Editorials

Opioids and chronic pain in primary care

INTRODUCTION

The number of opioid analgesics prescribed in the UK for non-cancer pain over the past few years is on a steadily upward trajectory.[1] Alongside this, the numbers of deaths reported to involve opioid analgesics are rising as well.[2] There are concerns that there may be some echoing of the situation in the US where overdose deaths from prescription opioids are a major issue.

However, the rises in prescription numbers and deaths only tell a small part of the story. There is no definitive answer to how many patients may be dependent on these drugs, or how many may be misused, either via diversion, or taken in ways other than intended.

Opioid analgesics have been shown to have little benefit in the treatment of chronic pain and are associated with significant side effects,[3] so why do the numbers prescribed continue to rise and with a disproportionate amount in areas of higher deprivation?

Does it reflect the paucity of other treatment modalities that GPs feel they can offer a patient with chronic pain and that 'anything is better than nothing'?

Given the minimal efficacy of opioids in treating chronic pain, why do patients persist in taking them? Is it hope that eventually they will 'kick in' especially if doses are titrated upwards? Or do the other effects opioids exert play a role, with a greater effect on psychological distress than physical?

If this is to be addressed there must be focus on changing prescribing behaviour so that fewer patients with chronic pain are started on opioids, but also the large numbers of those currently receiving these drugs are properly assessed and where there is no evidence of significant benefit support to stop or at least reduce is provided. This is likely to require a multidisciplinary approach[4] with input from pain specialists, addiction services, mental health, and peer support groups.

HOW TO REDUCE PRESCRIBING OF OPIOIDS IN CHRONIC PAIN

As opioid analgesics are highly effective for acute pain and play a significant role in easing the pain of those with terminal cancer, it seems natural to expect benefit when used in those with chronic pain. Unfortunately, this seems to rarely be the case and when the large number of adverse effects are considered long-term prescribing should be the exception not the rule.

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The subjective experience of feeling pain has similarities to that of experiencing low mood. There is a great overlap between pain, particularly persistent pain, and expression of moderate mental health symptoms.[5] Pain responds to multiple psychological as well as physical factors and yet we tend to focus on how much pain is present and expect this to correlate in a linear way with medication and dose titrations. Perhaps we can change the paradigm and think in turn of what loss of function is associated with the pain — be that reduced physical capability, loss of employment, depression and anxiety, or social isolation. When looked at in this context, then other options such as physiotherapy, exercise, and cognitive behavioural therapy seem at least as applicable as medication.

Where medication is felt to be needed, then paracetamol and NSAIDs offer safer and just as effective options. If this fails to improve function, then a discussion with the patient to explain the option of a trial of opioids should take place. It is important that the potential side effects and risk of dependency are included in this. If a decision is then made by the patient to try opioids, then a short trial with a face-to-face review at the end can be used to establish if there is benefit to overall function. There is no evidence that increasing doses will produce more relief and non-response should result in a cessation of treatment, which is unlikely to produce a withdrawal syndrome if the trial has only been of 2–3 weeks duration. If longer, then the amount should be reduced down over a number of weeks. In terminal care there are no dose ceilings, but when prescribing for chronic pain 120 mg morphine equivalent should not be exceeded and a failure to respond at this dose can be taken as an indicator to withdraw opioid treatment. The *Opioids Aware* resource, produced by the Faculty of Pain Medicine, provides information not only for prescribers, but also for patients, so that a decision to initiate opioids can be fully informed.[6]

Where benefit is established and an agreement to continue prescribing made then regular review is essential, both to confirm ongoing benefit but also to assess if adverse effects are developing.

WORKING WITH THOSE ALREADY TAKING OPIOIDS FOR CHRONIC PAIN

While annual medication reviews can be an opportunity to discuss long-term opioid prescribing, an audit of those prescribed opioid analgesia allows a focus on those who are taking higher doses and therefore at risk of greatest harm. Contact these patients and offer them a review; flag notes so that at future consultations a discussion about medication can be initiated. Also, writing to patients with information on the potential harmful effects of long-term prescribing can reduce the number of repeat prescriptions requested.

Not all patients taking long-term opioids will have developed dependency and, if convinced of the benefits in reducing or even stopping their medication, it can slowly be reduced. Some may exhibit signs of dependency and misuse, this can range from opioid withdrawal if doses are missed to drug-seeking type behaviour such as 'lost' prescriptions, requesting early repeats, and moving around different doctors within the practice or even different practices. Some patients will also top up their prescribed medication with over-the-counter medications and it is important to ask about this.

If there is evidence of dependency — but little, if any, evidence of functional benefit — then consider an addiction-focused approach with assessment, development of a care plan that may include drug testing, provision of psychosocial interventions, and prescribing aimed to minimise harm. This could include switching the prescribed opioid to a long-lasting opioid substitution treatment such as buprenorphine or

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methadone.[4] This may be possible to provide in a primary care setting if practitioners have experience in dealing with addiction, however if not, then referral to addiction services may be appropriate. A number of addiction services will provide advice and support to GPs around this.

Whether or not there are signs of dependency, many patients still experience pain despite high doses of prescribed opioids and they may be reluctant to reduce, fearing that pain will increase. Where the perceived benefit is mainly psychological there may be anxiety about deterioration in mental health.

Access to pain specialists and mental health teams can provide support to address these issues, however these are less readily available in a primary care setting.

We also need to consider the role of peer support: the concept is well established in 'traditional' drug and alcohol services, and organisations such as the Painkiller Addiction Information Network (PAIN) can help provide patients with not just support and information, but the opportunity to share experiences with others who have been in similar situations.

There is evidence to suggest that a multidisciplinary approach, in particular those that target to understand the psychological processes, can lead to reductions in opioid analgesia average dosing and improvements in functioning.[7]

Many of these patients can be managed in primary care, however we also need 'chronic opioid use' clinics where pain, addiction, mental health, and peer expertise are available, and routes of entry can be from specialist or primary care services.

SUMMARY

It doesn't make sense to continue prescribing opioids in the way we have been for the last few years, albeit that this has probably been based on a desire to follow World Health Organization guidance.[8] Chronic pain is not acute pain that has simply continued, it is a separate entity with multiple modulating factors and rarely responds to analgesia in the way we would like. Starting opioids rarely, stopping them if they don't work, and focusing on function not pain per se can reduce the amount of opioids prescribed in the UK. As for those already prescribed, we need to encourage a willingness to change by offering support, information, and rational prescribing.

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