OPIOIDS FOR TREATMENT OF CHRONIC NONCANCER PAIN

A: Preamble

Pain is common. When considering duration, pain can be considered acute and chronic. Chronic pain is pain that has lasted for longer than six months and from a treatment perspective is usually considered as cancer related pain and noncancer pain. This document refers only to the latter. Figures vary but the prevalence of chronic noncancer pain is reported as 10%(17) of the population to 29%(18)

Chronic pain including noncancer pain is undertreated.(18) Management of chronic noncancer pain includes non pharmacological methods and pharmacological methods. Non pharmacological approaches often focus on physical and cognitive behavioral therapy. Pharmacologically, first-line treatment modalities must be used before opioids are considered. These include non-opioid medication such as acetaminophen, nonsteroidal anti-inflammatory drugs, tricyclic antidepressants, anticonvulsants and topical preparations and any other preparation shown to be useful in pain management.

When nonpharmacological methods and pharmacological non-opioid medications fail to provide satisfactory pain relief and acceptable quality of life, opioid drugs may be considered. Practitioners should recognize that there is very little scientific evidence addressing the safety and efficacy of opioids for the treatment of chronic noncancer pain.

If opioids are selected to treat chronic noncancer pain they must be used in accordance with accepted principles including those contained in this document.

B: Guidelines for prescribing controlled substances to treat chronic noncancer pain (CNCP)

Evaluation of the patient:

- History and physical examination: a complete history must be obtained, a physical examination performed and the results documented in the medical record.
- In addition to the usual medical history this evaluation should include the following topics.
  - Pain history. The pain history must be comprehensive and include all items contained in APPENDIX 1.
  - Assessment of the impact of pain on the patient’s physical and psychological function, and on the patient’s family.
  - Review of underlying and coexisting disease and conditions.
  - Review of previous diagnostic studies and assessments.
  - Review of current and past treatments and results.
- Assessment of significant psychological, social or behavioral factors that may affect the pain problem and treatment.
- History of substance abuse.
- Assess risk factors for addiction. SISAP and CAGE questionnaires must be completed on all patients being considered for opioid medication. (Appendix 2)
- Document one or more indications for use of a controlled substance.

**Treatment plan:**

1. A plan individualized to each patient, should be in writing.
2. The plan should indicate any diagnostic evaluations being contemplated.
3. The plan should define the objectives that will be used to determine treatment success. Since the primary purpose of opioid therapy is to improve quality of life, improved pain control and improved physical and psychological function are therefore appropriate goals. Functional goals may help to define and monitor physical and psychological function. These could include targets for physical activity, activities of daily living, hobbies and return to work.
4. The plan should state if other treatment modalities are being considered. These may include a pain rehabilitation program, cognitive and behavioral strategies, noninvasive and invasive techniques or the use of medication.

**Informed consent:**

- Before commencing opioid therapy informed consent must be obtained from the patient, the patient’s surrogate or guardian.
- The risks and benefits of opioid therapy and all points listed in Appendix 3 should be discussed.
- For patients deemed to be at risk of medication abuse or noncompliance a therapeutic agreement such as contained in Appendix 4 should be considered.

**Periodic review:**

- The patient must be interviewed and re-examined at reasonable intervals and the results documented in the medical record.
- During these meetings the physician should review any new information about the etiology of the pain and reevaluate the course of treatment.
- The following areas must be specifically documented:
  - Analgesia - The patient’s self-reported level of pain should be recorded. A pain scale should be used, preferably the same scale employed in the initial evaluation. (APPENDIX 1)
  - Activities - Record the level of physical and psychological function, listing specific activities and examples, as previously defined in the treatment plan. Attainment of these goals could indicate efficacy of opioid therapy. Failure to achieve these goals should be indicated and the reasons for failure documented. Any decline in function should be investigated. Whenever
there is a decline in function withdrawal of opioids should be considered.

**Adverse effects**
- Record any side effects of opioid therapy and their management.

**Abuse behavior**
- Record any suspicious drug related behavior observed by the physician or reported by others.
- Record the action taken by the physician

**Adequate documentation**
- Record any changes to therapy and the reasons for change.
- Prescriptions for opioids must specify the name of the drug, the strength, the number of dosage units and how the drug is to be taken.
- A copy of the prescription should be kept in the patient’s medical record.

**Consultation**
- Consultations should be sought when medically indicated.
- Consultations with specialists in pain management, although desirable, should not be a prerequisite to the use of opioid therapy. When the origin of pain is suspected to involve particular organs or anatomical systems, specialists with expertise in these areas should be consulted. If a psychiatric disorder is present consultation with a psychiatrist may be necessary. If there is potential for substance abuse, an addiction specialist must be consulted.

**Medical records**
The medical record should include the following:

1. History and physical examination
2. Diagnostic results
3. Evaluations and consultations
4. Treatment plan
5. Risk of addiction documentation (Appendix 2)
6. Copy of informed consent (Appendix 3)
7. Previous and current treatments and results.
8. Copies of opioid prescriptions given
9. Instructions and agreements
10. Periodic reviews

**Compliance laws and regulations**
- Physicians must ensure that they are compliant with all laws and regulations pertaining to the prescribing of controlled substances. (16)


C: Principles of using opioids

Choice of drug

Only nonparenteral opioids are recommended for treatment of chronic noncancer pain. Injectable opioids are rarely, if ever appropriate.

Titration can be achieved with either short acting or long acting preparations. Some feel that titration with sustained release opioids promotes smoother pain relief and improved compliance. It may be equally effective to titrate short acting opioids and convert to sustained release when maintenance dose is reached. Once a drug is selected the dose is gradually increased to improve pain control and function and avoid or minimize side effects.

Rescue or breakthrough analgesia. After maintenance analgesia has been established spontaneous or triggered exacerbations of pain may require additional treatment. This can be achieved with short acting opioids. The dose should be one-third to one-sixth of the 12 hourly maintenance dose. This should not be used frequently.

Which drug to use first depends on several factors including:

- Previous opioid exposure, efficacy and side effects. If a drug resulted in side effects it probably shouldn’t be used again.
- Cost and whether or not the drug is covered by insurance.
- Patient preference. Patients may not want oxycontin because of unfavorable publicity.
- History of drug abuse. Methadone may be preferred and short acting drugs for rescue may not be used.
- Concomitant medical conditions which may affect dosage or actual preparation. Morphine may not be suitable for someone in renal failure.
- Inability to use oral medications. May have to use transdermal or other routes in patients with inflammatory bowel disease.
- Pain characteristics. Methadone is very effective for relief of burning pain.

Switching to alternative opioids

- Published equianalgesic doses are approximations and may vary with any one person. (Appendix 5) A 10% to 20% reduction in the equianalgesic is recommended when switching.
- If switching to methadone extra caution is required. Methadone is 7 to 10 times more potent than morphine when given long term. As the original opioid is being withdrawn start with very low doses of methadone. Suggested doses for patients 65 years of age or younger are 2.5 to 5.0 mg every 12 hours. For those over 65 start with 1.0 mg every 12 hours. Methadone must be titrated very slowly over several weeks.
Age

- For patients over 65 a lower dose and slower titration are recommended.

Hepatic and renal disease.

- Patients with hepatic or renal disease are at risk because of the potential accumulation of toxic metabolites. This may result in decreased cognitive function, anxiety, clonus and allodynia. Lower doses and slower titration are recommended. If impairment of cognitive is a problem consider switching to transdermal fentanyl.

D: Problems related to the use of opioids

Addiction

A patient’s desperate efforts to obtain drugs for pain relief should never be confused with drug-seeking behavior or with addiction. Addiction is a biopsychosocial disorder and is defined as a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by one or more of the following 4C’s: impaired Control over drug use, Compulsive use, Consequences or continued use despite harm and Craving.(5) The risk is not known but the likelihood of addiction among those using opioids for pain relief is probably rare.

Pseudoaddiction

Restrictions on opioid prescribing, in part because of fear of addiction, can compromise pain relief. This in turn can lead to drug hoarding, attempts to secure extra drugs requests for increased dose and early prescriptions. These measures are an attempt to gain pain relief and will disappear when pain is relieved.

Tolerance

Tolerance is a state of adaptation where use of a drug results in changes that decrease the effects of that drug. Tolerance to euphoria, nausea and sedation appears early in most and is a positive effect. Analgesic tolerance occurs when progressively larger amounts of opioids are required to maintain control of pain. This probably occurs in a small percentage of patients. This can be managed by titrating the dose of opioid, switching to another opioid or adding other medications.

Tolerance is listed as one of the criteria for addiction in DSM-IV. According to the joint consensus statement(5) tolerance to prescribed drugs does not constitute sufficient evidence of psychoactive substance use disorder or addiction and should not be used to diagnose addiction in the absence of criteria listed in the paragraph on addiction.

Withdrawal and Physical Dependence
Physical dependence is a physiological phenomenon characterized by the appearance of withdrawal symptoms when the drug is suddenly reduced, terminated or blocked by opioid antagonists. Symptoms include coryza, tremors, sweats, chills, lacrimation, abdominal cramps, arthralgias, myalgias, vomiting and diarrhea. In the absence of other indicators physical dependence is not diagnostic of addiction.

**Psychological dependence**

Psychological dependence is a compulsion to use a drug. This appears rarely in patients prescribed a stable dose of opioid for pain relief.

**Diversion**

Diversion of opioids and other controlled substances should be a concern of all health care personnel. Measures to prevent diversion includes careful writing of prescriptions, close monitoring of prescriptions in each physician’s practice and the use of tamper resistant prescription pads and electronic prescription facilities. Under no circumstances should attempts to prevent diversion compromise effective pain management.

**Adverse effects**

- Nausea, vomiting, itching, somnolence and constipation are common.Constipation is often persistent and may be dose related. The other side effects are usually transient at the beginning of treatment.
- Respiratory depression, weight gain, weight loss and hormonal changes are more serious. Hormonal changes may include adrenal insufficiency, infertility and sexual dysfunction.
- Female patients who taking opioids and planning pregnancy or become pregnant, should be under the care of an obstetrician and when appropriate, a neonatologist. Safer pain medication should be used if possible. 50% of newborns of women taking opioids may show signs of withdrawal. These symptoms may persist up to five days with long acting preparations.
- It is not clear if changes to the immune system are of clinical importance.
- Driving may be possible when patients are on a stable dose of opioids. Patients should not operate a motor vehicle during dose titration, if medication causes drowsiness or results in any cognitive symptoms. Patients are responsible for ensuring their own suitability to drive. This is not the responsibility of physicians. Patients who question their ability to drive should contact the Highway Safety Division.
- These and other possible side effects must be discussed with the patient and the fact that the discussion took place should be documented in the medical record.

**D: Conclusion**

Physicians have an obligation to alleviate pain and suffering. At times this may require the use of narcotics. For the majority of patients using narcotics there will be no drug related problems. Unfortunately within the ranks of these patients there may be some who are addicts or potential addicts and a few who are social deviants and criminally inclined. The guidelines contained in this document
represent an attempt to help physicians use opioids safely and effectively in our patients who suffer from chronic non-cancer pain. Compliance with these guidelines should also help to identify and manage those who are addicted or who could become addicted. Finally, adherence to the principals and policies contained herein may help thwart the efforts of the criminal element shamelessly attempting to disguise themselves in this population of patients who so desperately need our help.

REFERENCES


APPENDIX 1

PAIN HISTORY

A comprehensive pain history should incorporate the following information.

- Person reporting pain:
  - patient
  - caregiver
  - other
- Pain locations
- Onset of pain
- Qualities of pain:
  - throbbing
  - aching
  - shooting
  - burning
  - stabbing
  - sharp
  - dull
  - other
- Frequency of pain:
  - no pain
  - occasional less than one third of the time in frequency or duration
  - often between one third and two thirds of the time in frequency or duration
  - almost continuous greater than two thirds of the time in frequency or duration
• Intensity of pain At least one of the pain scales illustrated below, should be used: record best, worst and tolerable scores at each visit
• Patterns of pain
• Exacerbations
  -frequency
  -duration
• Triggers
• Aggravating factors
• Relieving factors
• Effect of pain on
  -sleep
  -mood
  -appetite
  -activity
  -relationships
• Pain related disability
  -bedridden
  -able to care for self
  -able to help care for home and family
  -able to take part in activities outside of home
  -able to exercise
  -able to work

• Type of pain
  -chronic
  -acute
  -both
• Classification of pain
  -somatic
  -visceral
  -neuropathic
  -other

NUMERIC PAIN SCALE

0 1 2 3 4 5 6 7 8 9 10

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<table>
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<td>POSSIBLE</td>
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SIMPLE DESCRIPTIVE PAIN SCALE

(VERBAL PAIN SCALE)

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<th>SEVERE</th>
<th>VERY</th>
<th>WORST</th>
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VISUAL ANALOGUE PAIN SCALE

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</table>

The Wong-Baker Faces Pain Rating Scale

Designed for children aged 3 years and older, the Wong-Baker Faces Pain Rating Scale is also helpful for elderly patients who may be cognitively impaired. It offers a visual description for those who don't have the verbal skills to explain how their symptoms make them feel.
To use this scale, your doctor should explain that each face shows how a person in pain is feeling. That is, a person may feel happy because he or she has no pain (hurt), or a person may feel sad because he or she has some or a lot of pain.

- Face 0 is very happy because he or she doesn't hurt at all.
- Face 1 hurts just a little bit.
- Face 2 hurts a little more.
- Face 3 hurts even more.
- Face 4 hurts a whole lot.
- Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad.

You should point to each face using the words to describe the pain intensity. You should then choose the face that best describes how you feel.

APPENDIX 2 (Ref 1)

Suggested addiction screening questions

In screening patients with chronic noncancer pain for addiction risk, the clinician is primarily interested in assessing for patients with a history of alcohol abuse/dependence or with a history of polydrug abuse. A patient who has a past history of abusing one substance is at higher risk for abusing other psychoactive substances. The purpose of screening is not to deny patients opioids for pain, but to identify the small subgroup at higher risk for more detailed assessment and more careful monitoring.

The Screening Instrument For Substance Abuse Potential (SISAP) is a five-item screening tool created by Coambs et al in 1996 (1) that helps the clinician to categorize patients into lower or higher risk of abusing prescribed opioids. It requires that the physician already know the patient or have collateral information to confirm the accuracy of the answers. It has a high false positive rate but a low false negative rate when tested against the database of a large (n=11,634) Canadian epidemiological survey of alcohol and drug use. It has not yet been prospectively tested in the chronic pain population.

The five SISAP questions are:

1. If you drink alcohol, how many drinks do you have on a typical day?

2. How many drinks do you have in a typical week?

3. Have you used marijuana or hashish in the past year?

4. Have you ever smoked cigarettes?

5. What is your age?
Use caution when prescribing opioids for the following patients:

1. Men who exceed four drinks per day or 16 drinks per week

2. Women who exceed three drinks per day or 12 drinks per week

3. A patient who admits to marijuana or hashish use in the past year. (It is recreational use of cannabis for euphoric effect that is of concern. The use of tetrahydrocannabinol (THC) derivatives to treat pain is still very controversial. Clinicians should exercise caution in recommending opioid therapy to a patient who is using cannabis regularly.)

4. A patient under 40 years who smokes.

The majority of patients will pass the screen and are probably at low risk of abusing opioids, but clinical judgement is still required. The SISAP questions ask about recent drug or alcohol use and may, therefore, miss a patient who is at risk because of a previous history of chemical abuse or dependency. A simple but effective question to ask is:

Has your use of alcohol or other drugs ever caused a problem for you or those close to you?

A positive answer to the above or to any of the SISAP questions suggests further assessment.

The CAGE-AID questions comprise a quick screening tool to assess for the risk of serious alcohol or drug problems.

In the past have you ever:

   a) felt that you wanted or needed to Cut down on your drinking or drug use?

   b) been Annoyed by others’ complaining about your drinking or drug use?

   c) felt Guilty about the consequences of your drinking or drug use?

   d) had a drink or taken a drug in the morning (Eye-opener) to decrease hangover or withdrawal symptoms?

One positive response to any one of the CAGE-AID questions should raise concerns. Two or more positive responses means a high likelihood of a serious alcohol or drug problem and may require a formal addiction assessment by a specialist.

A family history of alcohol, drug abuse or significant psychiatric illness, or a personal history of previous physical, sexual or emotional abuse may also be risk factors for substance abuse and require assessment.

REFERENCE

APPENDIX 3 (Ref 1)

INFORMED CONSENT FOR TREATMENT WITH NARCOTICS

1. Describe and explain the purpose of opioid therapy (less pain rather than no pain) with the patient and/or guardian, along with explaining the common side effects and their management. Preventative management of constipation should specifically be discussed. The small risk of addiction in low risk patients should be addressed and differentiated from tolerance and physical dependence. Warn the patient regarding withdrawal symptoms due to abrupt discontinuation of opioids. Discuss the concept of dose titration and the importance of time-contingent dosing versus as required dosing for around-the-clock pain. Discuss the appropriate use of breakthrough medication.

2. Advise the patient and/or guardian that drowsiness is a common side effect during titration of opioid therapy. The patient should not drive a car or operate dangerous machinery until this phase of drowsiness has passed. Failure to comply with this advice may result in a duty to report to the provincial Ministry of Transportation.

3. The patient and/or guardian should be warned not to change the dosage of opioid analgesic nor the dosing interval without specific instructions from the doctor. The patient should be made aware that such unsanctioned dosage changes may compromise the physician-patient relationship.

4. Inform the patient and/or guardian that regular follow-up appointments are required to monitor the effectiveness of opioid treatment and to manage side effects. The frequency of follow-up appointments will vary depending on the phase of treatment – titration versus stable dosing.

5. Inform the patient and/or guardian that prescriptions for opioid analgesics should be obtained only from one physician or, in the absence of that physician, his or her designate. The patient should have all prescriptions for psychoactive medication dispensed at one pharmacy, except in emergencies. Inform the patient and/or guardian that seeking opioid treatment from other physicians and pharmacies without informing the prescribing physician undermines the trust essential to prescribing long term opioid therapy.

6. Advise the patient and/or guardian to keep the opioid analgesics in a safe and secure place, and to not give, lend or sell the medication to anyone.

7. Warn the patient and/or guardian that there is a potential for significant cognitive dysfunction if opioids are combined with sedatives such as benzodiazepines, barbiturates, muscle relaxants, or alcohol. The patient and/or guardian should be warned not to consume any of the above substances without first discussing this with the physician.

8. Although the potential for abuse or addiction to prescribed opioid analgesics is small in low risk patients, the concurrent abuse of illicit substances such as marijuana, cocaine, stimulants, hallucinogens, heroin or the consumption of alcohol in a high risk pattern identifies an individual at increased risk of also abusing opioids. The use of these substances may also interfere with the therapeutic effect of opioids or cause increased side effects such as cognitive dysfunction. It is therefore advisable that the patient abstain from taking any psychoactive substances without first discussing this with the physician. Advise the patient and/or guardian that the physician may, from time to time, take specific actions to monitor for this possibility such as periodic blood
and/or urine drug screening. This may also include an assessment with a specialist in addiction medicine.

9. Inform the patient and/or guardian that, as part of ongoing treatment, the physician may request additional consultations and assessments, or recommend other concurrent treatment modalities. The clinician should carefully re-evaluate a patient who consistently refuses to cooperate with recommendations for treatments other than opioid therapy.

10. Inform the patient and/or guardian that, aside from better pain control, a key measure of the efficacy of long term opioid therapy is improved physical and psychological function at home and/or work. The patient and the physician may, therefore, discuss a set of reasonable specific functional goals. The physician will assess progress towards these goals at each visit and will use this information in evaluating the overall success of long term opioid therapy. Persistent functional decline on opioids may result in re-evaluation of the patient and a reassessment of the treatment plan.

I consent to the use of narcotics (opioids) for the treatment of pain. I confirm that I have read the above information contained in sections 1 to 10, that I understand this information and that I have had an opportunity to ask questions and have had these questions answered to my satisfaction by Dr.

Name of patient or substitute

Signature

Date

Name of witness

Signature

Date
I confirm that I have discussed the necessary information pertaining to the use of narcotics with ____________________________ and have responded to any questions regarding this treatment.

Name of physician ____________________________

Signature ____________________________

Date ____________________________

APPENDIX 4 (Ref 1)

PATIENT AGREEMENT OF CONDITIONS GOVERNING TREATMENT WITH OPIOIDS

1. I, ____________________________, agree that Dr ____________________________ will be the only physician prescribing OPIOID (also known as NARCOTIC) pain medication.

2. I will take the medication at the dose and frequency prescribed by my physician. I agree not to increase the dose of opioid on my own and understand that doing so may lead to the treatment with opioids being stopped.

3. I will attend all appointments, treatments and consultations as requested by my physician.

4. I will not receive opioid pain medications from any other physician except in an emergency or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my prescribing physician as soon as possible.

5. I understand that the common side effects of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

6. I understand that there is small risk that I may become addicted to the opioids I am being prescribed. As such, my physician may require that I have additional tests and/or see a specialist in addiction should a concern about addiction arise during my treatment. I understand that tests may include urine and or serum for screening of drug levels.

7. I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore, I agree to refrain from the use of all of these substances without first discussing it with my physician.
8. I agree to be responsible for the secure storage of my medication at all times. I agree not to provide my prescribed pain medication to any other person.

9. If I break this agreement, my physician reserves the right to stop prescribing opioid medications for me.

10. I hereby agree that my physician has the authority to disclose the prescribing information in my patient file to other health care professionals when it is deemed medically necessary in the physician’s judgement.

Name of Patient or Substitute

Signature

Date
APPENDIX 5
Equivalent Dose (mg compared to standard morphine 10 mg im)

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<tr>
<th>DRUG</th>
<th>PARENTERAL</th>
<th>ORAL</th>
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<tbody>
<tr>
<td>Alfentanil</td>
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<td>na</td>
</tr>
<tr>
<td>Codeine</td>
<td>120</td>
<td>200</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.1-0.2</td>
<td>na</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.5-2</td>
<td>6-7.5</td>
</tr>
<tr>
<td>Morphine</td>
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<td>60 single dose</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>20-30 chronic dose</td>
</tr>
<tr>
<td>Oxycodone</td>
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<td>10-15</td>
</tr>
<tr>
<td>Oxymorphone</td>
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<td>na 5 (rectal)</td>
</tr>
<tr>
<td>Pethedine</td>
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<td>300</td>
</tr>
<tr>
<td>Propoxyphene</td>
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</tr>
<tr>
<td>Sufentanil</td>
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APPROVED AT JANUARY 12, 2005 COUNCIL MEETING.
Developed by: Dr. Reg Hutchings