Recommendations for safe opioid prescription in the management of chronic non-cancer pain

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Abstract

The treatment of chronic and severe pain is a principal goal of medicine. Natural opioids have been used for several years, and the recent development of synthetic opioids has increased therapeutic options; however, the addictive potential of these substances obliges the regulation of their use. International agencies recommend prudent rules in the therapeutic use of opioids.

KEY WORDS: *Pain therapy. Chronic pain. Opioids. Opioid addiction.*

Pain is one of the most common medical problems and its relief is an important therapeutic goal; analgesics constitute the cornerstone. Management of this symptom requires a multimodal approach according to its characteristics, intensity and access to different therapeutic options. A concern for health systems at the international level is appropriate use of drugs, especially opioids.

The bases of pharmacological treatment for chronic pain were proposed by the World Health Organization in 1986 according to its severity, legitimizing the use of opioids and their potential benefit for the relief of chronic cancer pain. In Mexico, important efforts have been made to improve opioid availability for the relief of chronic oncological pain and for palliative care.

However, in chronic non-cancer pain, the lack of clinical guidelines, the addictive potential of these drugs, their diversion, misuse and the worrying increase of drug overdose deaths in some countries, has forced health authorities, regulatory agencies, medical organizations, the scientific community, international organizations and pharmaceutical companies to implement coordinated strategies to promote safe and responsible prescription, as well as to mitigate the risks in the use of opioids.

The Ethics and Transparency Committee in the Physician-Industry Relationship (Cetremi – *Comité de Ética y Transparencia en la Relación Médico-Industria*) of the National Academy of Medicine of Mexico considers it to be essential for a balance to be designed in order to provide easy access to these drugs for those who need them and to establish a national strategy to prevent the risk of addiction, deviation, traffic and misuse of opioids acquired by means of licit prescription; therefore, in accordance with the standards established by the Centers for Disease Control and Prevention of the United States, it adheres to their authorized recommendations for their transcription:

Do not prescribe opioids as initial treatment of chronic pain (in adults older than 18 years with chronic

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Date of reception: 03-10-2017
Date of acceptance: 27-01-2018
DOI://dx.doi.org/10.24875/GMM.M18000185

Gac Med Mex. 2018;154:454-455
Contents available at PubMed
www.gacetamedicademexico.com

pain> 3 months, except in patients with cancer, for palliative or end-of-life care).

A) *Prior to starting treatment*

1. Evaluate the type of pain and function.
   Use a validated assessment scale, e.g., the visual analogue scale (VAS), which has the following gradation:
   - From 1 to 10 describing pain intensity (0 no pain-10 worst pain ever felt)
   - From 1 to 10 describing how much has pain interfered with daily activities (0 nothing-10 does not allow doing anything).
   - From 1 to 10 indicating how it affects well-being (0 nothing-10 completely affects well-being)
2. Consider whether non-opioid analgesics are indicated, for example, NSAIDs, tricyclic antidepressants, serotonin reuptake inhibitors, anticonvulsants, exercise, physical therapy.
3. Inform the patient about the treatment plan.
   - Establish realistic goals for diagnosis-based pain relief and function.
   - Discuss the benefits, side effects, and risks (e.g., addiction, overdose).
   - Establish the criteria to discontinue or to continue the treatment and a follow-up plan.
   - Make sure the patient understands and accepts the treatment plan.
4. Evaluate the risks, harm or aberrant use.
   - Known risks: use of illegal drugs, use of medications for non-medical reasons, history of substance abuse or overdose, mental illness.
   - Ask about the use of controlled medications, opioids or legally or illegally-obtained sedatives
   - If possible, perform urine screening to determine the presence of controlled medications or illicit drugs
   - Avoid possible drug-drug interactions.

B) *When prescribing*: Start slowly with low doses.

- Start with immediate-release opioids.
- If it is necessary to prescribe a dose greater than ≥ 90 morphine milligram equivalents (MME)/day, consider referring the patient to a pain specialist.
- When the prescription is ≥ 50 MME/day, establish patient follow-up with higher frequency.
- In case of acute pain, prescribe opioids for a short time, < 3 days, on rare occasions treatment is necessary for more than 7 days.
- Instruct the patient and his/her family about safe storage and disposal of unused opioids.

C) *At follow-up*: Assess, adjust and decrease.

- Reassess risks and benefits one to four weeks after starting.
- Assess pain and function, comparing with initial evaluation. Schedule reassessment at regular intervals.
- Continue opioid treatment if there is clinically significant improvement in pain relief and function without significant risk or harm.
- In case of drowsiness or overdose risk, adjust the dose, for example, 10 % decrease.
- Consider psychosocial support.
- Adjust the dose individually monitoring for suppression data.

In patients with of opioid abuse, treatments with buprenorphine or methadone and psychological support should be used.