Reducing the risks with prescription opioids & gabapentinoids

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Outline

- Background information
  - Appreciate lessons learnt from the US opioid epidemic
  - Understand why opioids have been used in chronic non malignant pain
  - Risks and benefits of opioids
  - Opioids Aware: key messages and content
  - Safety and opioids: what does a patient need to know?
  - Prescription opioids: recognising risk factors

- Opioid and gabapentinoid prescribing and deprescribing: sharing and learning from good practice

- How can a HCP promote and support self management within a consultation?

- Pain management: keeping your knowledge up to date, accessing education, training and resources
Prescription opioid deaths

CONTROLLED DRUGS NEWSLETTER
SHARING GOOD PRACTICE IN THE SOUTH WEST

April 2017
SPECIAL EDITION – FAYE’S STORY

What can happen when things go wrong with prescribing for chronic pain – lessons that must be learned by all healthcare professionals

As told by her parents, Linda and Steve

Faye (right), when she was well
USA: Opioid misuse epidemic

Overprescribing is major contributor to opioid crisis
Surgeons in particular must change their behaviour

What we must learn from the US opioid epidemic
Fiona Godlee, editor in chief
The BMJ

Public health emergency vs. national emergency
The primary difference between the two designations is access to funding.
11% Americans (adults) experienced chronic pain (CDC 2016)

Over prescribing of opioids has led to enormous societal problems in USA (Ballantyne 2012)

National epidemic of opioid related overdoses, deaths and addictions (Volkow & McLellan 2016)

2016: Overdoses involving opioids killed more than 42,249 people. 40% of those deaths were from prescription opioids (Hedegaard et al 2017)

2017: 70,237 drug overdose deaths: Opioids were involved in 47,600 overdose deaths (67.8% of all drug overdose deaths) (CDC 2018)

On average, 130 Americans die every day from an opioid overdose (CDC 2018)
Is the UK on the same slippery slope?
1. Cost
- £263 million of tax payers money spent in England in 2017 on prescription opioids

2. Increase in prescriptions
- 90% prescribed by GPs’ - GPs prescribe twice as many opioids as they did 10 years ago
- 90% of nearly 24 million opioids prescribed annually are for chronic non-cancer pain

3. Limited effectives
- 90% of opioids prescribed do not work for chronic non-cancer pain

4. Risks
- 300,000 people in the UK are said to be problem users
The number of people attending hospital with poisoning from opioids more than doubled to 11,000 between 2005-06 and 2015-16 (NHS Digital. Note: 2016-17 data provisional).
Variation in English CCGs in opioid prescribing in equivalent mg of morphine from August 2010 to February 2014
PHE: public-health focused review
Jan 2018

Included within the scope of the review are:

- adults (age 18 and over)
- medicines that may cause dependence and discontinuation syndrome:
  - opioids
  - gabapentinoids
  - benzodiazepines
  - Z-drugs
  - antidepressants

https://www.gov.uk/government/news/prescribed-medicines-that-may-cause-dependence-or-withdrawal
Why have opioids been used for chronic non-cancer pain?
Why have opioids been used for chronic non-cancer pain?

- Pain relief viewed as a basic human right - Pain as ‘the 5th vital sign
- Early emerging literature lead to a view that opioids may play a role in long term pain
- Significant pharmaceutical marketing
- Absence of guidance or direction about which opioids to use and to what dose
- Many patients ‘held/ still hold strong views’ that opioids are helpful
- Lack of access to non pharmacological strategies
- Traditional medications no longer in favour
- The known gap between knowledge and clinical practice
Why have opioids been used for persistent pain?

Stannard 2013

Because...

- People with persistent pain may exhibit distress
- Distress can lead to clinicians prescribe
- Persistent pain can be hard to treat so prescribing something strong is a tempting idea
Pain intensity ratings do **not** necessarily reflect extent or severity of tissue damage.

**Suffering** may be related as much to the meaning of pain as to intensity.

Persistent helplessness and hopeless may be the root causes of suffering for patients with chronic pain yet be reflected in a report of high pain intensity.

**Inappropriate reliance on pain intensity** ratings tends to result in the use of opioid treatment for patients with mental health or substance abuse problems.
Opioids Aware
2015

www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
1. Opioids are very good analgesics for acute pain and end of life pain but there is little evidence that they are helpful for long-term pain.

2. A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and use is intermittent, but it is difficult to identify these people at the start of treatment.

3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120 mg/day, but there is no increased benefit.

4. Opioids should be discontinued if the person is still in pain despite using opioids, even if no other treatment is available.

5. A detailed assessment of the emotional influences on the person's pain experience is essential for people with chronic pain who also have refractory and disabling symptoms, particularly if they are on high opioid doses.
Adverse selection is where ‘the most risky drug regimes are prescribed to the patients most likely to be harmed by them’ Stannard 2018 BJA 120(6) 1148

Risk of running into problems with high dose opioids

Patient factors
- Depression/common mental health diagnoses
- Alcohol misuse/non-opioid misuse
- Opioid misuse

Drug factors
- High doses
- Multiple opioids
- More potent opioids
- Concurrent benzodiazepines/sedative drugs
Chronic pain treatment strategies that focus on improving the quality of life, especially those integrating behavioural and physical treatments, are preferred.

- IASP recommends caution when prescribing opioids for chronic pain.

- There may be a role for medium-term, low-dose opioid therapy in carefully selected patients with chronic pain who can be managed in a monitored setting. However, with continuous longer-term use, tolerance, dependence, and other neuroadaptations compromise both efficacy and safety.

https://www.iasp-pain.org/Advocacy/OpioidPositionStatement
November 2018

Briefing Statement to Health Professionals on the Management of Opioid Medications

The Faculty of Pain Medicine of the Royal College of Anaesthetists

21

November 2018

Briefing Statement to Health Professionals on the Management of Opioid Medications

I. Key Messages

A. There is a great need to:
- Raise awareness about patients who are not taking their medication properly.
- Make clinical decisions about opioid reduction and optimal pain management when appropriate.
- Identify the best clinical approach and doses of opioids in pain management.
- Ensure that there are resources to deal with patients captured by new screening.
- Employ clinical approaches to manage those who are non-compliant.

B. The severity should be objectively and clinically assessed to determine the safest and most appropriate course of treatment.

C. The required services need to be fully commissioned to support patients.

II. Introduction

A. There are considerations and practices concerning the management of chronic pain in the United Kingdom. There is a clear professional and governmental concern regarding the use of opioid medicines and the number of prescriptions of opioid analogues. The findings of the various public health organizations in the country outline the issues and recommendations for the implementation.

B. Opioids in non-malignant pain

1. Opioids are considered the mainstay of analgesia in chronic non-malignant pain. They are effective in relieving pain, improving function, and reducing disability. However, the use of opioids in chronic pain is controversial and requires careful consideration.

2. The benefits of opioids include:
- Pain relief.
- Improvement in quality of life.
- Reduction in the use of non-opioid medications.

C. Opioids in chronic non-malignant pain

1. Opioids play a significant role in pain management, but their use is not without risks. They can be addictive, and their inappropriate use can lead to dependence and misuse.

2. Pain management should be individualized, and the risk of addiction should be minimized.

D. Opioids in chronic non-malignant pain

1. The use of opioids should be guided by evidence and best practice guidelines.

2. Pain management should involve a multidisciplinary approach.

E. Opioids in chronic non-malignant pain

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**Note:** The risks and harms greater than those associated with the use of opioids are not addressed in this briefing. The focus is on the risks associated with the use of opioids in pain management.
Prescription opioids: effectiveness versus harm

Three-talk model of shared decision making, 2017.
Glyn Elwyn et al. BMJ 2017;359:bmj.j4891
**Chronic pain and opioid effectiveness**

**In trials:**

- Most medicines for long-term pain only benefit around one in every four or five people and on average only provide a 30% reduction in pain (Opioids Aware 2015).

- **Clinical practice:** probably fewer than one in ten patients prescribed opioids in real life….will be helped much at all, with benefit being modest at best but potentially life changing for the better when it occurs (Stannard 2018 BJA 120 (6) 1148).

- There is no particular type of pain that is more suitable for or responsive to opioid treatment (Stannard 2018).

- Short term efficacy does not guarantee long-term efficacy (Opioids Aware 2015).
## Opioid adverse effects & risks

<table>
<thead>
<tr>
<th>Effect</th>
<th>System/Condition</th>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea or vomiting</td>
<td>Endocrine dysfunction</td>
<td>Overdose (risk is dose dependent)</td>
</tr>
<tr>
<td>Itching</td>
<td>Immune system</td>
<td>Misuse: 1.4-1.5 Abuse/diversion</td>
</tr>
<tr>
<td>Feeling dizzy/sleepy/confused</td>
<td>Opioid hyperalgesia</td>
<td>Addiction (dependency) 1.10-1.11</td>
</tr>
<tr>
<td>Chronic constipation</td>
<td>Falls and fractures</td>
<td>Co-prescriptions with hypnotics &amp; CNS depressants including alcohol</td>
</tr>
<tr>
<td>Weight gain</td>
<td>Road traffic accidents</td>
<td>Serotonin syndrome</td>
</tr>
<tr>
<td>Difficulty in breathing at night/respiratory depression</td>
<td>Neonatal abstinence syndrome</td>
<td>Refractory tolerance, when treating acute or end of life pain</td>
</tr>
</tbody>
</table>

**Notes:**
- Hypnotics: drugs used to induce sleep.
- CNS: Central Nervous System.
BNF app
Prescription opioids: patient information

Recognising the patient on high doses of opioids

<table>
<thead>
<tr>
<th>Prescription</th>
<th>Guesstimate of oral MED/d</th>
<th>Calculated dose of oral MED/d</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. OxyCodone modified release 60 mg twice a day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Fentanyl transdermal patch 75 microgram hour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Buprenorphine transdermal patch 70 microgram an hour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tramadol 100 mg four times a day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Buprenorphine 20 microgram an hour plus codeine 60 mg four times a day</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MED/d = Morphine equivalent dose / day
### Approximate equi-analgesic potencies of opioids for oral administration

<table>
<thead>
<tr>
<th>Drug</th>
<th>Potency ratio with oral morphine</th>
<th>Equivalent dose to 10mg oral morphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine phosphate</td>
<td>0.1</td>
<td>100mg</td>
</tr>
<tr>
<td>Dihydrocodeine</td>
<td>0.1</td>
<td>100mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5</td>
<td>1.3mg</td>
</tr>
<tr>
<td>Methadone</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Morphine</td>
<td>1</td>
<td>10mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>2</td>
<td>5mg</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>0.4</td>
<td>25mg</td>
</tr>
<tr>
<td>Tramadol</td>
<td>0.15</td>
<td>67mg</td>
</tr>
</tbody>
</table>

### Transdermal Opioids

#### A. Buprenorphine

Transdermal buprenorphine changed at weekly intervals

<table>
<thead>
<tr>
<th></th>
<th>5 microgram/hr</th>
<th>10 microgram/hr</th>
<th>20 microgram/hr</th>
</tr>
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<tbody>
<tr>
<td>Codeine phosphate (mg/day)</td>
<td>120mg</td>
<td>240mg</td>
<td></td>
</tr>
<tr>
<td>Tramadol (mg/day)</td>
<td>100mg</td>
<td>200mg</td>
<td>400mg</td>
</tr>
<tr>
<td>Morphine sulphate (mg/day)</td>
<td>12mg</td>
<td>24mg</td>
<td>48mg</td>
</tr>
</tbody>
</table>

Transdermal buprenorphine changed every three or four days (twice weekly)

<table>
<thead>
<tr>
<th>Morphine sulphate (mg/day)</th>
<th>35 microgram/hr</th>
<th>52 microgram/hr</th>
<th>70 microgram/hr</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>84mg</td>
<td>126mg</td>
<td>168mg</td>
</tr>
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#### B. Fentanyl

<table>
<thead>
<tr>
<th>Fentanyl patch strength (microgram/hr)</th>
<th>Oral morphine (mg/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>45</td>
</tr>
<tr>
<td>25</td>
<td>90</td>
</tr>
<tr>
<td>50</td>
<td>180</td>
</tr>
<tr>
<td>75</td>
<td>270</td>
</tr>
<tr>
<td>100</td>
<td>360</td>
</tr>
<tr>
<td>300</td>
<td>1120</td>
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<td>60 mg MED/d</td>
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<td>72 mg MED/d</td>
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MED/d = Morphine equivalent dose / day
Dose equivalence charts

OPIOID EQUIVALENCE, RISKS AND RECOMMENDATIONS

The information in the table below applies to non-cancer chronic pain in adults.

<table>
<thead>
<tr>
<th>OPIOID</th>
<th>Oral morphine &lt; 50 mg per day</th>
<th>Oral morphine 50 - &lt;100 mg per day</th>
<th>Oral morphine 100 mg per day</th>
<th>Oral morphine 120 mg per day</th>
<th>Oral morphine 200 mg per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone</td>
<td>&lt;12.5 mg bd = &lt;50 mg</td>
<td>&lt;25 mg bd = &lt;100 mg</td>
<td>25 mg bd = 100 mg</td>
<td>30 mg bd = 120 mg</td>
<td>50 mg bd = 200 mg</td>
</tr>
<tr>
<td>Fentanyl transdermal patch</td>
<td>12 mcg/hr = 45 mg</td>
<td>25 mcg/hr = 90 mg</td>
<td>25 mcg/hr = 90 mg</td>
<td>50 mcg/hr = 180 mg</td>
<td>75 mcg/hr = 270 mg</td>
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<tr>
<td>Buprenorphine transdermal patch</td>
<td>20 mcg/hr = 48 mg</td>
<td>35 mcg/hr = 84 mg</td>
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<td>52 mcg/hr = 126 mg</td>
<td>70 mcg = 168 mg</td>
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<tr>
<td>Tapentadol</td>
<td>50 mg bd = 40 mg</td>
<td>100 mg bd = 80 mg</td>
<td>100 mg bd = 80 mg</td>
<td>150 mg bd = 120 mg</td>
<td>250 mg bd = 200 mg</td>
</tr>
<tr>
<td>Tramadol</td>
<td>50 mg qds = 30 mg</td>
<td></td>
<td>100 mg qds = 60 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>60 mg qds = 24 mg</td>
<td></td>
<td></td>
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<td></td>
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RISK OF HARM

- Pregnancy, age ≥65, anxiety or depression, overdose history, personal or family history of alcohol, substance/opioid misuse, renal and hepatic impairment, COPD or underlying respiratory conditions.
- Drug factors: Multiple opioids, multiple formulations of opioids, more potent opioids, concurrent prescriptions of benzodiazepines/CNS depressants.
- Doses of ≥120 mg oral MED/d increase the risk of harm without increased benefit.
- Opioid-related overdose risk is dose-dependent.
- Doses of 50-<100 mg MED/d increases the risk for opioid overdose by factors of 1.9 to 4.6 compared with 1-<20 mg MED/d.
- Doses of ≥100 mg MED/d increases the risk of overdose significantly: 2.0-8.9 compared with 1-<20 mg MED/d.

DRIVING

- Patients may be particularly vulnerable to impairment when first starting a pain medication, following dose adjustments (up or down), when another drug is added or opioid taken in conjunction with alcohol.
- All opioid medicines have the potential to impair driving. A patient on high dose morphine (around 200-220 mg/24 hours) driving could be as impaired as someone with blood alcohol around the level above which it is illegal to drive. Alcohol and sedatives may impair driving at a lower morphine dose.

RECOMMENDATIONS

Undertake polypharmacy medication review, assess whether benefits outweigh risks and whether opioid trial goals are still being met. Consider opioid tapering and discontinuation. There may be a role for medium term, low dose opioid therapy in carefully selected patients who can be monitored. Provide patient information leaflets.

References:
Dose equivalence calculator

Enter 24-hour total doses below, then click the convert button to display 24-hour equianalgesic doses.

Morphine Oral
Codeine Oral
Dihydrocodeine Oral
Oxycodone Oral
Tramadol Oral
Hydromorphone Oral
Tapentadol Oral
Methadone Oral

Fentanyl SC
Diamorphine SC
Alfentanil SC
Hydromorphone SC
Oxycodone SC

Morphine IV
Fentanyl IV

Fentanyl Patch
Buprenorphine Patch

Morphine Epidural
Morphine Intrathecal

Recommended by NHS Scotland
http://paindata.org/calculator.php
Opioids and chronic pain: initiation trial and monitoring

PAIN LADDER - CHRONIC PAIN
Pain treatment pathway for non-cancer chronic pain ≥ 3 months duration in adults in primary care

Key Principles
- Consider early referral to West Suffolk Pain Service Single Point of Access in patients with excessive, uncontrolled or rapid escalating opioid requirements, and/or significant pain preventing sleep, function or work, or causing distress
- Progressing through the steps below does not guarantee increased benefit or better pain relief. Medication does not always work; stop medicines that are not working.
- 3-monthly medication reviews are recommended for all patients taking regular analgesics; prioritise Polypharmacy Medication Reviews for patients taking opioids or gabapentinoids

Assessment and non-pharmacological strategies
- Include red flags. Assess pain/infect and yellow flags
- Consider possibility of neuropathic pain: neuropathic pain ladder
- Establish expectations and agreed goals
- Discuss non-pharmacological strategies and provide signposting information
- Consider referral to: Wellbeing Service, physiotherapy, gentle exercise/weight loss programme, or TENS

Please turn over for steps 4 & 5
Opioid tapering resource pack

OPIOID TAPERING FOR CHRONIC NON-CANCER PAIN
Guidance for adults in primary care

Indications for opioid tapering and/or discontinuation:
- Unwilling patient condition, relative or stable for at least 3 months
- Side effects intolerable or impair function
- Patient requests definitive pain relief intervention
- Younger age than the patient's desire to continue treatment
- Not adherence to treatment plan
- Indication for independence

Precautions: preparation, stable status, 24-hour pain, and patient medication

OPIOID TAPERING FOR CHRONIC NON-CANCER PAIN
Guidance for adults in primary care

CONTINUED FROM STEPS 1, 2, 3 OVERLAP

CLINICAL REVIEWS
- Frequency of review: determine the rate and duration of support required e.g. monthly if 10% drop every 1.2 weeks
- Assess reduction in side effects, improvements in activity, daily living, mobility and emotional well-being as well as withdrawal symptoms and pain
- Same prescriber to ideally review patient telephone or face to face to prevent an abrupt decrease of opioid

Successful tapering
- Excretion of pain or worsening of mood
  - Discuss with patient
  - You will probably work with them to manage their pain and mood
  - The importance of using non-drug, multidisciplinary pain management strategies

Withdrawal symptoms
- Discuss with patient
- You will probably work with them to manage withdrawal symptoms
- Although withdrawal symptoms may occur during the tapering process and are unpleasant, they are rarely medically serious
- With the majority of withdrawal symptoms settle within a few weeks, some may persist for up to 6 months after discontinuation of opioid

CASE STUDIES
- Successful tapering
  - Maintain stable pain
  - Monitor patient closely
  - Follow-up: see attached monitoring sheet

OPIOID TAPERING FOR CHRONIC NON-CANCER PAIN
Guidance for adults in primary care

RESOURCES
- Opioid Assess: http://asthmatic.co.uk/clinical-guidance/opioid-assessment
- Opioid Assess: http://www.suffolkccg.nhs.uk/clinical-guidance/opioid-assessment
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**Education and therapies**

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### West Suffolk Pain Management Service
#### Non-pharmacological Services

**Education Options**
- Understanding pain
- Managing pain
- Pain medication education
- **Opioid education**
- Getting fit to stay or get back to work
- Diet, nutrition & pain
- Sleep & relaxation
- Journey towards change (based on CBT)
- Valued living (based on ACT)
- Education for discharge/admission avoidance

**Therapies**
- Psychological
- Specialist pain physiotherapy
- TENS
- Hypnotherapy and relaxation
- Mental health pain clinic

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**West Suffolk Pain Services: Opioid education**

**Evidence/information**
- Why have we used strong opioids for persistent pain?
- What lessons have we learnt from using opioids for persistent pain?
- Understanding risks and benefits of long-term opioid therapy
- Exploring your risk factors for taking opioids
- What are the current recommendations for the use of opioids in persistent pain?
- Driving and opioids: what should I know?
- Improving the safety of taking opioids in pain: what can you do?

**Opioid tapering**
- Overuse of opioids: exploring common reasons
- What are the challenges and benefits of reducing opioids?
- Useful tips for reducing opioids
- Dose reduction or not: what are your options?
- Useful resources
Key resources

https://dtb.bmj.com/content/56/10/118
OPIOID PRESCRIBING FOR ACUTE PAIN

KEY RECOMMENDATIONS

Prescribing opioids for acute pain is associated with an increased likelihood of long-term opioid use. To minimise the initial opioid exposure, keep the duration of treatment as short as possible and the total dose as low as possible. This also minimises the risk of overdose and the likelihood of diversion/inappropriate use; however, severe untreated acute pain may lead to the development of chronic pain.

1. GOAL
The goal for prescribing opioids in acute pain should be a tolerable level of pain that facilitates optimal physical and emotional function and avoids complications.

2. BEFORE PRESCRIBING OPIOIDS
- Undertake comprehensive assessment.
- Promote and optimise non-pharmacological strategies for acute pain.
- Optimise non-opioid therapy when benefits outweigh risks to maximise analgesia and reduce opioid requirements.
- Exercise caution when prescribing opioids for older or debilitated patients.
- Consider and address underlying anxiety and depression.

Absolutely avoid
- Co-proxamol.
- Avoid
- Compound analoges.
- prescribing separately gives flexibility in both adjustment of doses and in the selection of most appropriate combination.
- Modified-release opioid preparations.
- Oxycodeine as first line.
- Co-prescribing medications with sedating properties, whenever possible. In particular, avoid co-prescribing with benzodiazepines due to increased risk of potentially fatal overdose); and with gabapentinoids due to increased risk of CNS depression.

3. DOSE
- Refer to local acute pain guidelines.
- Prescribe lowest effective dose of immediate-release opioid for the expected duration of the pain severe enough to require opioids.
- Use age related dose if prescribing morphine or oxycodone.
- Adjust dose for clinical factors such as renal or hepatic insufficiency and pain intensity.
- With pm opioids include maximum daily amount or frequency of doses.
- Avoid making dose increases under pressure: A team decision for complex patients shares the load.

4. DURATION
- Each day of unnecessary opioid use increases the likelihood of physical dependence without added benefit.
- Prescribe
- For the expected duration of the pain severe enough to require opioids or until a follow-up appointment is scheduled. Duration of 3 days or less is usually sufficient. A duration of more than 7 days is rarely needed.
- Aim to stop strong opioids commenced for post-operative pain within 7 days of surgery. Duration of opioid prescription post-surgery, not dose, is a more significant risk factor for subsequent opioid misuse.
- Review diagnosis and treatment plan if severe acute pain continues longer than expected. Consider seeking advice.
- Avoid
- Replacing opioids on repeat prescriptions for acute pain - opioids should be a course of treatment with a definite end.
- Prescribing additional opioids in acute pain for the “just in case” scenario.

5. PROVIDE PATIENT INFORMATION
- Benefit and risks of opioid therapy and alternative options.
- How to use opioids.
- Driving impairment and opioid safety.
- Requirements for review and monitoring.
- How to taper and discontinue opioids.
- To take unwanted or unused opioids back to a community pharmacy or dispose of to minimise risks of diversion and inappropriate use.

REFERENCES
- Royal College of Psychiatry and心理健康

FURTHER INFORMATION
- NHS Clinical Knowledge Summary: Acute Pain.
Gabapentinoids

- The rate of patients newly treated with gabapentinoids has tripled from 2007 to 2017 in primary care.

By 2017
- 50% of gabapentinoid prescriptions were for an off-label indication.
- 20% of gabapentinoid prescriptions had a co-prescription for opioids.

Advice for healthcare professionals:
- be aware of the risk of CNS depression, including severe respiratory depression, with gabapentin
- consider whether dose adjustments might be necessary in patients at higher risk of respiratory depression, including elderly people, patients with compromised respiratory function, respiratory or neurological disease, or renal impairment, and patients taking other CNS depressants
- report any suspected adverse reactions on a Yellow Card

PHE 2014

MHRA 2017
Gabapentinoids

First option
- Amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment (except trigeminal neuralgia).

Second, third and fourth option
- If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated etc. etc.

Consider
- NSAIDs for LBP
- Weak opioids with or without paracetamol for management of acute LBP only if NSAID contraindicated, not tolerated or in effective

Do not offer
- Paracetamol alone for LBP
- Opioids routinely for acute LBP
- Opioids for chronic low back pain
- SSRIs, SNRIs, TADs or anticonvulsants for LBP

See NICE CG 173 for management of sciatica
# Gabapentinoid background and evidence


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**Gabapentinoid Prescribing for Chronic Pain in Primary Care - Resources for Clinicians and Boards v1.0**  

## Background & Evidence

Gabapentinoids, when used appropriately, have been shown to be effective for some patients in the management of neuropathic pain. The table below [1] provides the number needed to treat (NNT) and number needed to harm (NNH) for both drugs.[2]

<table>
<thead>
<tr>
<th>Drug</th>
<th>NNH (95% CI)</th>
<th>NNT (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregabalin</td>
<td>13.9 (95% CI 11.6-17.4)</td>
<td>7.7 (95% CI 6.5-9.4)</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>25.6 (95% CI 15.3-78.6) and 28.3 (95% CI 17-230) for extended release (ER) preparations</td>
<td>6.3 (95% CI 5.0-8.3) and 8.3 (95% CI 6.2-13) for extended release (ER) preparations</td>
</tr>
</tbody>
</table>

*Gabapentinoids are not licensed for non-neuropathic pain, nor is there any evidence to support their use.

Gabapentinoids will be reclassified class C controlled substances under section the Misuse of Drugs Act from April 2019[3]*

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Changing evidence base

- Gabapentin at doses of 1800 mg to 3600 mg daily (1200 mg to 3600 mg gabapentin encarbil) can provide good levels of pain relief to some people with post herpetic neuralgia and peripheral diabetic neuropathy. Evidence for other types of neuropathic pain is very limited.

- Moderate to high quality evidence that anti-convulsants are ineffective for treatment of LBP or lumbar radicular pain.

- High quality evidence that gabapentinoids have a higher risk of adverse effects.
Gabapentinoids for neuropathic pain
WSCCG 2017

- Gabapentinoids should be used only as part of a wider management plan
- Hyperlinks embedded within ladder
- Included trial and discontinuation guidance
- Pregabalin on advice from West Suffolk Pain Services
- Review patients 3-6 monthly
## Some of the adverse effects & risks

*(Adapted from Granger 2018)*

<table>
<thead>
<tr>
<th>Adverse Effect</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness</td>
<td>24-31%</td>
</tr>
<tr>
<td>Ataxia</td>
<td></td>
</tr>
<tr>
<td>Somnolence</td>
<td>22%</td>
</tr>
<tr>
<td>Cognitive impairment including memory</td>
<td></td>
</tr>
<tr>
<td>Peripheral oedema</td>
<td>Depression /suicidal ideation</td>
</tr>
<tr>
<td>Weight gain</td>
<td>Diversion/misuse/abuse</td>
</tr>
<tr>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Dry mouth/blurred vision</td>
<td>Co-prescriptions with hypnotics &amp; CNS depressants including alcohol</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td></td>
</tr>
<tr>
<td>Decreased libido 35%</td>
<td></td>
</tr>
<tr>
<td>Erectile dysfunction 51%</td>
<td></td>
</tr>
<tr>
<td>Decreased libido 35%</td>
<td></td>
</tr>
<tr>
<td>Anorgasmia 35%</td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>England and Wales 2016-165 deaths in England and Wales of which 147 involved an opioid (ONS 2017)</td>
</tr>
</tbody>
</table>

- Rate of adverse effects (AEs) are dose related which increases with higher doses
- No clear relationship between AEs to age
Misuse, abuse and dependent use

High risk patients

Assessment of the balance between benefits and risk essential

- History of substance misuse
- Request for initiation of gabapentinoids following liberation from prison services
- Specific request for initiation of gabapentinoids
- Repeated early prescription requests
- Repeatedly lost prescriptions
- Contact out of hours services for supplies of medication

Positive effects

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregabalin</td>
<td>• Euphoria, lifted mood, giddiness, relaxation, increased motivation and lower inhibitions. 13 May be used to enhance the effects of heroin and reduce the amount of heroin needed. 12</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>• Relaxation, calmness and euphoria. Some users have reported that the ‘high’ from snorting gabapentin can be similar to taking a stimulant. 24</td>
</tr>
</tbody>
</table>

Negative effects

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregabalin and gabapentin</td>
<td>• Drowsiness, sedation, respiratory depression and death may occur when used in combination with other central nervous system depressants including opioids, antidepressants, antihistamines, tranquillers and alcohol. 12,13 • Physical dependencies, illegal diversion, misuse and abuse.</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>• Chest pain, wheezing, swelling of extremities, weight gain, thirst, clumsiness, muddled thoughts, dizziness and drowsiness, sedation, vision changes and, less commonly, hallucinations. 12,18</td>
</tr>
</tbody>
</table>
Gabapentinoid reclassification
(2018)

- Gabapentinoid to placed under Schedule 3 of the Misuse of Drugs Regulations 2001 and Class C of the Misuse of Drugs Act 1971 form April 2019

**Patient information**

- Why: illicit drug use (dependency, misuse or diversion) increased in deaths.
- It is illegal to possess controlled substances without a prescription or to sell or otherwise supply them to others.
- Prescriptions of pregabalin and gabapentin will be limited to 30 days’ treatment, and repeat prescriptions will not be issued. Any prescription received must be dispensed within 28 days.
Pregabalin and gabapentin withdrawal summary guidance

WSCCG 2019

Pregabalin and Gabapentin: Withdrawal Summary Guidance for NON-CANCER pain in adults in primary care
Pharmacologic therapy should not be considered a long term management strategy.

How often to review
- At least monthly, as an absolute priority, for patients with a history of misuse or if recently released from prison.
- 3 weeks after initiation.
- At least every 3 months if co-prescribed with opioids.
- Every 3-6 months for all other patients.

Assess effectiveness, tolerability, adverse effects and adherence.

Indications for trial withdrawal
- After two months of relative improvement in pain following stabilisation on treatment.
- If pain is months for patients on long term treatment.
- If poor response to treatment.
- Where gabapentins are being prescribed for pain outside their licensed indication, e.g. for non-neuropathic pain (unless recommended by the West Suffolk Integrated Pain Management Service).
- On request of patient.
- If side effects are intolerable.
- If there is evidence of diversion or non-adherence to treatment.
- If patient is pregnant, breastfeeding or planning to conceive (unless the benefits to the mother outweigh the potential risk to the foetus or baby).

Warning patients of risk of overdose or death if a higher dose of pregabalin or gabapentin is taken following tapering as tolerance is reduced.

Unsuccessful withdrawal
- If complete withdrawal of treatment is not successful, continue on the last dose in the reduction regimen at which pain was tolerable and discuss long term goals and non-pharmacological management. Consider referral to West Suffolk Integrated Pain Management Service and/or condition specific service. Re-attempt tapering in 3-4 months as dictated by patient and clinical factors.

Drug | Reduction schedule
---|---
Pregabalin (total daily dose > 900 mg) | Reduce total daily dose by 100 mg every 10 days (range 7-14 days)
Gabapentin (total daily dose > 200 mg) | Reduce total daily dose by 100 mg every 10 days (range 7-14 days)
Pregabalin | Reduce total daily dose by 50-100 mg every 10 days (range 7-14 days)

Patient Support Available
- Patient Information Leaflet: [open link]
- Clinical advice via West Suffolk Integrated Pain Management Service. Tel: 01284 712252 or 0845 2441 3313 (option 4)
Pregabalin and Gabapentin: Withdrawal Summary Guidance
for NON-CANCER pain in adults in primary care

Pharmacologic therapy should not be considered a long term management strategy.

How often to review
- At least monthly, as an absolute priority, for patients with a history of misuse or if recently released from prison
- 8 weeks after initiation
- At least every 3 months if co-prescribed with opioids
- Every 3-6 months for all other patients

Assess effectiveness, tolerability, adverse effects and adherence

Indications for trial withdrawal
- After two months of relative improvement in pain following stabilisation on treatment
- Every 6 months for patients on long term treatment
- If poor response to treatment
- Where gabapentinoids are being prescribed for pain outside their licensed indication, e.g. for non-neuropathic pain (unless recommended by the West Suffolk Integrated Pain Management Service)
- On request of patient
- If side effects are intolerable
- If there is evidence of diversion or non-adherence to treatment
- If patient is pregnant, breastfeeding or planning to conceive (unless the benefits to the mother outweigh the potential risk to the foetus or baby)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Reduction schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gradual dose taper allows observation of emergent symptoms that may have been controlled by the drug.</td>
<td></td>
</tr>
<tr>
<td>Gabapentin (total daily dose &gt; 900 mg)</td>
<td>Reduce total daily dose by 300 mg every 10 days (range 7-14 days)</td>
</tr>
<tr>
<td>Gabapentin (total daily dose ≤ 900 mg)</td>
<td>Reduce total daily dose by 100 mg every 10 days (range 7-14 days)</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>Reduce total daily dose by 50-100 mg every 10 days (range 7-14 days)</td>
</tr>
<tr>
<td></td>
<td>Warn patients of risk of overdose or death if a higher dose of pregabalin or gabapentin is taken following tapering as tolerance is reduced</td>
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</tbody>
</table>

Unsuccessful withdrawal
- If complete withdrawal of treatment is not successful, continue on the last dose in the reduction regimen at which pain was tolerable and discuss long term goals and non-pharmacological management. Consider referral to West Suffolk Integrated Pain Management Service and/or condition specific service. Re-attempt tapering in 3-6 months as dictated by patient and clinical factors.

Patient Support Available
- Patient Information Leaflet: Gabapentinoid Reduction
- Clinical advice via: West Suffolk Integrated Pain Management Service. Tel: 01284 712528 or 0845 241 3313 (option 6)
Incidence and severity of withdrawal symptoms may be dose and speed of reduction related (PHE 2014, Granger 2018, SPC 2018).

Several case reports of serious withdrawals requiring hospitalisation or intensive therapy (Granger 2018).


Withdrawal symptoms:
- anger and irritability
- nausea and stomach cramps
- anxiety and panic
- restlessness
- sweating
- suicidal thoughts
- poor concentration
- sleep problems
- aches
- chills
- crying spells
- feeling like a zombie, unreal
- diarrhoea
- dizziness
- tiredness
- headaches
- hot flushes

Not everyone who is dependent on Pregabalin will experience significant withdrawal symptoms. Some do and they may experience quite a few of the above. We will discuss how to reduce the chances of these unpleasant symptoms later.

http://www.publichealth.hscni.net/sites/default/files/Pregabalin%20Guidance%20Booklet%20A4%20Final%20Web_0.pdf
### Gabapentinoids: Key resources and quick reference guide

**Gabapentinoid Prescribing for Chronic Pain in Primary Care**

**Resources for Clinicians and Boards**

**VERSION 1.2 – 11th December 2018**


https://www.therapeutics.scot.nhs.uk/pain/

Supporting self-management

It is recommended that health care professionals (HCPs) should work with patients to develop:

1. Their understanding of chronic pain.
2. The value of self-management and non-pharmaceutical approaches.
3. Supportive strategies to enable people to access the tools, resources and support available to put these approaches into practice.
Non-pharmacological hyperlinks
Steps to promote and support self-management

Step 1
- Discuss with patient the impact of pain - see pain cycle above
- Explain: persistent pain / reassure

Step 2
- Enable access: to resources/tools to increase knowledge & skills
- Assess: patient's confidence to self-management

Step 3
- Self referral: One Life Suffolk, Physiotherapy, Wellbeing
- Refer: West Suffolk Pain Services Single Point of Access

PLEASE TURN OVER FOR RESOURCES AND TOOLS

Pain Cycle

Depression & mood swings

Time off work, money worries, relationship concerns

Persistent Pain

Being less active

Loss of fitness, weak muscles, joint stiffness

Create ‘no go’ lists of things you cannot do

Sleep problems, tiredness & fatigue

Medication side effects

Stress, fear, anxiety, anger & frustration

Weight gain or loss

Negative thinking, fear of the future,
Step 1: Explain pain

Australian video:

Understanding pain and what to do about it in less than 5 mins
Step 2: Resources/tools

Prescribe a book

Despite the surge in popularity of self-help literature, books are not a greatly used resource by people with pain.

The Reading Agency is a good place to start. They have a range of books available, both fiction and non-fiction, that are recommended for people with pain.

An Introduction to Living Well with Pain

A pocket size book designed to guide people with pain through “70 steps” of self-management to live a full, valued life despite pain. An easy read, with illustrations – a great starter to self-management.

Published by Little, Brown Book Group
1E-99
ISBN 9781713172722
Available online from Amazon; Waterstones; Blackwells and from all good bookshops
For Clinicians

For patients

https://livewellwithpain.co.uk/

http://my.livewellwithpain.co.uk/
Summary—a good prescription

(Stannad 2016, 2018)

Is effective for the condition
Does not harm the patient
Does not harm anyone else
Is acceptable to the patient
Is legal and accurate

Key message

So giving a prescription for something that is likely not to work is a clinical ‘big deal’ in relation to iatrogenic harm

Stannard BJA 2018 120(6) 1148
Summary

- Opioids are valuable in the management of acute pain, pain related to cancer and for pain management at the end of life.
- There is a lack of robust evidence on the benefit of long-term opioids in the management of chronic pain.
- Ensure you are able to explain chronic pain and support self-management strategies.
- Inappropriate use of long-term opioids in chronic pain is associated with serious adverse effects.
- The risk of harm from opioids increases significantly above a dose equivalent to 120 mg/day of oral morphine.
- Identify patients most at risk of harm e.g. adverse selection.
- In conjunction with the patient, regularly review the effect of opioid treatment and consider whether there is a need to reduce the dose or stop the opioid.
- Keep abreast of changing evidence base with the use of gabapentinoids and follow local guidance.
Health coaching

Living with chronic long term illnesses can be challenging and distressing for patients - which is why they often visit their clinicians. Adding a health coaching approach to the tool box of communication skills you use in your consultations can help promote patient self-sufficiency, satisfaction and motivation, enabling people to manage their condition with greater independence and self-confidence.

The facts
- People with long term conditions account for 60% of all GP appointments, 70% of all outpatient beds, and 70% of overall NHS spend.
- The number of people with three or more long term conditions is predicted to grow from 1 million to 2.9 million by 2018.
- Three quarters of all deaths will be as a result of chronic disease by 2020.

What is health coaching?
Health coaching is taking people with long term conditions in a way that supports and empowers them to better manage their own care, fulfill their self-identified health goals and improve their quality of life.

What are the benefits of health coaching?
- Improves communication fundamental to care.
- Encourages people with long term conditions to practice their health and do more to care for themselves.
- Enables clinicians to shine the spotlight on personal awareness and responsibility in a supportive manner, and transform the doctor-patient relationship.
- Can increase patient self-sufficiency, self-efficacy, confidence, motivation, compliance, and reduce costs for organisations.

What skills will I learn?
You will learn a combination of skills and techniques you can use every day with patients that support behaviour change and help you listen, build rapport and challenge more skilfully, as well as set goals, motivate and encourage your patients.

Which teams and patients would benefit most?
The skills are useful with all patients but particularly in the following areas: with long term conditions, frail older persons, depression, medication compliance, pain management, lifestyle, recovery and rehabilitation.

How does this fit with other priorities for me and my organisation?
The training will help you work towards addressing the following:
- Improving patient experience and quality of care
- Increasing patient satisfaction scores
- Reducing complaints, especially around communication
- Reducing preventable readmissions and waiting time
- Builds relationships with colleagues, and collaborative working
- Supports the delivery of integrated care and care planning
- Enhances workflow for managing patients with long term conditions

Course Dates 2018/19:
The Health Coaching training is delivered over two full days, one week apart.
- 8th and 10th November 2018
- 12th and 14th December 2018
- 10th and 17 January 2019
- 6th and 14th February 2019
- 13th and 21st March 2019

Suffolk GP Federation
**NMP forums and conference**

**NMP forum**
- Friday 15th March 2019: 9:30 am - 12:30 pm
- Thursday 11th July 2019: 9:30 am – 12:30 pm
- Monday 21st October 2019: 9:30 am – 12:30 pm

**Venue:** Pod room 1 at Stow Lodge

**NMP conference**
- Monday 1st July 2019

**Venue:** UoS

**Further information**
Sarah Miller, Governance Manager, Suffolk GP Federation

NHS Email: sarah.miller29@nhs.net
e-Pain
Reflection and group discussion

Questions

1. Historically what has the role of the physiotherapist been in:
   a) Promoting medication safety with analgesia?
   b) reducing the risks associated with inappropriate analgesic polypharmacy?

2. What could the role of the physiotherapist be in:
   a) promoting medication safety with analgesia?
   b) reducing the risks associated with inappropriate analgesic polypharmacy?

3. Identify potential barriers and factors that would be helpful to maximise your potential as a physiotherapist with:
   a) promoting medication safety with analgesia?
   b) reducing the risks associated with inappropriate analgesic polypharmacy?
Key references


Stannard C. 2018 Where now for opioids in chronic pain. https://dtb.bmj.com/content/56/10/118


Canadian Guideline for Opioids for Chronic Non-Cancer Pain (2017)
http://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Opioids Aware 2015 : https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
Key resources for opioid information

Key Resources

- CDC Guideline for prescribing opioids in chronic pain: resources
  https://www.cdc.gov/drugoverdose/prescribing/resources.html

- NICE (NG 46 September 2016) Controlled Drugs: Safe use and management
  https://www.nice.org.uk/guidance/ng46

- NICE (KTT 21 January 2017) Medicines Optimisation in long term pain
  https://www.nice.org.uk/advice/ktt21

- Opioid resources

2017 Canadian Opioid Prescribing Guideline
  http://www.cfpc.ca/uploadedFiles/CPD/Opioid%20poster_CFP_ENG.pdf

- 2017 PresQIPP 149 Jan 2017; management of non neuropathic pain

Opioid resources recommendations (from chief pharmacists)

- PrescQIPP website
- NHSE are promoting practices (and pharmacies) to undertake high dose opioid audits (doses >120mg morphine or equivalent). The audit can be accessed via the following link: [https://www.prescqipp.info/component/jdownloads/category/420-high-dose-opiate-searches](https://www.prescqipp.info/component/jdownloads/category/420-high-dose-opiate-searches)

In conjunction with the audit, there is also a series of recorded webinars available from

Before we move on any questions?
Thank you

Further information and references on request
Christine.waters4@nhs.net
@Chrisrgwaters1