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. nociceptive with some benefit from a weak opioid?
    - Yes
      - Consider opioid trial
    - No
      - Pain is unlikely to respond to strong opioid, e.g. neuropathic, no analgesia from weak opioids
      - Avoid opioids
      - Consider specialist advice

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 (e.g. 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.

  Potential regimens (use one at a time):
  - Start with low dose of long-acting preparation. If the patient is already on an opioid such as codeine or dihydrocodeine then 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 effective dose.
  - Increase analgesic dose and titrate to response.

  
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- 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.

- Discuss with the patient:
  - Provide information leaflets
  - Establish goals of treatment
    - Relevant psychosocial factors
    - Risk factors for iatrogenic dependency
    - Other comorbidities
    - Other analgesics
  - Other analgesics:
    - As anxiolytics
    - Other comorbidities:
      - Cognitive impairment – cognitive side effects are more likely; concordance and safety may be an issue.
      - Mental health problems.
  - Risk factors for iatrogenic dependency:
    - History of heroin abuse
    - History of alcohol abuse
    - History of stimulant use
    - Mental health problems.
  - Other analgesics:
    - Use simple analgesics, topical therapies and antineuropathic agents (appropriate for opioid sparing effect).

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, e.g. 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.

- Review at least annually, more frequently if problems arise, ideally with one prescriber. The review should include dose, effectiveness and adverse effects.
  - If using >90 mg morphine equivalent dose/day seek specialist advice.

- Inadequate
  - Increase analgesic dose and titrate to response.

- No response
  - Reduce and STOP analgesic.

- Adequate
  - Ask patient about adverse analgesic effects.
  - Treat if possible.

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- Have a clear and comprehensive flare up plan.


See boxes 1 and 2 in annex 4 of the full guideline for choice of opioid and suggested dose conversion ratios.

Preventing and managing adverse effects

Gastrointestinal

- Nausea/vomiting: tolerance usually develops. Consider use of an antiemetic at initiation of therapy. Avoid cyclizine if possible due to the potential of abuse.
- Constipation: tolerance often does not develop to this. Use stool softeners/stimulant laxatives or a combination.
- Consider opioid preparations less likely to cause GI effects.

Central nervous system

- If these do not resolve, then either dose reduction or conversion will be needed.
- Impaired memory, concentration
- Hallucinations, miosis, visual disturbance
- Sedation, confusion, cognitive impairment
- Myoclonic jerks.
- Other
- Sweating
- Respiratory depression.
- Tolerance: Start opioid until resolved, consider factors contributing to event.
- Tolerances: Rotate opioid or reduce and stop.
- Opioid induced hyperalgesia: Rotate opioid or reduce and stop; seek specialist advice.

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.
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- Risk factors for iatrogenic dependency:
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