

1. Analgesia and non-cancer pain management

Introduction

This review is to help with the management of chronic non-cancer pain and builds on the previous pain audits produced by the Medicines Management team.

The Emis searches provided by the CCG will help with this audit.

The recommendations in this audit DO NOT apply to management of cancer pain.

Recommendations

The risk of harm from opioids increases substantially at doses above an oral morphine equivalent of 120mg per day, but there is no increased benefit.¹

A dose greater than 220mg morphine (or equivalent) daily impairs a person nearly as much as being over the legal limit of alcohol, and they are probably **not safe to drive**.²

Every patient taking opiates for non-cancer pain should have a review with the prescriber at least every 6 months to ascertain whether there is continuing benefit and to review potential harms.¹

Patients taking more than 120mg per day morphine equivalent (as morphine only or a combination of opioids) should have a reduction plan to bring the dose back to 120mg or lower.

There is no rationale for combining opioids.

If patients are taking other opioids or two or more opioids then dose calculators allow an estimation of the total morphine equivalent daily dose to support introduction of dose tapering.

Tramadol is a strong opioid. It is similar in adverse effect profile to codeine and dihydrocodeine but has a greater potential for drug interactions. **It should not be combined with other opioids for mild to moderate pain.** If converting to or from Tramadol and another opioid, be aware of the wide morphine equivalence range. Clinicians should be aware of the potentially serious side effects of prescribing tramadol with an SSRI, such as serotonin syndrome.³

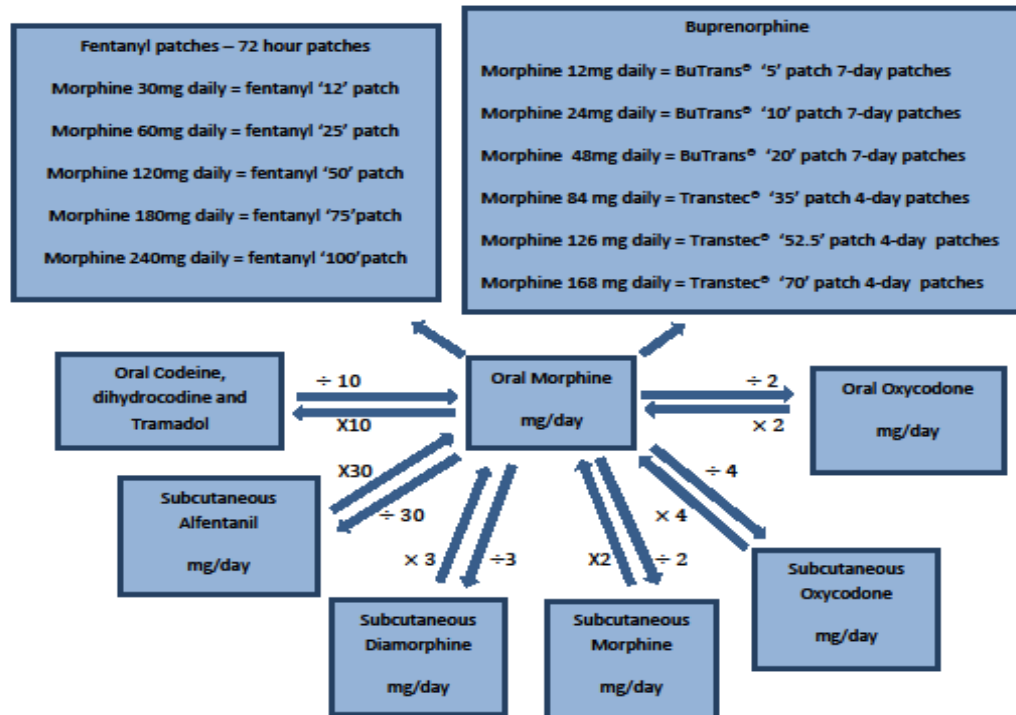
Dose equivalence Information

Dose equivalence calculators and tapering guides can facilitate switching or discontinuing opioids. However, it is important to point out that equivalent analgesic dose conversions are only estimates and patients may be more sensitive to the new opioid than expected, which may cause, for instance, life threatening over sedation, and/or respiratory suppression. If switching, ensure the dose is reduced on the new agent.

Online dose conversion tool: <http://paindata.org/calculator.php>

Somerset Partnership Opioid Dose Conversion tool (see next page):

OPIOID DOSE CONVERSION



Note:

- These conversions are a guide only.
- If switching opioid consider a dose reduction, particularly at higher doses.
- When converting from syringe pump to patch, stop the pump 6 hours after patch application.
- Morphine equivalences for traditional preparations are approximated to allow comparison with available preparations of oral morphine.
- The PRN dose of opioid is 1/6 of the 24H total opioid dose given 4 hourly.
- If unsure, phone 0845 070 8910 (St Margaret's 24 hour advice line).

Audit Questions

Emis web practices can use the searches set up by the medicines management team for this audit.

1. How many currently registered patients have opioid analgesic medication on current prescription?

(Notes : This search uses EMIS BNF group for “Opioid Analgesics” and includes all preps listed in this group including lower strength formulations of co-codamol.)

How does this compare to last year if the practice ran this audit?

Increased / reduced (please delete) this year compared with previous year.

2. The ability to create computer-generated prescriptions for Controlled Drugs has made the actual process of prescribing opioids much easier and opioids may be entered into opioids onto repeat prescribing systems. However, this practice is discouraged.

In general, **opioids should not be added to the repeat prescribing system** but should be generated as **acute prescriptions**.

a) How many patients with current prescriptions for opioid analgesics have **acute prescriptions for these medications**?

The search report for Question 2a has two columns: *acute prescriptions that are still on the current screen with recent issue date* and *acute prescriptions that have never been issued and therefore won't be removed automatically by Emis*.

Emis programming ensures that acute prescription items that have been issued will expire will automatically come off the acute prescription list. This does not happen for items on the acute screen that have **never been issued**.

Please review the items in the right-hand column of the report that were not added recently and discuss with prescribers about taking off the acute medication list.

b) How many patients with current prescriptions for opiates have this medication on a **repeat or repeat dispensed or automatic prescriptions for these medications**?

How does this compare to last year if the practice ran this audit?

Increased / reduced (please delete) in this year compared with last year

3. How many patients have not ordered the opiates that are Repeat prescription items in the last 3 months?

Generate a list of patients per GP so that **items not ordered** in the last 3 months can be reviewed and taken off repeat as appropriate.

4. Repeat the search in Question 3 after amendments have been made.

How many patients are now showing as having opiates on Repeat prescription that have not been ordered in the last 3 months?

5. DURATION OF TREATMENT AND MEDICATION REVIEW

It is estimated that 8-12% of patients taking long term opioid users meet criteria for a current or past opioid use disorder. The literature is clear that patients with co-morbid mental health disorders, including past or current substance misuse disorders, are more likely to receive opioid prescriptions for pain, are more likely to use problematic high doses and are more likely to be co-prescribed other psychotropically active and centrally-acting medicines including benzodiazepines.

If an opioid has a demonstrable positive benefit for an individual patient and there is a robust system for monitoring use then consideration may be given for short-term authorisation of repeat prescriptions.

The prescriber and patient together should review the continuing benefit of opioid therapy and potential harms at regular intervals (at least twice each year). (Please see <http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware> for further information)

a) How many patients with current prescriptions for opiates have NOT had a medication review coded in the last 6 months?

How many patients have been taking opioid medicines for :

b). More than 1 year and < 2 yrs. Number who have NO medication review code in the last 6m

Calculated % =

c) More than 2 yrs and < 5 yrs Number who have NO medication review code in the 6m

Calculated % =

d) More than 5 yrs and < 10yrs Number who have NO medication review code in the 6m

Calculated % =

e) More than 10 years Number who have NO medication review code in the last 6 m

Calculated % =

6. ROUTE OF ADMINISTRATION

Recommendation: The oral route is the preferred route of administration

TRANSDERMAL OPIATES

a) How many patients have transdermal opioid medications on their medication list?

b) How many patients having transdermal opioid medications have tablets or capsules on their medication list?
(Use the Emis report provided.)

*How does this compare to last year if the practice ran this audit. .
Increased / reduced (please delete).*

Please share these lists with the prescriber to see if transdermal patches can be changed to oral medications if the patient is able to swallow tablets

c) How many patients having transdermal opioid medications have not ordered them in the last 3 months?
Please ask about taking these patches off the medication list if no longer using.

7. HIGH DOSE OPIATES

Recommendation:

When treating **non-cancer pain**, the dose above which harms outweigh benefits is 120mg oral morphine equivalent/24hours.

Increasing opioid load above this dose is unlikely to yield further benefits but exposes the patient to increased harm.

Patients who are failing to derive benefit from large doses of opioids (greater than oral morphine equivalent of around 300mg/day) may need support from specialist services in order to reduce medication.

There is NO RATIONAL for combining different opiates or strong pain killers.

Please run the Emis searches provided and then complete the table below.

Calculate the total daily opiate dose using the dose conversion tools provided. Include other opiates prescribed for the patient in this calculation.

Add no of pts to this grid	A	B	C	D	E	F	G	H
Q7 (<i>Patient numbers should be very low</i>)	All Pts	Excluding Cancer Register Pts (B)	How many of B have had review in last year	How many of B have other opiates prescribed to them	Calculate the total equivalent morphine dose/ 24 hours for each pt	How many of B have a reduction plan to reduce dose to 120mg morphine equivalent/24 hours	How many of B have not had a review in the last year	How many of B need a review and a reduction plan
Transdermal Fentanyl 75microgram patch								
Transdermal Fentanyl 100microgram patch								
Oral morphine 120 - 180mg per day								
Oral morphine 180-240mg per day								
Oral morphine above 240mg per day								
Oxycodone 80mg -120mg per day								
Oxycodone above 120mg per day								

	A	B	C	D	E	F	G	H
<i>Q7 continued</i>	All Pts	Excluding Cancer Register Pts (B)	How many of B have had review in last year	How many of B have other opiates prescribed to them	Calculate the total equivalent morphine dose/ 24 hours for each pt	How many of B have a reduction plan to reduce dose to 120mg morphine equivalent/24 hours?	How many of B have not had a review in the last year?	How many of B need a review and a reduction plan?
Tapentadol above 300mg per day								
Transdermal buprenorphine 52.5microgram patch								
Transdermal buprenorphine 75microgram patch strength								

8. Multiple opiates

There is NO RATIONAL for combining different opiates or strong pain killers.

Please use emis web searches and dose conversion provided to complete the table below. Add the number of pts to this grid

Add no of pts to this grid	A	B	C	D	E	F	G
Q8 (Pt numbers should be very low)	All Pts	Excluding Cancer Register Pts (B)	How many of B have had review in last year?	Calculate the total equivalent morphine dose/ 24 hours for each pt?	How many of B have a reduction plan to reduce dose to 120mg morphine equivalent?	How many of B have not had a review in the last year?	How many of B need a review and a reduction plan?
Buprenorphine and co-codamol 30/500 or codeine							
Buprenorphine and tramadol							
Fentanyl and co-codamol 30/500 or codeine							
Fentanyl and tramadol							
Morphine and co-codamol 30/500 or codeine							
Morphine and fentanyl							
Morphine and tramadol							

	A	B	C	D	E	F	G
<i>Q8 continued</i>	All Pts	Excluding Cancer Register Pts (B)	How many of B have had review in last year?	Calculate the total equivalent morphine dose/ 24 hours for each pt?	How many of B have a reduction plan to reduce dose to 120mg morphine equivalent?	How many of B have not had a review in the last year?	How many of B need a review and a reduction plan?
Oxycodone and co-codamol 30/500 or codeine							
Oxycodone and fentanyl							
Oxycodone and morphine							
Oxycodone and tramadol							
Tramadol and co-codamol 30/500							
Tapentadol and buprenorphine							
Tapentadol and co-codamol 30/500 or codeine							
Tapentadol and oxycodone							
Tapentadol and fentanyl							
Tapentadol and morphine							
Tapentadol and tramadol							

Please use the opioid conversion charts or this online does converter <http://paindata.org/calculator.php> to calculate the patient's daily dose equivalent.

Please note: Dose equivalence calculators and tapering guides can facilitate switching or discontinuing opioids. However, it is important to point out that equivalent analgesic dose conversions are only estimates and patients may be more sensitive to the new opioid than expected, which may cause, for instance, life threatening over sedation, and/or respiratory suppression. If switching, ensure the dose is reduced on the new agent.

9. PAIN MANAGEMENT RESOURCES

- | | |
|---|----------|
| a. Does your practice show the Pain Management Video Clip in the waiting room? | Yes / No |
| b. Do you have a link to the Somerset Pain Service on your practice intranet? | Yes / No |
| c. Do GPs use the Pain Option Grids in consultations? | |
| Management in long term and flare up pain (Click on link to view) | Yes / No |
| Management of nerve pain. (Click on link to view) | Yes / No |
| d. Does your practice have salt campaign posters / leaflets on display for patients ? | Yes / No |

References:

1. Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain.
<https://rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware>
2. Controlled Drugs Newsletter Sharing Good Practice in the South West. Aug 2016
3. NHS Scotland. Quality Prescribing for Chronic Pain: A guide for improvement 2018 – 2021.
<http://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/03/Strategy-Chronic-Pain-Quality-Prescribing-for-Chronic-Pain-2018.pdf> accessed 26/4/18

ADDITIONAL USEFUL RESOURCES :

- Somerset Formulary. [Link](#) to Somerset Formulary Chapter 4.7 – Analgesics
- www.somersetpain.co.uk
- <http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware>
- <http://www.paintoolkit.org/>

PRACTICE ACTION PLAN

The Practice should develop an action plan following a review of the results of the audit.

The Practice is required to specify two specific actions the practice will be taking forward following this audit and if requested provide evidence of implementation;

ACTION 1

ACTION 2