

Frankston Pain Management

LONG-TERM OPIOID PRESCRIBING

Patient Selection

1. Know the patient. Prescribe only on the second or subsequent appointment.
2. Ensure all other avenues have been pursued with a reasonable trial of non-drug treatments, non-opioid medications, therapeutic injections or rehabilitation (as appropriate).
3. Identifiable causal pathology should exist. **Nociceptive pain responds best.**
4. Majority of the dose should be given during the day to increase function. Don't use as a night sedative.
5. Try to avoid long-term use in young patients.
6. Tolerability may vary and determine choice of opioid. A lack of response to this or other opioids suggests the pain is not opioid responsive and it should be stopped if co-analgesics don't help.
7. Patient must be considered psychologically stable. Assess and address psychosocial issues early to avoid complicating pain with emotional distress. Confront any misbeliefs.
8. Avoid prescribing to patients with a history of dependence on (or abuse of) any substance including alcohol, nicotine (and coffee). They are more vulnerable to dependency.

Universal Precautions and Safe Prescribing

1. Establish clear agreed pain, function goals and time frames for continuing or stopping medication.
2. Educate and consent the patient.
3. A single practitioner should take primary responsibility and have an agreed treatment plan with the patient.
5. Preferably use oral agents, topical, rectal or intranasal routes may be helpful.
 - DON'T use injections, unless clinically indicated, as the euphoria fosters dependency.
6. 4 hourly dosing increases distress as each dose wears off and so increases pain. Sustained release preparations for maintenance analgesia are preferable.
7. Use lower doses in the elderly, renal and hepatic impairment and patients on other psychoactive drugs.
8. Start with 4-6 week therapeutic trial.
9. Frequent reviews using the **4As** should be arranged (weekly initially) checking:
 - i) Analgesia (degree of Comfort)
 - ii) Activity of Daily Living (review initial goal setting)
 - iii) Adverse effects from medication
 - iv) Aberrant drug-related behaviours
9. Clearly document all patient interactions.
10. Consult with the pain management clinic if in doubt.

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Australian Pain Society Guidelines for using Opioids in Non-Malignant Chronic Pain

A number of studies have suggested that there is a small group of patients with non-malignant chronic pain who may benefit from the long-term administration of opioids.

Furthermore, new technology has allowed the administration of opioids via routes other than the oral route and this technology is increasingly being applied to patients with non-malignant pain.

It would appear that there are a number of patients with non-malignant pain being treated with long-term opioids without adequate assessment of all the factors contributing to their pain behaviour.

The foregoing indicates firstly that there is possibly a place for long term opioids in non-malignant pain management and secondly that expertise and guidelines are required for appropriate patient selection and management.

Widespread use and availability of opioids for non-malignant pain has implications for society, and the individual. Any increase in the availability of opioids will necessarily increase the availability also for their illicit use either in their original or modified forms. Individuals who are prescribed opioids in many instances may deteriorate clinically with a reduction in cognitive function, a deleterious effect on coping mechanisms, decrease in pain tolerance and develop the possibility for addictive behaviour. Consequently adequate monitoring is required.

It is therefore recommended that patients are screened prior to the consideration of oral opioids and to ensure that other practical conservative forms of treatment have been tried, psychological issues of significance to the pain behaviour assessed and managed. Where possible an attempt should be made to exclude patients at high risk of addictive behaviour, such as those with prior substance abuse or addictive problems with prescription or non-prescription drugs.

It is also suggested that a trial of therapy be instituted only after informed consent has been obtained from the patient. The informed consent should include information regarding the side effects of opioids, the potential for tolerance, dependence and addiction. It should also include information regarding the effect of opioids on children born to women taking them. The consent should outline a treatment regimen, which is to be strictly adhered to and clearly indicate the form of assessment, which will be undertaken.

Ideally patients, who demonstrate a reduction in pain and an increase in function after a trial would be considered suitable for opioid analgesia, others would have their trial ceased.

References:

Role of opioids in chronic non-cancer pain. Specialist pain management services can take the guesswork out of prescribing. Editorial. Allan Molloy, Michael Nicholas and Michael Cousins. MJA1997; 167:9-10

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Trescot, A.M., et al., Opioids in the management of chronic non-cancer pain: an update of American Society of the Interventional Pain Physicians' (ASIPP) Guidelines. Pain Physician, 2008. 11(2 Suppl): p. S5-S62

<http://www.opioidrisk.com/>

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Goal-Setting, Education and Treatment Agreement

Today's Date:

UR Number:

Name	
Address	
Date of Birth	

Preamble

The aim of treatment is to increase your ability to function and decrease your pain. This is achievable in a small group of patients with chronic pain. Both these goals need to be achieved for continued treatment.

A successful trial will improve your quality of life, sleep, general activity, work tolerance, recreation, and reduce your pain related disability and health care consumption. Long-term prescription will only occur when sustained improvements have been demonstrated.

Continuous use of strong morphine-like analgesics has serious side effects. Consequently, the drugs will be stopped unless improvement occurs.

Treatment Plan

Length of trial:

Review Schedule:

Treatment Goals	Indication to stop treatment
<u>Improved:</u> ADL, sleep, recreation, work, <u>Reduced:</u> pain & other drugs and health care use	Eg failure to reduce other drugs, improve or persistent side-effects
1	
2	
3	
4	

Patient Information

I, the undersigned, understand these drugs may cause the following **side effects**:

1. Constipation, Nausea, Vomiting, Decreased Appetite, Increased Dental Decay and Gum problems.
2. Urinary difficulties, Fluid retention and Weight gain and other hormonal changes.
3. Impotence in men and temporary loss of "periods" in women (pregnancy may still occur).
4. Decreased ability to think clearly, memory impairment or a loss of co-ordination & balance
(these may make driving a car or operating machinery impossible)
5. Sleepiness or Drowsiness
6. Slow / Laboured Breathing or sleep apnoea
7. Physical Dependence.
(this may result in withdrawal symptoms if the drug is stopped suddenly. This may be very unpleasant and include severe diarrhoea and stomach cramps, severe anxiety, yawning, goose pimples, a runny nose and hallucinations, which may continue for some days. Only stop with the guidance of your doctor.)
8. Tolerance to the drug
(this means a decreasing effect from the same dose and increasing dose required to get same effect).
9. Psychological Dependence to the drug
(a psychological craving or need to get a 'high' from the drug; Addiction involves compulsive use of medication even if causing harm)
10. Withdrawals in the baby
(if a baby is born to a mother who is taking these drugs).
11. Increased pain perception and decreased pain tolerance (opioid induced hyperalgesia syndrome)
12. Other as yet unrecognised effects

In order for my doctor to prescribe these drugs for me safely, I will:

- ❖ tell my pain specialist if I have ever had problems with or treatment for a drug dependence or abuse (including tobacco/alcohol/marijuana problems).
- ❖ tell my pain specialist if I have ever been involved in the illegal possession, sale, diversion or trafficking of drugs such as pain killers, sleeping pills, nerve pills, marijuana or other substances.

Permits and Legal Issues

Health regulations authorise only one doctor to provide prescriptions for these pain killers. This may be my GP or my pain clinic specialist. Where possible, all my prescriptions will be from either my GP or Pain Specialist or their locum in the same clinic and are to be filled by one chemist. I further authorise my doctors to obtain details of all prescribed medications from the department of health, Medicare or my insurer.

(A permit to prescribe morphine-like pain killers beyond 8 weeks is required for outpatients with non-cancer pain and from day 1 for methadone)

I am aware that this agreement is designed to make sure that these drugs are prescribed in a safe manner. The health department has records of all the strong pain killers which are prescribed and there is frequent communication between doctors and the health department, especially if large numbers of these drugs have been supplied or if multiple doctors prescribe. The health department will be notified if drug abuse is suspected.

Looking after My prescription and Drugs

I will take the drug only as prescribed. My doctor(s) is/are unable to give extra prescriptions if my script/drugs are lost, stolen, run out early, mix-ups or an alien invasion occurs! Medication is to be picked up from my nominated pharmacy in small regular amounts. Random urine samples may be requested for analysis. Failing to use medication as directed or using more than directed will result in daily pick-up or immediate cessation.

Hospital /Holiday Arrangements

Special arrangements may be required before elective surgery. I will advise my GP/Pain Specialist as soon as possible to enable liaison with my surgeon. I understand that my own prescribed medications will normally be used first during hospital admissions. Special arrangements may also be needed for vacations. Please allow 3-4 weeks for these to be made by my prescribing doctor.

Patient Responsibilities are:

1. To keep all scheduled appointments with my Pain Specialist or GP to prevent medication shortages.
2. To keep my medications in a safe place.
3. To ensure tablets are taken regularly as prescribed
4. To ensure tablets are only taken by myself

I will not call my GP or Pain Specialist after hours or at weekends about this treatment, except in the direst emergencies. Urgent care will normally be available through the Accident and Emergency department of the nearest public hospital.

I understand that this treatment will be stopped **IMMEDIATELY** if any of the following occur:

- I am involved in illegal activity involving the drug (eg. selling or buying other illegal drugs)
- I take the drug other than as prescribed
- If I am irresponsible with the medication
- Doctor shopping, unauthorised drug soliciting or hoarding
- The drug is no longer effective
- I have side effects, which are thought to be significant by my doctor.

I have read this agreement and have had all my questions answered. I agree to use of strong pain killers according to the terms of this contract. **I acknowledge continuing use is my doctor's decision.**

Physician Signature:

Patient Signature

Date:

Patient Full Name.