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 (sometimes known as long-term pain or persistent pain) is pain that lasts for more than 3 months. Pain can be secondary to (caused by) an underlying condition (for example, osteoarthritis, rheumatoid arthritis, ulcerative colitis, endometriosis). Chronic pain can also be primary. Chronic primary pain has no clear underlying condition, or the pain (or its impact) appears to be out of proportion to any observable injury or disease[1].

It can affect people of all ages but is more common in older people and can be difficult to manage. Staying active with regular exercise is particularly useful in low back pain and osteoarthritis[2].

To manage chronic primary pain, NICE states: offer exercise programmes and physical activity, taking people's specific needs, preferences and abilities into account, and consider psychological therapy and a single course of acupuncture, having developed a care and support plan with the patient. Pharmacological therapy is not generally recommended with the exception of off-label use of an antidepressant, either amitriptyline, citalopram, duloxetine, fluoxetine, paroxetine or sertraline, for people aged 18 years and over, after a full discussion of the benefits and harms.

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[3,7].

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[4] 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. To achieve substantial benefit in post-herpetic neuralgia, the NNT is 6.7. In diabetic neuropathy, the NNT is 6.6[5]. 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[6]. 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 Cochrane review[7] 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[8].

Both gabapentin and pregabalin have been associated with a rare risk of severe respiratory depression even without concomitant opioid medicines[9,10]. 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[11].

The Pan Mersey safety guidance, Opioids: considerations for safe and effective prescribing in Chronic Pain brings together a number of resources clinicians can use to support the appropriate use and review of opioids used for chronic pain[12].

NICE

NICE Quality Standard 155[13] 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.

NICE NG 215[14] covers general principles for prescribing and managing withdrawal from opioids, benzodiazepines, gabapentinoids, Z-drugs and antidepressants in primary and secondary care. It includes supporting people taking these medications, making decisions about taking them, and starting, reviewing and withdrawing the medication.

References

1. NICE NG193 Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain 7 April 2021
2. SIGN. http://www.sign.ac.uk/assets/sign136.pdf
3. Opioids Aware: Faculty of Pain Medicine https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
4. NICE NG 59. Low Back Pain and Sciatica in over 16s: assessment and management. https://www.nice.org.uk/guidance/ng59/resources/low-back-pain-and-sciatica-in-over-16s-assessment-and-management-pdf-1837521693637
5. Cochrane. Intervention review June 2017. Gabapentin for chronic neuropathic pain in adults. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD007938.pub4/full
6. NICE CG 173. Neuropathic pain in adults: pharmacological management in non-specialist settings. Neuropathic pain in adults
7. Cochrane. Adverse events associated with medium and long term use of opioids for chronic non-cancer pain: an overview of Cochrane Reviews (Review) October 2017 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD012509.pub2/full
8. IASP (International Association for the Study of Pain) Statement on Opioids. February 2018.IASP Statement on Opioids - IASP
9. MHRA Drug Safety Update. Gabapentin (Neurontin): risk of severe respiratory depression. October 2017. Gabapentin (Neurontin): risk of severe respiratory depression - GOV.UK
10. MHRA Drug Safety Update. Pregabalin (Lyrica): reports of severe respiratory depression. February 2021. Pregabalin (Lyrica): reports of severe respiratory depression - GOV.UK
11. Public Health England. Advice for prescribers on the risk of the misuse of pregabalin and gabapentin. December 2014.Pregabalin and gabapentin: advice for prescribers on the risk of misuse - GOV.UK
12. Pan Mersey Safety Guidance: Opioids: considerations for safe and effective prescribing in Chronic Pain
13. NICE Quality Standard (QS155). Statement 5: Opioids for chronic low back pain without sciatica. Low back pain and sciatica in over 16s | Guidance and guidelines | NICE
14. NICE NG 215. Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults. April 2022. NICE NG 215