Opioids for Chronic Non- Cancer Pain In Adults Guideline

(excluding end of life pain)

Pain is usually described as acute (short term) or chronic (long term - usually more than three months).
This guideline does not include management of acute pain

Understanding and managing chronic pain

- Chronic pain is classified into 3 categories (chronic primary pain, chronic secondary pain, or both) by NICE193: Chronic Pain (primary and secondary) guideline.
- Chronic pain is a multifaceted biopsychosocial phenomenon. Medications, including opioids, are often minimally effective for persistent pain and generally play a limited role in its management.
- Non-pharmacological methods, incorporating physical and psychological techniques, **are far more impactful i**n the long-term management of chronic pain.

Management Strategies:

- **Before considering opioids**, explore **non-pharmacological** and **non-opioid pharmacological** treatment options:

Non-Pharmacological Methods

- **Self-Care:** Empower patients to actively engage in self-management strategies. Living well with chronic pain necessitates ongoing self-care and resilience.
- **Non-Drug Treatments:** Explore techniques such as acupuncture (note: currently not commissioned within Nottingham ICS).
- **Psychological Therapies:** Such as Cognitive Behavioural Therapy (CBT), meditation, and mindfulness practices to address the psychological dimensions of pain.
- **Physical Activity:** Encourage regular physical activity and structured exercise programs. Reassure patients that movement typically does not lead to further tissue damage.
- Refer to physiotherapy or psychological therapy services as appropriate. Utilise social prescribing initiatives.
- See APC Management of chronic pain overarching guideline for sign posting/referral/resources for patients/clinicians.

Non-Opioid Pharmacological Treatments

- Review options in line with NICE193: Chronic Pain (primary and secondary) guideline and the APC Management of chronic pain overarching guideline

Opioid Therapy

- **Chronic Primary Pain** (pain not clearly related to a specific underlying condition) **-** NICE NG193 emphasizes the limited evidence supporting opioid use for chronic primary pain and recommends non-pharmacological and non-opioid pharmacological approaches as outlined above.
- **Chronic Secondary Pain** (related to an underlying condition e.g. arthritis)- Management should follow the relevant NICE or local guidance for the specific condition. Opioids have a **limited role** and should only be considered when explicitly recommended.
- **Coexisting Pain Types -**Chronic primary and secondary pain may co-occur. Clinical judgment is essential to determine if elements of the pain should be managed as chronic primary pain alongside treatment for the underlying condition.
- Therefore, initiation of opioids should be reserved for patients with chronic secondary or mixed pain types, strictly adhering to condition-specific guidance.
- For full details see APC Management of chronic pain overarching guideline and NICE NG193.
- Initiating prolonged-release opioids for **post-operative pain** is not recommended unless advised by specialist pain team (MHRA warning ,March 2025)

Before initiating opioid therapy

- Before starting opioids refer to NICE NG215 guideline on medicines associated with dependence or withdrawal symptoms for information that should be considered and discussed with the patient, including steps to reduce the risk of dependence.
- 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 it clear to patients that if trial is unsuccessful then opioid treatment will be stopped.
- **Give realistic expectations.** Opioids are unlikely to give complete pain relief. Some pains, particularly long-term pain, do not respond to opioids. See APC Neuropathic Pain guidance or NICE: Low back pain and sciatica guideline.

Cautions

- **Risk of dependence and addiction** - see MHRA warning (Sept 2020) and NICE guideline on medicines associated with dependence or withdrawal symptoms
- Renal impairment. Dose reduction if eGFR < 30 ml/min. Seek specialist advice.
- Liver impairment
- 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.
- Considerations should be given into factors such as polypharmacy, drug to drug interactions and co mobilities
- Often opioids are used concomitantly with anti-neuropathic medications and there could be potential interactions. Refer to BNF and SPC full list of interactions , cautions and contra-indications
- The MHRA warns of the **risk of sedation, severe respiratory depression, coma, and death**—particularly when gabapentin, pregabalin, or benzodiazepines (or benzodiazepine-like drugs) are used in combination with opioid medicines. Only co-prescribe if there is no alternative and, if necessary, the lowest possible doses should be given for the shortest duration. See
  MHRA warning 2020: Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory depression.
  MHRA warning 2017:Gabapentin (Neurontin): risk of severe respiratory depression.
  MHRA warning 2021: Pregabalin (Lyrica): reports of severe respiratory depression.

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**. Only switch to a more potent opioid on specialist advice.
- Do not exceed maximum recommended doses, without consulting a specialist service. The maximum dose that can be prescribed in primary care is 120mg daily morphine equivalent (see **table overleaf for maximum doses of other opioids that primary care can prescribe**).
- Discuss alternative strategies for exacerbations of pain – See NHS Live Well - 10 Ways to Reduce Pain or Live Well with Pain - Ten Footsteps.
- 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. See Opioid Deprescribing guideline.
- Adding a useful read-code allows easier and quicker identification of patients prescribed opioids on regular basis.
- When on a stable dose monitor at least biannually.

Adverse effects

- **Constipation:** Common. **Recommend** laxatives. Offer an osmotic laxative (Laxido®) and a stimulant laxative (bisacodyl), or docusate is an alternative which also has stool-softening properties. See NICE CKS for more detail. Specialist can initiate naldemedine or naloxegol in line with NICE TA651 and NICE TA345 respectively.
- In addition, give lifestyle advice (fibre, fluid, toilet habit and exercise – see APC patient information leaflet).
- Possible long-term endocrine / immunological effects. Consider measuring plasma testosterone or oestradiol after 6 months, seek advice if levels low.

Dependence and addiction

- Physical dependence is inevitable. Addiction (psychological dependence and craving) is not rare.
- Effects of physical dependence and ease of discontinuation helped by limiting max. dose **(see overleaf).**
- See MHRA warning (Sept 2020) and NICE guideline on medicines associated with dependence or withdrawal symptoms

More information

- See **OPIOIDS AWARE**: Information for prescribers and information for patients..
- For sign posting, referral and for patients or clinicians resources see APC Management of chronic pain overarching guideline

Strong Opioids Modified Release Formulary Options

Strong opioids should always be used as part of a multimodal strategy for pain management utilising non-pharmacological and non-opioid pharmacological interventions as outlined above.

Initiating prolonged-release opioids for **post-operative pain** is not recommended unless advised by specialist pain team (MHRA warning March 2025)

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. Regular monitoring and review are necessary to avoid both under dosing and excessive dosing.

*Note that secondary care may use different brands –switch to preferred brand in primary care

GREEN **FIRST LINE STRONG OPIOID**	**Morphine Sulphate MR Capsules (Zormorph®)** *Prescribe by brand See Preferred Prescribing List	• Starting dose usually 10mg MR every 12 hours. Titrate slowly as outlined above. • Maximum dose for non-cancer pain initiated in primary care = 60mg every 12 hours • Higher doses by specialist recommendation or advise only • **Risk of harm/ mortality from oral morphine increases substantially at doses exceeding 120mg a day, but there no increased benefit**
AMB 3 **NOT FOR FIRST LINE USE**	**Transdermal Buprenorphine Patches (Sevodyne® Patch, Bupeaze® Patch)** *Prescribe by brand See Preferred Prescribing List.	**Sevodyne® Patch (Weekly patch)** • Usual starting dose is 5 micrograms/hr changed each week. Titrate slowly as outlined above • Useful for patients new to more potent opioids • **Specialist do not recommend doses greater than 20micrograms/hr changed each week for management chronic non-cancer pain** **Bupeaze® Patch (Twice weekly patch)** • Starting dose is usually 35 micrograms/hr changed twice weekly. Titrate slowly as outlined above. • Maximum dose for non-cancer pain initiated in primary care = Bupeaze® 52.5 micrograms/hr changed twice weekly • **For chronic non-cancer pain, doses greater than 70 micrograms / hour by specialist recommendation only**
AMB 2 **Pain Specialist Recommendation Only** 1	**Tapendadol MR Tablets (Palexia®, Ationdo®)**	• 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 • Starting dose usually 50mg MR every 12 hours. Titrate slowly as outlined above • Maximum dose for non-cancer pain initiated in primary care = 200mg every 12 hours • Specialist to provide first 28 days and assess efficacy • Risk of seizures and serotonin syndrome when co-administered with other medicines (MHRA Jan 2019)
	Oxycodone MR Tablets (Longtec®)	• Starting dose usually 5mg MR every 12 hours. Titrate slowly as outlined above • Maximum dose for non-cancer pain initiated in primary care = 40mg every 12 hours
	Transdermal Fentanyl patches (Opiodur®) ***Prescribe by brand. See Preferred Prescribing List.	• **Not recommended** for non-cancer-related pain unless **on pain team specialist advice only** • Contra-indicated in opioid-naïve patients (MHRA Sept 2020). • Reports of life threatening and fatal opioid toxicity from accidental exposure (MHRA Oct 2018)

Switching opioids - Link to calculator for equianalgesic dose conversion

- Efficacy and adverse effects are similar for all opioids, though patients may tolerate one opioid better than another.
- **Only switch to a more potent opioid on specialist advice** (may be via Advice & Guidance)**.**
- When switching, for safety reasons, consider reducing dose by 25-50% to allow for incomplete cross tolerance and monitor regularly.
- 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.