NHS
Pan Mersey
Area Prescribing Committee

OPIOIDS and GABAPENTINOIDS for chronic pain in adults

SCOPE

This document aims to discourage the inappropriate initiation and prescribing of opioids and gabapentinoids for non-neuropathic, non-palliative chronic pain.

Chronic pain is defined as pain lasting for more than 3 months. It can affect people of all ages but is more common in older people. It can be difficult to manage.

In addition to pharmacological therapy, patients should be advised to make lifestyle changes, stay active and take regular exercise. This is particularly useful in low back pain and osteoarthritis[1].

Prescribing Opioids for chronic pain

There is very little evidence for the effectiveness of opioids in long term pain such as low back pain, osteoarthritis, neuropathic pain, chronic pelvic pain or fibromyalgia[2,5].

For information and support, including patient information at opioid initiation, see the Faculty of Pain Medicine Guidance Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain and the British Pain Society website.

Patients who do not achieve useful pain relief from opioids within 2-4 weeks are unlikely to gain benefit in the long term. If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.

Patients should be reviewed regularly. Many patients who have taken opioids for a long time will experience limited pain relief and medication should be tapered and discontinued.

A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and especially if their use is intermittent. (However, it is difficult to identify these patients at the point of initiation).

The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day (if the patient takes more than one opioid, this is a combined dose), but there is no increased benefit. Dose conversion and switching information is available on the Faculty of Pain Medicine website.

Prescribing Gabapentinoids for chronic pain

Gabapentin and Pregabalin are not suitable for treating long-term low back pain[3] unless the pain is of neuropathic character. Some lower back pain is made up of a combination of musculoskeletal and neuropathic symptoms so gabapentin or pregabalin can be used as initial treatment options in these cases. If there are no neuropathic symptoms, there is no evidence for their use in lower back pain as the incidence and nature of side effects does not justify their use in this group of patients. As neuropathic pain can resolve over time, gabapentinoids should be reviewed every 3-6 months and the patient tapered off to see if the medicine is still needed.

Prescribing Opioids for neuropathic pain

Opioids should not be started to treat neuropathic pain in non-specialist settings unless advised by a specialist to do so[4]. See Pan Mersey Neuropathic Pain Guidelines for alternatives to opioids.

Tapering and Stopping Opioids – for consideration in selected patients in the following situations:

- The medication is not providing useful pain relief. Increasing the opioid dose above morphine equivalent 120mg/day is unlikely to yield further benefits but exposes the patient to increased harm.
- The underlying painful condition resolves
- The patient develops intolerable side effects
- There is strong evidence that the patient is diverting the medication to others.

See the Faculty of Pain Medicine Guidance for supporting information: https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/structured-approach-to-prescribing/tapering-and-stopping

The decision to taper /stop an established opioid regimen needs to be discussed carefully with the patient including the potential benefits of opioid reduction (avoidance of long-term harms and improvement in the ability to engage in self-management strategies).

Safety

A recently published Cochrane review[5] concludes that a number of adverse events, including serious adverse events, are associated with the medium and long-term use of opioids for chronic non-cancer pain. The absolute event rate for any adverse event, compared with placebo is 78% with an absolute rate of 7.5% for any serious adverse event.

Recent open-ended and indiscriminate long-term prescribing of opioids, largely for the treatment of chronic pain, in the United States and Canada has led to high rates of prescription opioid abuse, unacceptable death rates, and an enormous burden to the affected societies[6].

Gabapentin has been associated with a rare risk of severe respiratory depression even without concomitant opioid medicines[7]. Patients should be carefully observed for signs of CNS depression, such as somnolence, sedation, and respiratory depression, and the dose of either gabapentin or the opioid should be reduced appropriately.

Information on the potential for misuse and diversion of gabapentin and pregabalin was published in December 2014, jointly by Public Health England and NHS England[8].

NICE

NICE Quality Standard 155[9] states: the use of opioids does not have a significant clinical benefit in the management of chronic low back pain without sciatica. It can therefore lead to unnecessary side effects for the person, risk of dependency and inappropriate use of resources.

Weak opioids should only be prescribed for acute lower back pain if NSAIDs are contraindicated. Opioids should not be offered for managing low back pain.

References

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