Safe use of Essential Narcotic Drugs in acute and long term pain

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Background

Opioids have not been adequately available even for severe pain relief in India due to stringent regulations imposed to prevent their misuse and diversion. Whereas, in western countries, opioids have been available for decades and were used liberally for all pains including for non-malignant chronic pains. The accumulated information on their long-term use is suggestive of additional adverse effects, addiction potential in patients, especially when on long term opioid therapy.

As the availability for medical use improves, it is our collective responsibility to ensure that these prescription only drugs are not misused or abused. It is for this reason that many statutory requirements for procuring, stocking, supervised prescribing, record keeping and annual reporting are woven into the use of these drugs and these have been discussed in detail in another section.

Besides the statutory requirements, we need to develop our own sensitivity and competence to evaluate pain and the person in pain, learn to utilise essential narcotics when needed to treat pain; but not in excess of what is needed, and also know when to discontinue them, when it is no longer serving the intended purpose.

The objective of this section is to provide some guidance in preventing misuse of opioid therapy when used for controlling acute pain and for treating pain in long-term conditions.

What are the best practices for using opioids in acute pain?

Due diligence entails the following practices while using ENDs for managing acute pain.

1. Know when to choose opioids for pain relief and when to transition to other drugs.
2. Ensure opioids are used for short term, only to control the brief period of severe pain.
3. Prescribe immediate release [IR] preparations only - for the day and next day.
4. AVOID Sustained Release /Trans Dermal preparations in managing pains that are transient – for example – post-operative pains.
5. Cover side effects prophylactically even in short-term treatments.
6. Multimodal pain management with acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), and adjuvant medications remains the mainstay of effective analgesia.
7. Clarify understanding of the prescription and the logic of PRN dosing for breakthrough pains, with the patient, and the person who is administering the medicine, and ensure comprehension.
8. Review, assess pain relief, and need for further opioid prescriptions.
9. Step down early - to non-opioid analgesics. Use the lowest effective dose for the shortest period of time, ensuring satisfactory pain relief until healing and recovery.
10. Ensure smooth monitored transition from parenteral formulations to oral immediate release Morphine formulations and then to non-opioid analgesics. This would be required during the transfer from ICU setting to in-patient setting and then during home discharge.

When managing pain in long term conditions, how do we select the right patient for opioid therapy?

Please refer to 'Best practices for using step 3 analgesics' for details.

The goal of opioid therapy is reducing the suffering due to pain, improving functionality and hence the quality of life. The *Lowest dose that achieves analgesia with maximum function and minimum side effects* is to be used *only* for *the duration of clinical need.* For this to happen, evaluating the nature of pain and the person with pain – both are important. We need to be satisfied with the following aspects of evaluation;

1. Is the pain opioid sensitive?
2. Which drug would be appropriate for this patient, and for how long?
3. Are there major psychological contributors to this pain?
4. Are there negative thoughts and emotions that may be addressed?
5. Is there a non-pharmacological inputs that can help in this situation?
6. How can I follow up this patient's progress?

Opioids are safe, effective and economical analgesics for cancer patients with advanced disease, with moderate to severe pain and should be considered early. However, in a patient with chronic conditions, where analgesia is required for decades, it is a much more deliberated decision. If the pain is persisting and severe, and the non-pharmacologic and non-opioid therapies have failed, the patient may be considered for opioid therapy after thorough evaluation of the type of pain.

The detailed consent and contract as practiced in western countries for long-term opioid therapy add to the safety and prevents misuse and diversion; but may not be practical in India.

How can addiction potential be detected?

Addiction is compulsive use of a drug despite physical harm. There is craving, drug seeking behavior with instances of unsanctioned increase in dosage, even when not experiencing pain.

It is important to realize that patients are reluctant to disclose a history of substance abuse. A history of substance abuse indicates greater risk of opioid addiction, but getting an accurate picture of past and current drug use can be difficult. Recommendation is to *"trust but verify" through s*tandardized screening procedures for addiction potential in a clinical situation.

Can we score addiction potential?

Greater care is exercised in above situations especially in non-cancer patient population where the therapy may be for decades unlike in cancer population where the duration of therapy is months to years. Higher than usual risk may be suspected when the patient;

1. has current or previous history of substance abuse disorder – nicotine / alcohol;
2. is adolescent, young adult
3. or has family history of drug abuse; or is depressed.

The score suggested by Freynhagen in 2013, is given below. A **score of 4 or more**, indicates moderate to high risk for addiction.

Figure 1: Assessing the Risk for Addiction Behavior[1]

Check the box if the item applies. A score of 0-3 indicates low risk, a score of 4-7 indicates moderate risk, and a score of 8 or higher indicates high risk

ITEM	WOMEN	MEN
1. Family history of substance abuse:		
• alcohol	[ ] 1 point	[ ] 3 points
• illegal drugs	[ ] 2 points	[ ] 3 points
• prescription drugs	[ ] 4 points	[ ] 4 points
2. Personal history of substance abuse:		
• alcohol	[ ] 3 points	[ ] 3 points
• illegal drugs	[ ] 4 points	[ ] 4 points
• prescription drugs	[ ] 5 points	[ ] 5 points
3. Age between 16 and 45 years	[ ] 1 point	[ ] 1 point
4. History of preadolescent sexual abuse	[ ] 3 points	[ ] 0 points
5. Psychological disease:		
• attention deficit disorder, obsessive-compulsive disorder, bipolar disorder, or schizophrenia	[ ] 2 points	[ ] 2 points
• depression	[ ] 1 point	[ ] 1 point
TOTAL		

[1] Ref: Rainer Freynhagen et al. BMJ 2013;346:bmj.f2937

What are the Best Practices when using opioids long term?

1. Always start with immediate-release opioids and NOT the extended-release/long-acting (ER/SR/ LA) opioids.
2. Carefully reassess individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day
3. Prescribe the lowest effective dosage. Justify any decision to titrate dosage to ≥90 MME/day.
4. Titrate over a week with close follow up of functions, analgesia and adverse effects, and stabilize the daily dose as per the patient's preferred goal of pain relief. This would be different for Methadone.
5. Evaluate benefits and harms with patients within 1 - 4 weeks of stabilised opioid therapy and then every 2 months. The interval would vary for Methadone.
6. If benefits do not outweigh harms, optimize other therapies and taper and discontinue opioids.

Know	The aim of opioid therapy is always improvement in function and quality of life through adequate analgesia -Bringing pain score to zero is not the goal.
Check	It is irresponsible to give prescription for strong opioids in a situation where follow up is deemed impossible.
Speak	Before starting opioid therapy, discuss known risks and realistic benefits and establish specific treatment goals with patients.
Prescribe	Use opioids by mouth, by clock, by the ladder; maintain non-opioid inputs; evaluate, address psycho-social concerns; pay attention to individual details.
Review	Opioid therapy is continued only if clinically meaningful improvement in pain and function outweighs risks to patient safety.

How do we monitor a patient on long term opioid therapy?

Even after the initial titration is done, planned clinical reviews are done to monitor adherence and to ensure that the opioids in the prescribed dose is indeed the right treatment to be continued for that patient. The follow-ups may be done using the care giver, the family doctor or through home –based care, if the patient is very sick to travel. The best policy is "trust but verify". It is the prescribers' responsibility to ensure that the medicine is used by the intended person for the intended reason and in the prescribed dose and duration.

The clarifications we seek during these clinical reviews are the 4 **A**s.

1. Is the **A**nalgesia satisfactory?
2. Is the pain relief improving patient's **A**ctivity?
3. Have we achieved the right balance between Pain relief and **A**dverse effects??
4. Is there an abuse potential? **A**berrant behaviour

Opioid prescription is a very responsible decision, done with due deliberation, only after careful patient evaluation, risks and realistic expectations of benefits, and with clear explanation and written instructions ensuring ground rules for safe use.

How do we assess patient's adherence to prescription?

Adherence monitoring practices followed in western countries to check aberrant usage of prescription medications are[2];

1. One prescribing doctor and one designated Pharmacy.
2. Prescription monitoring programs e.g. pill counts – patient presents the empty strips during each visit
3. Double check on reports of lost or stolen medicines
4. Urine analysis during follow up

All the above, except urine analysis for drug levels, are feasible and should be applied on every visit even within the Indian scenario.

Which are the aberrant behaviours that should alert the clinician3?

Craving - The Focus of patient in getting opioids into the prescription more than any other requirement

1. The person always asks about opioids, is unwilling to try non-opioid modalities, requests for the medicine and is unduly upset when denied opioids
2. Unsanctioned escalations - Opioid overuse
3. The person visits the emergency unit for getting medicines for pain and repeatedly uses up own supply very fast. Alternatively, she/he may 'lose' prescriptions and approach other doctors for repeat prescriptions.
4. History of using other addictive substances – smoking, alcohol, benzodiazepine or other drugs
5. Vagueness/ inconsistencies/ exaggerations- in symptom descriptions - Poor functional status with unclear etiology of pain which exacerbates with minor stimuli.

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[2] Opioids in the Management of Chronic Non-Cancer Pain: An Update of American Society of the Interventional Pain Physicians' (ASIPP) Guidelines, 2008

[3] Atluri SL et al. Pain Physician 2004; 7:333-338

Are there additional and different adverse effects when a patient is on long term opioids?

Yes, besides constipation, nausea and vomiting, long term opioid usage comes with additional adverse effects. These include;

1. Chronic constipation and serious fecal impaction
2. Chronic dry mouth which can lead to tooth decay
3. Unintentional overdose leading to respiratory depression. This is higher when using sustained release preparations.
4. Increased incidence of falls due to dizziness
5. Hypogonadism
6. Increased pain sensitivity
7. Sleep-disordered breathing

What are the common misconceptions when prescribing opioids long term?

Table 1 - Common misconceptions amongst professionals and provides explanatory facts.

Myths	Facts
Physical dependence happens only with high dosage over very long periods of time	With daily opioid use, physical dependence can develop in days or weeks
In patients who develop physical Dependence, opioids can easily be tapered off and stopped.	Successfully tapering of chronic pain patients from opioids can be difficult, withdrawal symptoms can be prolonged and disturbing.
Opioid overdoses only occur among drug abusers and patients who attempt suicide	Patients using prescription opioids long term are at risk of unintentional overdose. Risk increases with dose and when combined with other CNS depressants like benzodiazepines and alcohol.

DOs and DON'T's when considering long term opioids

DOs	DON'Ts
1. Choose opioids when evaluated absolutely essential for pain relief	1. DON't start opioids when review is not feasible
2. Consider alternatives such as primary disease management, appropriate referrals, non-pharmacological inputs, physical therapy, non-opioid analgesics and exercise	2. DON'T continue opioids in patients who show no progress toward treatment goals defined by increased function, quality of life and reduced pain.
3. Explain that discontinuing opioids may be difficult after prolonged usage e.g. increased pain, insomnia, or anxiety and withdrawal symptoms	3. DON'T assume patients know how to use opioids. Risks increase with higher dose and are greater for extended-release preparations[4].
4. Take time to talk clearly and empathetically with patients about how they are using opioids. Ask patients about their problems and concerns	4. DON'T assume patients use opioids as you intend. Many patients vary their dose and use combinations of other CNS depressant drugs or alcohol. Hence *trust but verify.*
5. Screen patients for depression and other psychiatric disorders; they may be better served by mental health treatment	5. DON'T abandon patients with a prescription drug problem. Offer help or refer to someone who can treat their substance abuse

[4] Patients may mistakenly take extended-release opioids "as-needed" for pain.

Take home message

Every drug has its share of therapeutic benefits and adverse effects. Physician must balance the medical need for long term opioids especially in a non-cancer pain situation, with the possibility of abuse and diversion. Kerala is one of the earliest states in India, to have used opioids in pain management in cancer and other diseases and hence has had extensive experience. A study published in The Lancet, in 2001, describes the follow up of 1723 patients in Calicut, India, who were being treated for pain with oral morphine on an outpatient home-care basis. Over the 2 years of the study, the investigators did not identify any instances of misuse or diversion[5].

The above study, concluded that care and diligence in selection of patients, regular follow-up, adherence monitoring, and committed record keeping were all important to prevent misuse.

The result of this study published in Lancet suggest that, after establishing medical necessity by a trained professional, along with systematic record keeping and regular review, oral morphine can be dispensed safely to patients with pain, for use at home without fear of misuse or diversion.

We may conclude that essential narcotic medications are safe and effective in managing pain. It is our responsibility to follow the statutory procedures as per the NDPS regulations, for stocking and dispensing them. It is also our responsibility to enhance professional competence and undertake the necessary training to understand indications, identify patients who would benefit, apply ground rules for safety and ensure that relief of pain and suffering is achieved while possibilities for diversion and abuse of these prescribed medications are prevented.

[5] Medical use, misuse, and diversion of opioids in India, M R Rajagopal, David E Joranson, Aaron M Gilson; THE LANCET • Vol 358 • July 14, 2001