Pathway for using strong opioids in patients with chronic pain

1. Assess suitability for strong opioid use

- Assess pain
  - Is the pain likely to respond to an opioid e.g. noxious or with some benefit from a weak opioid?
  - No: Pain is unlikely to respond to strong opioid eg neuropathic, no analgesia from weak opioids
  - Yes: Consider opioid trial

Discussion with the patient:
- Relevant psychosocial factors
- Risk factors for iatrogenic dependency
- Other comorbidities
- Other analgesics

Define how the trial will work
- Set a timescale including expected duration of trial frequency of review.
- Set a dose including: the upper dose limit and aim for lowest effective dose.
- Agree stopping rules with the patient before starting:
  - if the treatment goals are not met
  - if there is no clear evidence of dose response
  - if rapid tolerance develops necessitating high-dose opioids. Under these circumstances proceed to reduction and cessation, or consider specialist referral/advice.

Assess the patient
- Relevant psychosocial factors
- Risk factors for iatrogenic dependency
- Other comorbidities
- Other analgesics

2. Starting a strong opioid

- Aim to establish the patient on a long-acting opioid with no immediate release opioid if the chronic pain is stable. For mild 'breakthrough pain' consider non-opioids (eg paracetamol, NSAIDs), a weak opioid.

Consider:
- Choice of opioid
- Route of administration. Oral and transdermal are the main routes for chronic non-malignant pain.
- Dose. There is considerable variability in the dose needed to effectively treat pain. Careful titration to the lowest effective dose, balanced against side effects, requires regular review. If >90 mg morphine equivalent dose/day seek specialist advice.

- Define how the trial will work
- Provide information leaflets
- Discussion with the patient:
  - Agree stopping rules with the patient before starting:
    - effective dose.
    - Set a dose including:
      - expected duration of trial
      - frequency of review.
    - Set a timescale including:
      - as anxiolytics
      - cognitive impairment – cognitive side effects are more apparent on an opioid such as cocodamol or dihydrocodeine than they are not opioid naive, particularly if on a high dose of one or more of these agents.
      - While establishing dose, use an immediate-release preparation for short-term use only, to determine approximate dose range, then convert to equivalent long-acting preparation as soon as possible. This may be more appropriate if the patient has multiple comorbidities.

Potential regimens (use one at a time):
- Start with low dose of long-acting preparation. If the patient is already on some opioids, a weak opioid, consider conversion both to reduce physical withdrawal and while optimum dose is being established.
- Consider opioid preparations less likely to cause GI effects.
- Use stool softeners/stimulant laxatives or a combination.
- Consider opioid conversion if these do not resolve, then either dose reduction or conversion will be needed.
- Impaired memory, concentration
- Hallucinations, milder visual disturbance
- Sedation, confusion, cognitive impairment
- Musculoskeletal pain

3. Monitoring opioid trial

- At all times before and during opioid treatment signs of iatrogenic substance misuse should be sought. If problems arise consider early specialist advice.

- Consider opioid conversion
  - Short-acting opioids may need to be used during the conversion both to reduce physical withdrawal and while optimum dose is being established.
  - If the patient is on a large dose of opioids, consider phased conversion, eg gradual reduction of the current opioid dose to 50% and introduce the new opioid dose at less than the morphine equivalent dose because of incomplete cross-reactivity.
  - Continue with reduction of the old opioid and increase in new opioid as indicated by response.

- Consider specialist advice
- Other analgesics
- Other comorbidities
- Risk factors for iatrogenic dependency
- Relevant psychosocial factors

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<tr>
<th>Relevant psychosocial factors:</th>
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<td>other family members with a history of substance misuse problems</td>
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<td>history of alcohol abuse</td>
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<tr>
<td>history of stimulant use</td>
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<td>mental health problems</td>
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<td>renal impairment – accumulation of active metabolites with some opioids</td>
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<td>gastrointestinal pathology – adverse effect on bowel function</td>
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<th>SICN patient booklet</th>
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<th>Primary goals:</th>
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<td>pain relief (define the degree that would be acceptable to the patient)</td>
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<td>improved function, sleep, mood</td>
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The patient needs to be aware of the potential side effects and they need to be acceptable to the patient, eg:
- GI dysfunction (nausea, vomiting, constipation)
- central nervous system (memory and cognitive impairment, nightmares, hallucinations, visual disturbance)
- endocrine (fertility, sexual function)
- immune function
- musculoskeletal pain
- tolerance
- opioid-induced hyperalgesia.

Other analgesics:
- as anxiolytics
- other family members with a history of substance misuse problems

Relevant psychosocial factors:
- children in house
- other family members with a history of substance misuse problems

Risk factors for iatrogenic dependency:
- history of heroin abuse
- history of alcohol abuse
- history of stimulant use
- mental health problems

Other comorbidities:
- cognitive impairment – cognitive side effects are more likely;
- concordance and safety may be an issue
- renal impairment – accumulation of active metabolites with some opioids
- gastrointestinal pathology – adverse effect on bowel function

Other analgesics:
- use simple analogues, topical therapies and antineuropathic agents (if appropriate for opioid sparing effect)