Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

PRESCRIBING IN CHRONIC NON-MALIGNANT PAIN IN ADULTS

(Non-neuropathic pain)

Assess patient using appropriate tool

- ASK2QUESTIONS,
- BPS Pain Scales in different languages
- Link to Sheffield Neuropathic Pain Guidance and Sheffield Palliative Care Formulary

Medicines only play a minor part in managing chronic pain, and should only be used as part of a wider management plan.

- Start by finding out the **patient's pain story** (Opioids Aware: **Patient Assessment**).
- Explain role of **sensitisation of the nervous system** with chronic pain. It may be that the pain signalling becomes self-sustaining over a prolonged period; like the volume on our pain system being left turned up. Managing pain requires turning the volume down.
- Consider other ways apart from medicines to manage pain. **Refer patient to resources to help them learn about chronic pain and what they can do to try and improve their pain and quality of life** e.g. Sheffield Aches and Pains and My Live Well with Pain website which has this leaflet Explaining Pain and 'Ten Foot Steps towards supporting your patients to live well with pain' (available as a leaflet or an interactive guide).

First line:

- **Paracetamol** (encourage OTC). Low body weight <50 kg consider reducing dose (see link for local advice).
- Consider NSAID if inflammatory component taking into account patient risk factors. Use lowest effective dose for shortest period of time. **Ibuprofen** (encourage OTC) or **naproxen**. Prescribe gastro protection if appropriate - PPIs risks vs benefits.

Second line:

- Paracetamol plus separate codeine *(easier to titrate than combination preparations).* If poor response to codeine, consider dihydrocodeine standard tablets (may be poor metaboliser of codeine).

Considerations:

- Soluble tablets have much higher sodium content than standard tablets and are more expensive.
- **Tramadol** is neither more effective nor better tolerated than other weak opioid analgesics for moderate to severe pain (PrescQIPP Bulletin 62); can lead to tolerance, psychological and physical dependence. Use immediate release for short term use. Modified release may be more appropriate for long-term use (Tramulief® is Sheffield's preferred choice).
- **Nefopam:** limited evidence base and high risk of adverse effects. Only use if NSAID or opioid is contraindicated or not tolerated.

****Do not offer opioids for chronic back pain and chronic sciatica** (NICE NG 59) and **pain typical of fibromyalgia****

- See relevant **NICE guidance for specific conditions** e.g. Osteoarthritis, Low Back Pain and Sciatica, Headaches.

What to consider before prescribing a strong opioid:

- See Opioids Aware: Checklist for Prescribers (what to discuss with patient, record keeping and frequency of review).
- **Opioids are very good analgesics for acute pain and pain at the end of life but there is little evidence they are helpful for long term pain (use for longer than 3 months carries an increased risk of dependence & addiction):** a small proportion of patients may benefit if the dose is kept low and use intermittent but identifying these patients is difficult.
- Have open and honest discussion with patient **regarding risks and features of tolerance, dependence, and addiction,** including potentially fatal unintentional overdose, and counsel patients and caregivers on signs and symptoms of opioid overdose to be aware of.
- Provide patient with information: MHRA Opioid Safety Leaflet and Opioids Aware: Taking Opioids for Pain.
- **Opioid toxicity is more likely with increasing age, co-prescribing and co-morbidity:** Discuss **common side effects** and potential **long term harms**, including increased risk of falls. Monitor for side effects and reduce dose.
- **DVLA:** Patients have responsibility to determine if their driving is impaired by medication and must inform DVLA.
- Consider **referral to Pain Clinic** before starting a strong opioid especially if young and/or history of substance misuse.
- **Opioids initiated in hospital should not be routinely added to repeat medication.** Taper and stop opioid to avoid unnecessary long-term use. Remember to taper a temporary dose increase that occurred in hospital.

Author: Helen Taylor, Practice Pharmacist. In Consultation with Specialists at Pain Clinic Sheffield Teaching Hospitals. Approved by APG: 20th September 2018. Review date: 20th September 2021 (interim update: 3rd Nov 2020)

Decision to commence strong opioid:

- Document relevant clinical findings that support decision to prescribe opioids & information given to patient. **Discuss with patients that prolonged use of opioids may lead to drug dependence and addiction, even at therapeutic doses.**
- **Start with Opioid Trial**. This establishes whether the patient achieves any reduction in pain with the use of opioids. The patient and prescriber should agree some readily assessable outcomes that indicate opioids may play a role in the patient's management e.g. **Aim for 30-50% improvement in pain and / or significant improvement in functional ability or if pain affects sleep, sleep improvement could be an outcome**
- **If there is no useful pain relief within 2-4 weeks then any long term benefit is unlikely; and the opioid should be tapered and stopped within one week**. A successful short-term opioid trial does not predict long-term efficacy.
- A diary may help when starting new medication or changing dose.
- **STOP weak opioid and care with polypharmacy**. Potential for cumulative central nervous system depressant effects of e.g. drowsiness, respiratory depression if prescribed with other central nervous system depressants such as **pregabalin** and **gabapentin** (Advice for prescribers on the risk of the misuse of pregabalin and gabapentin).

Long term prescribing of strong opioid:

- **Agree with patient a treatment strategy and plan for the end of treatment. Keep dose low and intermittent.**
- **Always use alongside non-pharmacological ways of managing pain.**
- **First line strong opioid: Oral morphine (Zomorph® is formulary choice for modified release).** Alternative opioids, see local guidance on: TD opioids (fentanyl & buprenorphine), Oxycodone.
- Discuss and document circumstances under which opioid therapy should be discontinued. Set ground rules for lost scripts or early requests for script. Avoid repeat prescribing. Consider Opioid prescription agreement.
- Keep under **regular review** (at least 6 monthly) in order to detect emerging harms and assess ongoing effectiveness – preferably one prescriber to manage reviews and prescriptions. Provide regular support especially to individuals at increased risk, such as those with current or past history of substance use disorder or mental health disorder.
- Document total morphine daily dose equivalent.

****Do not increase above oral morphine 120mg /day as risk of harm increases substantially with no increased benefit****
(approximately equivalent to oxycodone 80mg/day, fentanyl 50mcg/hr patch, buprenorphine 52.5mcg/hr patch)

Opioid Tapering

When to consider opioid tapering:

- **Daily dose of opioid medication > 120mg/day oral morphine equivalent**
- If opioid is not providing useful pain relief it should be discontinued even if no other treatment options are available.
- If there is an increase in pain following period of stable dosing, and where there is no evidence of malabsorption or disease induced pain progression consider reducing the opioid as unlikely to be beneficial.
- To check for on-going benefit (e.g. underlying painful condition resolves) or the patient receives a definitive pain relieving intervention (e.g. joint replacement).
- The patient develops intolerable adverse effects.
- Strong evidence patient is diverting medication to others or showing drug seeking behaviour e.g. early or lost scripts

How to taper the opioid dose: (Sheffield Opioid Tapering Resource **and** Opioids Aware: Tapering and stopping)

- **Reduce slowly. Tapering the dose of drug by 10% every 1-2 weeks is usually well tolerated.**
- Patient engagement is essential. Explain rationale to patient e.g. avoidance of long term harms. Offer reassurance - often no increase in pain. Monitor for signs and symptoms of opioid withdrawal. Offer regular review and support.
- **If patient is willing to engage in dose reduction but specialist support is required consider referral to START (Sheffield Treatment and Recovery Team) or Pain Clinic as appropriate.**

References:

- Opioids Aware: https://fpm.ac.uk/opioids-aware
- PrescQIPP bulletin 149i: Management of non-neuropathic pain, January 2019, bulletin 256i: Dependence Forming Medications, April 2020 and bulletin 218i: Reducing opioid prescribing in chronic pain, February 2019. Accessed: https://www.prescqipp.info/
- CQC: Safer Management of Controlled Drugs: The Safer Management of Controlled Durgs Annual Update. 2019
- MHRA Drug Safety Update. Vol 14. September 2020. Opioids: risk of dependence and addiction
- Public Health England's: Evidence review of dependence and withdrawal associated with some prescribed medicines.
- BNF: https://www.medicinescomplete.com/#/browse/bnf. Accessed 26.10.2020

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