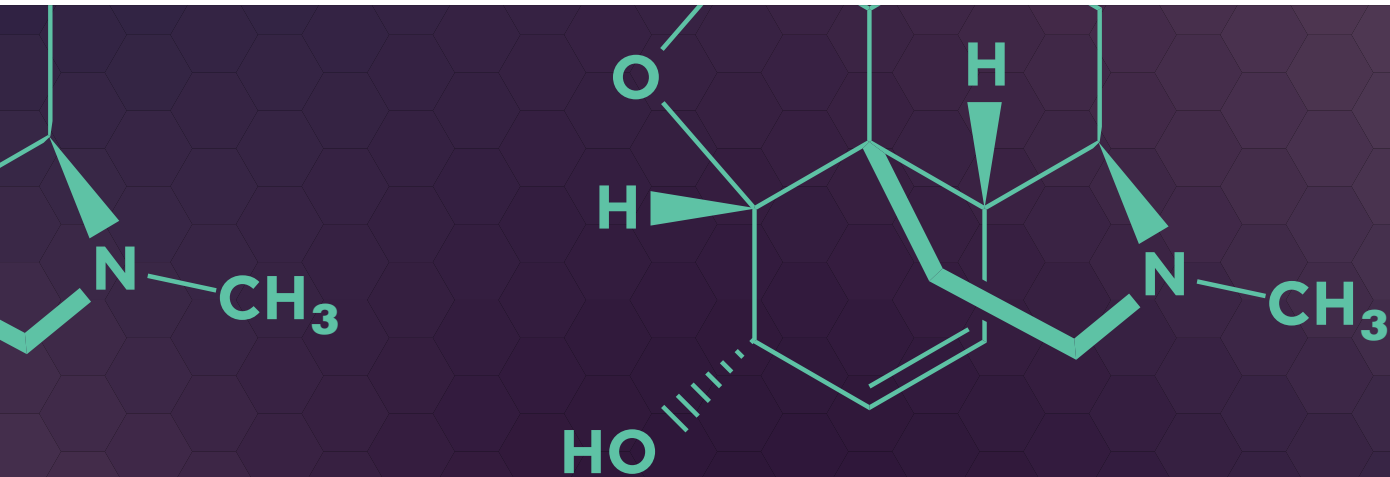


Prescribing drugs of dependence in general practice – Part C

Summary



The RACGP series *Prescribing drugs of dependence in general practice* recognises that drugs of dependence have important therapeutic uses, but that prescription of these medicines must always be clinically appropriate and supported by national and state law.

During the development of *Prescribing drugs of dependence in general practice, Part C* it became apparent that pain management needed its own focus. Hence, we have *Part C1: Opioids* and *Part C2: The role of opioids in pain management*. These two together provide evidence and strategies to support accountable prescribing of opioids in general practice.

Key principles

- As with any treatment, prescription of opioids should be based on a comprehensive biopsychosocial-based assessment; a diagnosis; thoughtful consideration of the likely benefits and risks of any medication, as well as of non-drug alternatives interventions; and a management plan derived through shared decision making and continual clinical monitoring.
- General practitioners (GPs) should be aware of the common concerns associated with opioids, such as potential dependence, withdrawal, problematic drug use (including diversion and misuse) and known harmful effects, including falls, potential cognitive effects and motor vehicle accidents. These risks should be discussed with patients.
- Opioid treatment seeks to maximise outcomes for health and social functioning of the patient while minimising risks. To minimise risks, opioids should be prescribed at the lowest effective dose for the shortest clinical timeframe.
- Avoid prescribing opioids to patients with comorbid alcohol or substance use disorders or polydrug use. GPs should consider seeking specialist opinion in the management of these patients. Patients who use two or more psychoactive drugs in combination (particularly benzodiazepines and opioids) and those with a history of substance misuse may be more vulnerable to major harms.
- Opioids are generally regarded by clinical practice guidelines as a short-term therapeutic option. Long-term use should be uncommon, made with caution and based on consideration of the likely risks and benefits of opioids.

- If alternatives to opioid treatment fail, have limited benefit or are inappropriate, supervised opioid treatment may remain an acceptable long-term therapeutic option.
- Long-term opioid prescriptions should be at the lowest effective dose, and regular attempts at reduction should be scheduled. Continued professional monitoring of health outcomes is required.
- Opioids should be prescribed from one practice and preferably one GP and dispensed from one pharmacy.
- GPs may wish to use the diagnosis of substance use disorder rather than dependence, addiction or abuse; this is based on the sedative, hypnotic or anxiolytic use disorder criteria in the *Diagnostic and statistical manual of mental disorders* (5th edition) (DSM-5). This is a more neutral term that may reduce stigmatisation of patients with problematic use of opioids, benzodiazepines and other drugs or alcohol.
- GPs should have communication strategies and safety processes in place to manage inappropriate requests for opioids by patients.
- All patients, including those who use opioids and other drugs or alcohol problematically, have the right to best practice care that is respectful and promotes their dignity, privacy and safety.

Opioid use for acute pain in general practice

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).

Acute pain includes inflammatory pain; that is, pain that occurs in response to tissue injury and the subsequent inflammatory response. Typically, inflammatory pain disappears after resolution of the initial tissue injury. However, in some chronic disorders (eg rheumatoid arthritis) the pain may persist for as long as inflammation is active.

Effective management of acute pain requires:

- tailoring treatment to the individual patient
- awareness of the science behind contextual and placebo effects
- competence with multimodal analgesia (ie the concurrent use of different classes of analgesics)
- providing patient reassurance
- providing education, including expected duration of pain episode and warning signs that would require immediate medical attention.

For accountable prescribing in managing acute pain, GPs should:

- undertake a complete biopsychosocial assessment of the patient with pain
- be familiar with the evidence for selected acute pain presentations in general practice where opioids are not routinely recommended
- prescribe opioid medications only for the treatment of acute nociceptive pain when non-opioid pain medications and therapies have failed or are likely to fail
- undertake a patient selection/exclusion process before commencing opioids.

If opioids are commenced for the pain of acute nociception, there is a need to give clear direction about the anticipated duration of therapy. Typically, opioids should be weaned and ceased as the acute injury heals. Usually three days or less of opioid therapy will be sufficient for non-traumatic pain not related to major surgery. Even in complex post-operative cases, the duration of opioid therapy should be within 90 days.

GPs need to be familiar of the complexities of care in patients on long-term opioids who present with an acute exacerbation or new acute pain.

Opioid use in chronic non-cancer pain in general practice

Chronic pain has historically been defined as continuous or recurrent pain that persists for an extended period (generally more than three months). However, the biological mechanisms for chronic pain are quite different from those of acute nociception, and should not be considered as 'unhealed' acute pain. Chronic non-cancer 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.

Due to methodological weaknesses of chronic pain studies, interpretation and translation of evidence into practice is difficult. There is limited evidence to determine long-term benefits (outside of end-of-life care), however there is evidence of risk of harm that increases with dose. While guidelines suggest opioids in the management of some chronic pain conditions, they are not recommended for routine or first line use.

For accountable prescribing in managing CNCP, GPs should:

- undertake a complete biopsychosocial assessment of the patient with pain
- optimise non-drug therapies, and optimise non-opioid therapies as the primary interventions of care.

Opioids for CNCP should be reserved for selected patients with moderate or severe pain that has not responded to other therapies and that significantly affects function or quality of life. If primary interventions fail or are suboptimal, opioid therapies may be considered. GPs should share the decision-making process with the patient, and if opioid therapy is considered, there should be:

- a patient selection/exclusion process before a therapeutic opioid trial
- formal care planning based on specific goals and risks
- an opioid trial, which is undertaken to determine a patient's response to opioid therapy. This trial includes the selection of an appropriate opioid, formal measures of analgesia and functionality, a trial of dose reduction, and a drug cessation plan if the trial fails
- an ongoing assessment and evaluation by the accountable prescriber if the trial shows opioid benefit
- opioid tapering and cessation if suboptimal results or aberrant behaviour occurs.

Long-term use should be uncommon, made with caution and based on consideration of the likely risks and benefits of opioids. Intermittent use is preferable.

GPs should also be aware of chronic pain conditions where there are known clinical complexities involving opioids. These complex clinical areas include the exacerbation of pain or new acute pain in patients on long-term opioids, managing opioids after a non-fatal overdose, and managing the inherited patient.

Some patients on long-term treatment with opioids in CNCP may represent de facto maintenance treatment for iatrogenic opioid dependence. GPs should aim to taper patients taking >100 mg oral morphine equivalent (OME) per day.

Note: This document is extracted from *Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management*. It is produced here in summary only. It should not be read in isolation but as part of the broader publication.

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