Prescribing Corner

Highlights of new opioid guideline recommendations

Introduced in the last *Messenger* and released in May, the *Canadian Guideline for Safe and Effective Use of Opioids in Chronic Non-Cancer Pain* offers 24 recommendations to help physicians safely use opioids to treat patients with chronic non-cancer pain.

For easy reference, the recommendations are organized into five clusters, each of which will be featured in issues of *The Messenger*, beginning with Cluster 1 below:

Cluster 1: Deciding to Initiate Opioid Therapy

R01: Before initiating opioid therapy, ensure comprehensive documentation of the patient's pain condition, general medical condition and psychosocial history (Grade C)[1], psychiatric status, and substance use history. (Grade B)[1]

Comprehensive knowledge about the patient's medical history and appropriate documentation is important. Consider reviewing prior medication use by accessing data from the CPSA's Triplicate Prescription Program and/or information from the Pharmaceutical Information Network.

Note: It is appropriate to decline prescribing opioids until you have compiled the patient's medical history and decided on a treatment plan.

R02: Before initiating opioid therapy, consider using a screening tool to determine the patient's risk for opioid addiction. (Grade B)[1]

The key risk factor for addiction is current or past history of addiction – this should be explored before initiating opioid therapy. The Canadian Guideline offers a variety of screening tools to help physicians assess the risk of addiction.

Note: Opioid addiction has a prevalence of 3.3 per cent in patients receiving opioids for chronic non-cancer pain.[2]

R03: When using urine drug screening (UDS) to establish a baseline measure of risk or to monitor compliance, be aware of benefits and limitations, appropriate test ordering and interpretation, and have a plan to use results. (Grade C)[1]

Urine drug screening and other adherence monitoring methods have been shown to reduce the risk of substance abuse but are generally underutilized.[3] The Canadian Guideline describes point-of-care testing and laboratory options, including the advantages/disadvantages of each version and how to interpret unexpected results.

To employ these methods of monitoring, determine what tests are available at your lab and specify which medication you are monitoring.

R04: Before initiating opioid therapy, consider the evidence related to effectiveness in patients with chronic non-cancer pain. (Grade A)[1]

Part A of the Canadian Guideline examines the literature review and evaluation of the evidence that support the guideline recommendations. The results demonstrate:

- Opioids were shown to be more effective than placebo for both pain and function.
- Opioids were found to work better for pain than for function.

More specifically:

- Opioids were shown to be effective in placebo-controlled trials for the chronic non-cancer pain conditions nociceptive pain of musculoskeletal origin and neuropathic pain.
- Two randomized trials of the weak opioid Tramadol, used for Fibromyalgia, showed a small benefit in pain reduction only.

Note: Chronic non-cancer pain conditions that have not been studied in placebo-controlled trials include headaches, migraines, irritable bowel syndrome and pelvic pain.

R05: Before initiating opioid therapy, ensure informed consent by explaining potential benefits, adverse effects, complications and risks. (Grade B)[1]

Informed consent is important for all medical treatments, including opioids.

Prescribing Corner cont'd Pg. 7...

Prescribing Corner...cont'd from page 6

Set realistic goals with your patient early on, such as improved pain intensity by 30 per cent and/or increased function. Consider using a treatment agreement with firm boundaries - many physicians find this tool useful.

Note: Physicians and patients should be aware of the adverse effects and medical complications that stem from long-term opioid use.

R06: For patients taking benzodiazepines, particularly for elderly patients, consider a trial of tapering (Grade B)[1]. If a trial of tapering is not indicated or is unsuccessful, opioids should be titrated more slowly and at lower doses. (Grade C)[1]

The combination of opioids and benzodiazepines increases the risk of sedation, overdose and diminished function in patients. Opioids should be prescribed more slowly and at lower doses for patients on benzodiazepines. The Canadian Guideline offers practical advice for conducting a benzodiazepine taper in its Appendices.

(Next issue: Cluster 2: Conducting an Opioid Trial)

The complete guideline and practice tools are available on the National Pain Centre website at McMaster University[4] or from the College website. Practice tools can be downloaded or printed for clinical use. If you have feedback or comments on this month's Prescribing Corner, contact Dr. Susan Ulan, Senior Medical Advisor at: 780-969-4930, 1-800-561-3899 ext. 4930 (in Alberta), or email Susan.Ulan@cpsa.ab.ca.

References:

[1]McMaster University; National Pain Centre website, Recommendation Grading (http://nationalpaincentre.mcmaster.ca/opioid/cgop_a10_literature_search_methods.html#table_a10_03_02).

[2]Fishbain, DA et al. *What percentage of chronic non-malignant pain patients exposed to chronic opioid analgesic therapy develop abuse/addiction and/or aberrant drug-related behaviors?* Pain Medicine. 2008 May-June; 9(4):444-59.

[3]Manchikanti, K et al. *Does adherence monitoring reduce controlled substance abuse in chronic pain patients?* Pain Physician.2006;9:57-60.

[4]McMaster University; National Pain Centre website (http://nationalpaincentre.mcmaster.ca/opioid/).

Prescribing CORNER Rx

Next issue: Cluster 2: Conducting an Opioid Trial