Lifelong Learning

CPD ARTICLE NUMBER FOUR

Opioid Prescribing in General Practice: A Trial Run Approach

GPs can facilitate opioid prescribing in their practices by following five principles of opioid prescribing, using five tools for assessment of use and using five criteria for evaluating outcomes of an opioid trial run.

The predicament of the patient with chronic non-cancer pain also impacts the primary care physician, requiring that both grapple with management of this complex problem. Applying the desired bio-psycho-social framework for assessment requires skill and time, the latter being at a premium in general practice. So it is not at all surprising that in practice the management of such patients generally defaults to the use of analgesic drugs, frequently opioids.

As an alternative we present a set of principles that could be applied for the more judicious use of opioids in this context. It describes a practical approach to opioid prescribing for patients with chronic non-cancer pain and reflects consensus views and practices. The framework for this approach comprises five principles, five tools that may assist assessment and five criteria for evaluating the outcome of the ongoing trial run of opioid pharmacotherapy in patients with chronic pain (see box).

Step 1: Comprehensive (bio-psycho-social) assessment

The experience of chronic pain has biological, psychological and social contributions, each of which needs to be assessed.

About the authors

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'Bio-' (what's happening to the body)

Try to identify an underlying treatable condition, if suspected, on the basis of clinical red-flag features (eg. inflammation, infection, neural pathology, neoplasm). However, most chronic pain is not due to a broken part but is more likely to reflect altered function (in particular altered central nociceptive processing). This is especially so for pain experienced in musculoskeletal tissues. Finding the correct diagnostic language to use is difficult here. For example, lumbar spondylosis is a statement of age-related anatomical fact and does not imply either the presence or mechanism of pain.

'Psycho-' (what's happening to the person)

Assess the impact of pain on the patient's sleep and daily activities (work and recreation). Explore the role of fatigue in the patient's condition. Chronic pain is often associated with changes in mood, especially depression and anxiety, and with loss of self-esteem. Much pain-related behaviour stems from patients' beliefs regarding diagnosis and prognosis that are frequently catastrophic and incorrect. Much distress can be alleviated by careful, accurate and realistic explanations, often about what is not wrong.

'Social' (what's happening in the person's world)

Assess not only the effects of pain on relationships – family, friends, work and leisure – but the influence of other life events, ranging from changes within families to environmental disasters.

A useful tool to aid this assessment is the brief pain inventory (see toolbox 1). It allows patients to rate their pain on a scale of 0 to 10, where 0 is no pain and 10 is the worst pain possible.

An important part of this step is to

Key points

- The experience of chronic pain has biological, psychological and social contributions, each of which you need to assess.
- Drug therapy for patients with chronic non-cancer pain is only part of a multi-faceted, if not also multi-disciplinary, treatment approach. If drugs are needed to treat patients with chronic non-cancer pain, ensure you also pay attention to psychological and social stresses.
- Ensure opioid pharmacotherapy for patients with chronic non-cancer pain is always an ongoing trial run of therapy.
- Document any opioid trial run carefully and if it is not working start tapering the dose to zero. If you are not sure what to do, ask for advice from a colleague experienced in chronic pain, a pain specialist, an indication medicine specialist or a psychiatrist.

Toolbox 1. Brief Pain Inventory

Name: _____

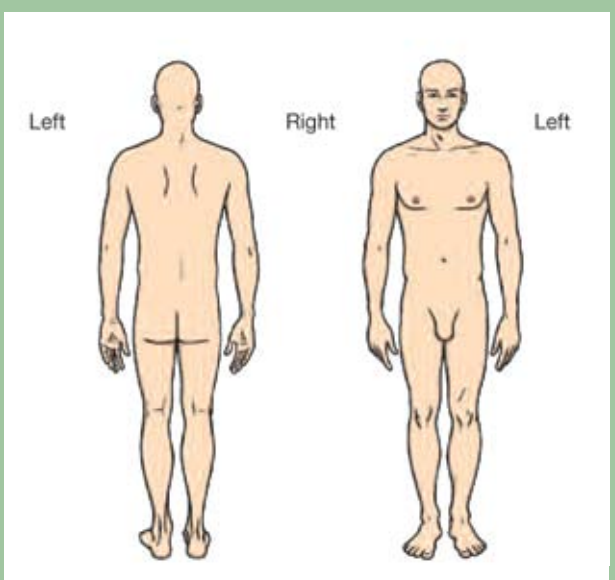
Date: _____

Time: _____

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes **2. No**

2. On the diagram, shade in the area where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on average.

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

_____

_____

_____

_____

8. In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No pain — Complete relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

* Reproduced with permission from Dr Charles S. Cleeland (1991).

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References: 1. Fudala PJ, Bridge TP, Herbert S, *et al.* Office-Based Treatment of Opiate Addiction with a Sublingual-Tablet Formulation of Buprenorphine and Naloxone. *N Engl J Med* 2003; **349**:949-958. **2.** Fareed A, Vayalapalli S, Casarella J, Drexler K. Effect of Buprenorphine Dose on Treatment Outcome. *Journal of Addictive Diseases* 2012; **31**:8-18.

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Framework for a practical approach to opioid prescribing in chronic non-cancer pain

Five principles

- Comprehensive assessment
- Poor response to other therapies
- Agreement regarding an opioid trial run
- Conduct of opioid test
- Responses to difficulty achieving or maintaining goals in an opioid trial run

Five tools

- Brief pain inventory
- Opioid risk tool (or other instrument)
- Sources of advice regarding prescribing
- Opioid treatment contract
- Chart of opioid equianalgesic doses

Five criteria

- Analgesia
- Activity
- Adverse effects
- Affect
- Aberrant behaviour

Problematic or aberrant drug-taking behaviour

- Overwhelming focus on opioid issues, impeding progress with other issues
- Resistance to change in therapy despite evidence of adverse drug effects
- Aggressive complaining about the need for more drugs
- Noncompliance with use instructions, including non-sanctioned dosage escalation
- Pattern of prescription problems (ie. lost, spilled or stolen medications)
- Supplemental opioids (from other providers, emergency departments or illicit sources)
- Stealing or borrowing drugs
- Selling prescription drugs
- Prescription forgery
- Evidence of deterioration in function including family, work and social life
- Concurrent abuse of alcohol or other illicit drugs
- Injecting oral formulations

assess the risk of problematic opioid use, by asking the following questions:

- Is there a personal or family history of past or current alcohol or drug problems?
- Is an active or recent psychiatric disorder present?
- Is there evidence of problematic drug-taking behaviour? (See box). Positive responses here do not necessarily preclude a trial run of opioid therapy but rather act as an alert to guide monitoring of a trial run. A useful tool is the opioid risk tool (see toolbox 2).[1]

Step 2: Adequate trial of other reasonable therapies

Drug therapy – for symptom control – is an adjunct to a comprehensive care plan. Often that plan will need to include the help of other health professionals.

Non-drug treatment options include an accurate explanation, especially realistic prognostication (there is often no cure for chronic pain) and advice regarding nutrition, exercise, sleep hygiene and the pursuit of pleasurable activities. Emphasise the need for daily activity, not rest, and the important role of pacing to limit fatigue. Consider referral of the patient to appropriate healthcare personnel, if available, for more intensive exploration of these options.

As symptom control is important, consider the role of non-opioid analgesic medications, especially paracetamol. So-called adjuvant analgesics include tricyclic antidepressants, such as amitriptyline (used off label), serotonin noradrenaline re-uptake inhibitors, such as duloxetine and venlafaxine (both used off label), and anticonvulsants, such as gabapentin and pregabalin (both indicated for the treatment of neuropathic pain). These analgesics may have a role but may be limited by cognitive side effects, drowsiness or, in some cases, high cost.

In this context, invasive therapies, ranging from injections to implants, may not be considered reasonable, especially when there is no local broken part to be fixed. Opioid use should be considered before invasive options.

Step 3: Agreement regarding opioid trial run

Opioid pharmacotherapy for patients with chronic pain is an ongoing trial run, repeatedly addressing the question, 'Is this patient's predicament opioid-responsive?'

Such a trial run is always a part of a multi-modal treatment plan. Given that opioids are restricted and tightly controlled drugs, a 'treatment contract' between prescriber and patient should be explicit, with ongoing prescription depending on the evidence of worthwhile ongoing benefit and minimal harm.

The agreement extends to:

- identifying realistic activity goals, tailored to the individual patient, that emphasise improved function, not just less discomfort
- one prescriber (and deputy) and a single pharmacy dispensing according to risk assessment and no early repeat prescriptions or loss replacements
- setting review intervals, perhaps weekly for initial trial run and up to quarterly for stable patients

- tapering termination of the opioid trial run if treatment goals (including review appointments) are not met, there are serious adverse outcomes, or there is evidence of misuse, especially unsanctioned use such as self-injection, stockpiling, selling or giving drugs to others
- including an option for random drug monitoring, such as by urine drug screen or pill counts.

Prescribers should be familiar with the regulatory requirements that govern the prescription of opioids to patients in the country in which they practice. All prescribers should note the importance of attention to documentation, regulation and adherence to advice from the relevant authorities.

Step 4: Conduct of an opioid trial run

A trial run of opioid analgesic therapy requires goal-setting, explicit agreements, skilled titration of dose and regular monitoring of the 5A criteria.

The pharmacological principle of an opioid trial run is to use long-acting (long half-life) oral or transdermal opioid preparations, dosing according to age (see table). The starting dose should be low if the patient is opioid naïve, of the order of 10mg/day oral morphine equivalent. If the patient is already taking an immediate-release opioid (eg. codeine, morphine or oxycodone) or tramadol, calculate the daily dose and use the equianalgesic chart (see toolbox 4) to convert it to an approximate daily equivalent of a long-acting oral or transdermal preparation.

Regularly reassess the patient and document details, according to the 5A criteria, which are:

- analgesia
- activity
- adverse effects
- affect
- aberrant behaviour.

Whether initiating or continuing therapy, review weekly initially, then according to achievement of goals. Titration of dose according to the 5A assessment over four to six weeks should allow the fundamental question, 'Is this person's predicament opioid-responsive?', to be answered. A decision can then be made to continue maintenance therapy, subject to ongoing satisfactory assessments of the 5As, test the effects of dose reduction or taper to withdrawal.

The main focus of the opioid trial run should be on improved function – physical, cognitive and social. How active does the patient want to be? Is the patient able to achieve this level of activity? Is that level of activity appropriate under the circumstances? Given the variable course of chronic pain, it may well be that over time opioid requirements fluctuate, not necessarily upward.

Try to tailor the drug regimen to individual patient needs, such as only taking the drug at night to ameliorate sleep, or asymmetrically varying the dose during the day according to required or anticipated activity levels. Limit the dose to a maximum of 100mg/day oral morphine equivalent (see toolbox 4). It is suggested that an apparent opioid requirement approaching this should trigger a comprehensive reassessment of the patient. If tapering of opioid therapy is required, the suggested rate is to reduce the daily dose by 10% each week.

If in doubt about any aspect of the opioid trial run, enlist the opinion of a colleague or a specialist pain or addiction medicine physician. For regulatory purposes, this should be done at least annually in any case.

Toolbox 2: Opioid risk tool*[1]

Risk factor	Male (max score)	Female (max score)
Family history (parents and siblings)		
Alcohol abuse	☐ (3)	☐ (1)
Illegal drug use	☐ (3)	☐ (2)
Prescription drug abuse	☐ (4)	☐ (4)
Personal history		
Alcohol abuse	☐ (3)	☐ (3)
Illegal drug use	☐ (4)	☐ (4)
Prescription drug abuse	☐ (5)	☐ (5)
Mental health		
Diagnosis of ADD, OCD, bipolar disorder, or schizophrenia	☐ (2)	☐ (2)
Diagnosis of depression	☐ (1)	☐ (1)
Other		
Age 16 to 45 years	☐ (1)	☐ (1)
History of preadolescent sexual abuse	☐ (0)	☐ (3)
Total score	_____	_____

Total score risk category:

0 to 3 = Low risk: 6% chance of developing problematic behaviours.

4 to 7 = Moderate risk: 28% chance of developing problematic behaviours.

≥ 8 = High risk: more than 90% chance of developing problematic behaviours.

ADD = attention deficit disorder; OCD = obsessive compulsive disorder.

*Adapted with permission from Webster LR, Webster RM. Predicting aberrant behaviours in opioid-treated patients: preliminary validation of the opioid risk tool. Pain Med 2005; 6: 432-442.

Toolbox 3: A treatment contract for the use of opioids for the management of chronic pain*

Patient name: _____

I, [Add name here], understand that opioid painkillers are being prescribed to me in an attempt to improve my level of functioning and reduce my pain intensity. My medical practitioner and I agree to the following conditions regarding my treatment and the prescribing of opioid medications for my pain. We have discussed that strong opioid (morphine-like) painkillers may be only partially helpful in achieving this goal and on occasion will not help at all. I understand that painkillers are only one part of the management of my chronic pain.

1. My medical practitioner is responsible for prescribing a safe and effective dose of opioids. I will not use opioids other than at the dose prescribed and I will discuss any changes in my dose with my medical practitioner.
2. I am responsible for the security of my opioid medicine. Lost, misplaced or stolen prescriptions or medicine will not be replaced.
3. I will obtain opioid medications only from the medical practitioner who signs this treatment contract, or other doctors in the same practice authorised to prescribe to me. I understand that no early prescriptions will be provided.
4. Whilst most people do not have any serious problems with this type of medicine when used as directed, there can be side effects. My medical practitioner will let me know what these are and I will tell him or her if I experience them.
5. I agree to tell my medical practitioner if I have ever been dependent on alcohol or drugs, or if I have ever been involved in illegal activity related to any drugs including prescription medicines. I am aware that providing my medicine to other people is illegal and could be dangerous to them.
6. My medical practitioner respects my right to participate in decisions about my pain management and will explain the risks, benefits and side effects of any treatment.
7. My medical practitioner and I will work together to improve my level of functioning and reduce my pain.
8. I understand that my medical practitioner may stop prescribing opioids or change the treatment plan if my level of activity has not improved or I do not show a significant reduction in pain intensity, or if I fail to comply with any of the conditions listed above.

Patient signature: _____

Date: _____

Medical practitioner: _____

* Adapted from the Drug and Alcohol Office/Pharmaceutical Services Branch, Western Australia Department of Health.

Step 5: Response to difficulty achieving or maintaining goals in an opioid trial run, including demands for an increase in dose

Difficulty achieving or maintaining the goals of an opioid trial run should trigger comprehensive reassessment of the patient (steps 1 to 4), which may then require referral.

The two main problems that may be encountered in an opioid trial run are:

- a claim that there has been no change in pain despite evidence of increased function
- evidence of unsanctioned use of the drug.

However, the same principles apply, starting with repeat assessment, especially at the 'psycho' and 'social' levels of the framework. In patients with established chronic pain, it is unlikely that there will be a change in the underlying disease state, although alertness to clinical features suggesting such change is important. It is more likely that difficulty in achieving the goals reflects a change in the patient's psychosocial situation or a response to other life stressors.

In this situation, a new treatment contract can be negotiated, perhaps with revised goals and review plans, provided that the fundamental question, 'Is this person's predicament opioid-responsive?', has a positive answer. If there is evidence of increased function, it is probable that the trial run is positive but the patient needs to observe better pacing of activity. If relative under-dosage is suspected, a trial run of increased dose can be considered, again to be evaluated using the 5A criteria. If adverse effects of the opioid are a problem but the trial run is otherwise positive, opioid rotation could be considered (see toolbox 4). However, if there is evidence of unsanctioned opioid use, taper the opioid to withdrawal and refer the patient to a specialist pain or addiction medicine physician.

What about the inherited patient?

The inherited patient, especially one taking more than 100mg/day oral morphine equivalent, is a common situation.

Table: Sustained release or long acting opioid preparations for use in patients with chronic non-cancer pain

Generic name	Seek advice if dose exceeds
Oral opioid agonists	
Hydromorphone	16mg daily
Methadone	30mg daily
Morphine	100mg daily
Oxycodone	60mg daily
Oral opioid like activity	
Tramadol	400mg daily
Transdermal opioids	
Buprenorphine	40µg/hr weekly
Fentanyl	25µg/hr every three days

The same principles apply as for patients undergoing an opioid trial run, namely: perform a bio-psycho-social reassessment (over time)

- establish new treatment contract with set goals
- carry out regular 5A criteria assessment
- refer patient if in doubt.

When conducting an opioid trial run in these patients:

- convert all current opioids that the patient is taking to only one form of non-parenteral opioid (but not transdermal fentanyl because rapid tolerance appears to be a problem and dose titration is difficult) in stages. For example, 80% current opioids and 20% new opioid for a week, then 60% current opioids and 40% new opioid for a similar period, then 40% current opioids and 60% new opioid, etc. to full conversion
- the patient may find that the current preferred opioid has high likeability. In that case, conversion may take several months. Be prepared to slightly increase the dose of the new main opioid.
- seek to establish the lowest dose of the one opioid species that facilitates the patient maintaining activity, reasonable comfort and minimal side effects. Each decrement could be 10% of the current daily dose. It may not matter if the opioid cannot be withdrawn completely provided that the patient is able to be as active as he or she wishes to be
- involve the patient in decision-making about the transition unless it becomes clear that the patient is sabotaging the transition. In that case, the patient should be referred to a specialist.

Toolbox 4: Approximate opioid dose equianalgesic to oral morphine 30mg

Oral		**Parenteral**	
Tramadol	150mg	Tramadol	100mg
Codeine	180mg	Morphine	10mg
Methadone	10mg*	**Transdermal**	
Oxycodone	20mg	Buprenorphine	20µg/hr
Hydromorphone	4mg	Fentanyl about	12µg/hr
Sublingual			
Buprenorphine	0.4mg		

* Morphine:methadone 3:1 for morphine less than 100mg/day only.

Pain management in the opioid dependent (addicted) patient

Many people on opioid-substitution treatment programmes (with methadone or buprenorphine) have concurrent chronic pain. This is likely to be as incurable as in other patients and only partly responsive to opioid treatment.

The request for an increased opioid dose to reduce the severity of pain can be considered on a trial run basis but any change to a drug of the patient's choice should be resisted. If possible try to manage chronic pain in patients on opioid-substitution treatment by increasing the dose of methadone or buprenorphine rather than by introducing another opioid. Otherwise consider referring the patient for specialist advice. An exception might be presentation with an episode of acute nociception, such as bony trauma, in which case a temporary increase in dosage of the current opioid could be considered.

Conclusion

The cornerstones of quality use of opioids in the management of patients with chronic non-cancer pain are:

- comprehensive bio-psycho-social assessment
- ongoing trial runs of opioid responsiveness using long-acting oral or transdermal preparations
- regular 5A re-evaluation
- careful documentation of goals, decisions and advice received.

Reference

1. Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the opioid risk tool. Pain Med 2005; 6: 432-442.