



Therapeutic Brief

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Chronic pain rehabilitation: It's about improving function and day-to-day life

Understanding pain is the first step to recovery for patients with pain that has persisted for more than 12 weeks.^{1,2}

A biopsychosocial strategy, that incorporates pain neuroscience education, helps patients to understand why persistent or chronic pain can hurt so much, even when the tissues have healed, and how they might overcome the pain.¹⁻³

When used in combination with active self-management strategies, there is clear evidence that this is the most effective way for most patients to change the impact of chronic pain on their day-to-day functioning, and lessen their pain-related worries.³⁻⁵

In Australia, approximately 86% of patients with chronic pain take at least one medicine to manage their pain. Of these, two-thirds don't receive any other form of management.⁶ Opioid use for the treatment of chronic pain has increased almost four-fold over the last two decades.⁷

A shift in focus from opioids to active self-management strategies, while slowly tapering and ceasing opioids as the patient's ability to regain control and self-manage increases, is current best practice.^{1,5,8}

The rise in opioid dispensing has resulted in significant harm (see Figures 1 & 2). Between 2008 and 2014, there was an 87% increase in prescription opioid deaths in Australia, with the greatest increase occurring in rural areas.⁹

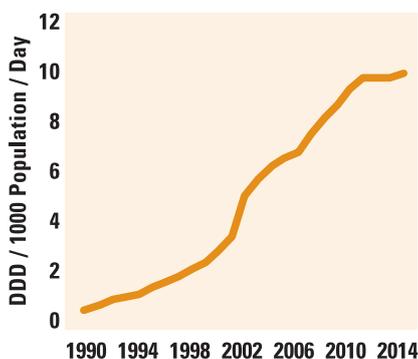


Figure 1: Opioid dispensing from 1990 to 2014. Australian Government Drug Utilisation Subcommittee

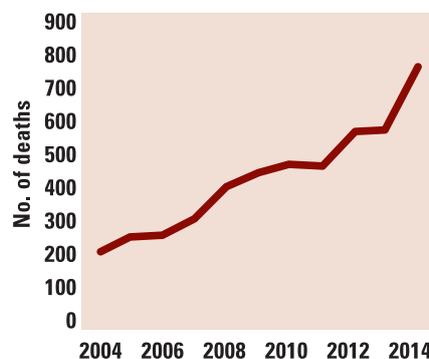


Figure 2: Opioid-related deaths (oxycodone, codeine, fentanyl, pethidine, tramadol and morphine) from 2004 to 2014.⁹

Note: Deaths from tapentadol were not included in the data in Figure 2 as it was not listed on the PBS until June 2014.¹⁰

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Key points

- With your patient, review their opioid use during the last month and their ability to function
- Shift the focus of treatment from opioids to active self-management strategies and slowly taper and cease the opioids
- Include a combination of medical and educational approaches, and psychological and physiotherapy interventions in the rehabilitation plan
- If opioids are required, be clear with your patient about their time-limited role before you start



✓ Chronic pain is a common problem in Australia

- One in five Australians suffer from chronic pain, which increases to one in three for those aged 65 years and older.⁶
- Almost 40% of people with chronic pain are severely or moderately limited in their day-to-day lives.⁶
- Back problems, osteoarthritis, and musculoskeletal and neurological problems are the most common causes of chronic pain.⁶

✓ Many patients feel pain even when there is no tissue damage

Pain is a unique and complex experience for each person. It can result from a significant or insignificant injury, emerge over time, be unpredictable and can involve a person's emotions, thoughts, beliefs and behaviours.¹¹

In persistent or chronic pain the amount of pain felt seldom reflects the amount of tissue damage.^{1, 11} The nervous system and the brain can become over-protective, producing more pain, more often.¹¹ Not understanding this over-protective system often leaves the patient feeling depressed, anxious and misunderstood, further contributing to the cycle of ongoing pain and disability. Let your patient know that you believe their pain is real and that it's not 'all in their head'.¹²

✓ Catastrophising contributes to chronic pain

Chronic pain is often associated with psychological comorbidities, including post-traumatic stress disorder (PTSD), catastrophising, anxiety and depression.^{12, 13} Pain catastrophising is a significant risk factor for developing chronic pain and disability. It contributes to heightened levels of pain and emotional distress, and increases the likelihood that pain will persist over an extended period of time.¹⁴ Pain catastrophising has also been linked to an increased risk for opioid misuse, due partly to a heightened level of pain-related anxiety.¹⁵ Evidence suggests that if catastrophic thinking can be minimised,

Box 1. The Pain Catastrophising Scale (PCS)¹⁴

The PCS, a 13 item questionnaire that you can work through with your patient, can be completed in less than five minutes, and provides an insight into what your patient thinks about when they are in pain.¹⁴

A total score of 30 or more represents a clinically relevant level of catastrophising. If the score is high, consider referring your patient to a psychologist. A psychologist can talk to your patient about what this means and how it can influence perception of pain. They can help reduce fears and change the way the patient thinks about pain.

Research shows that catastrophic thinking associated with pain can be reduced using multimodal interventions, including education, instruction in active self-management strategies and physical activity.¹⁴

The PCS can be accessed at: www.painbc.ca/sites/default/files/events/materials/Pain_Catastrophizing_Scale.pdf

the likelihood of pain and disability becoming chronic can be reduced.^{11, 14}

If you are concerned that your patient goes over their pain repeatedly in their mind, worries constantly that something serious will happen or feels helpless to do anything about their pain, consider assessing them for catastrophising (see Box 1).

✓ Talk with your patient before starting opioids

Careful consideration is warranted before initiating opioids for chronic pain, especially in younger patients and in those with complex physical and mental needs.^{16, 17}

If starting a trial of opioids, patients need to know:

- the limited benefits and potential for harm of regular opioid use¹⁸
- opioids will be one component only of a multi-modal rehabilitation plan¹⁸
- the early onset and long-term adverse effects of regular use¹⁹
- the potential opioid use disorders including physical and psychological dependence²⁰
- the importance of taking no more than the dose of opioid prescribed¹⁹
- the importance of not combining opioids with benzodiazepines or other medicines that depress the central nervous system^{16, 17}
- how long opioids will be trialled for and how they will be tapered and ceased.

✓ Long-term use of opioids won't reduce chronic pain or improve function

There is no evidence to suggest that long-term use of opioids is effective in resolving chronic pain or improving function.^{8, 21-24} Opioids have a modest effect only in relieving chronic pain in the short-term, with little effect on improving function.²¹

As patients proceed from acute to chronic opioid therapy, there is an increased risk of harm, including cognitive impairment, worsening sleep apnoea, sexual impairment and other endocrine dysfunction, immunosuppression, falls, driving impairment and an increased risk of death.^{9, 16-18, 24, 25} A paradoxical effect of opioid-induced hyperalgesia can occur as doses increase, which can strengthen the cycle of pain, misuse and dependency.²¹

If opioids are to be a part of the rehabilitation plan for chronic pain, the principles of opioid prescribing should be applied stringently. This includes a comprehensive assessment and a clear contractual agreement with the patient stipulating opioids are a time-limited component of a multimodal plan subject to review.⁸ **The aim of time-limited opioid use is to provide patients with some relief while developing active self-management skills to regain control.**²⁶ Consider referring your patient to appropriate allied health professionals trained in pain management and review

them each week during this time to monitor their progress (see insert *Teaming up against chronic pain*).

Before starting opioid therapy, be clear with your patient that opioids will be a trial for four to six weeks,²⁰ subject to evaluation weekly in the beginning, then monthly if continued.^{8, 20} If opioids are started, prescribe a low dose, monitor and assess the response, and increase by the smallest possible amount if needed.¹⁹

Refer to a previous MATES topic: *Chronic musculoskeletal pain: changing the way we think about pain* to apply the Principles for Prescribing Opioids at: www.veteransmates.net.au/topic-38

✔ More than 90 days of opioids is usually too long

Opioid therapy for longer than 90 days is associated with continuing use, opioid use disorders, overdose and worse functional status, including an inability to work.^{27, 28}

If you have concerns that your patient is developing physical or psychological dependence, consider referring them to an addiction specialist for their opinion or for continuing management.⁸ To find an addiction specialist view the list of AChAM Fellows at: <https://www.racp.edu.au/about/racps-structure/adult-medicine-division/australasian-chapter-of-addiction-medicine>

A word of caution about short-term use of opioids for acute pain

Long-term use of opioids often begins with the treatment of acute pain.¹⁹ If opioids are used to treat acute pain, only immediate-release formulas should be prescribed at the lowest possible effective dose for the minimal amount of time needed; usually no longer than seven days. If pain requiring opioids persists after seven days, re-evaluate the patient.¹⁹

If your patient has been started on opioids for acute pain, make a follow-up appointment to review them in a week or so and develop a treatment plan if appropriate.

Medicines containing codeine will be available by prescription only from the 1st February 2018^{20, 29, 30}

- Have a conversation with your patients taking over the counter (OTC) codeine products to ascertain why they take them and to discuss alternative treatment options if needed.
- Most patients are unaware of the evidence that combination products containing low-dose codeine (less than 30 mg) with paracetamol, aspirin or ibuprofen don't have any additional benefits over each medicine used alone.
- Misuse of codeine can lead to tolerance and dependence and contribute to overdose and death.
- Over-use of OTC codeine fixed-dose combinations can lead to toxicity from the non-opioid medicine, for example gastrointestinal perforation or renal failure from ibuprofen and liver damage from paracetamol.
- Effects can vary considerably from patient to patient; some patients' pain might be made worse, while others might be ultra-rapid metabolisers and achieve higher morphine concentrations increasing their risk of toxicity.

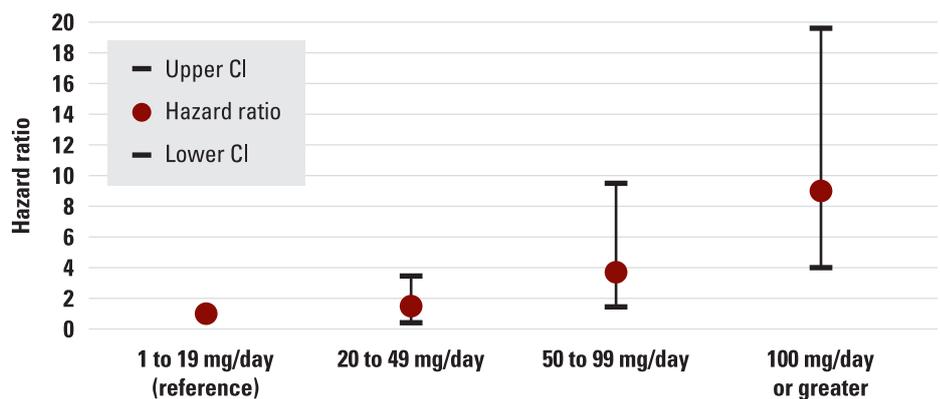


Figure 3: Increasing opioid dose and risk of overdose³⁴

✔ Keep the dose down

In Australia, 40mg of oral morphine equivalent (OME) per day is the recommended maximum dose.²⁵ The risk of adverse effects rises as the opioid dose rises.³¹ Risk of serious adverse events, including opioid use disorders, overdose and death, increases significantly as the dose exceeds 100mg OME per day. A person taking 100mg OME or more per day is nine times more likely to overdose than a person taking less than 20mg OME per day (see Figure 3).³² Patients taking benzodiazepines and opioids together have a 15 fold increase in risk of death compared to patients taking neither medicine.³³

Refer your patient for an evaluation by a specialist in addiction or pain, if pain response to opioids is poor, the dose is escalating with no improvement, or has exceeded the maximum daily dose.²⁰

Older people taking opioids are at an increased risk of adverse effects including cognitive impairment, sedation, respiratory depression and falls. If initiating opioids in an older person, start at the lower end of the dosing range and increase in small increments to achieve adequate pain relief with minimal adverse effects.³⁵ Irrespective of the dose, monitor and review your older patient taking opioids.³⁵

Preventing and managing opioid-induced constipation²⁰

-  When initiating opioids, start a stimulant laxative combined with a stool softener, for example docusate sodium + senna (e.g. Coloxyl with Senna[®]) or an osmotic laxative, for example macrogol (e.g. Movicol[®], OsmoLax[®]) and lactulose (e.g. Actilax[®])(not on RPBS).
-  For resistant established constipation, also use:
 -  glycerol suppositories
 -  small volume enema (e.g. Bisalax[®] or Micolette[®]).
-  Encourage your patient taking opioids to keep well hydrated and mobile to help prevent constipation. Bulk-forming laxatives are generally not recommended as they might worsen constipation, particularly if the patient is dehydrated or immobile.
-  If the patient's current laxative regimen is inadequate and there is a fixed-dose combination of the patient's current opioid with naloxone available, consider changing it.
-  For further information, refer to a previous MATES topic *Opioid-induced constipation – a preventable problem* at: www.veteransmates.net.au/topic-27

At each visit aim to taper and cease opioids

Tapering and ceasing opioid therapy can be very uncomfortable and difficult for some patients, particularly those on higher doses.²⁸ It can also be a difficult challenge for GPs, especially when treating patients with complex physical and mental needs. For some patients, stopping will be easier. Patients taking high opioid doses of more than 120mg OME per day, and those misusing opioids, might need extra help to cease.²⁸

There is no single tapering strategy that fits all.³⁶ The aim is to taper the dose while limiting withdrawal symptoms and avoiding mounting distress.¹⁸

Physical dependence is common in long-term users of opioids and common withdrawal symptoms including nausea, vomiting, diarrhoea, sweating and anxiety can occur if treatment is stopped suddenly.^{20, 35} Less common symptoms might include musculoskeletal aches and pains, anorexia, insomnia, irritability, tachycardia, fever, or mildly elevated blood pressure.³⁶

Full reference list available on the website: www.veteransmates.net.au

Steps to tapering and ceasing opioid therapy^{20, 25, 26, 36-38}

-  Negotiate and agree upon a plan for tapering and ceasing, including the tapering rate, with your patient before beginning, and set up regular appointments.
-  Re-evaluate rehabilitation strategies. Refer your patient to various healthcare professionals to learn active self-management skills, including distraction, goal setting, pacing, exercise, mindfulness meditation and relaxation techniques that are based on cognitive behavioural therapy (see insert *Teaming up against chronic pain*).
-  Be clear with your patient about why you are tapering their opioid dose and what they can expect during the process. Address their fears associated with reducing the dose or stopping, and reassure them you will be there to support them during the entire tapering process. Provide written and verbal information for your patient and their family. Take into consideration your patient's level of anxiety and reassure them you are working together with them to manage their pain.
-  Reduce the dose gradually, taking into consideration the individual person, their history and psychological comorbidities, social support, adverse effects as the opioid dose is reduced and their ability to self-manage.
-  For patients taking opioids long-term, reduce the daily dose by five to ten percent per week or ten to 25% of the starting dose per month according to their tolerance; this generally achieves cessation in three to nine months. Generally, the longer the patient has been taking opioids, the slower the tapering should be.
-  Consider advice from a pain medicine specialist if unsure about the process, or refer to an addiction specialist or a drug and alcohol service in your state if there is a dependency/addiction problem.
-  Review weekly or fortnightly.