WEBINAR

Thursday, 17 September 2020
7.00 – 8.00 pm AEST

SUPPORTING PATIENTS LIVING WITH CHRONIC NON-CANCER PAIN

The role of the pharmacist

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SUPPORTING PATIENTS LIVING WITH CHRONIC PAIN

The interdisciplinary discussion will focus on these actions:

- Discuss with patients the limited role of opioids in improving pain and function for chronic non-cancer pain
- Identify practical steps to help implement the recent opioid regulatory changes in practice
- Discuss with patients non-opioid management strategies and clarify their role in chronic non-cancer pain
- Identify patients at increased risk of harms from opioids and recommend strategies for minimising these harms

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A CASE:
JOHN HAS CHRONIC NON-CANCER PAIN

- John is a 55-year-old man who is a regular at your pharmacy
- History of non-specific low back pain as a result of an injury 3 years ago
- Has been prescribed opioids for 3 years for his pain condition
- Presents with a repeat prescription for oxycodone 80 mg MR tablets
- John is enquiring about the recent regulatory changes to opioids and what this means for him

REGULATORY CHANGES

TGA reforms:

- Smaller pack sizes of IR opioids (10-12 tablets/capsules)
- Updated safety information on PI and CMI documents
- Updated indication:
  - IR opioids are indicated when other analgesics are not suitable or have proven to be ineffective.
  - MR opioids are not indicated to treat chronic non-cancer pain (other than in exceptional circumstances)

PBS changes:

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

IMPLEMENTING CHANGES IN PRACTICE

- Reassure patients that the changes are not designed to take their medicines away from them, but to increase patient safety and reduce opioid-related harms
- Advise patients of the new 12-monthly review requirement, where appropriate, and reassure them that this is an opportunity to reassess opioid treatment and to explore other management options that are available
- Use resources to facilitate the discussion with patients, where appropriate
- The PSA has introduced a new cautionary label “Use of this medicine has the risks of overdose and dependence” as well an accompanying patient leaflet

WHY?

Every day...

3 deaths

150 hospitalisations

14 emergency department presentations

Pharmaceutical opioids are responsible for more deaths than heroin.

Australian Institute of Health and Welfare. Opioid harm in Australia and comparisons between Australia and Canada. Canberra: AIHW, 2018.

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BENEFITS AND HARMS OF OPIOIDS

A 2018 meta-analysis of 96 RCTs involving 26,169 patients with chronic non-cancer pain found **no clinically important improvements in pain and function** for patients taking opioids compared with placebo.

The only long-term RCT (n=240) comparing opioid to non-opioid therapy found **treatment with opioids was not superior to non-opioid therapy for improving pain and function** over 12 months.

Constipation
Death
Depression
Falls and fractures
Hormonal effects
Hyperalgesia
Motor vehicle collisions
Opioid use disorder
Respiratory depression and sleep-disordered breathing
Tolerance, physical dependence and withdrawal

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FACTORS CONTRIBUTING TO PAIN

- Biomedical factors, including pathology and pathophysiology
- The person's medical history, including injury, trauma and other medical conditions, contributes to the chronic pain experience
- Psychological characteristics, including anxiety, depression, fear and catastrophising, impact on a person's experience of chronic pain
- Social context factors, such as loss of work, loss of income, family roles and relationships, and cultural or religious issues, can have an impact on chronic pain
- Cognitive factors, such as interpretation of pain and coping style, contribute to the overall experience of chronic pain

NON-PHARMACOLOGICAL OPTIONS

Non-opioid management should be optimised first before trialling opioids

Active physical therapies and techniques	▸ activity pacing ▸ hydrotherapy ▸ exercise-based physiotherapy ▸ occupational therapy
Psychological therapies	▸ acceptance commitment therapy (ACT) ▸ attentional techniques (distraction from the pain) ▸ cognitive behavioural therapy (CBT) ▸ mindfulness-based stress reduction (MBSR) ▸ relaxation training
Other treatment options	▸ acupuncture ▸ attending a group pain management program

NON-PHARMACOLOGICAL OPTIONS

Cognitive behavioural therapy (CBT)

- Helps patients to modify their emotional and behavioural response to pain
- Uses “thought challenging” and behavioural reinforcement principles
- Evidence for small positive effects on disability associated with chronic pain
- Effective in altering mood and catastrophising outcomes

Acceptance and mindfulness-based interventions

- Focuses on psychological flexibility as the ultimate treatment goal
- Setting goals that are important and valuable, instead of focusing on pain control

Activity pacing

- Coping strategy that involves activity behaviour that is goal-contingent rather than pain-contingent

NON-OPIOID TREATMENT

Simple analgesia (paracetamol, NSAIDs)

- Paracetamol: analgesic and antipyretic actions within the CNS
- NSAIDs: Anti-inflammatory and antipyretic properties (some antiplatelet effects)
  - Consider safety issues with NSAID use in certain patient groups

Tricyclic antidepressants (amitriptyline and nortriptyline)

- Recommended for neuropathic pain
- Start low and go slow
- Consider nortriptyline as a less sedating alternative

Gabapentinoids

- Adjuvant analgesia for neuropathic pain
- Adverse effects include drowsiness and peripheral oedema
- Reports suggesting an abuse potential, including euphoria and ‘feeling drunk’
- Inform patients about the potential for pregabalin and gabapentin to lead to misuse or dependence

serotonin-noradrenaline reuptake inhibitors (duloxetine and venlafaxine)

- Recommended for neuropathic pain
- Start low and go slow

Optimise non-opioid management for patients with chronic non-cancer pain before trialling opioids

- Adopt a patient-centred, multidisciplinary, multimodal approach to pain management which includes non-pharmacological and pharmacological treatment options.
- Emphasise that the primary aim of chronic pain management includes functional improvement, not just pain reduction.

Assess the benefits and harms of opioids before considering a trial if patients have not responded to other treatment

- Opioid-induced adverse effects will develop in about 80% of patients on long-term opioids.
- The risk of harm from opioids is increased for patients with complex comorbidities, and when co-prescribed with benzodiazepines and other sedatives. Avoid prescribing opioids for these patients.

OPIOID TRIAL – SETTING EXPECTATIONS

Duration	▸ An acceptable trial period is up to 8 weeks ▸ Success or failure of opioid therapy can usually be determined within 2–4 weeks
Formulation and dose	▸ Start with a low dose ▸ Any beneficial response to a trial should be evident at oral morphine equivalent daily dose ≤ 60 mg
Treatment outcomes	▸ Agree on the goals of opioid treatment with the patient and how these will be monitored ▸ Goals should extend beyond pain relief and include goals for physical and cognitive functioning
Exit strategy	▸ It's important to agree on circumstances in which opioid treatment will be stopped
Follow up	▸ Review the patient every 1–2 weeks to monitor progress and assess if ongoing opioid treatment is needed

TIPS FOR ENGAGING PATIENTS

- Use language that builds relationship and reduces stigma (eg, “We are doing this together”)
- Avoid creating unnecessary fear around opioids
- Use open-ended questions to best understand patient's views on opioids and pain
- Use reflective statements to explore patient ambivalence
- Avoid the urge to correct misinformation or provide advice before patients are ready to receive it
- See NPS MedicineWise Conversation starter resource for useful verbatims as well as tips for starting conversations with patients

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JOHN RETURNS TO THE PHARMACY

- John comes back to the pharmacy 2 months later and asks to speak to you
- He explains that he saw a second medical practitioner as part of the 12-month review
- His doctor explained that they'll need to 'cut down' his oxycodone
- He is anxious that his 'pain medicine' will be taken away from him and doesn't understand why

What support can the pharmacist provide as John's opioid dose is tapered?

ENGAGE THE PATIENT

- Ask for permission to provide more information and explore patient concerns and beliefs about pain and benefits of opioid treatment
- Present a balanced view of tapering
- Discuss the benefits of tapering as the patient may be confused or not aware of latest evidence (reinforcing what the doctor may have already discussed with the patient)
  - Tapering has been shown to improve function without worsening pain
  - Benefits of opioids reduce over time, while risk of harms increases
  - Pain management alternatives have fewer side effects
- Provide resources for the patient to read in their own time and ask them to come back for a full discussion

RISK FACTORS – WHEN TO CONSIDER TAPERING

- Patients who are not benefiting from opioid treatment
  - Function has not improved after a reasonable trial period
  - Harms outweigh benefits
- Patients at risk of opioid use disorder
  - Doctor shopping
  - Refilling prescriptions early
  - Repeated claims of misplaced or lost opioids
- 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)

TAPERING PROCESS

- The rate of taper should be individualised for each patient as part of an agreed plan between the doctor and the patient
  - slow taper (10%–25% of the starting dose per month) if patient has been taking opioids for long periods of time
  - fast rate of taper (10%–25% of the starting dose per week) if patient has been taking opioids for a short period of time, or in response to opioid misuse or intolerable adverse effects.
- Optimise use of other non-opioid management options prior to starting the taper
- The aim is to reduce the dose to the lowest effective dose – for some patients this may mean stopping opioid treatment completely
- Reinforce to the patient that the tapering process and rate can be individualised based on their circumstances and that tapering can be paused if they experience challenges, and resumed later

HOW TO INCREASE CHANCE OF SUCCESS?

- Using an informed consent process and agreeing on a tapering plan including the rate of taper, the duration of opioid use and consideration of comorbidities
- Helping the patient feel supported, not abandoned, as they consider the opioid taper
- Implementing multimodal pain management strategies and engaging with other health care professionals as appropriate before tapering
- Ensuring the patient has appropriate team care support, including involving friends, family, carers and pain support groups
- Motivating the patient to continue the taper schedule – tapering may take months to years for some patients

WHEN TAPERING IS NOT APPROPRIATE

- If the patient is not ready to taper – poor outcomes from forced taper reported
- Moderate to severe OUD, rotation to opioid agonist treatment (OAT) may be more appropriate
  - Taper may increase risk due to loss of tolerance
  - Should be supported by addiction medicine services
- 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
  - Delivered as a supervised treatment

REDUCING HARMS FROM LONG-TERM OPIOID USE

- Emphasise that opioids are just a tool (to regain a more functional life) not an end in themselves
- Highlight the importance of safe use, storage and disposal of opioids
- Ask about the use of over-the-counter, complementary or prescription medicines, or substances such as alcohol which may interact with opioids
- Reinforce the role of non-pharmacological treatment options
- Optimise the use of non-opioid medicine options
- Discuss the need for a pain management plan with the patient
- Use real time prescription monitoring systems where available

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REDUCING OPIOID HARMS

Community pharmacists

- Recommend and supply OTC nasal naloxone
- Recommend staged supply where appropriate
- Perform a Chronic Pain MedsCheck (where available)
- Consider a Home Medicines Review for the patient
- Document clinical interventions that improve the quality use of opioids
- Check your local Primary Health Network for any alcohol and other drug (AOD) facilities that can treat patients

Hospital pharmacists

- Limit supply of opioids at discharge to clinical need by using the new half pack sizes
- Adopt an opioid stewardship program in the hospital
- Add information about the opioid to the discharge summary (including indication, intended duration and a recommendation for the GP to assess at the next consultation)

RESOURCES

Patients

NPS MedicineWise – Resources on opioids and chronic pain
https://www.nps.org.au/professionals/opioids-chronic-pain#resources

TGA – Information for consumers
https://www.tga.gov.au/prescription-opioids-information-consumers-patients-and-carers

ACI NSW – Pain Management Network on pain medications for chronic pain
https://www.aci.health.nsw.gov.au/chronic-pain/for-everyone/pain-and-role-of-medications

Health professionals

NPS MedicineWise program – Opioids and chronic pain https://www.nps.org.au/professionals/opioids-chronic-pain

TGA – Opioids prescription hub
https://www.tga.gov.au/hubs/prescription-opioids

Monash University – Maximising opioid safety
https://www.monash.edu/medicine/ehcs/marc/research/opioid-safety

PainWISE – Professional Service Program to continue on being mentored for pain management through more education and mentoring support - www.painwise.com.au

PSA/SHPA – Talking pain modules
https://www.psa.org.au/talking-pain/

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