

# Opioid Pain Management Clinic for Chronic Non-Cancer Pain



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9<sup>th</sup> November 2017

# Disclaimer

I have previously spoken about 'The Opioid Pain Management Clinic at Guy's and St. Thomas' Hospital' at a Grunenthal-sponsored Knowledge Exchange (March 2017) and GP Educational Meeting (July 2017).

# Outline

- Serious adverse effects of high dose chronic opioids
- GSTT 'Opioid Pain Management Clinic'
- 'Opioids Aware' & CDC Guidelines
- Considerations in managing acute pain on a background of chronic opioids

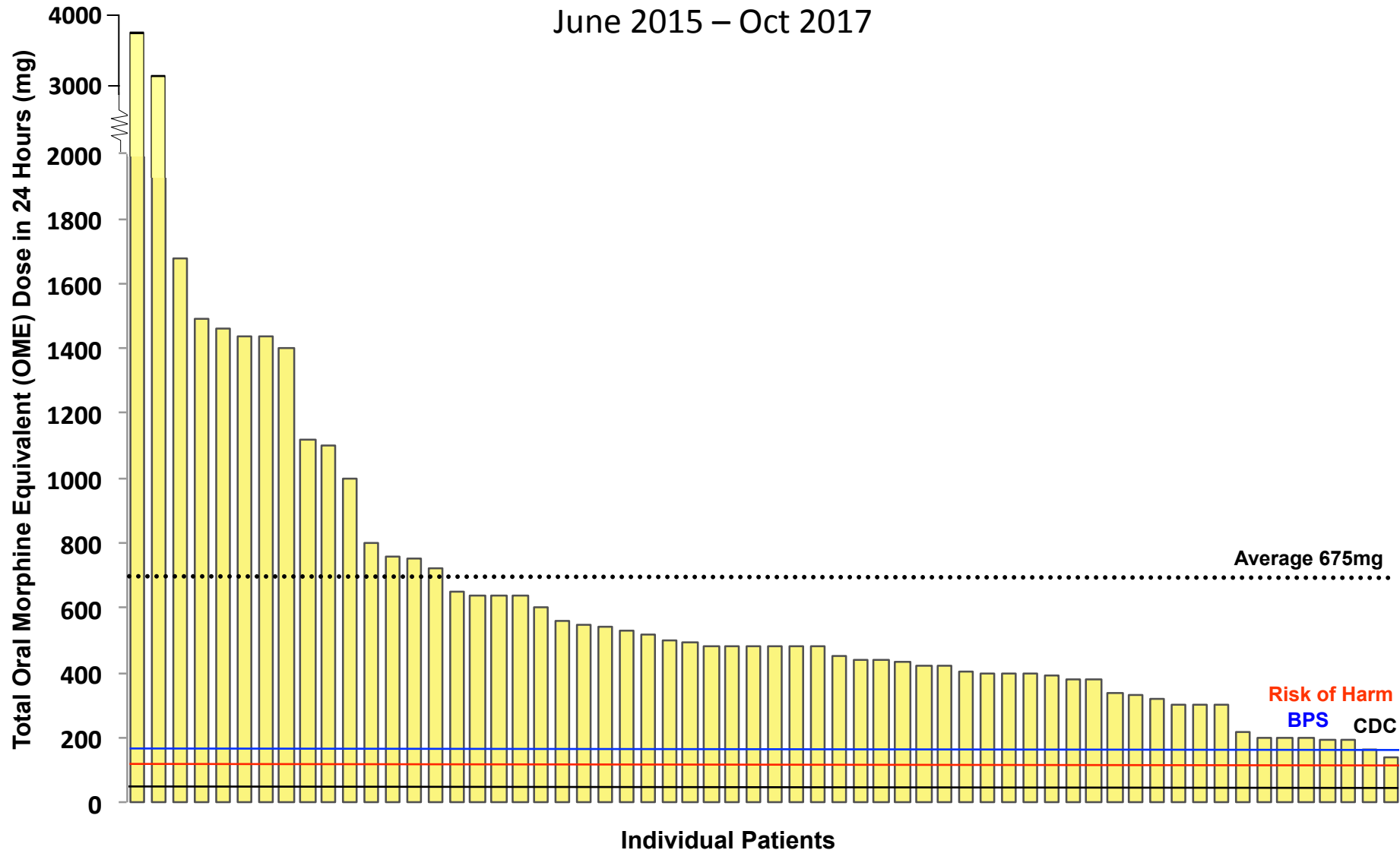
# Serious Adverse Effects of Chronic High Dose Opioids

- Fatality due to respiratory depression and accidental drug overdose
- Addiction/ opioid dependence syndrome
- Endocrine dysfunction (sex hormones – opioid-induced androgen deficiency)
- Secondary effects of hypogonadism:
  - Bone metabolism - osteoporosis and increased fracture risk
  - Anxiety
  - Depression
  - Glucose intolerance
  - Increased cardiac risk
- Suppression of immune function (innate and acquired)
- Link with breast cancer in animal models
- Structural and functional changes within the brain
- Opioid-induced hyperalgesia (OIH)



# GSTT Opioid Pain Management Clinic: Opioid Burden in Chronic Non-malignant Pain (n=61)

June 2015 – Oct 2017



Rationalise, Optimise & Educate



# GSTT Opioid Pain Management Clinic

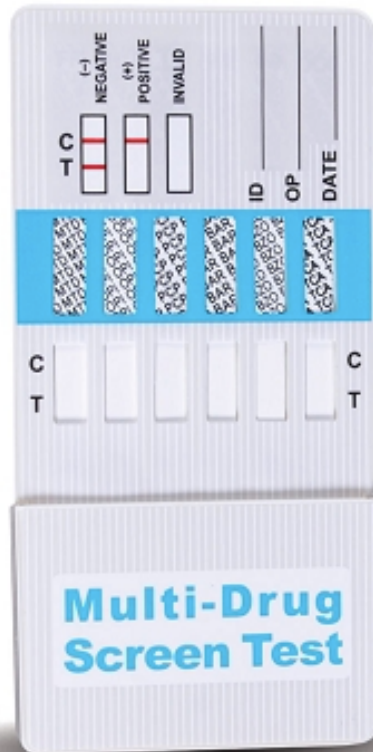
- Monthly
- Multidisciplinary: Pain Specialist, Nurse, Clinical Psychologist
- Referral criteria  $\geq 120$ mg OME (previously  $\geq 300$ mg OME)
- Nurse-led second triage
- New & F/Us 45 mins
- Questionnaires: Patient-related outcomes
- Education: BPS, 'Opioids Aware' & DfT 'Drug Driving'
- Treatment agreement (and consent forms)
- Named GP prescriber
- Exit strategy
- Urine & blood testing



## Urine & Blood Testing

# Urine Immunoassay

- Purpose of testing
- Simultaneous, qualitative detection of 10 drugs and their metabolites
- 98% Accuracy



SYMBOL	TARGET DRUG	CONC.
THC	MARIJUANA	50 ng/ml
COC	COCAINE	300 ng/ml
PCP	PHENCYCLIDINE	25 ng/ml
MOR	OPIATES	2000 ng/ml
MET	METHAMPHETAMINE	1000 ng/ml
MTD	METHADONE	300 ng/ml
AMP	AMPHETAMINE	1000 ng/ml
BAR	BARBITURATES	300 ng/ml
BZO	BENZODIAZEPINES	300 ng/ml
TCA	TRICYCLIC ANTIDEPRESSANTS	30 ng/ml

# Considerations in Weaning

<b>Formulation</b>	Immediate release vs sustained; liquid to tablets
<b>Dosing interval</b>	Scheduled rather than PRN to avoid toxicity-withdrawal; increase dosing interval to address frequency
<b>Rate of wean</b>	Slow; 10% of total daily dose every 1-2 weeks; let patient choose which dose is decreased
<b>Rebound pain</b>	Adjuvants - Gabapentinoids are opioid-sparing (caution with polypharmacy); or non-opioid strategies/ psychological support
<b>Withdrawal</b>	Education; taper more slowly; Lofexidine/ Clonidine
<b>Opioid rotation</b>	Weaning strategy – reduce OME by 25-30% to account for incomplete cross-tolerance
<b>Frequency of pharmacy dispensing</b>	weekly, alternate day or daily; named GP prescriber
<b>End point of wean</b>	Ideally <50mg OME; <120mg for PMP or SCS (motivation to wean)
<b>Support</b>	Increase frequency of visits; Clinical Psychology/ Nurse

# Opioids Aware

[www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware](http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware)

- In Jan 2016, FPM/RCoA launched 'Opioids Aware'
- Evidence-based online prescribing resource to support healthcare professionals & patients
- Broad support – developed in collaboration with medical royal colleges, RPS, BPS, Public Health England, NHS England, NICE, CQC
- Links to other sources

The screenshot displays the 'Opioids Aware' website. At the top, there is a navigation bar with the Faculty of Pain Medicine logo and a search bar. Below this, a breadcrumb trail reads: Home > Faculty of Pain Medicine > Faculty Initiatives > Opioids Aware: A resource for patients and healthcare professionals to support. The main heading is 'Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain'. A sidebar on the left lists various links under 'Faculty Initiatives', with 'Opioids Aware' highlighted. The main content area features a list of five key points about opioid prescribing. To the right, there are sections for 'About the Resource' and 'Contents'. At the bottom, there are three boxes for 'Best Professional Practice', 'The Condition, The Patient, The Context', and 'Clinical Use of Opioids', each with a brief description. A 'Quick Links' section is also present at the bottom right.

Home > Faculty of Pain Medicine > Faculty Initiatives > Opioids Aware: A resource for patients and healthcare professionals to support

**Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain**

Good practice in prescribing opioid medicines for pain should reflect fundamental principles in prescribing generally. The decision to prescribe is underpinned by applying best professional practice; understanding the condition, the patient and their context and understanding the clinical use of the drug. This resource, developed by UK healthcare professionals and policymakers, provides the information to support a safe and effective prescribing decision.

1. Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.
2. A small proportion of people may obtain good pain relief with 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).
3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.
4. If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.
5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

Initially funded by Public Health England

**Public Health England**

**Best Professional Practice**  
Opioids and the law, writing opioid prescriptions, patient safety, reporting harms, record

**The Condition, The Patient, The Context**  
Assessment and challenges of long-term pain, the role of medicines, a stepped approach to opioid

**Clinical Use of Opioids**  
Opioids for different types of pain, their effectiveness and harms, dependence and addiction

**Quick Links**  
Pain assessment  
The opioid trial  
Dose equivalence  
Oxford Analgesic

# Opioids Aware

[www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware](http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware)

- Doses >120mg OME – risk of harm escalates with no added benefit
- Avoid prescribing ‘risk multipliers’ (BDZ, Pregabalin)
- Identify patients at risk of:
  - Opioid dependence
  - Aberrant drug-related behaviour
- Opioid trials
  - *Goal orientated*
  - *Dose-limited*
  - *Time-limited*

## Best Professional Practice

Opioids and the law, writing opioid prescriptions, patient safety, reporting harms, record keeping, prescribing

## The Condition, The Patient, The Context

Assessment and challenges of long-term pain, the role of medicines, a stepped approach to opioid prescribing

## Clinical Use of Opioids

Opioids for different types of pain, their effectiveness and harms, dependence and addiction

## A Structured Approach to Opioid Prescribing

Patient assessment, the opioid trial, long-term prescribing, stopping opioids, equivalents, the addicted patient

## Information for Patients

Types of pain, thinking about starting opioid medication and frequently asked questions about taking opioids




# Opioids Aware

[www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware](http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware)

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# CDC Guidelines (March 2016)

- For Primary Care Clinicians
- 12 Recommendations
- **Caution when prescribing opioids at any dose**
- **Prescribe lowest effective dose to reduce risks of opioid use disorder and overdose**
- **Reassess individual risk/benefit when prescribing doses of  $\geq 50\text{mg}$ ; avoid prescribing at  $\geq 90\text{mg}$**
- Overdose risk doubles at 50-99mg OME/day; increases up to x9 at 100mg+ OME/day



## CDC RECOMMENDATIONS

### DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

- OPIOIDS ARE NOT FIRST-LINE THERAPY**  
Nonpharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Opioid therapy only if expected benefits are anticipated to outweigh risks to patients, and should be combined with nonpharmacologic therapy, as appropriate.
- ESTABLISH GOALS FOR PAIN**  
Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients for pain and function, and should do so will be discontinued if benefits do not outweigh risks to patients, and should only continue opioid therapy if there is improvement in pain and function.
- DISCUSS RISKS AND BENEFITS**  
Before starting and periodically during treatment, clinicians should discuss realistic benefits of opioid therapy.
- EVALUATE BENEFITS AND HARMS FREQUENTLY**  
Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

### ASSESSING RISK AND ADDRESSING HARMS

- USE STRATEGIES TO MITIGATE RISK**  
Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages ( $\geq 50$  MME/day), or concurrent benzodiazepine use, are present.
- REVIEW PMP DATA**  
Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
- USE URINE DRUG TESTING**  
When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
- AVOID CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING**  
Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
- OFFER TREATMENT FOR OPIOID USE DISORDER**  
Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

### OPIOID SELECTION, DOSAGE

- USE IMMEDIATE-RELEASE OF**  
When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioid long-acting (ER/LA) opioids.
- USE THE LOWEST EFFECTIVE**  
When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should consider individual benefits and risks when increasing dosage to  $\geq 50$  MME/day, increasing dosage to  $\geq 90$  MME/day, titrate dosage to  $\geq 90$  MME/day.
- PRESCRIBE SHORT DURATION**  
Long-term opioid use often begins when opioids are used for acute pain. When opioids are used for acute pain, the lowest effective dose of immediate-release opioid should be prescribed no greater quantity than is needed to manage the acute pain. For chronic pain, the lowest effective dose should be prescribed no greater quantity than is needed to manage the chronic pain.

**Naloxone:** a drug that can reverse the effects of opioid overdose

**Benzodiazepine:** sometimes called "benzos," is a sedative often used to treat anxiety, insomnia, and other conditions

**PMP:** a prescription drug monitoring program (PMP) is a statewide electronic database that tracks all controlled substance prescriptions

**NEARLY 2M**  
Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014

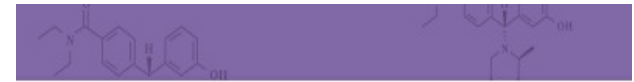
**Medication-assisted treatment:** treatment for opioid use disorder including medications such as buprenorphine or methadone

LEARN MORE | [www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)

# CDC Guidelines (March 2016)

## 6. PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN

- Long-term opioid use often begins with treatment of acute pain
- When opioids are used for acute pain, prescribe the lowest effective dose of immediate-release opioids
- Prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids
- 3 Days or less will often be sufficient; >7 days will rarely be needed.



## CDC RECOMMENDATIONS

### DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

- 1 OPIOIDS ARE NOT FIRST-LINE THERAPY**  
Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
- 2 ESTABLISH GOALS FOR PAIN AND FUNCTION**  
Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- 3 DISCUSS RISKS AND BENEFITS**  
Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

#### Nonpharmacologic therapies and nonopioid medications include:

- Nonopioid medications such as acetaminophen, ibuprofen, or certain medications that are also used for depression or seizures
- Physical treatments (eg, exercise therapy, weight loss)
- Behavioral treatment (eg, CBT)
- Interventional treatments (eg, injections)

### OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

- 4 USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING**  
When starting opioid therapy for chronic pain, clinicians should prescribe **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids.
- 5 USE THE LOWEST EFFECTIVE DOSE**  
When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to  $\geq 50$  morphine milligram equivalents (MME)/day, and should avoid increasing dosage to  $\geq 90$  MME/day or carefully justify a decision to titrate dosage to  $\geq 90$  MME/day.
- 6 PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN**  
Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

**Immediate-release opioids:** faster acting medications with a shorter duration of pain-relieving action

**Extended release opioids:** slower acting medications with a longer duration of pain-relieving action

**Morphine milligram equivalents (MME)/day:** the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse and overdose potential of the amount of opioid that is being given at a particular time

# Challenges in Managing Acute Pain in Opioid-Tolerant Patients

## **Biological**

- Chronic stimulation of opioid receptors leads to central sensitisation (OIH/ tolerance)

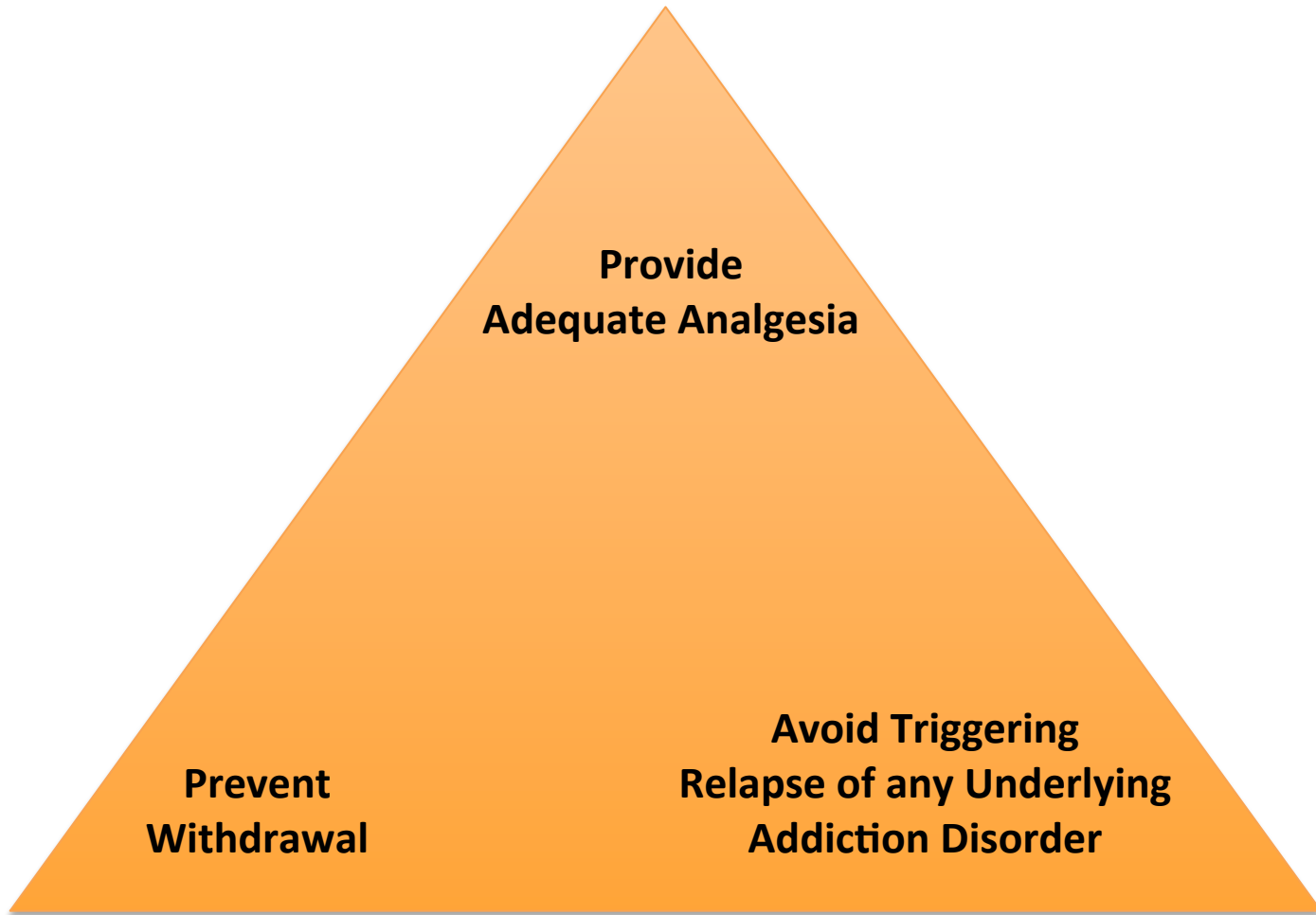
## **Clinician-related Barriers**

- Stigmatisation of all opioid-tolerant individuals as 'addicts' or 'drug seekers'
- Possibility of reports of pain being fabricated to acquire opioids
- Diversion of prescribed opioids
- Fear of causing a drug overdose
- Lack of knowledge about opioid equivalent doses

## **Patient Concerns**

- Fear of withdrawal/ drug cravings (OST)
- Restricted access to analgesia/ fear of pain
- Clinician distrust/ fear of discrimination/ not being taken seriously

# Goals in Managing Acute Pain in Opioid-Tolerant Patients



# Evaluation of Acute Pain in Opioid-Tolerant Patients

## **Is this an exacerbation of baseline pain?**

- Development of tolerance
- Drug interaction causing decreased effectiveness of an existing regime
- Exacerbation of underlying disease

## **Is this a new pain?**

- OIH (change in quality, pain becomes more diffuse)
- Pain in an area of known disease may reflect a new complication e.g. cord compression
- Pain unrelated to the primary disease process e.g. appendicitis



# Managing Acute Pain on a Background of Chronic Opioids:

## Principles in Prescribing and Treating

1. Determine baseline daily opioid requirement prior to the onset of the acute event (OME dose in 24 hours)
2. Prescribe adequate doses of opioids to treat this baseline pain – continue patient's previous long-acting oral or transdermal opioid
3. Add short-acting opioids to cover acute pain (e.g. PCA), monitor side-effects
4. Change from parenteral to oral formulation
5. If opioid titration is ineffective, consider 'opioid rotation'
6. Establish whether other drugs are being misused
7. Optimise non-opioid analgesia:
  - Multi-modal & opioid-sparing e.g. Gabapentinoids, NSAIDs
  - Adjuvants: Ketamine, Clonidine
  - Interventional pain injections/ nerve blocks/ neuraxial analgesia
8. Multidisciplinary discharge planning/ community support to provide follow-up to manage the process of analgesia reduction

# Summary

- **Complex and challenging patients:** Significant functional impairment, psychopathology and high risk for aberrant drug-related behaviour
- **Clinical need to effectively manage in a multidisciplinary setting**
- **Significant improvement in patient outcomes with weaning**
- **Tailored approach:** Rationalise, optimise and educate
- The problem is not opioids per se but the way in which patients are treated with opioids i.e. **without appropriate indication/ precautions and with excessive doses**



## References

- Arnold RM and Childers JW Management of acute pain in the patient chronically using opioids. [www.uptodate.com](http://www.uptodate.com) 2017
- Dowell D *et al.* CDC Guideline for prescribing opioids for chronic pain – United states, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1-49
- Manchikanti L *et al.* Responsible, safe, and effective prescription of opioids for chronic non-cancer pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines. Pain Physician: Opioid Special Issue 2017;20:S3-S92
- Opioids Aware: [www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware](http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware)
- Starrels *et al.* Systematic Review: Treatment agreements and urine drug testing to reduce opioid misuse in patients with chronic pain. Ann. Intern. Med. 2010;152:712-720
- Quinlan J and Cox F Acute pain management in patients with drug dependence syndrome. IASP Pain Clinical Updates Vol XXV. No 1. April 2017

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