Opioid recommendations in General Practice

Opioid Indications:
- Acute pain, cancer pain, palliation toward end of life, opioid dependency — strong evidence
- Chronic non-cancer pain — limited evidence

Opioid Prescribing:
- Prescribing recommendations in non-cancer pain:
  - Maximum 90 days treatment duration
  - ≤ 40mg daily oral morphine equivalent
- Prescribing recommendations in cancer pain:
  - ≤ 300mg daily oral morphine equivalent
- Choice of opioid:
  - Short acting agents for acute pain or cancer breakthrough pain
  - Long acting agents for chronic non-cancer pain
  - Injectable opioids are not recommended for long term use
  - Use lower dose with old age and co-morbidities: “start low and go slow”
  - Beware increased opioid sensitivity in hepatic impairment
  - Beware accumulation of opioid metabolites in renal impairment; fentanyl has no active metabolites.
  - Use methadone with caution; long half-life and frequent drug interactions
- Opioid misuse
  - Assess risk of opioid misuse: drug and alcohol history or Opioid Risk Tool.
  - In “at risk” patients adjust prescribing boundaries eg. once or twice weekly pickup from local pharmacy. If this does not bring stability consider Drug and Alcohol referral.
- Review of therapy includes 4 A’s: Analgesia, Activity, Adverse effects and Aberrant behaviour
- Opioid rotation can be used to treat tolerance or other adverse effects; start the new opioid at 50% of equivalent dose (see table below).
- If weaning maintenance opioids negotiate an appropriate time frame to limit opioid withdrawal and minimise patient distress. A typical plan reduces the opioid by 10 - 25% of the starting dose each month. This achieves cessation within 3 - 9 months.

Adverse effects:
- Tolerance and hyperalgesia limit opioid effectiveness with long term use
- There is growing evidence of harm: constipation, cognitive impairment, worsening sleep apnoea, sexual impairment and other endocrine dysfunction, immunosuppression, driving impairment
- A focus on opioid therapy can distract both patient and prescriber from the evidence based active self-management strategies which lead to sustained long term pain reduction

Opioid dose equivalence (approximate):

<table>
<thead>
<tr>
<th>Opioid</th>
<th>5 mg</th>
<th>10 mg</th>
<th>20 mg</th>
<th>40 mg</th>
<th>100 mg</th>
<th>300 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (oral)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Codeine (oral)</td>
<td>40mg</td>
<td>80 mg</td>
<td>160 mg</td>
<td>320mg</td>
<td>800 mg</td>
<td>2400mg</td>
</tr>
<tr>
<td>Oxycodone (oral)</td>
<td>7 mg</td>
<td>14 mg</td>
<td>28 mg</td>
<td>66 mg</td>
<td>200 mg</td>
<td></td>
</tr>
<tr>
<td>Buprenorphine (patch)</td>
<td>5 mcg/hr</td>
<td>10 mcg/hr</td>
<td>20 mcg/hr</td>
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<tr>
<td>Fentanyl (patch)</td>
<td></td>
<td>12 mcg/hr</td>
<td>37 mcg/hr</td>
<td>100 mcg/hr</td>
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<td></td>
</tr>
<tr>
<td>Hydromorphone (oral)</td>
<td>2 mg</td>
<td>4 mg</td>
<td>8 mg</td>
<td>20 mg</td>
<td>60 mg</td>
<td></td>
</tr>
</tbody>
</table>

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