

KISS

Keep It Simple and Straightforward

Oxycodone for chronic pain

Bottom line	<p><u>NB the following relates to chronic pain, <i>not</i> acute or end of life care</u></p> <p>Oxycodone is:</p> <ul style="list-style-type: none">• Limited in its effectiveness for the management of chronic pain (1)• Hazardous (2)• Expensive (3)• No better than morphine (4)
Make it happen	<p>Look for:</p> <ul style="list-style-type: none">• Use of oxycodone in chronic pain.• Dose greater than oxycodone modified release 30mg bd (which will be a morphine equivalent of 120mg per day and the usual maximum dose for chronic pain).• Review patients on oxycodone for chronic pain, if it is not effective, stop it.• If it is not safe, review, ensure patient safety. You may have to modify collection intervals, or stop.• Co prescribing of other sedatives e.g. benzos, Z drugs, gabapentin/pregabalin, opiate polypharmacy (work out total morphine equivalent dose per day; AVOID multiple opiates).• Prescribing where there is other chronic disease, e.g. respiratory disease, depression.• Evidence of misuse or overuse; reduce/stop, great care where there is drug/alcohol history.• Evidence of diversion – STOP.• Remember to ask about driving; it is the patient's duty not to drive under the influence of drugs. Patients must report high use to DVLA.
The detail	<ol style="list-style-type: none">1. All opiates are of limited effectiveness in the management of chronic pain: Opiates are very effective for end of life care pain, there is <u>little evidence they are helpful for long term, chronic, pain</u>. Only a small proportion of people with long term pain will benefit from opiates particularly if the use is intermittent and the dose low. Risk of harm increases beyond a morphine equivalent dose of 120mg per day (i.e. 60mg oxycodone per day), but no increase in benefit. If the patient is using opiates and not benefitting, they should be stopped, even if there are no alternatives. Chronic pain is a complex phenomenon (bio psycho social) and needs detailed assessment.2. Hazards: Oxycodone SPC advises that 10mg oxycodone is equivalent to 20mg morphine i.e. it is very strong and the maximum dose per day should usually not exceed 60mg per day (120mg morphine equivalent). Confusion can arise re long acting and short acting formulations e.g. OxyContin® (long acting modified release) OxyNorm® (standard release) –confusing the two can lead to fatal overdose. It is subject to misuse, and has the potential for diversion.3. Expensive: Wherever possible switch to morphine equivalent. Oxycodone MR 60mg bd costs approximately four times more than Morphine Sulphate equivalent dose (or even more depending on brand chosen). Savings of approx. £56,000 per 100,000 patients by switching to Morphine Sulphate MR4. No evidence for advantages over morphine re efficacy and tolerability
Links	<p>https://www.prescqipp.info/resources/send/61-oxycodone-mr/864-bulletin-52-oxycodone-mr</p> <p>https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware</p> <p>https://www.surreyandsussex.nhs.uk/wp-content/uploads/2013/04/CQC-Safer-use-of-Controlled-Drugs-Preventing-harm-from-Oral-Oxycodone-preparations.pdf</p>
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Date	January 2018