Opioid overprescribing: stemming the tide

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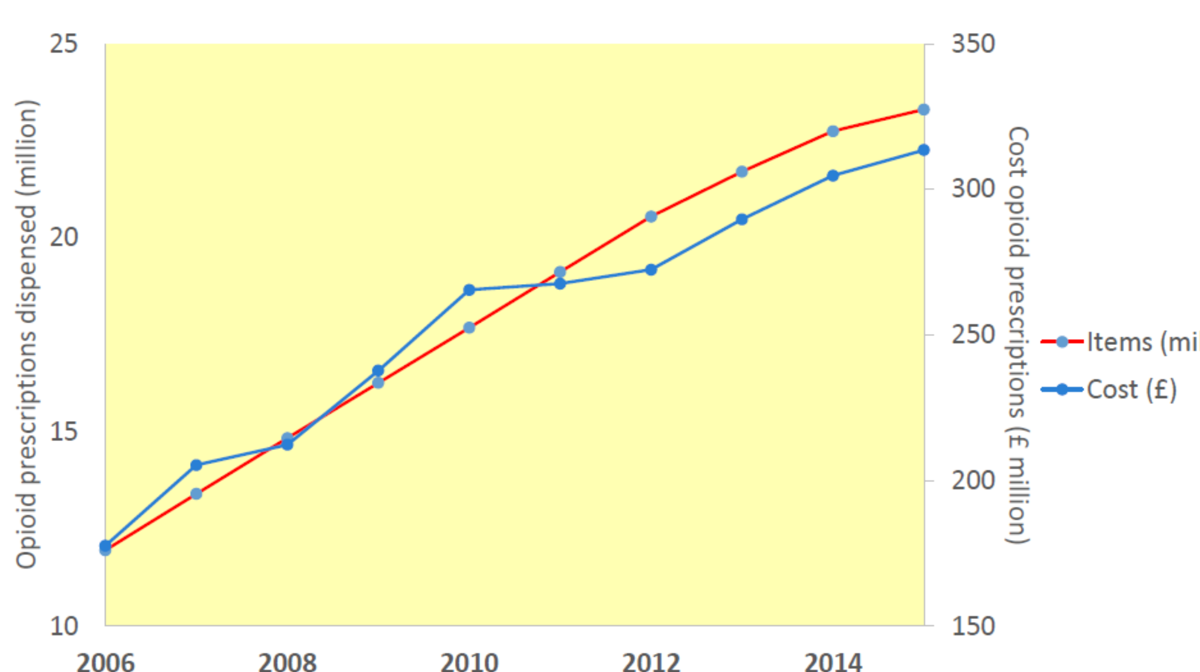
Opioids for chronic pain: What's the problem?
Opioid prescribing for chronic non-cancer pain has risen dramatically
Opioids don't seem to help most people with chronic pain
Long-term opioids are associated with risk of serious harm
Pain
Your Personal

Trends in opioid prescribing



Opioid prescriptions dispensed in the community in England 2005-2015
NHS Digital

A Total items for all opioid-containing preparations

Other
Methadone hydrochloride
Co-dydramol
Codeine phosphate
Dihydrocodeine tartrate
Buprenorphine
Co-proxamol
Oxycodone hydrochloride
Fentanyl
Tramadol hydrochloride
Morphine sulfate
Co-codamol

Number of items per 1000 population

800
700
600
500
400
300
200
100
0

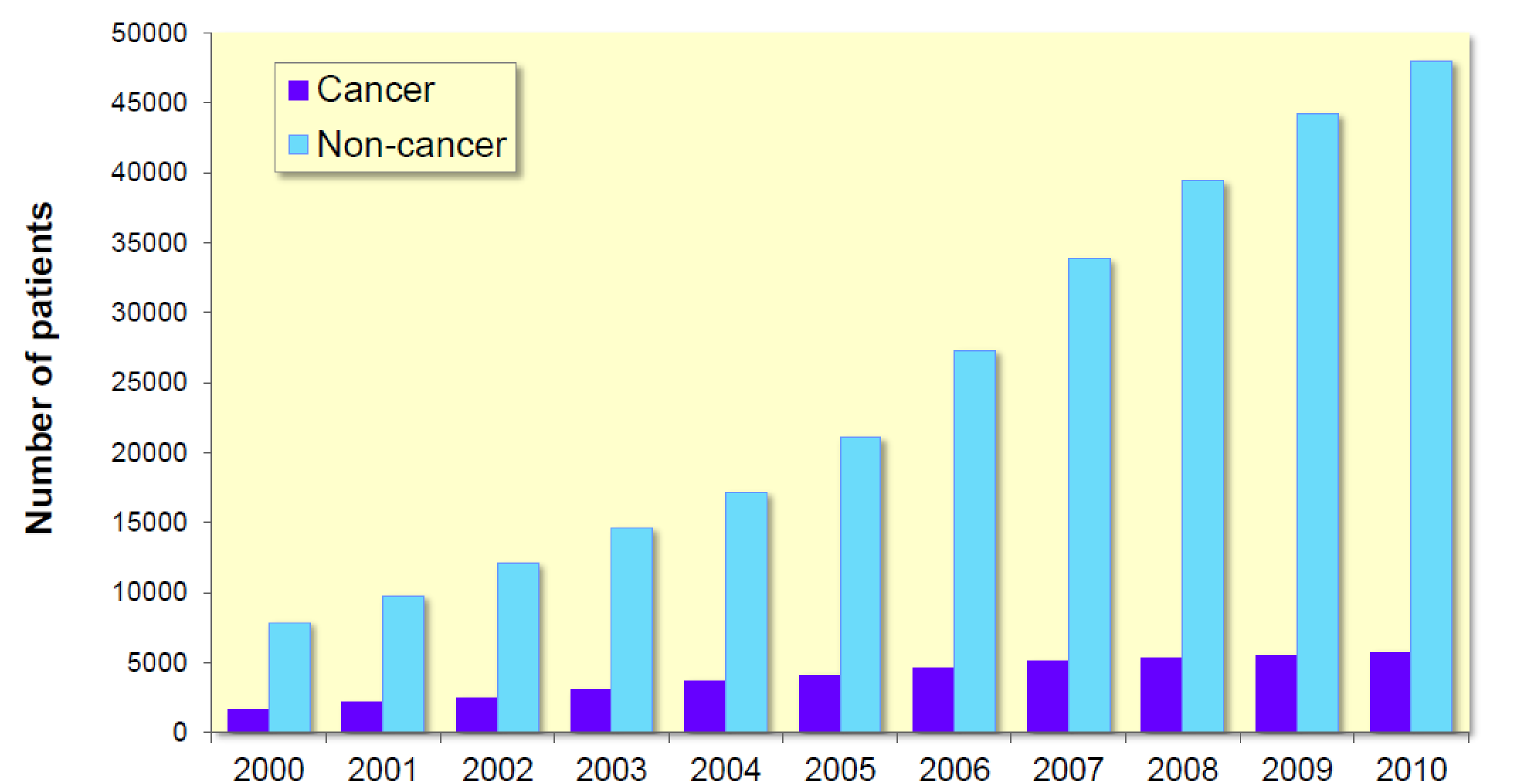
B Total OME (mg) for all opioid-containing preparations

OME (mg) per 1000 population

400 000
300 000
200 000
100 000
0

Opioids↑ 34% & ↑ 127% adjusted for morphine equivalence (England 1998 -2016)

Curtis (2019) Lancet Psychiatry;140–50



Trends in strong opioid prescribing

- Between 2001-2010, strong opioid prescribing ↑ 466% more patients prescribed strong opioids in UK primary care
- 87% for chronic non-cancer pain
- Between 2002-2009, long-term (≥3 months) opioid prescribing ↑ 38% [2]
- Long-acting, strong opioids ↑ & earlier

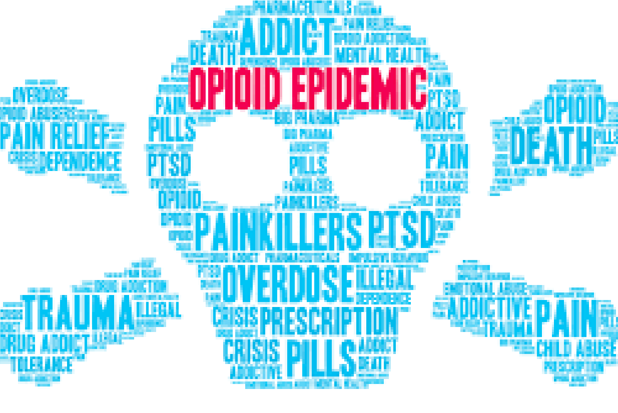
1. Zin C et al. *Eur J Pain* 2014; 18: 1343 – 1351. 2. Bedson et al (2016) *Pain*;157:1525–1531

Public Health England

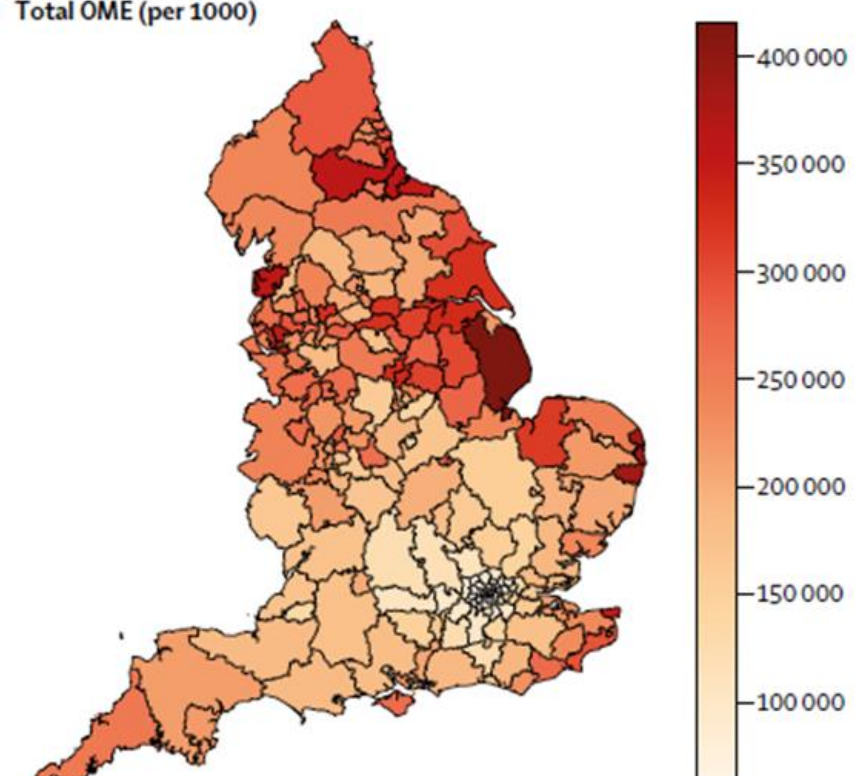
Protecting and improving the nation's health

Dependence and withdrawal associated with some prescribed medicines

An evidence review



Opioids dispensed to 5.6 million patients (13% of adult population) in 2017-18)



Variation in opioid prescribing by clinical commissioning groups in England, Mar – Aug 2018

Sept 2019
https://www.gov.uk/government/publications/prescribed-medicines-review-report

Public Health England

Prescription Medicines Review: Prescription medicines in England

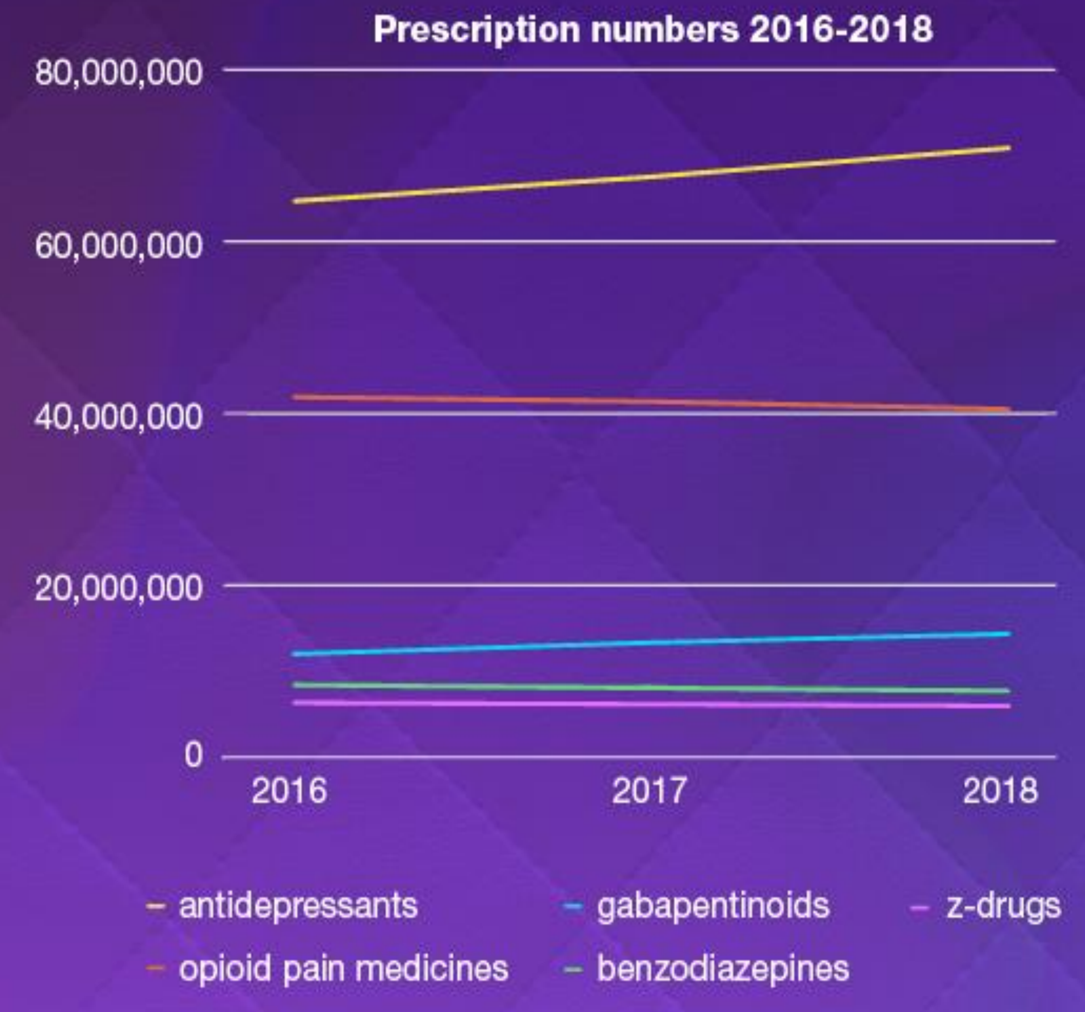
Prescribing rates are higher and duration longer in some of the most deprived areas of England

(apart from benzos and z-drugs), with duration higher in the North and East of England

Long term prescribing of **opioid pain medicines** and **benzodiazepines** and **z-drugs** is not supported by guidelines or evidence on effectiveness for most people

Public Health England

Prescription Medicines Review: Trends in prescribing numbers



- Prescriptions for **antidepressants** and **gabapentinoids** are rising
- Prescriptions for **opioid pain medications** are beginning to decline after years of substantially increasing
- Prescriptions for **benzodiazepines** are continuing to fall and **z-drugs** are falling recently after years of increasing

Are opioids effective for chronic non-cancer pain?

Most (80%) patients with chronic pain do not get good long-term pain relief long-term from opioids.[1,2]

A few patients may benefit, but we can't predict who will respond e.g. by demographics, cause of pain, comorbidity. [2]

In fact overall….

Opioid use for chronic pain associated with worse pain, poorer self-rated health, and lower quality of life.[1,3]

Opioid use in back pain patients was associated with slightly worse functioning at 6-month follow-up, even after adjusting for potential confounders.[4]

1. Jensen MK. et al. Eur J Pain. 10 (2006) 423–433 2. Chou et al. Annals of Internal Medicine. 2015;162(4), 276-28
3. Eriksen J,et. al. Pain.2006;125:172-9 4. Ashworth J. et al. Pain. 154 (2013) 1038–1044

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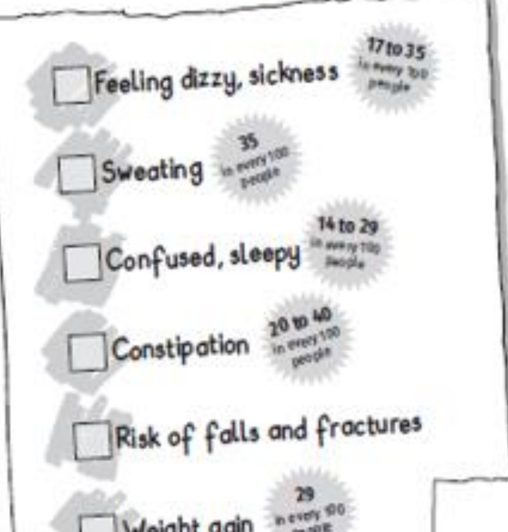
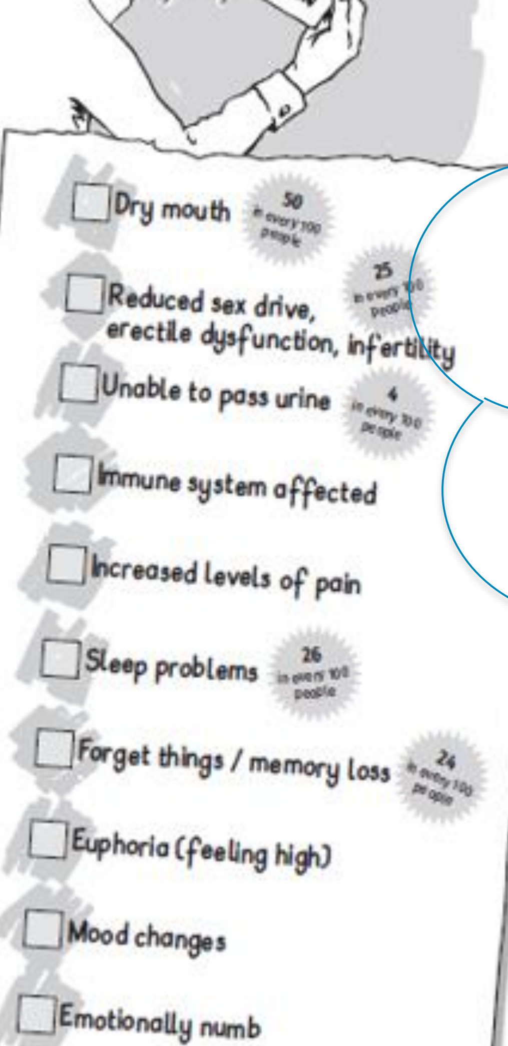
Opioids ('strong painkillers') can be really useful for a short time – after an injury or surgery. But longer term they aren't much help. They only reduce pain for about 20 percent of people in the long term.

So out of every 100 people, 80 get no benefit long term. And they'll still get the side effects.

If you're taking opioids, the chances are you'll be experiencing at least some of the side effects listed here. Tick the ones that affect you, and you may decide it's time to review your medicines with your clinician.

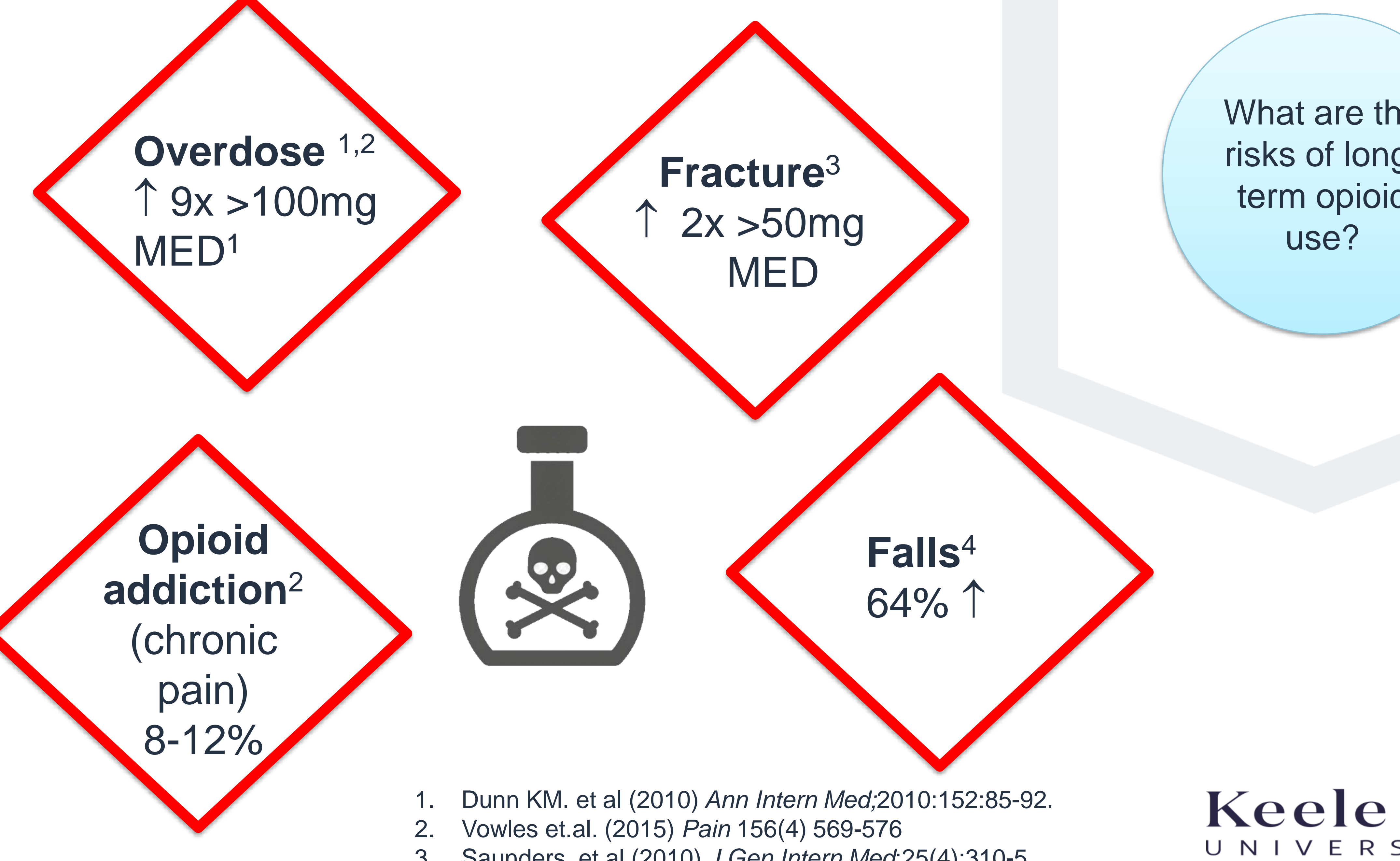
(Remember – never come off your medicines suddenly as this may cause other problems).





Opioid side-effects are common and may interfere with quality-of-life & ability to engage in self-care to improve life with pain

What are the risks of long-term opioid use?



1. Dunn KM. et al (2010) *Ann Intern Med*;2010:152:85-92.
2. Vowles et.al. (2015) *Pain* 156(4) 569-576
3. Saunders. et al (2010) *J Gen Intern Med*;25(4):310-5
4. Bedson et al. (2016) *Pain*;157:1525–1531

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Higher risk of opioid-related harm

Higher dose

AND

- Comorbid mental health disorder
- Concurrent benzodiazepines & other sedative medication
- History of substance abuse

Wilsey et al. Pain Med. 2008;9(8):1107-1117.
Gudin et al. Postgrad Med. 2013;125(4):115-130.
Fishbain et al. Pain Med. 2008;9(4):444-459.
Chou et al. Ann Int Med. 2015;162(4);276-286.

More likely to get high dose long-term opioids

Patients

WITH

- Comorbid mental health disorder
- Concurrent benzodiazepines & other sedative medication
- History of substance abuse

Edlund et al.Clin J Pain 2010;26(1):1-8.
Morasco et al. Pain. 2010;151(3):625-632
Sullivan et al. Pain. 2010;151(3):567-568.

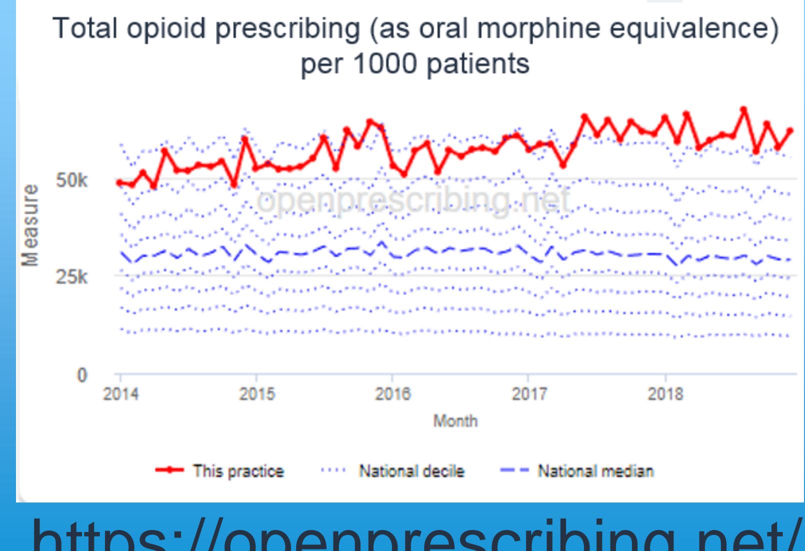
Adverse selection

Sullivan, M.D. Pain. 2010;151(3):567-568.

Stemming the tide of opioid overprescribing

Prescription Medicines Review: Rec

- Give NHS commissioners and doctors **better insight into prescribing data**
- Update **clinical guidance** on these five classes of medicines
- **Improving training** for clinicians to ensure their prescribing adheres to best practice
- New clinical guidance on **safe management** of dependence and withdrawal
- **Better information to patients** about the benefits and risks



https://openprescribing.net/

Opioids for Chronic Pain: Guidelines

Guideline for Prescribing Opioids for Chronic pain (2016)

Opioid therapy for chronic pain: Clinical Practice Guideline (2017)

The 2017 Canadian Guideline for opioid therapy chronic non-cancer pain

Opioids Aware

Opioid guideline recommendations

Use non-pharmacological & non-opioid analgesics if possible

Opioids only if potential benefit outweighs potential harm - & combine with non-pharmacological & non-opioid medicines as appropriate

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Opioid guideline recommendations

Agree realistic functional goals for treatment

Assess after trial period and continue only where clinically meaningful improvement outweighs individual risks

If treating acute pain, avoid supplying greater quantity than needed

Opioid guideline recommendations

Guideline for Prescribing Opioids for Chronic pain (2016)

Opioid therapy for chronic pain: Clinical Practice Guideline (2017)

The 2017 Canadian Guideline for opioid therapy chronic non-cancer pain

Opioids Aware

Initiate opioids using immediate release preparations

Maintain at lowest effective dose

Careful consideration of balance of benefits vs risks before escalating ≥ 50mg daily MED

Avoid increasing ≥ 90mg* daily MED

Stemming the tide of opioid overprescribing

STOP STARTING

1. Avoid starting opioids
2. Avoid continuing opioids
3. Avoid escalating opioids
4. Attempt to taper and/or stop opioids

START STOPPING

Discussing opioids

Allow enough time
Listen
Build Rapport
Build a personalised picture of benefits vs side-effects and risks

4 A's:
Analgesia, **A**ctivity, **A**dverse Effects, **A**berrant behaviour

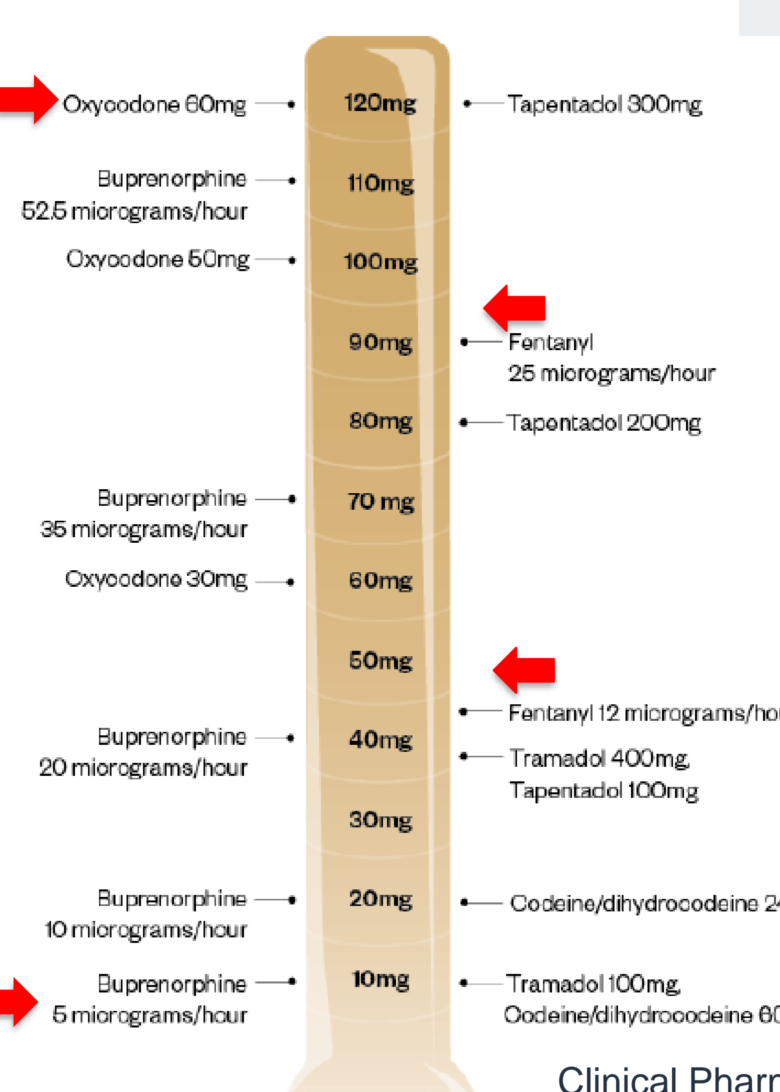
Myths about long-acting (slow release) opioids

- Recent evidence does not support claims that long-acting opioids provide more consistent analgesia with less risk of addiction
  - Analgesia not improved
  - Addiction not reduced
  - Tolerance & escalation more likely – high doses[1,2]
- Increase risk of unintentional overdose reported after initiation of opioids with long-acting preparations.[1,3]
  - initiation with immediate release recommended.[2-4]

1. Von-Korff et al Pain, 2011;152:1256–1262
2. Sullivan, M. Pain. 2014;155:843–844
3. Dowell et al CDC Guideline. JAMA. 2016;315(15):1624
4. Opioids Aware https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

Myths about oxycodone & 'Morphine patches'

- Oxycodone may be better tolerated than morphine in some patients but is 1.5-2x more potent than morphine
- Risk of prescribing very high MED
- More addictive than morphine[1]
- One of most commonly abused medicines in US
  'Rolls Royce of highs….'



2 types of opioid patch

- Buprenorphine
  Butec®, BuTrans® etc. (7day)
  Transtec etc. (96 hrs)
- Fentanyl
  Durogesic, Matrifen etc. (3 day)

- They are not the same & neither contains morphine …

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1. Wightman et al J. Med. Toxicol. (2012) 8:335–340

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Tapering opioids

- Little evidence for advantages of rapid tapering
  - For outpatient tapering – go slow
- Mayo Clinic Program – reduction by 10% of original dose every 5-7 days down to 30% of dose – then by 10% of remaining dose
  - Depends on smallest dose unit available 10-25% reduction acceptable
- In practice – speed to suit patient & practical arrangements (e.g. GP prescribing / community pharmacy etc)
- Avoid switching opioids before tapering where possible, reduce doses down to lowest available first, then increase time between doses

Berna et.al. Mayo Clin Proc. n June 2015;90(6):828-842

Won’t my pain be even worse?

- If a patent is taking regular opioids and still in a lot of pain, opioids aren’t working[1]
- Evidence form observational studies of patients tapering opioids as part of a pain rehabilitation programme suggests pain does not usually increase[2]
- In fact, often patients report improvements in QoL, functioning and even pain after reducing opioids
- There may be some ups & downs along the way
- Slower reductions reduce the risk on short-term pain increase & / or withdrawal symptoms

1.Opioids Aware www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
2. Berna et.al. Mayo Clin Proc. 2015;90(6):828-842

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What is the evidence for interventions to support patients with chronic non-cancer pain to taper opioids ?

- Systematic (Cochrane) review[1] - 5 small RCTs, mixed results, no recommendations
- Non-randomised studies, indicate that intensive rehabilitation packages may bring about reduction in opioid use[1,2].

Studies in progress

- iWOTCH – RCT of group-based intervention to reduce strong opioid use – results awaited
- PROMPPT

1. Eccleston C. et.al. *Cochrane Database of Systematic Reviews* 2017, Issue 11. Art. No.: CD010323.
2. Frank J. et al *Ann Intern Med.*2017 doi:10.7326/M17-0598
3. https://warwick.ac.uk/fac/sci/med/research/ctu/trials/iwotch/
4. www.promppt.co.uk

What is ?

- 5 year research programme funded by NIHR
- Aim:
  - to develop & test a primary care clinical pharmacist-led intervention (PROMPPT) to reduce opioid use for persistent pain and support patient self-management

- **P**roactive clinical **R**eview of patients taking **O**pioid **M**edicines long-term for persistent **P**ain led by clinical **P**harmacists in primary care **T**eams.

Improving outcomes for patients using opioid medicines for persistent non-cancer pain

Proactive clinical Review of patients taking Opioid Medicines long-term for persistent Pain led by clinical Pharmacists in primary care Teams

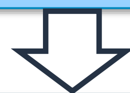
Find Out More

www.promppt.co.uk

- Compared with usual primary care review for patients using opioids long-term (>6months) for persistent pain…..
- Does providing PROMPPT reduce opioid use without making pain or pain-related interference worse?
- Is it cost-effective?

Year 1
Intervention development

Year 2
Feasibility Study



Years 3-5
Main Trial

- Cluster randomised controlled trial
- 3 centres (Keele, Nottingham, Southampton)
- 24 - 40 GP practices
- Over 1000 patients

Thanks for listening

Any questions?