POLICY DOCUMENT

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PRESCRIBING FOR PAIN MANAGEMENT IN OPIOID DEPENDENT CLIENTS

This guidance has been produced to identify options for the management of pain in substance misusers, dependant on opioids. It may be used by a number of medical agencies where clients are seen e.g. acute hospitals, primary care, mental health, and specialist pain services. It is important to note that this is not intended to be a comprehensive list of prescribing options, and close liaison with the substance misuse service is advised in individual cases.

INTRODUCTION

- Pain in people who use drugs is common, complex, often forgotten and poorly treated, and 10-25% of people who use opioids say they start opioids because of pain.
- Prevalence of chronic pain is between 30 and 50% in treated substance users, compared with 10-15% of the general population. (1)
  Under-treatment is common and is often based on misconceptions including: (1)
  - Maintenance opioid agonists provide adequate analgesia. (This is not the case, as the duration of analgesic action, four to eight hours, is substantially shorter than that required for suppression of opioid withdrawal, 24 to 48 hours.)
  - The use of opioids for analgesia may trigger relapse. (The reverse is true: acute pain is a well-recognised potential trigger for relapse.)
  - The additive effects of opioid analgesics and maintenance opioids may increase the likelihood of respiratory and central nervous system depression. (This is not the case when pain is present.)
  - The pain complaint may simply be a manifestation of drug-seeking behaviour. (Experience teaches clinicians that this is rarely the case.)
  - Reluctance to prescribe due to prescriber concerns about side effects or diversion may result in opioid users receiving inadequate analgesia.

PAIN MANAGEMENT ISSUES

- People taking opioids (i.e. methadone or buprenorphine treatment and people actively addicted to heroin) often experience difficulties receiving pain relief when hospitalised. The key is to prevent withdrawal by continuing prescribed opioids or by initiating methadone for hospitalised heroin users, please see Appendix 3 for guidance, to provide additional analgesia where necessary, monitoring patients to confirm pain relief is satisfactory, and to prevent respiratory depression.
- Opioids are not contraindicated in abstinent, former addicts with acute pain. There is probably a small risk that exposure to opioids will trigger relapse to addiction. Where possible, the risk should be discussed with the patient who may prefer non-opioid analgesia. (2)
- If opioids are used for pain management in recovering addicts, medication should be transferred to long-acting opioids at the earliest opportunity. Support should be offered during hospitalisation, and follow-up arrangements put in place. This will help protect patients against the risk of relapse.
- Patients on naltrexone do not benefit from opioid analgesics. Naltrexone should be stopped 72 hours prior to elective surgery and opioid analgesia will be needed. (2)
- In many patients tolerance is uncertain, and addiction status is uncertain. Prescribers need to balance risks of opioid withdrawal and opioid toxicity, with adequate analgesia, by titrating opioid dose against response, and monitoring for withdrawal, sedation and analgesia.

FIRST STEPS

- ✓ check the drug and dosage with the service user
- ✓ confirming opioid use with an on-site urine test
- ✓ ask the community pharmacist about the last dose of medication
- ✓ confirm all this with the prescriber/CDAT service
- ✓ treatment can be continued only if the prescription has been dispensed daily in the community and was preferably supervised

Out of hours

If the prescription cannot be verified, if there is any doubt that the person is taking the total prescribed dose or if the hospital cannot confirm the dose, then titration should be undertaken, see Appendix 3.

Key treatment principles for acute pain in patients on opioid substitution treatment

- Keep the treatment of drug dependency separate from the pain control, i.e. maintain the usual dose of opioid replacement.
- Be aware that non-pharmacological approaches may be useful and when prescribing use non-opioid and adjuvant analgesics, e.g. paracetamol, NSAIDs and tricyclic antidepressants at low dosage. (1)
- If these are ineffective, try increasing the opioid dosage with dose-splitting (e.g. oral **methadone** four to eight-hourly) or introduce a weak opioid in high dosage or another strong opioid e.g. morphine sulphate, which is available as immediate release or slow release preparations. (1)

If the patient is prescribed **buprenorphine**, acute pain can be treated in one of the following ways:

- Split the daily dose to six to eight-hourly. (The analgesic qualities of buprenorphine show a disparity with tolerance/dependence, though less so than with methadone.)
- Discontinue buprenorphine and introduce a full opioid agonist until the acute phase is over.
- Give high doses of a short-acting opioid agonist in addition to buprenorphine in an attempt to flood the *mu* receptors.
- Admit to hospital care, convert buprenorphine to methadone, titrate the opioid requirement for analgesic effect and prevention of acute withdrawal, and then re-introduce buprenorphine after the acute pain subsides.

Key principles of treatment of chronic pain in the context of substance use (1)

The assessment of chronic pain in the context of substance use is more complex and time-consuming than for acute pain. It should not only take account of the pain history but also:

- Provide a mental state assessment (because of the close correlation of chronic pain with chronic psychiatric morbidity);
- Include a psychological assessment, looking especially for chronic anxiety and depression, and also coping styles;
- Look at relevant psychosocial factors;
- Give a past medical history (because of the co-relation of chronic pain with chronic illness);
- Provide other information including beliefs and attitudes to pain, to doctors and carers, and to possible referral.
- Use non-opioid analgesia wherever possible and refer to a specialist pain management service if necessary
- There is no evidence that using opioids will trigger a relapse. It is more likely that inadequate analgesia and the stress associated with pain will play a role in relapse and continued use

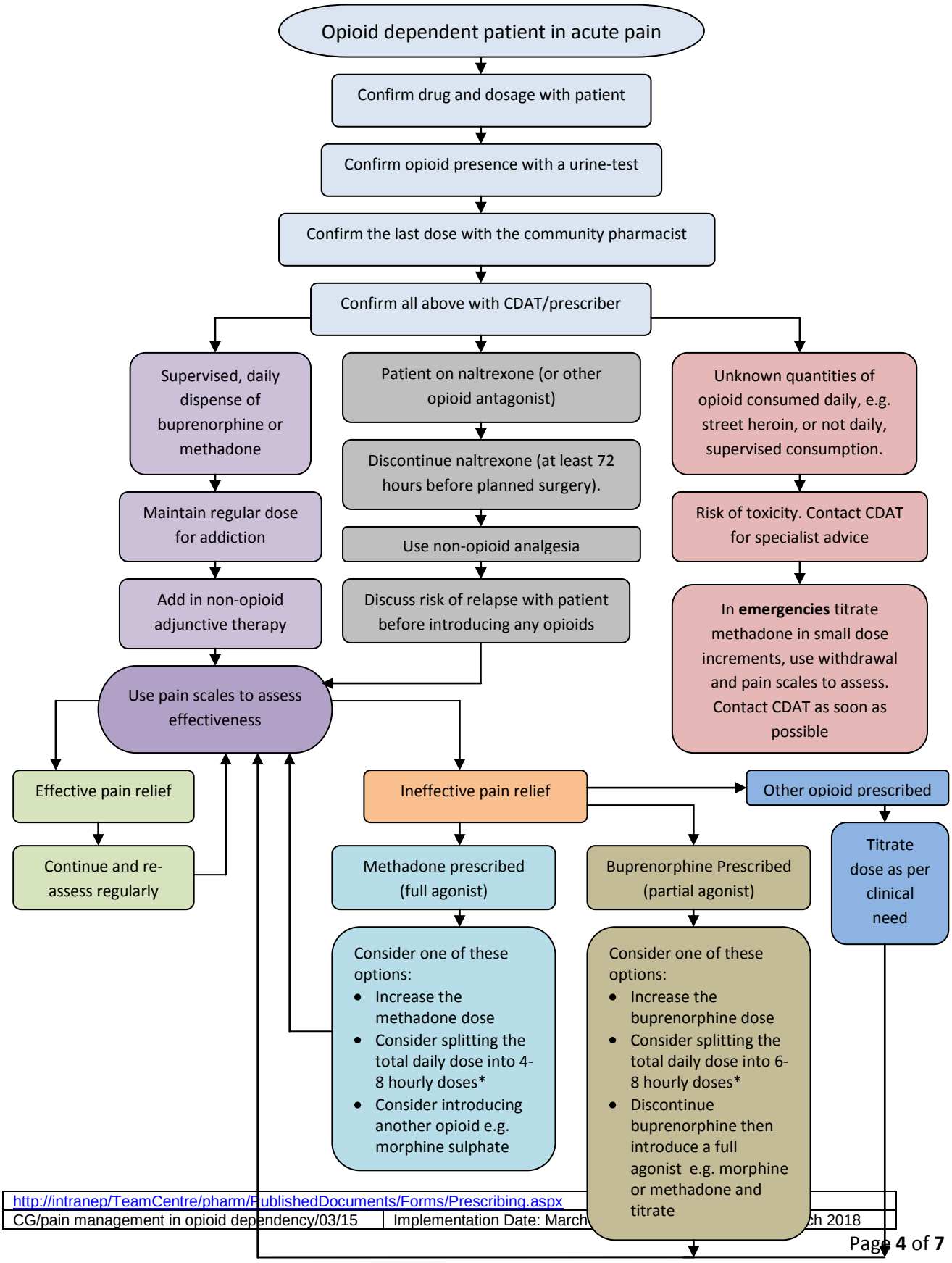
References

1. Royal College of General Practitioners (RCGP) - Guidance for the use of Substitute Prescribing in the Treatment of Opioid Dependence in Primary Care, 2011.
2. Action on Addiction. The Management of Pain in People with a Past or Current History of Addiction, 2013. http://www.actiononaddiction.org.uk/Documents/The-Management-of-Pain-in-People-with-a-Past-or-Cu.aspx
3. British Association of Psychopharmacology (BAP) updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, 2012.
4. West Essex CCG Management of Pain in People with a past or current history of addiction, Medicine Management, 2014.
5. NEP Policy for Community Opiate Substitute Prescribing of Methadone/Buprenorphine. Available at http://intranep/TeamCentre/pharm/PublishedDocuments/Forms/Prescribing.aspx

SUMMARY OF CHANGES

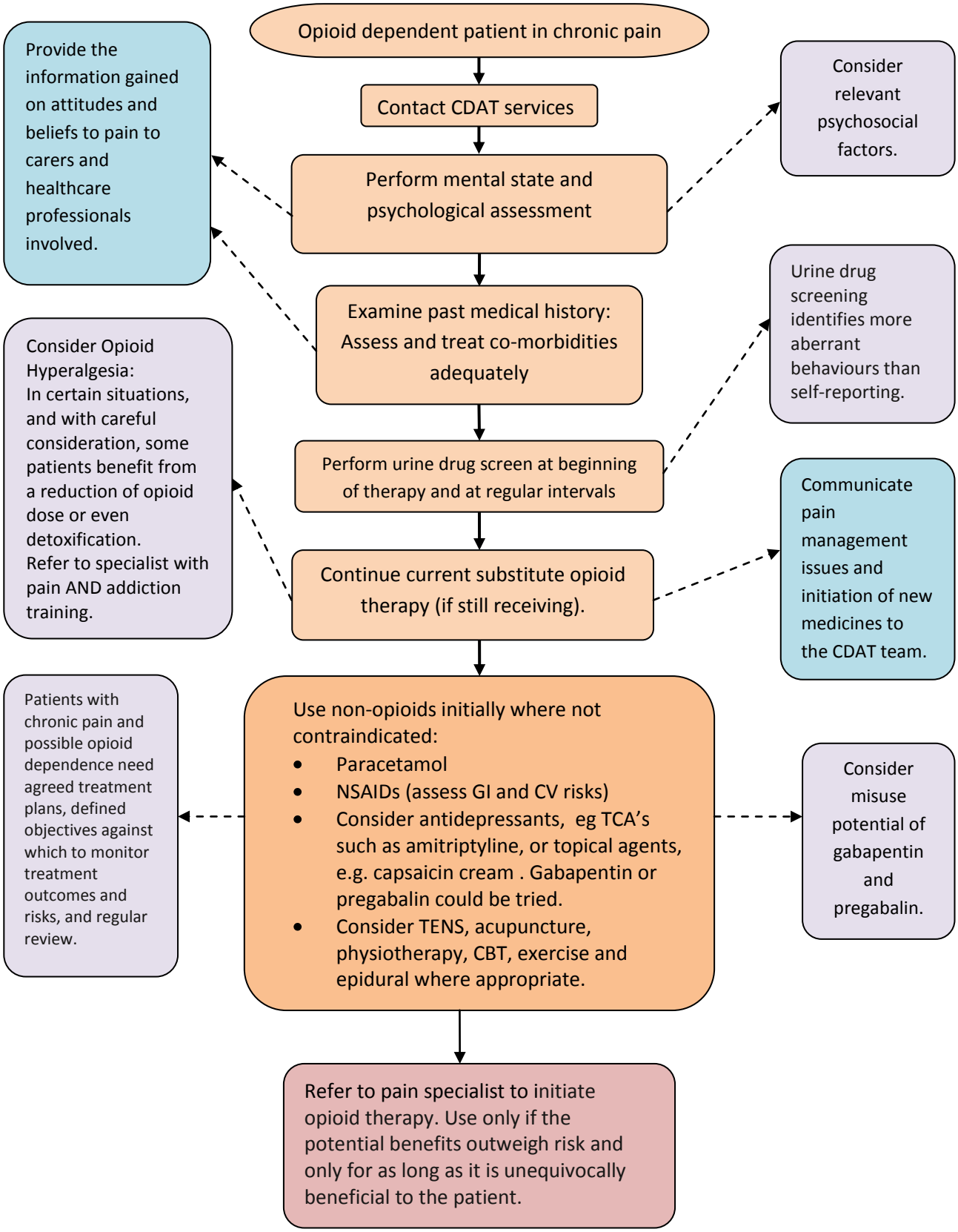
Date	Page Number(s)	Summary of Changes
Nov 2014	All	First draft
Jan 2015	4-7	Appendix 2 Flow chart for chronic pain. Appendix 3 Quick Reference Guide for methadone/buprenorphine prescribing and supply

Appendix 1: Flow Chart For Treating ACUTE Pain In Opioid Dependent Patients



*Splitting the dose is for short term use only as there is a risk of accumulation

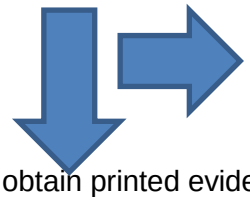
Appendix 2: Flow Chart For Treating CHRONIC Pain In Current and Former Opioid Dependent Patients



Appendix 3: Methadone and Buprenorphine: Quick Reference Guide for Prescribing and Supply for Inpatients During Working Hours (9am-5pm)

Admission of opioid dependent Service User (SU)

Confirm if SU is part of a community substance replacement programme or Drug & Alcohol Team (DAT) (local pharmacy staff can assist during office hours)



Also confirm use with urine screen (with approved test kit)

Effort should be made to obtain printed evidence (e.g. fax) of treatment regimen before prescribing on chart. Inform community prescriber of admission and have them cancel any active prescription at the community pharmacy

If unconfirmed ask for advice from DAT on an individual patient basis to prevent withdrawal on ward and document agreed management plan (see notes 1 and 2)

Notes 1

a) No substance replacement drug should be prescribed based only on information obtained from a service user or out of date documentation.

b) Patients who miss three days or more of their regular prescribed dose of opioid substitution therapy are at risk of overdose because of loss of tolerance. Consider reducing the dose in these patients (BNF 66).

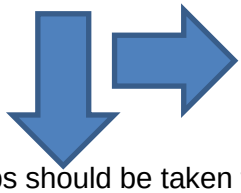
c) If the patient misses five or more days of treatment, an assessment of illicit drug use is recommended before restarting substitution therapy; this is particularly important for patients taking buprenorphine because of the risk of precipitated withdrawal (BNF 66).

d) Do not prescribe any TTAs for opiate substitution medication. Ensure the community prescriber is informed of the patients discharge and is able to restart prescribing. Fax or send details of opiate substitution dose.

e) The NEP medicines procedure tab 10 gives detailed instructions on how to manage CDs.

Appendix 3 continued: Methadone and Buprenorphine: Quick Reference Guide for Prescribing and Supply for Inpatients Out of Hours (after 5pm till 9am of next working day)

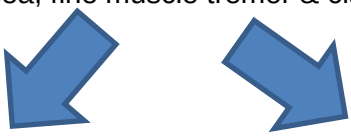
Admission of opioid dependent Service User (SU)



Confirm use with urine screen (with approved test kit)

Necessary steps should be taken to confirm treatment regimen (if possible check Drug & Alcohol Team (DAT) electronic records e.g. Poppie or Theseus and see notes 1a)

Assess for signs of opiate withdrawal (objective signs could start 4-24hrs after last dose of opiate and can include yawning, lacrimation, sneezing, runny nose, raised pulse/BP, dilated pupils, diarrhoea, nausea, fine muscle tremor & clammy skin)



Provide symptomatic relief if non-severe (see notes 2)

If severe and in absence of appropriate advice follow protocol for emergency substitution. Document & report via Datix, see also notes 1b-e

Notes 2

Adjunctive therapy and symptomatic relief for non-severe withdrawal symptoms:

Symptom	***Treatment***
Diarrhoea	Loperamide 4mg stat then 2mg after each loose stool (16mg max/day)
Stomach cramps	Mebeverine 135mg tds
Nausea & vomiting	Metoclopramide 10mg tds (oral/IM), short term only (5 days) or Prochlorperazine 5mg tds oral/12.5mg IM 12 hourly.
Muscular pains and headaches	Paracetamol/NSAIDs as per BNF regimen
Anxiety/agitation	Diazepam 5mg – 10mg tds
Insomnia	Zopiclone 3.75mg-7.5mg ON

Protocol for emergency substitution

Methadone: initial dose 10 – 20mg orally (SF mixture 1mg/1mL)

An additional 5-10mg can be given 4hrly if objective withdrawal symptoms persist within first 8 hours. For following two days give total previous day dose as a single dose each morning. All consumption must be supervised.

Dose can be adjusted up or down depending on patient response.

No more than 50mg daily should be prescribed unless advised otherwise by specialist service (DAT)