

# Opioids for persistent pain

## Summary of guidance on good practice from the British Pain Society

A consensus statement prepared on behalf of the British Pain Society, Faculty of Pain Medicine of the Royal College of Anaesthetists, Royal College of General Practitioners and the Faculty of Addictions of the Royal College of Psychiatrists

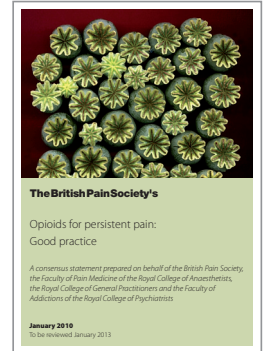
**Full guidance for prescribers and patients available at** [http://www.britishpainsociety.org/book\\_opioid\\_main.pdf](http://www.britishpainsociety.org/book_opioid_main.pdf)  
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This advice relates to the use of strong opioids (and weak opioids at doses higher than recommended in BNF) for persistent pain.

### Cautions

- The safety and efficacy of long term opioid use is uncertain (there are few trial data for use more than 12 weeks), although use may be appropriate in some cases of persistent pain (somatic, visceral or neuropathic).
- Local and national prescribing guidance should be followed carefully.
- Medication for pain should be used only as part of a wider management plan aimed at reducing disability and improving quality of life.
- Opioids should not usually be used as first line therapy for pain.
- Opioids should not be used in children or pregnant women without specialist advice, and they should be used with caution in older people (particularly those with medical co-morbidity).
- Patients with a history of addiction to opioids or other drugs need referral to services with expertise in pain medicine and addiction management.
- Patients should not drive when starting opioids or adjusting dose or if they feel unfit to drive.



### Prescribing

- **Comprehensive assessment** is important; patients with depression, anxiety, or other psychiatric or psychological co-morbidity will need additional support and monitoring to avoid problem drug use.
- **Goals of therapy** should be agreed before a trial of opioids; complete pain relief is unlikely, and treatment success is demonstrated by the patient becoming able to do things that the pain currently prevents. Treatment should be reviewed at least monthly, more often if there are any concerns.
- Start with a low dose and titrate up according to analgesia and side effects. Doses greater than **180 mg morphine daily (or equivalent) require specialist advice.**
- Where possible use regular dosing with **modified release preparations**; immediate release opioids may be associated with tolerance and problem drug use.
- Efficacy and adverse effects are similar for all opioids, though patients may tolerate one drug better than another.
- Requests for **dose increase** need careful evaluation.
- **NEVER prescribe opioid injections, or pethidine** in any form, for the management of persistent non cancer pain (unless on the advice of a specialist pain management team).
- If care is shared between hospital and community, **be clear who is responsible for prescribing.** Within the GP practice, only one clinician should be signing repeat opioid prescriptions. Acute prescriptions may be safer if there are concerns.

### Adverse effects

- 80% of patients taking opioids will experience at least one adverse effect e.g. constipation, nausea, itching, dizziness. Side effects should be managed promptly with laxatives, anti-emetics etc as appropriate.
- Opioid toxicity (sedation, slow respiration, cyanosis) is more likely with increasing age, co-morbidity, co-prescribing, and if opioids are taken with alcohol or illicit drugs.
- Opioids have long term endocrine and immunological effects.
- Withdrawal symptoms occur if opioid is stopped/dose reduced abruptly e.g. sweating, yawning, abdominal cramps. This is common with Tramadol even after a short course.
- Addiction is characterised by impaired control over use, craving and continued use despite harm.
- Opioid induced hyperalgesia may occur: pain becomes more diffuse and qualitatively different from pre-existing pain. Specialist advice is needed.



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