



NSW
THERAPEUTIC
ASSESSMENT
GROUP

GENERAL PRINCIPLES

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Rational Use of Opioids in Chronic or Recurrent Non-malignant Pain

Background

One in five people in NSW suffers from chronic pain (defined as pain experienced every day for three months or more).¹

Patients with chronic pain may present for treatment of

- acute pain from unrelated injury or illness,
- exacerbation of chronic pain, or
- ongoing management of chronic pain.

These guidelines are intended to assist general practitioners (GPs) and other primary care clinicians to manage the complex medical, ethical and regulatory considerations involved in treating such patients, especially where there is exacerbation of chronic pain.

There are several published guidelines on the use of opioids in patients with chronic non-malignant pain.^{2,8} This document integrates the key points from these guidelines with practice-based experience from general practitioners, emergency physicians, pain specialists and others with expertise in this area. The recommendations are based on the best available evidence where such evidence has been identified, and the consensus views of experts where research evidence is lacking.

ISSUES IN MANAGEMENT

Goal of treatment

Management of chronic or recurrent non-malignant pain aims to enhance functioning (physical, psychological and social) and minimize distress. It should be possible to control pain to a tolerable level and maintain an acceptable level of function in social, occupational and personal life. It is rarely possible to completely eliminate chronic pain.

Pain is a subjective experience

Most cases of acute pain can be reliably attributed to an identifiable disease or damage process. By contrast, in chronic pain an identifiable process is less likely to be found. In addition to the obvious sensory dimension of pain (acute or chronic) there is an emotional component, which may include anxiety, depression, apprehension and fear. Particularly in chronic pain, where the link to obvious tissue damage may be unreliable, the emotional dimension may play a major role.

There is no objective test for pain; its assessment is always based on clinical judgement.

For further information on the cognitive and behavioural aspects of chronic pain, refer to *Therapeutic Guidelines: Analgesic*, 4th Edition, published by Therapeutic Guidelines Limited (2002)⁸, which contains useful information for clinicians and patients. A self-help book which may also be helpful is *Manage Your Pain: practical and positive ways of adapting to chronic pain*, by Nicholas et al, published by ABC Books (2001).⁹

Multi-disciplinary approach to management

It is generally accepted that the management of chronic pain requires a multi-modality approach, which emphasises the role of non-drug techniques. Access to specialised health professionals (eg physiotherapists, psychologists) may be limited. Non-drug techniques can be utilised by doctors. (See Box, page 3) Management should not rely on pharmacological therapy alone.

Pain management plan

A written pain management plan, agreed between patient, general practitioner and pain management team, is an important component of treatment. It helps general practitioners, Emergency Department physicians and locum practitioners provide consistent care. It also encourages patients to take an appropriate role in the management of their pain and helps them to deal with exacerbations that may occur out of normal business hours. Liaison between senior Emergency Department physicians and the general practitioner should occur as early as possible. Use of Enhanced Primary Care items for case conferencing and care planning (see Medical Benefits Schedule) may facilitate such liaison.

'After-hours' management

Management principles should be the same for patients who present 'in hours', 'after hours' or in the locum situation. The aim of 'after hours' care is to reduce immediate distress and assist in creating or implementing a treatment plan which

is followed consistently irrespective of the health setting in which the patient presents. The patient's regular general practitioner and/or pain management team is central to the patient's care. They should be informed of Emergency Department visits and locum consultations, especially where there is an increased frequency of these presentations. Frequent, ongoing communication between Emergency Departments and general practitioners (with patient consent) is important to achieve continuity of care. Similarly, careful communication between regular and locum services is important. Management decisions and response to treatment should be clearly documented and communicated.

Consultation or referral

Consultation with or referral to a specialist in pain medicine, mental health or drug and alcohol services may be warranted depending on the complexity of the presenting problem and the expertise of the practitioner. Whether or not referral is planned, attempts should be made as early as possible to identify and address the patient's beliefs and behaviours. (Note: Psychosocial factors which may contribute to long-term disability ('yellow flags') are outlined in NSW TAG's Guidelines on Low Back Pain. See www.nswtag.org.au.)

Determining the appropriate opioid dose

When opioids are required, it is important that the appropriate dose is prescribed. The appropriate dose of an opioid analgesic is that which achieves satisfactory functioning with adequate pain control and tolerable side effects. Thus the dosing decision requires clinical judgement. A common error is to use inadequate doses of opioid analgesics.

Management Principles

Aims of treatment:

- Control pain to a tolerable level (may not be possible to eliminate pain)
- Minimise distress
- Enhance functioning (physical, psychological, social)

Evaluation over time should include:

- Detailed pain history and assessment of impact of pain
- Psychosocial assessment
- Directed physical examination
- Review of previous diagnostic investigations
- Review of outcomes of previous interventions and strategies, including patient self-management
- Assessment of co-existing diseases/conditions

Management approach:

- Use both pharmacological and non-pharmacological modalities (see examples following)
For more information on non-pharmacological modalities see NSW TAG's Guidelines on Low Back Pain⁷
- Assess regularly
- Use designated primary clinician
- Involve family and other supports
- Manage pain consistently in all settings, including 'after hours' attendances
- Encourage communication between primary clinician, Emergency Department and locum services
- Reassess: if analgesics not effective, discontinue and consider alternative management (see examples following)
- Refer to a multi-disciplinary pain clinic if appropriate and practical, and/or take advice from specialists by telephone if referral is impractical or delayed

Multi-disciplinary approach to chronic pain management

Multidisciplinary collaborations involving general practitioners and allied health professionals provide the best outcomes. Multidisciplinary pain programs emphasise a range of strategies:

Strategy**	Examples
Educate patient	Explain nature of chronic pain and relationship between mind and body, encourage realistic expectations, promote and support self-help, address beliefs
Prevent secondary dysfunction	Promote return to normal activity, encourage return to work, address fear avoidance behaviour
Optimise physical functioning	Encourage active physiotherapy/exercise
Enhance psychological well being	Use cognitive behavioural therapy, stress management, other psychological techniques

** For more information about strategies, see Nicholas et al, 2001¹⁰

Levels of evidence

- Level 1 Evidence obtained from systematic review of relevant randomised controlled trials
- Level 2 Evidence obtained from one or more well-designed, randomised controlled trials
- Level 3 Evidence obtained from well-designed, non-randomised controlled trials; or from well designed cohort or case control studies
- Level 4 Opinions of respected authorities based on clinical experience, descriptive studies, reports of expert committees

Chronic Non-Malignant Pain: Pharmacological Management and Rational Use of Opioids

- Use a step-wise approach.
- Use regular dosing rather than 'as required'.
- Use maximal doses before moving to the next step.
- Assess response to medications after 2-3 weeks.
- If the patient does not respond, review and explore reasons for non-response
- Consider combination therapy or addition of adjuvant medications. Choice of agents will depend on the diagnosis as well as pharmacological properties.
- Injectable opioids are rarely necessary. They should be reserved for patients with acute pain.
- Ideally, assessment by a pain clinic or consultation with a pain physician should precede the prescription of oral opioids.

Step	Therapy	Comments	Painful disorders for which evidence of efficacy exists (see Note)	Level of evidence
First line: Non-opioid analgesics	Paracetamol OR	Use maximum doses before moving to the next step.	Osteoarthritis (knee) ¹⁰	Level 2
	oral NSAID or topical NSAID	Avoid NSAIDs, including COX-2 inhibitors, in patients who are volume depleted, elderly or have renal dysfunction. Avoid conventional NSAIDs in patients with a history of peptic ulcer disease.	Osteoarthritis (knee) ^{10, 11}	Level 2
			Osteoarthritis, tendonitis ¹²	Level 1
Second line: Combination therapy Use non-opioids first. Consider adding or substituting weak opioid analgesics if unresponsive to non-opioids.	Paracetamol /NSAID	Use suppositories if oral therapy not tolerated.	Osteoarthritis (hip) ¹³	Level 2
	Paracetamol + codeine (fixed dose preparations) OR Tramadol	Codeine is short-acting: place in long-term management of chronic pain is limited. Explain potential side effects (especially constipation). Sustained release formulation of tramadol is potentially useful, but there is limited evidence for long-term use. Beware of interactions, especially with monoamine oxidase inhibitors or selective serotonin reuptake inhibitors leading to serotonin syndrome ¹⁴ . Dependence has been reported.	Chronic back pain ¹⁵ Chronic conditions including low back pain, joint conditions, neuro-pathic and orthopaedic pain ¹⁶	Level 2 Level 2
If pain is ongoing or involves neuropathic component¹⁷:				
Add adjuvant medications.	Tricyclic antidepressants	Use low doses of tricyclics (eg amitriptyline up to 75mg at night). Trial of at least two weeks required.	Chronic low back pain, osteoarthritis, rheumatoid arthritis, fibrosis, fibromyalgia ¹⁸ , postherpetic neuralgia, diabetic neuropathy ¹⁹ Post-stroke pain ²⁰	Level 1 Level 2
	OR Anticonvulsants	Anticonvulsants are useful in neuropathic pain but adverse effects are common.	Trigeminal neuralgia, diabetic neuropathy, ²¹ post-herpetic neuralgia, post-stroke pain ²⁰	Level 1
Third line: Strong opioids Continue above therapies: add opioids. Use immediate release preparations to assess responsiveness. Use oral route and long-acting drugs wherever possible.	Oxycodone (immediate release) 5-10mg every six hours	Assess after 24-48 hours, depending on clinical circumstances. Note that duration of action may be as short as 3 hours: titrate dose and frequency to effect (efficacy and functioning).	Chronic back pain ²²	Level 3
	If satisfactory response: Oxycodone SR 12 hourly, titrate dose OR Morphine SR every 12 or 24 hours (depending on formulation), titrate dose	Use sustained release (SR) preparations in preference once effective daily dose has been determined. Reassess after 2-3 weeks. If response unsatisfactory, taper dose over several days and discontinue.	Chronic back pain ²²	Level 3
	Agree on how to assess outcome of therapy	Explain about potential physical dependence and other side effects (especially constipation)		
	Note: Avoid benzodiazepines	Benzodiazepines are not effective in managing pain. Combination with opioids potentiates adverse effects and increases risk of dependence.		

Note: Chronic pain is associated with a diverse range of conditions. It is not necessarily appropriate to extrapolate evidence from one condition to another. Levels of evidence in the table are annotated to explain the predominant condition or conditions to which evidence relates. Evidence is generally based on short term studies (less than 6 weeks).

Injectable opioids in the management of chronic non-malignant pain

- The prescription of opioid injections is appropriate for management of acute injury or unrelated pain (eg trauma, myocardial infarction). However, it is inappropriate in patients presenting with an exacerbation of chronic pain. Repeated administration of opioids by injection increases the risk of dependence, infection and nerve damage.
- Use of opioids should be part of a planned treatment strategy, not the consequence of patient pressure.
- When patients claim intolerance of oral medication, this should be tested, if possible, in a supervised setting to ensure that they are not unnecessarily given drugs by injection.
- If an opioid injection is prescribed by a locum or Emergency Department practitioner, this should be brought to the attention of the primary practitioner as soon as possible.

- Patients should not be prescribed injectable medication for self-administration or administration by carers, except in very exceptional circumstances (eg terminal care).
- Use of injectable opioids in drug dependent patients who have an acute injury is not necessarily contraindicated, but requires careful consideration and supervision.

- In NSW (with some exceptions) if a patient is prescribed Schedule 8 drugs for periods in excess of 2 months, or if the patient is considered to be drug dependent, it is a legal requirement that authority for ongoing prescription be obtained from NSW Health Pharmaceutical Services Branch. This includes prescriptions for patients whose therapy has been initiated previously by another practitioner. Contact 02 9879 5239 for further information about authorities.

WHY PETHIDINE IS NOT RECOMMENDED²

- Pethidine has a shorter duration of action than morphine with no additional analgesic benefit
- It has similar side-effects to morphine, including increased biliary pressure
- Pethidine is metabolised to norpethidine, which has potential toxic effects (eg convulsions), especially in patients with renal dysfunction,
- Pethidine is associated with potentially serious interactions in combination with other drugs.

Because of its euphoric effects:

- Pethidine is the drug most commonly requested by patients seeking opioids, and
- Pethidine is the drug most commonly abused by health professionals.

Use of opioids in patients known or suspected to be drug dependent

Patients known or suspected to be drug dependent may require treatment for pain. They have a right to have their pain managed in the same way as other patients, but management of their pain should be planned so that harm associated with drug dependence is minimised.

For clinical advice on the management of a patient with problems related to opioid dependence, call the NSW Drug and Alcohol Specialist Advisory Service on 1800 023 687 or 02 9557 2905. Doctors can call the Commonwealth Health Insurance Commission (HIC) on 1800 631 181 or the NSW HIC on 02 9895 3333 to check whether there is any information on a patient seeking benzodiazepines or opioids who may be seeing other doctors or obtaining multiple PBS prescriptions. However there are limitations to the value of such information (eg it may not be current or comprehensive).

Where drug-seeking behaviour is suspected (see box), doctors should usually refuse to prescribe opioids unless they believe they are clinically indicated or unless they feel that they will be putting themselves in danger by refusing.

Consultation with an expert in drug and alcohol management may be helpful. As usual, management decisions should be clearly documented. When a doctor refuses to prescribe opioids, it will usually be appropriate to refer the patient to a colleague experienced in drug and alcohol management. In some cases it may be desirable to refer the patient to hospital where they can be observed.

It is not appropriate to withhold analgesia from a patient who may be in genuine need of pain relief. Where the clinical situation is not clear despite investigation, and a decision needs to be made between prescribing or withholding opioid therapy, the worse error is to withhold analgesia.

DRUG SEEKING BEHAVIOUR should be suspected when a patient

- Seeks injectable rather than oral opioids, or steadily increasing dose
- Seeks repeated supply of opioids
- Insists on a specific medication and refuses alternatives
- Requests supplies of opioids in more than one form (eg oral and injectable)
- Requests opioids by name, particularly pethidine
- Gives a vague or evasive history or has atypical pain or non-anatomical distribution
- Has lack of accompanying signs (eg no haematuria in renal colic)
- Denies having a regular practitioner and cannot provide names of previous doctors
- Attends multiple practitioners (history of 'Doctor Shopping')
- Is non-compliant with suggested treatment
- In addition to requesting opioids, requests other 'fashionable' drugs (eg Rohypnol®)

None of these clues in isolation is completely reliable. Use professional judgement. A complete history and thorough examination are particularly important in such situations.

Management of acute pain in opioid dependent patients

Therapy	Comments
Assess pain as usual.	Do not withhold opioid analgesia if clinically indicated.
Assess drug-seeking behaviour.	Make contact with previous prescriber(s) if possible. If undergoing methadone or buprenorphine treatment establish details of last dose, including time of administration. (Refer to NSW Health Department guidelines for methadone and buprenorphine maintenance treatment ^{23, 24}).
Start with usual doses of opioids. Reassess frequently and titrate dose to achieve adequate analgesia.	Opioid dependent patients will have greater tolerance to opioids and may have a lower pain threshold. Higher doses may be required at more frequent intervals. Consult with pain team if possible.
Consider oral or parenteral NSAIDs or tramadol, especially if drug seeking behaviour is suspected.	Where an organic cause for pain cannot be found, consider referral to a multi-disciplinary pain clinic.

Long-term management of patients who regularly use pethidine

Appropriate management of patients who regularly use pethidine will depend on patient circumstances. Most GPs will find it helpful to receive advice from a specialist pain physician and/or drug and alcohol physician and have access to back-up resources if required.

The following principles should form the basis of management:

- Patients should be strongly encouraged to use alternate pain management strategies. Young patients with an otherwise good prognosis and few concurrent conditions are likely to benefit from review and re-negotiation of their management plan. Patients with a long history of aberrant drug-related behaviour^{3, 25} will be more difficult to manage and may not respond positively.
- Objectives of management must be clearly defined and agreed by both doctor and patient. As with other patients, the goal should be to control pain to a tolerable level and maintain an acceptable level of function in social, occupational and personal life.

- In a small proportion of patients, withdrawal from pethidine can be managed by GPs under close supervision and in consultation with a specialist in drug dependence. A staged approach is usually effective and involves:
 - As a brief intermediate step, transfer from parenteral to non-parenteral route of administration eg, intramuscular pethidine to oral pethidine (do not change drug of preference and route of preference at the same time).
 - Then transfer from oral pethidine to oral morphine.
 - Then transfer from high dose oral morphine to lower dose, then cease.
- At each stage, targets and achievements must be negotiated and agreed with the patient.

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These guidelines were developed by the NSW Therapeutic Assessment Group Inc (NSW TAG). NSW TAG is an association of clinical pharmacologists, directors of pharmacy and other clinicians from the teaching hospitals in New South Wales. NSW TAG aims to investigate and establish therapeutic initiatives that foster high quality, cost-effective drug usage in the public hospitals of NSW and the wider community.

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