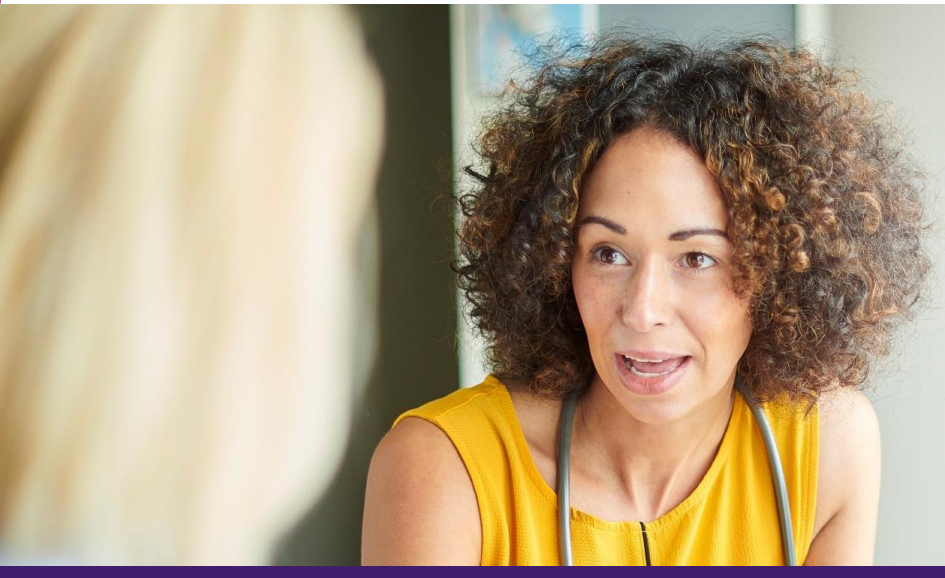


WEBINAR

Thursday, 15 October 2020
7–8:30pm AEST

OPIOID PRESCRIBING: STRATEGIES FOR GPs TO OPTIMISE CHRONIC (NON-CANCER) PAIN MANAGEMENT AND MINIMISE HARMS

RACGP

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

NPS MEDICINEWISE

OPIOID PRESCRIBING: GP STRATEGIES TO OPTIMISE PAIN MANAGEMENT AND MINIMISE HARMS

The interdisciplinary discussion will focus on these actions:

- Identify patients with risk factors and implement strategies to reduce opioid-related harms.
- Recommend appropriate strategies and support patients during the opioid tapering process to increase the chance of success.
- Identify and refer patients with complex needs to appropriate support services.

PAIN PHYSIOLOGY

Nociception

- respond to thermal, chemical and mechanical stimuli
- Somatic, visceral

Multiple brain sites activated

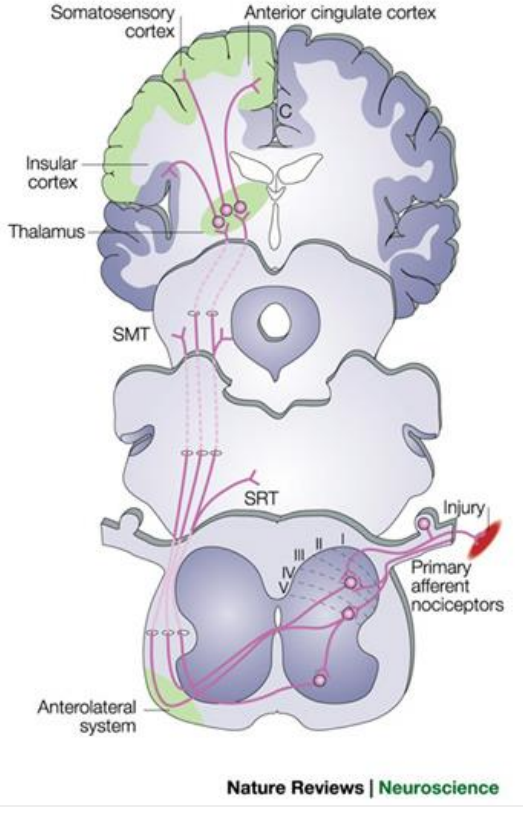
Pain is a multidimensional experience involving sensory, affective and evaluative (meaning) components.

Neuropathic pain secondary to pathology of nociceptive system.

Nociplastic pain develops secondary to sensitisation of the nociceptive system.

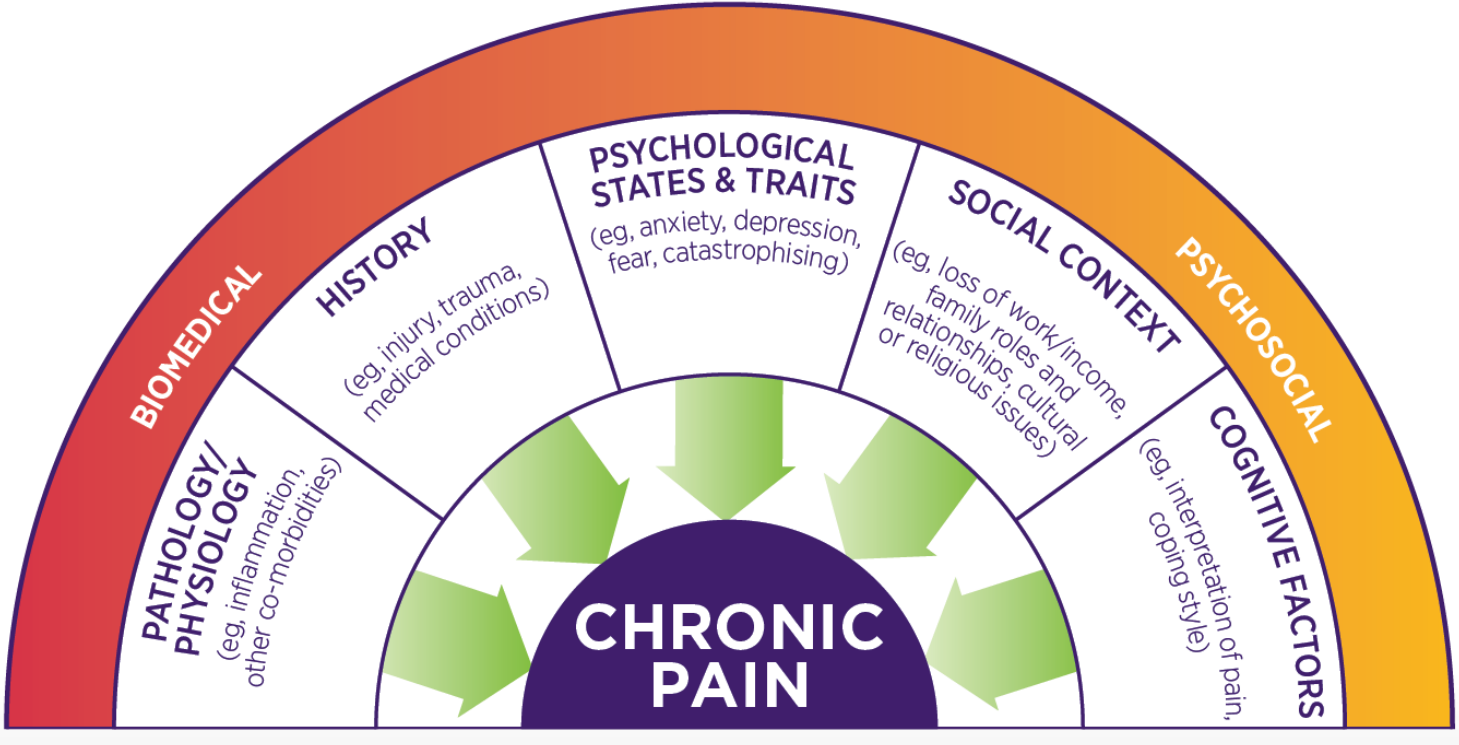
This can be peripheral, spinal or supraspinal.

This is exacerbated by opioids (opioid-induced hyperalgesia).



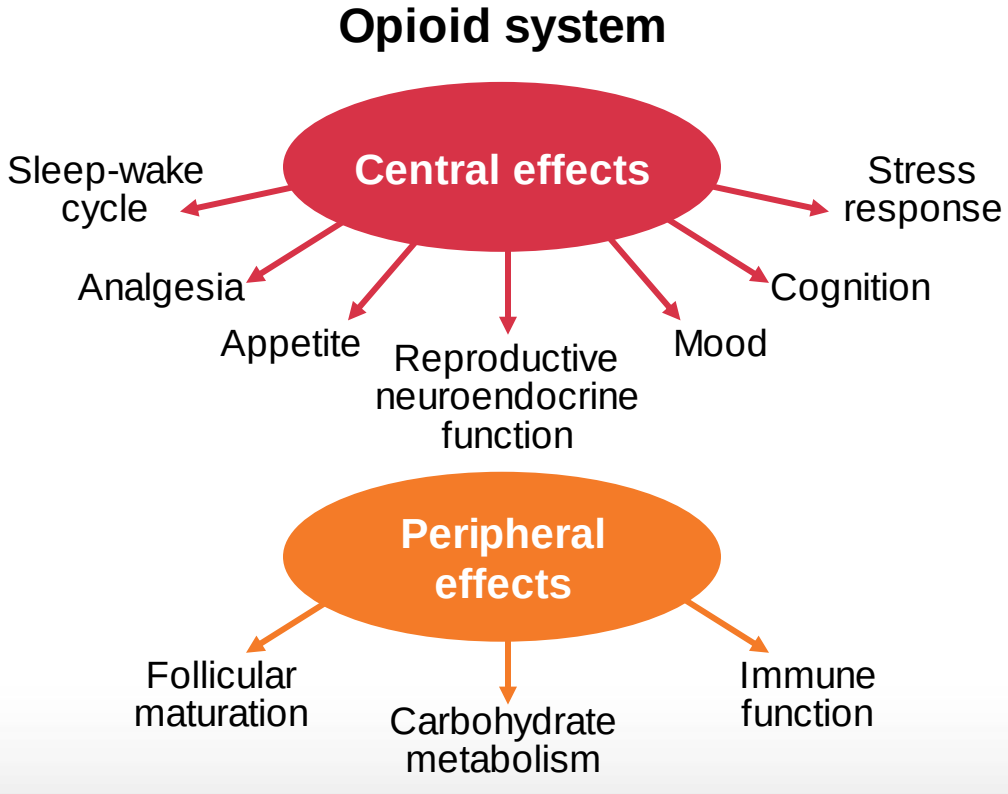
Fields H. Nature Reviews Neuroscience 5, 565-575 (2004)

CONTRIBUTORS TO PAIN



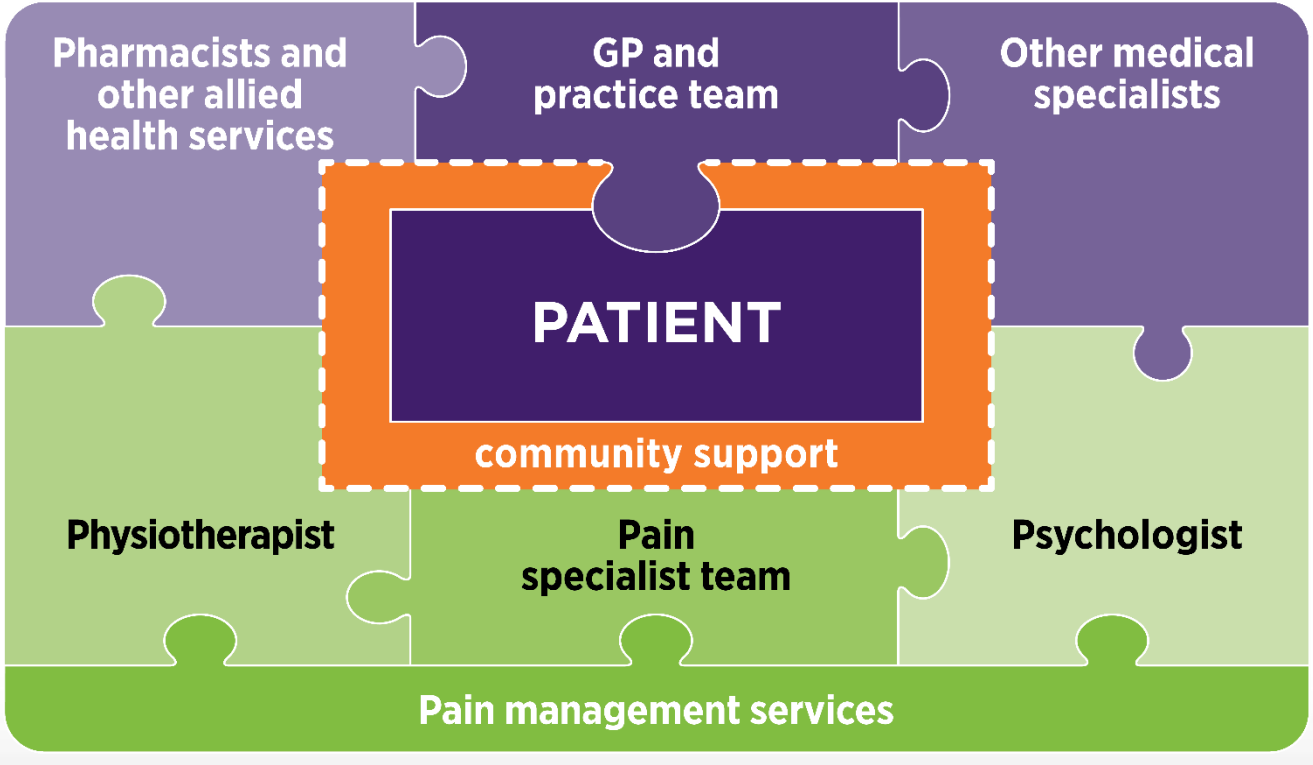
ENDOGENOUS OPIOID SYSTEM

- Modulates pain, mood, stress and social bonding.
- Controls social reward and social pain.
- Engages with the dopamine system (reward) to calculate which behaviours are unconsciously promoted.



Adapted from Eyvazzadeh et al. Fertil Steril 2009; 92: 1- 12.

USE A MULTIMODAL MULTIDISCIPLINARY APPROACH



DEVELOP A MANAGEMENT PLAN WITH YOUR PATIENT

Individualise treatment choices, drawing on different treatment types depending on each patient's preferences, pain, function and previous/ongoing response to treatment.

Aim for patients to gradually increase their activity each week as appropriate and use an outcome measure as appropriate (eg, PEG, OMEBRO-10).

Encourage patients to move in a way they find tolerable, enjoyable and meaningful.

Discuss with the patient, agree on and document realistic treatment goals not only for pain relief, but also to improve the patient's function and quality of life.

Familiarise yourself with your local multidisciplinary pain management resources.

Explain to the patient that there is good evidence for involving other health professionals in the management of chronic pain.

Ensure continuity of care by reassuring patients that if referral to other health professionals is required, you will remain their primary point of care for pain management.

ESSENTIAL CONSIDERATIONS FOR PRESCRIBING OPIOIDS

- Use a pain assessment tool at baseline and follow up (eg, BPI, PEG, 5As).
- Optimise use of non-opioid (pharmacological and non-pharmacological) management strategies.
- Consider other pharmacological options and optimise use of these.
- Discuss with the patient and agree on treatment duration, formulation, dose, treatment outcomes, expectations, follow-up and circumstances for stopping treatment.
- Inform the patient about risks of harms (eg, hyperalgesia, overdose and death).
- Always use the lowest effective dose and for the shortest possible duration.
- Review the patient regularly and assess benefits (pain and function) and risks of harms.

BE AWARE OF TOTAL OPIOID DOSE

- Seek specialist advice before prescribing more than 60 mg OMEDD (> 30 mg for older patients and those with comorbidities).
  - Any beneficial response to an opioid in a trial should be evident at an OMEDD ≤ 60 mg
  - The risk of harms increases with increased dose and duration
- Examples of doses equivalent to 60 mg OMEDD include:
  - fentanyl patches 25 mcg/hr
  - oxycodone tablets 40 mg/day and
  - tapentadol 200 mg/day

OPIOIDS – THE EVIDENCE

Busse et al, 2018

- Opioids do not provide clinically important improvement in pain or function for most patients compared with placebo.
- Opioids were associated with less pain relief during longer trials which may be a result of opioid tolerance or opioid-induced hyperalgesia.

Krebs et al, 2018

- Treatment with opioids was not superior to treatment with non-opioid medications for improving pain-related function over 12 months.
- Results do not support initiation of opioid therapy for moderate to severe chronic back pain or hip or knee osteoarthritis pain.

OPIOID-RELATED HARMS

80% of patients on long-term opioids will develop at least one opioid-induced adverse effect

Hormonal effects

- Opioids affect the release of hormones from the anterior pituitary (eg, growth hormone, prolactin, TSH).
- These are well recognised and include reduced adrenal function, reduced sexual function and infertility.
- Occur in about 50% of those taking long-term high-dose opioids.

Depression

- This is a common comorbidity of chronic pain.
- Some patients may experience depression as a reversible harm associated with opioid treatment.

OPIOID-RELATED HARMS

Overdose and death

- Opioid overdose risk increases in a dose-response manner.
- Risk factors include co-prescribing sedative medications and concomitant psychiatric symptoms (anxiety, depression).
- In 2018, more than half (58%) of drug-induced unintentional overdoses were related to opioids.
- Epidemiological studies suggest fewer fatalities with ‘atypical’ opioids.

Respiratory effects

- Include respiratory depression and sleep disordered breathing.
- Effects appear related to dose and duration of use.

Falls and fractures

- Opioids use increases risk of falls through its CNS effects and hormonal effects.

OPIOID-RELATED HARMS

- **Gastrointestinal effects**
  - Include constipation, nausea and vomiting.
  - Opioid use increases the risk of bowel obstruction, and can result in hospitalisation or death.

- **Motor vehicle collisions**
  - Use of opioids by drivers is increasingly seen as a factor in fatal motor vehicle crashes.

- **Tolerance, physical dependence and withdrawal**
  - For some patients, the primary benefit of opioids becomes the avoidance of withdrawal.

HYPERALGESIA AND TOLERANCE

- **Opioid-induced hyperalgesia** (OIH): increased sensitivity to pain mediated by opioid use.
- **Tolerance**: a decrease in opioid analgesic effect over time, often mixed with OIH.
- Other factors affecting pain
  - Disease change and advancing disease.
  - Psychosocial factors (eg, anxiety, OUD, diversion).

Reassessment is recommended when a patient presents stating they need more opioid.

OPIOID USE DISORDER

- A problematic pattern of opioid use leading to clinically significant impairment or distress (DSM-5).
- Estimates of prescription opioid misuse and abuse range from <1% to 40%.
- Moderate to severe OUD, rotation to opioid agonist treatment (OAT) may be more appropriate.
- Opioid agonist treatment may be a better long-term option
  - Methadone and buprenorphine are both effective in prescription opioid dependence.
  - Buprenorphine less restrictive and has a good safety profile (eg, depot buprenorphine).

EXAMPLE BEHAVIOURS THAT MAY INDICATE MISUSE

Take a thorough patient history (including use of other medicines) and where appropriate, implement opioid agonist treatment.

- Concurrent misuse of alcohol and/or illicit substances.
- Requesting specific opioid medicines.
- Resisting change in therapy despite side effects or harms.
- Reporting lost prescription or requesting early repeats.
- Unsanctioned dose escalation.
- Unapproved use of medicine to treat other symptoms.
- Requesting opioids from other providers.
- Selling opioid prescriptions.

OPIOIDS REGULATORY CHANGES

TGA reforms

- Updated indication:
  - MR opioids are NOT indicated to treat chronic non-cancer pain (other than in exceptional circumstances).
  - Potent opioids (hydromorphone, fentanyl) should NOT be used in opioid-naïve patients.
- Smaller pack sizes of IR opioids (10–12 tablets/capsules).

PBS changes

- New and amended criteria for prescribing IR and MR opioids.
- Changes to restriction level to PBS listings.
- 12-monthly review PBS requirement when requiring increased quantities and/or repeats (if opioid treatment exceeds 12 months).

REVIEW PAIN MANAGEMENT PLAN

- Encourage the patient to set specific meaningful and realistic goals that emphasise active self-management.
- Optimise use of other management strategies, such as:
  - cognitive behavioural therapy (CBT) techniques
  - acceptance and mindfulness-based interventions
  - physical therapies.
- Consider leveraging networks when planning to taper opioids (eg, coordinating medication management reviews with a local pharmacist).
- Encourage patients to try online pain management programs/pain support groups.

WHEN TO CONSIDER TAPERING

- Patients who are not benefiting from opioid treatment:
  - the cause of pain has resolved, function has not improved, harms outweigh benefits.
- Patients at risk of opioid use disorder (OUD).
- Patients at risk of overdose:
  - using > 60 mg OMEDD (or > 30 mg OMEDD for certain populations , eg, older patients)
  - concomitant use with other CNS depressants (eg, alcohol, benzodiazepines, pregabalin).
- Patients with serious unstable mental or physical health concerns - require specialist input.

TAPERING – THE EVIDENCE

Fishbain et al (2018)

- Tapering opioids for patients with chronic pain does not lead to increased pain, but can lead to decreased (or the same) pain once tapering is completed.

Frank et al (2017)

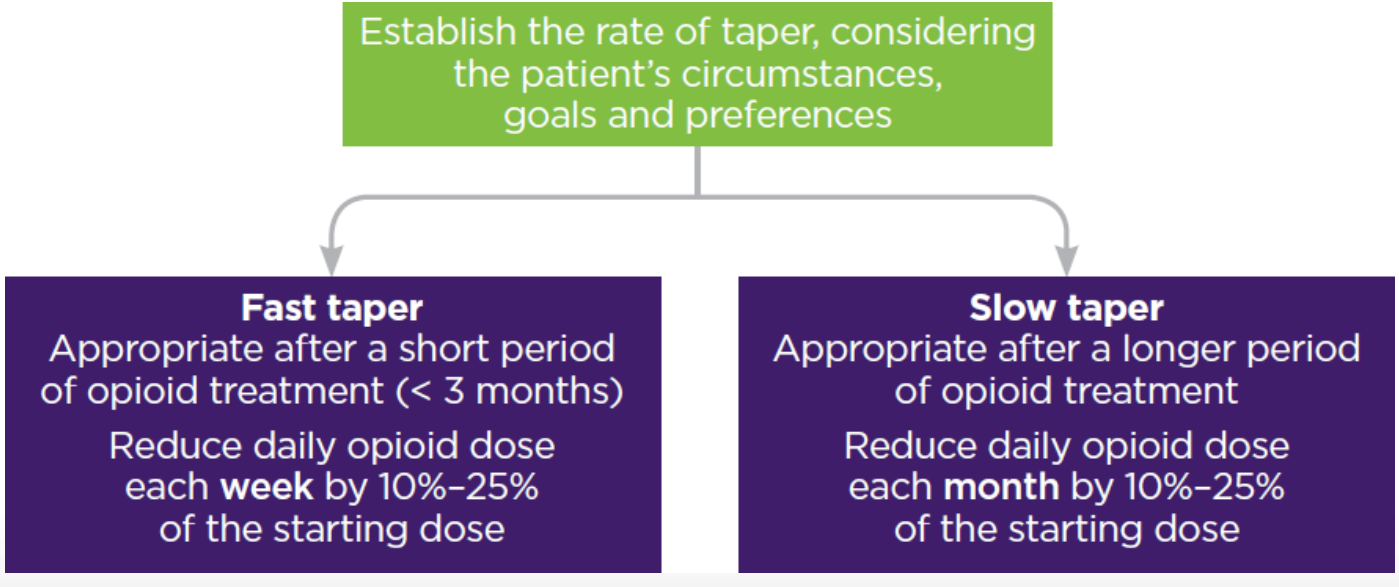
- Tapering opioids can improve pain, functioning and quality of life.
- Strategies for effective tapering of long-term opioids including:
  - tapering opioids with input from patients
  - an emphasis on non-pharmacological and self-management strategies
  - multidisciplinary care through interdisciplinary pain programs

TAPERING – WHERE TO START?

- Familiarise yourself with the tapering process, withdrawal symptoms and strategies to increase chance of success.
- Explore patient expectations and help them understand the benefits and challenges of tapering.
  - Use non-judgmental open-ended questions to start the conversation about tapering.
  - Allow for an honest and frank discussion.
  - Reassure the patient that the taper can be paused and resumed if needed.
- Perform a thorough patient-centred assessment incorporating tools such as the ‘5As’ framework of chronic pain management.

DEVELOP A TAPERING PLAN

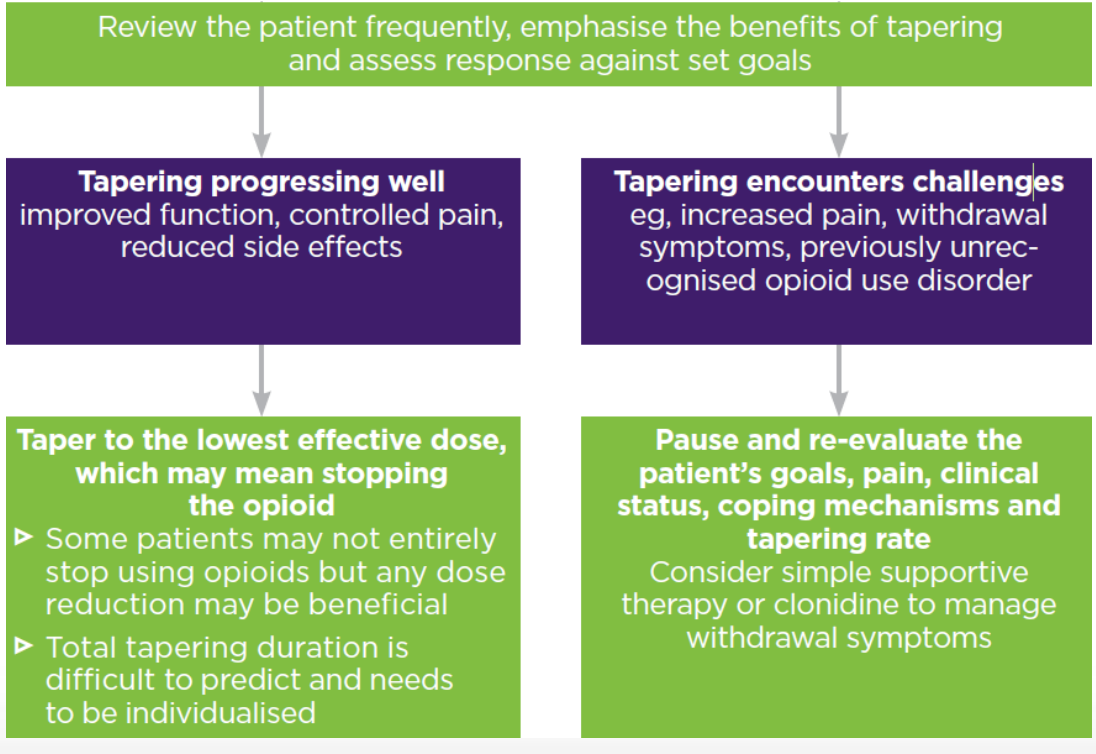
The rate of taper should be individualised for each patient as part of an **agreed plan between the doctor and the patient.**



PRACTICAL TIPS WHEN TAPERING

- Ultimate aim of tapering is to stop opioid treatment for most patients.
  - However, complete cessation of opioids may not be feasible or appropriate for all patients.
  - An alternative approach to tapering in these patients is to reduce to the lowest effective dose where the benefits of treatment outweigh the risk of harm.
- If more than one opioid is used, consider rationalising to a single MR opioid formulation (the starting equianalgesic dose should be reduced by 25%–50%).
- Where the opioid formulation does not allow tapering within the recommended rate, consider rotating to another opioid (noting above reduction in starting equianalgesic dose).
- Ask for help if unsure (eg, local pain clinic, experienced colleagues, Drugs and Alcohol Specialist Advisory Service).

TAPERING TAKES TIME AND PATIENCE



ENSURE PATIENT IS PREPARED

- Advise patients of the likelihood of a temporary increase in pain or an increased sensitivity to pain, reassuring them that these symptoms should improve over 1–2 weeks.
- Inform patients about withdrawal symptoms and what to expect.
  - Withdrawal symptoms and their severity vary among patients.
  - For patients on long-term opioid therapy who have developed opioid dependence, extended withdrawal symptoms can last for weeks or months.
- Ensure patient has a documented plan for managing withdrawal symptoms, including medicines to take at home and when to seek help.
- Schedule regular appointments for follow-up and review.

USE MOTIVATIONAL INTERVIEWING TO EMPOWER AND REASSURE THE PATIENT

Ask	Ask the patient about their treatment goals and their perception of the advantages and disadvantages of opioid treatment.
Listen	Listen to the patient's beliefs and concerns about, and motivations for, tapering.
Inform	Inform the patient of the benefits and challenges of tapering.
Ensure	Ensure the patient is aware that tapering may take several months.
Reassure	Reassure the patient that they are not alone in the tapering process; discuss how you will monitor and support them

EXPECT WITHDRAWAL SYMPTOMS

- More likely with rapid large decreases in dose.
- Short-term withdrawal can lead to transitory increases in pain and hyperalgesia.
- Other symptoms include: sweating, runny nose, nausea, diarrhoea, abdominal cramps, piloerection, dilated pupils, agitation, tachycardia, anxiety, insomnia, opioid cravings.
- α_2 adrenergic agonists (eg, clonidine) may be useful for difficult withdrawal symptoms (eg, muscle pain, myoclonus) as they reduce sympathetic activity.
  - There is anecdotal evidence for their use when tapering long-term opioids.
  - Dosage is 0.1 – 0.2 mg every 6 hours and/or simple supportive therapy until the opioid taper is complete.
  - Adverse effects include dry mouth, bradycardia, rebound hypertension (when ceased abruptly).

MEET LIZ

- Female aged 40 years
- History of endometriosis, PCOS, past intimate partner violence, father alcohol dependent, anxiety and depression, bullying as a teenager.
- Started on oxycodone in hospital 10 years ago, successfully ceased after 5 years.
- Restarted after a relationship breakup and a mental health admission, prescribed up to 150mg oxycodone per day since then.

MEET LIZ (CONTINUED)

- Co-prescribed quetiapine 300mg daily, diazepam 15mg, venlafaxine 225mg, metformin 1000mg and smokes cannabis to help with insomnia
- Multiple investigations, physiotherapy and some session with a psychologist.
- Tapered to oxycodone 90mg daily –

'I really want to get off them…'

FACTORS INDICATING COMPLEX NEEDS

- **Mental health conditions.** It is recommended that active mental health issues are stabilised before considering opioids.
- **Past, current or suspected substance use disorder (SUD).**
- **Previous non-fatal overdose.**
- **Concomitant use of sedatives medicines** (eg, benzodiazepines, antihistamines, antidepressants, antipsychotics).
- **Renal or hepatic insufficiency and age > 65 years**.
- Use of **> 60 mg OMEDD** and/or for **longer than 90 days.**
- **Failing to respond** to multidisciplinary management in primary care.

SUPPORT PATIENTS WITH COMPLEX NEEDS

- Schedule frequent reviews and at each appointment:
  - ask about and emphasise the benefits of tapering
  - assess risk of harm.
- Facilitate psychosocial support for the patient.
- Check for co-prescription of benzodiazepines and other sedatives.
- Consider rationalising to a single opioid if applicable.
- Consider staged supply and/or naloxone.
- Consider specialist input if the patient is experiencing serious challenges or if the main problem is opioid dependence rather than pain.

MINIMISE HARM FOR BOTH STAFF AND PATIENTS

Systems of care

- Check state and territory requirements before prescribing opioids.
- Set up reminders for regular medication review.
- Ensure that the same GP oversees all opioid prescribing for a patient whenever possible.
- Plan for clinical handover to ensure continuity of care when GPs go on leave.
- Provide clear guidance on when to refer patients to pain management, mental health, drug and alcohol, and addiction specialists.

Patient safety

- Limit the quantity and dose when prescribing opioids to necessitate regular, timely patient review.
- Consider requesting staged supply of opioids from the pharmacist.
- Provide education on managing overdose and distribute naloxone for those at high risk.
- Refer patients at high risk of SUD and/or overdose to an addiction specialist.
- Refer patients to pain management specialists where appropriate.

Staff safety

- Ensure staff are aware of practice policies and clinic workflows for opioids.
- Develop policies for managing:
  - patients demanding opioids or seeking prescriptions from other prescribers.
  - new patients requesting opioids
  - inherited patients on long-term opioids initiated by other prescribers.

RACGP

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

NPS MEDICINEWISE

IF IN DOUBT, SEEK SUPPORT

- Be aware of key predictors of opioid tapering dropout.
- Seek multidisciplinary advice or support for patients who are having difficulty with tapering.
  - Support could include pain specialists, drug and alcohol services, mental health teams and physiotherapists.
  - Where these services are not readily available, consider contacting interstate specialist services for advice.
  - Most Primary Health Networks (PHNs) have information about specialist services in local and regional areas.

RESOURCES FOR YOU

- NPS MedicineWise program – Opioids and chronic pain (includes tools and resources such as the conversation starter, tapering algorithm and tapering plan)
- TGA – Prescription opioids hub
- Faculty of Pain Medicine ANZCA – Opioids calculator
- Victoria Health – Opioid Risk Tool
- RACGP – Prescribing drugs of dependence in general practice
- ACI Pain Management Network – Assessment tools and Quick steps through opioid management
- Victoria Health – Opioid Risk Tool
- Painaustralia – list of pain services and programs

RESOURCES FOR YOU

- Health Education in Practice – Prescribers or Multidisciplinarians? An Evaluation of Brief Education for GPs on Chronic Pain Management
- HealthPathways – localised information about drug and alcohol, addiction and pain management services
- Australian Prevention Partnership Centre – list of chronic pain initiatives
- Australian Pain Society – National directory of pain treatment facilities
- National Drug and Alcohol Research Centre (NDARC) – List of state-based drug information services
- Faculty of Pain Medicine – Better pain prescribing modules

RACGP

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

NPS MEDICINEWISE

RESOURCES FOR YOUR PATIENTS

- NPS MedicineWise – resources on opioids and chronic pain
- TGA – information for consumers
- Painaustralia – resources for patients
- Local community and online support networks such as the Pain Management Network, PainLink helpline or Chronic Pain Australia forum
- ACI NSW Pain Management Network – pain management information
- PainHealth – Pacing and goal setting
- ACI NSW – Brainman Pain Management Resources

RESOURCES FOR YOUR PATIENTS

NPS MedicineWise –

- Opioid prescribing changes – improving safety, reducing harm
- Opioid medicines and chronic non-cancer pain
- Opioids information video
- Managing pain and opioid medicines
- Chronic pain explained
- Pain: what is going on?
- Medicines for pain relief: what are the options?
- Nerve pain explained

- ACI NSW Pain management network, Pain management: For everyone, Pain and thoughts
- Hunter New England Local Health District, Understanding pain in less than 5 minutes, and what to do about it!