Opiate use in non-malignant persistent pain

North Cumbria Position Statement

Patients with non-malignant persistent pain should not be prescribed more than:

- **120mg oral morphine (or equivalent) per day.**

Ideally doses should not exceed:

- **50 mg oral morphine (or equivalent) per day**

The risk of harm increases substantially above 120mgs oral morphine per day (or equivalent) **WITH NO INCREASED BENEFIT**

- If a patient is using opioids but is still in pain, the opioids are ineffective and should be reduced with a view to discontinuing, **even if no other drug treatment is available**

Opioids are effective analgesics for acute pain and for pain at the end of life but there is very little evidence that opioids are helpful for persistent (chronic) pain.

A small proportion of people may obtain good pain relief with opioids if the dose can be kept low and use is intermittent, but it is difficult to recognise these people at the point of initiation.

The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.

Supported self-management is a recognised intervention for persistent pain. It does not seek to cure, but helps patients manage their condition and minimise the impact of the pain has on their everyday life.

NICE NG59 2016 *Low back pain and sciatica in over 16s: assessment and management* states '*Do not offer opioids for managing chronic low back pain'*.

NICE Clinical Guideline (CG) 173 *Neuropathic pain in adults: pharmacological management in non-specialist settings* (2013) recommends that morphine should not be started to treat neuropathic pain in non-specialist settings, unless advised by a specialist.

The most recently published guidelines on opiate prescribing in persistent non-malignant pain (The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain) essentially recommend a maximum of 50mg oral morphine a day or its equivalent, with possibly 90mg oral morphine a day or equivalent if good benefit demonstrated.

In the UK, Public Health England funded the Royal College of Anaesthetists to produce Opioids Aware (click to access), a resource for patients and healthcare professionals to support prescribing of opioid medicines for pain, which states 'the risk of harm increases substantially at doses above an oral morphine equivalent greater than 120mg/day, but there is no increased benefit'.

Also see Fayes' story: Controlled Drugs: Learning from Incidents newsletter August 2017 Issue 8 *What can happen when things go wrong when prescribing for chronic pain.*

Agreed: 1st March 2019 by North Cumbria MOC **For review:** 1st March 2022

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Guidance for clinicians

Key Principles

The aim is to promote quality improvement in prescribing for adults with persistent pain, leading to structured review of appropriateness, efficacy and tolerability of treatment and promotion of optimal care. Through consideration of non-pharmaceutical management of persistent pain, there is the potential to reduce medication burden on patients and the risk of adverse effects, as well as better outcome overall. There are a number of principles which should be considered.

- Chronic pain is a condition which is individual to the patient and any therapeutic management plan needs to place the patient at the centre. The approach should be based on assisting the patient to achieve goals which have been identified in partnership with the prescriber.

- Prescribers should help patients to develop their understanding of the value of self-management and non-pharmaceutical approaches, and support people to access the tools, resources and support available to put these approaches in to practice.

- Prescribers should work with patients to develop their understanding of chronic pain, how it differs from acute pain and the impact this may have on goals of therapy. Difficult and honest conversations may be required to establish an understanding with the patient that it is highly unlikely that the therapeutic management plan will result in full resolution of their pain symptoms (>30%), but it may assist them with coping.

- Patients should be given information on the potential benefits of their medicine as well as risks and reported side effects. This is particularly important regarding drugs which have the potential for misuse, including gabapentinoids and opioids.

- Patients should be aware that non-pharmaceutical options or those offered along with prescribed medicines, may result in better achievement of goals and result in less harm than medicines alone. This may include referral to physiotherapy, mental health or occupational therapy services.

- A robust plan for ongoing review should be at the centre of care for every patient.

- Clinicians should ensure extra care is taken when prescribing in non-healthcare settings, particularly around storage and administration of medicines.

- Prescribers should particularly review patients who are co-prescribed analgesics and other potentially problematic drugs such as benzodiazepines, and those with a history of substance misuse.

NICE have produced a resource document that collates all the current evidence and guidelines on the management of chronic pain - https://www.nice.org.uk/advice/ktt21/chapter/Evidence-context .

NECS Medicines Optimisation website opioid resources:

https://medicines.necsu.nhs.uk/opioidresources/