Health
Hunter New England
Local Health District

Opioid Quick Steps

Health Professional Resources
Hunter Integrated Pain Service
May 2014

1. **Evidence**
   Evidence based indications for opioid therapy:
   i. Acute pain
   ii. Cancer pain
   iii. Palliative or “comfort” care
   iv. Opioid dependency/addiction
   Evidence does not support the efficacy or safety of opioid therapy for chronic non-cancer pain.

2. **Practice principles**
   i. **Acute pain**: In most acute settings opioids if used can be ceased within 1 week. In more complex cases opioids should be weaned and ceased **within 90 days** at most.
   ii. **Chronic non-cancer pain**:
      a. Opioid therapy should not be initiated based on current scientific evidence.
      b. If chronic opioid therapy is already established the standard treatment is to negotiate weaning and cessation over an appropriate time frame.
   iii. **Cancer pain**, **palliative care** and **opioid dependency/addiction**: Chronic opioid therapy may be used with careful attention to the balance of benefit and harm.

3. **Practical strategy**
   i. **Multidimensional assessment**: for all types of pain leads to broad based treatment potentially including aspects of biomedicine, mindbody, connection, activity and nutrition.
   ii. **Risk of opioid misuse**:
      a. A drug and alcohol history and/or screening with the Opioid Risk Tool inform prescriber and recipient about the risks of misuse.
      b. Contact with the Australian Prescription Shopping Information Service (1800 631181) is recommended for “at risk” cases. An Australian "Electronic Recording and Reporting of Controlled Drugs" system offering on-line, real time information is awaited.
      c. In “at risk” cases consider tamper-resistant formulations, urinary drug screens and pill counts.
   iii. **Treatment agreements**: A written or verbal treatment agreement may assist discussion of potential benefits, adverse effects and therapeutic boundaries (no early prescriptions; no replacement of lost prescriptions/medications; single prescriber with deputy; regular pharmacy).
   iv. **Dose limits**: In primary care recommended dose limits are **100mg** (daily oral morphine equivalents) for non-cancer pain and **300mg** for cancer pain. Seek specialist advice if considering prescription above these limits.
   v. **Review of opioid therapy**:
      a. Use the 4 A’s: **A**nalgesia, **A**ctivity, **A**dverse effects and **A**berrant behaviour.
      b. Simple questionnaires such as the Brief Pain Inventory or ultra-brief PEG can be used to measure pain and functional outcomes.
   vi. **Opioid rotation**: can be used to treat side effects or tolerance and to facilitate dose reduction. A typical rotation involves changing to a new opioid at approximately 50% of the equivalent dose.
   vii. **Opioid weaning**:
      a. With chronic opioid therapy a typical weaning plan reduces the opioid by 10-25% of the starting dose each month. This achieves cessation in 3-9 months.
      b. Weaning can be undertaken more quickly in acute pain or in cases of opioid misuse.
      c. Contact with a pain medicine specialist may be helpful to support the weaning process.
      d. Planned weaning limits opioid withdrawal and patient distress.
      e. If it emerges during weaning that opioid dependency/addiction is the primary problem then opioid maintenance via a Drug and Alcohol service can be considered.

4. **Consultation**: Discuss variation from recommendations with a pain medicine or addiction specialist.