NHS Shropshire, Telford and Wrekin Guidance: Opioid Use and Reduction in Primary Care for Non-Cancer Pain

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Contents

Background

Acute Pain

Opioids are very effective in treating acute pain and for pain at the end of life. They are best used as part of a multimodal analgesic approach in combination with paracetamol, non-steroidal anti-inflammatory drugs and local anaesthetics where appropriate. Initiating opioids for acute pain requires a prescriber to ensure that the opioids are not continued beyond the expected period of tissue healing.[1]

Non-Cancer Pain

Opioid use in non-cancer pain gained momentum following their effectiveness in cancer pain. It is now recognised evidence is limited to support this use. The benefit of long-term opioid use in patients with persistent non-cancer pain has not been demonstrated with regards to reducing pain or improving quality of life and functioning.[2] Side effects are very common, occurring in 50 –80% of patients. Notably up to a quarter of patients taking long term opioids have developed a dependence on them.[3]

Chronic Pain

Updated NICE guidance was published in April 2021 for the treatment of chronic primary pain.[4] The committee found no evidence for the effectiveness of opioids against chronic primary pain. This alongside the evidenced increased risk of dependence associated with long-term use of opioids, forms the basis on which the recommendation is **against** initiating opioid treatment for patients with chronic primary pain.[2]
The following guide should be used for patients exempt from this category when initiating opioids. Opioid initiation should only be considered for patients with chronic secondary pain or mixed pain types in line with the condition specific guidance. Where patients with chronic primary pain are prescribed opioids, prescribing should be reviewed as part of shared decision making:

- Patients should be made aware of the lack of evidence for opioid use in chronic primary pain **and**
- A shared plan for continuing opioids safely should be agreed with the patient if benefit is reported at a safe dose and there are few harms **or**
- Where there is little benefit or significant harm, risk of continuation should be explained to the patient, and they should be provided with encouragement and support to reduce and discontinue the opioid where possible.

Overall, there is little evidence that opioids are helpful for long term pain. The risk of harm and mortality increases substantially above 120mg oral morphine daily or equivalent but there is no increased benefit. There needs to be an agreed outcome of opioid reduction, with an explanation of the benefits of stopping an opioid. If pain has not been reduced by at least 30% (or other pre-agreed objective such as functional improvement), then opioids should be considered as not effective and the opioid dose tapered with a view to stopping, even if no other treatment is available. Shared decision making and monitoring of the patient's pain, level of function, and signs of withdrawal will be required whilst tapering, with regular follows up.[1,5,6]

Headline Points from Opioids Aware

Opioids Aware [1] is a website resource for patients and healthcare professionals to support safe prescribing of opioid medicines for pain. It was developed in collaboration with Public Health England, the Faculty of Pain Medicines and the British Pain Society with representatives from the Royal College of General practitioners, the Royal Pharmaceutical Society and the Faculty of Addictions, Royal College of Psychiatrists. Its key messages are as follows:

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

Patient Assessment

The experience of pain is complex and influenced by the degree of tissue injury, current mood, previous experience of pain and an understanding of the cause and significance of pain. Previous unpleasant thoughts, emotions and experiences can also contribute to the current perception of pain and if unresolved, can act as a barrier to treatment.
The NICE guidance for Chronic Pain and Faculty of Pain Medicine both recommend a person-centred, full holistic assessment of patients presenting with chronic pain which takes these complex factors into account. Further information can be found here.[7]

Opioid Trial

An opioid trial can determine whether opioids may prove useful as part of a pain management strategy or not. It is important to remember that a short-term opioid trial does not predict long term efficacy.

An opioid trial should not be considered unless all non-pharmacological and non-opioid pharmacological options have been tried in line with condition specific guidance.

A structured approach and details of how to perform an opioid trial can be found here.[8]
If there is no improvement in pain, sleep and functionality then the opioid should be reduced slowly and stopped rather than escalating to a higher dose.

Side Effects of Long-Term Opioids

Side effects are extremely common with opioid therapy. Between 50% and 80% of patients in clinical trials experience at least one side effect. However, in everyday use the incidence may be even higher. They include:

Constipation	Nausea
Daytime somnolence	Poor concentration and memory loss
Increased risk of falls	Opioid induced ventilatory insufficiency
Driving and operating machinery [9]	Effects on hormones
Effects on immune system	Opioid induced hyperalgesia
Opioid analgesic dependence	Increased risk of mortality

Opioid Reduction

The opioid risk tool (ORT) [10] is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid dependency among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behaviour.
The ORT can be used and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.
Initial determination of total morphine equivalent daily dose can be made using the faculty of pain medicine equipotencies of opioids tables.[11]

Five Practical Steps to Reduce High Dose Opioids

1. Education

Explain the importance of reducing opioids to the patient. The following patient resources may be of assistance during patient education:

Websites:
The Pain Toolkit [12]
Ten Footsteps Your Journey to Living Well with Pain [13]

Youtube videos:
Understanding Pain what to do About it in Less than 5 Minutes [14]
Understanding Pain: Brainman Stops his Opioids [15]

2. Engagement

Giving the patient as much choice as possible around how to reduce their opioids promotes patient engagement.
It doesn't matter how the opioids are reduced as long as the overall daily dose continues to decrease and there is an understanding the doses will not increase once reduced. Empowering patient choice on how this is achieved gives them more control and ownership of the process, improves engagement and is more likely to yield results.

Option 1: Reduce As Required Dose
Maintain the modified-release dose and taper down the immediate release as required doses by keeping the frequency the same and reducing the dose each week or by maintaining the same dose but reduce the frequency.

Alternatively, the patient could replace the as required dose gradually with paracetamol or ibuprofen to maintain the habit of taking a tablet and concentrate on non-pharmacological aspects of pain management. This way when the modified release tapering happens there is no subsequent increase in as required doses.

Example:

	Modified release Morphine 60mg twice a day		Tramadol 50mg four times a day when required			
Week 1	60mg	60mg	2 x 50mg	2 x 50mg	2 x 50mg	2 x 50mg
Week 2	60mg	60mg	2 x 50mg	2 x 50mg	2 x 50mg	1 x 50mg
Week 3	60mg	60mg	2 x 50mg	2 x 50mg	1 x 50mg	1 x 50mg
Week 4	60mg	60mg	2 x 50mg	1 x 50mg	1 x 50mg	1 x 50mg
Week 5	60mg	60mg	1 x 50mg	1 x 50mg	1 x 50mg	1 x 50mg
Week 6	60mg	60mg	1 x 50mg	1 x 50mg	1 x 50mg	none
Week 7	60mg	60mg	1 x 50mg	none	1 x 50mg	none
Week 8	60mg	60mg	1 x 50mg	none	none	none
Week 9	60mg	60mg	none	none	none	none

Option 2: Reduce the Regular Dose

Reduce the modified-release dose by around 10% per week and keep the as required dose steady. However, caution the patient against increasing the as required dose as this would negate the modified-release reduction.

Example:

	Modified release Morphine 60mg twice a day		When required Tramadol 50mg four times a day when required			
Week 1	**60mg**	**60mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 2	**60mg**	**50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 3	**50mg**	**50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 4	**50mg**	**40mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 5	**40mg**	**40mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 6	**40mg**	**30mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 7	**30mg**	**30mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 8	**30mg**	**20mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 9	**20mg**	**20mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 10	**20mg**	**10mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 11	**10mg**	**10mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 12	**5mg**	**5mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**
Week 13	**None**	**None**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**	**2 x 50mg**

3. Changes to Tapering Plan

Changing Oral Solution to Immediate Release Tablets

Switching from Oramorph to Actimorph may help in the dose tapering process. Both are immediate release morphine, but a fixed dosing of the tablets allows the prescriber more control over the patients use and subsequent reduction.

Patients may find reduction with a liquid particularly difficult when the whole bottle is available and there is a temptation not to measure doses accurately. This also applies to oxycodone liquid.

Oramorph contains 10% alcohol so a patient reporting that Oramorph is more effective than Actimorph tablets could be a flag for an issue with the alcohol content.

Plan the Reduction

Templates [16] may be used to plan the initial reduction if needed. The table will self-populate based on a decrease of approximately 10% per dose. The plan may be adjusted during the course of tapering by increasing the time between reductions or reducing the dose decreases if the patient is struggling.

A note of caution: OPIOID DEPENDENCE, MISUSE AND ADDICTION

Prolonged use of opioids leads to many patients developing a physical dependence which can occur without an opioid use disorder. In these patients, cessation causes an unpleasant withdrawal syndrome, which may include both physical and psychological features. Opioid dependence may emerge at different times for different patients and withdrawal symptoms may occur if cessation is sudden, therefore tapering is recommended.

Problem use of prescription opioids ranges between overuse (occasionally or more often using more than prescribed), misuse (using for purpose not consistent with medical or legal guidelines, resulting in harmful or dangerous consequences) or opioid use disorder (addiction). Addiction is characterized by repeated compulsive drug seeking and continued use despite adverse social, psychological, or physical consequences. Some patients may seek to purchase over the counter opioids, such as codeine, dihydrocodeine and morphine. Often these products are combined with other medicines such as analgesics, which can be harmful to the patient. It is important to educate patients about recognising these harms and risks when withdrawing from high dose opioids and to encourage open and honest communication by building mutual trust.

It would be good practice to inform local community pharmacies of any high dose opioid deprescribing clinics being held at the practice, so they are aware of requests for large quantities or repeated purchases of opioid containing medication. In cases where it becomes apparent during weaning that the primary problem is opioid dependence rather than pain, involvement with the Addiction Medicine service is recommended.

4. Manage Emotional Impact e.g. Anxiety and Depression

Anxiety is to be expected during opioid reduction. If a patient has taken opioids for many years, they may have a sense that they won't be able to cope without them. Evidence suggests that withdrawal symptoms are to be expected at significant reductions, but if the reduction is less than 50-75% of the previous day's dose then the patient shouldn't experience withdrawal. Theoretically, a patient would need to go from 80mg oxycodone one day to 20-40mg the next before getting true withdrawal.

In practice many patients experience what they feel to be withdrawal symptoms with small dose reductions; although this is often related to anxiety rather than opioid

withdrawal (anxiety exacerbates withdrawal symptoms). Plenty of reassurance is needed that this is not dangerous and is a safe reduction.

If necessary, it is wise to work with the patient to reduce the size of the dose reductions (e.g. to 5mg rather than 10mg) or increase the duration between step decreases (e.g. every fortnight rather than every week) to maintain their engagement in a continued wean.

Do not be tempted to treat withdrawal symptoms with more opioids or benzodiazepines. The clinical opiate withdrawal scale (COWS) [17] can be used to quantify the severity of opioid withdrawal and help distinguish between objective and subjective symptoms that can be reassuring to both the patient and clinician. See prescriber resources.

Anxiety and depression often worsen during an opioid reduction, either because the long-term opioids have suppressed noradrenaline and dulled usual emotions (in which case the increased anxiety then settles back down again), or because the reduction unmasks pre-existing psychopathology. If not managed well, this can derail the opioid reduction. Psychological support with psychologists, counsellors, NHS Talking therapies, (previously known as IAPT, improving access to psychological therapies) or from Connect Health, will be helpful.

5. Manage Patient Expectations

Inform patients that the pain is likely to worsen in the short-term during opioid tapering. Despite slow reductions they may also experience withdrawal symptoms, together with increased anxiety and depression. For this reason, it is important that they have engagement, understanding and support from friends and family throughout the process.

They should also develop non-drug techniques (relaxation, distraction, music, DVDs, walks etc.) to manage their pain and reduce the reliance on pharmacological treatment. The pain tool kit provides useful strategies: http://www.paintoolkit.org/. [12]

It can take 4-6 months after the cessation of opioids before they feel back to normal, i.e. for the pain, anxiety and depression to reduce. In the longer term, the pain will reduce to a degree due to the reversal of opioid induced hyperalgesia (where long-term opioids increase, rather than decrease, pain sensitivity).

For patients with abdominal pain, this pain will also improve as the opioids will have been contributing to gut dysmotility.[18]

Patient Resources; Education, Emotional and Physical Support

Apps	
Mindfulness	https://www.headspace.com/headspace-meditation-app
Active walking	https://www.nhs.uk/oneyou/active10/home#xfEeV0FM3W4Xo5gM.97

Videos	
Understanding Pain what to do about it in less than 5 minutes	https://www.youtube.com/watch?v=RWMKucuejls
Understanding pain: Brainman stops his Opioids	Chronic pain management video resource - Brainman | Therapeutic Goods Administration (TGA)
How mood can affect pain	https://www.tamethebeast.org/#tame-the-beast
Understanding pain in less than 5 minutes	www.youtube.com/watch?v=5KrUL8t0aQs
Managing back pain	https://www.youtube.com/watch?v=24P7cTQjsVM&feature=youtu.be

Websites	
The Pain Toolkit	www.paintoolkit.org.
Ten Footsteps Your Journey to living well with Pain	https://livewellwithpain.co.uk/resources/resources-for-patients/ten-footsteps/
British Pain Society reading list	https://www.britishpainsociety.org/suggested-reading-list/
Pain Concern	http://painconcern.org.uk

World Health Organisation (WHO) animated videos	
Depression	www.youtube.com/watch?v=XiCrniLQGYc
Stress	www.youtube.com/watch?v=I6402QJp52M

Resources for Prescribers in Primary Care

Opioids aware website- resources from the faculty of pain medicine	https://fpm.ac.uk/opioids-aware
Pain assessment tool	https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/patient-assessment
Opioid trial	https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/opioid-trial
Supporting self management	https://livewellwithpain.co.uk/resources/supporting-self-management/
Shifting the conversation - video's to support consultations with patients.	https://livewellwithpain.co.uk/resources/shifting-the-conversation/
Driving and pain	https://fpm.ac.uk/sites/fpm/files/documents/2019-08/FPM-Driving-and-Pain-patient-information.pdf
Opioid Risk tool – assessing abuse potential	https://www.drugabuse.gov/sites/default/files/opioidrisktool.pdf
Equipotencies of opioids tables	https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/dose-equivalents-and-changing-opioids
Opiate reduction templates to assist effecting a reduction may be found here:	http://www.ouh.nhs.uk/services/referrals/pain/opioids-chronic-pain.aspx
Opiate withdrawal scale tool	https://www.drugabuse.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf

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