

Shropshire, Telford and Wrekin CCG Guidance for Primary Care

Opioid use and reduction in Primary Care for Non-Cancer Pain

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1. Background

Acute Pain

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

Non Cancer Pain

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

Chronic Pain

New guidance was released in April 2021 for the treatment of chronic primary pain. The committee found no evidence for the effectiveness of opioids against chronic primary pain. This alongside the evidenced increased risk of dependence associated with long-term use of opioids, forms the basis on which the recommendation has been made to recommend **against** initiating opioid treatment for patients with chronic primary pain.³ The following guide should be used for patients exempt from this category when initiating opioids, opioid initiation should only be considered for patients

with Chronic Secondary pain or mixed pain types in line with the condition specific guidance. Where patients with Chronic Primary Pain are prescribed opioids, prescribing should be reviewed as part of shared decision making:

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

Overall, patients are not benefiting from continued prescribing of long term opioids. If 120mg daily morphine or equivalent does not provide substantial pain relief or functional improvement, then taking nothing is a better option. The reality may be difficult to accept for both patient and prescriber, however tapering the opioid dose and stopping will enable patients to function better in the world, and feel less ill. They may still have the pain, but are more likely to have improved wellbeing.

2. Five Headline Points from Opioids Aware

- Opioids are very good analgesics for acute pain and for pain at the end of life

but there is little evidence that they are helpful for long term pain.

- If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.
- The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.
- A small proportion of people may obtain good pain relief with opioids in the long term
- if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).
- Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

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

3. Patient assessment

The experience of pain is complex and influenced by the degree of tissue injury, current mood, previous experience of pain and an understanding of the cause and significance of pain. Previous unpleasant thoughts, emotions and experiences can also contribute to the current perception of pain and if unresolved, can act as a barrier to treatment.

The NICE guidance for Chronic Pain and Faculty of pain medicine both recommend a person-centred, full holistic assessment of patients presenting with Chronic pain which takes these complex factors into account. An [Assessment tool](#) is available to support this.

4. Opiate Trial

A small number of patients with chronic non-cancer secondary pain may derive some functional benefit from low dose opiates (less than 120mg morphine equivalent dose per day). An opiate trial can determine whether opioids may prove useful as part of a pain management strategy or not. It is important to remember that a short term opioid trial does not predict long term efficacy.

An opioid trial should not be considered unless all non-pharmacological and non-opiate pharmacological options have been tried in line with condition specific guidance. A structured approach and details of how to perform an opioid trial can be found below

Assessment tool:	https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/patient-assessment
A structured approach and details of how to perform an opioid trial:	https://fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/opioid-trial
Important Considerations for Opioid Trials from live well with pain:	https://livewellwithpain.co.uk/wp-content/uploads/CEP_OpioidManager-main-chart-2017.pdf
If there is no improvement in pain, sleep and functionality then the opiate should be reduced slowly and stopped rather than escalating to a higher dose	

5. Side Effects Long Term Opioids

Side effects are extremely common with opioid therapy. Between 50% and 80% of patients in clinical trials experience at least one side effect; however in everyday use the incidence may be even higher.⁴

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

Five practical steps to reduce high dose opioids

1. **Education:** explain the importance of reducing opioids to the patient – see [patient resources](#)

Websites

[The Pain Toolkit](#)

[Ten Footsteps Your Journey to living well with Pain](#)

Youtube videos:

[Understanding Pain what to do about it in less than 5 minutes](#)

[Understanding pain: Brainman stops his Opioids](#)

2. **Engagement:** Give the patient as much choice as possible around how to reduce their opioids.

It doesn't matter how the opioids are reduced as long as the overall daily dose continues to decrease and there is an understanding the doses will not increase once reduced. Giving the patient choice over how this is achieved gives them more control and ownership of the process, improves engagement and is more likely to succeed

Option 1 – Reduce “as required” dose

Keep the modified-release dose stable and wean down the immediate release as required doses by keeping the frequency the same and reducing the dose each week or by maintaining the same dose but reduce the frequency.

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

6. Opioid Reduction

The [opioid risk tool](#) (ORT) see [resources](#) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid dependency among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behaviour. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

Initial determination of total morphine equivalent daily dose can be made using the faculty of pain medicine equipotencies of opiates [tables](#).

Example:

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

Option 2 – reduce the regular dose

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

Example:

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

It may be necessary to extend the time period between reductions in dose if withdrawal symptoms are a significant problem. Opiate reduction templates to assist effecting a reduction may be found [here](#) and in prescriber [resources](#)

3. Effecting the weaning plan

I Change liquid medication to immediate release tablets.

e.g. Oramorph to Sevredol. Both are immediate release morphine but a fixed number of tablets allows the prescriber more control over the patients use and subsequent reduction.

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

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

II Plan the reduction.

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

4. Emotional impact. - Manage anxiety and depression

Anxiety is to be expected during opioid reduction. If a patient has taken opioids for many years they may have a sense that they won't be able to cope without them.

Evidence suggests that withdrawal symptoms are to be expected at significant reductions, but if the reduction is less than 50-75% of the previous day's dose then the patient shouldn't experience withdrawal.

Theoretically, a patient would need to go from 80mg oxycodone one day to 20-40mg the next before getting true withdrawal.

In practice many patients experience what they feel to be withdrawal symptoms with small dose reductions; although this is often related to anxiety rather than opioid withdrawal (anxiety exacerbates withdrawal symptoms). Plenty of reassurance is needed that this is not dangerous, and is a safe reduction.

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

Do not be tempted to treat withdrawal symptoms with more opioids or benzodiazepines.

The [clinical opiate withdrawal scale](#) (COWS) can be used to quantify the severity of opioid withdrawal and help distinguish between objective and subjective symptoms that can be reassuring to both the patient and clinician. See [prescriber resources](#).

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

5. Expectations

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

They should also develop non-drug techniques (relaxation, distraction, music, DVDs, walks etc.) to manage their pain and reduce the reliance on pharmacological treatment.

The pain tool kit provides useful strategies: <http://www.paintoolkit.org/>.

It can take 4-6 months after the cessation of opioids before they feel back to normal, i.e. for the pain, anxiety and depression to reduce.

In the longer term, the pain will reduce to a degree due to the reversal of opioid induced hyperalgesia (where long-term opioids increase, rather than decrease, pain sensitivity).

For patients with abdominal pain, this pain will also improve as the opioids will have been contributing to gut dysmotility.⁵

7. Patient resources; education, emotional and physical support

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

Videos	
Understanding Pain what to do about it in less than 5 minutes	https://www.youtube.com/watch?v=RWMKucuejls
Understanding pain: Brainman stops his Opioids	https://www.youtube.com/watch?v=MI1myFQPdCE
How mood can affect pain	https://www.tamethebeast.org/#tame-the-beast
Understanding pain in less than 5 minutes	www.youtube.com/watch?v=5KrUL8tOaQs
Managing back pain	https://www.youtube.com/watch?v=24P7cTQjsVM&feature=youtu.be

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

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

8. Resources for Prescribers in Primary Care

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

Reference

1. <https://fpm.ac.uk/opioids-aware-clinical-use-opioids/opioids-and-acute-pain-management> accessed 24/2/20
2. <https://fpm.ac.uk/opioids-aware-clinical-use-opioids/opioids-long-term-pain> accessed 24/2/20
3. <https://www.nice.org.uk/guidance/ng193>
4. <https://fpm.ac.uk/opioids-aware-clinical-use-opioids/side-effects-opioids>
5. Oxford University Hospital <https://www.ouh.nhs.uk/services/referrals/pain/documents/gp-guidance-opioid-reduction.pdf>