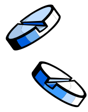
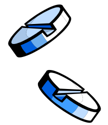


Tablet Press EXTRA

The prescribing newsletter for GPs, nurses and pharmacists
NHS Northamptonshire



June 2019

Be Opioid Aware!

There are concerns nationally regarding the increase in prescribing of high dose opioids. NHS England Midlands and East recently sent all practices an audit tool to audit GP prescribing of opioids at doses above an oral morphine equivalent of 120mg/day. Practices are encouraged to run the audit and review patients where possible. The new GP contract has a focus on prescribing safety and it's very possible that high dose opioids will be monitored in the future as there are concerns regarding this nationally. This bulletin is intended to give some background to the concerns and provide information and education, and to sign-post to useful resources to help tackle this growing problem.

Why audit?

- There has been a 466% increase in prescribing of strong opioids in the last 10 years.
- There has been a rising number of opioid related deaths
- Data suggests death is more common in those co-prescribed pregabalin or gabapentin. (Reversal of opiate tolerance of morphine and oxycodone with pregabalin, leading to increased effect)

Searches to identify patients on greater than morphine 120mg/day equivalent audit can be found here: System Searches

Good Practice: Opioids Aware Website https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

Important Practice Points

- Opioids are very good for acute pain and for pain at the end of life, but there is little evidence that they are helpful for long term pain.
- A small proportion of people may obtain good pain relief from opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation)
- Patients who do not achieve pain relief from opioids within 2-4 weeks are unlikely to gain long term benefit.
- Patients who may benefit from opioids in the long term will a get a favourable response within 2-4 weeks.
- Short-term efficacy does not guarantee long-term efficacy.
- There is no good evidence of dose-response with opioids, beyond doses used in clinical trials, usually up to 120mg/day morphine equivalent. There is no evidence for efficacy of high dose opioids in long-term pain.
- Doses greater than this are more likely to do harm with no benefit.
- Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high dose opioids a detailed assessment of the many emotional influences on their pain experience is essential.

Side Effects

- Between 50% and 80% in trials experience at least one S/E from opioids, but in everyday use this may be higher
- Falls, fractures, confusion, pruritus
- Long term: amenorrhoea, erectile dysfunction, decreased libido, infertility, depression and fatigue
- Opiate hyperalgesia
- Respiratory depression and death

Prudent Prescribing

- Trial 2-4 weeks, if it doesn't work don't continue.
- Do not increase higher than 120mg/day morphine equivalent
- Don't put onto repeat
- Review regularly to ensure patient is still getting benefit.
- Challenge over use
- Recognise and manage drug seeking behaviour
- Patient agreement

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The RCG have produced "Top 10 Tips: Dependence Forming Medications: RCGP Top 10 Tips DFMs"

See Faculty of Pain and Live Well with Pain Websites for useful resources when initiating or reviewing opioids:

Faculty of Pain: Prescribing Opioids

Live Well With Pain: Opioid Zone

Reducing Opioids

It is important to taper and where possible stop the opioid regimen if:

- the medication is not providing useful pain relief. The dose above which harms outweigh benefits is 120mg oral morphine equivalent/24hours. Increasing opioid load above this dose is unlikely to yield further benefits but exposes the patient to increased harm
- the underlying painful condition resolves
- the patient receives a definitive pain relieving intervention (eg, joint replacement)
- the patient develops intolerable side effects
- there is strong evidence that the patient is diverting his/her medications to others

Preparation for dose reduction includes:

- explanation of the rationale for stopping opioids including the potential benefits of opioid reduction (avoidance of long term harms and improvement in ability to engage in self-management strategies)
- agreeing outcomes of opioid tapering
- do not stop abruptly - incremental taper of existing drug
- deciding which patients may need admission for opioid taper/cessation informed by existing opioid dose
- physical co-morbidities
- mental health co-morbidities including significant emotional trauma
- monitoring during taper of pain
- symptoms and signs of opioid withdrawal
- choice of opioid reduction scheme
- close collaboration between the patient, his or her carers and all members of the patient's health care team
- arrangements for follow-up including agreed prescribing responsibilities
- the dose of drug can be tapered by 10% over 1-2 weeks
- may need to pause the reduction but don't increase the dose back up – one way path.
- Avoid confrontation. Plan and prepare, choose time and place

See Faculty of Pain Medicine Advice on reducing opioid doses: Here

Resources to share with patients

- Faculty of Pain Medicine – Information for Patients: https://www.rcoa.ac.uk/node/21133
- Pain Toolkit: https://www.paintoolkit.org/resources/for-patients
- Live Well with Pain: https://livewellwithpain.co.uk/resources/resources-for-patients/
- Ten Footsteps: your Journey to Living Well with Pain: Live well with pain:10 footsteps
- Retrain Pain Foundation: Slideshow lessons targeted at patients (one minute each) under the following subject headings: Understand Pain; Mind and Goals; Sleep and Pain; Medications; Relationships https://www.retrainpain.org
- Brain Man You Tube Video. Understanding pain in less than 5 minutes, and what to do about it! Useful educational tool to use with patients, explains nature and origin of chronic pain. https://www.youtube.com/watch?v=RWMKucuejIs
- Brain Man stops his opioids https://www.youtube.com/watch?v=MI1myFQPdCE

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