Approved at BCAP PTC July 18

NHS Wiltshire Clinical Commissioning Group

Pain Management Documents

- NHS Wiltshire, NHS BaNES and NHS Swindon CCGs

Contents:

- Prescriber and Patient Resources
- Non-cancer Pain Guidance
- Low Back Pain Guidance
- Neuropathic Pain Guidance
- Stopping or Switching low strength Buprenorphine Patches
- Dose Equivalence
- Oxycodone Guidance
- Red and Yellow Flags

Caveats to prescribing analgesics:

- **Each drug should be trialled and assessed for efficacy and side effects. Continuation should be on the basis of meaningful improvement in pain and function with minimal side effects. Or the side effects are acceptable to the patient if the benefit is sufficiently great.**
- **Remember, no drugs are better than drugs that don't work (and may cause harm).**

References and Resources

For Prescribers:

Brief Pain Inventory (short form) assessment tool: http://prc.coh.org/pdf/BPI%20Short%20Version.pdf Use to quantify level of pain & provide a baseline.
Pain Assessment and Documentation Tool (PADT):
https://healthinsight.org/Internal/assets/SMART/PADT.pdf
Pain assessment in advanced dementia tool (PAINAD):
http://dementiapathways.ie/_filecache/04a/ddd/98-painad.pdf
British Pain Society, pain scales in multiple languages:
https://www.britishpainsociety.org/british-pain-society-publications/pain-scales-in-multiple-languages/
Opioid Risk Tool (to assess for mental health problems, alcohol abuse & addiction potential):
https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf
DN4 Neuropathic pain screening tool:
https://www.physio-pedia.com/DN4_questionnaire
LANSS neuropathic pain scale (will ask for a password but just press cancel):
http://www.endoexperience.com/documents/Apx4_LANSS.pdf
General Pain management tools: www.britishpainsociety.org
Faculty of Pain medicine: 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
STarT back screening tool (Keele University): http://www.keele.ac.uk/sbst/ - a brief validated tool (**Hill et al 2008**), designed to screen primary care patients with low back pain for prognostic indicators that are relevant to initial decision making.
Lancet abstract about this tool: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60937-9/fulltext#article_upsell
Drugs and driving the law: https://www.gov.uk/drug-driving-law
Patient Health Questionnnaire (PHQ9) score: http://www.patient.co.uk/doctor/Patient-Health-Questionnaire-(PHQ-9).htm
CKS Osteoarthritis: https://cks.nice.org.uk/osteoarthritis
NICE NG59- Low back pain and sciatica in over 16s (Nov 2016) https://www.nice.org.uk/guidance/ng59
NICE CG177- Osteoarthritis (Feb 2014) http://www.nice.org.uk/guidance/cg177
NICE CG173- Neuropathic pain- pharmacological management (Nov 2013, April 2018 update)
http://guidance.nice.org.uk/CG173/Guidance/pdf/English

Weight loss services/referrals:

Tier 1 & 2 services: Wiltshire Weight Management Pathway:
https://prescribing.wiltshireccg.nhs.uk/?wpdmdl=1680
NHS Wiltshire CCG: Tier 3 and 4 services:
https://www.nbt.nhs.uk/sites/default/files/North%20Bristol%20Centre%20for%20Weight%20Loss,%20Metabolic%20&%20Bariatric%20Surgery%20-%20Information%20for%20GPs%20(November%202014).pdf
NHS Wiltshire CCG Weight Management on referral - Eligibility & Referral Guidance:
https://prescribing.wiltshireccg.nhs.uk/?wpdmdl=1681
Wiltshire Council Health Improvement Services: https://prescribing.wiltshireccg.nhs.uk/?wpdmdl=1682
NHS BaNES CCG: Passport to Health programme, Health Improvement Services, The Bungalow, 11 Park Road, Keynsham. Tel 01225 831852

For Patients:

www.paintoolkit.org and 'Understanding Pain in less than 5 minutes' on YouTube:
https://www.youtube.com/watch?v=cLWntMDgFcs
NHS choices back pain guide: http://www.nhs.uk/Tools/Pages/Back-pain-guide.aspx
https://iapt-wilts.awp.nhs.uk/ NOTE: There are also courses on dealing with depression, stress, anxiety/worry etc. which commonly co-exist with and precipitate pain. They also offer a wellbeing service for patients with chronic pain where you can learn tools and techniques to help you to manage your emotional wellbeing and maximise your physical health.
Wiltshire Council Top tips for a healthier, happier you - https://prescribing.wiltshireccg.nhs.uk/?wpdmdl=1683

NHS Wiltshire Clinical Commissioning Group

Guidelines for the pharmacological management of non-cancer pain in adults

If pain settles at any step, consider a step-wise trial of reduction of analgesia. Check compliance at every step before moving up.

***Consider* regular paracetamol 1g QDS. Only continue if beneficial due to increasing evidence of harm in long-term use.**

Non-opioid Analgesic

1. Assess patient using appropriate tool (see page 2)

- Red flags or neuropathic pain --> see specific guidance on pages 6, 7 & 12
- Medicines only play a minor part in managing persistent pain www.paintoolkit.org

2. *Consider* regular Paracetamol 1g QDS. Only continue if patient finds it beneficial due to increasing evidence of harm in long-term use. *Patients to buy themselves OTC for short-term use/self-limiting illness such as toothache/sore throat/headaches/colds.*

3. ADD NSAID (Naproxen or Ibuprofen) **+ PPI if necessary**

Review effect after 2 weeks. Not for long term use. Monitor renal function

- NSAIDs should be used cautiously and long term use of high doses avoided

Opioid for Moderate to Severe Pain

4. ADD Codeine 30mg - 60mg QDS

- Approx 10% of patients will not respond to codeine - if so, try Dihydrocodeine 30mg every 4-6 hrs instead
- Only for short term use as can be constipating

5. STOP codeine / dihydrocodeine ADD Tramadol 50mg qds (up to 100mg qds)

- Agree max dose & acceptable response with patient

6. Re-assess patient - review at least monthly and reduce dose as soon as possible to lowest effective dose

- **Before prescribing stronger opioids,** consider that there is little evidence to support long term use of opiates, and there are endocrine and immunological risks e.g. opioid induced hypogonadism
- Consider amitriptyline as an option - for dosage and titration guidance see neuropathic pain section (p6/7)
- Opioids are NOT usually helpful for Mechanical back pain, Fibromyalgia, Pelvic or Abdominal pain, or non-specific visceral pain - only use in these conditions with advice from specialists

7. Consider referral to other services such as IAPT, physiotherapy and weight loss programmes (see page 2)

Opioid for Severe Pain

8. STOP tramadol (or codeine/dihydrocodeine); ADD Morphine SR (Zomorph Caps) 10-20mg bd

- Titrate by no more than 10mg bd morphine at a time to **maximum of 90-100mg per day**.
- Doses above this only in discussion with a pain specialist as risk of harm can outweigh benefits
- Prescribe initially on acute medication records (not on repeat) until efficacy established
- Patients should keep a diary during the opioid trial (twice daily report of pain intensity, sleep, activity levels and side-effects)
- Consider written contract - set max dose, treatment period and acceptable response
- Assess abuse potential (Use opioid risk tool, link provided on page 2)
- Discuss potential harms of opioid therapy and impairment of driving skills
- Do not increase dose without seeing patient
- If swallowing difficulties, zomorph capsules can be opened
- If patient does not gain 30-50% pain relief within 2-4 weeks consider withdrawing opioid
- It is unlikely that an alternative opioid will work where morphine has not
- Avoid immediate release opiates such as oramorph in non-cancer pain (may be of use in non-specific visceral pain)
- There is little evidence that opioids are helpful long term. During long term treatment, review at least monthly in the first 6 months after stable dosing achieved, then at least annually.

9. Refer to pain management specialist if failure to achieve adequate analgesia, concerns about excessive or uncontrolled opioid use or rapid escalation

- Problem drug/alcohol use should trigger referral to an addiction specialist

Guidelines for the pharmacological management of low back pain in adults: NICE NG59

1. Consider using risk stratification e.g. the STarT Back risk assessment (see page 2 for links)

- Use at first point of contact with healthcare professional for each new episode of low back pain with or without sciatica to inform shared decision making about stratified management.
- Medicines only play a minor part in managing persistent pain www.paintoolkit.org
- Encourage patients to continue with normal activities as far as possible.

2. For patients with sciatica, see pages 6-7, Neuropathic pain section for Pharmacological treatment options.

3. Based on risk stratification, consider:

1.) Simpler and less intensive support for people with low back pain with or without sciatica likely to improve quickly and have a good outcome (e.g. reassurance, advice to keep active and guidance on self-management).

2.) More complex and intensive support for people with low back pain with or without sciatica at higher risk of a poor outcome (e.g. exercise programmes with or without manual therapy or using a psychological approach).

4. Consider oral NSAIDs (Naproxen or Ibuprofen) **+ PPI if necessary**

Review effect after 2 weeks. Not for long term use. Monitor renal function

Take into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age.

5. Consider weak opioids (+/- paracetamol)

Only if an NSAID is contra-indicated, not tolerated or has been ineffective. Patients need to understand that these drugs do not work very well and hence short-term trials need to be undertaken to see how well they work.

6. DO NOT OFFER:

Paracetamol on its own for managing low back pain

Opioids for managing ACUTE low back pain. Only prescribe with specialist advice.

Opioids for managing chronic low back pain

Selective serotonin reuptake inhibitors (SSRIs), Serotonin-nor-epinephrine reuptake inhibitors or tricyclic antidepressants for managing low back pain

Anticonvulsants for managing low back pain

7. Do not offer benzodiazepines

NICE do not include the use of benzodiazepines in their updated low back pain guidance. Although guidelines from many other countries do offer the use of benzodiazepines, the evidence for use is with drugs that are not licensed for use in the UK. Due to the limited evidence base to support use and the risks associated with using this group of drugs, NICE have asked for further research before they can make any recommendations. However, pragmatically, if a patient has severe sciatica related to their back pain, then a very short course (up to 3 days) of diazepam might be helpful.

General Guidance on treating pain

- Do not prescribe more than one opioid to the same patient
- Consider non-pharmacological treatments alongside education, explanation and reassurance
- If for OA of hand or knee, consider topical NSAID initially (as per NICE CG177) such as Ibuprofen 5% gel
- If analgesia fails, consider treating for neuropathic pain (see p.6)
- Caution using all opiates if eGFR < 30mls/min
- Effective analgesia means at least 30% reduction in mean pain score
- If this is not achieved within within 2 – 4 weeks, consider withdrawing opioid
- There is not usually a basis for giving immediate release or breakthrough opioid analgesia
- Ensure prescriptions are written with regard to legal handwriting requirements
- Quantities should not exceed 30 days supply (good practice)
- Do not use more than 90-100mg morphine equivalent per day without pain specialist advice
- If using TPP, ensure the repeat template interval is set correctly to monitor compliance
- Prescribing opioids for elderly patients should take account of relevant age-related changes in pharmacokinetics and pharmacodynamics. Starting doses should be cautious with frequent reassessment and dose adjustment as appropriate as increased analgesic sensitivity can occur
- Consider compliance when prescribing in the elderly particularly in patients who cannot tolerate oral formulations, with mental health problems, those who are socially isolated or with limited access to care.
- Effervescent preparations should be reserved for patients who cannot swallow. Use with care as these have high sodium content.

Non-pharmacological management - see page 2 for links

- Include education, explanation and reassurance
- Manage patient's expectations of pain control - they may never be completely pain free - see pain toolkit
- NICE OA guidance CG177 recommends exercise, weight loss and TENS
- NICE Lower back pain guidance NG59 (November 2016) recommends structured exercise programes, that may include manual therapy and/or psychological therapy

High Strength Buprenorphine (Transtec, Hapoctasin) and Fentanyl Patches

- Fentanyl and high strength buprenorphine patches should not be used for non-cancer pain so do not feature in this guidance
- If patients are already prescribed these patches, please note the different duration of each patch:
  - High strength Buprenorphine patches should be replaced every 96 hours (Transtec) or 72 hours (Hapoctasin), and Fentanyl every 72 hours.
- Hapoctasin is non-formulary and should not be prescribed.

Advice on driving when taking a strong pain killer

- Patients should inform the DVLA and insurance companies when taking strong opiates (see page 2).
- Patients should not drive for 5 days after starting or changing dose, or on days where they have taken extra 'breakthrough' or 'rescue' doses, or if they feel sleepy or start taking other drugs that cause drowsiness (prescribed or purchased OTC)

Signs of excess opioid / toxicity

- Increasing drowsiness
- Vivid dreams/hallucinations
- Pinpoint pupils
- Muscle twitching/ jerking/ myoclonus
- Hyperalgesia on light touch

Neuropathic Pain Guidance

Recognising and Diagnosing

- Use a diagnostic tool such as:
  - DN4 (see p.2)
  - LANSS pain scale (see p.2)
- Many possible causes:
  - Diabetes, herpes zoster (shingles)
  - Ongoing conditions e.g. sciatica, neck pain, low back pain
  - Consider underlying disease e.g. cancer, that will require investigation.
- See "Red and Yellow Flag" information (p.12) --> referral for investigation.

Signs and Symptoms

- Neuropathic pain can be spontaneous or evoked, continuous or intermittent
- Often worse at the end of the day
- Can be made worse by hot or cold, touch or movement (even wearing clothes)
- Patients are unresponsive to conventional analgesics
- Skin in painful area may look different from normal e.g. atrophic or cyanosed

Trigger words to aid diagnosis

- Always encourage patients to describe their pain
- Key words:
  - Burning
  - Shooting
  - Stabbing

Sensory Signs and Symptoms

- Allodynia – pain produced by a stimulus that does not normally produce pain
  - e.g. touch, pressure, warmth
- Dysaesthesia – an unpleasant, abnormal sensation
- Hyperaesthesia – increased sensitivity to stimulation
- Hyperalgesia – an increased response to a stimulus which is normally painful

Consider early specialist referral if

- There is diagnostic uncertainty
- Patient has severe pain
- Pain significantly limits daily activities
- The underlying health condition has deteriorated
- Continue to work through the medication management section whilst waiting for an appointment

Dose titration (for step by step approach overleaf)

Patient leaflets available here: https://prescribing.wiltshireccg.nhs.uk/prescribing-guidance-by-bnf-chapter/cns

Amitriptyline *(Off-label for this indication)*				
Week 1	Week 2	Week 3	Week 4	Week 5
10mg ON	20mg ON	30mg ON	40mg ON	50mg ON

CNS side-effects are common with **amitriptyline** particularly in the elderly, therefore low doses should be used for initial treatment in this group. If contra-indicated try gabapentin instead:

Gabapentin				
	Week 1	Week 2	Week 3	Week 4
Morning		300mg	300mg	300mg
Midday			300mg	300mg
Night	300mg	300mg	300mg	600mg

Slower titration may be required in the elderly, starting at 100mg and increasing by 100mg increments. Somnolence, peripheral oedema and asthenia may be more frequent in elderly patients.

Neuropathic Pain Guidance cont.

Medication management of Neuropathic Pain

Step 1
Non-opioid Analgesic / baseline analgesia

- Consider Paracetamol 1g four times a day
- Only continue if patient finds it beneficial
- Increasing evidence of harm with long-term use.

Step 2 Tricyclic Antidepressant
(usually first choice)
+ baseline Paracetamol

- Amitriptyline, start at 10mg and increase by 10mg per week
- Analgesic effect is separate from antidepressant effect
- Best taken in the evening to reduce 'hangover effect' (6-8pm)
- Slowly titrate to reduce side effects. Ensure titration occurs even if dose is later reduced
- Normal maximum dose is 50mg but can use up to 100mg if patient has benefit with limited side effects
- Alternative TCAs e.g. Imipramine can be used if amitriptyline is not tolerated. Nortriptyline is much more expensive and should only be used on pain specialist advice. Do not prescribe liquid specials which are prohibitvely expensive.
- Not licensed for this indication but widely accepted treatment
- If no response after 8 weeks stop TCA and go to step 3
- If sub-optimal response, continue TCA and add an anticonvulsant as per step 3.

Step 3 Anticonvulsant
First choice if TCAs are contraindicated or lancinating 'electric shock' pain
+ baseline Paracetamol

- Gabapentin - titrate dose weekly according to table overleaf
- Continue increasing to 600mg three times a day (TDS) – determined by efficacy and side-effects
- A further increase to a maximum of 1200mg TDS can be made if tolerated without benefit
- Should be used for at least an 8 week trial period
- Taper and stop if no benefit
- If this does not work or is not suitable see other possible options below

Reassess patients every two weeks until pain is well controlled.
Refer if there is no significant improvement and to clarify the diagnosis.

Other Possible Options:

Pregabalin– step 3 alternative if steps 1 and 2 and gabapentin have failed/not been tolerated/ contra-indicated. Start at 75mg per day and increase in 75mg weekly steps aiming for 300mg bd. Slow titration in elderly patients and those susceptible to side-effects. Review use at 6-8 weeks, taper and stop if no benefit. Refer patient to specialist pain service if there is no response or it is ineffective. Slower titrations may be required if it is not tolerated very well or in elderly patients.

Duloxetine (Cymbalta®) –consider in painful **diabetic neuropathy** (this is the only pain indication it is licensed for), where Amitriptyline and Gabapentin have either failed or are contraindicated. Discuss with patient's mental health team before initiation if already on antidepressants. Start at 30mg *nocte,* increasing to 60mg *nocte* after 1 week. Maximum 60mg BD. Discontinue if no response after 2 months.

Tramadol – Only for use if acute rescue therapy is needed while the patient is waiting for a referral appointment, NOT for long-term use. Start at 50mg qds and increase to a maximum of 400mg/day. Do not start other opioids. The combination of Tramadol with Amitriptyline, Imipramine or Duloxetine is associated with only a low risk of serotonin syndrome.

Opioids - Only to be used on recommendation from a specialist pain service.

Capsaicin: Localized areas of neuropathic pain may respond to topical capsaicin (e.g. 0.075% cream 3-4 times a day), especially for those who cannot tolerate oral treatments. This is licensed for treatment of post-herpetic neuralgia, after lesions have healed.
Capsaicin patches require an Individual Funding Request application via pain clinic consultants ONLY.

Although **NICE CG173** https://www.nice.org.uk/guidance/CG173 - Neuropathic pain - pharmacological management (April 2018 update) recommends that for "all neuropathic pain (except trigeminal neuralgia) that patients should be offered a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment", o*ur local consensus that suggests that amitriptyline and gabapentin should be used as the first-line treatment options.*

Please note that Lidocaine plasters are not recommended in the NICE CG173 for neuropathic pain and also is included in the NHSE document "Items that should not routinely be prescribed in primary care: Guidance for CCGs". NHS BaNES, Swindon and Wiltshire do not support the use of lidocaine plasters in primary care.

Low strength Buprenorphine (BuTec®) seven day patches 5, 10 or 20mcg/hr; Appropriate use and how to stop

Background prescribing data: Financial year 2017-18

	WILTSHIRE CCG		BaNES CCG		Swindon CCG	
	Items	Cost	Items	Cost	Items	Cost
All Opioid Analgesics	197,322	£1,616,395	77,282	£619,807	92,469	£970,947
All Opioid patches	25,040	£524,931	15,380	£293,077	13,216	£314,756
% of all Opioid analgesics	13%	32%	20%	47%	14%	32%
Low strength Buprenorphine patches	18,167	£321,920	12,891	£206,454	9,898	£200,239
% of all Opioid analgesics	9%	20%	17%	33%	11%	21%

Licensing and use

- BuTec® patches are licensed for treatment of non-malignant pain of moderate intensity when an opioid is necessary for obtaining adequate analgesia
- BuTec® is not suitable for the treatment of acute pain
- BuTec® patches take approximately 17 hours to deliver detectable levels of buprenorphine. After removal, it takes around 30 hours for levels of buprenorphine to decrease
- Patients receiving buprenorphine low strength (5, 10 or 20 mcg/hr) patches should be assessed frequently, e.g. after two weeks, to assess the efficacy of treatment, improvements in functional status, tolerability of side-effects, and compliance
- **NOTES for prescribing**: Start with 5mcg patch and change every 7 days (apply to a different site) - avoid same area for at least 3 weeks. Allow at least 72 hours before evaluating analgesic effect
  - Maximum of 2 patches to be worn at any one time, up to a maximum total dose of 40 microgram/hour.
  - Do NOT cut patches in half
  - Do not administer other opioids within 24 hrs of patch removal

Consider using patches:

- only when the person has stable pain AND one of the following criteria:
  - difficulty/inability to swallow or the oral route is inappropriate
  - poor absorption from the GI tract
  - compliance problems or a tendency to increase their analgesic dosage on their own – supervised patch changes will assist this

How to STOP BuTec ® patches and switch to an oral alternative

- The Summary of Product characteristics for BuTec® states that as a general rule, a subsequent opioid should not be administered within 24 hours after removal of the patch
- If you have a patient on these patches who does not fit the above criteria for use, they should be reviewed and if possible switched to a **weak** opioid oral alternative (i.e. NOT morphine) that is suitable for the patient as per the tables below on page 9.
- Codeine or dihydrocodeine would be considered first-line options before considering tramadol
- Wiltshire CCG pain pathway guidance (see page 3 and 4) should be referred to when switching patients onto an oral alternative. Ensure that the patient is also taking regular paracetamol (not if treating low back pain).
- These patches are on our local formularies in Wiltshire as a GREEN drug (second-line BLUE on 3T's formulary (GWH))

Opiate Conversion Doses

- **These conversions are provided only as an approximate guide to equivalences and therefore individual patient variability needs to be considered when switching from one opioid to another**
- See the products Summary of Product Characteristics (SPC) for full prescribing information

Weak-Moderate Opiate Conversion Doses

DRUG NAME	DRUG DOSE	EQUIVALENT ORAL MORPHINE DOSE
Codeine	30mg	4.5mg
Dihydrocodeine	10mg	1mg
Tramadol	50mg	5-10mg

Strong Opiate Conversion Doses

DRUG NAME	DRUG DOSE	EQUIVALENT ORAL MORPHINE DOSE
Diamorphine (sub-cutaneous)	10mg	30mg
Oxycodone MR (Oral, use LONGTEC®)	10mg	20mg
Pethidine (oral)	50mg	5-6.25mg
Pethidine (injected)	12.5mg	3mg

Patch Conversion

Oral Morphine equivalent (mg/24hrs)	**10**	**15**	**30**	**40**	**45**	**60**	**90**	**120**	**180**	**270**	**360**
Oral Codeine (mg/24hrs)	60-90	120	240					**ONLY WITH ADVICE FROM PAIN SPECIALIST**			
Oral Dihydrocodeine (mg/24hrs)	80										
Oral Tramadol (mg/24hrs)	100	150	300	400							
Oral Oxycodone (mg/24hrs) Longtec	5	7.5†	15	20	22.5†	30	45	60	90	135	180
Transdermal Buprenorphine (µg/hr)	5*	10*	20*			35	52.5	70			
Transdermal Fentanyl (µg/hr)					12		25		50	75	100

*BuTec patches should only be used as per the patch advice on page 8. Be aware that higher strength buprenorphine patches are also available (35/52.5/70mcg/hr) which are licensed for moderate to severe chronic cancer pain, which are not applicable in this non-cancer pain guidance. †Round to nearest whole dose equivalent.

Managing Opiate Side Effects

- Constipation is inevitable - Use prophylactic laxatives and encourage regular fluid intake
- Nausea is common particularly with higher doses or rapid escalation, therefore titrate slowly
- If anti-emetic required, use e.g. cyclizine 50mg tds or haloperidol 1.5mg nocte for first 2 weeks. There is no need for on-going treatment as tolerance to the opiate develops.
- Drowsiness or hallucinations implies dose too high - reduce dose or consider other options
- Other problems include dry mouth, hiccups or sweating
- Respiratory depression is very rare if opioids are titrated sensibly
- Elderly patients have an increased risk of adverse effects from analgesics and many have some degree of renal impairment
- Effects of long-term use include increased risk of falls, endocrine effects (e.g. erectile dysfunction, amenorrhoea, infertility, depression & fatigue) and opioid induced hyperalgesia.

Oxycodone Prescribing Advice and Guidance

Oxycodone Prescribing Advice

- **Oxycodone should only be used for patients in whom oral morphine is not tolerated, ineffective or inappropriate. It is not recommended for routine first-line use**
- Any patients who are on oxycodone but who haven't tried morphine sulphate previously should be reviewed & switched to morphine sulphate MR (Zomorph®) if appropriate (NOT palliative care patients)
- Oxycodone is approximately **three times the cost** of Zomorph® (oral morphine MR) if the cheapest formulary brand of oxycodone is used (Longtec®). Any FP10s written for oxycodone MR must be written for this brand.

Background Prescribing Data

- Of all ORAL opiates prescribed in NHS Wiltshire CCG, Morphine ≃ 13% of items, and only 15% of cost; Oxycodone ≃ 2% of items, and 7% of cost
- The average item cost for oral morphine is **£7.17,** average item cost for oral oxycodone is **£22.70**

Oxycodone Licensing

- For the treatment of moderate to severe pain in patients with cancer and post-operative pain
- For the treatment of severe pain requiring the use of a strong opioid
- The usual starting dose for opioid naïve patients or patients presenting with severe pain uncontrolled by weaker opioids is 10 mg, 12-hourly
- Some patients may benefit from a starting dose of 5 mg to minimise the incidence of side effects
- N.B. **Oxycodone is a schedule 2 controlled drug. Maximum of 30 days supply on FP10 at any one time**

Cost Comparison (Prices as per MIMS May 2018)

Morphine capsules (as Zomorph)		**Oxycodone MR (i.e. Oxycontin)**		**Oxycodone MR as Longtec**	**Annual Saving** by prescribing Longtec vs Oxycontin
total daily dose	annual cost	total daily dose	annual cost	annual cost	
20mg	£ 42	10mg	£ 326	£ 163	**£ 163**
40mg	£ 84	20mg	£ 326	£ 163	**£ 163**
80mg	£ 143	40mg	£ 652	£ 326	**£ 326**
160mg	£ 281	80mg	£ 1,306	£ 653	**£ 653**
320mg	£ 562	160mg	£ 2,612	£ 1,306	**£ 1306**

N.B. Not all strengths that are available are shown here

Background Information

- NICE (National Institute of Health and Care Excellence) Clinical Guideline 140 (http://www.nice.org.uk/guidance/cg140) on the safe and appropriate prescribing of strong opioids for pain in palliative care of adults recommends morphine sulphate as the first line oral opioid of choice when initiating treatment and sustained release morphine sulphate as the strong oral opioid of choice for maintenance treatment
- It also recommends that laxatives and/or antiemetic treatments are prescribed and optimised before considering changing oral opioid therapy due to adverse effects
- For patients experiencing drowsiness from therapy, NICE recommends either reducing the treatment dose if pain is controlled or switching the opioid if pain is not controlled
- There is no advice from NICE on the use of strong opioids for long term pain that is outside of palliative care

Oxycodone Prescribing Advice and Guidance (cont.)

Clinical Effectiveness

- The use of oxycodone first line over morphine sulphate as a strong opioid is rarely justified as there is a lack of evidence to suggest oxycodone has any clinical advantages over morphine sulphate and the cost of oxycodone is significantly higher than morphine sulphate
- A stepwise approach to pain management in line with the World Health Organisation (WHO) recommendations should be adopted as this minimises the risk of respiratory depression and other adverse effects in opioid naïve patients

Limited criteria for prescribing Oxycodone first line

- Oxycodone may be initiated in preference to morphine for the management of pain by a GP with experience in palliative care or on the advice of the pain team when:
  - Dose escalation with morphine is not possible due to opioid toxicity eg. hallucinations, myoclonic jerks and confusion
  - Patients on morphine suffer from severe side effects/ intolerance, such as opioid induced vomiting, which have not responded to pharmacological interventions or dose reduction
  - Patients are allergic to sulphates and need a strong oral opioid

First Line Oral Opiate

- Morphine SR as Zomorph® Capsules
- if ≥180mg/day required to control pain refer to specialist pain management team

Second Line Oral Opiate

- Oxycodone MR as Longtec® tablets
- 10mg oxycodone bd approx = 20mg bd morphine but BNF states 6.6mg oxycodone = 20mg morphine
- Titrate each patient's dose on an individual basis

Prescribing Advice

- Use Oxycodone where morphine is not tolerated. Ensure that adverse effects such as constipation and nausea have been managed with adjunctive treatments before switching to oxycodone. There is no evidence that oxycodone has fewer side effects compared to morphine
- Use modified release oxycodone
- Check that the correct formulation is prescribed (OxyContin®/Longtec® are examples of controlled release formulations and Oxynorm®/Shortec® formulations are standard release)
- To avoid confusion between the modified release products and standard release products, oxycodone (and all modified release opioids) should be **prescribed by brand name**.
- Prescribers should be aware of the abuse potential of all opioids and careful consideration should be given when prescribing opioids for non-cancer pain to patients with a history of substance misuse or where abuse is a concern
- Targinact (oxycodone + naloxone) is NOT recommended for use and is not on any of our local formularies see prescribing advice here: https://prescribing.wiltshireccg.nhs.uk/prescribing-guidance-by-bnf-chapter/cns

Contact information and Queries

- If you have any queries regarding the use of oxycodone then please contact the medicines management team for your CCG
- For full prescribing details about oxycodone please refer to the SPC for the appropriate product.

Red and Yellow Flags

Red flags are clinical indicators of possible serious underlying conditions requiring further medical intervention. Red flags were designed for use in acute low back pain, but the underlying concept can be applied more broadly in the search for serious underlying pathology in any pain presentation.	**Differential diagnosis**	**Red Flags from patient history**	**Red Flags from examination**
	Possible fracture	• Major trauma • Minor trauma in elderly or osteoporotic	• Evidence of neurological deficit (in legs or perineum in the case of low back pain)
	Possible tumour or infection	• Age < 20 or > 50 years old • History of cancer • Constitutional symptoms (fever, chills, weight loss) • Recent bacterial infection • Intravenous drug use • Immunosuppression • Pain worsening at night or when supine	
	Possible significant neurological deficit	• Severe or progressive sensory alteration or weakness • Bladder or bowel dysfunction	

The presence of red flags in acute low back pain suggests the need for further investigation and possible specialist referral as part of the overall strategy. If there are no red flags present in this situation it is safe to reassure the patient and move ahead with a multimodal management approach.

Yellow flags are psychosocial indicators suggesting increased risk of progression to long-term distress, disability and pain. Yellow flags were designed for use in acute low back pain. In principle they can be applied more broadly to assess likelihood of development of persistent problems from any acute pain presentation.	**Attitudes and Beliefs**	• Pain is harmful or severely disabling • Expectation that passive treatment rather than active participation will help • Feeling that 'no-one believes the pain is real' – may relate to previous encounters with health professionals
	Emotions and Behaviour	• Fear-avoidance behaviour (avoiding activity due to fear of pain) • Low mood and social withdrawal
	Other psychosocial factors	• Poor family relationships or history of abusive relationships • Financial concerns particularly related to ill- health or ongoing pain • Work related factors e.g. conflict over sick-leave, ability to perform current job tasks • Ongoing litigation related to persistent pain condition

The presence of multiple biopsychosocial factors may highlight the need for a multi-disciplinary approach to care.