OPIOIDS FOR PERSISTENT NON-CANCER PAIN

Before initiating opioid therapy

- Use only as part of a wider management plan that aims to improve physical function, reduce disability and improve quality of life. Agree individualised treatment goals for each patient and document.
- Treatment success is demonstrated by pain relief and progress towards treatment goals. Make clear to patients that if trial is unsuccessful then opioid treatment will be stopped.
- Inform patient that the max. dose that can be prescribed in primary care is 120mg daily morphine equivalent.
- **Give realistic expectations.** Opioids are unlikely to give complete pain relief. Some pains do not respond to opioids. See APC Neuropathic Pain guidance or NICE: Low back pain and sciatica guideline.

Cautions

- Renal impairment. Dose reduction if eGFR < 30 ml/min. Seek specialist advice.
- Patients should not drive when starting opioids, adjusting dose or if they feel unfit to drive.
- Patients should be informed of the drug driving legislation. See Department for Transport website.

Prescribing

- Be clear who is responsible for prescribing – ideally a single prescriber.
- For an initial opioid trial, prescribe a short (1-2 week supply) of morphine immediate release tablets or liquid. The patient may explore different doses within a specified range e.g. morphine 5-10mg. If reduction in pain is not achieved following a single dose of morphine 20mg, opioids are unlikely to be beneficial in the long term.
- Initial positive outcomes do not predict outcomes in the longer term. A small proportion of patients may do well with opioids in the long term if the dose can be kept low and particularly if use is intermittent.
- **A trial period of FOUR weeks is adequate.**
- **Do not exceed maximum recommended doses**, without consulting a specialist service (see **table and approximate opioid equivalences overleaf**).
- Discuss alternative strategies for exacerbations of pain – 'short acting' opioids are not appropriate for the majority of patients.
- Ensure that the dosing instructions are clear. The instructions for "as required" opioids must include a maximum daily dose. "As directed" is not acceptable.

Monitoring

- Review regularly. Initially at least monthly, more often if there are concerns. If not progressing towards agreed outcomes, taper and consider alternative strategies.
- **When on a stable dose monitor at least biannually.**

Switching opioids

- Efficacy and adverse effects are similar for all opioids, though patients may tolerate one opioid better than another.
- When switching, for safety reasons, consider reducing dose by 25-50% to allow for incomplete cross tolerance and monitor regularly. **See table and approximate opioid equivalences overleaf.**
- Withdrawal symptoms (e.g. sweating, yawning and abdominal cramps) occur if an opioid is stopped/dose reduced abruptly. This is common with tramadol and can occur with weak opioids even after a short course.

Adverse effects

- **Constipation:** Common. Always prescribe laxatives. For example, a combination of stimulant laxative (bisacodyl) and stool-softener (docusate) and add an osmotic laxative (Laxido) if needed.
- In addition, give lifestyle advice (fibre, fluid, toilet habit and exercise – more detail and patient information in appendix 1 of APC Laxative guideline). If constipation problematic with morphine, transdermal fentanyl is the preferred alternative.
- Possible long term endocrine / immunological effects. Consider measuring plasma testosterone or oestradiol after 6 months, seek advice if levels low.

More information—See OPIOIDS AWARE

- Information for prescribers and information for patients.

Dependence and addiction

- Physical dependence is inevitable. Addiction (psychological dependence and craving) is relatively rare.
- Effects of physical dependence and ease of discontinuation helped by limiting max. dose **(see overleaf).**

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OPIOIDS FOR PERSISTENT NON-CANCER PAIN

NHS
Nottinghamshire Area Prescribing Committee

Updated: July 2018 **Review date: July 2020**	Note that secondary care may use different brands –switch to preferred brand in primary care				**Tapentadol MR tablets (Palexia® SR)** Amber 2 — specialist initiation by pain / palliative care teams only*. Specialist to provide first 28 days and assess efficacy / tolerability.
	First Line Strong Opioid **Morphine Sulphate MR capsules (Zomorph®)**	**Transdermal fentanyl patches (Matrifen®)**	**Oxycodone MR tablets (Longtec®)**	**Transdermal buprenorphine patches (use either Butec® or Bupeaze®)**	
Starting doses	10mg every 12 hrs (£3.24)		5mg every 12 hrs (£12.52)	Butec® 5 micrograms/hr changed each week (£7.92)	
Titrate **slowly** to effect (no more frequently than every 2 weeks) If the pain does not improve after adequate trial of opioids (4 weeks), the opioid is not effective and should be stopped even if there is no other treatment available.	20mg every 12 hrs (£6.48) (2x10mg capsules)	12 micrograms/hr changed every 3 days (£14.04)	10mg every 12 hrs (£12.52)	Butec® 10 micrograms/hr changed each week (£14.20)	50mg every 12 hrs (£24.92)
	30mg every 12 hrs (£7.75) (1 x 30mg capsule)	25 micrograms/hr changed every 3 days (£20.09)	15mg every 12 hrs (£19.06)	Butec® 20 micrograms/hr changed each week (£25.86)	
	40mg every 12 hrs (£10.99) (30mg + 10mg capsule)		20mg every 12 hrs (£25.04)	Bupeaze® 35 micrograms/hr changed **twice weekly** (£23.70)	100mg every 12 hrs (£49.82)
	50mg every 12 hrs (£14.23) (2x10mg + 1x30mg capsules)		25mg every 12 hrs (£31.58) (10mg + 15mg capsule)	Bupeaze® 52.5 micrograms/hr changed **twice weekly** (£35.56)	
<u>Maximum dose</u> for non-cancer pain initiated in primary care	60mg every 12 hrs (£15.12) (1x60mg capsule)	50 micrograms/hr changed every 3 days (£37.56)	30mg every 12 hrs (£38.11)	Bupeaze® 70 micrograms/hr changed **twice weekly** (£47.40)	150mg every 12 hrs (£74.73)
<u>Higher doses by specialist recommendation or advice only</u> Risk of harm/ mortality from oral morphine increases substantially at doses exceeding 120mg/day, but there is no increased benefit.					

Tapentadol:** For chronic pain in patients either unresponsive or unable to tolerate morphine, fentanyl, oxycodone and buprenorphine. Can be used 3rd line if the patient has not responded to morphine and buprenorphine and is showing symptoms of neuropathic pain. ***Key: Costs (in brackets) are from the Drug Tariff (Jun18) for 28 days treatment. Dose equivalences are approximate only. Regular monitoring and review is necessary to avoid both under dosing and excessive dosing.

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