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Welsh Medicines Resource Centre
Canolfan Adnoddau Moddion Cymru

Online content

Stopping compound medications containing codeine

Numerous compound analgesic preparations combine a 'weak' opioid (codeine or dihydrocodeine) with a non-opioid (paracetamol or a nonsteroidal anti-inflammatory drug [NSAID]). As with other compound products, these can be convenient but "reduce the scope for effective titration of individual components."[1] Using compound analgesics reduces flexibility when managing pain of varying intensity and can complicate the management of adverse effects and overdose.

Prescription products that deliver a 'full dose' of both non-opioid and opioid (e.g. 60 mg of codeine) are effective analgesics for mild to moderate pain, but are associated with the full range of opioid-related adverse effects.[1] Codeine is a prodrug, whose principal metabolite is morphine. There is some concern that variations in genetic factors can influence the metabolism of codeine and, therefore, the predictability of its effects.[2] Furthermore, the dose of opioid that causes toxicity varies between individuals and may be dependent on other factors, including medical co-morbidity (particularly hepatic and renal impairment) and concomitant medication (including over-the-counter [OTC] medications and illicit drugs).[1,3] Many patients who become dependent[§] on prescription codeine medicines supplement their use with OTC codeine-containing products. This puts them at even greater risk of adverse effects and overdose from both the opioid and non-opioid components.[4]

Combination products that utilise a low dose of opioid (e.g. 8 mg codeine) have not been shown to be more effective than non-opioids alone[5] and may still cause adverse opioid effects. These products are available both with and without a prescription. Continual use of these products can be associated with dependency and overuse headache and the Medicines and Healthcare products Regulatory Agency (MHRA) has issued warnings regarding these effects.[6] The inclusion of other agents can also be problematic (for example, the addition of caffeine, and the relatively high amounts of salt present in some soluble formulations). To minimise the potential for harm to consumers, further measures, including changes to indications, labels and leaflets, pack size, and advertising, have also been introduced.[6]

A number of other organisations are also raising awareness of the problems associated with abuse of these medicines. The British Pain Society (BPS) and the support group, Codeinefree, produce a variety of materials aimed at educating people about the potential problems associated with overuse of analgesics and helping sufferers understand and manage their pain better.[7,8] Research on the prevalence of problematic use is lacking; however, analysis in Wales reveals that there is marked unexplained variation in sales of OTC products between local health board areas.[9] The Welsh National Database for substance misuse for the year ending March 2010 records that, where a drug was specified, 4.4% of patients (494 of 11 216) referred to treatment providers for drug misuse had a problem with "other opiates" (which included codeine).[10]

Health professionals should inform patients of the risks and benefits associated with compound medications containing weak opioids. People should be advised to consult their doctor if they need to take these medicines for longer than specified, if they need more than recommended, or if they need to continue taking them to prevent feeling unwell. Symptoms of opioid withdrawal typically include aches and pains, shivers, running nose, and other flu-like symptoms.[11]

The BPS, in collaboration with The Royal College of Psychiatrists, The Royal College of General Practitioners, and The Advisory Council on the Misuse of Drugs, has produced a statement that includes a discussion of good practice in pain management: "A pain management plan, with goals, aims, and time scales, should be discussed and agreed with the patient."[12] It acknowledges that complete relief of pain is often not achievable

and the aim should be to balance a reduction in pain intensity against potential adverse effects. Medication may need to be part of a wider pain management strategy.

For patients requiring analgesia following hospitalisation, the potential for dependency can be minimised by ensuring arrangements for monitoring and follow-up are made.[3] Some recommendations to consider might be that tapering of doses should begin wherever possible in secondary care, and take home supplies should be restricted to, for example, one week.[13] Repeat prescribing of opioids should not be routine.

For some patients requiring opioids long-term, dependency may have no adverse implications; however, for others it will be problematic. The potential for addiction may be influenced by various factors: psychological features; social concerns; personality disorders; and other current or previous substance misuse.[8] Prescribers need to understand the potential for dependence and addiction,[9,§] be able to assess dependent patients appropriately, and discuss these issues openly and sensitively.

Dependency is usually managed by withdrawing medication gradually.[14] 'Tapering' or 'weaning patients off' combination codeine products can usually be managed in an outpatient setting if there are no severe medical or psychiatric co-morbidities. Patients taking large doses of compound products or several products simultaneously may need to be converted to a single opioid agent to simplify withdrawal and to minimise toxicity from the non-opioid analgesics.

The value of flexible pathways of care is recognised.[12,15] Where necessary, referral to a support organisation or treatment centre may be possible. Services currently operating in Wales include the Prescribed Medication Support Unit in North Wales, and the Community Addiction Unit in Cardiff.

When managing analgesia in addicted patients:[12]

- Obtain a full substance misuse and medication history (look for drug interactions; appropriate analgesia, use of OTC or complementary medicines, alcohol use.)
- Evaluate pain – dependent patients may require larger opioid doses (but consider illicit use and aberrant behaviour; product selection may be important).
- Consider non-pharmacological interventions. Brief treatments for chronic pain patients with problematic opioid use, such as cognitive behavioural therapy (CBT) can be beneficial.[14,16]
- Communicate expectations and establish clear goals.
- Assess regularly.

§ For definitions and explanations of the terms 'dependency' and 'addiction', please refer to the WeMeReC *Things to Know* publication (December 2010).

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