Prescribing...

Opioids & Chronic Non-Cancer Pain June 2016

- New US guidance on opioids in chronic pain has been published.
- It state that there is an "epidemic" in the US of prescription opioid deaths : more than 14,000 in 2014 and 165,000 in total since 1999.
- Nearly 2 million Americans aged 12 years or older, either abused or were dependant on prescription opioids in 2014.
- It states that up to one quarter of patients on long term prescribed opioids in primary care struggle with addiction.

Opioids have an established role in treating acute pain and cancer-related pain, but the effectiveness of long-term use in chronic pain is less certain. They are also associated with serious risks, including dependence and overdose. In the USA, concern over the widespread use of long-acting and extended-release **opioids** and an increase in deaths from unintentional drug overdoses has led to a review by the Food and Drug Administration and the Centers for Disease Control and Prevention or CDC.

It is estimated that more than 11% of the population of the USA experiences chronic pain, and that up to 4% of the population has been prescribed long-term opioid treatment. The CDC states that up to a quarter of patients on prescribed long term opioids struggle with addiction. Risk factors include history of overdose, history of substance misuse, higher opioid doses or concurrent benzodiazepine use.

As a result, the CDC has issued recommendations to guide primary care clinicians in prescribing **opioids** to adults with pain that lasts longer than 3 months. The guideline does not apply to opioid treatment for cancer, palliative care or end-of-life care.

The recommendations are based on a CDC update of a 2014 systematic review on the effectiveness and risks of long-term opioid use for chronic pain. The CDC found no studies that evaluated the long-term (≥1 year) benefit of **opioids** for chronic pain. There was extensive evidence of the possible harms of **opioids**, including 'opioid use disorder' (problematic pattern of opioid use leading to clinically significant impairment or distress), overdose and motor vehicle injury. In addition, there was evidence suggesting some benefits of non-pharmacological and non-opioid pharmacological therapy, with less harm. Alternative therapies include cognitive behavioural therapy, exercise therapy, paracetamol, NSAIDs, anticonvulsants and antidepressants.

In light of these findings, the CDC advises that **opioids** should not be considered for first-line or routine therapy for chronic pain. Other recommendations include:

- Focus should be placed on functional goals and improvement, as well as pain relief, and patients engaged actively in their disease management.

- Patient education is recommended for lower back pain, osteoarthritis and fibromyalgia. Exercise, weight loss, CBT , increased activity and limiting bed rest are recommended for lower back pain.

- For fibromyalgia education and non-pharmacological treatments such are low-impact aerobic exercise, CBT, biofeedback and inter disclipinary rehabilitation are specifically recommended.

- For migraine preventative therapies such as beta blockers, anticonvulsants or TCAs, CBT, relaxation, exercise therapy and avoidance of triggers are recommended.

- Co-existing mental health conditions such as depression, anxiety, PTSD should be identified and addressed.

- Disease specific treatments should be used where available. Non-opioid therapies: paracetamol, NSAIDs, Gabapentin, tricyclics, SSRIs or SNRIs, and topical agents should be used to the extent possible before opioids are considered.

- Interventional therapies, such as corticosteroid injections, should be considered in patients who fail non-invasive therapies.

- **Opioids** should be used for chronic pain only when the benefits for pain and function are expected to outweigh risks. Provider and patient responsibilities for managing therapy should be discussed. Before starting **opioids**, clinicians should establish treatment goals with patients and consider how and when **opioids** will be discontinued if benefits do not outweigh risks.

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release **opioids** using the lowest effective dose; carefully re-assess benefits and risks when considering increasing the dose to the equivalent of 50mg of morphine or more per day; and avoid concurrent use of **opioids** and benzodiazepines whenever possible.

- Clinicians should evaluate benefits and harms of continued opioid therapy with patients at least every 3 months.

- If harms outweigh any benefit, the drug should be reduced, tapered or discontinued and non-opioid approaches intensified. When stopping opioids an individualized approach is extremely important. To minimise symptoms of withdrawal, decreasing by 10% per week is usually recommended. Appropriate specialists should be involved if required.

For local clinicians, the CDC's analysis provides a useful assessment of the current evidence on opioid use for chronic pain and the scale of the problem in the US. It confirms earlier findings of a lack of research to support long-term use of these drugs, particularly given their significant potential harms.

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