GWENT GUIDANCE
THE USE OF STRONG OPIATES
IN CHRONIC NON-MALIGNANT PAIN

Long-term treatment of patients’ with chronic non-malignant pain with strong opiates is only justified if:

1. Other drugs and methods with less risk of side-effects have failed
2. Pain relief from an opiate analgesic is significant and sustained
3. Quality of life is improved enough to tolerate side effects and the risk of long-term adverse effects of opioid therapy(1)

Opioids should be used to facilitate a rehabilitation plan with the aim of improving physical and social function. These plans should involve clear goals, with a steady plan for progress towards them. A contract could be drawn up with the patient and signed to ensure that all parties understand the goals. This needs to also include withdrawal of these medications if there is deviation from the rehabilitation plan or if there is no benefit after a trial of these drugs. They should be considered to be only one aspect of an overall rehabilitative strategy. Complete pain relief is rarely achievable and so the goal is to improve quality of life. Other treatment options that could lie alongside opioids are: - exercise/physiotherapy, TENs, generalised life style advice such as pacing/planning activities, acupuncture, Expert Patient Programmes. This means the patient must take on some responsibility for their treatment as with all other chronic disease states.

Patient selection

1. Strong opioids should only be considered after the use of other established strategies - neuropathic pain should be recognised and treated as per GPMTC guidance(3); the locally adapted WHO pain ladder should be used for nociceptive pain. Weak opiates should be being taken to the maximum recommended dose in the BNF, regularly.
2. All patients should undergo a thorough physical, psychological and social assessment. During this the patients' concerns should be addressed and it needs to be made clear to the patient what these drugs can and cannot achieve.

3. A short acting preparation of fentanyl – actiq lozenge – has NO place in non-malignant pain management. Oromorph should only be used for a short period of time – maximum 4 weeks – as dependence/addiction can develop more readily with this form of strong opiate (see below).

4. If the patient is presenting with an acute exacerbation of their pain and is normally reasonably well controlled between times, the long term use of strong opioids is not appropriate (there may be a case for short-term use of a short acting strong opiate, such as oromorph, and then withdrawal of said drug).

5. Ensure patient is referred for appropriate advice if there is an underlying problem that needs a more long-term solution (e.g. primary hip/knee disease). Opiates may still be appropriate but as part of a multi-professional management plan.

6. Evidence for the use of strong opiates for fibromyalgia is very poor.

ABHB adapted WHO pain ladder
7. Current/previous history of drug or alcohol misuse, and significant mental illness may be a contra-indication to strong opiate use. Care should also occur in families with other members with a known drug/alcohol misuse and psychiatric history.

**Practical aspects of prescribing**

1. Should be considered as only one aspect of the overall rehabilitative strategy.
2. A single practitioner should undertake the prescribing – this may involve liaison with secondary care colleagues if others are involved in patient’s care. Fixed supplies of drugs should be prescribed at fixed intervals.
3. Patient and health care professionals should develop a treatment plan prior to starting these drugs. Informed consent should be obtained (see below with regards to adverse effects).
4. Emphasis should be on achieving desirable treatment goals – realistic treatment goals are partial pain relief, leading to an improvement in physical and/or psychological functioning.
5. Sustained release oral medication should be the first line choice (see GPMTC guidance[4]). Short acting drugs may predispose to tolerance and addiction, although these drugs may be useful initially as part of the titration process. The lowest dose of strong opiate (taking into account the equivalence of any weak opiate already being used) should be the initial starting dose. (A conversion table is available with the GPMTC guidance reference 4 below.)
6. Patients should ideally be monitored at least monthly during dose titration. If opioid therapy is successful monitoring can be less frequent and agreed as part of the treatment plan (this will vary between patients).
7. It must be accepted that some chronic pain is not opioid sensitive. Generally if a patient is on morphine 60mg BD, or a fentanyl patch 75mcg/hr with no obvious benefit then these drugs should be weaned off and stopped. Referral to pain clinic at this point would be appropriate. (Patients who have been on high dose opiates for a long time should NOT be referred to pain clinic purely for opiate withdrawal – see referral guidance to pain clinics in Gwent[5]).
8. It is worth remembering that use of opiates may shift the patient’s sense of control towards an external agent – namely opioid medication – for relief of pain, leading to a sense of dependency on the medical system and
neglecting other treatment goals such as increased function and return to normal activities\(^6\). Hence an agreed treatment plan is very important and it should be reviewed as part of the monitoring.

**Adverse effects of persistent opioid use**

*These should all be discussed with the patient prior to starting treatment. It should be documented in the medical notes that this has occurred. There is a good patient information leaflet produced by the British Pain Society\(^7\).*

Nausea, vomiting, itching, mood changes and somnolence are common side effects which occur within a few days of starting treatment. They decrease with time for the majority of patients. Itching may persist and prevent continuation of the drugs. Constipation in common and tends to persist often worsening with increasing doses. Laxatives and dietary advice should be given to all patients on commencing opiate medication.

More serious problems include respiratory depression, weight gain, weight loss and hormonal effects such as reduced adrenal function, reduced sexual activity and infertility. Particular care is needed in women of child-bearing age. (Babies born to women taking opioid medications have a 50% chance of showing signs of drug withdrawal.) There is also evidence of effects on the immune system leading to the potential for increased infections.

There is now a consensus between pain consultants across the UK that investigations for endocrinopathy should be carried out yearly on patients who are using more than the stated doses suggested above. They should also be considered for patients who complain of fatigue, loss of muscle mass, changes in sexual activity and infertility on lower doses that have been used for over 12 months.

Research shows that once patients reach a stable dose of opioid medications they are generally fit to drive but they need to consider additive effects of other medications. Patients should not drive during dose titration or at any time that they feel cognitively impaired. The patient should be advised it is their responsibility to ensure their fitness to drive and if they have any doubts they should contact the DVLA and their insurance company. Again this should be documented in the medical notes.
There is also evidence of opioid induced hyperalgesia in some patients which needs to be considered especially if increasing doses seem to be needed to control what was a stable drug dose\(^6\).

**Tolerance, withdrawal and addiction**

In the past there has been confusion with regards to these terms by patients and some health care professionals. Clarification may be needed to address patients’ fears and concerns.

**Tolerance** – state of adaptation in which, with time, an increase in drug is needed to achieve the same effect. Data suggests that this is uncommon in chronic non-malignant pain.

**Withdrawal** – occurs when these drugs are stopped suddenly (or the dose is reduced substantially) or an antagonist/partial agonist is given concurrently. It is due to the body’s dependence on the medication. Symptoms include anxiety, irritability, chills and hot flushes, joint pain, lacrimation, rhinorrhea, sleep disturbances, nausea, vomiting, stomach cramps and diarrhoea.

**Addiction** – this is the compulsive use of opioids to the detriment of the user’s physical and/or psychological health and/or social function. Signs of this include increasing demands for medication often aggressively, increasing numbers of “lost” prescriptions, seeking opioids from other sources either legitimately (out of hours/A&E) or illegitimately, failure to follow treatment plan, etc.

**References**