Is There a Role for Opioids in Non-Cancer Pain?

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Paid Consultant - Boston Sci, Nevro, Abbotts, Mundi Pharma.

Is There a Role for Opioids in Non-Cancer Pain?

- Yes – But limited in Duration of use (3- 6 months)
- What should I be considering / Assessing?
- What Do I use, Where do I start?
- What do I say?
- What else can I do or be offered?
- What are the Goals / Expected Outcomes of Therapy?

Yes – But!

- Initial benefits of Opioid use after 3 months diminish, functional gains diminish.
- Risk of Addiction and Overdose is up to 26%
- Daily Doses > 80-90mg OME Impart Multiple Risks (OIH, Death, Endocrinopathy, ADI)
- Concurrent Mental Health conditions may deteriorate further (Depression / Anxiety etc)
- Short acting agents carry greater risks


The NEW ENGLAND JOURNAL of MEDICINE

Perspective

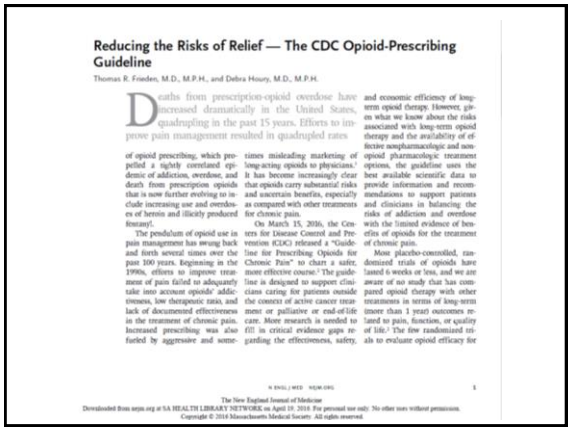
Reducing the Risks of Relief — The CDC Opioid-Prescribing Guideline

Thomas R. Frieden, M.D., M.P.H., and Debra Houry, M.D., M.P.H.

Deaths from prescription-opioid overdose have increased dramatically in the United States, quadrupling in the past 15 years. Efforts to improve pain management resulted in quadrupled rates of opioid prescribing, which propelled a tightly correlated epidemic of addiction, overdose, and death from prescription opioids that is now further evolving to include increasing use and overdoses of heroin and illicitly produced fentanyl. The pendulum of opioid use in pain management has swung back and forth several times over the past 100 years. Beginning in the 1990s, efforts to improve treatment of pain failed to adequately take into account opioids' addictiveness, low therapeutic ratio, and lack of documented effectiveness in the treatment of chronic pain. Increased prescribing was also fueled by aggressive and sometimes misleading marketing of long-acting opioids to physicians.[1] It has become increasingly clear that opioids carry substantial risks and uncertain benefits, especially as compared with other treatments for chronic pain.

On March 15, 2016, the Centers for Disease Control and Prevention (CDC) released a "Guideline for Prescribing Opioids for Chronic Pain" to chart a safer, more effective course.[2] The guideline is designed to support clinicians caring for patients outside the context of active cancer treatment or palliative or end-of-life care. More research is needed to fill in critical evidence gaps regarding the effectiveness, safety, and economic efficiency of long-term opioid therapy. However, given what we know about the risks associated with long-term opioid therapy and the availability of effective nonpharmacologic and nonopioid pharmacologic treatment options, the guideline uses the best available scientific data to provide information and recommendations to support patients and clinicians in balancing the risks of addiction and overdose with the limited evidence of benefits of opioids for the treatment of chronic pain.

Most placebo-controlled, randomized trials of opioids have lasted 6 weeks or less, and we are aware of no study that has compared opioid therapy with other treatments in terms of long-term (more than 1 year) outcomes related to pain, function, or quality of life.[3] The few randomized trials to evaluate opioid efficacy for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longer than 6 weeks had consistently poor results. In fact, several studies have showed that use of opioids for chronic pain may actually worsen pain and functioning, possibly by potentiating pain perception. A 3-year prospective observational study of more than 60,000 postmenopausal women with recurrent pain conditions showed that patients who had received opioid therapy were less likely to have improvement in pain (odds ratio, 0.42; 95% confidence interval [CI], 0.36 to 0.49) and had worsened function (odds ratio, 1.25; 95% CI, 1.04 to 1.51).[3] An observational case–control study of patients undergoing orthopedic surgery showed that those receiving long-term opioid therapy had significantly higher levels of preoperative hyperalgesia.[4] After surgery, patients who had received long-term opioid therapy reported higher pain intensity (a rating of 7.6 vs. 5.5 out of 10) in the recovery room than patients who had not been taking opioids.

Whereas the benefits of opioids for chronic pain remain uncertain, the risks of addiction and overdose are clear. Although partial agonists such as buprenorphine may carry a lower risk of dependence, prescription opioids that are full mu-opioid-receptor agonists — nearly all the products on the market — cancer-related pain.[2] Risk-stratification tools do not allow clinicians to predict accurately whether a patient will become addicted to opioids, although persons with a history of mental illness or addiction are at higher risk.[5] Overdose risk increases in a dose–response manner, at least doubling at 50 to 99 morphine milligram equivalents (MME) per day and increasing by a factor of up to 9 at 100 or more MME per day, as compared with doses of less than 20 MME per day.[2] Overall, 1 of every 550 patients started on opioid therapy died of opioid-related causes a median of 2.6 years after the first opioid prescription; the proportion was as high as 1 in 32 among patients receiving doses of 200 MME or higher.[6] We know of no other medication routinely used for a nonfatal condition that kills patients so frequently.

The new CDC guideline emphasizes both patient care and safety. We developed the guideline using a rigorous process that included a systematic review of the scientific evidence and input from hundreds of leading experts and practitioners, other federal agencies, more than 150 professional and advocacy organizations, a wide range of key patient and provider groups, a federal advisory committee, peer

are likely to outweigh the substantial risks inherent in this class of medication.

Nonpharmacologic therapies can ameliorate chronic pain while posing substantially less risk to patients. In some instances, other therapies result in better outcomes than opioids. These therapies include exercise therapy, weight loss, psychological therapies such as cognitive behavioral therapy, interventions to improve sleep, and certain procedures. The evidence review conducted in developing the guideline revealed that exercise therapy helped improve, and sustain improvements in, pain and function in patients with osteoarthritis. It did not find evidence that opioids were more effective for pain reduction than nonopioid treatments such as nonsteroidal anti-inflammatory drugs for low back pain or antidepressants for neuropathic pain, but it did find that nonopioid treatments could be better tolerated and superior for improving physical function while conferring little or no risk of addiction and substantially lower risks of overdose and death.[2]

Second, when opioids are used, the lowest possible effective dose should be prescribed to reduce the risks of opioid use disorder and overdose. Clinicians should

opioids and should monitor all patients closely. Prescribers should mitigate risk by, for example, avoiding concurrent use of benzodiazepines if possible, reviewing data from a prescription-drug monitoring program when deciding whether to start or continue opioid therapy, offering naloxone at least to patients who are at greater risk for overdose, having a clear "off-ramp" plan to taper and discontinue therapy, reevaluating the dosage and necessity of opioid treatment regularly, and obtaining urine toxicology screening at the initiation of treatment and, for some patients, periodically thereafter. For patients who become addicted to opioids, treatment with methadone, buprenorphine, or naltrexone improves outcomes.

Initiation of treatment with opioids is a momentous decision and should be undertaken only with full understanding by both the physician and the patient of the substantial risks involved. Clinicians need to recognize the risk associated with any treatment with opioids and should prescribe only the shortest course needed. Although the guideline addresses chronic pain, many patients become addicted to opioids after being treated for acute pain. Three days of treatment or less will often be sufficient; more than 7 days will rarely be required. Some trauma and surgery may require

The CDC Opioid-Prescribing Guideline.

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and provider responsibilities for managing therapy.
4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME) per day, and should avoid increasing dosage to ≥90 MME per day or carefully justify a decision to titrate dosage to ≥90 MME per day.
6. Long-term opioid use often begins with treatment 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. Three days or less will often be sufficient; more than 7 days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1–4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use are present.
9. Clinicians 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. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

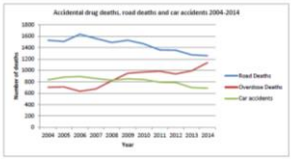
PENNINGTON INSTITUTE

Australia's Annual Overdose Report 2016

A Pennington Institute report

August 2016

1. Accidental deaths due to drug overdose in comparison to the road toll 2004 – 2014

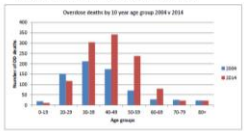


	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Road Deaths	1,530	1,508	1,635	1,561	1,491	1,529	1,460	1,360	1,355	1,274	1,259
Overdose Deaths	705	711	635	676	810	951	971	986	938	965	1,137
Car accidents	855	881	894	858	829	853	840	795	780	690	689

Key statistics:

- Deaths due to accidental overdose reached 1,137 in 2014, an increase from 705 deaths in 2004 – this is a 61 per cent increase in the past 10 years.
- Deaths due to road accidents have steadily declined over the ten years from 1,530 in 2004 to 1,259 in 2014 – a decrease of 18 per cent.
- Overdose deaths outnumbered car accidents for the first time in 2009 – and since that time, the gap has continued to grow.

2. Accidental deaths due to drug overdose by age 2004 - 2014



	2004	2014	% change
0-19	19	11	-42%
20-29	132	117	-11%
30-39	212	304	43%
40-49	174	342	96%
50-59	71	158	255%
60-69	18	80	345%
70-79	16	22	41%
80+	13	22	4%
All ages	705	1136	61%

Key statistics:

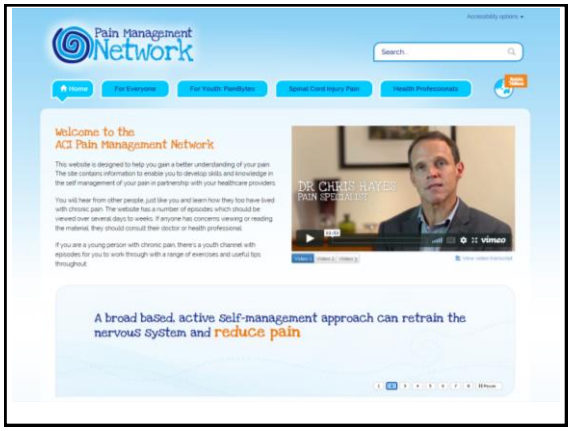
- Australians aged 40-49 are the most likely to die of a drug overdose. Second are 30-39 year olds. Third are 50-59 year olds.
- In 2014, people in their 30s, 40s and 50s accounted for 70 per cent of all overdose deaths.
- The number of people dying from overdose in their 30s and 40s in Australia has more than tripled in the past 10 years. It was less than 100, in 2014 it was 318.
- If the current trend for drug overdoses continues, in five years the age group most likely to die of overdose will become 50-59.
- Accidental deaths from drug overdose decreased 19 per cent from 2004 to 2014 for people under 30.

Australia's Annual Overdose Report 2016 – a Pennington Institute report

3

Opioids for Non-Cancer Pain? OK – What can I do?

- Screen Patient Appropriately / Counsel about reasonable outcomes (functional / Analgesic)
- Slow Release Opioid (reduce and remove RR)
- Duration of therapy Approximately 3 months
- Continued use based on Improvements in Functioning – reviewed regularly
- Doses start low and go slow (max 50mg OME)
- No concurrent Benzodiazepines, confirm Drug Toxicology screen completed Prior to therapy
- Clear Plan / mechanism for medication cessation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Spinal Cord Injury Pain
Health Professionals
Welcome to the ACI Pain Management Network
This website is designed to help you gain a better understanding of your pain. The site contains information to enable you to develop skills and knowledge in the self management of your pain in partnership with your healthcare providers.
You will hear from other people, just like you and learn how they too have lived with chronic pain. The website has a number of episodes which should be viewed over several days to weeks. If anyone has concerns viewing or reading the material, they should consult their doctor or health professional.
If you are a young person with chronic pain, there's a youth channel with episodes for you to work through with a range of exercises and useful tips throughout.
DR CHRIS HAYES
PAIN SPECIALIST
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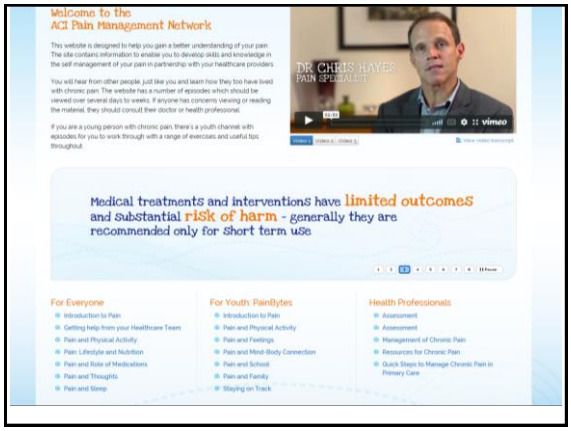
A broad based, active Self-management approach can retrain the nervous System and reduce pain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Medical treatments and interventions have limited outcomes and substantial risk of harm - generally they are recommended only for short term use
For Everyone
Introduction to Pain
Getting help from your Healthcare Team
Pain and Physical Activity
Pain: Lifestyle and Nutrition
Pain and Role of Medications
Pain and Thoughts
Pain and Sleep
For Youth: PainBytes
Introduction to Pain
Pain and Physical Activity
Pain and Feelings
Pain and Mind-Body Connection
Pain and School
Pain and Family
Staying on Track
Health Professionals
Assessment
Assessment
Management of Chronic Pain
Resources for Chronic Pain
Quick Steps to Manage Chronic Pain in Primary Care


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EPISODE 7 Pain and Sleep
QUICK TIP 1
CHRONIC PAIN
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Health Plan
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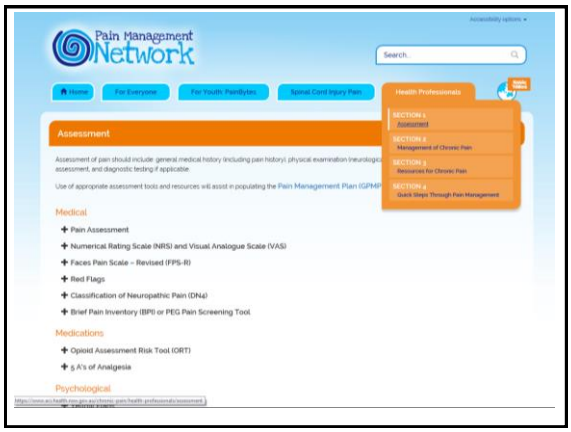
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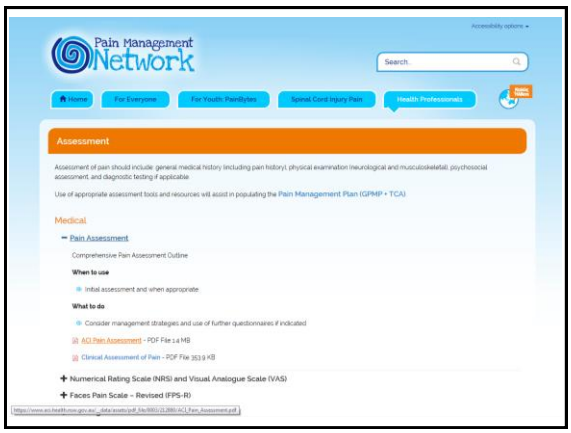
SECTION 1 Assessment
SECTION 2 Management of Chronic Pain
SECTION 3 Resources for Chronic Pain
SECTION 4 Quick Steps Through Pain Management
Assessment
Assessment of pain should include: general medical history (including pain history); physical examination (neurological and musculoskeletal); psychosocial assessment, and diagnostic testing if applicable.
Use of appropriate assessment tools and resources will assist in populating the Pain Management Plan (GPMP + TCA)
Medical
Pain Assessment
Numerical Rating Scale (NRS) and Visual Analogue Scale (VAS)
Faces Pain Scale – Revised (FPS-R)
Red Flags
Classification of Neuropathic Pain (DN4)
Brief Pain Inventory (BPI) or PEG Pain Screening Tool
Medications
Opioid Assessment Risk Tool (ORT)
5 A's of Analgesia
Psychological


Psychological
Yellow Flags
Kessler 10 (K10)
Depression and Anxiety Scale (DASS 21)
Pain Catastrophizing Scale (PCS)
Orebro short form (OMSPQ-10) and Örebro musculoskeletal pain questionnaire (ÖMPQ)
Pain Self Efficacy Questionaire (PSEQ)
Physical/Lifestyle
Pain Diary
Numerical Rating Scale (NRS) and Visual Analogue Scale (VAS)
Faces Pain Scale – Revised (FPS-R)
Brief Pain Inventory (BPI)
Pain Self Efficacy Questionaire (PSEQ)
Orebro short form (OMSPQ-10) and Örebro musculoskeletal pain questionnaire (ÖMPQ)
Obstructive Sleep Apnoea (OSA) Guidelines and Screening Tool
Alcohol Calculator
Specialised Populations Resources
Elderly Pain Assessment Tools and Resources
Paediatric Assessment Tools and Resources
Culturally and Linguistically Diverse (CALD) Assessment Tools and Resources
We'd love your feedback!
Here are some quick questions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Medical
Pain Assessment
Comprehensive Pain Assessment Outline
When to use
Initial assessment and when appropriate
What to do
Consider management strategies and use of further questionnaires if indicated
ACI Pain Assessment - PDF File 1.4 MB
Clinical Assessment of Pain - PDF File 353.9 KB
Numerical Rating Scale (NRS) and Visual Analogue Scale (VAS)
Faces Pain Scale – Revised (FPS-R)

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ACI

CHRONIC DISEASE MANAGEMENT- CHRONIC PAIN COMBINED

PREPARATION OF A GP MANAGEMENT PLAN (GPMP) (MBS ITEM NO. 721) & COORDINATION OF TEAM CARE ARRANGEMENTS (TCA) (MBS ITEM NO. 723)

Date these services were provided:	
Patient's name and address:	
Date of Birth:	
Contact Details:	
Medicare No.	
Private health insurance details, if applicable:	

Existing care plan: notes and outcomes

Other notes or comments relevant to the patient's care planning:

Medications:

Allergies:

Assessment of pain should include: general medical history (including pain history), physical examination (neurological and musculoskeletal), psychosocial assessment, and diagnostic testing if applicable.

Use of appropriate assessment tools and resources will assist in populating the Pain Management Plan (GPMP + TCA)

Medical

- Pain Assessment
- Numerical Rating Scale (NRS) and Visual Analogue Scale (VAS)
- Faces Pain Scale – Revised (FPS-R)
- Red Flags
- Classification of Neuropathic Pain (DN4)
- Brief Pain Inventory (BPI) or PEG Pain Screening Tool

Medications

- Opioid Assessment Risk Tool (ORT)

Indicates risk for aberrant behaviour

When to use

- When considering commencing a person on opioids
- Opioid misuse concerns

What to do

- Scores > 3 indicate a moderate risk for aberrant behaviour
- Develop a Pain Management Plan and refer where appropriate

Opioid Risk Assessment Tool - PDF File 490.0 KB

- 5 A's of Analgesia

Psychological

Mark each box that applies:	Female (Score)	Male (Score)
1. Family history of substance abuse		
• Alcohol	1	3
• Illegal drugs	2	3
• Prescription drugs	4	4
2. Personal history of substance abuse		
• Alcohol	3	3
• Illegal drugs	4	4
• Prescription drugs	5	5
3. Age (mark box if between 16-45 years)	1	1
4. History of preadolescent sexual abuse	3	0
5. Psychological disease		
• Attention deficit disorder, obsessive compulsive disorder, bipolar, schizophrenia	2	2
• Depression	1	1
Scoring Totals	0	0
	Low Risk	Low Risk

ACI PDF Template_2.jpg

ORT Scoring and risk of aberrant behaviour

0-3:	low risk	estimated 6% risk of aberrant behaviour
4-7:	moderate	estimated 28% risk of aberrant behaviour
>8 :	high risk	estimated 91% risk of aberrant behaviour

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5 A's – Opioid therapy monitoring tool

Once initiating opioid therapy, it should be monitored regularly by assessing what has been called the "5As" of Analgesia therapy. This monitoring tool, will assist you in adapting the treatment and management plan of your patient by evaluating whether the patient has a reduction in pain **(Analgesia)**, has demonstrated an improvement in level of function **(Activity)**, is experiencing significant **Adverse effects**, whether there is evidence of **Aberrant** substance-related behaviours, and mood of the individual **(Affect)**.1

1. Activity

What progress has been made in the patient's functional goals?

- Sitting tolerance
- Standing tolerance
- Walking ability
- Ability to perform activities of daily living

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2. Analgesia

How does the patient rate the following over the last 24 hours?

Eg) on a scale from 0 to 10, where 0 = no pain, 10 = worst pain imaginable

- Average pain ?
- Worst pain ?
- How much relief have pain medications provided? e.g. 10%, 20%, 30% or more?

---

2. Analgesia

How does the patient rate the following over the last 24 hours?

Eg) on a scale from 0 to 10, where 0 = no pain, 10 = worst pain imaginable

- Average pain ?
- Worst pain ?
- How much relief have pain medications provided? e.g. 10%, 20%, 30% or more?

3. Adverse effects

Has the patient experienced any adverse effects from medication?

Eg) constipation, nausea, dizziness, drowsiness

4. Aberrant behaviours

Has the patient been taking medication/s as prescribed?

Has the patient exhibited any signs of problematic behaviours or medication abuse/misuse?

- Signs of drug and alcohol use
- Unsanctioned dose escalations
- Has the patient reported lost prescriptions or requested early repeats?

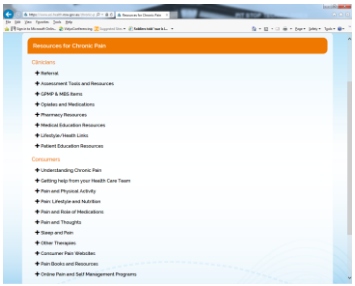
ACI PDF Template_2.jpg

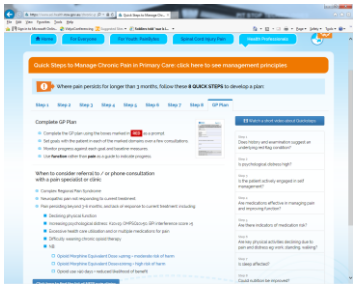
5. Affect

Have there been any changes to the way the patient has been feeling?

- Is pain impacting on the patient's mood?
- Is the patient depressed or anxious?

Reference: 1. Executive Committee of the Federation of State Medical Boards of the United States, Inc. Model policy on the use of opioid analgesics in the treatment of chronic pain. July 2013. (Sourced 25/2/14) www.fsmb.org/pdf/pain_policy_july2013





Opioids May have a complementary Role in Multi Modal Treatment of Non-Cancer Pain

- Explain the Pro / Cons of use
- Set Clear Goals – Expectations Prior to use
- Identify all treatment options / expectations
- Complete full assessments prior to engaging in Prescription (Identify Patient Risks)
- Allow Patients to be part of this process – the use of Nationally recognised On Line services / Tools can be very persuasive / powerful in engaging patients – to achieve a satisfactory outcome.

Thank You

Any Questions?

- www.aci.health.nsw.gov.au/chronic-pain
- https://painhealth.csse.uwa.edu.au
- www.painaustralia.org.au
- www.sahealth.sa.gov.au – Chronic Pain
- https://www.tga.gov.au/tips-talking-about-codeine-guidance-health-professionals-prescribing-authority