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.

Dose of opioids for chronic non-malignant pain

A major problem at the time opioids began to be used for chronic pain was that there was an absence of guidance or direction about which opioids to use and to what dose.

The current view of the Faculty of Pain Medicine is that opioids do work for chronic pain in selected patients as part of a comprehensive pain management plan. They should be used in low doses with close monitoring of clinical effect. Dose escalation suggests that the pain is probably not opioid-responsive and the dose should be tapered down. Doses above 120mg morphine equivalence per day should be considered high dose and are associated with increasing risks to the patient. This might change as new information becomes available. Best practice is to keep the opioid dose as low as possible and the balance of dose-related risks and benefits should be actively reviewed.

History: Why we are where we are

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

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

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

USA vs. UK

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

However, there is a growing concern about the increase in use of opioid painkillers in the UK and whether this is clinically justified. Increase in opioid prescription could be attributed to an improvement in the understanding and assessment of pain problems, but this is unlikely to be the full explanation. The Faculty of Pain Medicine 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

effects, overdose, abuse or diversion. The risks are also greater when other psychoactive medications are used, prescription or otherwise. It is also increasingly clear that many patients who reach higher doses of opioids simply followed a pattern of escalating dose steps through recurrent tolerance with no significant effect on their level of pain or function.

Against this backdrop, public understanding of this issue is complicated by competing lobbies (with both commercial and non-commercial interests). One view focuses on their value while the second competing view focuses on harm and the notion of an opioid epidemic. In this debate, emphasis must remain on the devastating impact of chronic pain on individuals causing distress, disability and leading to huge societal costs. The need to treat pain and provide comprehensive interdisciplinary pain services must not be overlooked. The careful use of opioids for chronic pain can only ever be part of a package of care. Deficiencies in the provision of pain services must be considered part of the problem resulting in a lack of availability of other treatments and an overreliance on opioids.

Opioids Aware

The negative effects of opioid drugs in certain circumstances should not be ignored but, while recognising the risks, it is important to avoid inappropriate knee jerk responses promoting widespread withdrawal. Opioid painkillers have benefits to many patients, which are not replicated in other drugs and cannot be easily replaced.

The Faculty of Pain Medicine recognises the management of complex pain is not straightforward and with Public Health England has developed the "Opioids Aware Resource"[1] for professionals and patients to enable the effective and safe use of opioid medications. The resource has a dedicated area for patients, which they can access.[2]

Our greater understanding of medications can improve the quality of life for tens of thousands of patients in the United Kingdom living with complex pain. However, all healthcare staff need to ensure they are not doing more harm than good.

Regional variations

There is considerable variation in the prescription of opioids across the United Kingdom. Pain physicians believe it is imperative that we act robustly in investigating, assessing and, where necessary, acting.

Recommended Actions

Continue practice of screening in pain units. Currently, all patients attending a Pain Unit should have their medicines assessed including opioid doses, and advice given. A careful risk benefit analysis has to be considered because there is a risk of morbidity and mortality in reducing opioids. Increased pain or withdrawal may worsen psychiatric co-morbidity. If the patient is well established on a dose that has not escalated for a long period of time with improved quality of life and significant reduction in pain, any opioid dose changes must be tailored for the patient. For most patients, opioid reduction can be done slowly in the community, but General Practitioners and local pharmacies should have the facility to work closely with support and advice from specialist pain units and if necessary, jointly with addiction centres. Patients will also require support in reducing their does and managing their withdrawal.
Reducing patients to safe and stable 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

Screen, triage and assess. We need to find local mechanisms through regional pharmacy and GP authorities to identify those patients on high dose opioid (e.g. >120mg daily morphine equivalents) and to undertake triage and clinical assessment to identify the correct course of action, both to manage pain and the level of opioid dose.

Manage non-compliance. It is recognised in this process that there are some patients who will not be compliant. These patients cannot be treated without consent because they will not meet the criteria for legislative medical intervention. Therefore, very careful consideration is required for patients who either do not attend or comply with the medical recommendations. These patients should be managed in conjunction with the General Practitioners to have a plan for opioid reduction.

Specialist resources. In view of the complex issues involved, best care involves collaborative working between community services, pain services, General Practitioners and, where necessary, addiction services with experience in prescription opioids. Most addiction services will not treat prescription opioids for pain. There are some specialist centres with opioid reduction clinics and these centres might be a useful resource for patients.

In addition, some highly specialist inpatient pain medication optimisation clinics will be required for opioid optimisation or reduction in complex cases.

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