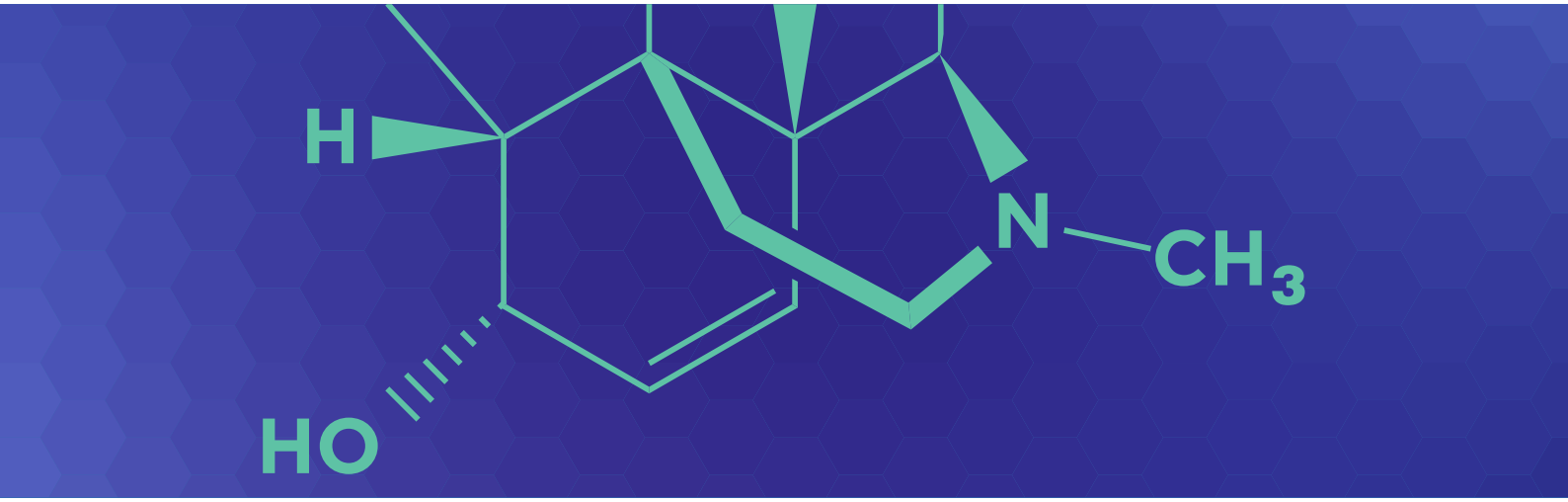
RACGP

Royal Australian College *of* General Practitioners

Prescribing drugs of dependence in general practice, Part C

Key recommendations and practice points for management of pain with opioid therapy



Acute pain

Acute pain is an unpleasant sensory and emotional experience usually related to surgery, an injury or a disease. It is associated with actual or potential tissue damage to non-neural tissue and is experienced due to activation of nociceptors (nociceptive pain).

Key points

- Most acute pain conditions presenting in general practice can be treated with non-opioid analgesia.
- GPs should prioritise non-opioid therapies for initial pain management.
- GPs should be familiar with common acute pain presentations where opioids are not recommended.
- Opioid medications should only be used for the treatment of acute pain when non-opioid pain medications and therapies have failed or are likely to fail to provide adequate pain relief.
- When opioid medications are prescribed for treatment of acute pain, they are often prescribed in addition to paracetamol and non-steroidal anti-inflammatory drugs (NSAIDs).

Evidence statements

- The efficacy of opioid therapy in acute pain is supported by strong evidence from randomised controlled trials (RCTs).
- Long-term opioid use often begins with mistreatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

Strong recommendation, very low quality of evidence

- Less than three days of opioid analgesia will often be sufficient for acute pain; more than seven days will rarely be needed.

Strong recommendation, very low quality of evidence

Key point

- Patients with an acute pain in the context of existing chronic pain should be assessed with caution and usually by, or in conjunction with, their usual doctor or healthcare team.

Managing acute pain presentations

- Paracetamol by itself is no longer first-line treatment for most mild to moderate acute pain because of lack of clinical effect and possible superiority of NSAIDs.
- Ibuprofen and naproxen are appropriate first-line NSAIDs for mild to moderate acute pain (based on effectiveness, adverse effect profile, cost and over-the-counter [OTC] availability).
- Non-selective NSAIDs given in addition to paracetamol improve analgesia compared with either medicine given alone, in particular ibuprofen combined with paracetamol.
- Paracetamol or NSAIDs combined with codeine (at a dose above 60 mg) provide clinically important pain relief in the immediate term.
- Cyclooxygenase-2 (COX-2) selective NSAIDs are second-line medications for mild to moderate pain based on their similar effectiveness to non-selective NSAIDs.

Acute pain conditions where opioid medications are **not** recommended:

- Uncomplicated back and neck pain
- Uncomplicated musculoskeletal pain (eg shoulder pain)
- Uncomplicated headache or migraine
- Renal colic
- Non-traumatic dental pain
- Self-limited illness (eg sore throat)
- Trigeminal neuralgia
- Primary dysmenorrhea
- Irritable bowel syndrome
- Any functional or mental disorder of which pain is a leading manifestation
- Acute exacerbation of chronic non-cancer pain (CNCP)

Chronic pain

Chronic pain has been historically defined as continuous or recurrent pain that persists for an extended period. However, the biological mechanisms for chronic pain are quite different from those of acute pain. CNCP is a collection of clinical conditions with involvement of single or multiple pathophysiological mechanisms leading to persistent pain. It is also an individual, multifactorial experience influenced by culture, previous pain events, beliefs, expectations, mood and resilience.

Assessment of patients with chronic non-cancer pain

Key point

- Management of CNCP should be based on a comprehensive biopsychosocial assessment, a diagnosis, and thoughtful consideration of the likely risks and benefits of any intervention or medication.

Non-drug therapies for chronic pain

Key point

- The basis for good chronic pain management is a strong continuous therapeutic relationship.

Evidence statement

- Non-drug therapy and non-opioid pharmacologic therapy are preferred for chronic pain.

Strong recommendation, low quality of evidence

Patient selection/exclusion process before an opioid trial

Key point

- Long-term opioid therapy is dependent on an appropriate patient selection process, considered care planning, and an 'opioid trial' to determine responsiveness to opioid treatment.

Evidence statements

- GPs should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.

Strong recommendation, low quality of evidence

- Before starting opioid therapy, GPs should evaluate risk factors for opioid-related harms.

Strong recommendation, very low quality of evidence

- GPs should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose.

Strong recommendation, very low quality of evidence

Care planning for an opioid trial

Key point

- A treatment plan is discussed including a plan to discontinue opioids if there is no objective functional improvement.

Evidence statements

- Before starting opioid therapy, GPs should discuss with patients known risks and realistic benefits of opioid therapy, and patient and clinician responsibilities for managing therapy.

Strong recommendation, very low quality of evidence

- Before starting opioid therapy for chronic pain, GPs should establish treatment goals with all patients, including realistic goals for pain and function, and consider how opioid therapy will be discontinued if benefits do not outweigh risks.

Strong recommendation, very low quality of evidence

- When prescribing opioids for chronic pain, GPs should consider using a urine drug test (UDT) before starting opioid therapy to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Strong recommendation, low quality of evidence

- GPs should incorporate into the management plan strategies to mitigate risk, including consideration of offering naloxone, when factors that increase risk for opioid overdose (such as history of overdose, history of substance use disorder, higher opioid dosages [50 mg oral morphine equivalent (OME)] or concurrent benzodiazepine use) are present.

Strong recommendation, very low quality of evidence

Undertaking an opioid trial

Key point

- An opioid trial is undertaken to discover the individual's responsiveness to opioid therapy in terms of decreased pain, increased function and improved quality of life.

Evidence statements

- If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

Strong recommendation, low quality of evidence

- GPs should use caution when prescribing opioids at any dosage. Carefully reassess evidence of individual benefits and risks when increasing dosage to 50 mg OME or more per day. Avoid increasing dosage to 100 mg or more OME per day, or carefully justify a decision to titrate dosage to 100 mg or more OME per day.

Strong recommendation, low quality of evidence

Ongoing therapy, assessment and monitoring

Key points

- Long-term opioid therapy requires ongoing structured monitoring and review of benefits and harms.
- GPs should taper and discontinue opioids in the absence of functional improvement, when planned care fails, or aberrant behaviours become apparent.
- Lack of improvement, intolerable side effects and abnormal behaviour are signs of opioid trial failure and indicate the need to taper and/or discontinue opioids.
- GPs should use caution in patients presenting with acute exacerbations of chronic pain.

Evidence statements

- GPs should evaluate benefits and harms with patients within 1–4 weeks of starting opioid therapy for chronic pain or of dose escalation.

Strong recommendation, very low quality of evidence

- GPs should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

Strong recommendation, very low quality of evidence

- Periodically during opioid therapy, GPs should discuss with patients known risks and realistic benefits of opioid therapy, and patient and clinician responsibilities for managing therapy.

Strong recommendation, very low quality of evidence

- GPs should evaluate benefits and harms of continued therapy with patients at least every three months.

Strong recommendation, very low quality of evidence

- GPs should consider a UDT at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Strong recommendation, low quality of evidence

- If benefits do not outweigh harms of continued opioid therapy, GPs should optimise non-opioid therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Strong recommendation, very low quality of evidence

Discontinuing opioids in general practice

Key points

- GPs should follow an 'exit strategy' for dealing with failure to achieve agreed outcomes of opioid treatment.
- GPs should be familiar with opioid reduction and withdrawal processes.
- Long-term treatment with opioids in CNCP may represent de facto maintenance treatment for iatrogenic opioid dependence.
- GPs can effectively wean their patients from opioids if there is no benefit, or if risks outweigh benefits.

Evidence statements

- For patients with CNCP who are currently using >100 mg OME of opioids per day or more, we suggest tapering opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy.

Weak recommendation, very low quality evidence

- Where there is evidence of substance use disorder (SUD) doctors should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioural therapies) for patients with opioid use disorder. Referral to clinics experienced in substance use disorder is advised.

Strong recommendation, low quality of evidence

Note: This information is extracted from *Prescribing drugs of dependence in general practice, Part C1: Opioids* and *Part C2: The role of opioids in pain management*. It should not be read in isolation but as part of the broader publication. For more information go to www.racgp.org.au/opioids

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