Health
Hunter New England
Local Health District

Opioid recommendations for hospital settings

1. **Evidence** **15 February 2016**

Evidence based indications for opioid therapy:

i. Acute pain
ii. Cancer pain
iii. Palliative or "comfort" care
iv. Opioid dependency/addiction

Evidence does not support efficacy or safety of opioid therapy for chronic non-cancer pain.

2. **Practical strategies**

i. **Multidimensional pain assessment**:
- Screen for red flag conditions (underlying tissue damage) then broaden the approach.
- Consider brief questionnaires (eg. Orebro 10, Brief Pain Inventory or ultra-brief PEG).
- Multidimensional assessment for all types of pain leads to broad based treatment addressing biomedicine, mindbody, connection, activity and nutrition.

ii. **Risk assessment for opioid misuse**:
- A drug and alcohol history and/or Opioid Risk Tool screening quantifies risk of misuse.
- Contact with the Australian Prescription Shopping Information Service (APSIS 1800 631181) is recommended for "at risk" cases. An Australian "Electronic Recording and Reporting of Controlled Drugs" system offering on-line, real time information is awaited.

iii. **Opioid prescribing boundaries**:
- Standard boundaries include no early prescriptions; no replacement of lost prescriptions/medications; single prescriber with deputy; designated pharmacy.
- A written or verbal treatment agreement facilitates discussion of prescribing boundaries.

iv. **Opioid rotation**:
- Opioid rotation can be used to treat adverse effects or tolerance or to dose reduce.
- Rotation involves changing to another opioid typically at 50% of the equivalent dose.
- . Consider seeking advice from a pain, addiction or palliative medicine physician.

v. **Monitoring opioid therapy**:
- Use 4 A's: **A**nalgesia, **A**ctivity, **A**dverse effects and **A**berrant behaviour.
- In the acute setting it is more important to ask about specific function than pain intensity (0-10); for example "are you able to take a deep breath?" or "are you able to walk?"

vi. **Acute pain (<3 months duration)**:
- In most acute settings, opioids if used, should be ceased within 1 week. Injured workers with low back pain using opioids for >1 week have poorer outcomes.
- In complex cases opioids should be weaned and ceased **within 90 days**.
- Titrate opioids to functional and analgesic end points.
- Short acting opioids are preferred. Long acting opioids can be used in selected cases.
- *Start low and go slow* in children, older people and those on other psychoactive medication.
- Consider non-opioid medication, nerve blocks and self-management strategies (eg. distraction, mindfulness and relaxation).
- If a new acute pain problem develops in a person on long term opioids, tolerance may necessitate the use of higher opioid doses to achieve analgesia.

vii. **Cancer pain and palliative care**:
- Analgesic effect needs to be carefully balanced with adverse effects.
- For a person with recently diagnosed or progressive cancer short and/or long acting agents can be titrated to functional and analgesic end points.
- Consider opioid deprescribing for a person who has successfully completed cancer treatment.
- Careful consideration is needed before classifying an older person or person with a chronic condition as palliative and commencing opioid treatment.

viii. **Opioid dependency/addiction**:
- Opioid therapy may be used with attention to the balance of benefit versus harm.
- Contact APSIS and seek advice from Addiction Medicine services.

- The systematic use of prescribing boundaries is particularly important in this context.
- Additional boundary measures to consider in this setting include random urinary drug testing, pill counts and observed dosing.

ix. **Chronic non-cancer pain (≥3 months duration)**:
- Opioid therapy should not be initiated based on current scientific evidence.
- For people already on opioid therapy the standard treatment is deprescribing (weaning) over an appropriate time frame.

3. **Additional considerations for primary care**
   i. **Recommended dose limits**: In primary care recommended dose limits are **100mg** (oral morphine equivalent daily dose) for non-cancer pain and **300mg** for cancer pain.
   ii. **Opioid deprescribing**:
   - To deprescribe long term opioids the standard approach is to reduce by 10-25% of the starting daily dose each month. This achieves cessation in 3-9 months and allows time to develop active self-management strategies.
   - Consider offering a choice between faster or slower opioid reduction.
   - Deprescribing is undertaken more quickly in the setting of acute pain or opioid misuse.
   - Contact between general practitioner (GP) and a specialist pain medicine physician may help to support deprescribing. Pain service nursing staff can provide patient support.
   - If it emerges during opioid reduction that dependency/addiction is the primary problem then opioid maintenance via an Addiction Medicine service can be considered.

4. **Additional considerations for the emergency department (ED) and inpatient wards**
   i. **Flags for exacerbations of chronic pain**: see Division of Emergency Medicine Guideline.
   ii. **Cancer pain or palliative care**
   - Talk to regular prescriber if considering change to an established opioid regimen.
   iii. **Opioid substitution therapy for dependency**
   - Communicate with opioid prescriber and/or Drug and Alcohol team.
   - Do not give additional opioids unless there is a new red flag condition.
   iv. **Chronic non-cancer pain**:
   - Differentiate between a flare up of chronic pain and increased pain associated with a new red flag condition (acute pain component).
   - Do not initiate or increase opioids for flare ups of chronic pain.
   - Additional opioids can be used if there is a new red flag condition.
   - Do not prescribe opioids to replace lost or stolen prescriptions/medications or if the person has overused supply and run out.
   - Discuss the possibility of deprescribing with any person on long term opioid therapy for chronic non-cancer pain presenting to the hospital system. Advise referral to a pain service.
   - For frequent presenters an individualised pain treatment plan may be helpful.
   v. **Discharge from ED or inpatient wards if opioid therapy has been used**:
   - Communicate with GP about the opioid plan and deprescribing.
   - Discuss opioid risks including driving impairment and the need for secure storage at home.
   - Limit amount of opioid medication given to take home (maximum 3 day supply).

5. **Consultation**: Discuss any proposed variation from the above recommendations with a pain, addiction or palliative medicine physician.

6. **Resources**
   i. NSW Therapeutic Advisory Group: Preventing and managing problems with opioid prescribing for chronic non-cancer pain http://www.ciap.health.nsw.gov.au/nswtag/reviews/guidelines.html
   ii. National Prescribing Service Medicinewise: Chronic Pain http://www.nps.org.au/publications/health-professional/nps-news/2015/chronic-pain
   iii. Faculty of Pain Medicine: Recommendations regarding the use of opioid analgesics in patients with chronic non-cancer pain – 2015 http://www.fpm.anzca.edu.au/resources/professional-documents and opioid dose equivalence http://www.fpm.anzca.edu.au/resources/professional-documents/OPIOID%20DOSE%20EQUIVALENCE.pdf
   iv. Hunter Integrated Pain Service: Reconsidering opioid therapy 2014 http://www.hnehealth.nsw.gov.au/Pain/Pages/Health-professional-resources.aspx