ABCs of opioid Prescribing

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May 16 2019

I have no disclosures and no associations with industry/pharma.

Objectives

By the end of this session, participants will be able to:

- Review available evidence for opioid use in cancer patients
- Describe guidelines for opioid prescribing in cancer patients
- Develop individualized cancer pain management treatment plans.

It's not ALL about the drugs...

Interventional
Rehabilitative
Psychological
Neurostimlatory
Integrative

Portenoy RK & Ahmed E. Principles of Opioid Use in Cancer Pain. J Clin Oncol 32:1662-1670.

Belinda

58yo taxi driver
Recurrent breast cancer to liver, bone, lymphadenopathy

She is a skeptic...
She is suffering.

Opioids and Cancer

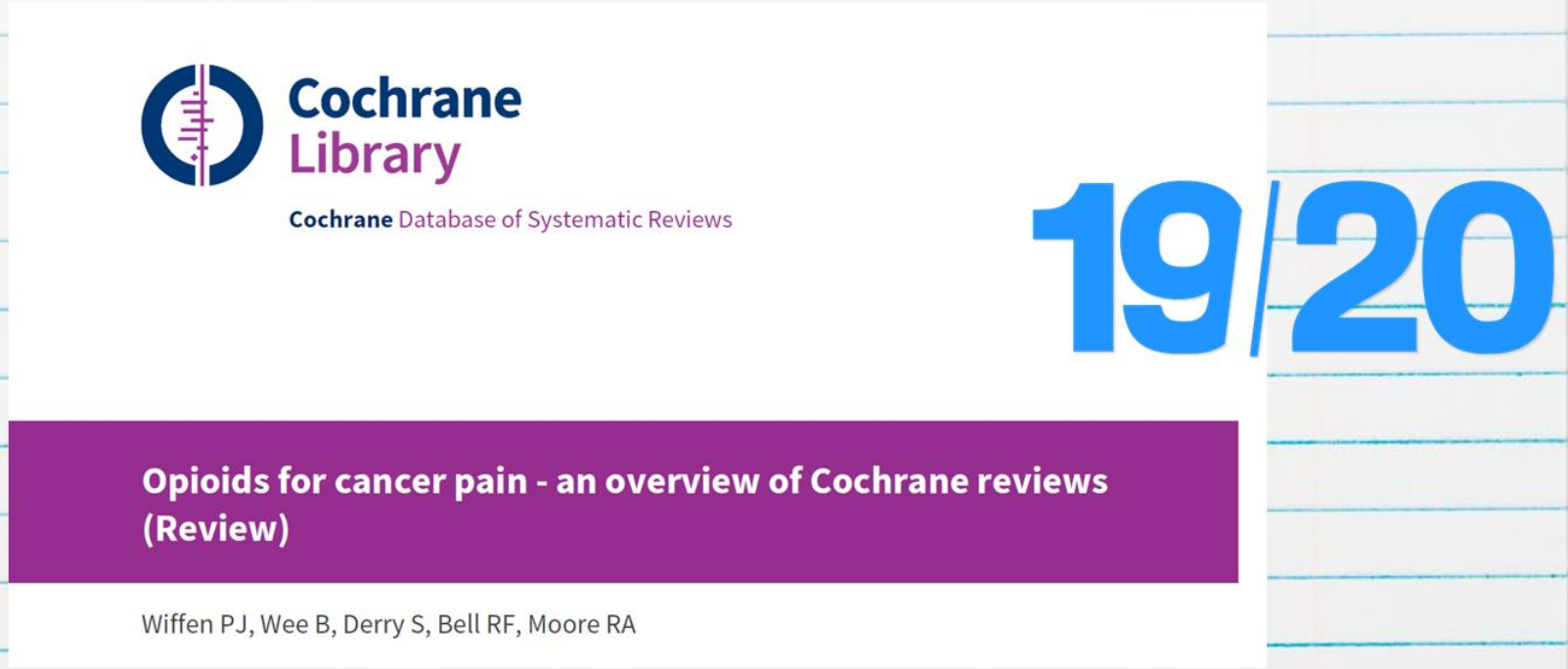
Opioids may be Immunosuppressive

VS.

Pain and stress have adverse influence on cancer progression

Wigmore T & Farquhar-Smith P. Opioids and Cancer: friend or foe? Curr Opin Support Palliat Care 2016, 10:109–118

Evidence of the Evidence



Wiffen PJ, Wee B, Derry S, Bell RF, Moore RA. Opioids for cancer pain - an overview of Cochrane reviews. Cochrane Database of Systematic Reviews 2017, Issue 7.

What kind of pain are you Treating?
Who are you treating?

Management of Chronic Pain in Survivors of Adult Cancers: American Society of Clinical Oncology Clinical Practice Guideline
J Clin Oncol 34:3325-3345.

GUIDELINES

JOURNAL OF CLINICAL ONCOLOGY | ASCO SPECIAL ARTICLE

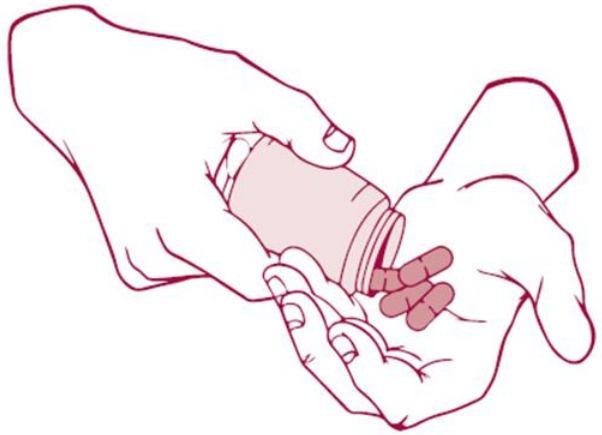
Management of Chronic Pain in Survivors of Adult Cancers: American Society of Clinical Oncology Clinical Practice Guideline

Judith A. Paice, Russell Portenoy, Christina Lacchetti, Toby Campbell, Andrea Cheville, Marc Citron, Louis S. Constine, Andrea Cooper, Paul Glare, Frank Keefe, Lakshmi Koyyalagunta, Michael Levy, Christine Miaskowski, Shirley Otis-Green, Paul Sloan, and Eduardo Bruera

BC Centre for Palliative Care

PAIN | B.C. Inter-Professional Palliative Symptom Management Guidelines

WHO GUIDELINES FOR THE PHARMACOLOGICAL AND RADIOTHERAPEUTIC MANAGEMENT OF CANCER PAIN IN ADULTS AND ADOLESCENTS



And Here the evidence ends...

The ABCDs of Opioid Prescribing

Assessment - get a baseline

Breakthrough dosing

Constipation (&proactive prescribing)

Details - titrating, rotating, adjuvants and complexities

Ingram C, Deming J and Bock A. The A,B,C,Ds of Opioid prescribing for People Living with Cancer. Minnesota Medicine 2015 Sep; 98(9); 44-6.

A for Assessment

Onset
Provoking/Palliating
Quality
Region/Radiation
Severity
Treatment → current and past therapies tried
U
V

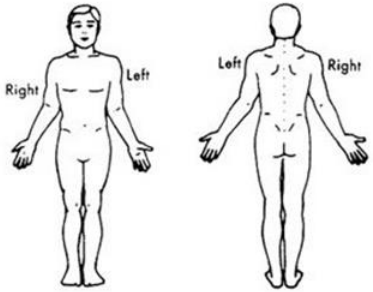
FORM 3.2 **Brief Pain Inventory**

Date____ / ____ / ____ Time:_____

Name: _____ _____ _____
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
1. Yes 2. No

2) On the diagram shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **average**

0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the Past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much releif you have received

0% 10 20 30 40 50 60 70 80 90 100%
No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Understanding → what do you think is causing the pain?
how is it affecting you and your family?
what are your beliefs about opioids?

Values → are you having to make compromises because of the pain?
what overall goals do we need to keep in mind?
what is your acceptable level of pain (0-10)?
are there any beliefs views or feelings about this symptom important to you and your family?

Risk vs Fear

Opioid Risk tool

Score 8 or higher indicates High risk for opioid abuse

... that doesn't mean don't prescribe, just discuss and be aware of the risk!

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Risk vs Fear

Fear	Reassurance
Addiction	Rare and can be screened for
Side effects	Most can be treated and/or diminish with time
Won't be effective when the pain becomes worse, tolerance	Doses can be adjusted, opioids won't 'run out'
People will think you are giving up Opioids hasten death	Pain control should allow patients to do more, have better QoL

A for Assessment

Focused physical exam

Blood work/Imaging

Social History

Other symptoms


What do I need
to know about
your pain?

Initiate Treatment and Set Expectations

Identify the three simple stepwise goals for pain management:

- A good night's sleep.
- Pain control during the day while at rest.
- Pain control when active and ambulatory.

Belinda

58yo taxi driver
Recurrent breast cancer to liver, bone, lymphadenopathy

She is struggling to do chores and activities around the house due to RUQ pain.

What would you start her on?

Could start oxycodone/acetaminophen combination, or tramadol
Could start lower dose pure opioid for mild/moderate incident pain

Morphine 5mg PO q2hr PRN
= Hydromorphone 1mg PO q2hr PRN
= ~2.5mg Oxycodone PO q2hr PRN

Starting doses:

- Start Low, Go Slow
- Better to start with low dose at higher frequency based on time to FULL effect
  [as close as q15min for IV, q30min for SC, q60min for PO Doses]
- USUALLY:
  - Don't start a regular dose when initiating opioids
  - Don't start a long acting formulation when initiating opioids
- 10mg PO Morphine equivalent for severe pain in robust Patients*
  - Reduce for frailty (not age dependent!) by 50%
  - Reduce for Renal insufficiency (no absolute cut off) by 50%

B for Breakthrough

Incident Pain

- often predictable; treat proactively if possible

Spontaneous Pain

- not predictable; requires reactive treatment

End of dose Failure

- occurs prior to next regular dose; increase regular dosing in most cases

Stick with the same Opioid... Except...

Fentanyl Patch

- Look at morphine equivalency
- Calculate 10% of this
- Give breakthrough in short acting opioid

Methadone

- Methadone can be used for breakthrough dosing (q3hr PRN due to accumulation)
- Usually a shorter acting opioid is used instead

Belinda is now using Morphine 5mg 5x/day with some relief. What is your next step?

Belinda is now using Morphine 5mg 5x/day with some relief. What is your next step?

Morphine 5mg x 5 = 25mg

Long acting eg 15mg Morphine Long Acting q12hrs + 2.5mg q1hr PRN

OR Morphine 5mg q4hrs (can skip overnight dose) + 2.5mg q1hr PRN

Breakthroughs & establishing a dose:

- Reassess the Pain and when it "breaks through"
- Most cancer patients with good pain control will require 2-3 PRNs / Day
- Calculate total daily dose = Regular + all breakthrough doses
- Regular dosing should generally encompass the total daily dose, up to a 50% increase*
  - Use a long acting formulation - your patient will thank you
- How often can they use it? As often as the time to FULL EFFECT
  Half life determines how often to dose REGULARLY
- New Breakthrough Dose = Total daily dose x 10%
  - In some cases up to 20% may be needed (eg acute incident pain)

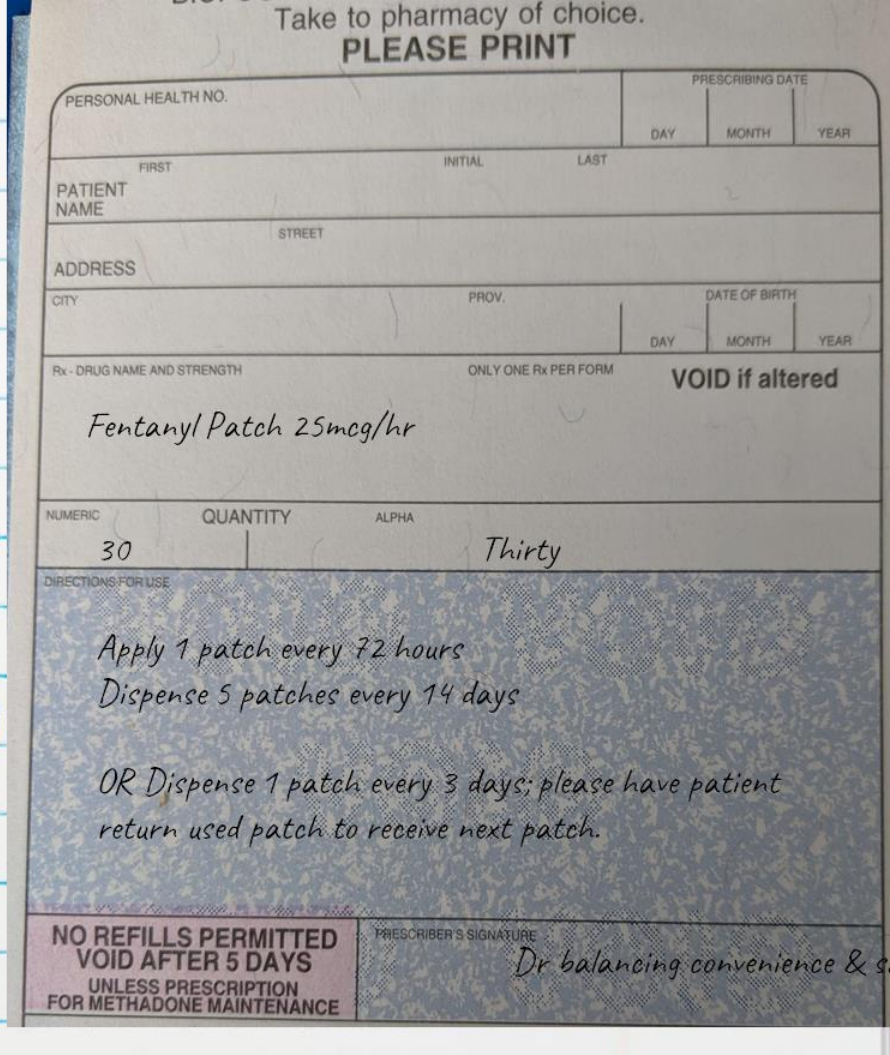
PRESCRIBING....

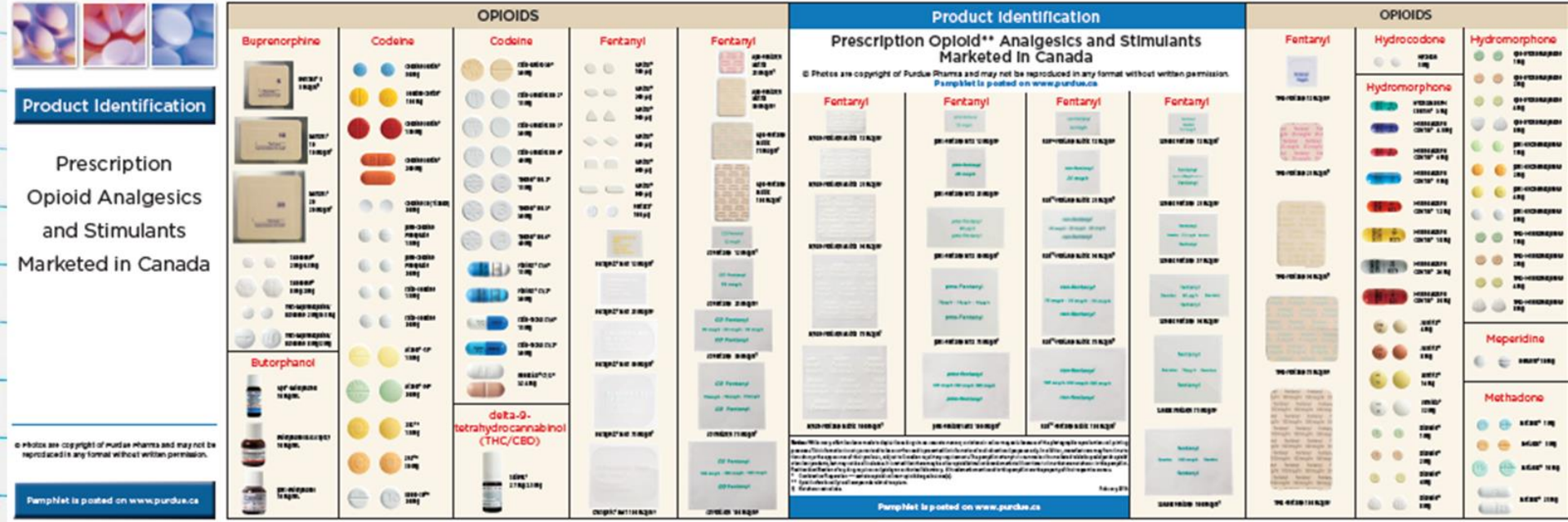
Generally prescribe generics
(eg Morphine Long Acting)

Know your Formulary

Document your prescriptions clearly
(in your clinic notes and on the Rx)

Dispense in intervals if prudent


Take to pharmacy of choice.
PLEASE PRINT
PERSONAL HEALTH NO.
PRESCRIBING DATE
DAY MONTH YEAR
FIRST INITIAL LAST
PATIENT NAME
STREET
ADDRESS
CITY
PROV.
DATE OF BIRTH
DAY MONTH YEAR
Rx - DRUG NAME AND STRENGTH
ONLY ONE Rx PER FORM
VOID if altered
Fentanyl Patch 25mcg/hr
NUMERIC QUANTITY ALPHA
30 Thirty
DIRECTIONS FOR USE
Apply 1 patch every 72 hours
Dispense 5 patches every 14 days
OR Dispense 1 patch every 3 days; please have patient return used patch to receive next patch.
NO REFILLS PERMITTED
VOID AFTER 5 DAYS
UNLESS PRESCRIPTION
FOR METHADONE MAINTENANCE
PRESCRIBER'S SIGNATURE
Dr balancing convenience &



SEARCH FOR:

"PRESCRIPTION OPIOIDS ANALGESICS AND STIMULANTS MARKETED IN CANADA PDF"

C for Constipation

Expect the expected!

Prescribe a laxative
Prescribe an anti-nauseant

Docusate is pill burden
Senna and PEG get you far
Metoclopramide for most

ASK ASK ASK ABOUT STOOL.

D for details

Assess, Educate, Treat, Repeat

Look for opioid side effects & toxicities
Look for opioid ineffectiveness

Educate

Increment doses and
Rotate if needed

Opioid side effects

Extinguishing

Somnolence/Sedation

Nausea

Itching*

Non-Extinguishing

Constipation

Confusion/Nightmares/Hallucination

Urinary Retention

Myoclonus

Hyperesthesia

Hypotension

(Respiratory Depression)

Patient and family education

- What the medications are & why they have been prescribed.
- How & when they should be taken.
- Potential adverse effects & how they can be managed if they occur.
- Medication safety processes
- How prescriptions are filled.
- Safe handling, storage, & pharmacy take-back disposal of analgesics, particularly opioids.

Opioid rotation

May be required if:

- Non-extinguishing symptoms
- Previous route is unavailable
- Current opioid is ineffective
- Side effect management not effective

ROTATION

1) Calculate total dose
2) Convert to Oral Morphine Equivalents
3) Convert to 'new' Opioid
4) Reduce by ~33% to account for incomplete cross tolerance

An Example...

Table B Appendix 8.1 Oral Opioid Analgesic Conversion Table

	Equivalence to oral morphine 30 mg:	To convert to oral morphine equivalent, multiply by:	To convert from oralmorphine, multiply by:
Morphine	30 mg	1	1
Codeine	200 mg	0.15	6.67
Oxycodone	20 mg	1.5	0.667
Hydromorphone	6 mg	5	0.2
Meperidine	300 mg	0.1	10
Methadone and tramadol	Morphine dose equivalence not reliably established.		

2. **Equivalence between oral morphine and transdermal fentanyl:**

Transdermal fentanyl*	60–134 mg morphine = 25mcg/h
	135–179 mg = 37 mcg/h
	180–224 mg = 50 mcg/h
	225–269 mg = 62 mcg/h
	270–314 mg = 75 mcg/h
	315–359 mg = 87 mcg/h
	360–404 mg = 100 mcg/h

Guideline for opioid therapy and chronic noncancer pain. Busse JW, et al. CMAJ May 08, 2017 189 (18) E659-E666

Belinda

58yo taxi driver
Recurrent breast cancer to liver, bone, lymphadenopathy

She comes in with increased pain, significant nausea and constipation.

Belinda is now using Morphine Long Acting 20mg q12hrs + 40mg of PRN Morphine.
What is your next step?

Belinda is now using Morphine Long Acting 20mg q12hrs + 40mg of PRN Morphine.
What is your next step?

Calculate total dose, Convert to Oral Morphine Equivalents → 20x2 +40 = 80mg OME
Convert to Hydromorphone → 80mg * 0.2 = 16mg Hydromorphone
Reduce by ~33% to account for incomplete cross tolerance → 12mg Hydromorphone
→ Hydromorphone Long Acting 6mg PO q12hrs

OR
Rotate to Fentanyl Patch - 80mg OME
= 25mcg/hr Patch + 1mg q2hr PRN Hydromorphone

Opioid toxicities and Rotations:

- Use a consistent table as none is Perfect!
- Generally move from a 'dirtier' to a 'cleaner' opioid for improved side effects
  - Codeine⟶ morphine ⟶ hydromorphone ⟶ oxycodone ⟶ fentanyl/methadone
- Reduce by 25-50% for incomplete cross tolerance
- In most cases, calculate oral morphine equivalents and then convert to target opioid
- For fentanyl patch
  - use a chart, Don't need to dose reduce
  - To rotate FROM patch, reduce morphine dose by 50% if using standard chart
  - Often better for constipation, compliance
  - May not be as good for neuropathic pain

Caveats

Codeine has a ceiling effect, variable metabolism, only PO doses - usually avoided unless pain will be only mild/moderate and not chronic

In renal insufficiency, hydromorphone or oxycodone are preferred at lower doses, methadone and fentanyl are much preferred if higher doses are needed (eg >90mg morphine/day)

Call for help if needed! PSMPC teams are happy to help/give advice.

METHADONE

Seems better for Neuropathic pain*

Often works when other opioids don't*

- Interacts with other medications
- Long Half Life
- QTC prolongation

Online course - 2 Mainpro+ credits

CANADIAN VirtualHospice

Methadone for Pain in Palliative Care

Methadone4Pain.ca is a series of three education modules for physicians, nurses and pharmacists seeking to improve their knowledge in prescribing and managing patients prescribed methadone for pain in palliative care.

Thanks!

Questions?

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