Dr Graham Gulbransen

Senior Medical Officer
Auckland Community Alcohol and Drugs Services

Opioids and Chronic Pain - Concurrent Breakout Session Repeated

Friday, 10 June 2011	Start 2:00pm	Duration: 60mins	Kandinsky
	Start 4:00pm	Duration: 60mins	Kandinsky

Opioids & Chronic Pain

Graham Gulbransen
FRNZCGP, FAChAM
Rotorua GPCME 10 June 2011

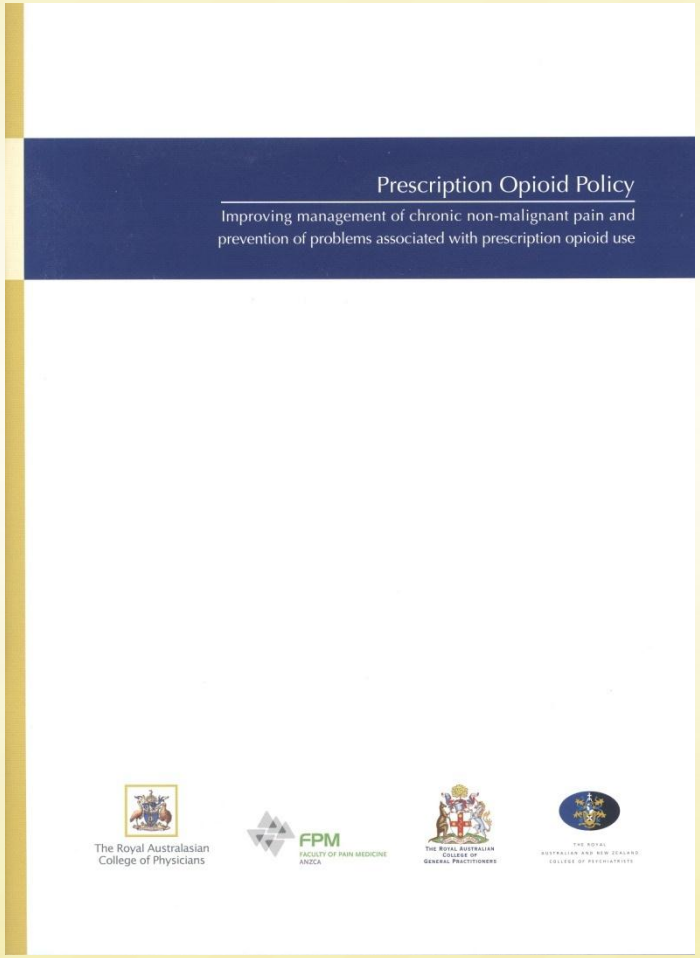
Contact me for Opioid Pathways & Contracts,
Pain & Dependence score sheets:
kfhc@xtra.co.nz

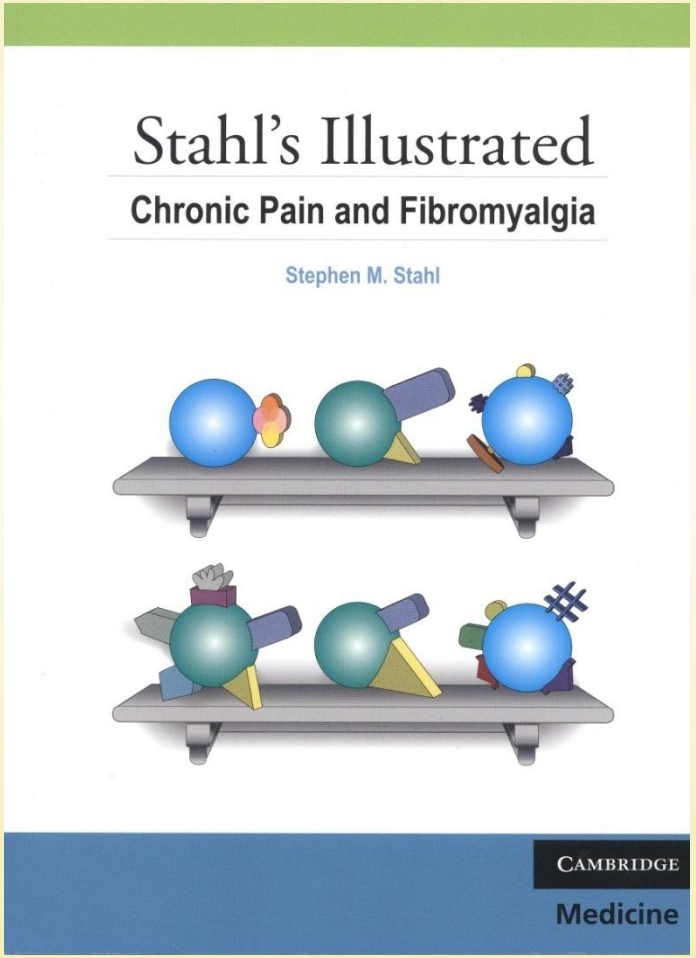
Outline:

how to manage 10% of patients who take 90% of time

- Background
- Discuss a standardised approach to assessing chronic pain using validated tools
- Risk assessment
- “Universal Precautions” in pain management
- Ensure essential documentation

Main references





Other references

- Brigitte Gertoberens, TARPS. June 2008
- Chronic Pain presentation, Des Gorman, September 2008
- Pain Matters, Opioid Use Guidelines, Hunter Integrated Pain Service, NSW, April 2009
- David Jones, Faculty of Pain Medicine, Otago, at NZ Pain Soc Mtg, July 2009
- Roman Jovey, MD, Medical Director, CPM Centres for Pain Management, Ontario, June 2010
- *The 10 steps of universal precautions in pain medicine*, MundiPharma

- Alistair Dunn, Oxycodone presentation
- Pain Medicine, 4 presenters, Addiction in Medicine Conference, Melbourne, March 2011
- Time Magazine, March 2011

Douglas Gourlay

MD, FRCPC, FASAM

Wasser Pain Management Centre; Centre for Addiction and Mental Health

Toronto, Canada

- Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. Gourlay et al. Pain Medicine 6(2), 107-112 (2005)
- http://www.thci.org/opioid/mar05docs/Gourlay.pdf Accessed 7 April 2011

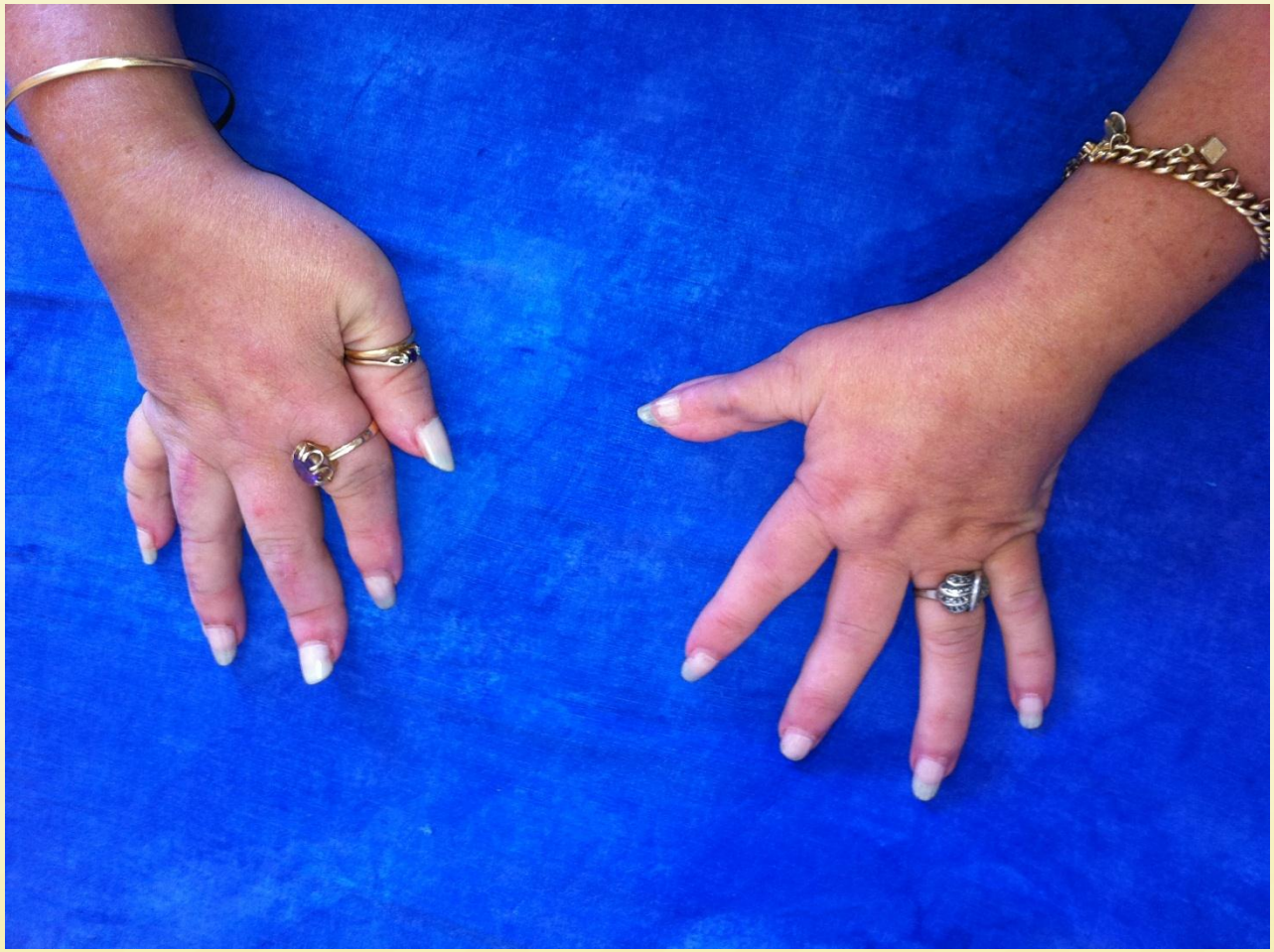
Take Home Messages

- Opioids are never first line and are rarely sole treatment: use rational polypharmacy
- Frequent pain assessments including functioning is important: monthly or more frequent visits
- Within local resources try to create a biopsychosocial treatment plan
- To reduce the risk of opioids prescribe using Universal Precautions
- Monitor the 4 A's: Analgesia, Activities, Adverse effects, Aberrant behaviour
- Close control: dispense weekly, M/W/F or daily with higher doses

Who of you has patients on opioids for chronic pain?

In a few minutes I will ask how many patients you have on opioids – I'm curious....

What do we do for Lee?



Lee

- 30yo woman
- Rheumatoid Arthritis since childhood
- Multi-joint destruction
- Awaiting joint fusion healing before starting humira [adalimumab]
- On diclofenac, paracetamol
- Morphine LA 120mg/day, dispensed every 10 days.

Nigel

What do we do for Nigel?

- 48yo male part time sound engineer, married
- L5-S1 work injury 1995
- Previously assessed & managed by Pain Service
- 2007: on morphine 120mg + codeine 150mg daily
- Weaned opioids, but substituted alcohol +++
- Now recurrent pancreatitis + low back pain. Currently 150mg morphine, MWF.

Dave

What do we do for Dave?

- 41 yo married property maintenance man
- 1990: head injury while drink-driving
- Chronic R facial pain
- First consult while drug-seeking in 1999
- IV morphine user, then MMT
- Next contact 2006, Medical Detox goal of stopping morphine
- Discharged on maintenance morphine for analgesia
- Morphine 500mg daily Mon/Wed/Fridays.

Who of you has patients on opioids?

1. For chronic pain?
2. For opioid substitution/MMT?
3. Palliative care?

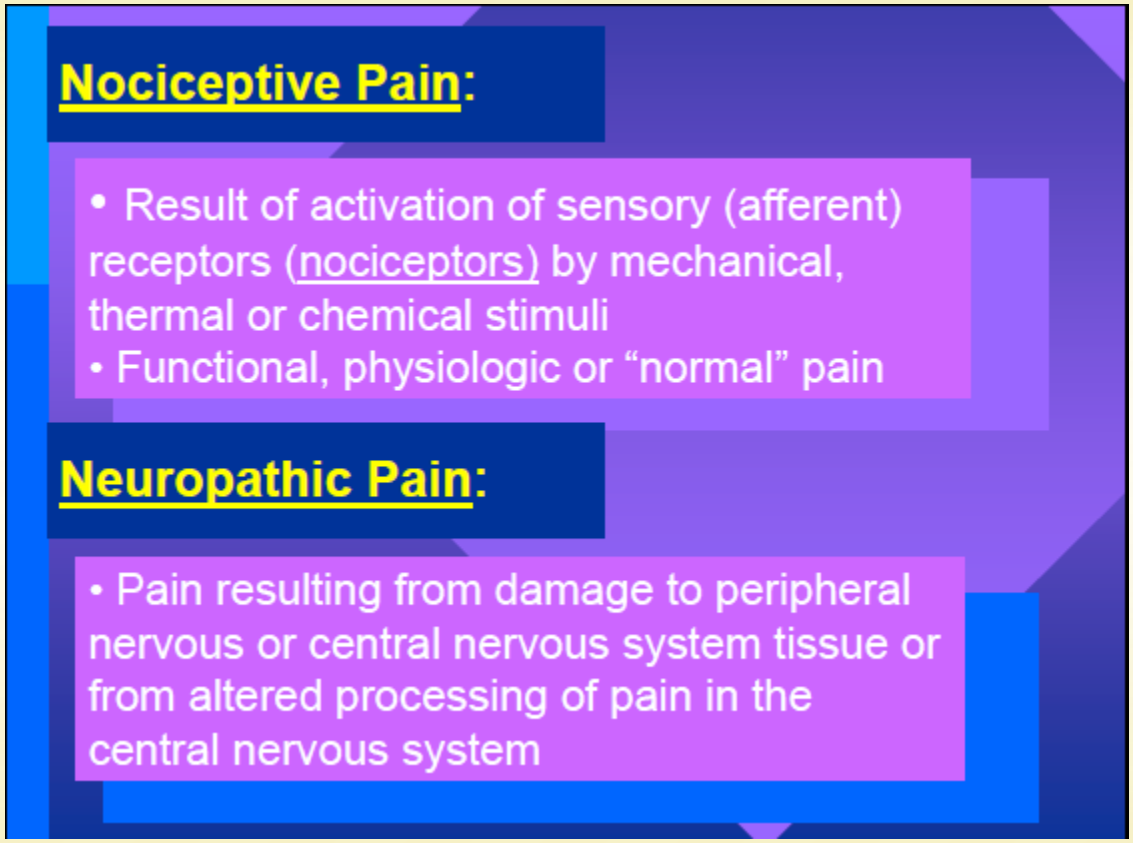
Chronic Pain

- Pain that exists beyond an expected time frame for healing

- Because pain is subjective, we rely mainly on the patient's report of the existence and intensity of the pain.

Reddy, B. (2006). The epidemic of unrelieved chronic pain. *The Journal of Legal Medicine, 27*, 427.

- AKA Chronic Non-Malignant Pain – CNMP
- AKA Chronic Non-Cancer Pain – CNCP



[Peggy Compton]

Useful Definition:
Neuropathic Pain

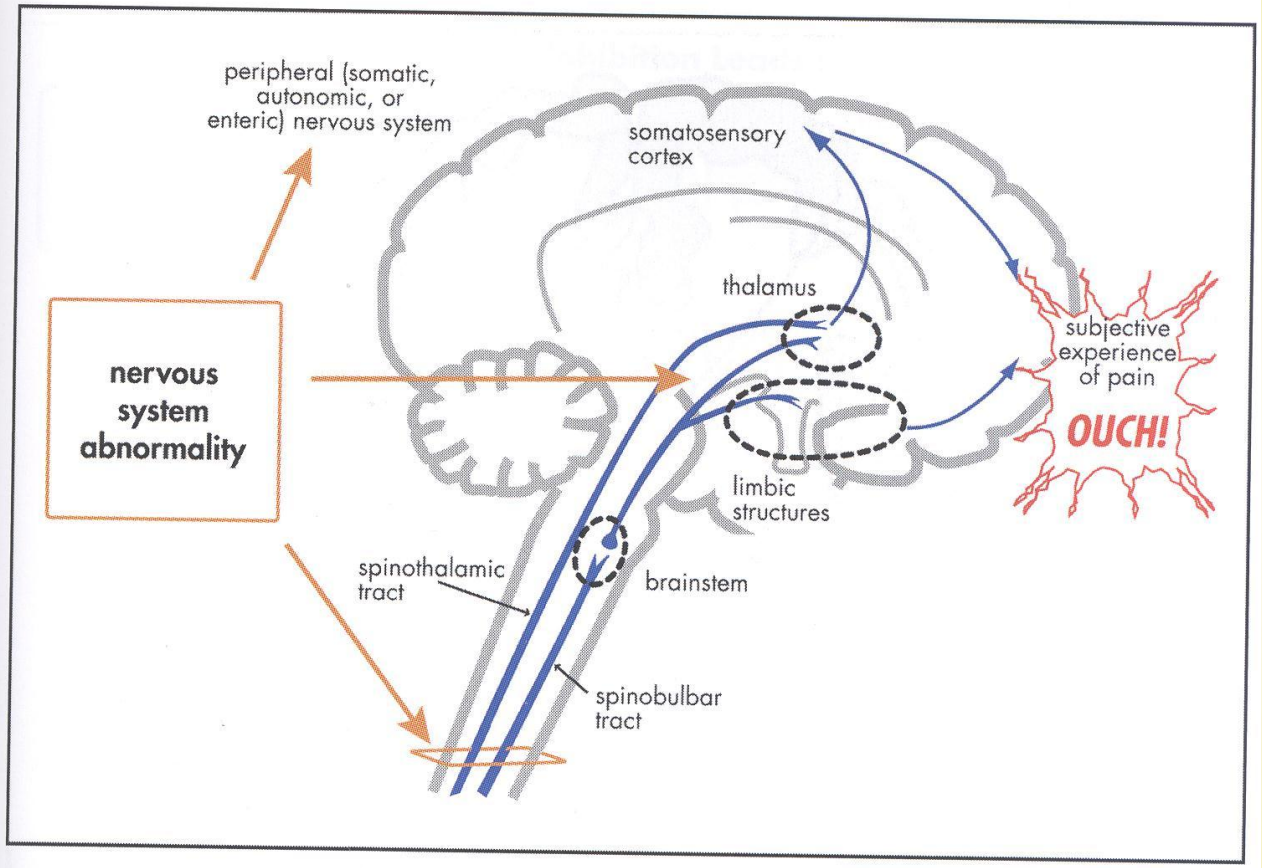


FIGURE 2.14. Neuropathic pain is pain that arises from damage to, or dysfunction of, any part of the peripheral or central nervous system.

pain

- Peripheral sensitisation: Inflammation around damaged neurons alters firing & conduction, crossed connections: neuromas
- Amplification of pain in thalamus &/or sensory cortex: 'chemical soup' or maladaptive neuroplasticity
- Deficient 'pain signal inhibiting' noradrenaline & serotonin in descending pathways from brain
- Genetic predisposition, stressors.

Useful Definition:
Allodynia

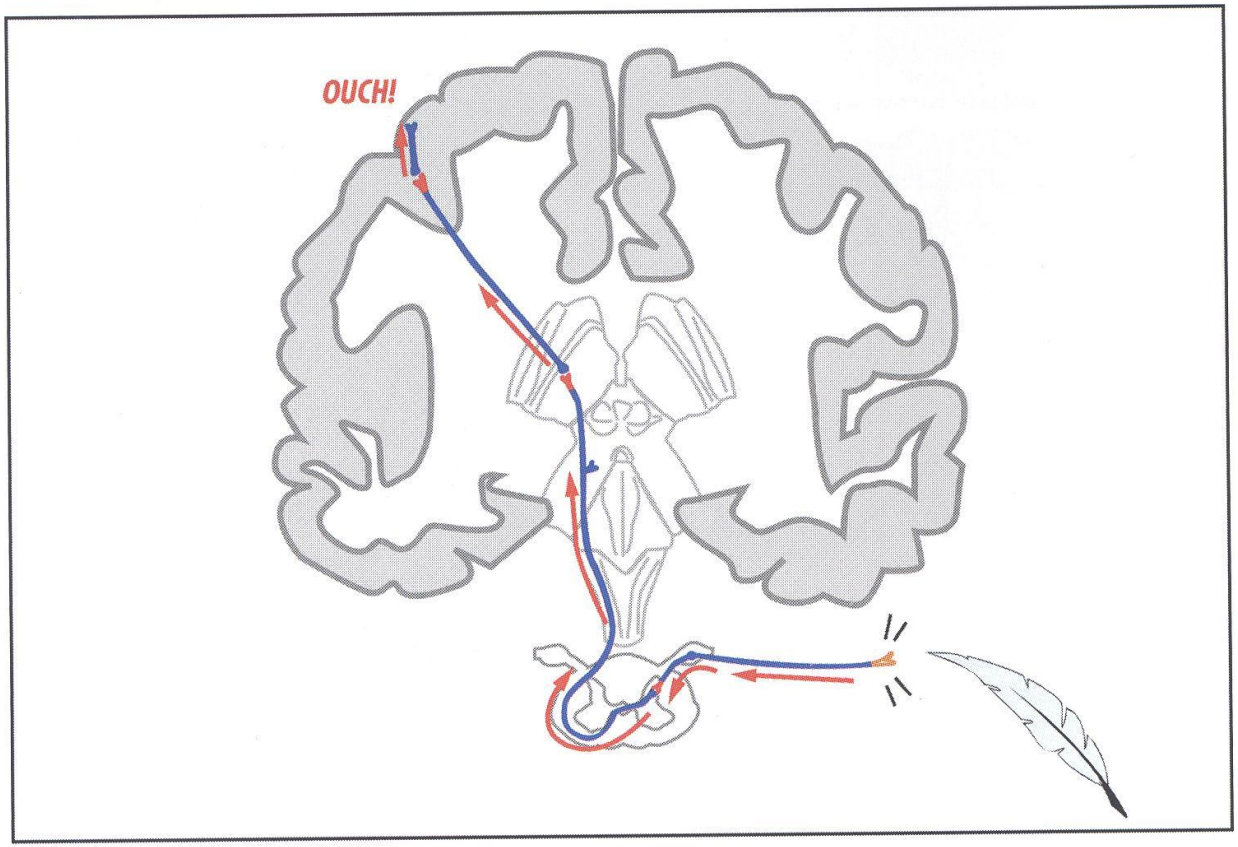


FIGURE 2.13. Allodynia is pain caused by a stimulus that does not normally provoke pain. The figure denotes allodynia in the case of abnormal sensory processing in response to the touch of a feather, which should not normally cause pain.

Useful Definition:

Hyperalgesia

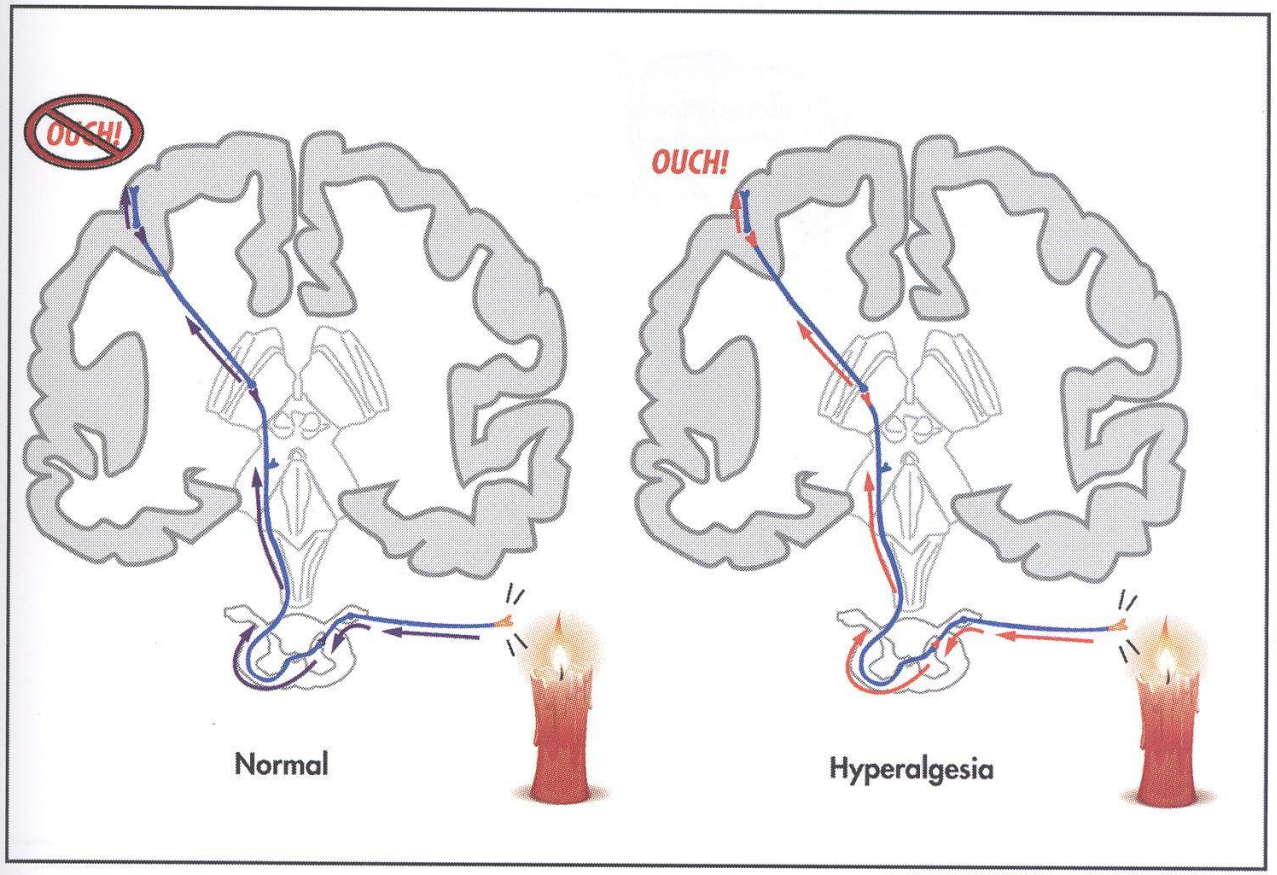


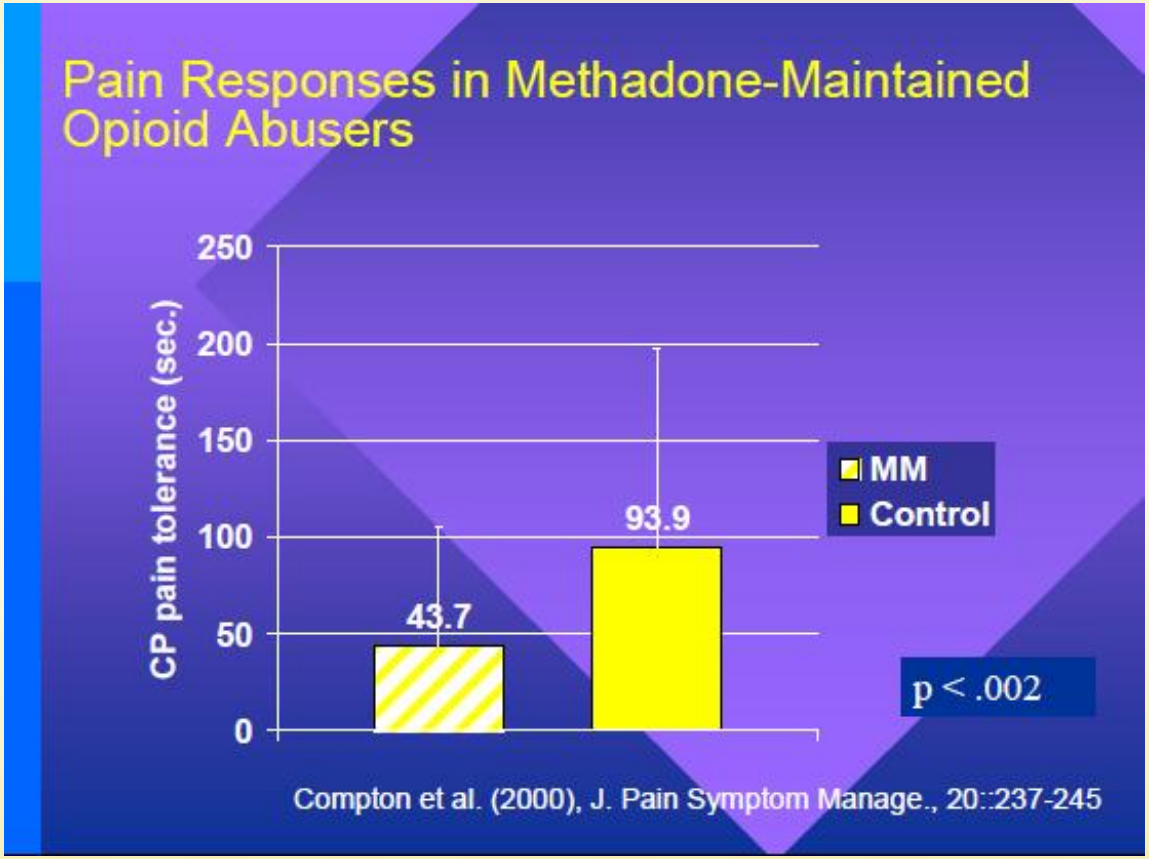
FIGURE 2.12. Hyperalgesia is an increased response to a stimulus that is normally painful. The figure denotes normal pain processing in response to heat from a candle (left) in contrast to pain processing in the case of hyperalgesia (right).

Opioid Induced Hyperalgesia (OIH)

- Definition:
  - A state of sensitization to painful stimuli caused by exposure to opioids.
- Characterized by:
  - A paradoxical response to opioids whereby a patient with worsening pain receiving opioids for that pain may actually experience more pain as the dose of opioids increases.

Mitra,S. J of Opioid Management. May/June 2008
Vorobeychik Y. Pain Medicine 2008

Opioid induced hyperalgesia

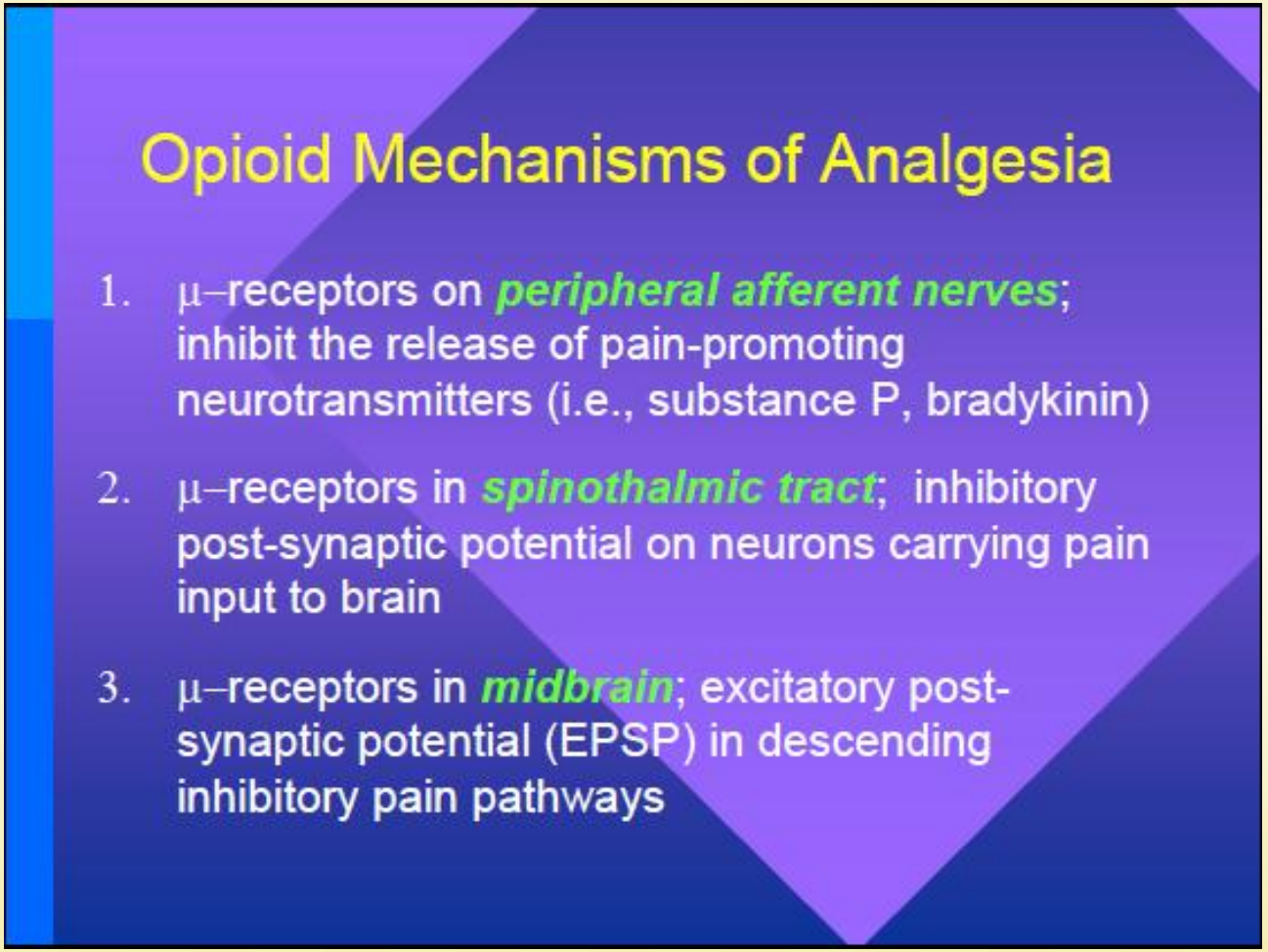


Complex Regional Pain Syndrome

- Previously reflex sympathetic dystrophy
- Hyperalgesia extended to area greater than the injury for longer than expected
- May involve glutamate neurotransmitter & NMDA [N-methyl-d-aspartate] receptor
- Early Tx → best outcome
- NSAIDs, anticonvulsants, TCAs

Opioids

- Substances binding to opioid receptors
- May be endogenous or synthetic, agonist or antagonist [Compton]
- This presentation deals w strong opioids: morphine, methadone, buprenorphine & fentanyl patches and oxycodone, when other treatments have not been successful


Opioid Mechanisms of Analgesia
1. μ–receptors on peripheral afferent nerves; inhibit the release of pain-promoting neurotransmitters (i.e., substance P, bradykinin)
2. μ–receptors in spinothalmic tract; inhibitory post-synaptic potential on neurons carrying pain input to brain
3. μ–receptors in midbrain; excitatory post-synaptic potential (EPSP) in descending inhibitory pain pathways

Pain is an extremely common primary care complaint

Why is chronic pain poorly managed?

- Fear of iatrogenic problems
  - Abuse / Addiction / Diversion
- Fear of regulatory sanction
- Concern over long-term efficacy
- Lack of time / Inadequate compensation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Pakistan: Battles over blasphemy
Could your baby be depressed?
Building a middle class in the West Bank
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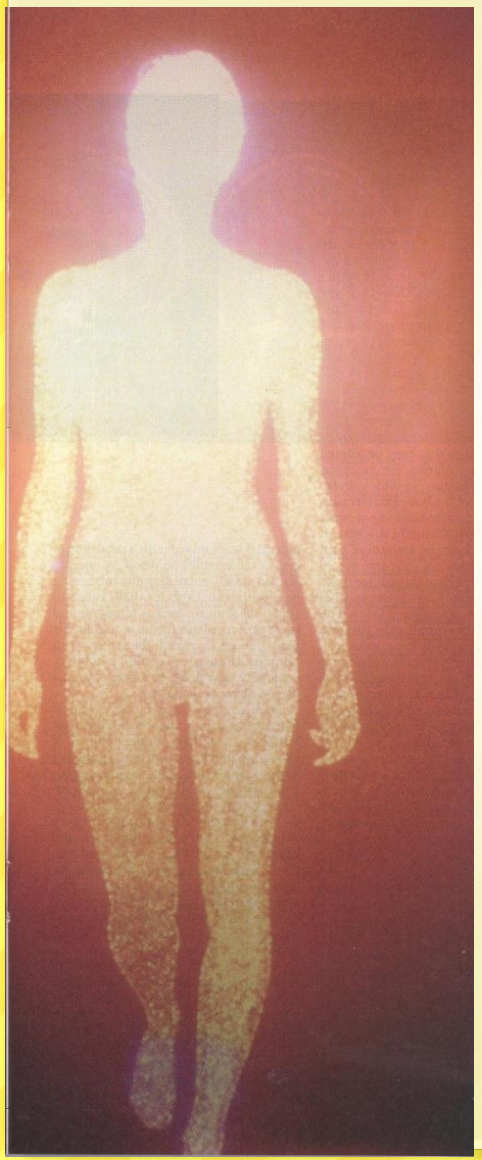
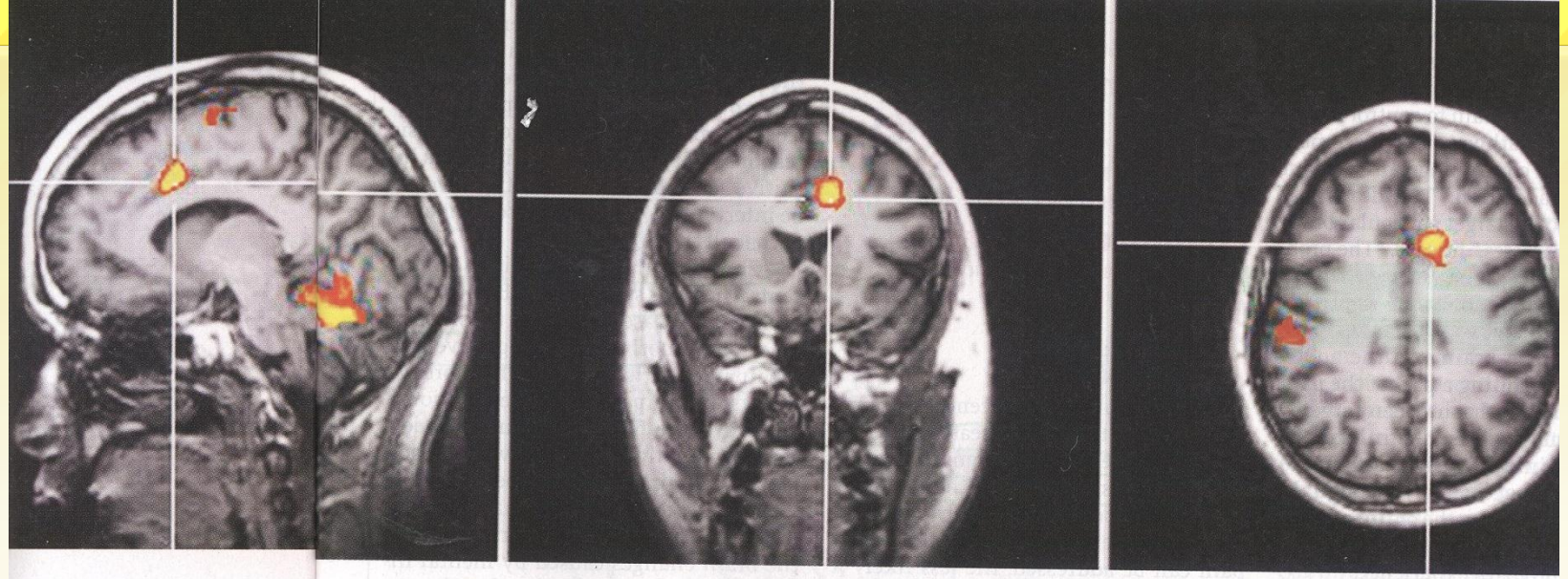
Time Magazine 21 March 2011

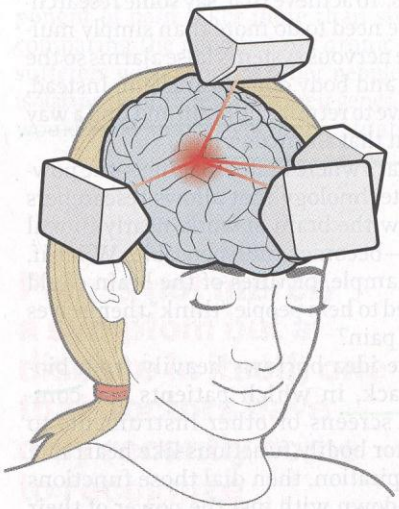


- Pain is sensation we seek to avoid, but is essential for survival
- ‘what happens when pain goes rogue, when it sends off false alarms so that all the sirens keep sounding... all the hurt keeps hurting?’
- ‘Rather than saving lives, it wrecks them.’



Training the brain to ignore pain *Subjects in a study were given a heat stimulus on thei allowed to see how their brain responded. After being taught to ignore pain signals by th thoughts, they succeeded in activating and exerting some control over the region*

Remapping with Magnets. Magnetic waves can reset neural circuits involved in pain



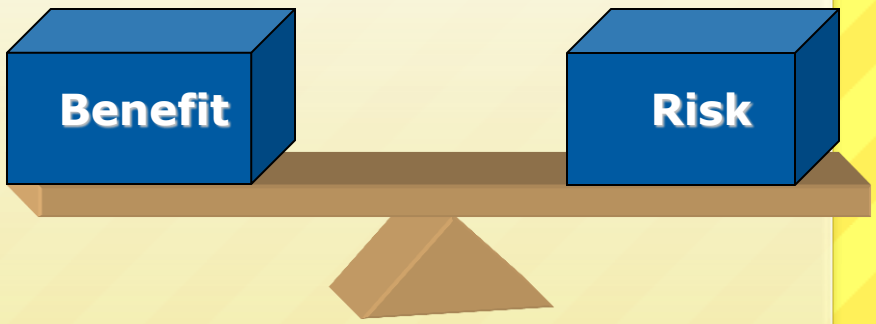
Something borrowed Deep-brain transmagnetic stimulation (TMS) is being used to reroute nerve connections and relieve symptoms of bipolar disorder. A similar reorganization may alleviate pain

3-D target Just like gamma-knife therapy, which aims radiation at brain tumors from multiple angles, TMS directs magnetic energy toward the anterior cingulate cortex, the brain's pain center

Quieted brain The magnetic fields should reset constantly activated pain nerves and make them less sensitive to stimuli. The first studies involve giving subjects heat stimuli before and after TMS to observe any differences in sensation caused by the treatment

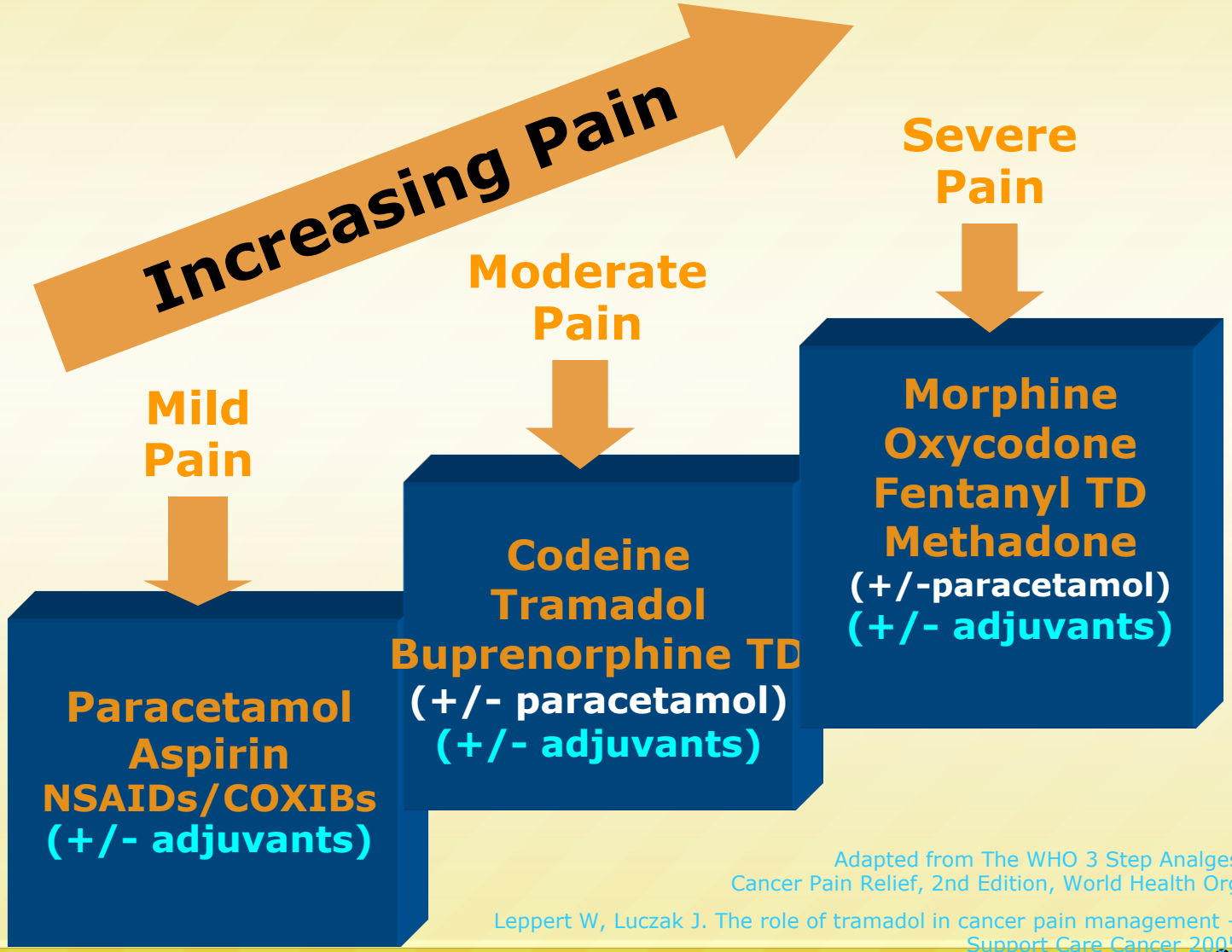
Pain Management Goals

- Decrease pain
- Improve function
  - physical
  - psychosocial
- Minimize adverse effects
  - for the patient
  - for the doctor
  - for society



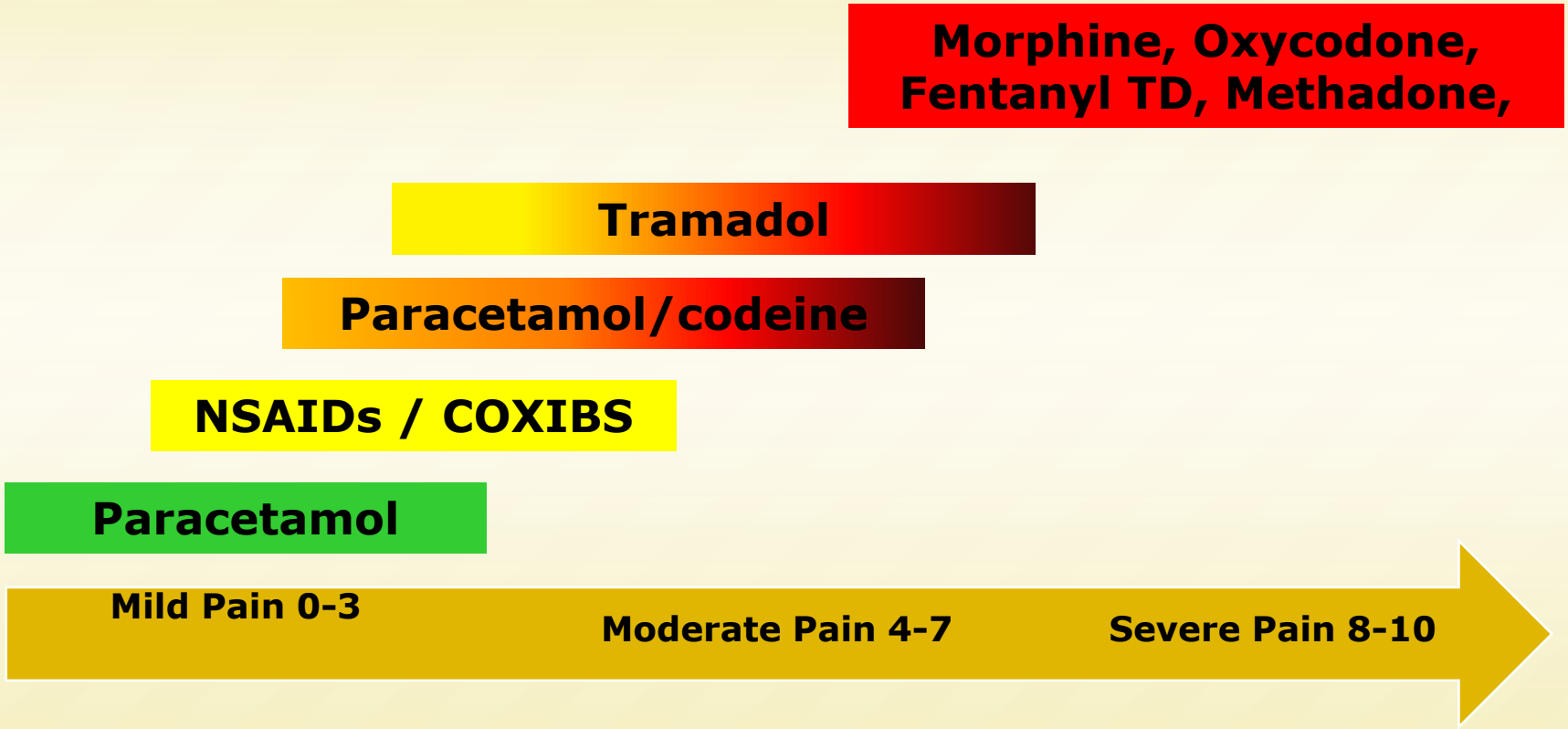
Maintaining the Balance

Analgesic Stepped Approach



Adapted from The WHO 3 Step Analgesic Ladder, Cancer Pain Relief, 2nd Edition, World Health Organization.

Leppert W, Luczak J. The role of tramadol in cancer pain management – a review. Support Care Cancer 2005;13:5-17.


Morphine, Oxycodone,
Fentanyl TD, Methadone,
Tramadol
Paracetamol/codeine
NSAIDs / COXIBS
Paracetamol
Mild Pain 0-3
Moderate Pain 4-7
Severe Pain 8-10

Paracetamol / Codeine

- Inexpensive
- Codeine requires conversion via the CYP450 2D6 enzyme to active metabolites (morphine, C-3-G, C-6-G)
  - **Poor metabolizers**
    - will have no analgesic effects but all of the adverse effects when taking codeine for pain (7% Caucasians, 3% Blacks, 1% Asians)
  - **Rapid metabolizers**
    - are at risk of exaggerated response and serious toxicity (29% Ethiopians, 10% Greeks, Portuguese, 1% Finns/Danes)
- More constipation relative to analgesia
- Short duration of action

NSAID/COXIBs

- Not abused on the street
- GI risk – reduce by using COXIB or NSAID + PPIs
- CV risk – avoid in those with CV risk factors or on anti-coagulants
- Renal risk - avoid in those with renal insufficiency
- Monitor all patients on long term NSAIDs/COXIBs
  - **Weight, BP, CBC, electrolytes, creatinine**

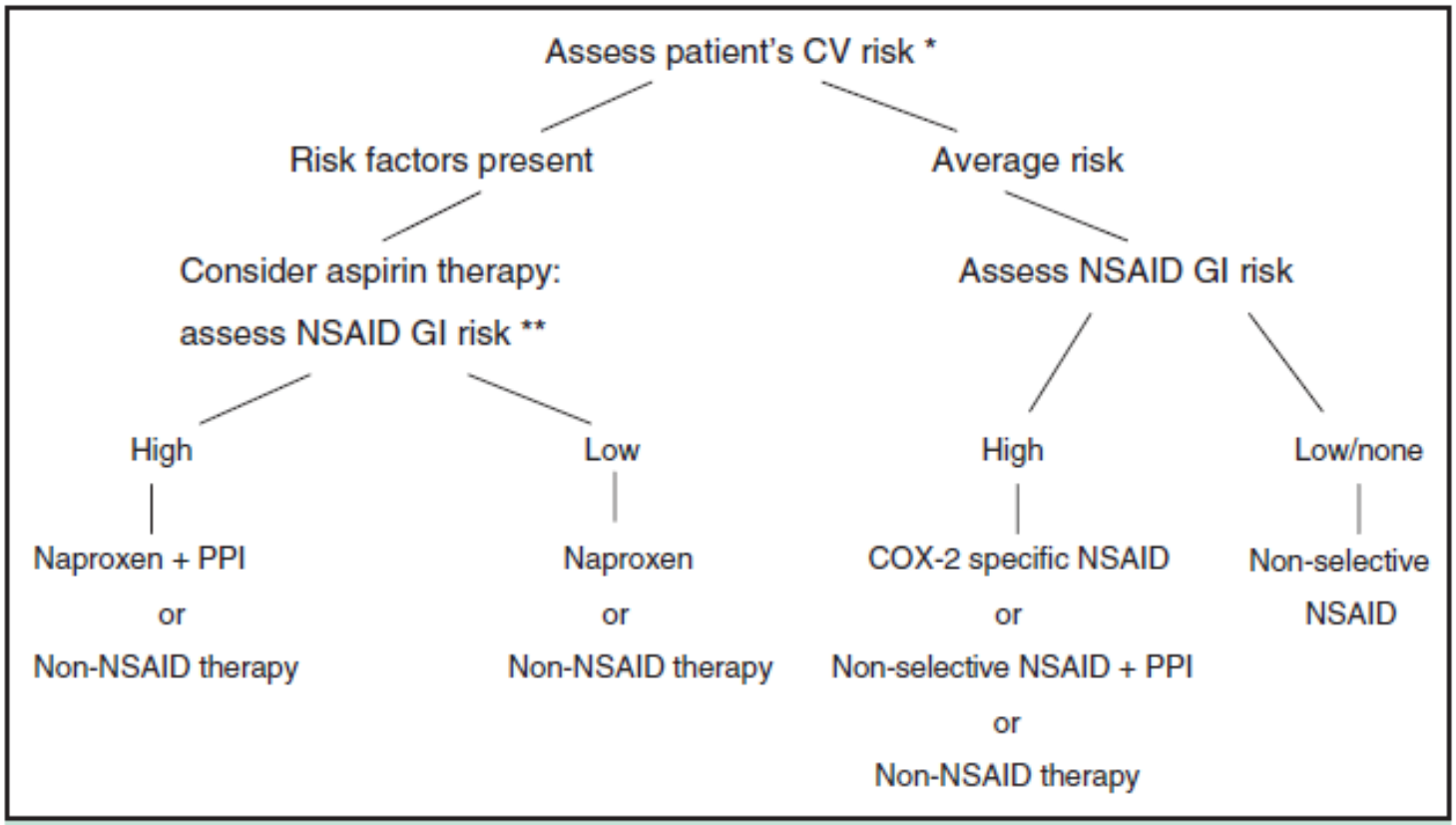


Figure 2 Decision tree for NSAID-related gastroprotection.
*Presence of ischemic heart disease, peripheral vascular disease, cerebrovascular disease, 10-year cardiovascular disease > 10% (Framingham equation).
**Age, GI history, co-prescriptions, co-morbidity.

Gastrointestinal and cardiovascular risks of nonsteroidal anti-inflammatory drugs.

Jones R et al. *Am J Med* - 01-JUN-2008; 121(6): 464-74

Tramadol

- Agonist at μ-receptors + serotonin & noradr reuptake inhibition
- Evidence in nociceptive, neuropathic pain, fibromyalgia
- No renal, CV, hepatic toxicity with therapeutic use
- IR and once daily formulations
- WHO Expert Committee On Drug Dependence (2006)
  - "…even after a recent major increase in the extent of its use because of its therapeutic usefulness, tramadol continues to show a low level of abuse."

WHO Expert Committee on Drug Dependence

Rational Polypharmacy in Pain

- Limit concurrent use of sedating medications
  - i.e. sedatives, muscle relaxants, sleeping meds
- For sleep try: tricyclics (amitriptyline, doxepin), gabapentin, pregabalin, mirtazepine, quetiapine, INSTEAD OF BENZODIAZEPINES

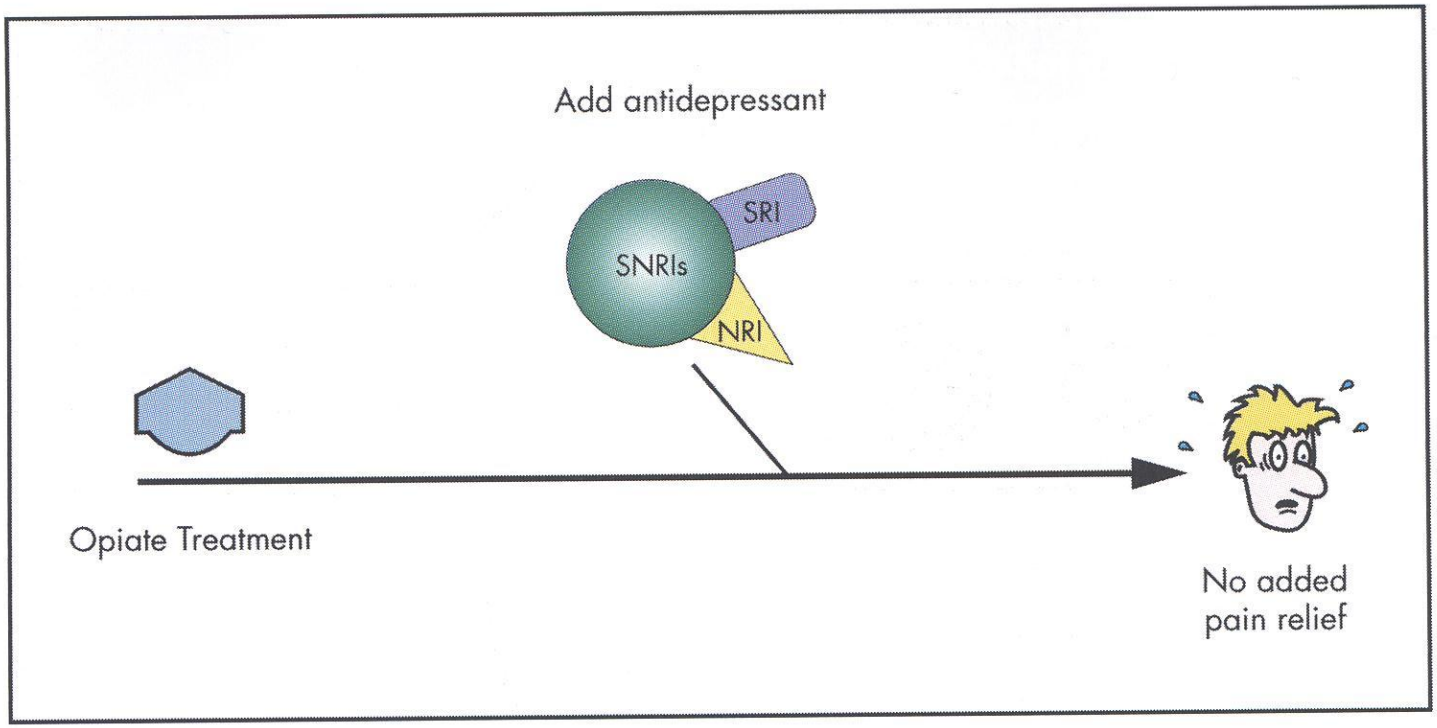
Rational Polypharmacy in Pain

- Concurrent depression: use anti-depressants with some evidence in pain (TCAs, venlafaxine, duloxetine)
- Concurrent anxiety: consider venlafaxine, pregabalin, quetiapine

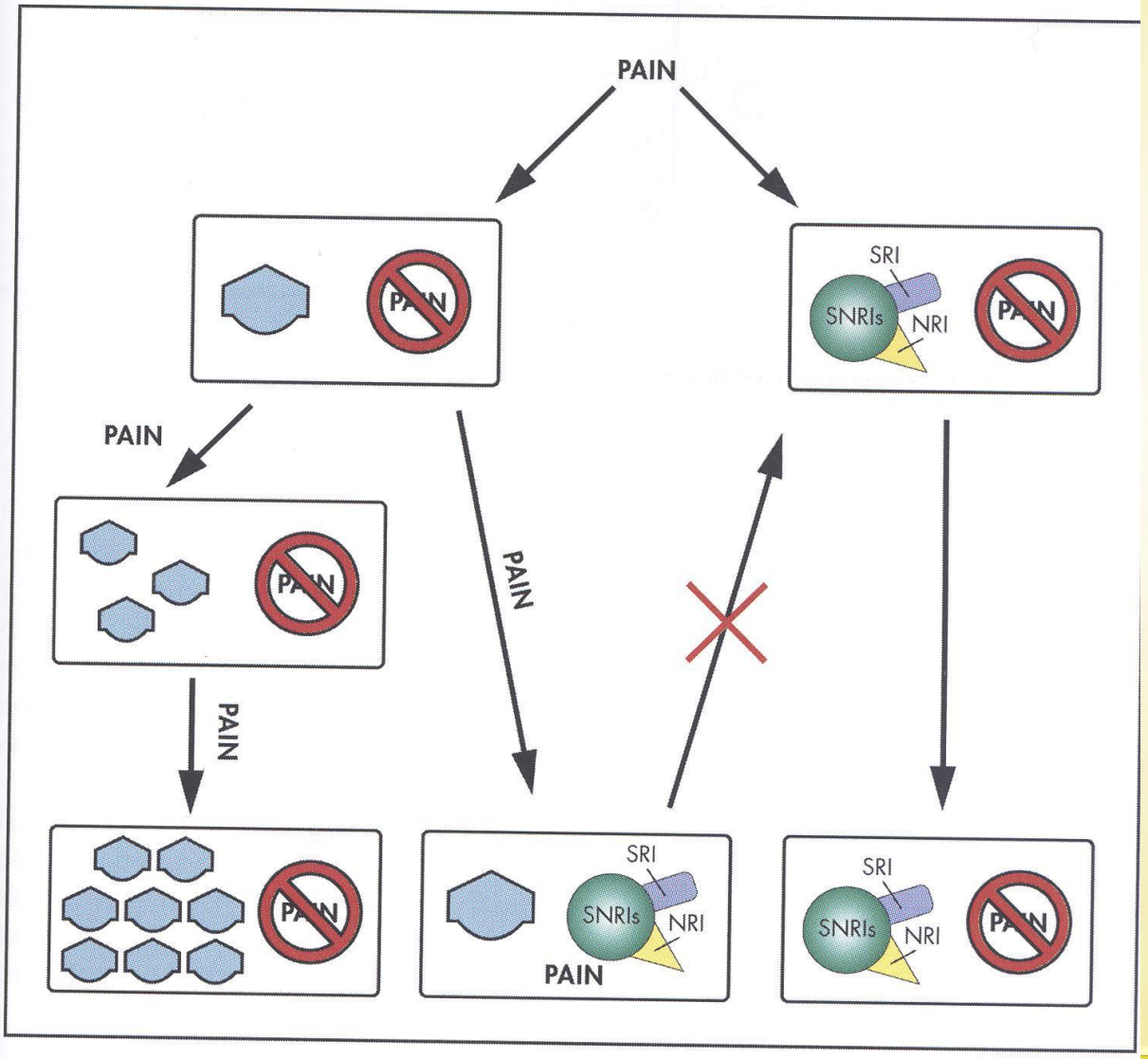
Pain Drugs

- A single drug is unlikely to relieve all pain
- Opioids can decrease effectiveness of other drugs
- Early non-opioid treatment may obviate need for opioids

The "Opiate Problem":
Part 2

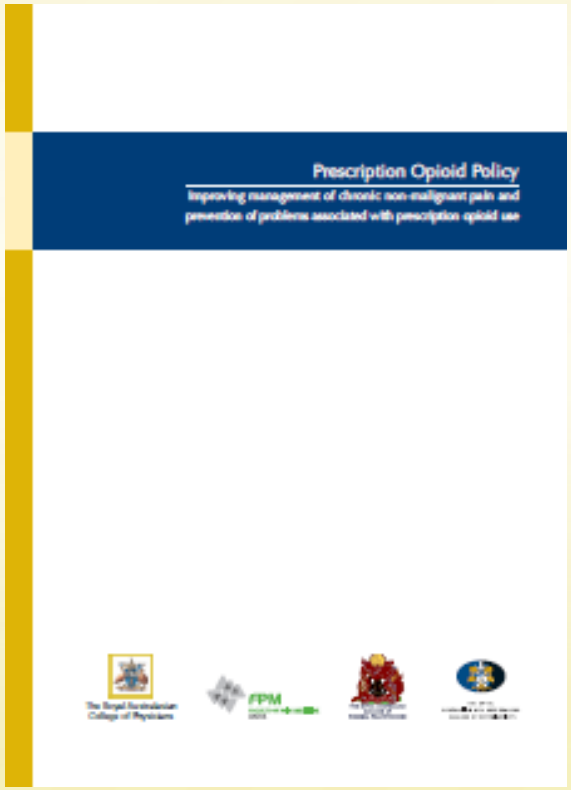


Once You Go Opiate You Never Go Back



Prescription Opioid Policy

Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid misuse. RACP April 2009



- Google: RACP Prescription Opioid Policy

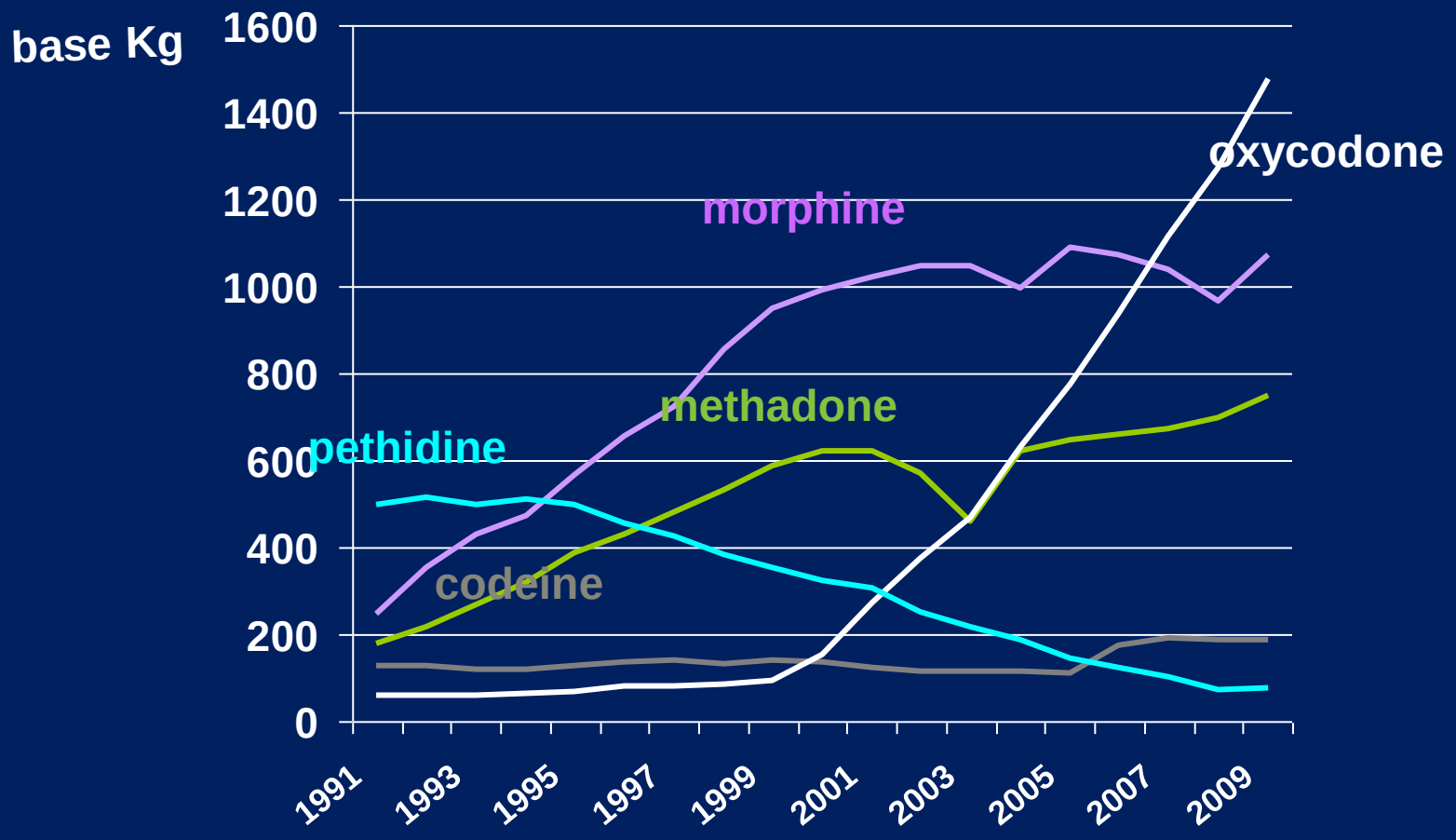
Ethical Considerations [RACP]

- Duty of care to control pain ‘as well as possible’
- Evidence for benefit of long term opioids is weak
- Evidence for harm is unclear

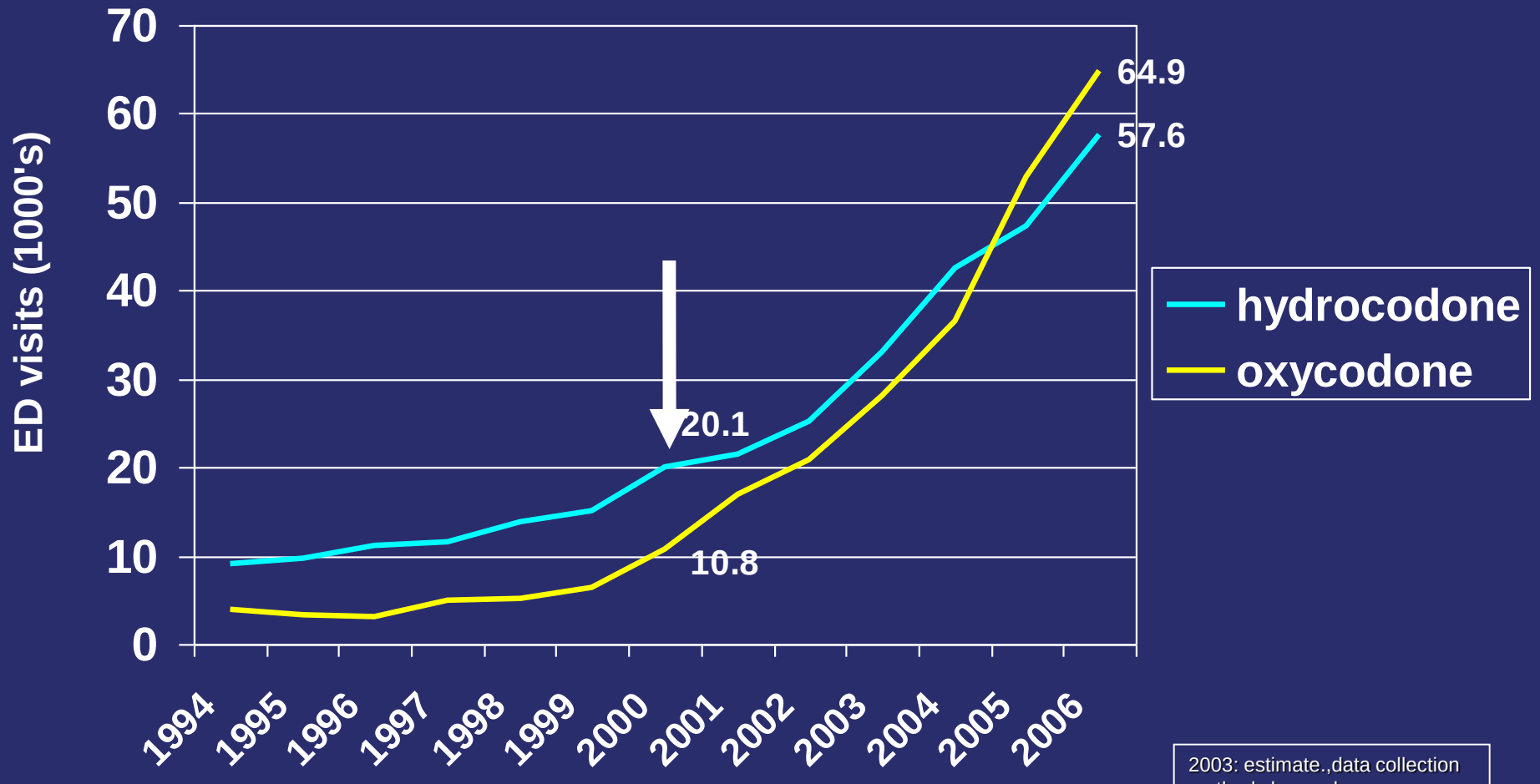
continued

- Opioid prescriptions are increasing eg oral morphine 40x increase in 20 years
- Opioid abuse has ‘potential to be major health burden’

Opioid base supply: Australia, 1991-2009

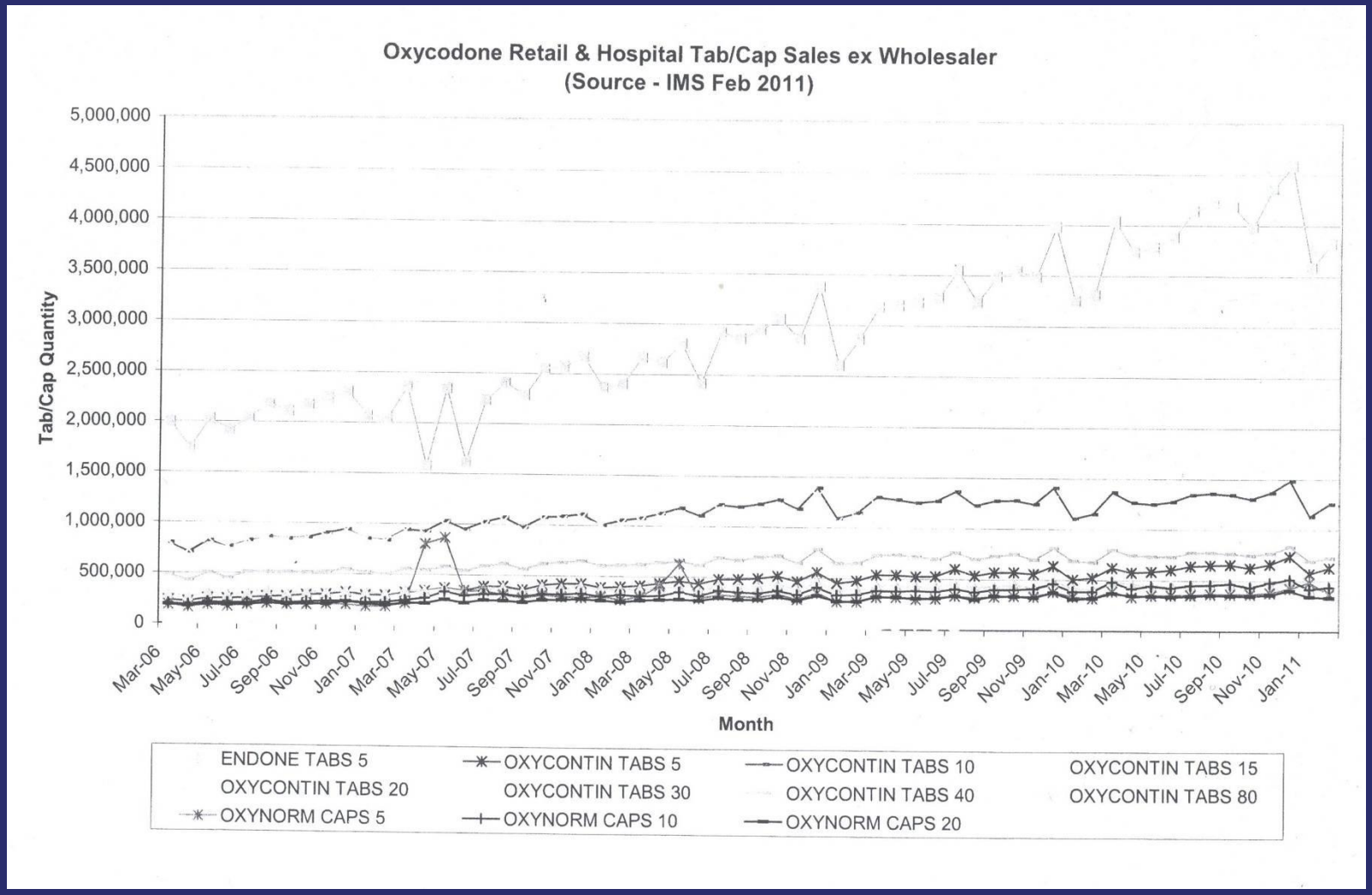


Emergency Department visits: USA 1994-2006



2003: estimate.,data collection method changed

DAWN – **non-medical use**


Oxycodone Retail & Hospital Tab/Cap Sales ex Wholesaler
(Source - IMS Feb 2011)
Tab/Cap Quantity
5,000,000
4,500,000
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
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ENDONE TABS 5
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OXYCONTIN TABS 30
OXYCONTIN TABS 40
OXYCONTIN TABS 80
OXYNORM CAPS 5
OXYNORM CAPS 10
OXYNORM CAPS 20

RACP Guidelines continued

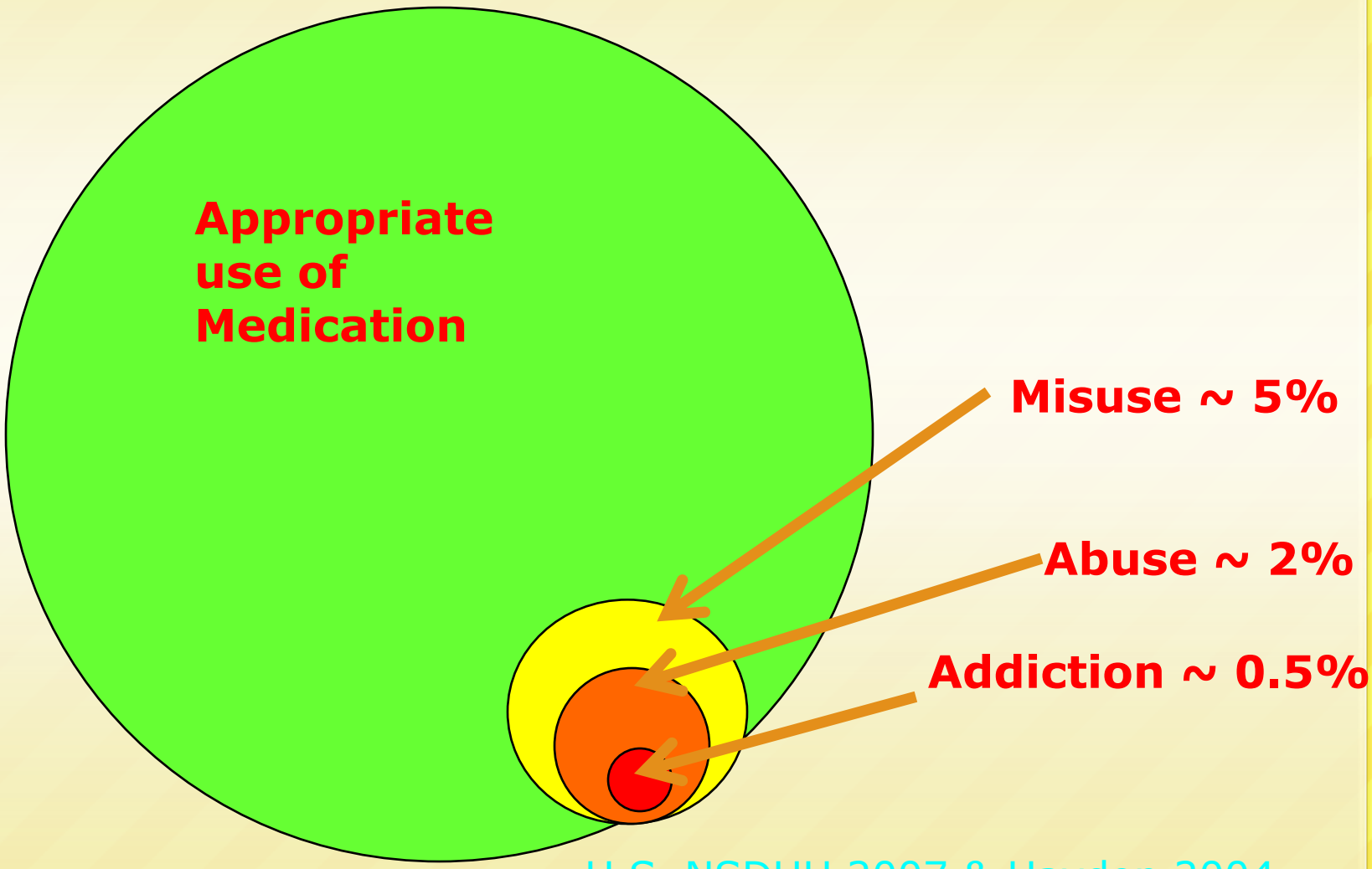
- Follow comprehensive treatment principles
- Concept of universal precautions in pain medicine
- 'The risk of developing opioid dependence ('addiction') in the context of treating CNMP is unknown'

Opioids are NOT Addicting

- No evidence in literature that any drug 'causes' addiction
- Some drugs have higher abuse liability
- Only in the 'at-risk' population, in the right setting with the right drug does addiction occur

Douglas Gourlay, 2005

Rx Opioid Misuse, Abuse, Addiction



U.S. NSDUH 2007 & Haydon 2004

Pseudoaddiction

- Pseudoaddiction is a term for those with untreated pain displaying preoccupation with drugs and drug seeking behaviours, ie a misdiagnosis.
- When given the medication they need they tend to stabilise. (Reddy, 2006)

Opioid drug trials have shown

- Opioids reduced pain & improved function over short periods
- Morphine & oxycodone superior to naproxen & nortriptyline for pain relief but not for functional outcomes

continued

- Weak opioids tramadol, codeine no better than NSAIDs or TCAs for analgesia or function
- 10% on opioids have significant constipation &/or nausea
- Endocrine and sexual problems may result

Lack of long term trials

‘This suggests that the long term role of opioids in the management of CNMP depends on the outcome of a therapeutic trial in individual patients using agreed outcome measures.’

RACP p37

An Opioid Tx Pathway

Work thru the
10 Steps of
Universal Precautions
in Pain Medicine

Universal Precautions in Infectious Disease

- 1985 CDC published 'Universal Precautions'
- Need to protect both the health worker (infection) AND the patient (unnecessary stigmatization)
- Inability to accurately identify the "at-risk" patient

–A set of recommendations if applied to all patients, would reduce the risk of transmission of infectious disease

Douglas Gourlay

MD, FRCPC, FASAM

Wasser Pain Management Centre;

Centre for Addiction and Mental Health

Toronto, Canada

- Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. Gourlay et al. Pain Medicine 6(2), 107-112 (2005)
- http://www.thci.org/opioid/mar05docs/Gourlay.pdf Accessed 7 April 2011

Universal Precautions in Infectious Disease

By applying to all patients, three goals achieved:

–Reduced risk to health workers

–Decreased stigmatization of patients

–Didn’t have to ‘know’ who was at risk

Universal Precautions

- How do we implement them?
  - Thoroughly inquire into drug and alcohol history
  - Set boundaries around medication use
  - Identify aberrant behaviour

- Triage
  - CNCP patients managed by primary care
  - Those managed with specialist support
  - Tertiary level CNCP patients

- Assess Opioid Responsiveness through rational trials of opioid therapy

Universal Precautions in Pain Medicine

1. Diagnosis
2. Psychological assessment including risk of addictive disorders
3. Informed consent
4. Treatment agreement
5. Pre and post-intervention assessment of pain level and function
6. Appropriate trial of Opioid Therapy ± Adjuvant Meds
7. Reassessment of pain score and level of function
8. Regularly assess the "4 A's" of pain medicine
9. Periodically review pain diagnosis and co-morbid conditions including addictive disorders
10. **DOCUMENT, DOCUMENT, DOCUMENT**

1. Diagnosis with reasonable differential

Comprehensive assessment

- Identify nociceptive or neuropathic contributions to pain & whether they can be treated
- Psychological assessment of beliefs, behaviour, mood
- Assess social environment
- Assess actual and potential substance abuse in patients and their families

Good Pain History

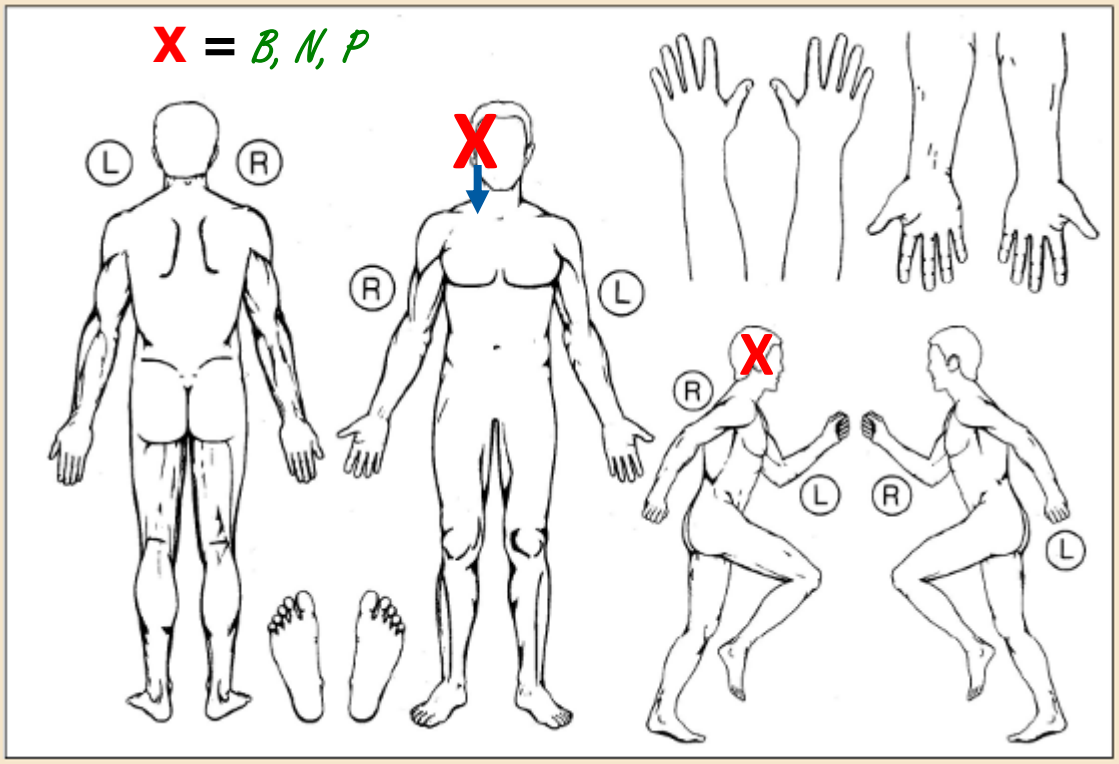
1. Current pain descriptions (including pain scoring)
2. Previous pain history (including treatments and results)
3. Current treatments, effectiveness and adverse effects
4. Other concurrent medical / psych problems
5. Social history (family, work, income, relationships)
6. Addiction screening
7. Current functioning and future goals

Brief Pain Inventory – BPI

Brief Pain Inventory (Short Form) - Modified

Name _____ Date _____

On the diagram below, shade in the areas where you feel pain. Put an "X" on the areas where it hurts the most. *(S=sharp/stabbing, B=burning, N=numbness, P=pins and needles, A=aching, Arrows = shooting pain.*
Use colours if you have more than one type of pain)



Brief Pain Inventory – BPI

What things make your pain feel worse?

Dressing, walking, household activites

What things make your pain feel better?

Morphine, ibuprofen, rest

What treatments or medications are you currently receiving for your pain?

Paracetamol 1000 mg three times per day
Glucosamine 500 mg three times per day
Ibuprofen 800 mg two times per day

Brief Pain Inventory – BPI

Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

No pain	0	1	2	3	4	5	6	7	(8)	9	10	Worst pain you can imagine

8/10

Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 24 hours.

No pain	0	1	2	3	(4)	5	6	7	8	9	10	Worst pain you can imagine

4/10

Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

No pain	0	1	2	3	4	5	(6)	7	8	9	10	Worst pain you can imagine

6/10

Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

No pain	0	1	2	3	4	5	(6)	7	8	9	10	Worst pain you can imagine

6/10

In the last 24 hours, how much relief have your pain treatments or medications provided? Please circle the one percentage that shows most how much **RELIEF** you have received.

No relief	0%	(10%)	20%	30%	40%	50%	60%	70%	80%	90%	100%	Complete relief

10%

Brief Pain Inventory – BPI

Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity:

Does not interfere 0 1 2 3 4 5 **(6)** 7 8 9 10 Completely interferes

B. Mood:

Does not interfere 0 1 2 **(3)** 4 5 6 7 8 9 10 Completely interferes

C. Walking Ability:

Does not interfere 0 1 2 3 4 5 **(6)** 7 8 9 10 Completely interferes

D. Normal Work (includes both work outside the home and housework)

Does not interfere 0 1 2 3 4 **(5)** 6 7 8 9 10 Completely interferes

E. Relations with other people:

Does not interfere 0 1 2 3 **(4)** 5 6 7 8 9 10 Completely interferes

F. Sleep:

Does not interfere 0 1 2 3 4 **(5)** 6 7 8 9 10 Completely interferes

G. Enjoyment of Life:

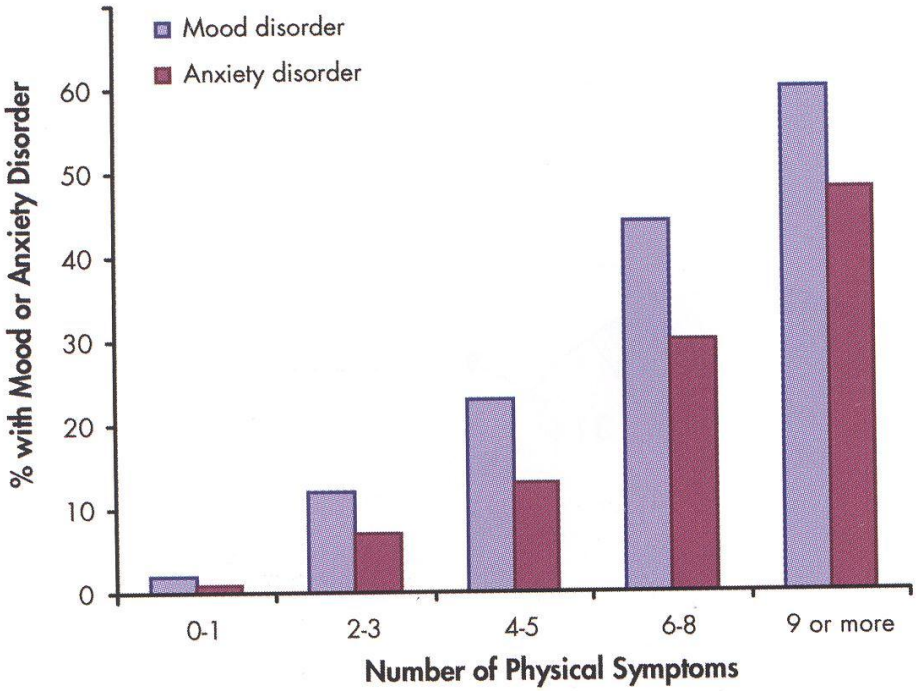
Does not interfere 0 1 2 3 4 5 **(6)** 7 8 9 10 Completely interferes

Adapted from: C.S. Cleeland and K.M. Ryan, Annals of the Academy of Medicine 1994

35/70

2. Psychological assessment including risk of addiction

Pain as Comorbidity:
Mood and Anxiety Disorders



If we can identify those at higher risk, we may be able to reduce opioid misuse by more careful prescribing and monitoring

Screening for Opioid Misuse Risk

- Initial Screening Questions:
  - **Ask** in a routine, straightforward manner
  - Tobacco, alcohol [My single screening question, 'how many drinks of alcohol do you have in the average 7 day week?']
  - Sedative use
  - Recreational drug use
  - Past history of substance abuse or dependence
  - Most people do not have past or current problematic use of alcohol or other drugs RACP p 37

Opioid Risk Tool
Clinician Form

(includes point values to determine scoring total)

	Mark each box that applies: Female	Male
1. Family History of Substance Abuse:		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription Drugs	☐ 4	☐ 4
2. Personal History of Substance Abuse:		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescription Drugs	☐ 5	☐ 5
3. Age (mark box if between 16-45)	☐ 1	☐ 1
4. History of Preadolescent Sexual Abuse	☐ 3	☐ 0
5. Psychological Disease		
Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals	_____	_____

The patient can be placed into one of three opioid risk categories based on their total score.

Low Risk = 0 - 3 points
Medium Risk = 4 - 7 points
High Risk = 8 points and above

3. Informed consent

4. Treatment agreement

Only after other Tx has failed

- Preferably start with multi-disciplinary assessment
- Including non-drug treatments
- Including non-opioid drugs
- Plan may be for short term use of opioids only

Contractual approach

- One prescriber (or team) only
- Caution with new patients not known to prescriber
- Acknowledge long term commitment from doctor & patient
- Set reasonable and measurable goals, withdrawing opioids if goals not met
- Goals should include improvement in function
- Set boundaries w some flexibility.

Opioid Treatment Agreement

Opioid treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling, or other therapies or treatments. Vocational counseling may be provided to assist in your return to work effort.

I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with Dr _____ and his or her associates.

1. I understand that I have the following responsibilities:

a**. I will treat the office staff that work as colleagues alongside Dr _____ and his or her associates with courtesy and respect at all times. I understand that Dr _____ has a zero-tolerance policy regarding rude or harassing comments or actions to the office staff. This includes repeated telephone calls requesting or demanding medications or early appointments with Dr _____ , and the use of swearing. Patients who exhibit this behaviour in the opinion of Dr _____ or the office staff may be withdrawn from the medication and asked to find a new doctor.**

b. I will take medications only at the dose and frequency prescribed by Dr _____ and his or her associates.

c. I will not increase or change medications without the approval of Dr _____ and his or her associates.

d. I will actively participate in return to work efforts and in any program designed to improve function including social, physical, psychological and daily or work activities.

e. I will not request opioids or any other pain medicine from physicians other than Dr _____ and his or her associates. Dr _____ or his or her associates will approve or prescribe all other mind and mood altering drugs.

f. I will inform Dr _____ or his or her associates of all other medications that I am taking.

etc etc

5. Pre & post intervention assessment of pain and function

6. Appropriate trial of opioids and adjuvant meds

7. Reassessment of pain and function

Practical considerations

- Consider opioids as adjunct, not sole Tx
- Use long acting oral, suppository or transdermal
- Avoid ‘breakthrough’ medication, esp parenterally
- Emphasise improved function, not just analgesia
- Initiate Tx as a trial to be reviewed in 4 – 6 weeks
- Monitor pill use, urine drug screens
- Good documentation

Consider withdrawing opioid Tx

- if unsafe alcohol or illicit substance use
- non-compliance with prescriptions
- eg repeatedly running out of medications early
- seeking opioids from other sources
- non-compliance with clinic procedures
- (eg refusing to do urine drug screens, repeatedly missing appointments, expecting repeat prescriptions by phone).

Respond to apparent increase in dose requirements

- Any change to underlying disease state?
- Stressors?
- Is function likely to be further improved?
- Tolerance?
- Hyperalgesia?

limit for CNCP?

- Animal data – 50 fold dose variability
- Human pharmacokinetics variable
  - genetic, dietary
- Cancer pain – no limits
- Human RCTs – no published RCT evidence above 180mg per day of morphine equivalent

8. Frequently assess the 4 A's

Documentation: The "4+2 As"

1. **A**nalgesia (pain relief)
2. **A**ctivities (physical and psychosocial functioning)
3. **A**dverse Effects (and your advice)
4. **A**berrant Drug Taking Behaviour (and your response)
5. **A**ccurate medication record
6. **A**ffect

Gourlay DL, Heit HA, Almahrezi A. Universal precautions in pain medicine: A rational approach to the treatment of chronic pain. Pain Medicine 2005;6:107-112.

9. Periodically review pain diagnosis, comorbid conditions, addiction

10. Keep complete documentation

11. Specialist review every 1 – 2 years

Urine drug screens

- Used in conjunction w history taking
- May confirm consumption of prescribed opioid
- May identify undisclosed substances
- Unlikely to help establish appropriate dose
- May not detect oxycodone

When to Stop Opioid Therapy

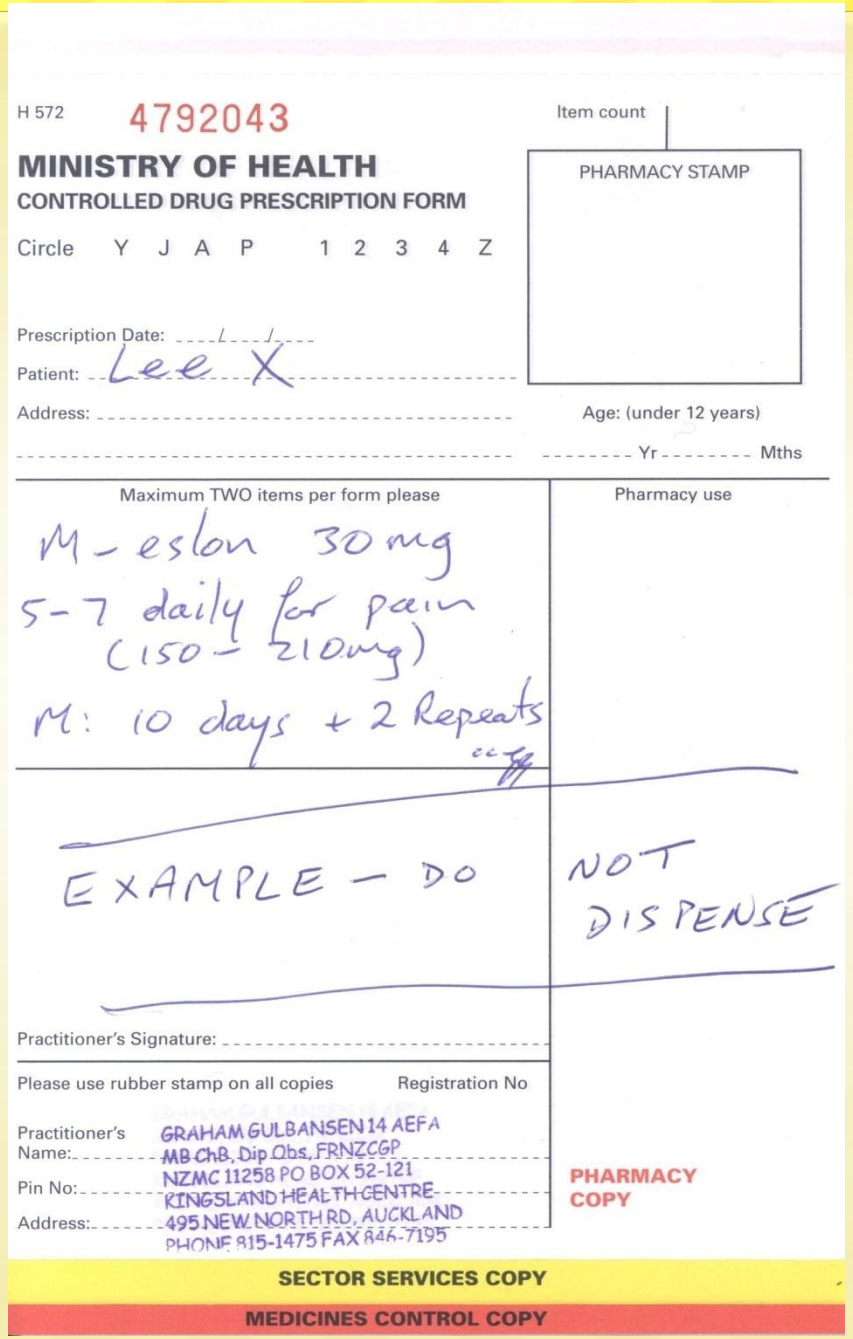
- Pain may reduce over time
- No meaningful pain relief
- Persistent adverse effects
  - ? Opioid hyperalgesia
- Does not achieve therapeutic goals, <u>even with effective pain relief</u>
  - ie. improved physical or social functioning

Ballantyne JC *et al*, 2003; Benyamin R *et al*, 2008; Chou R *et al*, 2009; Porreca F *et al*,2009; Slatkin NE, 2009

Take Home Messages

- Opioids are never first line and are rarely sole treatment: use rational polypharmacy
- Frequent pain assessments including functioning is important: monthly or more frequent visits
- Within local resources try to create a biopsychosocial treatment plan
- To reduce the risk of opioids prescribe using Universal Precautions
- Monitor the 4 A's: Analgesia, Activities, Adverse effects, Aberrant behaviour
- Close control: dispense weekly, or M/W/F with higher doses

Lee Rx



H 572 4792043

Item count

MINISTRY OF HEALTH

CONTROLLED DRUG PRESCRIPTION FORM

PHARMACY STAMP

Circle Y J A P 1 2 3 4 Z

Prescription Date: ---/---/---

Patient: Lee X

Address:

Age: (under 12 years)

Yr Mths

Maximum TWO items per form please

Pharmacy use

M - eslon 30 mg
5-7 daily for pain
(150 - 210mg)
M: 10 days + 2 Repeats

EXAMPLE - DO NOT DISPENSE

Practitioner's Signature:

Please use rubber stamp on all copies Registration No

Practitioner's Name: GRAHAM GULBANSEN 14 AEFA MB ChB, Dip Obs, FRNZCGP NZMC 11258

Pin No: PO BOX 52-121

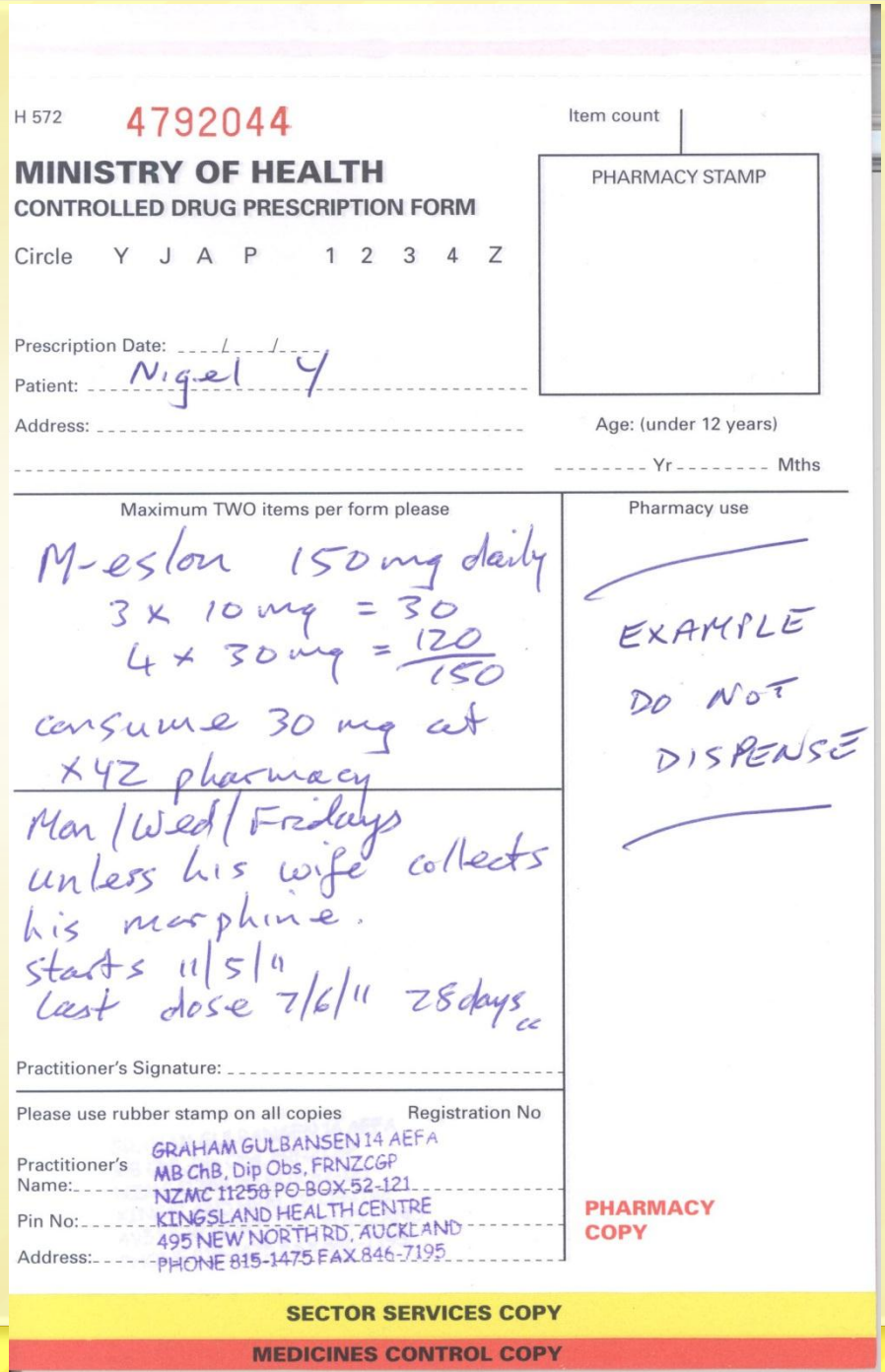
Address: KINGSLAND HEALTH CENTRE 495 NEW NORTH RD, AUCKLAND PHONE 815-1475 FAX 846-7195

PHARMACY COPY

SECTOR SERVICES COPY

MEDICINES CONTROL COPY

Nigel Rx



H 572 4792044

Item count

MINISTRY OF HEALTH

CONTROLLED DRUG PRESCRIPTION FORM

PHARMACY STAMP

Circle Y J A P 1 2 3 4 Z

Prescription Date: ../../..

Patient: Nigel Y

Address:

Age: (under 12 years)

Yr Mths

Maximum TWO items per form please

M-eslon 150 mg daily
3 x 10 mg = 30
4 x 30 mg = 120
150
consume 30 mg at
x42 pharmacy

Mon/Wed/Fridays
unless his wife collects
his morphine.
starts 11/5/11
last dose 7/6/11 28days cc

Practitioner's Signature:

Please use rubber stamp on all copies Registration No

Practitioner's Name: GRAHAM GULBANSEN 14 AEFA
MB ChB, Dip Obs, FRNZCGP
NZMC 11258 PO BOX 52-121

Pin No: KINGSLAND HEALTH CENTRE

Address: 495 NEW NORTH RD, AUCKLAND
PHONE 815-1475 FAX 846-7195

Pharmacy use

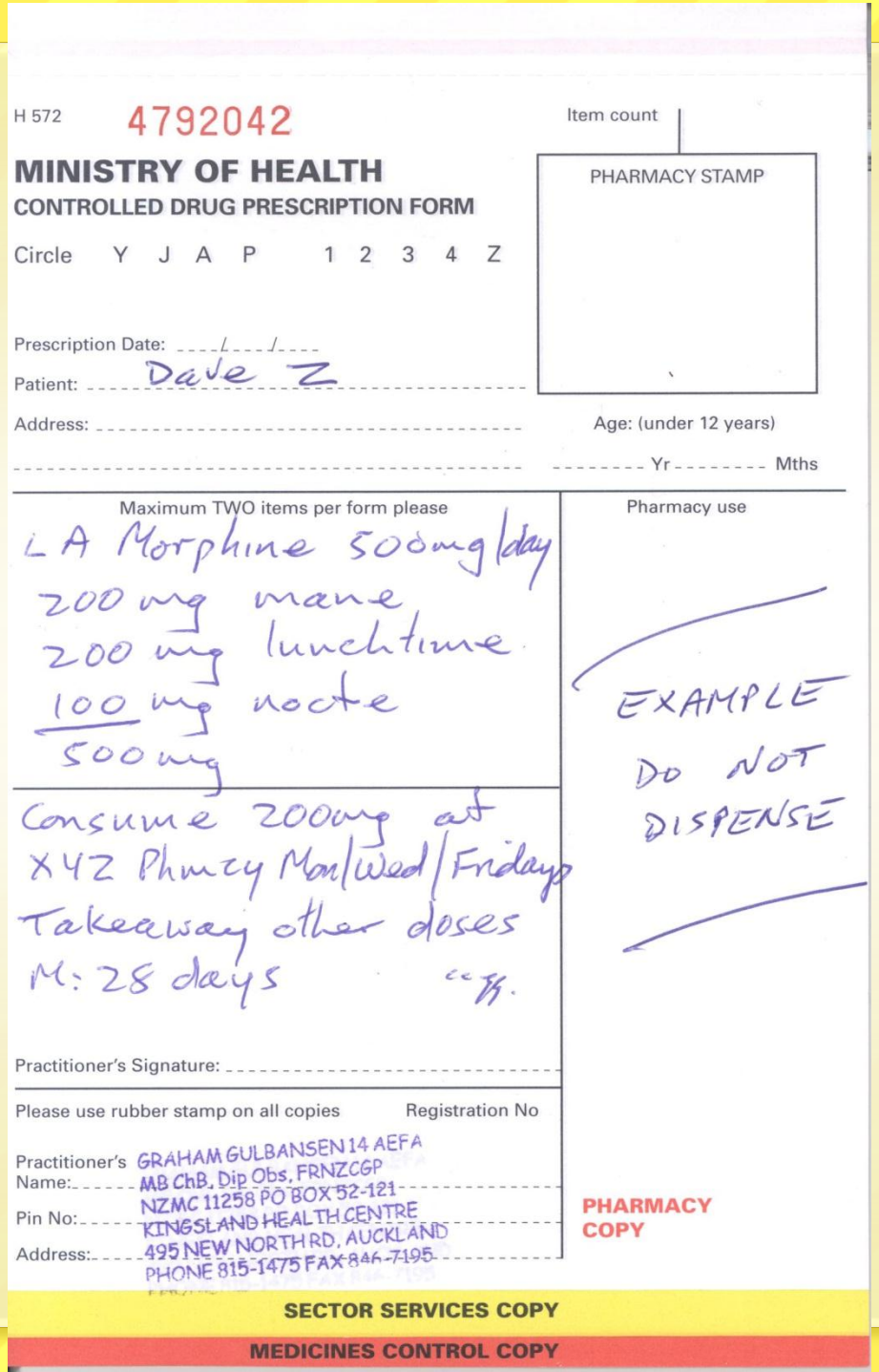
EXAMPLE
DO NOT
DISPENSE

PHARMACY COPY

SECTOR SERVICES COPY

MEDICINES CONTROL COPY

Dave Rx



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Item count

MINISTRY OF HEALTH

CONTROLLED DRUG PRESCRIPTION FORM

PHARMACY STAMP

Circle Y J A P 1 2 3 4 Z

Prescription Date: ___/___/___

Patient: Dave Z

Address:

Age: (under 12 years)

Yr Mths

Maximum TWO items per form please

Pharmacy use

LA Morphine 500mg/day
200 mg mane
200 mg lunchtime
100 mg nocte
500 mg

EXAMPLE
DO NOT
DISPENSE

Consume 200mg at
X42 Phmcy Mon/Wed/Fridays
Takeaway other doses
M: 28 days

Practitioner's Signature:

Please use rubber stamp on all copies Registration No

Practitioner's Name: GRAHAM GULBANSEN 14 AEFA
MB ChB, Dip Obs, FRNZCGP

Pin No: NZMC 11258 PO BOX 52-121
KINGSLAND HEALTH CENTRE

Address: 495 NEW NORTH RD, AUCKLAND
PHONE 815-1475 FAX 846-7195

PHARMACY COPY

SECTOR SERVICES COPY

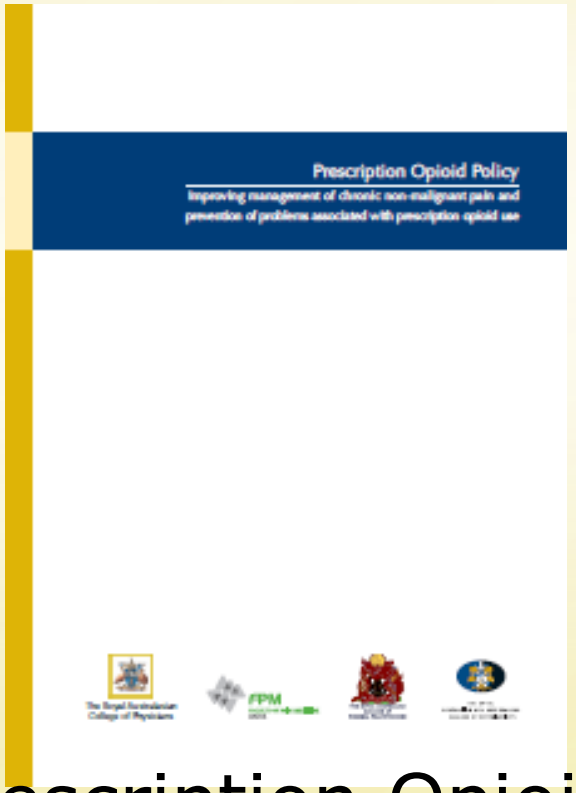
MEDICINES CONTROL COPY

Opioids are not a panacea for all pains in all patients

There is always an individual risk / benefit ratio

Prescription Opioid Policy

Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid misuse. RACP April 2009



Google: RACP Prescription Opioid Policy

•**Roman D. Jovey, MD.** Medical Director, CPM Centres for Pain Management, Physician Director, CVH ACDC, Mississauga, Ontario, Canada - drjovey@sympatico.ca

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Thank You All