Opioid Pain Management Clinic for Chronic Non-Cancer Pain

Dr Fauzia Hasnie
Consultant Lead Opioid Pain Management Clinic
Guy's & St Thomas' NHS Foundation Trust

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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

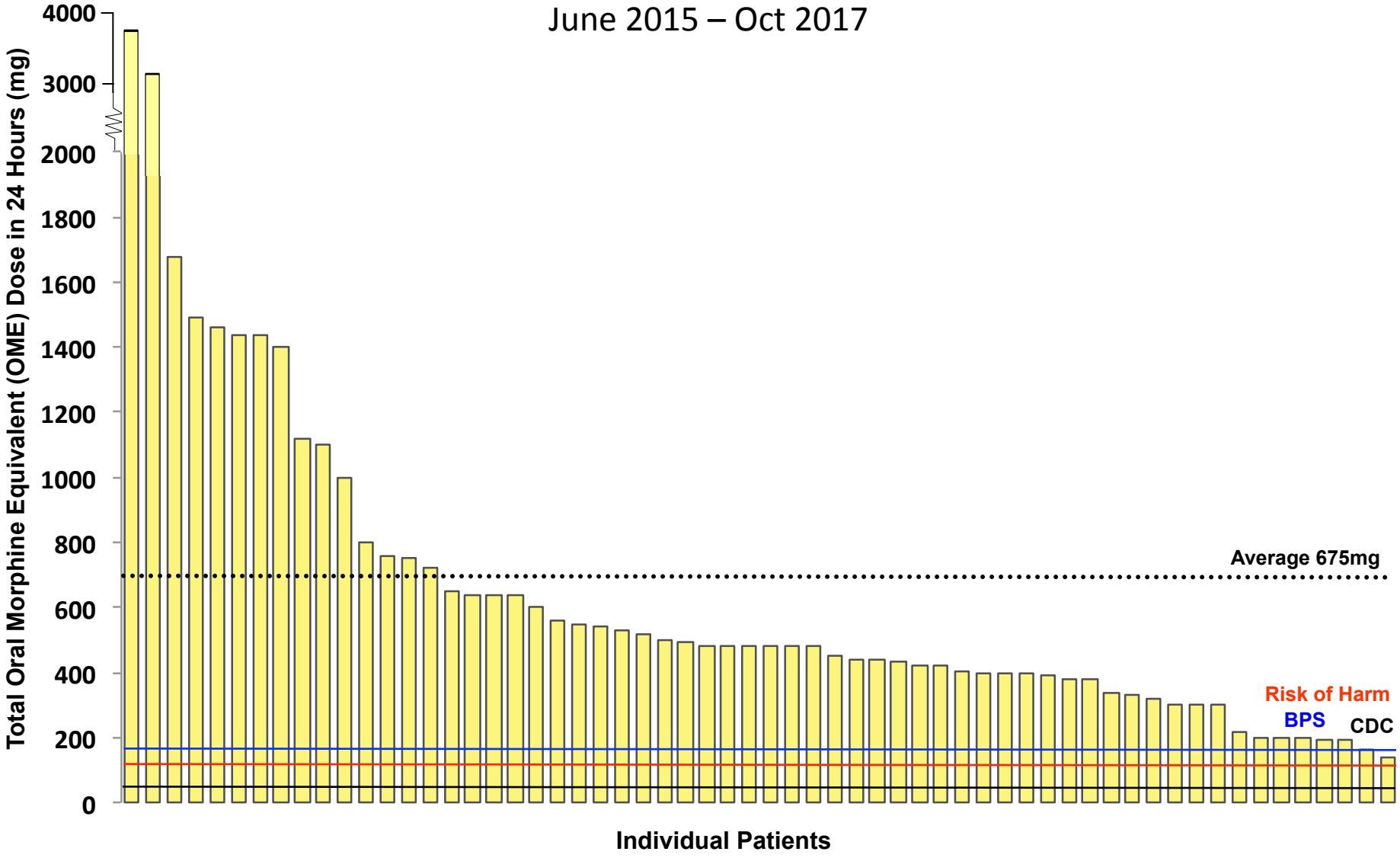
- Serious adverse effects of high dose chronic opioids
- GSTT ‘Opioid Pain Management Clinic’
- ‘Opioids Aware’ & CDC Guidelines
- Considerations in managing acute pain on a background of chronic opioids

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 ≥120mg OME (previously ≥300mg 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

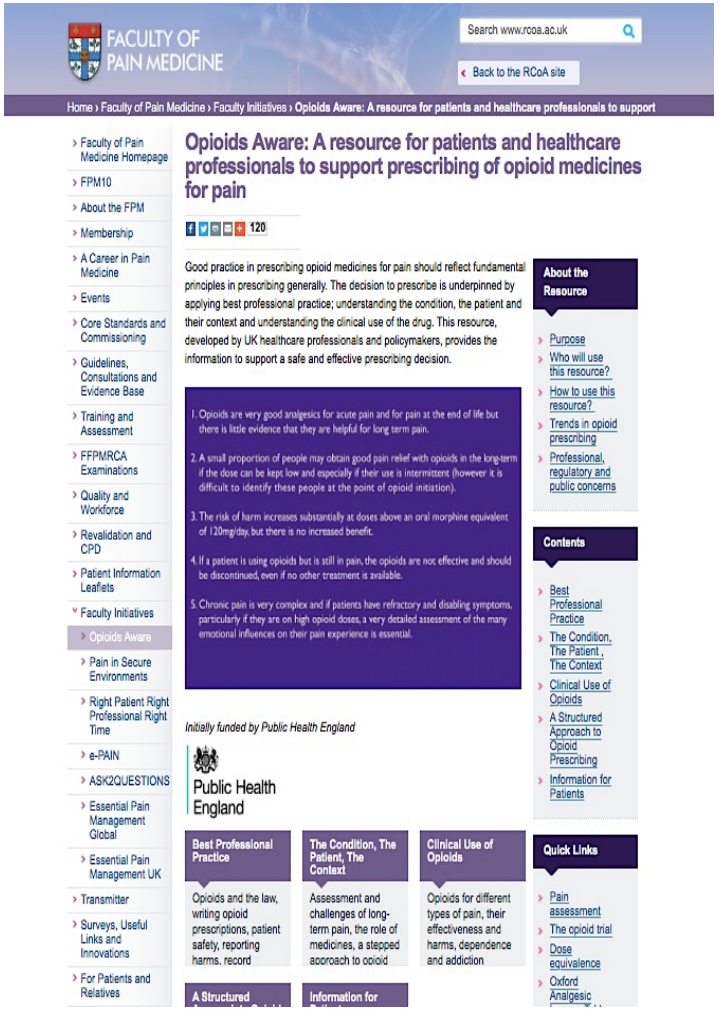
Considerations in Weaning

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

Opioids Aware

www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

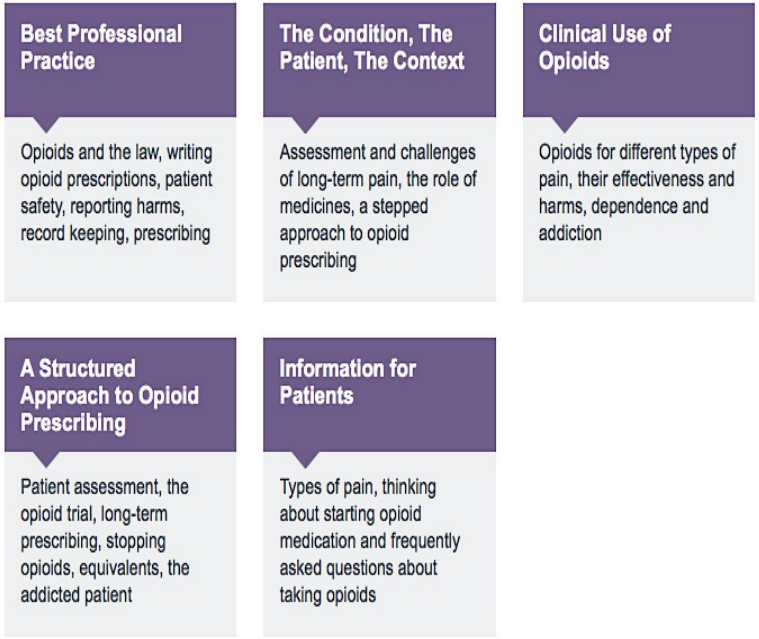
- In Jan 2016, FPM/RCoA launched 'Opioids Aware'
- Evidence-based online prescribing resource to support healthcare professionals & patients
- Broad support – developed in collaboration with medical royal colleges, RPS, BPS, Public Health England, NHS England, NICE, CQC
- Links to other sources



Opioids Aware

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*



Opioids Aware

www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

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).

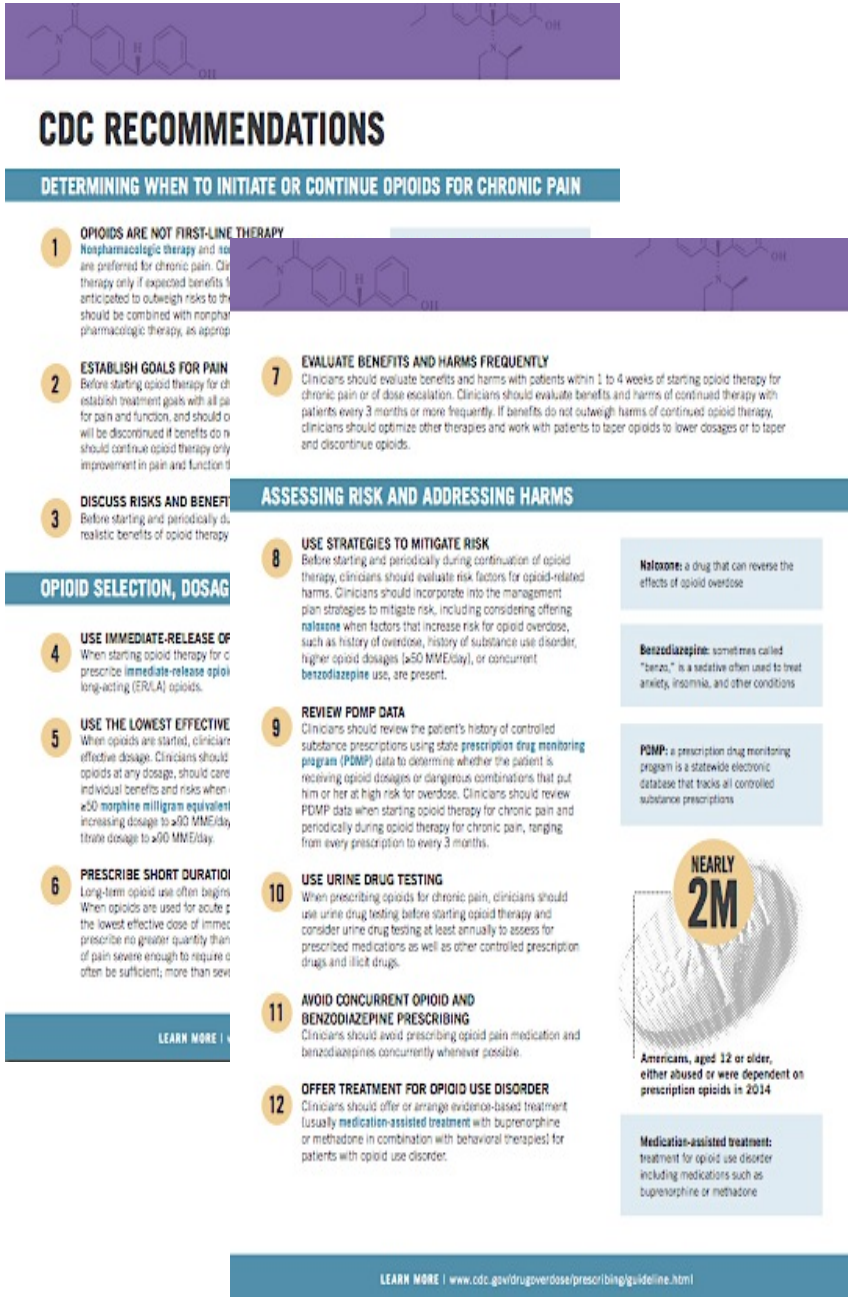
3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.

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.

CDC Guidelines (March 2016)

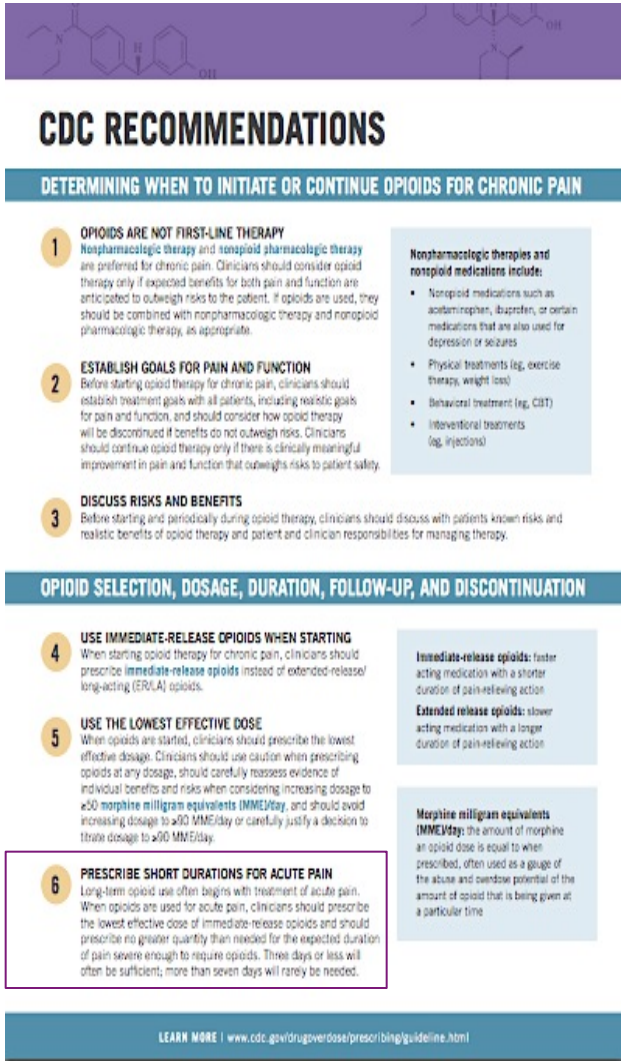
- For Primary Care Clinicians
- 12 Recommendations
- **Caution when prescribing opioids at any dose**
- **Prescribe lowest effective dose to reduce risks of opioid use disorder and overdose**
- **Reassess individual risk/benefit when prescribing doses of ≥50mg; avoid prescribing at ≥90mg**
- Overdose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



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.

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)

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.

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 ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥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 medication with a shorter duration of pain-relieving action

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

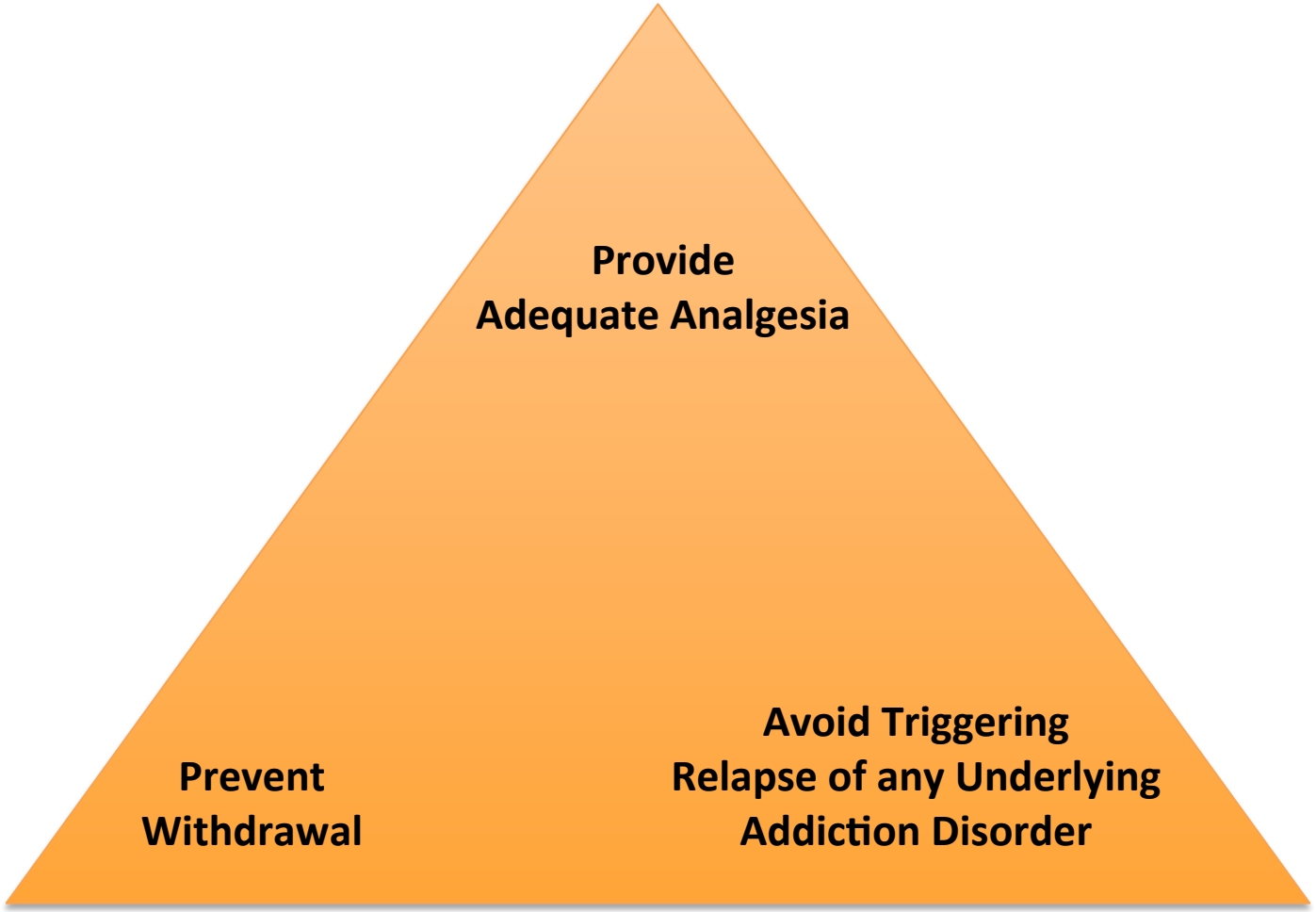
Morphine milligram equivalents (MME)/day: the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse and overdose potential of the amount of opioid that is being given at a particular time

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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**

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