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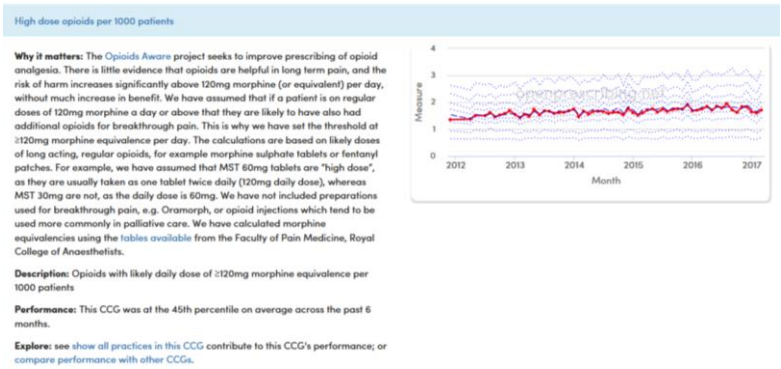
NHS
Mid Essex
Clinical Commissioning Group

Guidance and Support regarding the management of patients taking equivalent of 120mg morphine daily or greater

Within Mid Essex CCG we have a large proportion of patients who are taking ≥120mg of oral morphine daily or equivalent. The graph below was taken from Open Prescribing.net which compares the CCG against other CCGs across the country.



Reference: https://openprescribing.net/ccg/06Q/

This pack to support the management of patients identified as taking ≥120mg of oral morphine daily or equivalent has been divided into **Existing** patients taking these doses and **New** patients who are initiated on opioids for chronic pain during the course of the year and may be at risk of dependence.

The information provided for Existing patients includes:

- Letters to be sent to patients
- The Opioid Contract currently available on the MECCG website
- Guidance on titration and tapering doses
- Nationally produced Patient Information Leaflets that can be printed and provided to patients

The information provided for New patients includes:

- Information to guide GPs on patient assessment of pain and consultation advice prior to initiating opioids
- Information for patients
- The Opioid Contract currently available on the MECCG website
- Guidance for GPs on monitoring patients who have been started on opioid treatment

Existing patients taking ≥120mg of oral morphine daily or equivalent

Patients identified via searching prescribing systems as receiving >120mg/day oral morphine or equivalent should first be invited to attend the surgery for a doctors consultation to discuss their opioid therapy. If agreed within the practice, this initial consultation can be with the practice pharmacist and so the template letter can be adapted accordingly.

Template letter that can be adapted by the practice to invite patients in for a consultation to discuss their opiate prescription:

GP template letter for inviting patient to consultation

Dependence on prescribed opioid medicines, whether or not in the presence of ongoing pain, requires individualised assessment and treatment planning and will usually draw on the expertise of primary care physicians, healthcare professionals working in addiction and recovery services, specialists in pain and mental health professionals.
The best current evidence of addiction risk from samples treated for chronic pain in primary and speciality care estimates that 8-12% of long term prescribed opioid users meet criteria for a current or past opioid use disorder.

A comprehensive history should be taken from any patient in whom opioid dependence is suspected. It is important to understand the medical indication for which opioids were prescribed initially. As far as possible, confrontation should be avoided, as should judgement about the motivations of the patient. Important points that should be clarified include:

- Medical indication for opioid.
- Full list of all medication, routes of administration and how long prescribed.
- What other medication with addictive potential is prescribed to the patient including benzodiazepines and gabapentin/pregabalin.
- What the patient perceives as positive and negative attributes of prescribed opioids.
- Current alcohol and illicit drug use.
- Current physical health.
- Current psychological health.
- Current tobacco consumption.
- Previous history of drug and alcohol dependence and treatment.
- Physical health history and any interventions.
- History of psychiatric illness.
- Social functioning and employment status.
- Family and carer support.
- Appropriate physical examination.

Treatment
Once a diagnosis of dependence has been made a treatment plan should be developed. The decision on which treatment course is chosen should be a collaborative one between the patient and doctor. Depending on the complexity of the case and the skills and training of the prescriber this may be all under one doctor or it may involve a full network of clinicians, including GPs, addiction specialists, pain specialists, psychiatric specialists and acute services, or some point in between. Clear communication between all healthcare specialists involved in the patient's care is vital as is clear documentation. It is important to note that many patients will recognise that they have an issue with prescription opioid dependence and will be willing to work in collaboration with their doctor to develop a treatment plan. Usually one doctor should take over all prescribing of opioids and other potentially addictive drugs. If there is disagreement between the doctor and patient it may be beneficial if a different doctor who has not previously treated the patient takes over prescribing so that a new relationship and set of boundaries can be developed.
Information about the acute and chronic risks of opioids should be given to the patient.
Any underlying physical or psychiatric condition should be identified and appropriate treatment plans or referral made.

<u>Tapering and Stopping</u>
It is important to taper or stop the opioid regimen if:

- the medication is not providing useful pain relief. The dose above which harms outweigh benefits is 120mg oral morphine equivalent/24hours. Increasing opioid load above this dose is unlikely to yield further benefits but exposes the patient to increased harm
- the underlying painful condition resolves
- the patient receives a definitive pain relieving intervention (e.g. joint replacement)

- the patient develops intolerable side effects
- there is strong evidence that the patient is diverting his/her medications to others

Preparation for dose reduction includes:

- explanation of the rationale for stopping opioids including the potential benefits of opioid reduction (avoidance of long term harms and improvement in ability to engage in self-management strategies)
- agreeing outcomes of opioid tapering
- deciding which patients may need admission for opioid taper/cessation informed by existing opioid dose
- physical co-morbidities
- mental health co-morbidities including significant emotional trauma
- monitoring during taper of pain
- symptoms and signs of opioid withdrawal
- choice of opioid reduction scheme
- incremental taper of existing drug
- conversion to methadone or buprenorphine
- defining the role of drug and alcohol services to support dose reduction
- close collaboration between the patient, his or her carers and all members of the patient's health care team
- arrangements for follow-up including agreed prescribing responsibilities

The dose of drug can be tapered by **10% weekly or two weekly**.

Stopping opioids in primary care

The decision to taper/stop an established opioid regimen needs to be discussed carefully with the patient including:

- explanation of the rationale for stopping opioids including the potential benefits of opioid reduction (avoidance of long term harms and improvement in ability to engage in self-management strategies)
- agreeing outcomes of opioid tapering
- arrangements for monitoring and support during opioid taper
- documented agreement of tapering schedule

A drug wean should be considered a one-way process. Pick a target opioid dose. This may be zero. It may be a dose that you and the patient can agree upon as a reasonable, achievable dose. For patients on very high doses, the “generally accepted maximum” of 120mg Oral Morphine Equivalents (that’s about 37mcg/hr fentanyl) might be appropriate. A wean can be paused but should not be reversed except in exceptional circumstances.

In order to taper transdermal patches it may be necessary to switch the patient to the equivalent oral morphine dose, or supplement the tapered dose with immediate release oral morphine if the reduced transdermal tapered dose is greater than a 10% dose reduction.

Approximate equivalent doses for oral morphine to transdermal buprenorphine and transdermal fentanyl:

Transdermal buprenorphine changed at weekly intervals	Transdermal buprenorphine changed every three or four days (twice weekly)	Transdermal fentanyl	Oral Morphine
5 microgram/hr	-	-	12mg/day
10 microgram/hr	-	-	24mg/day
20 microgram/hr	-	-	48mg/day
-	35 microgram/hr	-	84mg/day
-	52 microgram/hr	-	126mg/day
-	70 microgram/hr	-	168mg/day
-	-	12 microgram/hr	45mg/day
-	-	25 microgram/hr	90mg/day
-	-	50 microgram/hr	180mg/day
-	-	75 microgram/hr	270mg/day
-	-	100 microgram/hr	360mg/day
-	-	300 microgram/hr	1120mg/day

Withdrawal symptoms (e.g. sweating, yawning, abdominal cramps, restlessness, anxiety) occur if an opioid is stopped/ dose reduced abruptly.

The Treatment Opioid Contract (published on the Mid Essex CCG website) may be helpful for use during the initial consultation with patients to assist with supporting the management and tapering process.

Treatment with Opioids contract (compact) April 2017

Patient information is likely to be helpful for patients to take away. One leaflet which provides detail on weaning opioids for patients is below:

Weaning opioids – advice for patients July 2017

Other PILs that are produced by the Opioids Aware resource available from the Faculty of pain Medicine include ‘About Pain’, ‘Thinking about opioid treatment for pain’, and ‘Taking opioids for pain’. https://www.rcoa.ac.uk/node/21133

Faculty of pain PIL – About Pain
Faculty of pain PIL – Thinking about opioid treatment for pain
Faculty of pain PIL – Taking opioids for pain

New patients for whom practice would like to trial opioids/ for whom have been started on opioids for long term pain.

Patient Assessment

The experience of pain is complex and influenced by the degree of tissue injury, current mood, previous experience of pain and understanding of the cause and significance of pain. Previous unpleasant thoughts, emotions and experiences can also contribute to the current perception of pain and if unresolved, can act as a barrier to treatment. A full pain history should therefore include:

- Description of pain
- Where is the pain?
- Does it radiate elsewhere?
- What does the pain feel like (e.g., aching, burning, stabbing)?
- Does it vary in intensity?
- What makes it worse?
- What makes it better?
- What is the effect on sleep?
- What is the effect on mood?
- What is the effect on physical function?
- What is the effect on vocational/social function?
- Current medications and response to drugs (it may be appropriate to continue non-opioid therapies which have been previously effective)
- response to previous medications and other interventions including self-management strategies and alternative therapies (If opioids have previously been ineffective it is unlikely that offering an alternative opioid preparation will be helpful.)
- physical health including operations and illnesses. NB some comorbidities such as renal or hepatic impairment and sleep apnoea, will influence the choice of drug, dose and safety of therapy
- mental health including emotional trauma, previous and current mood, contact with mental health circumstances. Mental health comorbidities and a history of significant emotional trauma are not a contraindication to opioid therapy but:

– are a risk factor for opioid therapy becoming prolonged and for high doses to be used
– patients may use opioids to blunt unpleasant thoughts and experiences: this may make opioids difficult to stop
– are a risk factor for addiction to prescribed opioids
– will be contributory to the current pain experience so need to be identified and managed separately

- current or previous history of addiction to drugs or alcohol. Patients with a current or past history of addiction will need careful management and support in collaboration with specialists with expertise in addiction
- patient circumstances and context (employment, family responsibilities, sources of support). Patients with a family/household member with addiction will need additional support and counselling about risks of diversion of controlled drugs
- patient's understanding of pain and expectations of outcome
- pain assessment tools e.g., VAS, Brief Pain Inventory, Leeds Neuropathic Pain Scale
- relevant physical examination including observation of patient mobility, distress
- imaging and other diagnostics (x-rays, scans, blood tests and electrophysiology)

The assessment of chronic pain needs to be wide-ranging and comprehensive. The persistence of symptoms is particularly relevant in relation to prescribing where patients may be exposed to cumulative harms of drugs over prolonged periods. If a patient continues to have pain despite taking a number of medications, drugs should be sequentially tapered or stopped to establish continued utility. Similarly, if a patient reports reasonable pain relief from a medication regimen in the longer term, it is also necessary to taper medications intermittently to assess whether the symptoms have resolved

spontaneously or whether the patient is relatively pain free because of continued efficacy of medication.

- Persistent non-cancer pain serves no physiological purpose and is influenced not only by tissue injury but by a number of emotional, social and cognitive variables
- Medicines are generally less effective for persistent pain than for other types of pain. When medicines are prescribed they should be used in combination with other treatment approaches to support improved physical, psychological and social functioning.
- Initial prescribing of opioid medicines for pain should be considered as a trial period, with outcomes of treatment agreed with the patient.
- If, at the end of the trial, agreed outcomes have not been achieved or progress made towards them, then the patient and prescriber need to discuss whether to continue treatment.
- Side effects are relatively common – these need to be considered and balanced with potential benefits. If patients continue to take medicines that provide limited analgesic benefit then they are exposed to harms unbalanced by the benefit that the medicines provide.
- When medicines don't give sufficient analgesia there is a risk of dose escalation. This is rarely helpful.

A stepped approach
When making medication choices to support patients with persistent pain, it may be rational to use a stepped approach but this should not be determined by reported pain intensity (which is the underlying principle of the analgesic ladder). Medications are usually a small part of the pain management plan and should be used in conjunction with non-pharmacological interventions such as advice regarding activity, physiotherapy and an explanation that pain may be resistant to medication and complete relief of symptoms is not a goal of therapy. Regardless of pain intensity, it is rational to start with non-opioid drugs, where these have some demonstrated efficacy for the condition being treated. Trials of both weak and strong opioid therapy may be considered for some patients with well-defined pain diagnoses in whom symptoms persist despite first line interventions. All drugs prescribed for pain should be subject to regular review to evaluate continued efficacy, and periodic dose tapering is necessary to evaluate on-going need for treatment.

It is important that:
- the patient and their carers understand the treatment plan including aims of therapy
- the patient continues to use self-care strategies such as weight loss, exercise and appropriate pacing of activity
- there is sufficient practical support available to allow adherence to the treatment plan
- the patient is informed about safe storage and disposal of opioid medicines

The Mid Essex Opioid Treatment Contract should be used when deciding to initiate opioids for new patients with chronic pain.

Treatment with opioids contract (compact) April 2017

Important Practice Points
1. **Patients who do not achieve useful pain relief from opioids within 2-4 weeks are unlikely to gain benefit in the long term.**
2. **Patients who may benefit from opioids in the long term will demonstrate a favourable response within 2-4 weeks.**
3. **Short-term efficacy does not guarantee long-term efficacy.**
4. **Data regarding improvement in quality of life with long-term opioid use are inconclusive.**

5. **There is no good evidence of dose-response with opioids, beyond doses used in clinical trials, usually up to 120mg/day morphine equivalent. There is no evidence for efficacy of high dose opioids in long-term pain.**

The Opioid Trial
If the prescriber and patient agree that opioid therapy may play a role in further management of the patient's pain, a trial of opioid therapy should be planned. The opioid trial establishes whether the patient achieves any reduction in pain with use of opioids. It is important to remember that short term response to opioid therapy does not predict long term therapy which may be limited by adverse effects or declining efficacy. Achieving optimal doses and managing side effects of opioids is not the purpose of the trial; these can be explored once it has been shown whether opioids are helpful for the patient.

Starting the trial
The patient and prescriber should agree some readily assessable outcomes that indicate that opioids may play a role in the patient's management. These will usually include reduction in pain intensity and ability to achieve specific functional improvement facilitated by the medication. For patients in whom sleep is significantly impaired by pain, improved sleep would be a reasonable outcome.

Duration of the opioid trial
This will depend on the periodicity of the patient's pain. If the patient has constant pain, the opioid trial may be concluded in one or two weeks. If the patient has intermittent disabling flare ups of pain on a background of more manageable symptoms, the trial should be long enough to observe the effect of opioids on two or three episodes of increased pain.

Choice of opioid formulation and dose
Where possible, the usefulness of opioids should be explored by prescribing a short (1-2 week supply) of immediate release morphine tablets or liquid. The patient may be advised to explore different doses within a specified range e.g., morphine 5-10mg. If reduction in pain is not achieved following a single dose of immediate relief morphine 20mg, opioids are unlikely to be beneficial in the long term. A trial of fixed dose regimens using modified release preparations needs to allow for one or two upwards dose adjustments and may therefore take three weeks or more.

Assessing whether the opioid trial is a success
The patient should keep a diary during the opioid trial. This should include a twice-daily report of pain intensity, comment on sleep, note of activity levels and how any of these are changed following a dose of opioid. All doses of opioid should be recorded in the diary with a comment on side effects. If the opioid trial is not successful, the drugs should be tapered and stopped within one week.

If the patient reports no improvement in symptoms following the trial it is very unlikely that long-term opioid therapy will be helpful.

Documentation
All stages of the opioid trial should be clearly documented and if appropriate, a copy of the agreed aims of therapy and how these may be monitored should be given to the patient. Documentation should also include the agreed starting dose and formulation of drug and details of planned dose escalation. If the opioid trial demonstrates that the medicines are unhelpful, the reasons for this (lack of efficacy/intolerable adverse effects) should also be clearly documented. If the patient reports reduction in pain but at the cost of side effects that preclude achievement of functional goals, it is reasonable to explore different dosing regimens with active management of side effects to see if a useful balance between benefits and harms can be achieved.

The following may be helpful as an opioid trial treatment agreement with patients:
Opioid trial agreement – July 2017

If the opioid trial demonstrates some benefit from opioids, further exploration of opioid treatment may be helpful. A successful short-term opioid trial does not predict long-term efficacy.

The Patient Information Leaflets available from the Faculty of pain Medicine include 'About Pain', 'Thinking about opioid treatment for pain', and 'Taking opioids for pain' are also helpful for new patients when initiating opioids.
https://www.rcoa.ac.uk/node/21133

Faculty of pain PIL – About Pain
Faculty of pain PIL – Thinking about opioid treatment for pain
Faculty of pain PIL – Taking opioids for pain

What to discuss with the patient when considering opioid treatment

- Explain that the evidence for the use of opioids as analgesics is best when used in the management of acute pain, over a period of hours from onset but tapering dose over days to a few weeks.
- Explain that opioids are poorly effective for long-term pain. For a small proportion of patients, opioids may be successfully used as part of a broader plan including non-medication treatments and self-management.
- Discuss the degree of pain relief that might be expected and understand that plan the aim is not complete pain relief but rather reducing pain sufficiently to engage in self management.
- Agree specific functional goals that might be achieved.
- Discuss the potential harms of opioid treatment including: -

• Sedation
• Nausea
• Constipation
• Effects on hormones
• Effects on the immune system
• Potential for the drugs to worsen pain
• Potential for problematic drug use and addiction

- Discuss opioids and impairment of driving skills
- Discuss the opioid trial
- Discuss the circumstances in which opioid therapy will be stopped
- Discuss arrangements for review