

**PART II:
GUIDE TO PRESCRIBING OPIOIDS
FOR CHRONIC NON-MALIGNANT PAIN**



Disclaimer

The information contained herein is provided in good faith to assist clinicians in managing patients with chronic pain. Recommendations are based on consensus guidelines, published medical literature, and expert opinion, and are not to be considered evidence-based or comprehensive in nature. Additionally, these recommendations are dynamic and will be revised as new information becomes available. This information is advisory only and is not intended to replace FDA-approved labeling information, or sound clinical knowledge, judgment, and expertise in the provision of healthcare. CareOregon assumes no responsibility for the actions of clinicians based upon their reliance on the information contained herein. Selection and management of drug therapy for individual patients is ultimately based on clinicians' assessment of clinical circumstances and patient needs.

SECTION 1: GENERAL PRINCIPLES

Conduct a detailed analgesic history.

- Include the use of over-the-counter (OTC) medications (acetaminophen, NSAIDs) and natural products in the analgesic history to assess analgesic use habits. When applicable, calculate the total daily acetaminophen dose and evaluate the risk of overdose.
- Patients often report, “I have taken everything” or “I’ve tried that and it didn’t work” or “I couldn’t handle the side effects.” It is essential to obtain all details regarding their analgesic history such as what analgesic or adjuvant was taken, at what dose, for how long, and a description of the adverse effects including prevention and treatment measures.
- Previously unfavorable experiences with analgesics or adjuvants are often a result of inadequate therapeutic trials, inappropriate dosage adjustments, inadequate management of adverse effects, and/or patient misconceptions.
- A history of large or “megadose” opioid requirements may indicate pain that is unresponsive to opioids, noncompliance, or poor drug absorption.

Maximize non-pharmacologic therapy.

- Focusing on drug therapy without incorporating behavioral, psychosocial, and/or physical modalities can reinforce pain-related behaviors and undermine an effective treatment plan. It is important to reinforce continually all aspects of the patient’s treatment plan and the patient’s ongoing efforts to learn new ways to manage their pain.

Institute analgesics sequentially, not concomitantly.

- Non-opioid analgesics (e.g. acetaminophen, NSAIDs, salicylates) are first-line for most non-malignant pain syndromes, although NSAIDs should be used with caution in the elderly.

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- Adjuvant analgesics such as tricyclic antidepressants and anticonvulsants may be considered as initial therapy for obvious cases of continuous neuropathic pain. Adjuvant analgesics have a “ceiling effect” and should be maximized prior to diagnosing a treatment failure and changing or adding additional analgesics. (Refer to Appendix D.)
- Drug substitution within a class should be considered before determining an entire class is ineffective or intolerable. This is important for all therapeutic classes including NSAIDs, tricyclic antidepressants, anticonvulsants, and opioids.
- Opioids may be considered when first-line analgesics do not achieve the treatment goal.
- Opioids are generally not recommended as primary or sole therapy. Concomitant analgesics are often recommended for opioid-sparing effects and additive analgesia.
- Discontinue analgesics or adjuvants that do not provide pain relief or contribute to achievement of the treatment goal as determined by an adequate therapeutic trial.

One size does not fit all.

- Some patients respond to one regimen but not another. Drug therapies must be individualized.

Select an analgesic by consideration of pain severity and frequency: Is the pain intermittent or continuous?

■ **Considerations for intermittent, chronic pain**

- Most patients with intermittent, chronic pain—such as low back pain that is present only upon activity—do not require continuous, around-the-clock pain control.
- Opioids are second-line therapy after failure of analgesics such as acetaminophen, salicylates, and NSAIDs.
- Effective pain relief should anticipate and prevent pain. Short-acting opioids or opioid-analgesic combinations can be administered PRN prior to activities or conditions known to provoke pain.
- Scheduling medications to facilitate activities that would be expected to increase pain reinforces increased function. Using opioids as “rescue” therapy can lead to avoidance of activity and overdosing.

EXAMPLE: A 47-year-old woman with a history of chronic neck pain after a motor vehicle accident is unable to work but has been doing well with antidepressants and PRN use of NSAIDs. She now complains that it is difficult for her to look after her grandchildren because the increased bending and lifting makes her neck pain so severe she is unable to sleep at night. You prescribe a short-acting opioid to use when she comes home from her grandchildren, but limit the number per month to cover only those visits.

■ **Considerations for continuous, chronic pain**

- Continuous, chronic pain refers to pain that is present around-the-clock or for more than 12 hours in a 24 hour period.
- Analgesics can be prescribed on a regular, around-the-clock schedule to keep serum levels from falling below a therapeutic concentration at which the patient experiences pain.
- The use of acetaminophen combinations with codeine, hydrocodone, oxycodone or other agents (e.g. Percocet, Vicodin) is limited by the ceiling on the maximum safe dose of the acetaminophen (4g/24 hrs). Frequent daily dosing of these agents for continuous or escalating pain risks acetaminophen toxicity.

EXAMPLE: A 34-year-old woman with a history of SLE and aseptic necrosis of the hip from chronic steroid use has been followed by her rheumatologist who prescribed Percocet one tablet qid. She is returning to her primary care provider for ongoing management. Her records indicate that she has been compliant with appointments and has not asked for early medication refills. Her chief complaint is that her pain is not always well-controlled throughout the day. After a thorough medication history, you discover she does not take her medications on a fixed schedule and is experiencing significant breakthrough pain. Rather than increase the short-acting Percocet, you prescribe a long-acting morphine 15 mg bid, which is equianalgesic to her current opioid dose, and schedule a follow-up for reassessment in 2 weeks.

