Chronic Non Malignant Pain - Strong Opioid Prescribing Guideline and Educational Pack

Background

Opioids have been increasingly prescribed to treat chronic non malignant pain. There is evidence from clinical trials that they can be effective, in the short and medium term, in providing symptomatic improvement in somatic, visceral and neuropathic pain. Complete relief of pain is rarely achieved. The goal should be to reduce pain sufficiently to facilitate engagement with rehabilitation and the restoration of useful function. The management of persistent pain focuses not only on reduction in pain intensity but also on improvement in sleep, mood, and physical, vocational, social and emotional wellbeing.

The safety and efficacy of opioids in the long term is uncertain, as is the propensity for these drugs to cause problems of tolerance, dependence and addiction. The benefits of opioid treatment for the patient must be balanced against burdens of long term use as therapy for persistent pain may need to be continued for months or years.

There is no good predictive factor of the analgesic effect of opioids in chronic non malignant pain. If deemed appropriate, the individual should have a monitored opioid trial over a period of 6 weeks to determine the effectiveness of the treatment and the presence of side effects. If the clinical decision is made to continue the prescription of the opioid, there should be ongoing timely reassessment.

Recommendations are made on determining the suitability of an opioid trial, the choice of opioid, the conduct of an opioid trial and long term monitoring of the patient.

When starting opioid therapy, there must be clear agreement regarding responsibility for prescribing. It is good practice for patients to be given prescriptions from one prescriber only. If concerns about addiction arise, the number of doses prescribed should be reduced.

The aim of this pack is to:

- Update clinicians on current prescribing guidelines for strong opioids
- Provide a range of reference materials which clinicians can use for continuing professional/ personal development
Before Initiating Opioids Consider
- What is the cause of persistent pain?
  - Biopsychosocial aspects considered?
  - Have other appropriate methods of pain management been tried?
  - Neuropathic pain? (Refer to local neuropathic pain guidelines)
  - Is a trial of opioids appropriate for this patient? (see below)

Long Term Effects of Opioids
- Endocrine - Influences HPA axis leading to hypogonadism & low bone mass
- Immunological - Not fully understood but may have an immunological modulating affect leading to immunosuppression
- Opioid induced hyperalgesia - Patient may present with increased diffuse pain

Suggested Areas Where Opioids Are Not Recommended
- No previous improvement with opioids
- Sleep Apnoea
- No Clinical Evidence of Long Term Effectiveness in:
  - Headache
  - Non Specific Low Back Pain
  - Fibromyalgia
  - Unexplained Persistent Pain

Closer Monitoring Required for Patients With
- Mental Health Disorders
- Depression and Anxiety Related to Pain
- Current or past history of substance misuse
- Family history of substance misuse

Complete Opioid Risk Tool to Assess Risk and Consider Referring to Local Pain Clinic

Commence Opioid Trial (Duration – 6 weeks)

AIM
- 30% Improvement in Pain And/or Significant Improvement in Functional Ability

Prior to Initiation
- Explain advantages and disadvantages of Opioids
- Explain the concept of an Opioid Trial and reasons for discontinuation
- Agree achievable patient specific goals
- Record baseline levels of pain and functional ability

Initiation
- Discontinue all Step 2 Analgesia i.e. Single or combination analgesics containing:
  - Codeine
  - Dihydrocodeine
  - Tramadol
  - Low Dose Buprenorphine
  - Patches
  
  *Continue step 1 analgesia such as paracetamol/NSAIDs

Commence Oral Morphine Sulphate MR
- 10mg BD for Opioid Naïve patients & increase by 10-20mg BD every 2 weeks.
- Alternatively use Opioid Conversion Chart to transfer from Step 2 analgesia minus 50% of total daily dose for safety.

Assess patient every 1-2 weeks

If trial is successful initially monitor every 3 months, then six monthly

If there is NO clinical benefit gained with a full trial of one opioid there are no randomised controlled trials, which suggests that one opioid is more effective than another.

If opioid trial unsuccessful, reduce dose by 10-20mg Morphine or equivalent every 2 weeks until discontinued

Consider Referral to a Pain Specialist for:
- Difficulty tapering or problem drug use
- Patients with opioid sensitive pain who require dose higher than 60mg Morphine Sulphate MR Capsules (Zomorph®) BD or equivalent.
- Opioid insensitive problematic pain
- Diagnostic difficulties

Measure sex hormones if patient reporting symptoms of hypogonadism and if abnormal seek advice from local endocrine clinic.

Consider weaning opioids every 6 months to see if dose is still optimal. Observe for signs of drug abuse. Avoid using short acting opioids

If Morphine MR is not tolerated
- Recomence trial using Oxycodone 5mg MR BD
- If problems with swallowing consider alternative oral slow release preparations e.g. suspension
- If issues with GI absorption use Fentanyl 12mcg/hr

Increase dose every 2 weeks until pain relief has been achieved or maximum dose of 60mg BD is reached.

Treat side effects as per NHS Fife Formulary as required

If there is NO clinical benefit gained with a full trial of one opioid there are no randomised controlled trials, which suggests that one opioid is more effective than another.

Regular Assessment

NHS Fife Chronic Non Malignant Pain Opioid Prescribing Guideline
Date written: April 2015 Review Date: April 2017 Fife Integrated Pain Management Service 2
Patients may be managed by the General Practitioner and/or the Pain Specialist. This guideline is to aid primary care and secondary care teams in managing patients, who have chronic pain, with opioids. This guidance should be used in conjunction with local and/or national guidance on the assessment of pain and with reference to British Pain Society Guidelines.

**Key Points**

- The aim of using opioids in the short to medium term is to support the rehabilitation and restoration of physical and mental function of patients.
- There is evidence from clinical trials that opioids can be effective, in the short and medium term, in providing symptomatic improvement in a variety of non-cancer pain conditions.
- The safety and efficacy of opioids in the long term is uncertain.
- Once dose of opioid is stabilised patients should be reviewed at least every 6 months to assess ongoing need, reducing dose as appropriate.
- Patients whose pain remains uncontrolled should be referred to specialist services.
- Opioids can also have untoward effects in terms of tolerance, dependence and addiction.

**Before Initiating opioids consider the following:**

- What is the cause (diagnosis) of persistent pain in your patient?
- Has a biopsychosocial assessment been made?
- Have other appropriate methods of pain management been tried? (e.g. other medications, graded exercises, psychological methods)
- Does your patient have neuropathic pain?  *(Refer to DN4 Tool available in NHS Fife Formulary, Appendix 4C: Guidance on the Management of Chronic Non-malignant Pain)*
- Would a trial of opioids be suitable for this patient? (see below)
- Does the patient drive? On the 2nd March 2015 in England and Wales it became an offence to drive with certain controlled drugs in excess of specified levels in the body, whilst this is not the case in Scotland patients should still be aware and recognise this is in addition to the existing rules on drug impaired driving and fitness to drive.

**Situations where opioids are not recommended or where closer monitoring would be required:**

There are no chronic pain conditions in which opioids are completely contraindicated. Consideration should be given to using the ‘Opioid Risk Tool’ (see Appendix 1) to assess for potential high risk/dependent patients. If patients are assessed as moderate to high risk closer monitoring will be required.

<table>
<thead>
<tr>
<th>Not Recommended</th>
<th>Potential High Risk/Dependent Patients Requiring Closer Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>No improvement with opioids in the past</td>
<td>Mental Health Disorders</td>
</tr>
<tr>
<td>Sleep Apnoea</td>
<td>Depression and Anxiety Related to Pain</td>
</tr>
<tr>
<td>No Clinical Evidence for Long Term Effectiveness</td>
<td>Current or past history of substance misuse</td>
</tr>
<tr>
<td>in the following conditions:</td>
<td>Family history of substance misuse</td>
</tr>
<tr>
<td>Headache</td>
<td></td>
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<tr>
<td>Non Specific Low Back Pain</td>
<td></td>
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<tr>
<td>Fibromyalgia</td>
<td></td>
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<tr>
<td>Unexplained Persistent Pain</td>
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</tbody>
</table>
Initiation of Opioids

Prior to the commencement of opioid therapy, it is essential that appropriate informed consent is obtained from the patient and if necessary family/carers. The discussion should include:

- A clear explanation of the advantages and disadvantages of opioid therapy, which should include short term and long term side effects, potential for tolerance and addiction, detrimental impact on quality of life and advice on driving and operating machinery as per the guidance on use of strong opioids in Chronic non malignant pain issued by the British Pain Society & the RCGP which can be found online [The British Pain Society's Opioids for persistent pain: Good Practice](https://www.britishpainsociety.org.uk). 
- Agreeing achievable patient specific goals. This may include an agreed expected reduction in pain score (30%), improvement in sleep pattern and functional ability. 
- An explanation of the concept of an Opioid Trial and what circumstances would surround the discontinuation of opioid medication. 
- A discussion about the legislation concerning taking strong opioids and driving, should the patient have a driving license and drive a vehicle. Information can be found online [https://www.gov.uk/drug-driving-law](https://www.gov.uk/drug-driving-law). 

Consider the Long Term Effects of Opioids:

- Endocrine - Influences HPA axis leading to hypogonadism & low bone mass 
- Immunological - Not fully understood but may have an immunological modulating affect leading to immunosuppression 
- Opioid induced hyperalgesia - Patient may present with increased diffuse pain

Opioid Trial

- Anticipated length of trial would be 6 weeks. 
- Expectation: 30% improvement in pain and/or significant improvement in functional ability. 
- **Discontinue all Step 2 analgesia and replace with Step 3 during the trial however continue with Step 1 analgesia such as paracetamol/NSAIDs and adjuvants. (See Appendix 4)**

Step 2 Analgesia:-

Formulary Single or combination analgesics: codeine, Co-codamol, Co-Dyramol or Tramadol 
Non Formulary Single or combination analgesics: Dihydrocodeine, Tramacet (non-SMC approved) 
Buprenorphine patches (Non SMC approved) Both Tramacet and buprenorphine patch would require an Individual Patient Treatment Request form to be completed if it was required to be prescribed)
### Step 3 Analgesia

<table>
<thead>
<tr>
<th></th>
<th>Starting Dose</th>
<th>Titration of dose if necessary</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Line</strong></td>
<td>Morphone Sulphate Sustained Release (Zomorph®)</td>
<td>10mg BD</td>
<td>Increase by 10-20mg BD Every 2 weeks</td>
</tr>
<tr>
<td><strong>2nd Line</strong></td>
<td>Oxycodone Sustained Release (Longtec®)</td>
<td>5mg BD</td>
<td>Increase by 5 – 10mg BD every 2 weeks</td>
</tr>
</tbody>
</table>

If there are issues with swallowing consider alternative oral slow release preparations e.g. suspension.

| **3rd Line or if issues with GI absorption** | Fentanyl (Matrifen®) | 12mcg/hr (Equivalent to 45mg morphine in 24 hours) | Increase by 12mcg/hr every 2 weeks | 25mcg/hr (Equivalent to ~80mg morphine in 24 hours) |

- Use a single agent by the oral route, using sustained release preparations. If no contraindication, first line choice is sustained release Morphone Sulphate SR 10mg BD prescribed as Zomorph® in opioid naïve patients. For patients already on reasonable dose step 2 analgesics, convert using opioid conversion chart see Appendix 2, then reduce total daily dose by 50% as a safety precaution.
- If Morphone Sulphate SR is not tolerated despite treatment of side effects (see below), recommence trial using sustained release Oxycodone SR.
- Oral route is preferred, however if the patient has problems with swallowing or GI absorption, Transdermal Fentanyl preparations should be used, recognizing that titration will take longer than oral preparations.
- Increase dose every 2 weeks until required pain relief has been achieved or side effects are intolerable or until 60mg BD Morphone Sulphate SR or equivalent is reached. For patients reaching doses in excess of 60mg BD Morphone Sulphate SR consider referral to the Pain Specialist Clinic.
- Reassess the patient 1-2 weekly.

### Regular Assessment

- Ongoing Efficacy – carry out recordings of pain score and functional assessment. Various tools can be used to help assess pain including verbal rating scales (VRS e.g. mild/moderate/severe) and numerical rating scales (NRS Pain scored on 0-10 scale where 0 is no pain and 10 is worst pain imaginable)
  **If the opioid trial is not successful, discontinue opioid by tapering dose slowly, reducing the daily dose by 10 – 20mg or equivalent once every 2 weeks. If pain flares up during reduction, this may be due to withdrawal or loss of placebo effect. The patient should be reassured and opioid reduction paused until symptoms settle.** (See patient information leaflet about reducing opioids)
- There are no high quality randomized controlled trials, to suggest that one opioid is more effective than another. If there is **NO** clinical benefit with a full trial of one opioid, there is no indication to repeat the trial with another opioid – seek opinion of Pain Specialist.
- If opioid trial is successful, continue with monitoring of dose, pain score, function and side effects every 3 months initially until dose is stable, then every 6 months. Consider weaning off opioids every 6 months to see if dose is still optimal.
- A patient information leaflet is available at: [Opioid Reducing Leaflet](#)
- **Avoid using short acting opioids for breakthrough pain.**
- Keep daily dose of long acting opioid as low as possible, with a maximum of 30 days supply.
- Measure hormones if patient reporting symptoms of hypogonadism and if abnormal seek advice from local endocrine clinic.
- Assess for signs of problem drug use. Refer to British Pain Society advice; [Pain & Substance misuse: Improving the patient experience](#)
Referral to a pain specialist is recommended for:

- Patients with previous mental health problems, substance misuse, dependency or addiction
- Difficulty tapering or problem drug use
- Patients with opioid sensitive pain who require dose higher than 60mg Morphine Sulphate Tablets BD or equivalent.
- Opioid insensitive problematic pain
- Diagnostic difficulties

## Treatment of Side Effects – further information

### Constipation

The majority of patients taking opioids for moderate to severe pain will develop opioid induced constipation; tolerance does not develop to this side effect. Guidelines suggest that the best prophylactic treatment for opioid induced constipation is a combination of a stimulant laxative and a stool softener. Refer to NHS Fife Formulary, Section 1.6 and [Appendix 1C management of Constipation in Adults](http://www.knowledge.scot.nhs.uk/pain/nhs-boards/nhs-file/medication-information-leaflets.aspx).

### Nausea/Vomiting

Nausea and vomiting are common when starting on opioids but generally tolerance develops after 5-10 days. If a prophylactic antiemetic is required for a patient commencing an opioid for moderate to severe pain please refer to the NHS Fife Formulary, Section 4.6.

### Itch

Opioid induced itch occurs in around 1% of those who receive a systemic opioid. It is thought to be caused by a central mechanism rather than by histamine release, therefore in some cases antihistamines are not effective. Emollients should be used liberally if the patient has dry skin. Trial of a sedating antihistamine such as chlorphenamine is suggested, if this is not effective after a few days it should be stopped. (3)

### Renal Impaired patients

For those patients with renal impairment, the likelihood of opioid toxicity with any opioid increases and the following guiding principles should be followed when prescribing opioids;

- Use the smallest effective dose/frequency.
- Titrate carefully and monitor for adverse effects.
- It should be noted there is no advantage in using Oxycodone over Morphine in CKD Stage 1-3 renal impaired patients.
- In patients with CKD stage 4/5 kidney disease, consult with the patients’ local renal specialist before commencing opioid treatment. General advice would be to avoid long acting preparations and where they are used, delay their introduction until the patient’s dose requirements are fully established.
- If there are clinical concerns consult local renal specialists.

## References

1. West of Scotland Chronic Non Malignant Pain Guideline. December 2012
### APPENDIX 1

**Opioid Risk Tool**

<table>
<thead>
<tr>
<th>Item</th>
<th>Mark each box that applies</th>
<th>Item score if female</th>
<th>Item score if male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family History of Substance Abuse:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>[ ]</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>[ ]</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>[ ]</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal History of Substance Abuse:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>[ ]</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>[ ]</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>[ ]</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3. Age (mark box if 16-45)</td>
<td>[ ]</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. History of Preadolescent Sexual Abuse</td>
<td>[ ]</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5. Psychological Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention Deficit Disorder, Obsessive-Compulsive Disorder, or Bipolar, Schizophrenia</td>
<td>[ ]</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>[ ]</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Score Risk Category:</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Low Risk: 0 to 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Risk: 4 to 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk: 8 and above</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Printed with permission from LifeSource Not-for-Profit on behalf of Dr Lynn Webster (@LynnRWebsterMD).

**Reference**


http://www.opioidrisk.com/node/884
## Opioid Equivalent Doses

### Transdermal Opioids: Approximate equivalence with oral morphine

<table>
<thead>
<tr>
<th>Oral morphine equivalent (mg/24 hours)</th>
<th>30 to 60</th>
<th>60 to 90</th>
<th>90 to 120</th>
<th>120 to 180</th>
<th>180 to 240</th>
<th>240 to 300</th>
<th>300 to 360</th>
<th>360</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transdermal fentanyl (mcg/hour)</td>
<td>12</td>
<td>25</td>
<td>37</td>
<td>50</td>
<td>62</td>
<td>75</td>
<td>87</td>
<td>100</td>
</tr>
</tbody>
</table>

N.B. Published conversion ratios vary and these figures are a guide only. Morphine equivalences for transdermal opioid preparations have been approximated to allow comparison with available preparations or oral morphine. Patient response may be variable. Please check the most recent BNF for current conversion guide.

### Oral morphine to other oral analgesics

<table>
<thead>
<tr>
<th>Oral to Oral</th>
<th>Conversion Ratio</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine to Oxycodone</td>
<td>2:1</td>
<td>Oral Morphine 10mg = Oral Oxycodone 5mg</td>
</tr>
<tr>
<td>Morphine to Tramadol</td>
<td>1:5- 1:10</td>
<td>Oral Morphine 10 mg = Oral Tramadol 50 - 100mg</td>
</tr>
<tr>
<td>Morphine to Codeine</td>
<td>1:10</td>
<td>Oral Morphine 10 mg = Codeine 100 mg</td>
</tr>
</tbody>
</table>

N.B. Published conversion ratios vary and these figures are a guide only. Patient response may be variable.
APPENDIX 3 (with Acknowledgement to Professor Stephan A. Schug MD FANZCA FFPMANZCA)

Treatment Contract for the use of Strong opioid medicine (morphine-like painkiller) for the management of chronic pain

Patient name: 
Address: 
Date of birth: 

PLEASE COMPLETE ALL DETAILS

I, ........................................................... understand that ......................... (a strong opioid ) is to be prescribed to me in an attempt to improve my level of functioning and reduce my pain. My medical practitioner and I have discussed that strong opioid (morphine-like) medicines may only be partially helpful in achieving this goal and on occasion will not help at all. I understand that an opioid medicine is only one part of the management of my chronic pain. My medical practitioner and I agree to the following conditions regarding my treatment and the prescribing of an opioid medicine for my pain:

1. My medical practitioner is responsible for prescribing a safe and effective dose of an opioid medicine. I will not use an opioid medicine other than at the dose prescribed and I will discuss any changes in my dose with my medical practitioner. Finding the right dose of opioid will mean having regular appointments with your doctor, to assess any benefit or problem.

2. I am responsible for the security of my opioid medicine. Lost, misplaced or stolen medicines or prescriptions for opioid medicines will not be replaced.

3. I will only obtain my opioid medicine from the medical practitioner who signs this contract, or other doctors in the same practice authorised to prescribe to me. I understand that no early prescriptions will be provided.

4. Whilst most people do not have any serious problems with this type of medicine when used as directed, there can be side effects. My medical practitioner has explained the main ones to me, and I will tell him or her if I experience what could be side effects.

5. Dependence or addiction to prescription pain killers is estimated to occur in 1 in 20 patients. Either your prescriber or the Pain & Dependency service can help you with any problem drug use.

6. As possible dependence is important in the management of my pain, I have informed my medical practitioner of any present or past dependence on alcohol or drugs that I may have had, and of any illegal activity related to any drugs (including prescriptions medicines) that I may have been involved in.

7. If there are concerns that the medication is not used properly as prescribed and there are issues of safety to children the prescriber may discuss this case with other non NHS agencies.

8. I am aware that providing my opioid medicine to other people is illegal and could be dangerous to them.

9. My medical practitioner respects my right to participate in decisions about my pain management and will explain the risks, benefits and side effects of any treatment.

10. My medical practitioner and I will work together to improve my level of functioning and reduce my pain.

11. I understand that my medical practitioner may stop prescribing my opioid medicine or change the treatment plan if my level of activity has not improved, if I do not show a significant reduction in my pain, or if I fail to comply with any of the conditions listed above.

Patient's signature:

Patient's name:

Date:

Medical practitioner's signature:

Medical practitioner's name:

Please provide a copy of the signed contract to the patient.

Why do I need to sign a treatment contract?

Both you and your doctor are subject to strict regulations when an opioid medicine is prescribed. A treatment contract is used so that your doctor is sure that you understand what is expected from you whilst you take this type of medicine, and that you consent to the requirements described in this contract.
Pain Management WHO Ladder

Step 0: Assessment of pain

Step 1: Paracetamol

- Tablets or caplets preferred formulation not capsules
- Patients with low body weight (>33kg to <50kg) max daily dose is 60mg/kg not exceeding 3g
- Patients > 50kg with risk factors for hepatotoxicity the max dose per administration is 1g (i.e. 2 x 500mg). Maximum daily dose is 3g

Step 2: (add weak opioid)

1st Line: Co-codamol 30/500 (Paracetamol + codeine)
2nd line: Co-Dyramol 20/500 (Paracetamol + DHC)
3rd line Paracetamol + Tramadol

Step 3: (add strong opioid)

1st line: Paracetamol + Morphine Sulfate SR (preferred brand Zomorph®)
2nd line: Paracetamol + Oxycodone MR

Consider Analgesics, NSAIDs & neuropathic adjuvants in combination at all stages. Consider non pharmacological measures at all stages BEFORE stepping up the pain ladder. There is limited evidence for long term use of opioids in chronic non malignant pain.

See Neuropathic guidance in Appendix 4C Guidance on the management of chronic non-malignant pain & NSAID guidance in Ch 10

Review of effect is essential after initiation or dosage change of any pain medication

Step 1:
Regular Paracetamol 500mg 2 four times daily
Annex 4
Pathway for using strong opioids in patients with chronic pain

This pathway is drawn from evidence identified in the guideline, information extrapolated in the research for the guideline and the clinical experience and consensus of the guideline development group. More detailed pathways on pain assessment and management are available from the British Pain Society.\(^{195}\)

Strong opioids should only be considered after a full assessment and as part of a wider management plan, rather than as sole agents. Prescribers should have knowledge of opioid pharmacology and be competent and experienced in the use of strong opioids.

### Step 1  Assessing suitability for strong opioid

**Assess pain**
- Likely to respond to opioid, eg nociceptive; some benefit from weak opioids → consider opioid trial
- Less likely to respond to opioid, eg neuropathic; no analgesia at all from weak opioids → consider specialist advice before opioid trial OR avoid opioids.

**Assess patient for**
- relevant psychosocial factors:
  - children in house
  - other family members with a history of substance misuse problems
- increased risk of misuse or developing iatrogenic dependency:
  - history of heroin abuse
  - history of alcohol abuse
  - history of stimulant use
  - mental health problems
- other comorbidities:
  - cognitive impairment - cognitive side effects are more likely; concordance and safety may be an issue
  - renal impairment - accumulation of active metabolites with some opioids
  - gastrointestinal pathology - adverse effect on bowel function.

- Other analgesics – use simple analgesics, topical therapies and anti-neuropathic agents (if appropriate) for opioid sparing effect.

Discuss the plan with the patient before starting opioids
- Provide information leaflets (eg SIGN patient leaflet, British Pain Society patient leaflet)
- Establish goals of treatment:
  - Primary: pain relief (define the degree that would be acceptable to the patient)
  - Secondary: improved function, sleep, mood

*Be aware that opioids should NOT be used as anxiolytics.*

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**NHS Fife Chronic Non Malignant Pain Opioid Prescribing Guideline**

**Date written:** April 2015  **Review Date:** April 2017  **Fife Integrated Pain Management Service**
- Discuss the side effects/potential problems. The patient needs to be aware of the potential side effects and they need to be acceptable to the patient, eg:
  - GI dysfunction – nausea, vomiting, constipation
  - Central nervous system – memory and cognitive impairment, nightmares, hallucinations, visual disturbance
  - Endocrine – fertility, sexual function
  - Immune function
  - Misuse potential
  - Tolerance
  - Opioid-induced hyperalgesia.

Define and discuss how the trial will work
- set a timescale - expected duration of trial, frequency of review
- set a dose - upper dose limit; aim for lowest effective dose
- agree stopping rules with the patient before starting:
  - if treatment goals are not met
  - if there is no clear evidence of dose response
  - if rapid tolerance develops necessitating high dose opioids. Proceed to reduction and cessation, or consider specialist referral/advice.

Consider opioid rotation if the pain is opioid responsive but efficacy and dose titration is limited by side effects. The medicines equivalent dose table is for guidance only and should be used with caution.

If the patient is on a high dose before conversion consider phased conversion to avoid withdrawal. Short acting opioids may need to be used during conversion until the correct dose is established.

**Step 2 Starting a strong opioid**

**Factors to consider**
- Route of administration - oral or transdermal are the main routes for chronic non-malignant pain
- Choice of opioid

- Dose: there is considerable variability in the dose needed to effectively treat pain. Careful titration to the lowest effective dose, balanced against side effects requires regular review.

There are two potential options for starting strong opioids:
1. Start with low dose of long-acting preparation. If the patient is already on cocodamol or dihydrocodeine, then they are not opioid naive, particularly if on maximum dose or more than one of these agents
   OR
2. While establishing dose, use an immediate release preparation for short term use, only to determine approximate dose range, then convert to equivalent long-acting preparation as soon as possible. This may be more appropriate if the patient has multiple comorbidities.

- Aim to establish on long-acting opioid with no immediate release opioid if the chronic pain is stable. Options for mild “breakthrough pain” – consider non-opioids (eg paracetamol, NSAIDs); weak opioid.
Step 3. Monitoring opioid trial

Monitor adverse effects:

- **Gastrointestinal**
  - Nausea/vomiting: tolerance usually develops. Consider use of an antiemetic at initiation of therapy. Due to the abuse potential of cyclizine, avoid if possible.
  - Constipation: tolerance often does not develop to this. Use stool softeners/stimulant laxatives or a combination. Consider opioid preparations less likely to cause GI effects.

- **Central Nervous System**
  - If these do not resolve, then either dose reduction or rotation will be needed.
    - Impaired memory, concentration
    - Hallucinations, milder visual disturbance
    - Sedation, confusion, cognitive impairment
    - Myoclonic jerks.

- **Other**
  - Sweating
  - Reduced libido, fertility – consider stopping, testosterone replacement, possible opioid rotation; may need endocrine review
  - Respiratory depression – stop opioid until resolves; consider factors contributing to event
  - Tolerance – rotate opioid or reduce and stop
  - Opioid induced hyperalgesia - rotate opioid or reduce and stop; seek specialist advice.

Assess pain relief

- If there is good pain relief on a stable dose of opioid without unacceptable side effects continue with at least annual review.
- If pain relief is inadequate due to:
  - dose titration not being possible due to adverse effects try opioid rotation
  - no/minimal evidence of opioid responsiveness reduce and stop opioid
  - intolerable side effects try opioid rotation. Short-acting opioids may need to be used during the conversion both to reduce physical withdrawal and while optimum dose is being established. If the patient on a large dose of opioid, consider phased conversion (eg reduce the current opioid dose by 50% and introduce the new opioid dose at less than the morphine equivalent dose replacement dose (because of incomplete cross-reactivity). Continue with reduction of the old opioid and increase in new opioid as indicated by response.

- At all times before and during opioid treatment signs of iatrogenic substance misuse should be sought and if problems arise, then consider early specialist advice/referral.

Step 4 Regular review, ideally with one prescriber:

- At least annual, more frequently if problems arise
- Have a clear plan for flare-up management (including availability to out of hours service).