Prescribing...

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Opioids in Palliative Care

- NICE has recently issued guidance on safe and effective prescribing of first-line strong opioids for pain in the palliative care of adults.
- Reassuringly, this advice is identical to our own local guidelines on the topic.
- Strong opioids are the principal treatments for pain related to advanced and progressive diseases, so their safe, effective prescribing has a major impact on patient comfort and hence quality of life.
- NICE now specifically recommends **morphine** as **first-line** oral **treatment,** in preference to all formulations of buprenorphine, diamorphine, **fentanyl** or **oxycodone**.
- Short acting formulations of fentanyl such as lollipops or nasal spray or lozenges are not recommended for first line relief of breakthrough pain.
- Oxycodone is many times more expensive than morphine, but some formulations are now available generically.

Background

As is well understood, pain is extremely common in advanced and progressive disease. Up to two thirds of patients with cancer regularly suffer pain sufficiently serious to require a strong opioid. This proportion is similar or even higher in many other advanced and progressive conditions. Every year 300,000 people are diagnosed with cancer in the UK and it is estimated that 900,000 are living with chronic heart failure. Many others live with chronic illnesses such as kidney, liver and respiratory disease, and with neurodegenerative conditions in which pain is common. Many of these patients will be prescribed a strong opioid in the later stages of their illnesses.

Recent years have seen an increase in the use of strong opioids locally and elsewhere, a trend which is likely to continue with the ageing population and improved survival from cancers.

The key points in the latest advice by NICE are as follows

1. **Starting opioids – titrating the dose**

When starting treatment with strong opioids, NICE recommends that patients be offered sustained-release or oral immediate-release morphine with rescue doses of oral immediate-release morphine for breakthrough pain. A typical total daily starting dose schedule of 20 to 30mg oral morphine (e.g. 10 – 15mg oral sustained-release morphine twice daily) plus 5 mg oral immediate-release morphine for rescue doses during the titration phase.

2. **First-line maintenance treatment**

NICE recommends oral sustained-release morphine as first-line maintenance treatment to patients with advanced disease. The guideline advises against transdermal patch formulations as first-line maintenance treatment for patients in whom the oral route is available.

3. **First-line treatment if oral opioids are not suitable : transdermal patches**

Transdermal patches with the lowest acquisition cost are an option for the minority of people in whom oral opioids are not suitable **and** where analgesic requirements are stable. Guides to equivalent doses

are in the BNF. For example a transdermal fentanyl 12 microgram patch equates to approximately 45mg oral morphine per day.

4. First-line treatment if oral opioids are not suitable : subcutaneous delivery

When analgesic requirements are unstable, s/c opioids with the lowest acquisition cost are recommended.

5. For breakthrough pain in patients on oral opioids

Oral immediate-release morphine is recommended for the first-line rescue medication of breakthrough pain in patients on maintenance oral morphine treatment. Fact-acting fentanyl formulations such as lollipops, nasal spray or lolipops are not recommended first line.

6. Management of constipation

NICE recommends that patients be advised that constipation affects nearly all patients receiving strong opioids. Laxative treatment should be prescribed for all patients and be taken regularly at an effective dose. Patients should be advised that laxatives take time to work and that adherence is important. It is important to optimise laxative treatment for managing constipation before considering switching strong opioids.

7. Management of other issues

Nausea is common with strong opioids at the beginning of treatment and at dose increase, patients should be reassured that this is likely to be transient. If it persists, prescribing and optimising anti-emetic treatment is recommended before switching strong opioids.

Mild drowsiness or impaired concentration may also occur, especially at the beginning of treatment and when the dose is increased, but like nausea this is usually transient. Impaired concentration may affect people's ability to drive and undertake other manual tasks. People experiencing either persistent or moderate-to-severe central nervous system side effects may benefit from a dose reduction if the pain is controlled or a change of drug if the pain is not controlled.

The guidance development group has made a number of recommendations for research. One is whether or not the early switching of an opioid, on development of side effects, is more effective at reducing side effects than persisting with current opioid and dose reduction.

Finally

Please note that the patent on some formulations of oxycodone has now expired, and slightly better value generics should be available soon. It is an expensive treatment, as shown below, so prescribers are kindly requested to ensure that it is prescribed generically.

Drug	Number of Prescriptions issued by MSG and Primary Care July 2012	Total Cost	Cost per Item
Morphine	310	£2,277	£7.35
Oxycodone	86	£2,903	£33.76

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Reference: Opioids in palliative care NICE CG 140, May 2012.