and/or significant improvement functionality during trial period, as set out during opioid treatment plan with patient. Trial period should be set at 2 weeks where possible.

Staring the trial

- Continue with simple analgesia such as Paracetamol/NSAIDSs if appropriate.
- For opioid naïve patients (not previously on weak or strong opioids) prescribe: **Immediate release oral Morphine (or Morphine equivalent) at the lowest effective dose, e.g. 5-10mg when required up to a maximum of every 4 hours**.
- Using immediate release preparations allow the trial to be conducted in a shorter time in comparison to modified release preparations. This allows clinical decisions to be made without delay.
- For patients currently taking weak opioids (e.g. Co-Codamol and Dihydrocodeine), discontinue these medications then treat as opioid naïve patients as shown above.
- For patients currently on Tramadol, wean this medication as much as possible, then treat as opioid naive as above.
- During the trial, there is limited benefit in exceeding morphine doses above 50mg per day.
- For patients with significant renal impairment, refer to appendix 2.
- In frail/elderly patients, the dosage should be guided by individual circumstances and co-morbidities, and not by guideline dose recommendations.

During the trial

- Encourage the patient to keep a pain diary during the opioid trial.
- Assess the pain within 1-2 weeks of starting trial. (Can use the PADT tool)
- Assess pain and functionality compared to baseline score.
- If the opioid such as oral Morphine is not tolerated despite treating side effects, then switch to an oral Morphine equivalent as per Lanarkshire formulary guidelines.
- Be observant for signs of abnormal behaviour, drug misuse or addiction. PADT tool can aid these observations and urine screens can be done also.

End of trial

- **Clinical effectiveness of opioids should be regularly assessed[2]. If there are no significant improvements in pain and function, then the opioid trial has failed. Wean off and discontinue the opioid medication** (see Tapering (weaning) off section).
- Continuing opioid therapy, or switching opioids, is unlikely to help.
- If there is an improvement in pain or function, continuing opioid therapy should be considered as described in the 'continuing opioid prescribing' section.

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3. Continuing opioid prescribing

- Use the oral route where possible.
- Switch to modified release opioids for continuing prescribing.
- Avoid using immediate release opioids unless the patient has significant incidental pain.
- Use lowest possible dose and establish a maximum dose with patient. Avoid doses greater than 90mg of Morphine-equivalent daily.
- Arrange regular reviews (3-6 monthly) to ensure lowest dose is being used and wean off where possible. Consider using PADT tool for review.
- Agree a plan to manage pain flare ups. (see appendix 3)
- If a dose of 90mg oral Morphine-equivalent has been reached and there is no clinical benefit, there is little evidence to recommend switching opioids - consider seeking advice of a Pain Specialist.
- Switching opioids can be considered if there are intolerable side effects.
- Monitor for side effects in relation to long term opioid prescribing. This includes; tolerance, withdrawal, cognitive impairment, weight change, reduced fertility and irregular periods, erectile dysfunction, hyperalgesia, depression, dependence, addiction, reduced immunity, osteoporosis and constipation.
- If hypogonadism suspected, consider measuring sex hormone. If abnormal seek advice from local endocrine clinic.

4. Tapering (weaning) and stopping guidance

Indication for stopping opioids

- No benefit (<30% pain reduction and no meaningful functional improvement)
- Pain resolved
- Patient receives definitive treatment for pain
- Intolerable side effects
- Aberrant behaviour with opioids

How to taper and stop

- Document decision to taper/stop and agree taper plan.
- Reduce dose gradually every 1-2 weeks (e.g. 10%). Some patient may require less than a 10% reduction.
- Monitor patient during taper. If patient experiencing withdrawal effects, then slow down rate of reduction.
- Consider additional support (e.g. psychological).
- Support from specialist services may be required whilst tapering and stopping patients on high dose opioids.

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5. Side effects

If side effects cannot be treated with symptomatic treatments, then opioid rotation should be considered.

Constipation

Most patients taking opioids will develop opioid induced constipation[3]. Guidelines suggest that the best prophylactic treatment for opioid induced constipation is a combination of a stimulant laxative and a stool softener[3].

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 antiemetic to be taken if required. Refer to Lanarkshire formulary for treatment options[4].

Itch

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

Appetite

Continued use of opioids may be associated with loss of appetite and therefore weight loss. If these symptoms are solely related to opioid therapy, then consider weaning off/rotating opioid therapy.

Withdrawal

Opioid withdrawal symptoms are well acknowledged. They include low energy, anxiety, agitation, runny nose, sweats, aches, abdominal cramping, and diarrhoea. Where appropriate, consider symptomatic treatments. If withdrawal symptoms are related to tapering/stopping, the consider doing so at slower rate to allow symptoms to subside.

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6. Opioid switch

Opioid switching can be considered in situations where the patient is benefitting from opioid therapy, but cannot tolerate the side effects.

If a switch is appropriate for the patient, use the minimum effective dose. This will typically be **50-75% dose equivalence of the original opioid (see example below)**. This can be calculated via the Opioid Dose Converter calculator [5]. This calculator is an approximate guide and clinical judgement should always be applied. It is available on the link below:

https://www.paindata.org/calculator.php

Upon switching, the original opioid should be stopped, and the patient should directly switch on the new opioid. The patient should start their new opioid the next time they are due to take their original opioid.

In patients taking high doses of opioid, elderly or frail, or are experiencing intolerable side effects, the starting dose of the new opioid should be at 50% dose equivalence of the original opioid. Patients should be reviewed within 1-2 weeks. Immediate release opioids can be used during the switch over to prevent withdrawal and/or increased pain but are not recommended for long term use.

Opioid switch example

Switching from 60mg/24hour of modified release (m/r) oral Morphine to modified-release Oxycodone.

- Using the calculator, the dose equivalent of Oxycodone is 30mg/24 hours.
- 75% dose equivalence of Morphine is shown at 22mg/24 hours of Oxycodone.
- Oxycodone m/r 10mg (twice daily), should be prescribed in this case, as there is no modified release of Oxycodone that would allow 22mg/24 hours.
- Oxycodone m/r 10mg twice daily would give 20mg/24 hours dosing. This is still within a 50-75% dose equivalence of the original opioid prescribing of Morphine m/r.

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Appendix 1

Driving

The law in Scotland allows you to drive if you are taking prescribed opioid medicines in accordance with the instructions from your prescriber (including what your prescriber advises you about driving safely). Your ability to drive may be affected by tiredness, your pain and other medicines you take. High doses of morphine can impair your ability to drive.

- You should never drive if you feel unsafe or your ability has been impaired.
- You are responsible for making sure you are safe on each occasion that you drive.
- It remains an offence to drive while impaired by your medications.

The law on drugs and driving in England and Wales changed in 2015. This will affect anyone crossing the border. If you're driving is impaired for any reason, including taking medicines, it is illegal to drive. It is also now illegal to drive when you are taking opioid medicines without them being prescribed, even if you are not impaired.

All opioid medicines have the potential to impair driving and your prescriber will advise whether the dose of opioid you are taking is likely to impair you. If you are taking a high dose of opioid your prescriber will advise you that you are probably not safe to drive and will document this in your medical notes.

Appendix 2

Renal impairment

For patients with renal impairment, the likelihood of opioid toxicity increases with any opioid. Opiates should be used with great care in patients with renal disease especially in opioid naive patients, those on long-acting preparations and those with changing and severe renal impairment [6]. Patients should always be started at the lowest possible dose and monitored closely before repeated dosing. If required doses should only be very gradually increased every 3-4 days to help prevent side effects[6]. Consult the renal team or pain team for specialist guidance. Further information on required dose reductions can be found within The Renal Drug Database. It is available on the link below:

https://renaldrugdatabase.com/

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Appendix 3

Flare up management

Flare ups are common in people with chronic pain. Although flare ups are often distressing and frightening, they rarely indicate new damage.

- Advise patient to continue taking medication as prescribed.
- If short term changes to the patient's medication are required, then a management plan needs to be agreed between the patient and the healthcare provider and be adhered to. Return to normal medication when flare up has settled.
- Reduce exercise and normal activity, but maintaining some gentle activity is important.
- Suggest patient ask others to help during the flare up and gradually get back to usual levels of activity.
- Advise patient to learn deep breathing exercises and relaxation techniques. Check for negative thoughts and "catastrophic" thinking. Water bottles, heat packs, electric blankets, warm baths or Jacuzzis can sometimes help.
- Encourage the patient to eat regularly and have a few meals in the freezer that can be heated up.
- Distraction is often helpful – TV, reading, having someone to talk to etc.
- Return to normal activities and exercise when flare up has settled.
- Encourage patient to develop a flare up management plan that works for them. They should start the plan as soon as the flare up begins.

Appendix 4

NHS Lanarkshire local resources

NHSL Chronic Pain Service webpage:
https://www.nhslanarkshire.scot.nhs.uk/services/chronic-pain/

NHSL Musculoskeletal Physiotherapy webpage: Musculoskeletal (MSK) Physiotherapy | NHS Lanarkshire (scot.nhs.uk)

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Resources

- https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware accessed Nov 2021.
- The West of Scotland (WoS) Chronic Non Malignant Pain Opioid Prescribing Group Guideline, December 2012
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