Approaching opioid reduction

General advice for GPs

The Leeds Teaching Hospitals NHS Trust

The use of strong opioids for long term management of chronic non-malignant pain has come under recent scrutiny. There is a growing body of evidence to suggest that the effectiveness of these medicines does not continue over time, and as a result doses escalate. There is also concern over possible adverse effects that may occur with regular long term use - effects on immune function, endocrine function, cognitive function and mood have all been identified. It is possible that rather than improving things, the use of regular high-dose strong opioids may lead to an overall reduction in quality of life. There is also the risk of developing opioid-induced hyperalgesia: a condition in which opioids paradoxically increase the level of pain.

There is no good quality evidence to support the use of doses ≥ 120mg morphine (or equivalent) per day, and the consensus view is that patients with chronic non-malignant pain should not exceed this dose. This presents a significant challenge for those patients already established on doses higher than this.

Suggestions on ways to approach this:

1. Discussion with the patient to include:

- Education on long term safety issues associated with strong opioid use and the need to balance out the present with any long term risks. Many people are not aware of these longer term effects. Helping the patient to identify any negative effects they are experiencing from the opioids can be a useful motivating factor for change.
- Loss of effectiveness over time. If the patient is on high dose opioids but still in significant pain then the medication is not helpful and should be stopped; **even** if no alternative is available
- Talk through the aims of treatment - overall the aim is for the patient to be on the lowest effective dose of medication. Ideally we want to be below 120mg morphine equivalent per day, but any reduction in dose should be beneficial
- Outline the reduction process

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2. Agree a reduction plan:

- Aim for slow and steady reduction, no more than 10% weekly
- Limited by the smallest dose preparation of each drug available:
    i. Morphine MR - Zomorph = 10mg, MST = 5mg
    ii. Fentanyl patch = 12mcg/hour (these cannot be cut for safety reasons)
    iii. Oxycodone MR- 5mg
    iv. Buprenorphine patch - BuTrans 5mcg/hour, Transtec = 35mcg/hour
- Suggest changes every 2- 4 weeks to allow the body time to adjust to the change
- It is helpful to make the patient aware of the potential for withdrawal symptoms, which may peak around 3 days and will usually settle within 2 weeks. The patient may feel that their pain increases as part of withdrawal; this is not a genuine increase in the levels of pain, so you need to allow the body time to adjust, then we can actually see what the 'normal' pain is like at the lower dose level. If withdrawal is a significant issue then it may be better to make a change every 4 weeks
- If the patient is on more than one opioid preparation, then discuss with them which they feel it may be easiest to tackle first.
- If the patient has access to an immediate acting opioid preparation, make sure they appreciate that any use of this adds to their total daily dose i.e. avoid the temptation to 'top up' with this if their regular dose is reducing.
- Regular review (including by phone) by a healthcare professional during the process has been shown to improve outcomes

Where can I find more information?

More detailed advice on the use of opioids in pain management, including dose reduction, can be found in the Opioid Aware document produced by the Royal College of Anaesthetists: http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

Leeds Pain Management have produced a leaflet for patients entitled 'Reducing your Pain Medication' written in conjunction with patients who have been through the process themselves. This is available at http://www.leedsth.nhs.uk/pain-management/

References:
Opioid aware document
Berna et al. Tapering long term opioid therapy in on-cancer pain: evidence and recommendations for everyday practice. Mayo Clinic Proceedings June 2015; 90 (6):828-842

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