Opioid Prescribing for Persistent (Non-Cancer) Pain in Adults

County Durham and Darlington
Area Prescribing Committee

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Scope

The purpose of this document is to provide prescribers with guidance when prescribing opioids for persistent (non-cancer) pain in adults. The guidance should be read in conjunction with the key messages document detailed below.

The guidelines and key messages (Treatment of Neuropathic pain, Strong Opioids and Tapering Opioids) have been developed by the County Durham and Darlington Pain Prescribing Guidelines Task and Finish Group; a sub group of the County Durham and Darlington Area Prescribing Committee and comprised of members from County Durham and Darlington Foundation Trust, North Durham CCG, Durham Dales Easington & Sedgefield CCG and North of England Commissioning Support. The key messages (Managing Persistent Pain and Non-pharmacological Management of Pain) have been approved by both the County Durham and Darlington Pain Management Education Group and also the Pain Management Project Group.

The guidelines:

- Pharmacological Treatment of Neuropathic Pain
- Opiate Prescribing in Persistent (Non-cancer) Pain

Key Messages:

- Managing Persistent Pain
- Non-pharmacological Management of Pain
- Treatment of Neuropathic Pain
- Strong Opioids
- Tapering Opioids for Persistent Pain

All references are provided as a guide and individual patient factors should be taken into account before a change to treatment is initiated.

Please refer to the BNF or Summary of Product Characteristics for further information on medications, side effects, cautions, contra-indications, interactions and formulations.

Background

The approach to the management of Persistent Pain has changed. This is reflected in the amendment in terminology from “chronic pain” to “persistent pain”.

Although medication continues to have a place to play in the management of persistent pain, it is no longer considered appropriate to continue the approaches that are indicated for acute pain in the management of persistent pain.

The pain ladder approach that was developed for malignancy related pain is recognised as often being unhelpful in persistent pain, as well as leading to patient safety issues as medication doses escalate.

Acute pain alerts us that something is wrong and our systems respond both to assess the reason for the pain and to assess the necessary action required.

Whilst in some people their pain persists long after an acute injury or disease process has healed, for many others pain arises and persists with no obvious initiating trauma or disease process.

Persistent pain is often referred to as a “maladaptive stress response” and the body’s systems not only remain on “high alert” but even become more sensitive with time.

The key elements of the approach to persistent pain is that:

1. Pain is created in the brain. We can only feel pain because we have a brain, we can only know we have pain because we have a brain.
2. Our brain is not permanently fixed in the way it operates and with practice it is possible to change the unhelpful ways the brain is operating (*neuroplasticity*).
3. The evidence base supports the use of strategies and practices that act on the brain to improve the impact of persistent pain.
4. Pain is real. “Created by the brain” does not mean “it’s all in your head”.

An important characteristic in persistent pain is that the pain will often ebb and flow. People are also prone to flare-ups and as such, there is a requirement to alter medication accordingly in order to reflect these changes rather than having a fixed regimen. Recognising a flare-up and appropriate up titration of medication (with an anticipation of reducing medication after the flare has resolved) is also key to effective pain management.

Further guidance on a non-pharmacological management approach is to be read in conjunction with this guidance and is available here [link to add once complete].

General Principles of Persistent Pain Management:

1. Manage patient expectations; promote and improve function over pain control.
2. Trial of medication for four to six weeks and withdraw if it is ineffective.
3. Push exercise, weight reduction, physiotherapy and psychological therapies.
4. For some people the medication side effects can be worse than the pain, particularly sedation, weight gain, risk of dependency, severe constipation.
5. Be aware that prescriptions for medications - particularly pregabalin, gabapentin and opiates are prone to being diverted/misused.

Patient Assessment:

1. Take the pain history and particularly concentrate on the nature of the pain (purely neuropathic pain does not respond well to opiates).
2. Consider co-morbidities especially renal function, hepatic function and a past history of sleep apnoea.
3. Consider co-existing psychological morbidities.
4. Check for previous history of substance misuse.
5. Consider whether the patient drives – further information for patients taking certain strong opioids and driving can be found here. Information for healthcare professionals can be found here.
6. Consider work and hobbies which may involve operating machinery, working at heights etc.

Opioid Prescribing in Persistent Pain:

1. Opiates are very effective in acute pain and terminal care but there is less evidence of their role in persistent (non-cancer) pain.
2. The dose of opiates in these situations should be under 100mg per day equivalent of morphine sulfate (see appendix for opioid equivalence) and opiates are more effective if used intermittently (not in palliative care).
3. The risk of harm substantially increases with doses equivalent to over 120mg of morphine sulfate particularly sedation, constipation, overdose and dependency.
4. If 100mg of morphine sulfate equivalent is not effective then it should be discontinued through tapered reduction, even if there are no other therapeutic options left as it is likely to do harm without any benefit.

Conducting a Trial of Opiates:

1. Explore the expectations of the patient, again concentrating on function over pure pain relief.
2. Prescribe one to two weeks of morphine sulfate modified release (Zomorph m/r) as a trial.
3. Initiate 10mg twice daily of morphine sulphate modified release (Zomorph m/r) titrating up to further improve function, or reducing due to side effects on review.
4. Consider anti-emetics and laxatives at this point.

Common Opioid Side Effects:

50–80% of patients in clinical trials experienced side effects with opiates and there is no evidence of any particular formulation or type of opioid having a better side effect profile than another.

Constipation and itching are the most common side effects and these do not tend to improve as other side effects are tolerated. Respiratory depression is a significant concern, particularly in patients with a history of sleep apnoea and this should be considered before starting treatment with an opioid.

Intermittent dosage can lead to more side effects as the patient develops tolerance but overall their dosage of opiates will be kept under control.

Transdermal opiates have additional risks; if the patient has a raised temperature whether due to a fever or taking a hot bath etc. this has led to fatalities in the past due to an increased amount of opioid being released from the patch.

Be aware of the risk of unplanned hospital admissions due to side effects of opioids, particularly faecal impaction, confusional states, falls and fractures.

Stopping Opioids:

If the condition resolves, for example post joint replacement or where 100mg equivalent of morphine is ineffective then opiates should be stopped. It is suggested a rate of 10% reduction per week is usually achievable without any signs of withdrawal. However, people vary and slower reductions may be necessary particularly when the person has been on regular opioids for a while. It may be necessary to change the formulation of the patient's opiates to achieve the reduction in dosage.

Switching opioids may be warranted due to severe side effects. Dose equivalence charts are a guide only and there is significant individual variation. Patient safety means that the guide should be taken as a maximum initial dose. Be aware of the half-life and the time of onset of action between different formulations so that the

patient does not end up receiving a double dose in the first 24 hours of a swap. Be aware of withdrawal symptoms from opiates which are typically sweating, yawning, abdominal cramps and anxiety symptoms. These may be seen if too little opioid is prescribed when switching is occurring.

Opioids Not Recommended in Primary Care:

1. Fentanyl patches - most doses are greater than the equivalent of 100mg of morphine. Immediate release fentanyl is not recommended.
2. Tapentadol - may be recommended by the pain clinic for the relief of severe persistent pain in adults which can be adequately managed only with opioid analgesics AND in whom morphine and oxycodone has failed to provide adequate pain relief or is not tolerated.
3. Hydromorphone – specialist prescribing only.
4. Oxycodone - only to be considered if intolerable side effects with morphine but there is no guarantee of it being more effective.
5. Targinact - not recommended on County Durham and Darlington Formulary.

Management of Opioid induced constipation.

At least 40% of patients experience constipation whilst taking opioid-based analgesia. Therefore it is wise to consider prophylaxis in these patients which consists of general advice about fluid intake, exercise and eating plenty of fruit and vegetables.

In terms of medication, the combination of a stimulant and an osmotic laxative are the most appropriate treatment for opioid induced constipation (i.e. to avoid bulk forming laxatives which are usually the mainstay of constipation treatment).

Suggested regime:

- Senna 15-30mg at night or bisocodyl 5-10mg at night **and**
- Laxido® 1-3 sachets per day.

Other options are docusate sodium and sodium picosulphate.
If patient presents with faecal impaction then Laxido® up to 8 sachets per day is the first line of treatment.

Specialist only drugs for constipation due to opioid usage

Naloxegol is for specialist initiation only. Methylnaltrexone is not currently included on the County Durham and Darlington formulary.

Appendix 1 Opioid Equivalent Chart

This table is for identifying patients who take equivalent doses of opioids which are equal to or exceed 100mg of morphine per day. It should not be used clinically for dose titration or to convert between opioid products, for this purpose other reference sources are available.

Opioid base	Name of Medication	Formulation	Usual frequency	Dose equivalent to 100mg of morphine in 24 hours
Morphine	Morphine sulphate	Oral solution	Every 4-6 hours PRN	Any dose totalling 100mg/24hrs or above
	Oramorph			
	Severedol	Tablets	Every 4-6 hours PRN	Any dose totalling 100mg/24hrs or above
	Morphine sulphate M/R	Capsules	BD	Doses of 50mg TWICE daily or above
	Zomorph**			
	Morphine sulphate M/R	Tablets	BD	Doses of 50mg TWICE daily or above
	MST			
	Morphgesic			
	MXL capsules	Capsules	OD	Doses of 100mg ONCE daily or above
Oxycodone	Oxycodone	Oral solution	Every 4-6 hours PRN	Any dose totalling 50mg/24hrs or above
	OxyNorm			
	ShorTec			
	OxyNorm	Capsules	Every 4-6 hours PRN	Any dose totalling 50mg/24hrs or above
	Lynlor			
	ShorTec			
	Abtard	Tablets	BD	Doses of 25mg TWICE daily or above
	Carexil			
	Leveraxo			
	Longtec**			
	Onexila			
	Oxeltra			
	Oxycodone M/R			
	OxyContin			
	Oxylan			
	Reltebon			
	Zomestine			
	Targinact (oxycodone + naloxone)	Tablets	BD	Doses of 25mg TWICE daily or above
Tapentadol	Palexia	Oral solution	Every 4-6 hours PRN	Any dose totalling 250mg/24hrs or above
	Palexia	Tablets	Every 4-6 hours PRN	Any dose totalling 250mg/24hrs or above
	Palexia SR	Tablets	BD	Doses of 125mg TWICE daily or above
Hydromorphone	Hydromorphone	Capsules	Every 4 hours	Any dose totalling 13mg/24hrs or above
	Palladone	Capsules	Every 4 hours	Any dose totalling 13mg/24hrs or above
	Hydromorphone SR	Capsules	BD	Doses of 8mg TWICE daily or above
	Palladone SR	Capsules	BD	Doses of 8mg TWICE daily or above

Dipipanone + cyclizine	Dipipanone + cyclizine	Tablets	6 hourly	Any dose totalling 200mg/24hrs or above
	Diconal			
Pethidine	Pethidine	Tablets	4 hourly	Any dose totalling 800mg/24hrs or above
Pentazocin	Pentazocine	Tablets	3-4 hourly	Any dose totalling 200mg/24hrs or above
		Capsules		
Methadone	Methadone	Tablets	Variable	Any patient taking Methadone for pain relief
	Methadone	Oral solution		
	Physeptone			
Buprenorphine	Butec**(7 day patch)	Transdermal patch	ONCE weekly	Doses of TWO or more 20micrograms/hr patches applied once weekly
	Buprenorphine			
	BuTrans			
	Panitaz			
	Reletrans			
	Sevodyne			
	Hapoctasin		Every 72 hours (3 days)	Any patch equating to 52.5micrograms/hr or above
	Prenotrix			
	Bupaeze		Every 96 hours (4 days)	Any patch equating to 52.5micrograms/hr or above
	Buplast			
	Transtec** (4-day patch)			
	Buprenorphine	Sublingual	OD	Any dose above 1.25mg daily
	Natzon			
	Prefibin			
	Subutex			
Fentanyl	Mezolar**	Transdermal patch	Every 72 hours (3 days)	Any patch equating to 37.5microgram/hr or above
	Durogesic			
	Fencino			
	Fentalis			
	Fentanyl			
	Matrifen			
	Mylafent			
	Osmanil			
	Tilofyl			
	Victanyl			
	Yemex			
	Abstral	Sublingual tablet	When required	Any dose totalling 600micrograms/24hrs or above
	Fentanyl			
	Recivit			

	Actiq	**Lozenge**	**When required**	**Any dose totalling 600micrograms/24hrs or above**
	Fentanyl			
	Effentora	**Buccal tablet**		
	Fentanyl			
	Instanyl	**Nasal spray**	**4 hourly**	
	Fentanyl			
Papavertum, diamorphine, alfentanil, remifentail are not included in this document ** formulary choice - however other brands are available				
Suppositories and injections are not included in this table				
This table is for identifying patients who take equivalent doses of opioids which are equal to or exceed 100mg of morphine per day. It should not be used clinically for dose titration or to convert between opioid products, for this purpose other reference sources are available.				