

Prescribing Corner

Highlights of new opioid guideline recommendations

The *Canadian Guideline for Safe and Effective Use of Opioids in Chronic Non-Cancer Pain* was released in May and offers 24 recommendations, organized into five clusters, to help physicians safely use opioids to treat patients with chronic non-cancer pain.

The June 2010 *Messenger* (issue 160) outlined Cluster 1 recommendations for deciding to initiate opioid therapy. In this issue, Cluster 2 recommendations for conducting an opioid trial are highlighted.

Physicians should keep in mind that this is an opioid *trial* and that the decision to continue opioids should be linked to decrease in pain and/or increase in patient functioning.

Cluster 2: Conducting an Opioid Trial

R07 During dosage titration in a trial of opioid therapy, advise the patient to avoid driving a motor vehicle until a stable dosage is established and it is certain the opioid does not cause sedation (Grade C¹); and when taking opioids with alcohol, benzodiazepines, or other sedating drugs (Grade B¹).

During titration, opioids may cause cognitive effects that could impair a patient's ability to drive. This is even more important in those patients also taking benzodiazepines, alcohol or other sedating medications.

The concept of *pharmacologically stable dose* is defined as one that produces a fairly steady plasma level; it is established when the *total daily dose* is fixed for at least two weeks and:

1. Frequency is scheduled and spread throughout the day *and/or*
2. At least 70 per cent of the prescribed opioid is controlled release.



R08 During an opioid trial, select the most appropriate opioid for trial therapy using a stepped approach, and consider safety (Grade C¹).

The most appropriate opioid choice for a particular patient will depend on the clinical circumstances. Physicians should use a stepped approach to opioid selection with consideration of the severity of pain. The Guideline includes a discussion of safety issues for the various opioids. Please note that meperidine (Demerol) is not recommended for use in chronic non-cancer pain.

R09 When conducting an opioid trial, start with a low dose, increase gradually, and monitor analgesic effectiveness until the optimal dose is attained (Grade C¹).

Optimal dose is considered to be the opioid dose that will improve function or reduce pain intensity by at least 30 per cent without causing major adverse effects.

The Guideline recommends starting the trial with a low dose and increasing in small increments. Consider a three-day tolerance check for the elderly and other patients at high risk of sedation.

The Guideline includes practice tools to assess response to opioids during the trial. Remember to document details about pain and function in your clinical records during an opioid trial. The decision to continue opioids needs to be linked to documented benefit.

R10 Chronic non-cancer pain can be managed effectively in most patients with dosages at or below 200 mg/day of morphine or equivalent (Grade A¹). Consideration of a higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes (Grade C¹).

Watchful dose = morphine or equivalent dose exceeding 200 mg/day. Before

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prescribing over 200 mg/day, you should consider the following: diagnosis of the pain condition, any co-morbid conditions, effectiveness, side effects, need for consultation, and indications of misuse. Going above 200 mg/day indicates that you should be monitoring more frequently and being more vigilant with your prescribing. How to calculate the oral morphine equivalent is included as an Appendix.

If you are prescribing opioids in doses above the watchful dose, it would be good practice to document your clinical

rationale, treatment response and compliance in detail on your clinical records.

R11 When initiating a trial of opioid therapy for patients at higher risk for misuse:

- **Prescribe only for well-defined somatic or neuropathic pain conditions (Grade A¹)**
- **Start with lower doses and titrate in small-dose increments (Grade B¹)**
- **Monitor closely for signs of aberrant drug-related behaviors (Grade C¹)**

For patients at higher risk of misuse, ensure that opioids have been shown to

be effective for their diagnosis and that all other available treatment options have been exhausted. Physicians should approach opioid prescribing in these patients more cautiously. Shorter dispensing intervals (daily, weekly etc.) and pill counting can improve patient compliance and safety. Consider using screening tools for aberrant drug-related behaviors.

(Next issue: Cluster 3: How to Monitor Long-Term Opioid Therapy)

The complete guideline and practice tools are available on the National Pain Centre website at McMaster University² 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:

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

²McMaster University; National Pain Centre website (<http://nationalpaincentre.mcmaster.ca/opioid/>).

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Cluster 3: How to Monitor Long-Term Opioid Therapy



Opioid Manager: A Practice Tool

The Opioid Manager is designed as a point-of-care tool for practising physicians to use when managing their chronic non-cancer pain patients. This one-page, double-sided tool can be downloaded from the National Pain Centre website at <http://nationalpaincentre.mcmaster.ca/opioid/>. Registration is required to download this tool. Please assist in making this a practical tool by providing feedback on the website.