Reducing the risks with prescription opioids & gabapentinoids

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Outline

- Background information
  - Appreciate lessons learnt from the US opioid epidemic
  - Understand why opioids have been used in chronic non malignant pain
  - Risks and benefits of opioids
  - Opioids Aware: key messages and content
  - Safety and opioids: what does a patient need to know?
  - Prescription opioids: recognising risk factors

- Opioid and gabapentinoid prescribing and deprescribing: sharing and learning from good practice

- How can a HCP promote and support self management within a consultation?

- Pain management: keeping your knowledge up to date, accessing education, training and resources

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Prescription opioid deaths

CONTROLLED DRUGS NEWSLETTER

NHS South Region South West

SHARING GOOD PRACTICE IN THE SOUTH WEST

April 2017

SPECIAL EDITION – FAYE'S STORY

What can happen when things go wrong with prescribing for chronic pain – lessons that must be learned by all healthcare professionals

As told by her parents, Linda and Steve

Faye (right), when she was well

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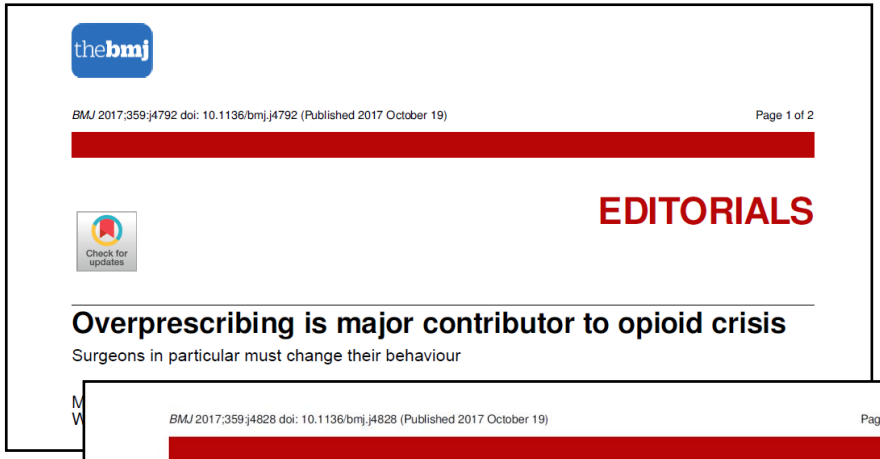
USA: Opioid misuse epidemic



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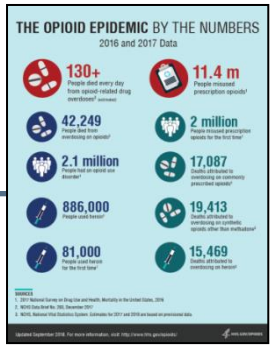
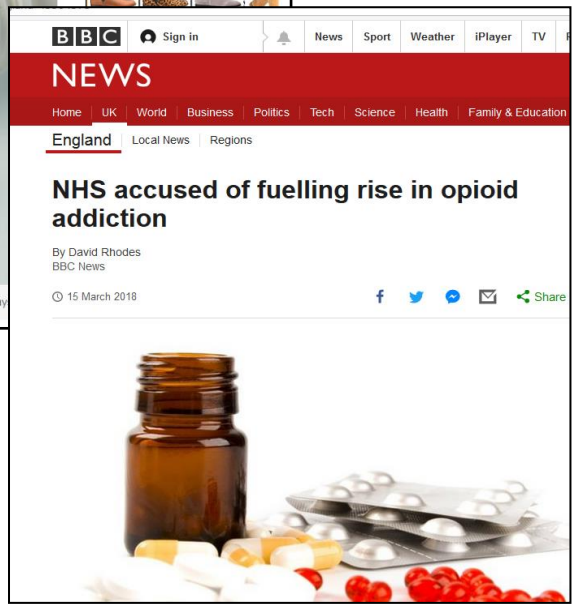
US opioid misuse epidemic



- 11% Americans (adults) experienced chronic pain (CDC 2016)
- Over prescribing of opioids has led to enormous societal problems in USA (Ballantyne 2012)
- National epidemic of opioid related overdoses, deaths and addictions (Volkow & McLellan 2016)
- **2016:** Overdoses involving opioids killed more than 42,249 people. 40% of those deaths were from prescription opioids (Hedegaard et al 2017)
- **2017:** 70,237 drug overdose deaths: Opioids were involved in 47,600 overdose deaths (67.8% of all drug overdose deaths) (CDC 2018)
- On average, 130 Americans die every day from an opioid overdose (CDC 2018)


Is the UK on the same slippery slope?



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Evening Standard: March 2018

https://assets.standard.co.uk/opioids/index.html

1. Cost

- £263 million of tax payers money spent in England in 2017 on prescription opioids

2. Increase in prescriptions

- 90% prescribed by GPs' - GPs prescribe twice as many opioids as they did 10 years ago
- 90% of nearly 24 million opioids prescribed annually are for chronic non-cancer pain

3. Limited effectives

- 90% of opioids prescribed do not work for chronic non-cancer pain

4. Risks

- 300,000 people in the UK are said to be problem users

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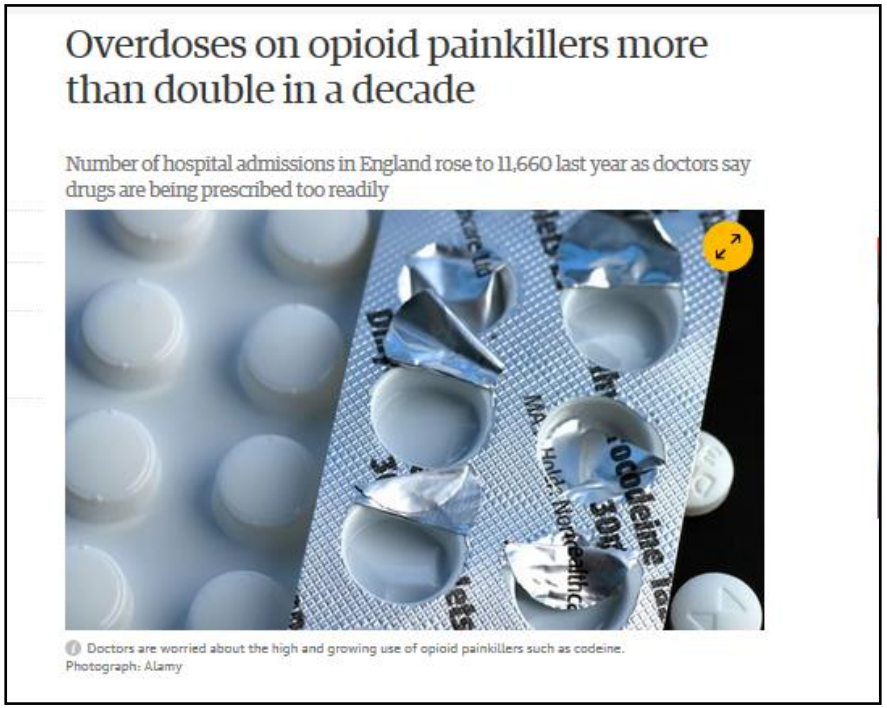
Overdose - prescription opioids



Overdoses on opioid painkillers more than double in a decade

Number of hospital admissions in England rose to 11,660 last year as doctors say drugs are being prescribed too readily

Doctors are worried about the high and growing use of opioid painkillers such as codeine. Photograph: Alamy

The number of people attending hospital with poisoning from opioids more than doubled to 11,000 between 2005-06 and 2015-16

(NHS Digital. Note: 2016-17 data provisional).

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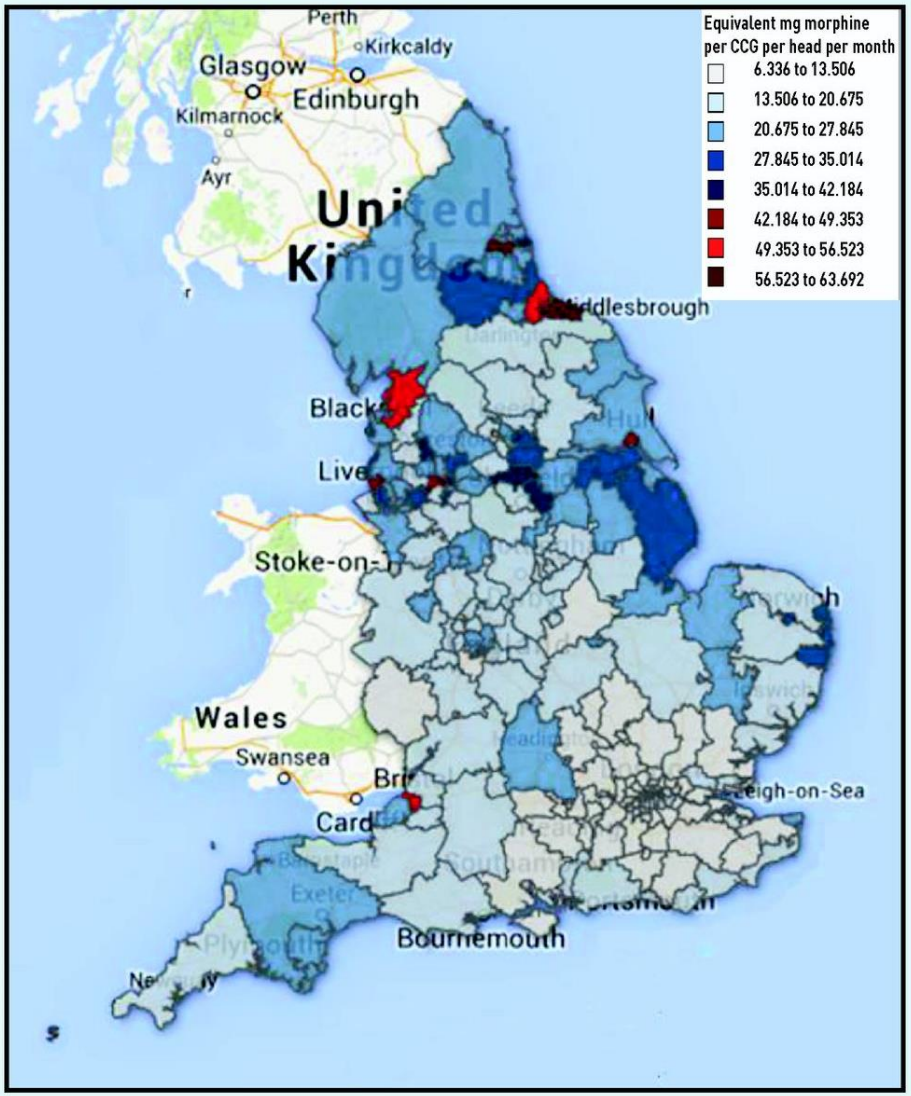
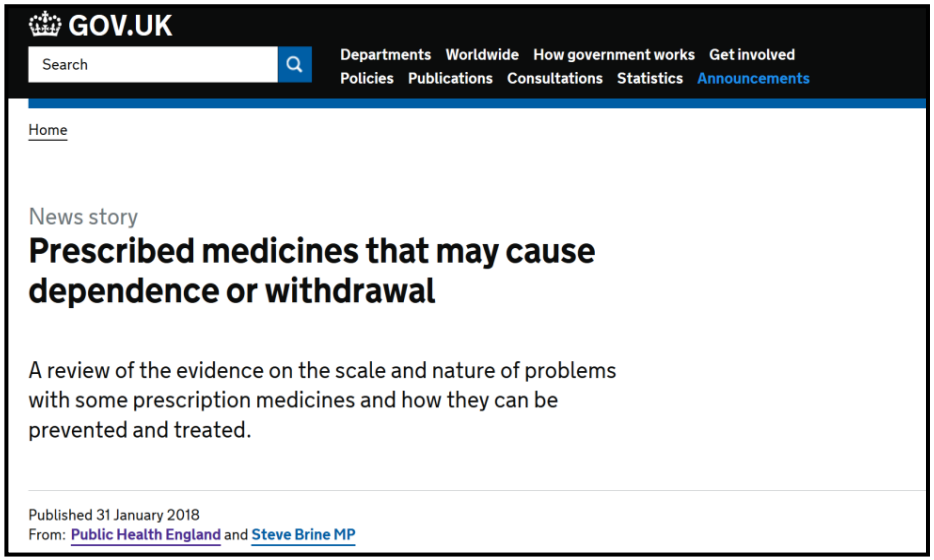
Variation in English CCGs in opioid prescribing in equivalent mg of morphine from August 2010 to February 2014



Luke Mordecai et al. Br J Gen Pract
doi:10.3399/bjgp18X695057

PHE: public-health focused review

Jan 2018



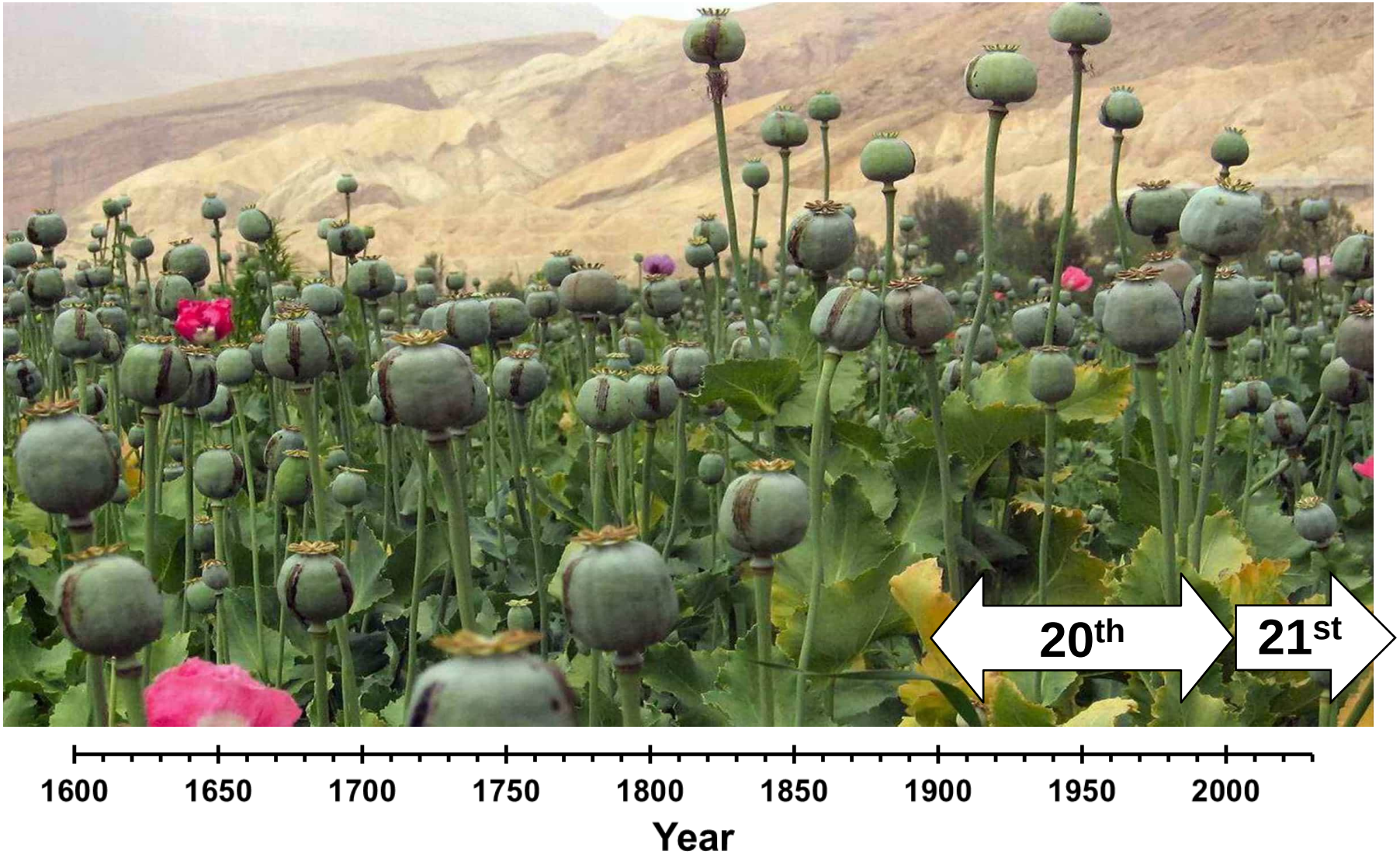
Included within the scope of the review are:

- adults (age 18 and over)

- medicines that may cause dependence and discontinuation syndrome:
  - opioids
  - gabapentinoids
  - benzodiazepines
  - Z-drugs
  - antidepressants

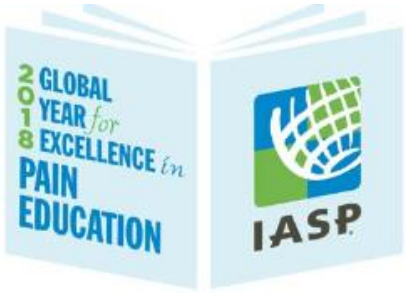
https://www.gov.uk/government/news/prescribed-medicines-that-may-cause-dependence-or-withdrawal

Why have opioids been used for chronic non-cancer pain?



Why have opioids been used for chronic non-cancer pain?

- Pain relief viewed as a basic human right- Pain as 'the 5th vital sign
- Early emerging literature lead to a view that opioids may play a role in long term pain
- Significant pharmaceutical marketing
- Absence of guidance or direction about which opioids to use and to what dose
- Many patients '*held/ still hold strong views*' that opioids are helpful
- Lack of access to non pharmacological strategies
- Traditional medications no longer in favour
- **The known gap between knowledge and clinical practice**



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L.1

Why have opioids been used for persistent pain?

Stannard 2013

Because...

- People with persistent pain may exhibit **distress**
- **Distress** can lead to clinicians prescribe
- Persistent pain can be hard to treat so prescribing something strong is a tempting idea

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L.2

Why have opioids been used for persistent pain?

Ballantyne and Sullivan 2015

Intensity of Chronic Pain — The Wrong Metric?

Jane C. Ballantyne, M.D., and Mark D. Sullivan, M.D., Ph.D.

- Pain intensity ratings do **not** necessarily reflect extent or severity of tissue damage.
- **Suffering** may be related as much to the meaning of pain as to intensity.
- Persistent helplessness and hopeless may be the root causes of suffering for patients with chronic pain yet be reflected in a report of high pain intensity.
- **Inappropriate reliance on pain intensity** ratings tends to result in the use of opioid treatment for patients with mental health or substance abuse problems.

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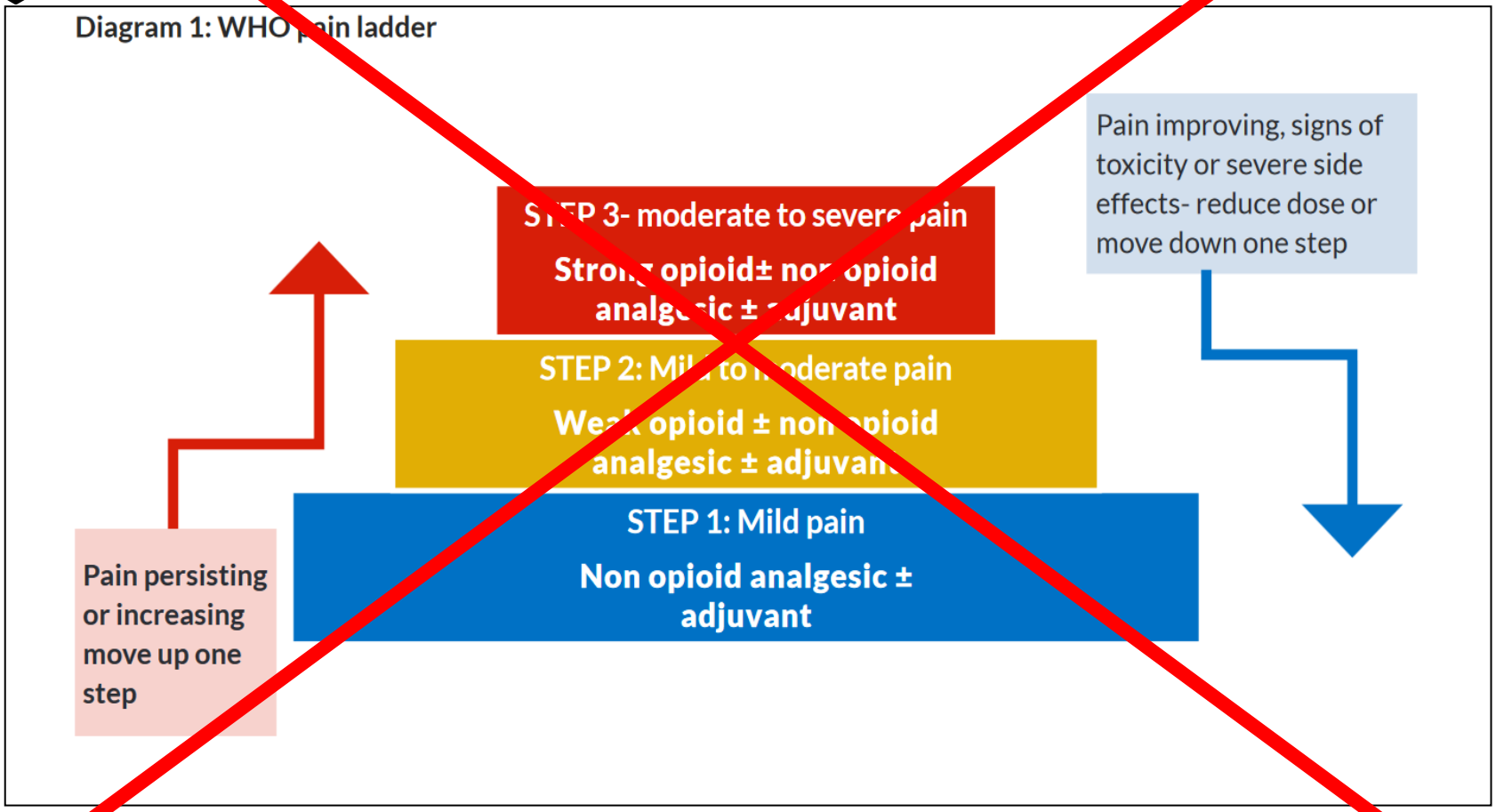
L.3

Chronic Pain & the WHO analgesic ladder



PresQuipp B 52 V2 2013

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Opioids Aware

2015

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

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1. Opioids are very good analgesics for acute pain and end of life pain 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 use is intermittent, but it is difficult to identify these people at the start of treatment.

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

4. Opioids should be discontinued if the person is still in pain despite using opioids, even if no other treatment is available.

5. A detailed assessment of the emotional influences on the person's pain experience is essential for people with chronic pain who also have refractory and disabling symptoms, particularly if they are on high opioid doses.

Opioids Aware: risk of adverse selection

Opioids Aware 2015

Adverse selection is where 'the most risky drug regimes are prescribed to the patients most likely to be harmed by them' Stannard 2018 BJA 120(6) 1148

Risk of running into problems with high dose opioids

Patient factors

- Depression/common mental health diagnoses
- Alcohol misuse/non-opioid misuse
- Opioid misuse

Drug factors

- High doses
- Multiple opioids
- More potent opioids
- Concurrent benzodiapines/sedative drugs


The New York Times

THURSDAY, MAY 24, 2018

Battling Opioid Overdoses

A fentanyl user and his girlfriend at a supervised injection site in Toronto. New York is interested in opening similar centers. Page A24.

Chronic pain and opioid effectiveness

IASP 2018

- **Chronic pain treatment strategies that focus on improving the quality of life, especially those integrating behavioural and physical treatments, are preferred.**

- IASP recommends caution when prescribing opioids for chronic pain.

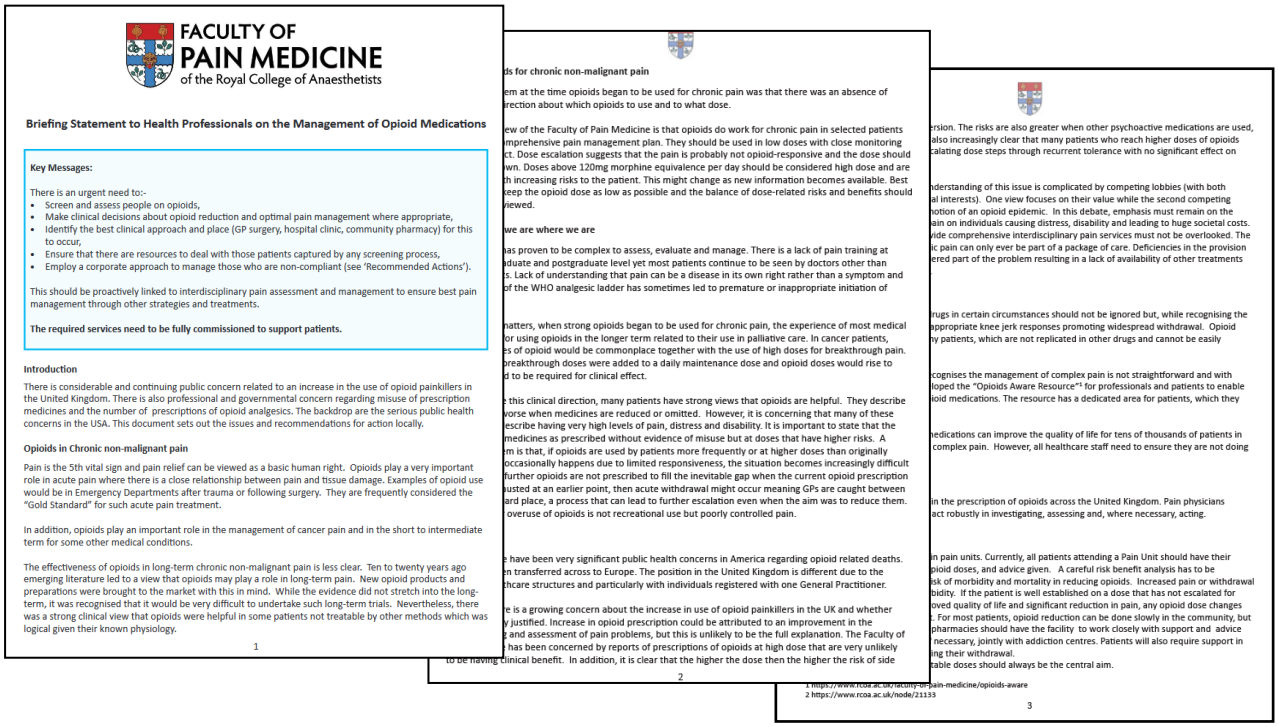
- There may be a role for medium-term, low-dose opioid therapy in carefully selected patients with chronic pain who can be managed in a monitored setting. However, with continuous longer-term use, tolerance, dependence, and other neuroadaptations compromise both efficacy and safety.

https://www.iasp-pain.org/Advocacy/OpioidPositionStatement

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

November 2018

Briefing Statement to Health Professionals on the Management of Opioid Medications



FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Briefing Statement to Health Professionals on the Management of Opioid Medications

Key Messages:

There is an urgent need to:-
- Screen and assess people on opioids,
- Make clinical decisions about opioid reduction and optimal pain management where appropriate,
- Identify the best clinical approach and place (GP surgery, hospital clinic, community pharmacy) for this to occur,
- Ensure that there are resources to deal with those patients captured by any screening process,
- Employ a corporate approach to manage those who are non-compliant (see 'Recommended Actions').

This should be proactively linked to interdisciplinary pain assessment and management to ensure best pain management through other strategies and treatments.

The required services need to be fully commissioned to support patients.

Introduction

There is considerable and continuing public concern related to an increase in the use of opioid painkillers in the United Kingdom. There is also professional and governmental concern regarding misuse of prescription medicines and the number of prescriptions of opioid analgesics. The backdrop are the serious public health concerns in the USA. This document sets out the issues and recommendations for action locally.

Opioids in Chronic non-malignant pain

Pain is the 5th vital sign and pain relief can be viewed as a basic human right. Opioids play a very important role in acute pain where there is a close relationship between pain and tissue damage. Examples of opioid use would be in Emergency Departments after trauma or following surgery. They are frequently considered the "Gold Standard" for such acute pain treatment.

In addition, opioids play an important role in the management of cancer pain and in the short to intermediate term for some other medical conditions.

The effectiveness of opioids in long-term chronic non-malignant pain is less clear. Ten to twenty years ago emerging literature led to a view that opioids may play a role in long-term pain. New opioid products and preparations were brought to the market with this in mind. While the evidence did not stretch into the long-term, it was recognised that it would be very difficult to undertake such long-term trials. Nevertheless, there was a strong clinical view that opioids were helpful in some patients not treatable by other methods which was logical given their known physiology.

1

ds for chronic non-malignant pain

em at the time opioids began to be used for chronic pain was that there was an absence of irection about which opioids to use and to what dose.

ew of the Faculty of Pain Medicine is that opioids do work for chronic pain in selected patients mprehensive pain management plan. They should be used in low doses with close monitoring ct. Dose escalation suggests that the pain is probably not opioid-responsive and the dose should wn. Doses above 120mg morphine equivalence per day should be considered high dose and are h increasing risks to the patient. This might change as new information becomes available. Best eep the opioid dose as low as possible and the balance of dose-related risks and benefits should viewed.

we are where we are

as proven to be complex to assess, evaluate and manage. There is a lack of pain training at aduate and postgraduate level yet most patients continue to be seen by doctors other than s. Lack of understanding that pain can be a disease in its own right rather than a symptom and of the WHO analgesic ladder has sometimes led to premature or inappropriate initiation of

natters, when strong opioids began to be used for chronic pain, the experience of most medical or using opioids in the longer term related to their use in palliative care. In cancer patients, s of opioid would be commonplace together with the use of high doses for breakthrough pain. breakthrough doses were added to a daily maintenance dose and opioid doses would rise to d to be required for clinical effect.

this clinical direction, many patients have strong views that opioids are helpful. They describe orse when medicines are reduced or omitted. However, it is concerning that many of these escribe having very high levels of pain, distress and disability. It is important to state that the medicines as prescribed without evidence of misuse but at doses that have higher risks. A m is that, if opioids are used by patients more frequently or at higher doses than originally occasionally happens due to limited responsiveness, the situation becomes increasingly difficult further opioids are not prescribed to fill the inevitable gap when the current opioid prescription usted at an earlier point, then acute withdrawal might occur meaning GPs are caught between ard place, a process that can lead to further escalation even when the aim was to reduce them. overuse of opioids is not recreational use but poorly controlled pain.

have been very significant public health concerns in America regarding opioid related deaths. n transferred across to Europe. The position in the United Kingdom is different due to the thcare structures and particularly with individuals registered with one General Practitioner.

e is a growing concern about the increase in use of opioid painkillers in the UK and whether y justified. Increase in opioid prescription could be attributed to an improvement in the and assessment of pain problems, but this is unlikely to be the full explanation. The Faculty of has been concerned by reports of prescriptions of opioids at high dose that are very unlikely to be having clinical benefit. In addition, it is clear that the higher the dose then the higher the risk of side

2

ersion. The risks are also greater when other psychoactive medications are used, also increasingly clear that many patients who reach higher doses of opioids calating dose steps through recurrent tolerance with no significant effect on

nderstanding of this issue is complicated by competing lobbies (with both al interests). One view focuses on their value while the second competing notion of an opioid epidemic. In this debate, emphasis must remain on the ain on individuals causing distress, disability and leading to huge societal costs. vide comprehensive interdisciplinary pain services must not be overlooked. The ic pain can only ever be part of a package of care. Deficiencies in the provision ered part of the problem resulting in a lack of availability of other treatments

rugs in certain circumstances should not be ignored but, while recognising the appropriate knee jerk responses promoting widespread withdrawal. Opioid ny patients, which are not replicated in other drugs and cannot be easily

cognises the management of complex pain is not straightforward and with loped the "Opioids Aware Resource"[1] for professionals and patients to enable ioid medications. The resource has a dedicated area for patients, which they

edications can improve the quality of life for tens of thousands of patients in complex pain. However, all healthcare staff need to ensure they are not doing

in the prescription of opioids across the United Kingdom. Pain physicians act robustly in investigating, assessing and, where necessary, acting.

in pain units. Currently, all patients attending a Pain Unit should have their pioid doses, and advice given. A careful risk benefit analysis has to be isk of morbidity and mortality in reducing opioids. Increased pain or withdrawal bidity. If the patient is well established on a dose that has not escalated for oved quality of life and significant reduction in pain, any opioid dose changes . For most patients, opioid reduction can be done slowly in the community, but pharmacies should have the facility to work closely with support and advice necessary, jointly with addiction centres. Patients will also require support in ing their withdrawal.
table doses should always be the central aim.

1 https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
2 https://www.rcoa.ac.uk/node/21133

3

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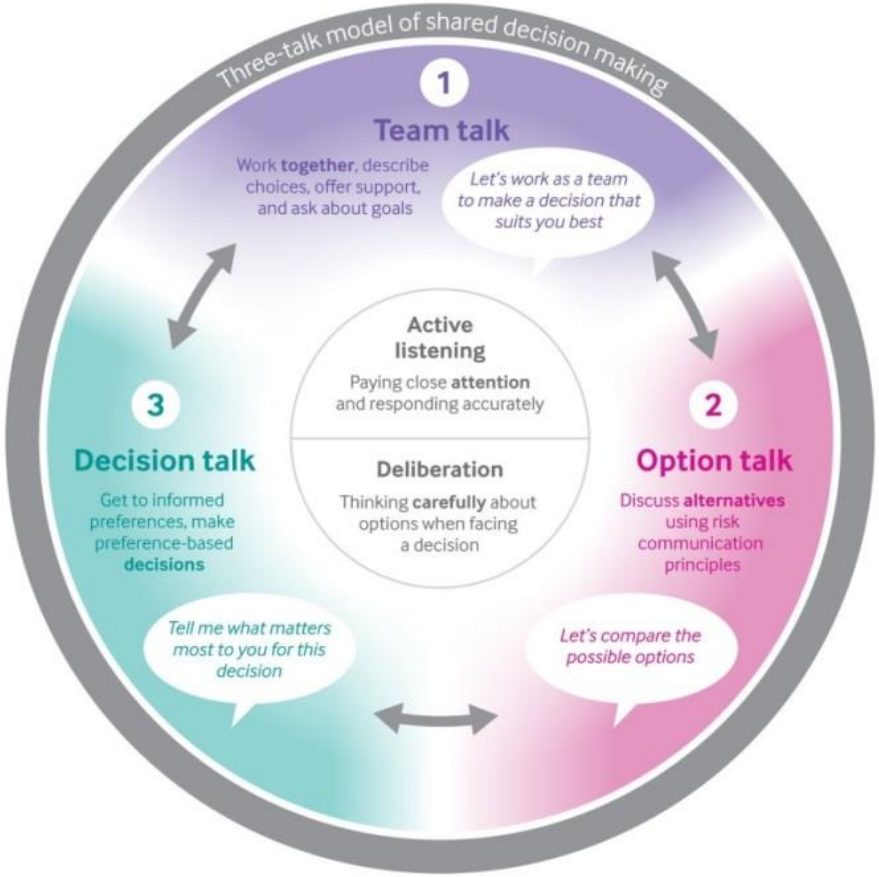
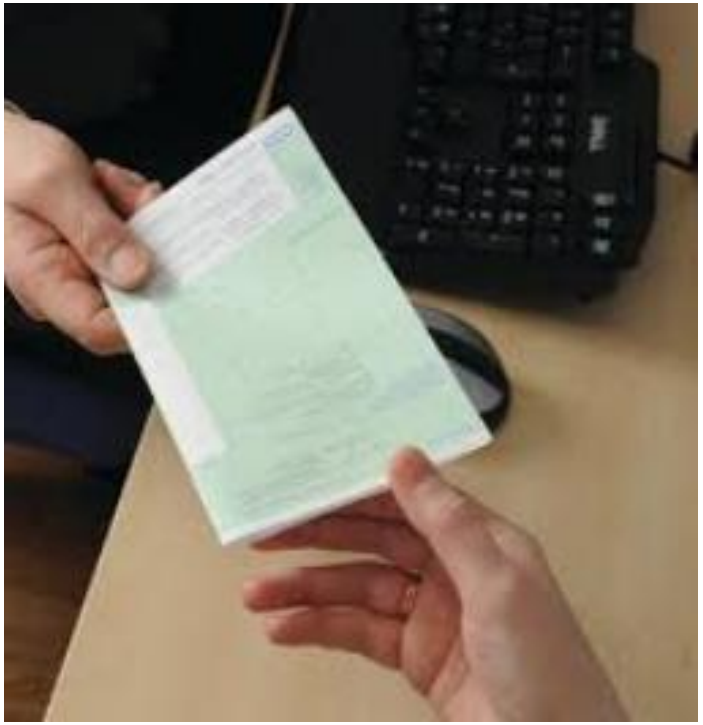
Prescription opioids: effectiveness versus harm



Three-talk model of shared decision making, 2017. Glyn Elwyn et al. BMJ 2017;359:bmj.j4891



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Chronic pain and opioid effectiveness

In trials:

- Most medicines for long-term pain only benefit around one in every four or five people and on average only provide a 30% reduction in pain (Opioids Aware 2015).

- **Clinical practice**: **probably fewer than one in ten patients** prescribed opioids in real life….will be helped much at all, with benefit being modest at best but potentially life changing for the better when it occurs (Stannard 2018 BJA 120 (6) 1148).

- There is no particular type of pain that is more suitable for or responsive to opioid treatment (Stannard 2018).

- Short term efficacy does not guarantee long-term efficacy (Opioids Aware 2015) .

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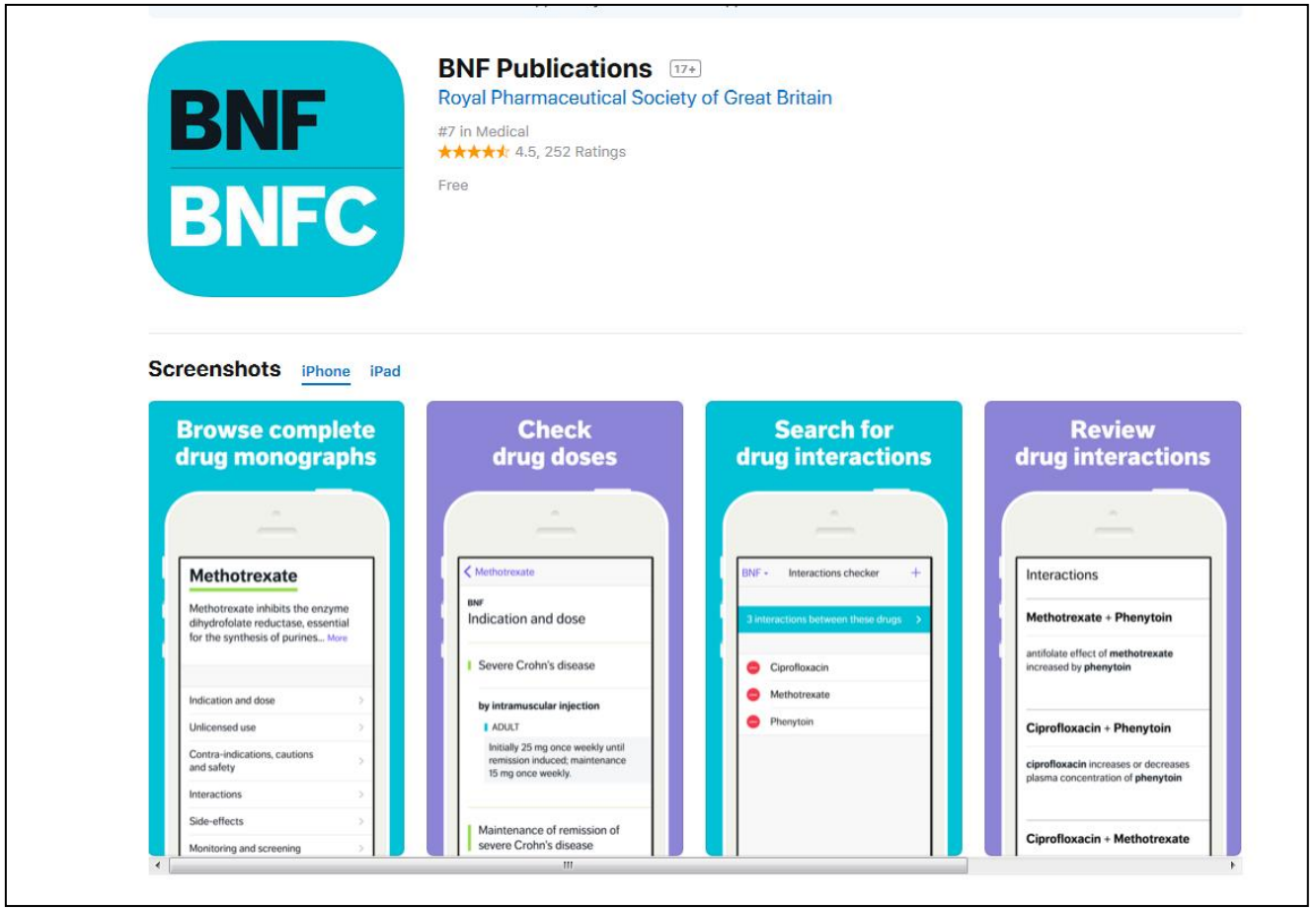
Opioid adverse effects & risks

Nausea or vomiting	Endocrine dysfunction	Overdose (risk is dose dependent)
Itching	Immune system	Misuse: 1.4-1.5 Abuse/diversion
Feeling dizzy/sleepy/ confused	Opioid hyperalgesia	Addiction (dependency) 1.10-1.11
Chronic constipation	Falls and fractures	Co-prescriptions with hypnotics & CNS depressants including alcohol
Weight gain	Road traffic accidents	Serotonin syndrome
Difficulty in breathing at night/respiratory depression	Neonatal abstinence syndrome	Refractory tolerance, when treating acute or end of life pain

BNF app



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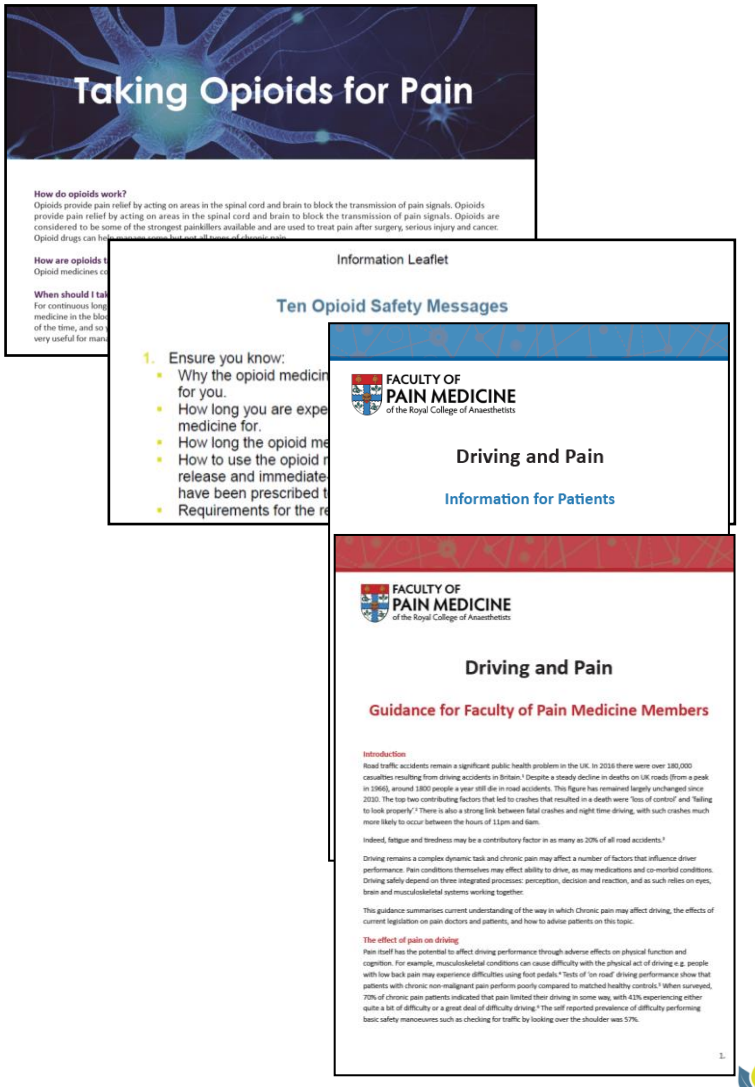
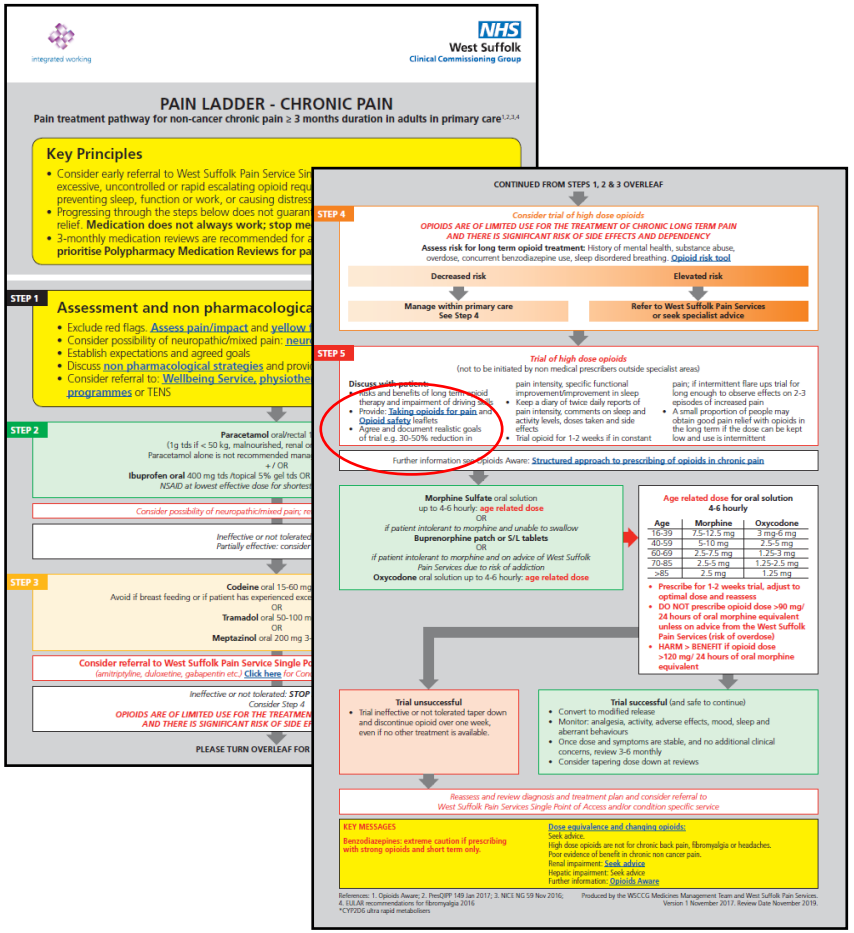
Prescription opioids: patient information





https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/

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Recognising the patient on high doses of opioids

	Prescription	Guesstimate of oral MED/d	Calculated dose of oral MED/d
1.	OxyCodone modified release 60 mg twice a day		
2.	Fentanyl transdermal patch 75 microgram hour		
3.	Buprenorphine transdermal patch 70 microgram an hour		
4.	Tramadol 100 mg four times a day		
5.	Buprenorphine 20 microgram an hour plus codeine 60 mg four times a day		

MED/d = Morphine equivalent dose / day

Approximate equi-analgesic potencies of opioids for oral administration

	Potency ration with oral morphine	Equivalent dose to 10mg oral morphine
Codeine phosphate	0.1	100mg
Dihydrocodeine	0.1	100mg
Hydromorphone	7.5	1.3mg
Methadone	*	*
Morphine	1	10mg
Oxycodone	2	5mg
Tapentadol	0.4	25mg
Tramadol	0.15	67mg

Transdermal Opioids

A. Buprenorphine

Transdermal buprenorphine changed at weekly intervals

	5 microgram/hr	10 microgram/hr	20 microgram/hr
Codeine phosphate (mg/day)	120mg	240mg	
Tramadol (mg/day)	100mg	200mg	400mg
Morphine sulphate (mg/day)	12mg	24mg	48mg

Transdermal buprenorphine changed every three or four days (twice weekly)

	35 microgram/hr	52 microgram/hr	70 microgram/hr
Morphine sulphate (mg/day)	84mg	126mg	168mg

B. Fentanyl

Fentanyl patch strength (microgram/hr)	Oral morphine (mg/day)
12	45
25	90
50	180
75	270
100	360
300	1120

https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/structured-approach-to-prescribing/dose-equivalents-and-changing-opioids

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Recognising the patient on high doses of opioids

	Prescription	Guesstimate of oral MED/d	Calculated dose of oral MED/d
1.	OxyCodone modified release 60 mg twice a day		240 mg MED/d
2.	Fentanyl transdermal patch 75 microgram hour		270 mg MED/d
3.	Buprenorphine transdermal patch 70 microgram an hour		168 mg MED/d
4.	Tramadol 100 mg four times a day		60 mg MED/d
5.	Buprenorphine 20 microgram an hour plus codeine 60 mg four times a day		72 mg MED/d

MED/d = Morphine equivalent dose / day

Dose equivalence charts

integrated working

NHS
West Suffolk
Clinical Commissioning Group

OPIOID EQUIVALENCE, RISKS AND RECOMMENDATIONS [1-3]

The information in the table below applies to non-cancer chronic pain in adults

OPIOID	Dose of stated opioid approximately equivalent in oral morphine equivalent dose/ day (MED/d)				
	Oral morphine < 50 mg per day	Oral morphine 50 - <100 mg per day	Oral morphine 100 mg per day	Oral morphine 120 mg per day	Oral morphine 200 mg per day
Oxycodone	<12.5 mg bd = <50 mg	< 25 mg bd = <100 mg	25 mg bd = 100 mg	30 mg bd = 120 mg	50 mg bd = 200 mg
Fentanyl transdermal patch	12 mcg/hr = 45 mg	25 mcg/hr = 90 mg	25 mcg/hr = 90 mg	50 mcg/hr = 180 mg	75 mcg/hr = 270 mg 100 mcg/hr = 360 mg
Buprenorphine transdermal patch	20 mcg/hr = 48 mg 10 mcg/hr = 24 mg	35 mcg/hr = 84 mg	35 mcg/hr = 84 mg	52 mcg/hr = 126 mg	70 mcg = 168 mg
Tapentadol	50 mg bd = 40 mg	100 mg bd = 80 mg	100 mg bd = 80 mg	150 mg bd = 120 mg	250 mg bd = 200 mg
Tramadol	50 mg qds = 30 mg	100 mg qds = 60 mg			
Codeine	60 mg qds = 24 mg				

RISK OF HARM

Patient factors: Pregnancy, age ≥65, anxiety or depression, overdose history, personal or family history of alcohol, substance/opioid misuse, renal and hepatic impairment, COPD or underlying respiratory conditions.
Drug factors: Multiple opioids, multiple formulations of opioids, more potent opioids, concurrent prescriptions of benzodiazepines/CNS depressants.

- Dosages ≥ 120 mg oral MED/d the risk of harm is substantially increased without increased benefit.
- Opioid related overdose risk is dose-dependent.
- Dosages of 50-<100 mg MED/d increases the risk for opioid overdose by factors of 1.9 to 4.6 compared with 1-<20 mg MED/d.
- Dosages ≥ 100 mg MED/d increases the risk of overdose significantly: 2.0-8.9 compared with 1-<20 mg MED/d.

DRIVING

- Patients may be particularly vulnerable to impairment when first starting a pain medication, following dose adjustments (up or down), when another drug is added or opioid taken in conjunction with alcohol.
- All opioid medicines have the potential to impair driving. A patient on high dose morphine (around 200-220 mg/ 24 hours) driving could be as impaired as someone with blood alcohol around the level above which it is illegal to drive. Alcohol and sedatives may impair driving at a lower morphine dose.

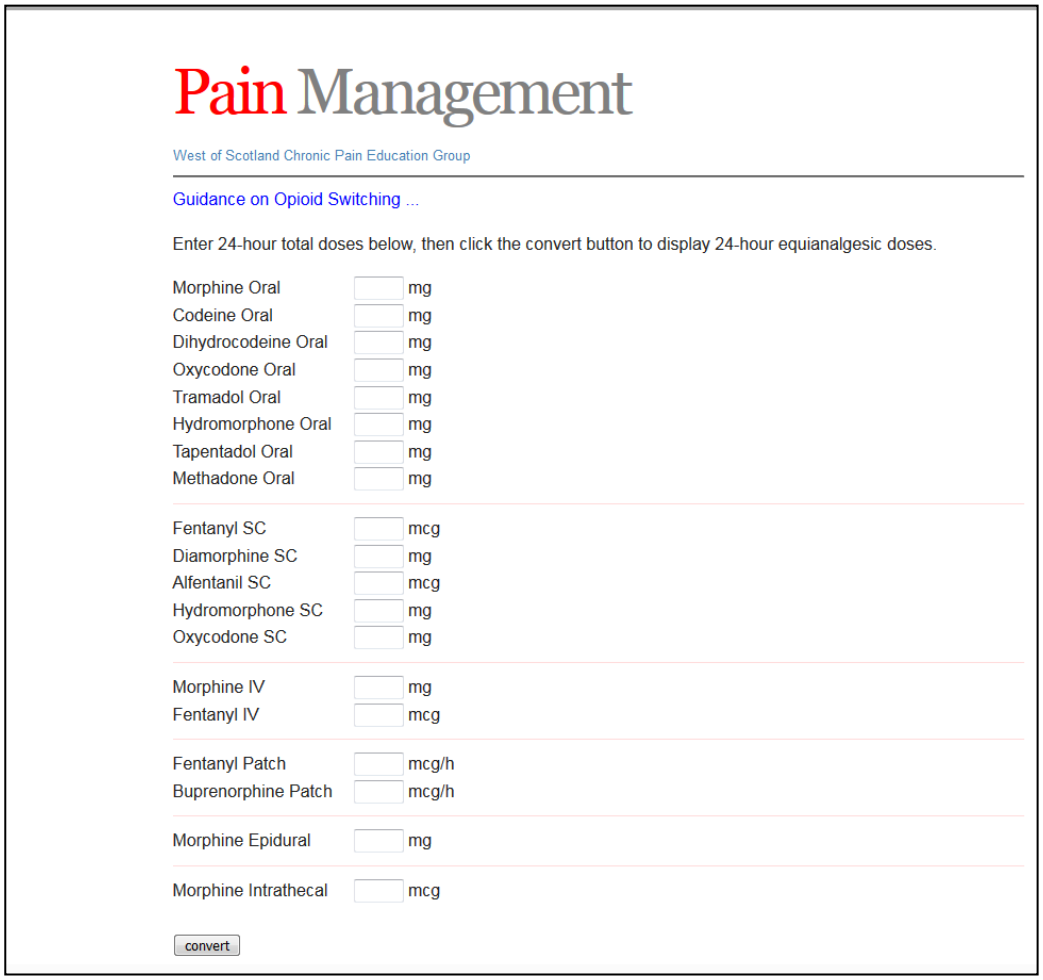
RECOMMENDATIONS

Undertake polypharmacy medication review, assess whether benefits outweigh risks and whether opioid trial goals are still being met. Consider opioid tapering and discontinuation.
There may be a role for medium term, low dose opioid therapy in carefully selected patients who can be monitored. Provide patient information leaflets.

References:
1. Opioids Aware 2. CDC Guidelines for Prescribing Opioids for Chronic Pain United States 2016, 3. IASP Statement on Opioids 2018

Produced by the WSCCG Medicines Management Team and West Suffolk Integrated Pain Management Service.
Version 1 March 2018. Review Date March 2020.

Dose equivalence calculator



Pain Management

West of Scotland Chronic Pain Education Group

Guidance on Opioid Switching ...

Enter 24-hour total doses below, then click the convert button to display 24-hour equianalgesic doses.

Morphine Oral		mg
Codeine Oral		mg
Dihydrocodeine Oral		mg
Oxycodone Oral		mg
Tramadol Oral		mg
Hydromorphone Oral		mg
Tapentadol Oral		mg
Methadone Oral		mg
Fentanyl SC		mcg
Diamorphine SC		mg
Alfentanil SC		mcg
Hydromorphone SC		mg
Oxycodone SC		mg
Morphine IV		mg
Fentanyl IV		mcg
Fentanyl Patch		mcg/h
Buprenorphine Patch		mcg/h
Morphine Epidural		mg
Morphine Intrathecal		mcg

convert

Recommended by NHS Scotland
http://paindata.org/calculator.php

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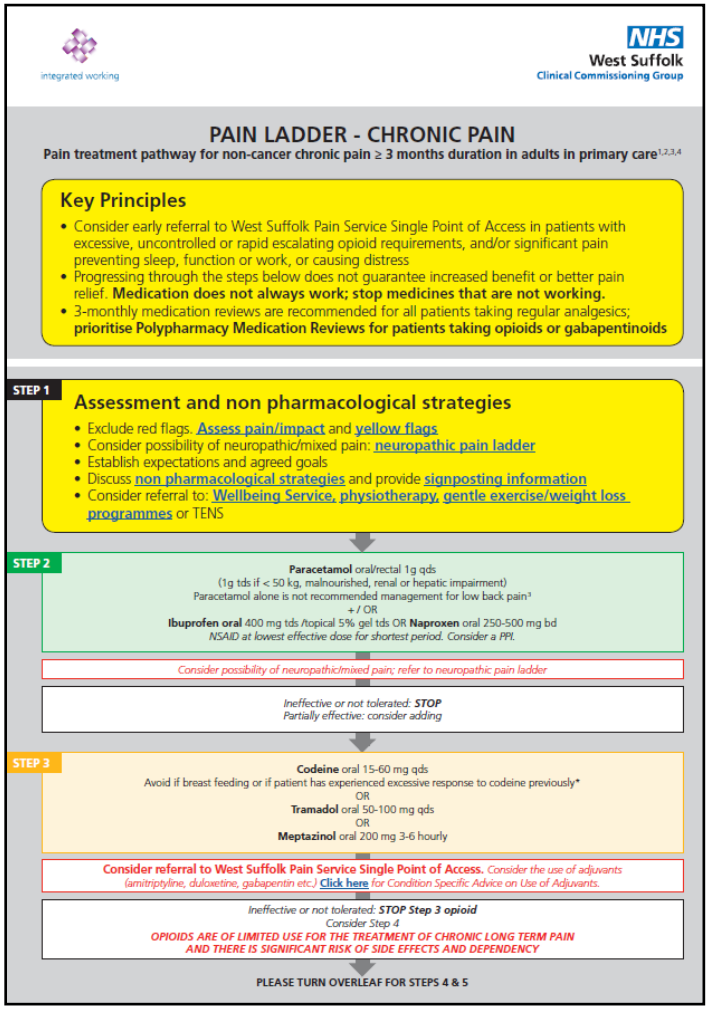
Opioids and chronic pain: initiation trial and monitoring



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PAIN LADDER - CHRONIC PAIN

Pain treatment pathway for non-cancer chronic pain ≥ 3 months duration in adults in primary care[1,2,3,4]

Key Principles

- Consider early referral to West Suffolk Pain Service Single Point of Access in patients with excessive, uncontrolled or rapid escalating opioid requirements, and/or significant pain preventing sleep, function or work, or causing distress
- Progressing through the steps below does not guarantee increased benefit or better pain relief. **Medication does not always work; stop medicines that are not working.**
- 3-monthly medication reviews are recommended for all patients taking regular analgesics; **prioritise Polypharmacy Medication Reviews for patients taking opioids or gabapentinoids**

STEP 1

Assessment and non pharmacological strategies

- Exclude red flags. Assess pain/impact and yellow flags
- Consider possibility of neuropathic/mixed pain: neuropathic pain ladder
- Establish expectations and agreed goals
- Discuss non pharmacological strategies and provide signposting information
- Consider referral to: Wellbeing Service, physiotherapy, gentle exercise/weight loss programmes or TENS

STEP 2

Paracetamol oral/rectal 1g qds
(1g tds if < 50 kg, malnourished, renal or hepatic impairment)
Paracetamol alone is not recommended management for low back pain[3]
+ / OR
Ibuprofen oral 400 mg tds /topical 5% gel tds OR **Naproxen** oral 250-500 mg bd
NSAID at lowest effective dose for shortest period. Consider a PPI.

Consider possibility of neuropathic/mixed pain; refer to neuropathic pain ladder

*Ineffective or not tolerated: **STOP***
Partially effective: consider adding

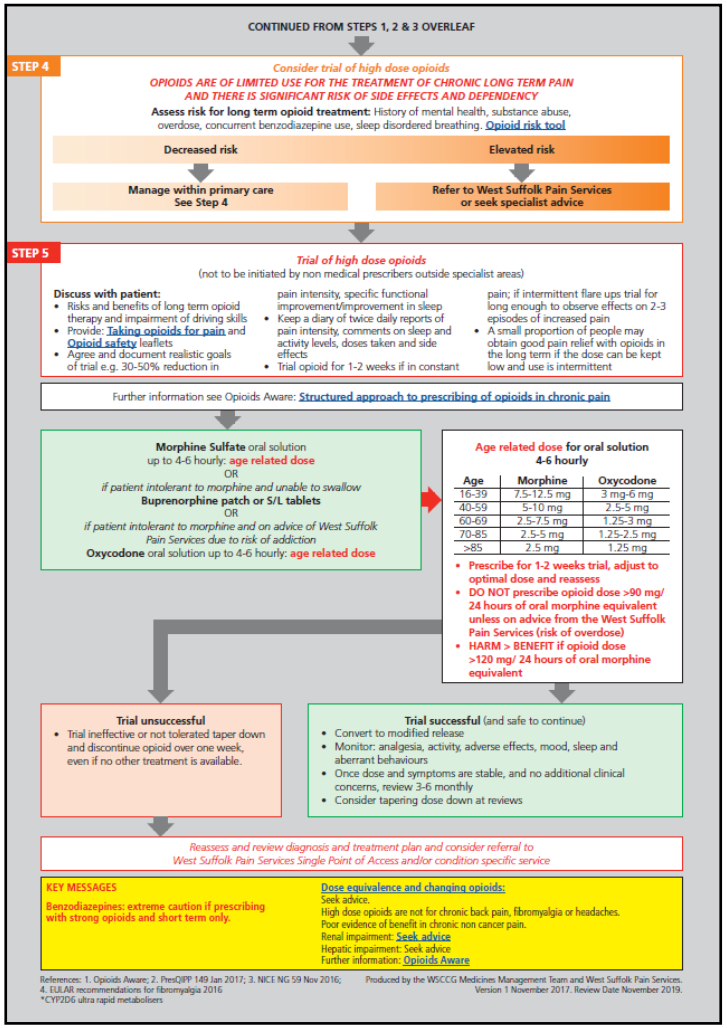
STEP 3

Codeine oral 15-60 mg qds
Avoid if breast feeding or if patient has experienced excessive response to codeine previously*
OR
Tramadol oral 50-100 mg qds
OR
Meptazinol oral 200 mg 3-6 hourly

Consider referral to West Suffolk Pain Service Single Point of Access. *Consider the use of adjuvants (amitriptyline, duloxetine, gabapentin etc.)* Click here *for Condition Specific Advice on Use of Adjuvants.*

*Ineffective or not tolerated: **STOP Step 3 opioid***
Consider Step 4
OPIOIDS ARE OF LIMITED USE FOR THE TREATMENT OF CHRONIC LONG TERM PAIN AND THERE IS SIGNIFICANT RISK OF SIDE EFFECTS AND DEPENDENCY

PLEASE TURN OVERLEAF FOR STEPS 4 & 5



CONTINUED FROM STEPS 1, 2 & 3 OVERLEAF

STEP 4

Consider trial of high dose opioids
OPIOIDS ARE OF LIMITED USE FOR THE TREATMENT OF CHRONIC LONG TERM PAIN AND THERE IS SIGNIFICANT RISK OF SIDE EFFECTS AND DEPENDENCY

Assess risk for long term opioid treatment: History of mental health, substance abuse, overdose, concurrent benzodiazepine use, sleep disordered breathing. Opioid risk tool

Decreased risk	Elevated risk
Manage within primary care See Step 4	Refer to West Suffolk Pain Services or seek specialist advice

STEP 5

Trial of high dose opioids
(not to be initiated by non medical prescribers outside specialist areas)

Discuss with patient:

- Risks and benefits of long term opioid therapy and impairment of driving skills
- Provide: Taking opioids for pain and Opioid safety leaflets
- Agree and document realistic goals of trial e.g. 30-50% reduction in pain intensity, specific functional improvement/improvement in sleep
- Keep a diary of twice daily reports of pain intensity, comments on sleep and activity levels, doses taken and side effects
- Trial opioid for 1-2 weeks if in constant pain; if intermittent flare ups trial for long enough to observe effects on 2-3 episodes of increased pain
- A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and use is intermittent

Further information see Opioids Aware: Structured approach to prescribing of opioids in chronic pain

Morphine Sulfate oral solution
up to 4-6 hourly: **age related dose**
OR
if patient intolerant to morphine and unable to swallow
Buprenorphine patch or S/L tablets
OR
if patient intolerant to morphine and on advice of West Suffolk Pain Services due to risk of addiction
Oxycodone oral solution up to 4-6 hourly: **age related dose**

Age related dose for oral solution 4-6 hourly

Age	Morphine	Oxycodone
16-39	7.5-12.5 mg	3 mg-6 mg
40-59	5-10 mg	2.5-5 mg
60-69	2.5-7.5 mg	1.25-3 mg
70-85	2.5-5 mg	1.25-2.5 mg
>85	2.5 mg	1.25 mg

- **Prescribe for 1-2 weeks trial, adjust to optimal dose and reassess**
- **DO NOT prescribe opioid dose >90 mg/ 24 hours of oral morphine equivalent unless on advice from the West Suffolk Pain Services (risk of overdose)**
- **HARM > BENEFIT if opioid dose >120 mg/ 24 hours of oral morphine equivalent**

Trial unsuccessful

- Trial ineffective or not tolerated taper down and discontinue opioid over one week, even if no other treatment is available.

Trial successful (and safe to continue)

- Convert to modified release
- Monitor: analgesia, activity, adverse effects, mood, sleep and aberrant behaviours
- Once dose and symptoms are stable, and no additional clinical concerns, review 3-6 monthly
- Consider tapering dose down at reviews

Reassess and review diagnosis and treatment plan and consider referral to West Suffolk Pain Services Single Point of Access and/or condition specific service

KEY MESSAGES

Benzodiazepines: extreme caution if prescribing with strong opioids and short term only.

Dose equivalence and changing opioids:
Seek advice.
High dose opioids are not for chronic back pain, fibromyalgia or headaches.
Poor evidence of benefit in chronic non cancer pain.
Renal impairment: Seek advice
Hepatic impairment: Seek advice
Further information: Opioids Aware

References: 1. Opioids Aware; 2. PrescQIPP 149 Jan 2017; 3. NICE NG 59 Nov 2016; 4. EULAR recommendations for fibromyalgia 2016
*CYP2D6 ultra rapid metabolisers

Produced by the WSCCG Medicines Management Team and West Suffolk Pain Services. Version 1 November 2017. Review Date November 2019.

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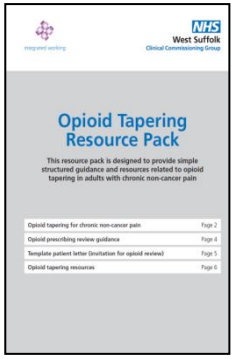
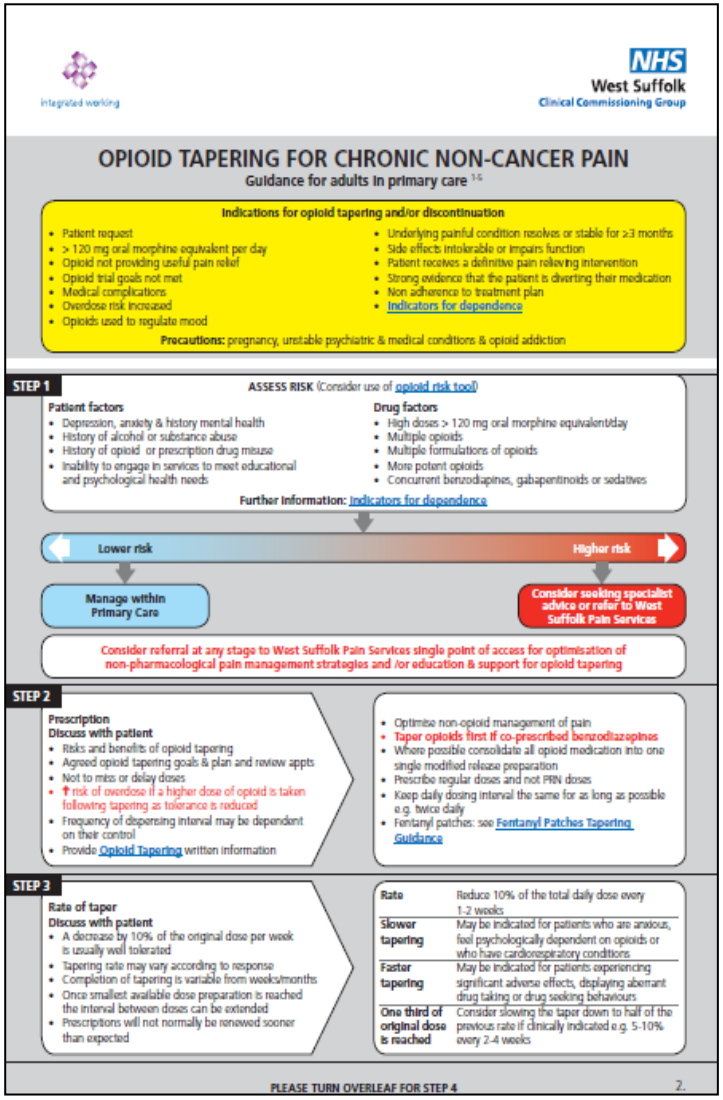
Opioid tapering resource pack



Opioid Tapering Resource Pack

This resource pack is designed to provide simple structured guidance and resources related to opioid tapering in adults with chronic non-cancer pain



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OPIOID TAPERING FOR CHRONIC NON-CANCER PAIN

Guidance for adults in primary care [1-5]

Indications for opioid tapering and/or discontinuation

- Patient request
- > 120 mg oral morphine equivalent per day
- Opioid not providing useful pain relief
- Opioid trial goals not met
- Medical complications
- Overdose risk increased
- Opioids used to regulate mood
- Underlying painful condition resolves or stable for ≥3 months
- Side effects intolerable or impairs function
- Patient receives a definitive pain relieving intervention
- Strong evidence that the patient is diverting their medication
- Non adherence to treatment plan
- Indicators for dependence

Precautions: pregnancy, unstable psychiatric & medical conditions & opioid addiction

STEP 1 — **ASSESS RISK** (Consider use of opioid risk tool)

Patient factors
- Depression, anxiety & history mental health
- History of alcohol or substance abuse
- History of opioid or prescription drug misuse
- Inability to engage in services to meet educational and psychological health needs

Drug factors
- High doses > 120 mg oral morphine equivalent/day
- Multiple opioids
- Multiple formulations of opioids
- More potent opioids
- Concurrent benzodiazepines, gabapentinoids or sedatives

Further information: Indicators for dependence

Lower risk → Higher risk

Manage within Primary Care

Consider seeking specialist advice or refer to West Suffolk Pain Services

Consider referral at any stage to West Suffolk Pain Services single point of access for optimisation of non-pharmacological pain management strategies and /or education & support for opioid tapering

STEP 2

Prescription
Discuss with patient
- Risks and benefits of opioid tapering
- Agreed opioid tapering goals & plan and review appts
- Not to miss or delay doses
- ↑ risk of overdose if a higher dose of opioid is taken following tapering as tolerance is reduced
- Frequency of dispensing interval may be dependent on their control
- Provide Opioid Tapering written information

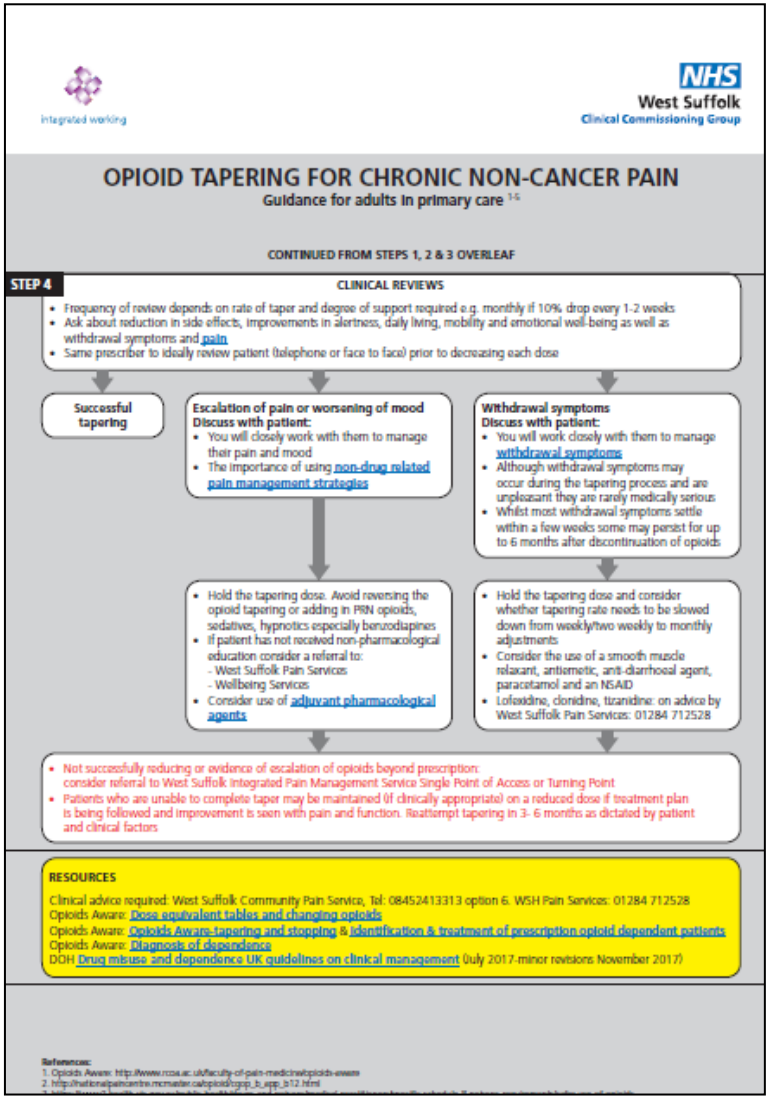
- Optimise non-opioid management of pain
- **Taper opioids first if co-prescribed benzodiazepines**
- Where possible consolidate all opioid medication into one single modified release preparation
- Prescribe regular doses and not PRN doses
- Keep daily dosing interval the same for as long as possible e.g. twice daily
- Fentanyl patches: see Fentanyl Patches Tapering Guidance

STEP 3

Rate of taper
Discuss with patient
- A decrease by 10% of the original dose per week is usually well tolerated
- Tapering rate may vary according to response
- Completion of tapering is variable from weeks/months
- Once smallest available dose preparation is reached the interval between doses can be extended
- Prescriptions will not normally be renewed sooner than expected

Rate	Reduce 10% of the total daily dose every 1-2 weeks
Slower tapering	May be indicated for patients who are anxious, feel psychologically dependent on opioids or who have cardiorespiratory conditions
Faster tapering	May be indicated for patients experiencing significant adverse effects, displaying aberrant drug taking or drug seeking behaviours
One third of original dose is reached	Consider slowing the taper down to half of the previous rate if clinically indicated e.g. 5-10% every 2-4 weeks

PLEASE TURN OVERLEAF FOR STEP 4



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OPIOID TAPERING FOR CHRONIC NON-CANCER PAIN

Guidance for adults in primary care [1-5]

CONTINUED FROM STEPS 1, 2 & 3 OVERLEAF

STEP 4 — **CLINICAL REVIEWS**
- Frequency of review depends on rate of taper and degree of support required e.g. monthly if 10% drop every 1-2 weeks
- Ask about reduction in side effects, improvements in alertness, daily living, mobility and emotional well-being as well as withdrawal symptoms and pain
- Same prescriber to ideally review patient (telephone or face to face) prior to decreasing each dose

Successful tapering

Escalation of pain or worsening of mood
Discuss with patient:
- You will closely work with them to manage their pain and mood
- The importance of using non-drug related pain management strategies

Withdrawal symptoms
Discuss with patient:
- You will work closely with them to manage withdrawal symptoms
- Although withdrawal symptoms may occur during the tapering process and are unpleasant they are rarely medically serious
- Whilst most withdrawal symptoms settle within a few weeks some may persist for up to 6 months after discontinuation of opioids

- Hold the tapering dose. Avoid reversing the opioid tapering or adding in PRN opioids, sedatives, hypnotics especially benzodiazepines
- If patient has not received non-pharmacological education consider a referral to:
  - West Suffolk Pain Services
  - Wellbeing Services
- Consider use of adjuvant pharmacological agents

- Hold the tapering dose and consider whether tapering rate needs to be slowed down from weekly/two weekly to monthly adjustments
- Consider the use of a smooth muscle relaxant, antiemetic, anti-diarrhoeal agent, paracetamol and an NSAID
- Lofexidine, clonidine, tizanidine: on advice by West Suffolk Pain Services: 01284 712528

- Not successfully reducing or evidence of escalation of opioids beyond prescription: consider referral to West Suffolk Integrated Pain Management Service Single Point of Access or Turning Point
- Patients who are unable to complete taper may be maintained (if clinically appropriate) on a reduced dose if treatment plan is being followed and improvement is seen with pain and function. Reattempt tapering in 3- 6 months as dictated by patient and clinical factors

RESOURCES

Clinical advice required: West Suffolk Community Pain Service, Tel: 08452413313 option 6. WSH Pain Services: 01284 712528
Opioids Aware: Dose equivalent tables and changing opioids
Opioids Aware: Opioids Aware-tapering and stopping & Identification & treatment of prescription opioid dependent patients
Opioids Aware: Diagnosis of dependence
DOH Drug misuse and dependence UK guidelines on clinical management (July 2017-minor revisions November 2017)

References:
1. Opioids Aware: http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
2. http://nationalpaincentre.mcmaster.ca/opioid/cropp_b_app_b12.html

https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/

Education and therapies

West Suffolk Pain Management Service
Non-pharmacological Services

Education Options

- Understanding pain
- Managing pain
- Pain medication education
- **Opioid education**
- Getting fit to stay or get back to work
- Diet, nutrition & pain
- Sleep & relaxation
- Journey towards change (based on CBT)
- Valued living (based on ACT)
- Education for discharge /admission avoidance

Therapies

- Psychological
- Specialist pain physiotherapy
- TENS
- Hypnotherapy and relaxation
- Mental health pain clinic

Services underpinned by shared decision making., Education and therapies delivered either 1:1 or in groups. On-line learning is available

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NHS West Suffolk NHS Foundation Trust

West Suffolk Pain Services: opioid education

Evidence/information

- Why have we used strong opioids for persistent pain?
- What lessons have we learnt from using opioids for persistent pain?
- Understanding risks and benefits of long term opioid therapy
- Exploring your risk factors for taking opioids
- What are the current recommendations for the use of opioids in persistent pain?
- Driving and opioids: what should I know?
- Improving the safety of taking opioids in pain: what can you do?

Opioid tapering

- Overuse of opioids: exploring common reasons
- What are the challenges and benefits of reducing opioids?
- Useful tips for reducing opioids
- Dose reduction or not: what are your options?
- Useful resources

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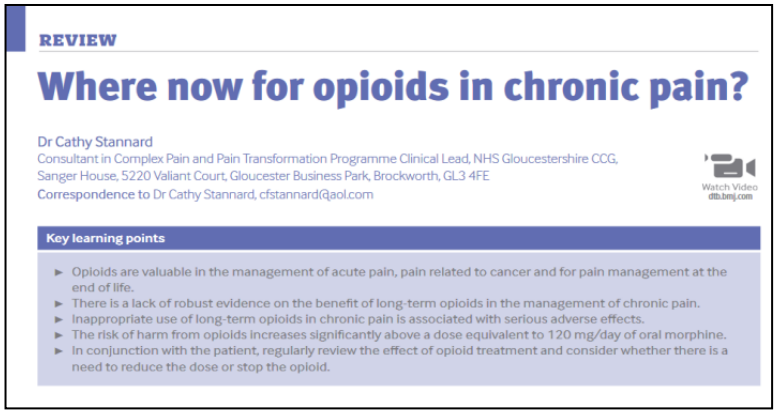
Key resources



REVIEW

Where now for opioids in chronic pain?

Dr Cathy Stannard
Consultant in Complex Pain and Pain Transformation Programme Clinical Lead, NHS Gloucestershire CCG, Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth, GL3 4FE
Correspondence to Dr Cathy Stannard, cfstannard@aol.com

Watch Video
dtb.bmj.com

Key learning points

- Opioids are valuable in the management of acute pain, pain related to cancer and for pain management at the end of life.
- There is a lack of robust evidence on the benefit of long-term opioids in the management of chronic pain.
- Inappropriate use of long-term opioids in chronic pain is associated with serious adverse effects.
- The risk of harm from opioids increases significantly above a dose equivalent to 120 mg/day of oral morphine.
- In conjunction with the patient, regularly review the effect of opioid treatment and consider whether there is a need to reduce the dose or stop the opioid.

https://dtb.bmj.com/content/56/10/118

thebmj

BMJ 2018;362:k2990 doi: 10.1136/bmj.k2990 (Published 27 September 2018) Page 1 of 5

PRACTICE

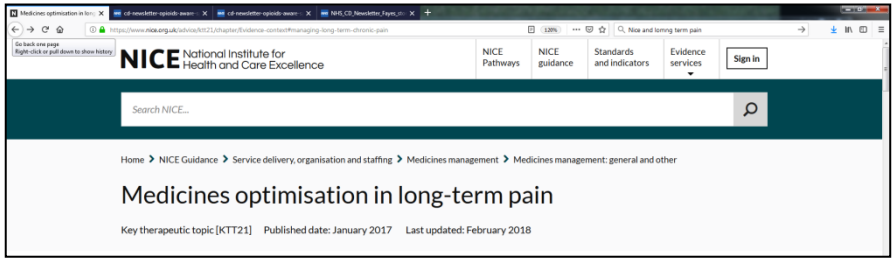
Check for updates

UNCERTAINTIES

What interventions are effective to taper opioids in patients with chronic pain?

H Sandhu *associate professor and consultant*[1] *health psychologist in pain management*[1], M Underwood *professor, primary care research*[1], AD Furlan *associate professor of medicine*[2], J Noyes *speciality trainee anaesthetics and pain research fellow*[3], S Eldabe *professor, consultant in pain medicine*[3]

[1]Warwick Clinical Trials Unit, Warwick Medical School, UK; [2]Department of Medicine, University of Toronto, Canada; [3]The James Cook University Hospital, Middlesbrough, UK



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Medicines optimisation in long-term pain

Key therapeutic topic [KTT21] Published date: January 2017 Last updated: February 2018

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OPIOID PRESCRIBING FOR ACUTE PAIN
KEY RECOMMENDATIONS

NHS West Suffolk Clinical Commissioning Group

Prescribing opioids for acute pain is associated with an increased likelihood of long-term opioid use. To minimise the initial opioid exposure, keep the duration of treatment as short as possible and the total dose as low as possible. This also minimises the risk of overdose and the likelihood of diversion/ inappropriate use;[1] however, severe untreated acute pain may lead to the development of chronic pain.

1 GOAL

The goal for prescribing opioids in acute pain should be a tolerable level of pain that facilitates optimal physical and emotional function and avoidance of complications.

2 BEFORE PRESCRIBING OPIOIDS

- Undertake comprehensive assessment.
- Promote and optimise **non-pharmacological strategies** for acute pain.*
- Optimise non-opioid therapy when benefits outweigh risks to maximise analgesia and reduce opioid requirements.
- Exercise caution when prescribing opioids for older or debilitated patients.
- Consider and address underlying anxiety and depression.

Absolutely avoid

- Co-proxamol.[2,3]

Avoid

- Compound analgesics.[2] Prescribing separately gives flexibility in both adjustment of doses and in the selection of most appropriate combination.
- Modified-release opioid preparations.[4]
- Oxycodone as first line.
- Co-prescribing medications with sedating properties, whenever possible. In particular, avoid co-prescribing with benzodiazepines due to increased risk of potentially fatal overdose[5] and with gabapentinoids due to increased risk of CNS depression.[6,7]

3 DOSE

- Refer to local acute pain guidelines.*
- Prescribe lowest effective dose of immediate-release opioid for the expected duration of the pain severe enough to require opioids.[5]
- Use age related dose if prescribing morphine or oxycodone.*
- Adjust dose for clinical factors such as renal or hepatic insufficiency and pain intensity.
- With prn opioids include maximum daily amount or frequency of doses.[8]
- Avoid making dose increases under pressure: A team decision for complex patients shares the load.

4 DURATION

- Each day of unnecessary opioid use increases the likelihood of physical dependence without added benefit.[5]

Prescribe

- For the expected duration of the pain severe enough to require opioids or until a follow-up appointment is scheduled. Duration of 3 days or less is usually sufficient. A duration of more than 7 days is rarely needed.[5]
- Aim to stop strong opioids commenced for post-operative pain within 7 days of surgery. Duration of opioid prescription post-surgery, not dose, is a more significant risk factor for subsequent opioid misuse.[9]
- Review diagnosis and treatment plan if severe acute pain continues longer than expected. Consider seeking advice.

Avoid

- Placing opioids on repeat prescriptions for acute pain - opioids should be a course of treatment with a definitive end date.
- Prescribing additional opioids in acute pain for the 'just in case' scenario.

5 PROVIDE PATIENT INFORMATION

- **Benefit and risks** of opioid therapy and alternative options.
- How to use opioids.
- **Driving impairment** and **opioid safety**
- Requirements for review and monitoring.
- How to taper and discontinue opioids.
- To take unwanted or unused opioids back to a community pharmacy or dispensary to minimise risks of diversion and inappropriate use.

REFERENCES

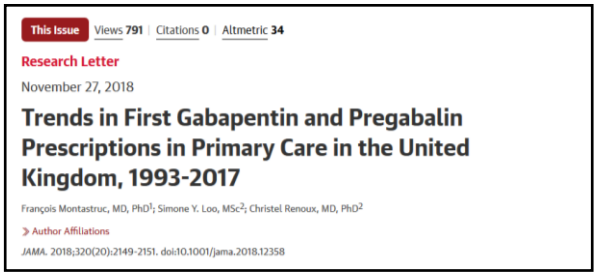
1. Pino A and Covington M., (2018). Prescriptions of opioids in opioid–naïve patients
2. BNF(2018). https://bnf.nice.org.uk/treatment-summary/analgesics.html
3. NHS England (2017). Items that should not routinely be prescribed in primary care: Guidance for CCGs
4. Levy N, Mills P., 2018. Controlled-release opioids cause harm and should be avoided in the management of post-operative pain in opioid naive patients. BJA. DOI https://doi.org/10.1016/j.bja.2018.09.005
5. CDC, (2016). CDC Guideline for Prescribing Opioids for Chronic Pain-United States, 2016
6. Public Health England, (2014). Advice for prescribers on the risk of the misuse of pregabalin and gabapentin
7. MHRA, (2017). Gabapentin (Neurontin): risk of severe respiratory depression
8. NICE NG 46, (2017). Controlled Drugs: safe use and management
9. Brat et al., (2018). Postsurgical prescriptions for opioid naive patients and association with overdose and misuse: retrospective cohort study

FURTHER INFORMATION

*WSCCG Acute Pain Ladder or WSCCG Chronic Pain Ladder

Produced by WSCCG Medicines Management Team in collaboration with West Suffolk Integrated Pain Service. Final Version 1. January 2019. Review January 2021.

Gabapentinoids



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Research Letter

November 27, 2018

Trends in First Gabapentin and Pregabalin Prescriptions in Primary Care in the United Kingdom, 1993-2017

François Montastruc, MD, PhD[1]; Simone Y. Loo, MSc[2]; Christel Renoux, MD, PhD[2]

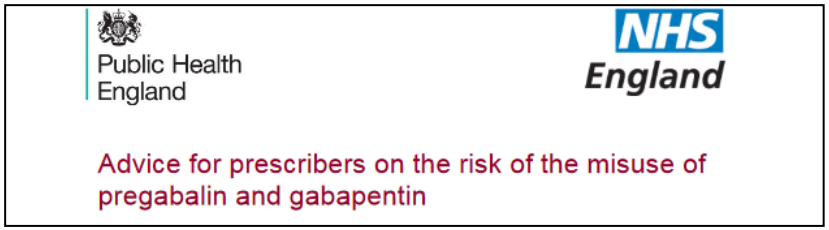
Author Affiliations

JAMA. 2018;320(20):2149-2151. doi:10.1001/jama.2018.12358

- The rate of patients newly treated with gabapentinoids has tripled from 2007 to 2017 in primary care.

By 2017

- 50% of gabapentinoid prescriptions were for an off-label indication.
- 20% of gabapentinoid prescriptions had a co-prescription for opioids.



Public Health England

NHS England

Advice for prescribers on the risk of the misuse of pregabalin and gabapentin

PHE 2014

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Advice for healthcare professionals:

- be aware of the risk of CNS depression, including severe respiratory depression, with gabapentin
- consider whether dose adjustments might be necessary in patients at higher risk of respiratory depression, including elderly people, patients with compromised respiratory function, respiratory or neurological disease, or renal impairment, and patients taking other CNS depressants
- report any suspected adverse reactions on a Yellow Card

MHRA 2017

Gabapentinoids

First option

- Amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment (except trigeminal neuralgia).

Second, third and fourth option

- If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated etc. etc

Consider

- NSAIDs for LBP
- Weak opioids with or without paracetamol for management of acute LBP only if NSAID contraindicated, not tolerated or in effective

Do not offer

- Paracetamol alone for LBP
- Opioids routinely for acute LBP
- Opioids for chronic low back pain
- SSRIs, SNRIs, TADs or **anticonvulsants** for LBP

See NICE CG 173 for management of sciatica

Gabapentinoid background and evidence

Articles

Pharmacotherapy for neuropathic pain in adults: a systematic review and meta-analysis

Nanna B Finnerup*, Nadine Attal*, Simon Haroutounian, Ewan McNicol, Ralf Baron, Robert H Dworkin, Ian Gilron, Maija Haanpää, Per Hansson, Troels S Jensen, Peter R Kamerman, Karen Lund, Andrew Moore, Srinivasa N Raja, Andrew S C Rice, Michael Rowbotham, Emily Sena, Philip Siddall, Blair H Smith, Mark Wallace

Gabapentinoid Prescribing for Chronic Pain in Primary Care - Resources for Clinicians and Boards v1.0

Quick Reference Guide (*full resource available at: https://www.therapeutics.scot.nhs.uk/pain/*)

Background & Evidence

Gabapentinoids, when used appropriately, have been shown to be effective for some patients in the management of neuropathic pain.
The table below [1] provides the number needed to treat (NNT) and number needed to harm (NNH) for both drugs.[2]

Drug	NNT	NNH
Pregabalin	7.7 (95% CI 6.5-9.4)	13.9 (95% CI 11.6-17.4)
Gabapentin	6.3 (95% CI 5.0-8.3) and 8.3 (95% CI 6.2-13) for extended release (ER) preparations	25.6 (95% CI 15.3-78.6) and 31.9 (95% CI 17-230) for ER preparations

* Gabapentinoids are **not** licensed for non-neuropathic pain, nor is there any evidence to support their use.
* Gabapentinoids will be reclassified class C controlled substances under section the Misuse of Drugs Act from April 2019[3]

https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/11/Gabapentinoid-Quick-Reference-Guide-23112018-Final-v1.0.pdf

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Changing evidence base

- Gabapentin at doses of 1800 mg to 3600 mg daily (1200 mg to 3600 mg gabapentin encarbil) can provide good levels of pain relief to some people with post herpetic neuralgia and peripheral diabetic neuropathy**. Evidence for other types of neuropathic pain is very limited**.

- **Moderate to high quality evidence that anti-convulsants are ineffective for treatment of LBP or lumbar radicular pain.**
- **High quality evidence that gabapentinoids have a higher risk of adverse effects.**

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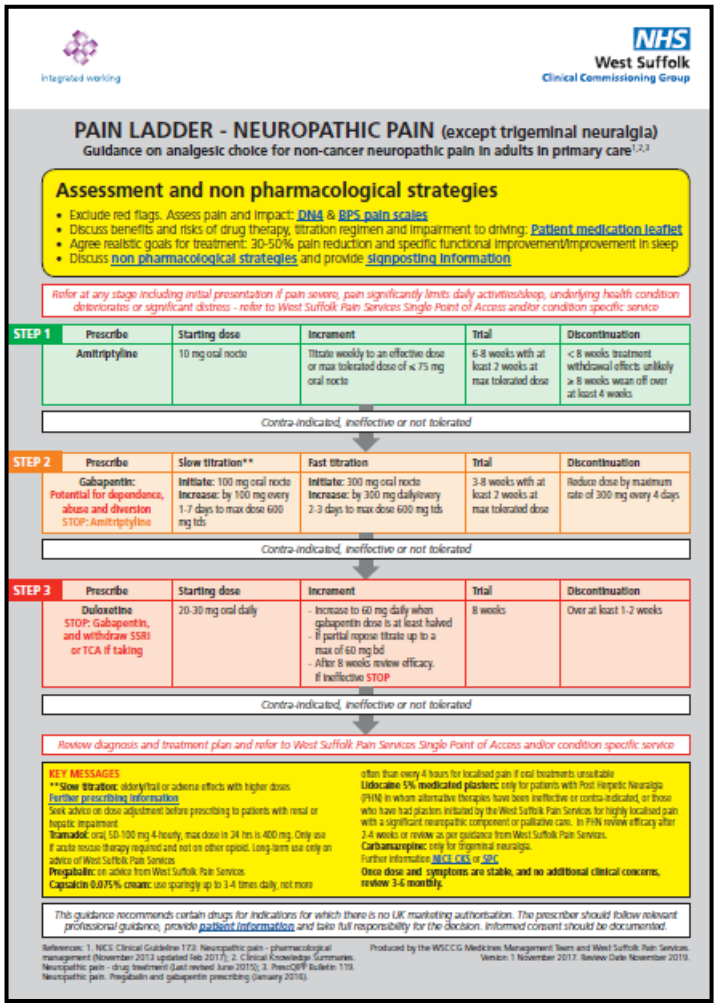
Gabapentinoids for neuropathic pain

WSCCG 2017



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PAIN LADDER - NEUROPATHIC PAIN (except trigeminal neuralgia)

Guidance on analgesic choice for non-cancer neuropathic pain in adults in primary care[1,2,3]

Assessment and non pharmacological strategies

- Exclude red flags. Assess pain and impact: DN4 & BPS pain scales
- Discuss benefits and risks of drug therapy, titration regimen and impairment to driving: Patient medication leaflet
- Agree realistic goals for treatment: 30-50% pain reduction and specific functional improvement/improvement in sleep
- Discuss non pharmacological strategies and provide signposting information

Refer at any stage including initial presentation if pain severe, pain significantly limits daily activities/sleep, underlying health condition deteriorates or significant distress - refer to West Suffolk Pain Services Single Point of Access and/or condition specific service

	Prescribe	Starting dose	Increment	Trial	Discontinuation
STEP 1	**Amitriptyline**	10 mg oral nocte	Titrate weekly to an effective dose or max tolerated dose of < 75 mg oral nocte	6-8 weeks with at least 2 weeks at max tolerated dose	< 8 weeks treatment withdrawal effects unlikely ≥ 8 weeks wean off over at least 4 weeks

Contra-indicated, ineffective or not tolerated

	Prescribe	Slow titration**	Fast titration	Trial	Discontinuation
STEP 2	**Gabapentin:** Potential for dependance, abuse and diversion STOP: Amitriptyline	**Initiate:** 100 mg oral nocte **Increase:** by 100 mg every 1-7 days to max dose 600 mg tds	**Initiate:** 300 mg oral nocte **Increase:** by 300 mg daily/every 2-3 days to max dose 600 mg tds	3-8 weeks with at least 2 weeks at max tolerated dose	Reduce dose by maximum rate of 300 mg every 4 days

Contra-indicated, ineffective or not tolerated

	Prescribe	Starting dose	Increment	Trial	Discontinuation
STEP 3	**Duloxetine** STOP: Gabapentin, and withdraw SSRI or TCA if taking	20-30 mg oral daily	- Increase to 60 mg daily when gabapentin dose is at least halved - If partial repose titrate up to a max of 60 mg bd - After 8 weeks review efficacy. If ineffective STOP	8 weeks	Over at least 1-2 weeks

Contra-indicated, ineffective or not tolerated

Review diagnosis and treatment plan and refer to West Suffolk Pain Services Single Point of Access and/or condition specific service

KEY MESSAGES

****Slow titration:** elderly/frail or adverse effects with higher doses

Further prescribing information

Seek advice on dose adjustment before prescribing to patients with renal or hepatic impairment

Tramadol: oral, 50-100 mg 4 hourly, max dose in 24 hrs is 400 mg. Only use if acute tissue therapy required and not on other opioid. Long-term use only on advice of West Suffolk Pain Services

Pregabalin: on advice from West Suffolk Pain Services

Capsaicin 0.075% cream: use sparingly up to 3-4 times daily, not more often than every 4 hours for localised pain if oral treatments unsuitable

Lidocaine 5% medicated plasters: only for patients with Post Herpetic Neuralgia (PHN) in whom alternative therapies have been ineffective or contra-indicated, or those who have had plasters initiated by the West Suffolk Pain Services for highly localised pain with a significant neuropathic component or palliative care. In PHN review efficacy after 2-4 weeks or review as per guidance from West Suffolk Pain Services.

Carbamazepine: only for trigeminal neuralgia.

Further information NICE CKS or SPC

Once dose and symptoms are stable, and no additional clinical concerns, review 3-6 monthly.

This guidance recommends certain drugs for indications for which there is no UK marketing authorisation. The prescriber should follow relevant professional guidance, provide patient information and take full responsibility for the decision. Informed consent should be documented.

References: 1. NICE Clinical Guideline 173: Neuropathic pain - pharmacological management (November 2013 updated Feb 2017); 2. Clinical Knowledge Summaries. Neuropathic pain - drug treatment (Last revised June 2015); 3. PrescQIPP Bulletin 119. Neuropathic pain. Pregabalin and gabapentin prescribing (January 2016).

Produced by the WSCCG Medicines Management Team and West Suffolk Pain Services. Version 1 November 2017. Review Date November 2019.

- Gabapentinoids should be used only as part of a wider management plan
- Hyperlinks embeded within ladder
- Included trial and discontinuation guidance
- Pregabalin on advice from West Suffolk Pain Services
- Review patients 3-6 monthly

Suffolk GP FEDERATION

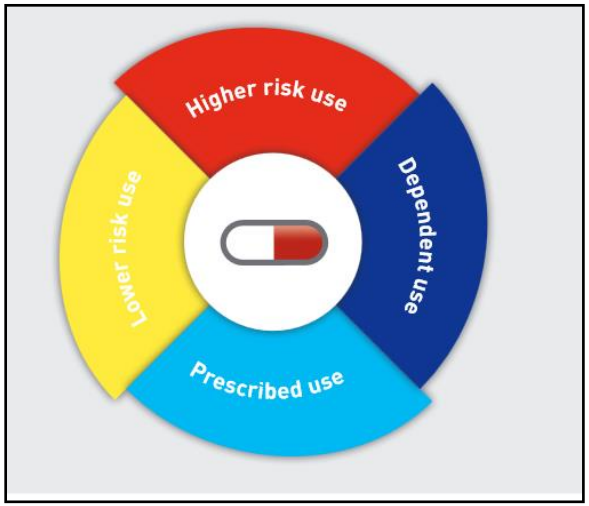
Some of the adverse effects & risks

(Adapted from Granger 2018)

Dizziness 24-31%	Ataxia
Somnolence 22%	Cognitive impairment including memory
Peripheral oedema	Depression /suicidal ideation
Weight gain 6%	Diversion/misuse/abuse
Dry mouth/blurred vision	Co-prescriptions with hypnotics & CNS depressants including alcohol
Sexual dysfunction Decreased libido 35% Erectile dysfunction 51% Decreased libido 35% Anorgasmia 35%	Death England and Wales 2016-165 deaths in England and Wales of which 147 involved an opioid (ONS 2017)

- Rate of adverse effects (AEs) are dose related which increases with higher doses
- No clear relationship between AEs to age

Misuse, abuse and dependent use



Positive effects	
Pregabalin	• Euphoria, lifted mood, giddiness, relaxation, increased motivation and lower inhibitions. [13] May be used to enhance the effects of heroin and reduce the amount of heroin needed. [12]
Gabapentin	• Relaxation, calmness and euphoria. Some users have reported that the 'high' from snorting gabapentin can be similar to taking a stimulant. [14]

Negative effects	
Pregabalin and gabapentin:	• Drowsiness, sedation, respiratory depression and death may occur when used in combination with other central nervous system depressants including opioids, antidepressants, antihistamines, tranquillers and alcohol. [12,13] • Physical dependencies, illegal diversion, misuse and abuse.
Pregabalin	• Chest pain, wheezing, swelling of extremities, weight gain, thirst, clumsiness, muddled thoughts, dizziness and drowsiness, sedation, vision changes and, less commonly, hallucinations. [12,13]

High risk patients

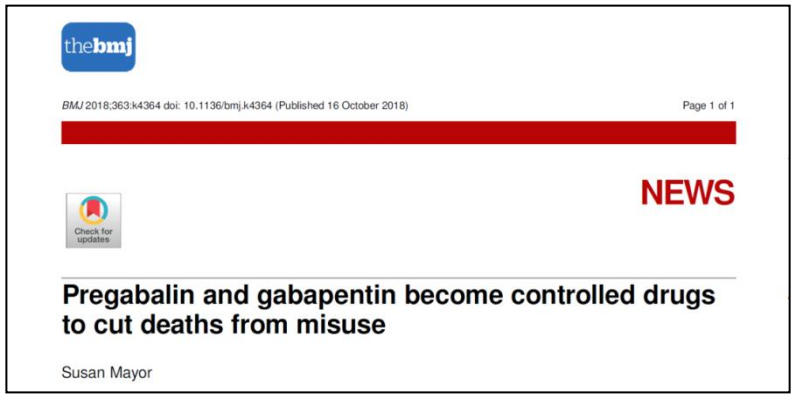
Assessment of the balance between benefits and risk essential

- History of substance misuse
- Request for initiation of gabapentinoids following liberation from prison services
- Specific request for initiation of gabapentinoids
- Repeated early prescription requests
- Repeatedly lost prescriptions
- Contact out of hours services for supplies of medication

- http://www.publichealth.hscni.net/sites/default/files/Pregabalin%20Guidance%20Booklet%20A4%20Final%20Web_0.pdf
- https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/11/Gabapentinoid-Quick-Reference-Guide-23112018-Final-v1.0.pdf

Gabapentinoid reclassification

(2018)



thebmj

BMJ 2018;363:k4364 doi: 10.1136/bmj.k4364 (Published 16 October 2018)

NEWS

Check for updates

Pregabalin and gabapentin become controlled drugs to cut deaths from misuse

Susan Mayor

- Gabapentinoid to placed under Schedule 3 of the Misuse of Drugs Regulations 2001 and Class C of the Misuse of Drugs Act 1971 form April 2019

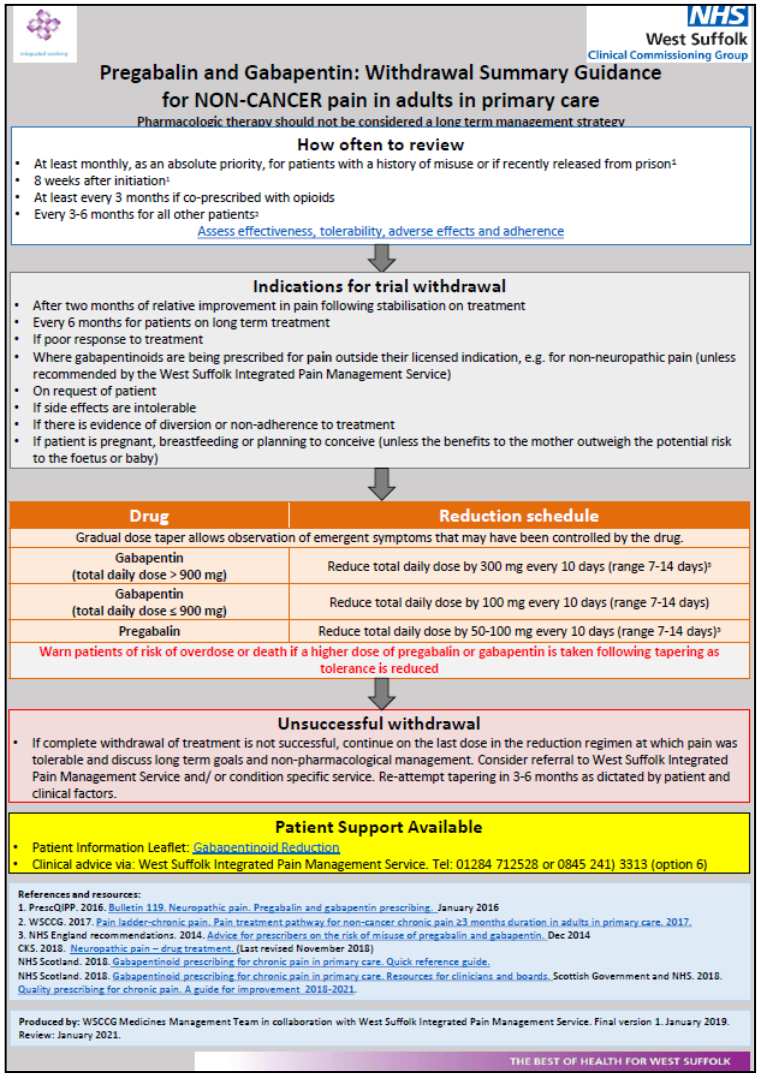
Patient information

- Why: illicit drug use (dependency, misuse or diversion) increased in deaths.
- It is illegal to possess controlled substances without a prescription or to sell or otherwise supply them to others.
- Prescriptions of pregabalin and gabapentin will be limited to 30 days' treatment, and repeat prescriptions will not be issued. Any prescription received must be dispensed within 28 days.

Suffolk GP FEDERATION

Pregabalin and gabapentin withdrawal summary guidance

WSCCG 2019



NHS West Suffolk Clinical Commissioning Group

Pregabalin and Gabapentin: Withdrawal Summary Guidance for NON-CANCER pain in adults in primary care

Pharmacologic therapy should not be considered a long term management strategy

How often to review

- At least monthly, as an absolute priority, for patients with a history of misuse or if recently released from prison[1]
- 8 weeks after initiation[1]
- At least every 3 months if co-prescribed with opioids
- Every 3-6 months for all other patients[2]

Assess effectiveness, tolerability, adverse effects and adherence

Indications for trial withdrawal

- After two months of relative improvement in pain following stabilisation on treatment
- Every 6 months for patients on long term treatment
- If poor response to treatment
- Where gabapentinoids are being prescribed for pain outside their licensed indication, e.g. for non-neuropathic pain (unless recommended by the West Suffolk Integrated Pain Management Service)
- On request of patient
- If side effects are intolerable
- If there is evidence of diversion or non-adherence to treatment
- If patient is pregnant, breastfeeding or planning to conceive (unless the benefits to the mother outweigh the potential risk to the foetus or baby)

Drug	Reduction schedule
Gradual dose taper allows observation of emergent symptoms that may have been controlled by the drug.	
Gabapentin (total daily dose > 900 mg)	Reduce total daily dose by 300 mg every 10 days (range 7-14 days)[3]
Gabapentin (total daily dose ≤ 900 mg)	Reduce total daily dose by 100 mg every 10 days (range 7-14 days)
Pregabalin	Reduce total daily dose by 50-100 mg every 10 days (range 7-14 days)[3]
Warn patients of risk of overdose or death if a higher dose of pregabalin or gabapentin is taken following tapering as tolerance is reduced	

Unsuccessful withdrawal

- If complete withdrawal of treatment is not successful, continue on the last dose in the reduction regimen at which pain was tolerable and discuss long term goals and non-pharmacological management. Consider referral to West Suffolk Integrated Pain Management Service and/ or condition specific service. Re-attempt tapering in 3-6 months as dictated by patient and clinical factors.

Patient Support Available

- Patient Information Leaflet: Gabapentinoid Reduction
- Clinical advice via: West Suffolk Integrated Pain Management Service. Tel: 01284 712528 or 0845 241) 3313 (option 6)

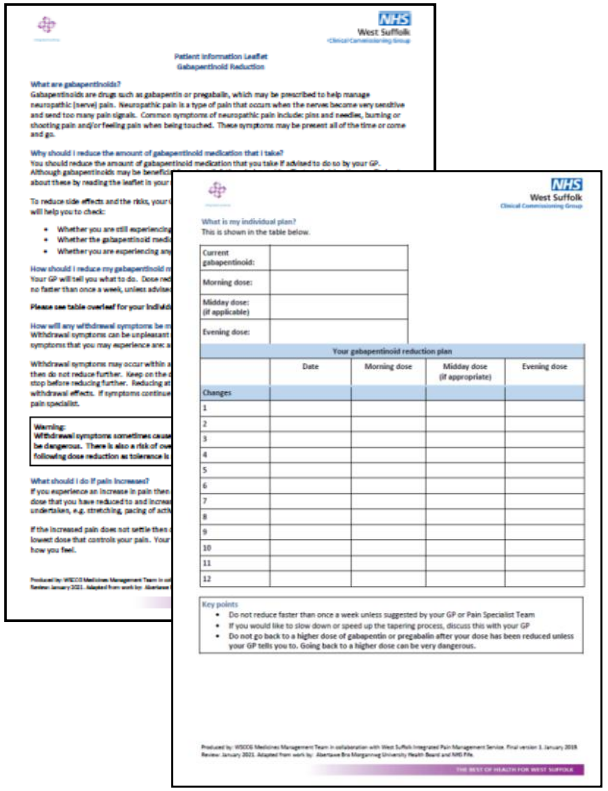
References and resources:

1. PrescQIPP. 2016. Bulletin 119. Neuropathic pain. Pregabalin and gabapentin prescribing. January 2016
2. WSCCG. 2017. Pain ladder-chronic pain. Pain treatment pathway for non-cancer chronic pain ≥3 months duration in adults in primary care. 2017.
3. NHS England recommendations. 2014. Advice for prescribers on the risk of misuse of pregabalin and gabapentin. Dec 2014

CKS. 2018. Neuropathic pain – drug treatment. (Last revised November 2018)
NHS Scotland. 2018. Gabapentinoid prescribing for chronic pain in primary care. Quick reference guide.
NHS Scotland. 2018. Gabapentinoid prescribing for chronic pain in primary care. Resources for clinicians and boards. Scottish Government and NHS. 2018.
Quality prescribing for chronic pain. A guide for improvement 2018-2021.

Produced by: WSCCG Medicines Management Team in collaboration with West Suffolk Integrated Pain Management Service. Final version 1. January 2019. Review: January 2021.

THE BEST OF HEALTH FOR WEST SUFFOLK



NHS West Suffolk Clinical Commissioning Group

Patient Information Leaflet
Gabapentinoid Reduction

What are gabapentinoids?

Why should I reduce the amount of gabapentinoid medication that I take?

What is my individual plan?
This is shown in the table below.

Current gabapentinoid:	
Morning dose:	
Midday dose: (if applicable)	
Evening dose:	

Your gabapentinoid reduction plan

	Date	Morning dose	Midday dose (if appropriate)	Evening dose
Changes				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Key points

- Do not reduce faster than once a week unless suggested by your GP or Pain Specialist Team
- If you would like to slow down or speed up the tapering process, discuss this with your GP
- Do not go back to a higher dose of gabapentin or pregabalin after your dose has been reduced unless your GP tells you to. Going back to a higher dose can be very dangerous.

NHS
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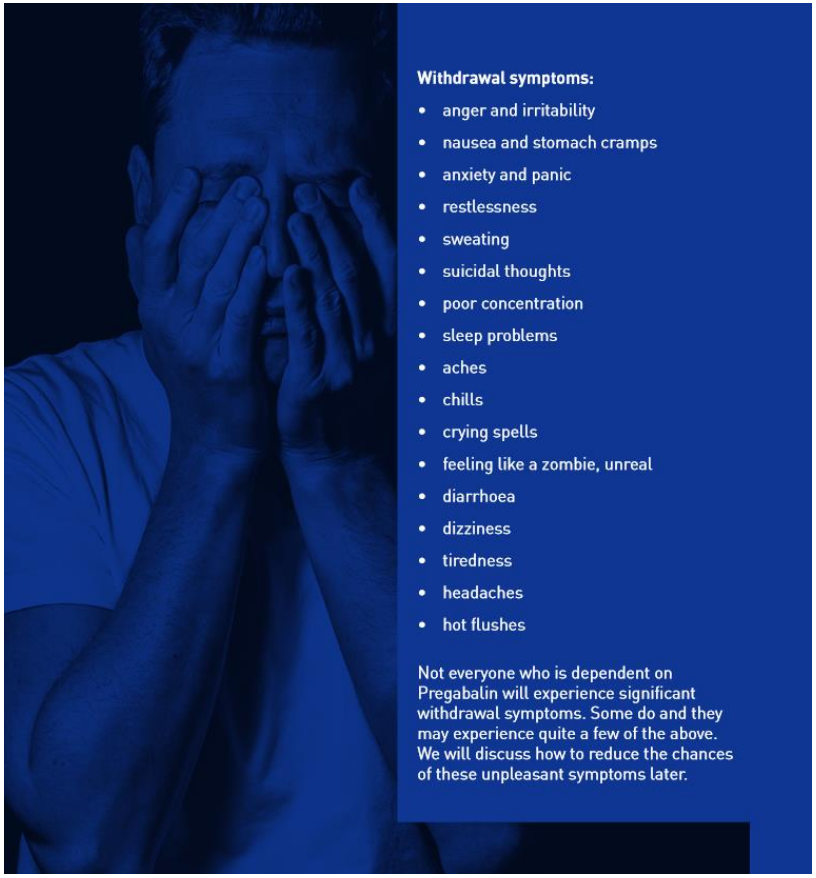
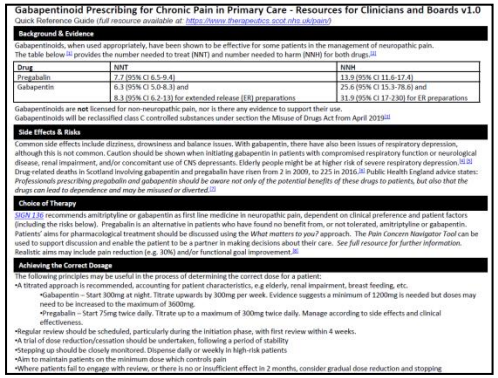
Pregabalin and gabapentin withdrawal summary guidance: withdrawal symptoms



http://www.publichealth.hscni.net/sites/default/files/Pregabalin%20Guidance%20Booklet%20A4%20Final%20Web_0.pdf

- Incidence and severity of withdrawal symptoms may be dose and speed of reduction related (PHE 2014, Granger 2018, SPC 2018).
- Several case reports of serious withdrawals requiring hospitalisation or intensive therapy (Granger 2018).
- Gradually reduction advised to minimise symptoms of withdrawal and allow assessment of response (NHS Scotland 2018) .

Gabapentinoids: Key resources and quick reference guide



Gabapentinoid Prescribing for Chronic Pain in Primary Care - Resources for Clinicians and Boards v1.0

Quick Reference Guide (full resource available at: https://www.therapeutics.scot.nhs.uk/pain/)

Background & Evidence

Gabapentinoids, when used appropriately, have been shown to be effective for some patients in the management of neuropathic pain.
The table below[1] provides the number needed to treat (NNT) and number needed to harm (NNH) for both drugs.[1]

Drug	NNT	NNH
Pregabalin	7.7 (95% CI 6.5-9.4)	13.9 (95% CI 11.6-17.4)
Gabapentin	6.3 (95% CI 5.0-8.3) and 8.3 (95% CI 6.2-13) for extended release (ER) preparations	25.6 (95% CI 15.3-78.6) and 31.9 (95% CI 17-230) for ER preparations

Gabapentinoids are **not** licensed for non-neuropathic pain, nor is there any evidence to support their use.
Gabapentinoids will be reclassified class C controlled substances under section the Misuse of Drugs Act from April 2019[11]

Side Effects & Risks

Common side effects include dizziness, drowsiness and balance issues. With gabapentin, there have also been issues of respiratory depression, although this is not common. Caution should be shown when initiating gabapentin in patients with compromised respiratory function or neurological disease, renal impairment, and/or concomitant use of CNS depressants. Elderly people might be at higher risk of severe respiratory depression.[9] [2]
Drug-related deaths in Scotland involving gabapentin and pregabalin have risen from 2 in 2009, to 225 in 2016.[9] Public Health England advice states: *Professionals prescribing pregabalin and gabapentin should be aware not only of the potential benefits of these drugs to patients, but also that the drugs can lead to dependence and may be misused or diverted.*[2]

Choice of Therapy

NICE CG 173 recommends amitriptyline or gabapentin as first line medicine in neuropathic pain, dependent on clinical preference and patient factors (including the risks below). Pregabalin is an alternative in patients who have found no benefit from, or not tolerated, amitriptyline or gabapentin.
Patients' aims for pharmacological treatment should be discussed using the *What matters to you?* approach. *The Pain Concern Navigator Tool* can be used to support discussion and enable the patient to be a partner in making decisions about their care. *See full resource for further information.*
Realistic aims may include pain reduction (e.g. 30%) and/or functional goal improvement.[8]

Achieving the Correct Dosage

The following principles may be useful in the process of determining the correct dose for a patient:
- A titrated approach is recommended, accounting for patient characteristics, e.g elderly, renal impairment, breast feeding, etc.
  - Gabapentin – Start 300mg at night. Titrate upwards by 300mg per week. Evidence suggests a minimum of 1200mg is needed but doses may need to be increased to the maximum of 3600mg.
  - Pregabalin – Start 75mg twice daily. Titrate up to a maximum of 300mg twice daily. Manage according to side effects and clinical effectiveness.
- Regular review should be scheduled, particularly during the initiation phase, with first review within 4 weeks.
- A trial of dose reduction/cessation should be undertaken, following a period of stability
- Stepping up should be closely monitored. Dispense daily or weekly in high-risk patients
- Aim to maintain patients on the minimum dose which controls pain
- Where patients fail to engage with review, or there is no or insufficient effect in 2 months, consider gradual dose reduction and stopping

https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/11/Gabapentinoid-Quick-Reference-Guide-23112018-Final-v1.0.pdf

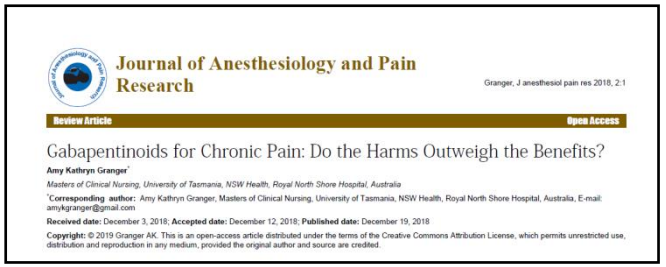
NHS SCOTLAND

Gabapentinoid Prescribing for Chronic Pain in Primary Care

Resources for Clinicians and Boards

VERSION 1.2 – 11th December 2018

https://www.therapeutics.scot.nhs.uk/pain/



Journal of Anesthesiology and Pain Research

Granger, J anesthesiol pain res 2018, 2:1

Review Article | Open Access

Gabapentinoids for Chronic Pain: Do the Harms Outweigh the Benefits?

Amy Kathryn Granger*

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https://www.omicsonline.org/open-access/gabapentinoids-for-chronic-pain-do-the-harms-outweigh-the-benefits.pdf

Suffolk GP FEDERATION

Supporting self-management

It is recommended that health care professionals (HCPs) should work with patients to develop:

1. Their understanding of chronic pain.
2. The value of self-management and non-pharmaceutical approaches.
3. Supportive strategies to enable people to access the tools, resources and support available to put these approaches in to practice.

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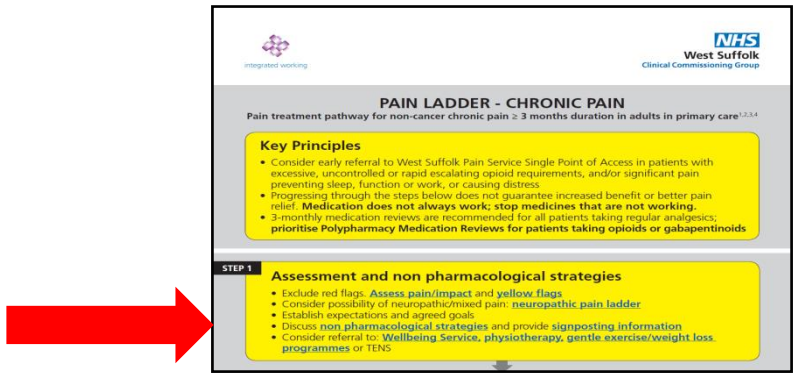
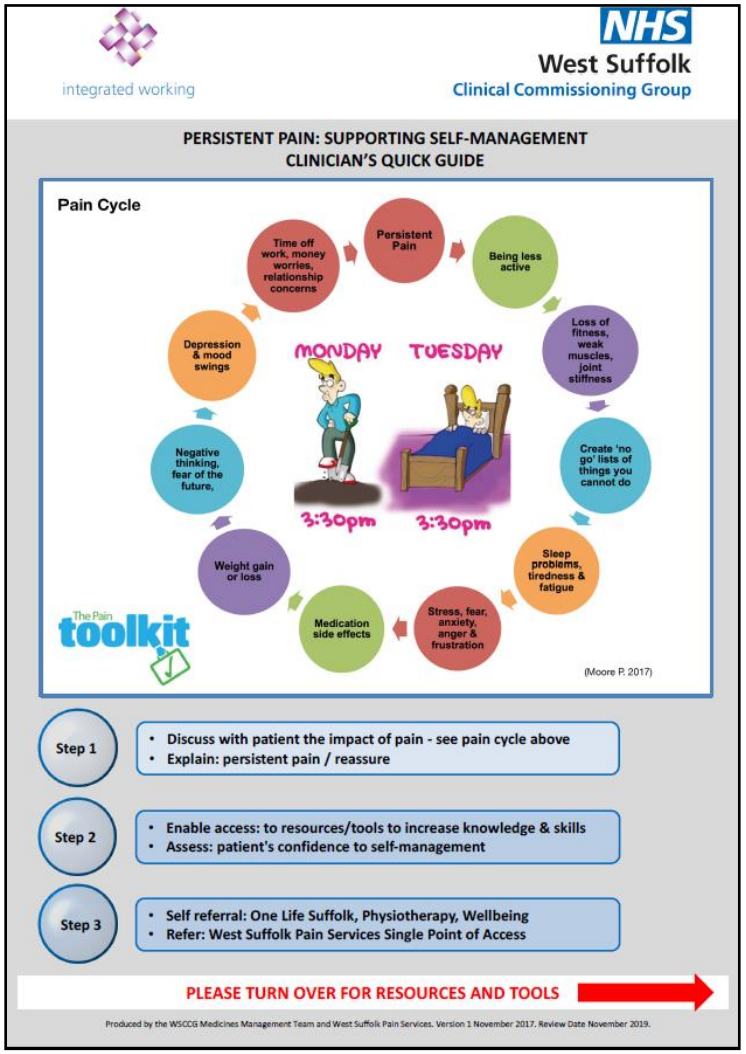


Non-pharmacological hyperlinks



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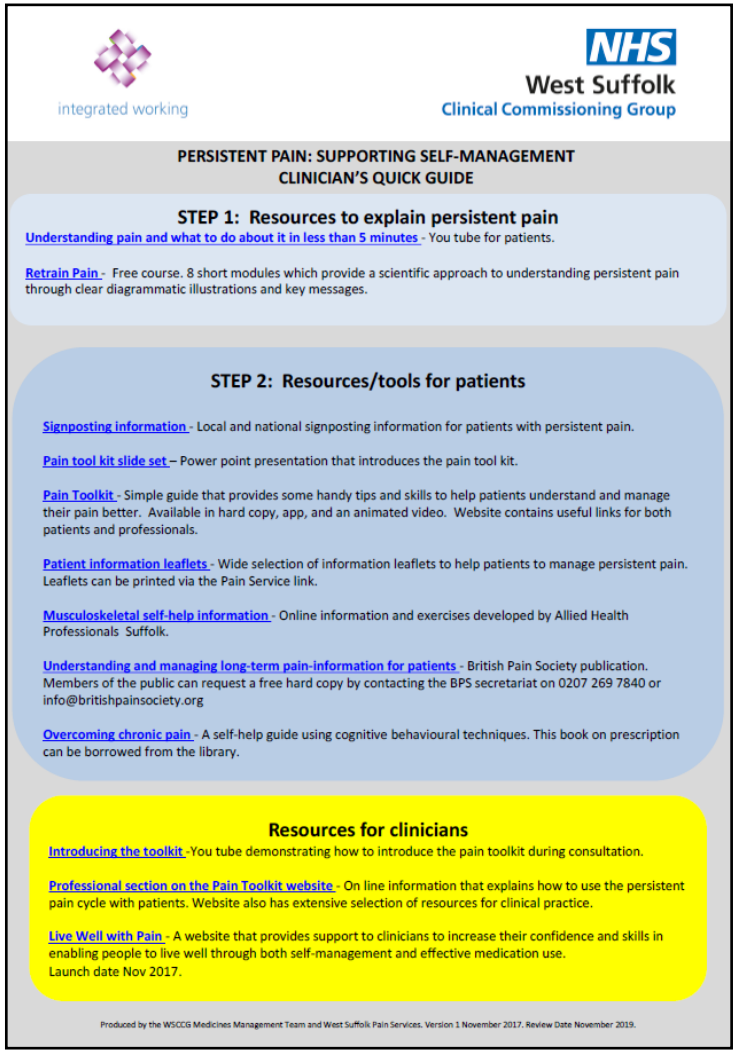
PERSISTENT PAIN: SUPPORTING SELF-MANAGEMENT
CLINICIAN'S QUICK GUIDE

Pain Cycle

Step 1	• Discuss with patient the impact of pain - see pain cycle above • Explain: persistent pain / reassure
Step 2	• Enable access: to resources/tools to increase knowledge & skills • Assess: patient's confidence to self-management
Step 3	• Self referral: One Life Suffolk, Physiotherapy, Wellbeing • Refer: West Suffolk Pain Services Single Point of Access

PLEASE TURN OVER FOR RESOURCES AND TOOLS

Produced by the WSCCG Medicines Management Team and West Suffolk Pain Services. Version 1 November 2017. Review Date November 2019.



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PERSISTENT PAIN: SUPPORTING SELF-MANAGEMENT
CLINICIAN'S QUICK GUIDE

STEP 1: Resources to explain persistent pain

Understanding pain and what to do about it in less than 5 minutes - You tube for patients.

Retrain Pain - Free course. 8 short modules which provide a scientific approach to understanding persistent pain through clear diagrammatic illustrations and key messages.

STEP 2: Resources/tools for patients

Signposting information - Local and national signposting information for patients with persistent pain.

Pain tool kit slide set – Power point presentation that introduces the pain tool kit.

Pain Toolkit - Simple guide that provides some handy tips and skills to help patients understand and manage their pain better. Available in hard copy, app, and an animated video. Website contains useful links for both patients and professionals.

Patient information leaflets - Wide selection of information leaflets to help patients to manage persistent pain. Leaflets can be printed via the Pain Service link.

Musculoskeletal self-help information - Online information and exercises developed by Allied Health Professionals Suffolk.

Understanding and managing long-term pain-information for patients - British Pain Society publication. Members of the public can request a free hard copy by contacting the BPS secretariat on 0207 269 7840 or info@britishpainsociety.org

Overcoming chronic pain - A self-help guide using cognitive behavioural techniques. This book on prescription can be borrowed from the library.

Resources for clinicians

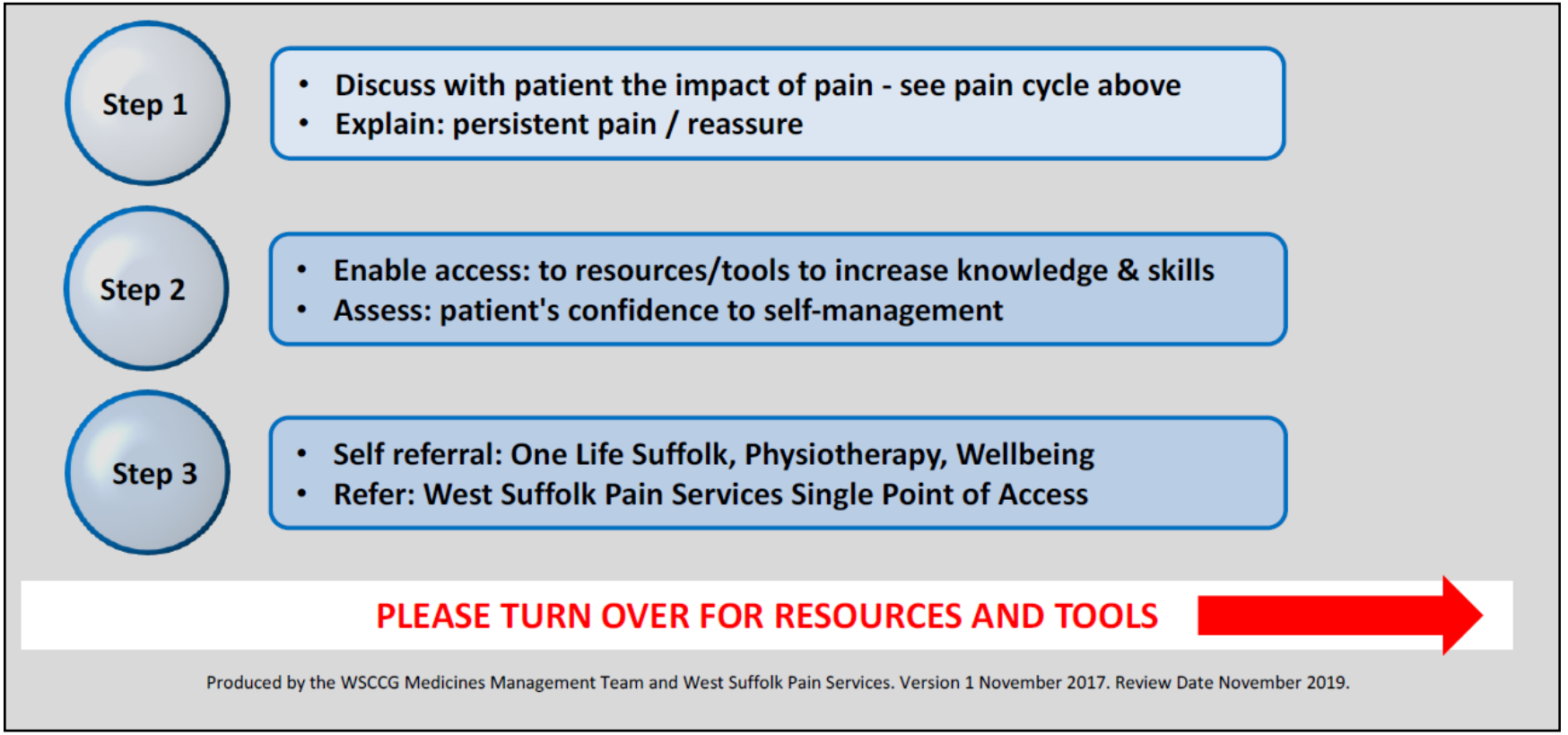
Introducing the toolkit -You tube demonstrating how to introduce the pain toolkit during consultation.

Professional section on the Pain Toolkit website - On line information that explains how to use the persistent pain cycle with patients. Website also has extensive selection of resources for clinical practice.

Live Well with Pain - A website that provides support to clinicians to increase their confidence and skills in enabling people to live well through both self-management and effective medication use.
Launch date Nov 2017.

Produced by the WSCCG Medicines Management Team and West Suffolk Pain Services. Version 1 November 2017. Review Date November 2019.

Steps to promote and support self-management



Suffolk GP FEDERATION

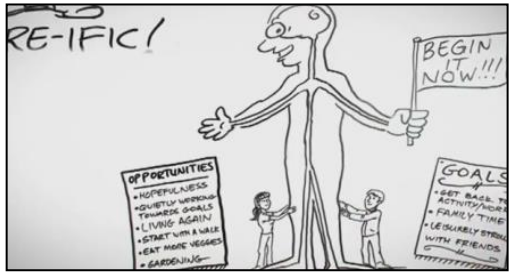
Pain Cycle

- Persistent Pain
- Being less active
- Loss of fitness, weak muscles, joint stiffness
- Create 'no go' lists of things you cannot do
- Sleep problems, tiredness & fatigue
- Stress, fear, anxiety, anger & frustration
- Medication side effects
- Weight gain or loss
- Negative thinking, fear of the future,
- Depression & mood swings
- Time off work, money worries, relationship concerns

The Pain toolkit
www.paintoolkit.org

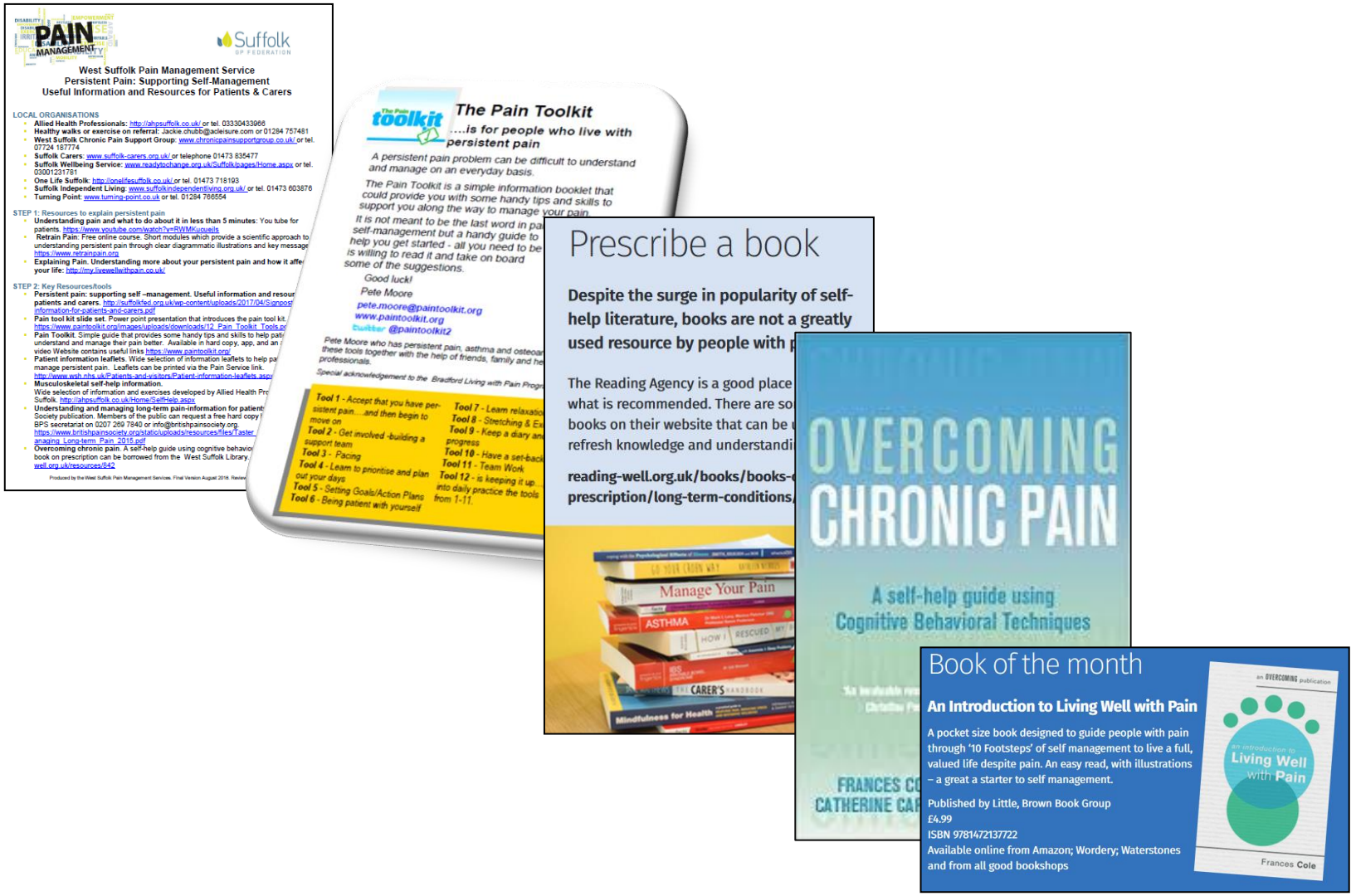
Step 1: Explain pain

Australian video:



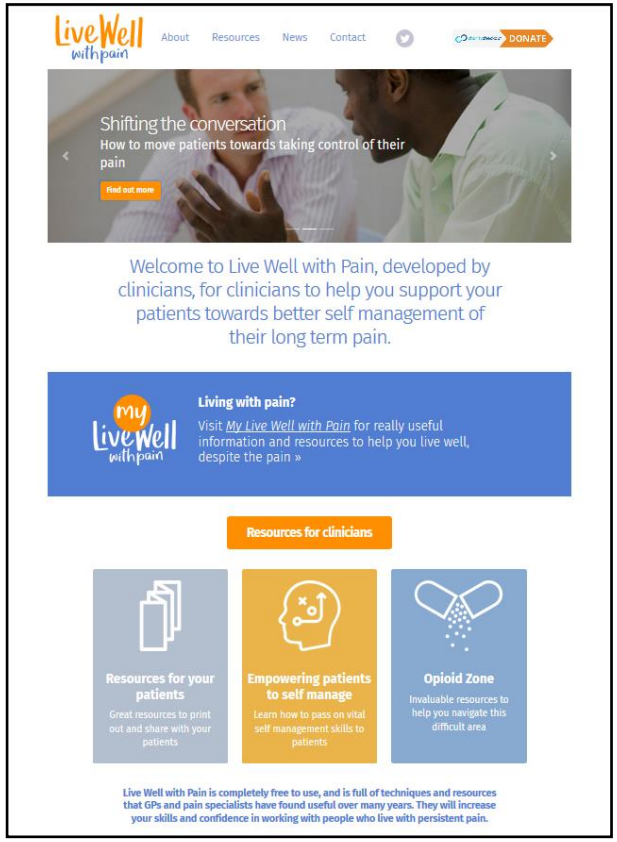
Understanding pain and what to do about it in less than 5 mins

Step 2: Resources/tools



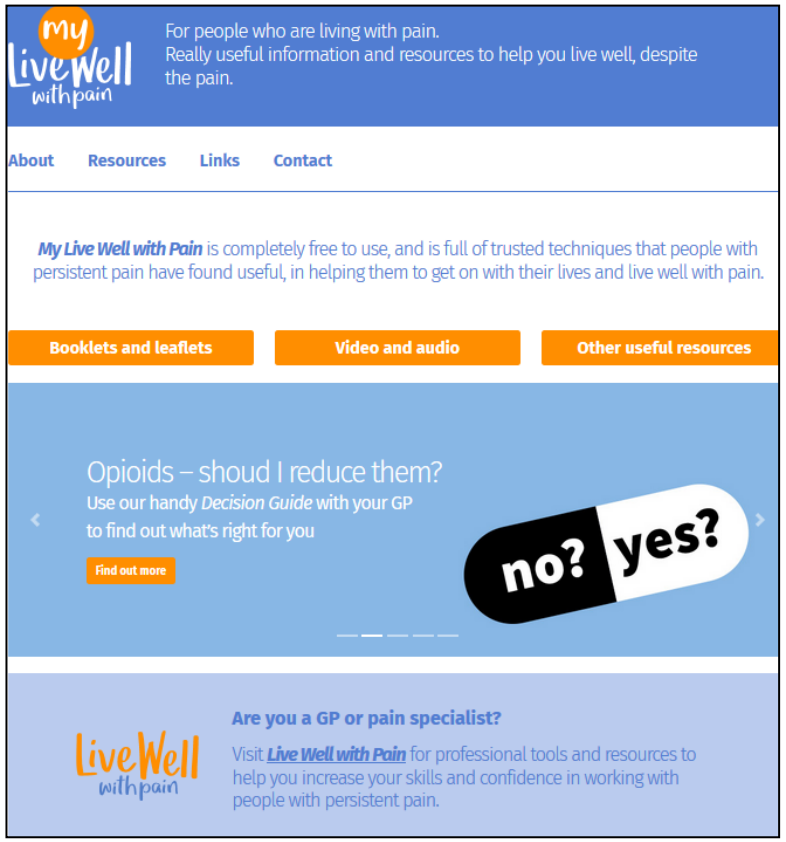
New websites developed by clinicians for clinicians and patients

For Clinicians



https://livewellwithpain.co.uk/

For patients



http://my.livewellwithpain.co.uk/

Summary-a good prescription

(Stannad 2016, 2018)

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Briefing Statement to Health Professionals on the Management of Opioid Medications

Key Messages:

There is an urgent need to:-

- Screen and assess people on opioids,
- Make clinical decisions about opioid reduction and optimal pain management where a
- Identify the best clinical approach and place (GP surgery, hospital clinic, community ph to occur,
- Ensure that there are resources to deal with those patients captured by any screening
- Employ a corporate approach to manage those who are non-compliant (see 'Recomm

This should be proactively linked to interdisciplinary pain assessment and management to management through other strategies and treatments.

The required services need to be fully commissioned to support patients.

Introduction

There is considerable and continuing public concern related to an increase in the use of opi the United Kingdom. There is also professional and governmental concern regarding misuse medicines and the number of prescriptions of opioid analgesics. The backdrop are the seric concerns in the USA. This document sets out the issues and recommendations for action lo

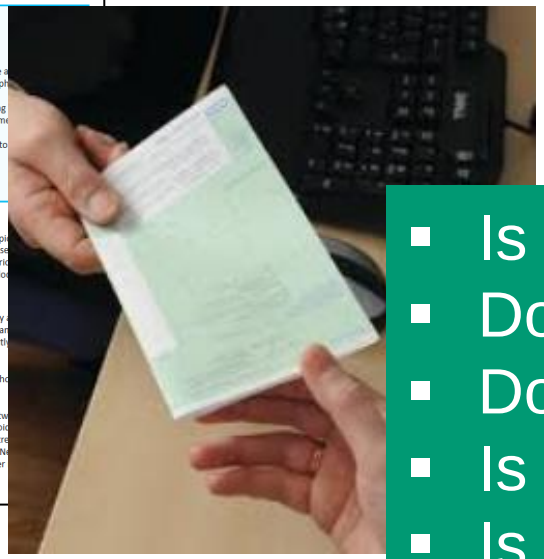
Opioids in Chronic non-malignant pain

Pain is the 5th vital sign and pain relief can be viewed as a basic human right. Opioids play role in acute pain where there is a close relationship between pain and tissue damage. Exar would be in Emergency Departments after trauma or following surgery. They are frequentl "Gold Standard" for such acute pain treatment.

In addition, opioids play an important role in the management of cancer pain and in the sho term for some other medical conditions.

The effectiveness of opioids in long-term chronic non-malignant pain is less clear. Ten to tw emerging literature led to a view that opioids may play a role in long-term pain. New opioi preparations were brought to the market with this in mind. While the evidence did not stre term, it was recognised that it would be very difficult to undertake such long-term trials. N was a strong clinical view that opioids were helpful in some patients not treatable by other logical given their known physiology.

1



- Is effective for the condition
- Does not harm the patient
- Does not harm anyone else
- Is acceptable to the patient
- Is legal and accurate

Key message

So giving a prescription for something that is likely not to work is a clinical 'big deal' in relation to iatrogenic harm

Stannard BJA 2018 120(6) 1148

Summary

- Opioids are valuable in the management of acute pain, pain related to cancer and for pain management at the end of life.
- There is a lack of robust evidence on the benefit of long-term opioids in the management of chronic pain.
- Ensure you are able to explain chronic pain and support self-management strategies
- Inappropriate use of long-term opioids in chronic pain is associated with serious adverse effects.
- The risk of harm from opioids increases significantly above a dose equivalent to 120 mg/day of oral morphine.
- Identify patients most at risk of harm e.g. adverse selection.
- In conjunction with the patient, regularly review the effect of opioid treatment and consider whether there is a need to reduce the dose or stop the opioid.
- Keep abreast of changing evidence base with the use of gabapentinoids and follow local guidance.

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Health coaching

Living with chronic long term illnesses can be challenging and distressing for patients - which is why they often visit their clinicians. Adding a health coaching approach to the tool box of communication skills you use in your consultations can help promote patient self-sufficiency, satisfaction and motivation, enabling people to manage their condition with greater independence and self-confidence.

The facts

- People with long term conditions account for 50% of all GP appointments, 70% of all inpatient bed days and 70% of overall NHS spend
- The number of people with three or more long term conditions is predicted to rise by 1 million to 2.9 million by 2018
- Three quarters of all deaths will be as a result of chronic disease by 2020.

What is health coaching?

Health coaching is talking to people with long term conditions in a way that supports and empowers them to better manage their own care, fulfil their self-identified health goals and improve their quality of life.

What are the benefits of health coaching?

- Improves communication fundamental to care.
- Encourages people with long term conditions to prioritise their health and do more to care for themselves
- Enables clinicians to shine the spotlight on personal awareness and responsibility in a supportive manner, and transform the clinician/patient relationship
- Can increase patient self-sufficiency, satisfaction, confidence, motivation, compliance, and reduce costs for organisations.

What skills will I learn?

You will learn a combination of tools and techniques you can use every day with patients that support behaviour change and help you listen, build rapport and challenge more skilfully, as well as set goals, motivate and encourage your patients.

Which teams and patients would benefit most?

The skills are useful with all patients but particularly in the following areas: with long term conditions; mild anxiety, depression; medication compliance; pain management; lifestyle; recovery, and rehabilitation.

How does this fit with other priorities for me and my organisation?

The training will help you work towards addressing the following:

- Improving patient experience and quality of care
- Increasing Friends and Family test scores
- Reducing complaints especially around communication
- Reducing organisational costs and saving time
- Builds relationships with colleagues, and collaborative working
- Supports the delivery of integrated care and care planning
- Enhances local plans for managing patients with long term conditions

Course Dates 2018/19:

The Health Coaching training is delivered over two full days, one week apart

8th and 15th November 2018
12th and 19th December 2018
10th and 17 January 2019
6th and 14th February 2019
13th and 21st March 2019

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NMP forums and conference

NMP forum

Friday 15th March 2019: 9:30 am - 12:30 pm

Thursday 11th July 2019: 9:30 am – 12:30 pm

Monday 21st October 2019: 9:30 am – 12:30 pm

Venue: Pod room 1 at Stow Lodge

NMP conference

Monday 1st July 2019

Venue: UoS

Further information

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e-Pain

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Reflection and group discussion

Questions

1. Historically what has the role of the physiotherapist been in:

a) Promoting medication safety with analgesia?

b) reducing the risks associated with inappropriate analgesic polypharmacy?

2. What could the role of the physiotherapist be in:

a) promoting medication safety with analgesia?

b) reducing the risks associated with inappropriate analgesic polypharmacy?

3. Identify potential barriers and factors that would be helpful to maximise your potential as a physiotherapist with:

a) promoting medication safety with analgesia?

b) reducing the risks associated with inappropriate analgesic polypharmacy?

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Key references

Key references

WSCCG Pain Guidance https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/

Stannard C. 2018 Where now for opioids in chronic pain. https://dtb.bmj.com/content/56/10/118

Stannard C. 2018 Pain and pain prescribing: what is in a number? British Journal of Anaesthesia,120 (6):1147-1149

Canadian Guideline for Opioids for Chronic Non-Cancer Pain (2017)
http://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf

CDC Guidelines for Prescribing Opioids in Chronic Pain. United States 2016 (2016)
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Opioids Aware 2015 : https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

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Key resources for opioid information

Key Resources

- CDC Guideline for prescribing opioids in chronic pain: resources

  https://www.cdc.gov/drugoverdose/prescribing/resources.html

- NICE (NG 46 September 2016) Controlled Drugs: Safe use and management

  https://www.nice.org.uk/guidance/ng46

- NICE (KTT 21 January 2017) Medicines Optimisation in long term pain

  https://www.nice.org.uk/advice/ktt21

- Opioid resources

https://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf

2017 Canadian Opioid Prescribing Guideline

http://www.cfpc.ca/uploadedFiles/CPD/Opioid%20poster_CFP_ENG.pdf

- 2017 PresQIPP 149 Jan 2017; management of non neuropathic pain

  https://www.prescqipp.info/media/1483/149-non-neuropathic-pain-23.pdf

2018 Quality Prescribing for Chronic Pain. A Guide for Improvement 2018-2021

http://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/03/Strategy-Chronic-Pain-Quality-Prescribing-for-Chronic-Pain-2018.pdf

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Opioid resources recommendations (from chief pharmacists)

- PrescQIPP website
- NHSE are promoting practices (and pharmacies) to undertake high dose opioid audits (doses >120mg morphine or equivalent). The audit can be accessed via the following link: https://www.prescqipp.info/component/jdownloads/category/420-high-dose-opiate-searches

In conjunction with the audit, there is also a series of recorded webinars available from

- https://www.prescqipp.info/media/opioid-aware-webinar-session-1-of-2-13-october-dr-ruth-bastable
- https://www.prescqipp.info/media/opioid-aware-next-steps-webinar-session-2-of-2-18-october-dr-ruth-bastable
- https://www.prescqipp.info/prescqipp/news/media/opioids-aware-audit-webinar-dr-ruth-bastable-9th-may

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Before we move on any questions?

Thank you

Further information and references on request

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