Connect Health

Improving Wellbeing through prescribing less

Deprescribing Challenges: Pain Medications and Opioids

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Mandy Wilson, Lead Nurse

Emily Byatt, Service Manager

Welcome and Intro

- Apologies from Mandy

"To me it was clear from the outset that Connect Health wanted to deliver a gold standard pain service and provide high standards of care to people with long term pain; that definitely attracted me to the role."

Lead Nurse and Clinical Lead, **Mandy Wilson** joined Connect Health after working in several pain management services around the country and was keen to join such a forward thinking team.

- A little about me

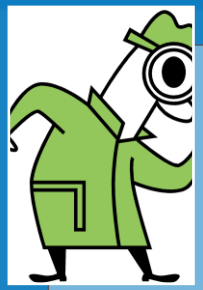
Emily Byatt, Service Manager, loves the values at Connect Health. It attracted her to take on a new role and reinvigorated her passion for healthcare delivery.

"Connect Health has a can-do culture, that's really focused on continual improvement and investing in its people. There's just so much opportunity."

Objectives

Think differently about prescribing for persistent pain

Consider non-pharmacological alternatives



Explore ways to get patients thinking/ behaving differently

The size of the problem

National Picture: 28 million in pain in UK = 43% of population

Local Picture: 134,560 People in LincoInshire Living with Low Back Pain = 17% of the population

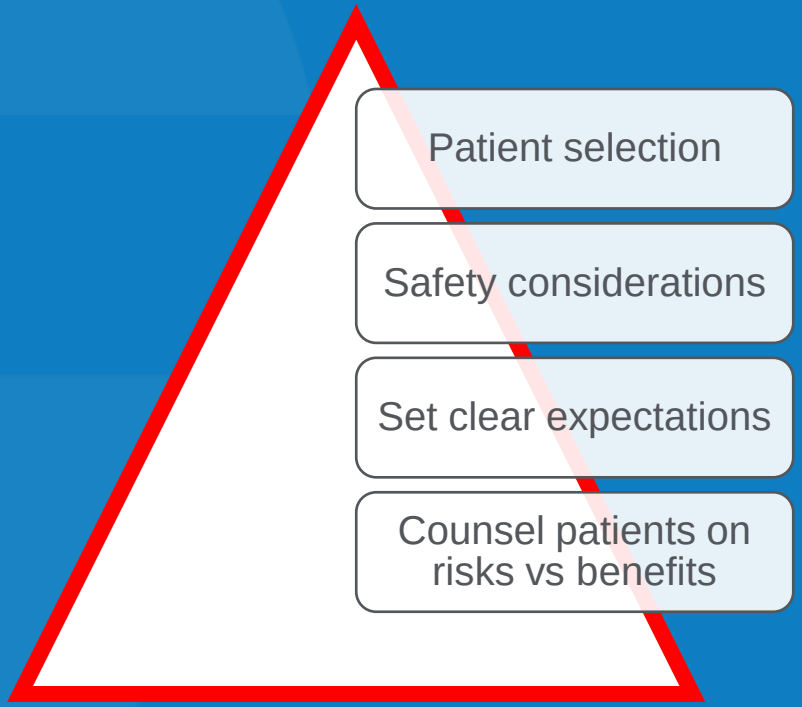
Why do we prescribe painkillers?

POLL

- Why do patients want to take painkillers?

POLL

Pain Medication & Prescribing issues



From the Patient's Perspective

Expectations / beliefs of what meds will offer

- More pain = more medications
- Cure seeking
- Some may believe meds are safe / without risk
- Some look to Dr Google or social media for drug knowledge

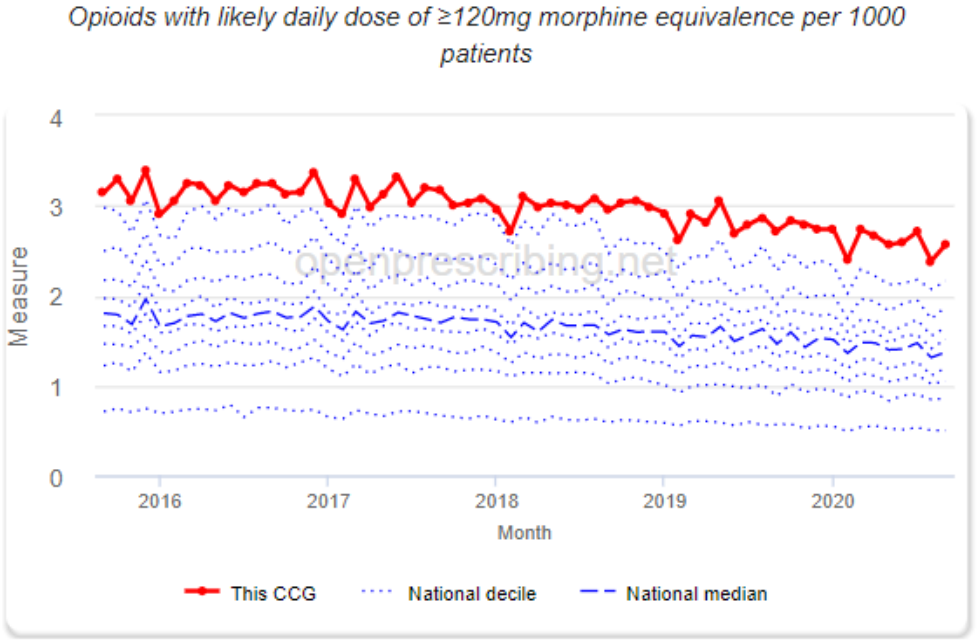
Behaviours

- Active vs. passive coper
- Risk of dependency
- Maladaptive coping strategies / unhealthy lifestyle choices

Why this often does not work?

Size of the problem: 1) High Dose Opioids

High dose opioids per 1000 patients



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Opioid Aware

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

Key Messages

1. Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.

2. 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 people at the point of opioid initiation).

3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit: tapering or stopping high dose opioids needs careful planning and collaboration.

4. If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available.

5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

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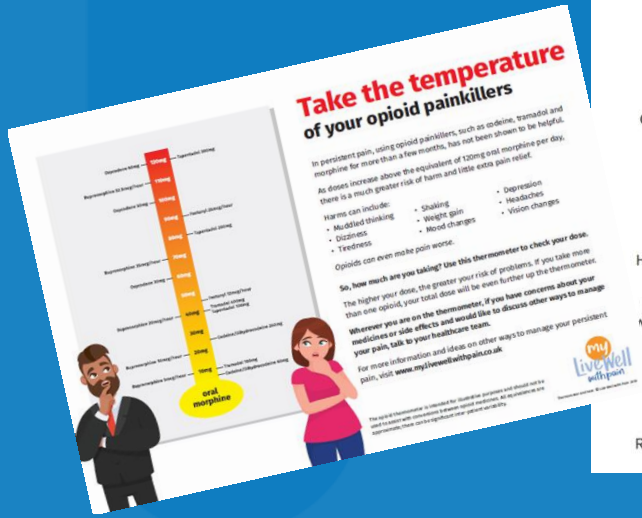
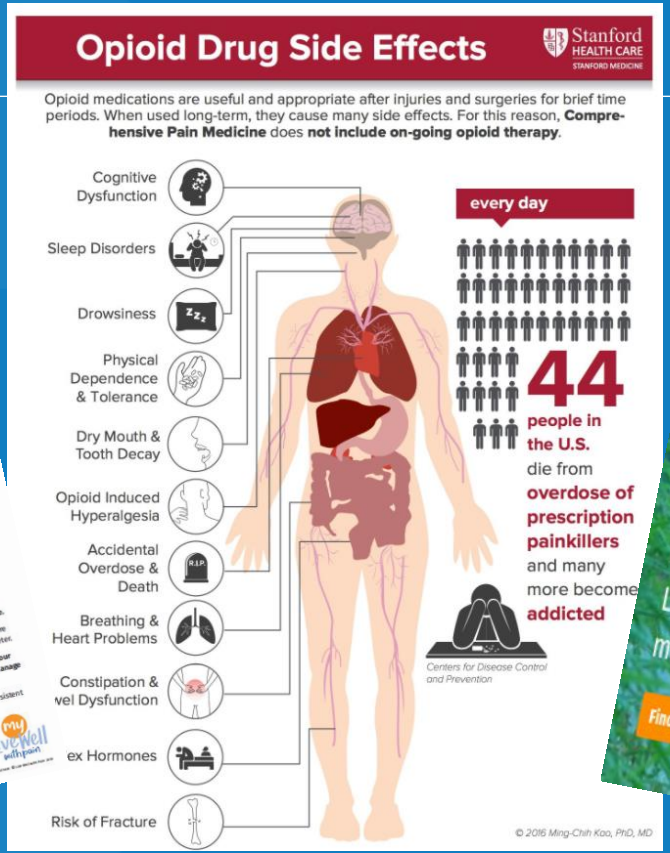
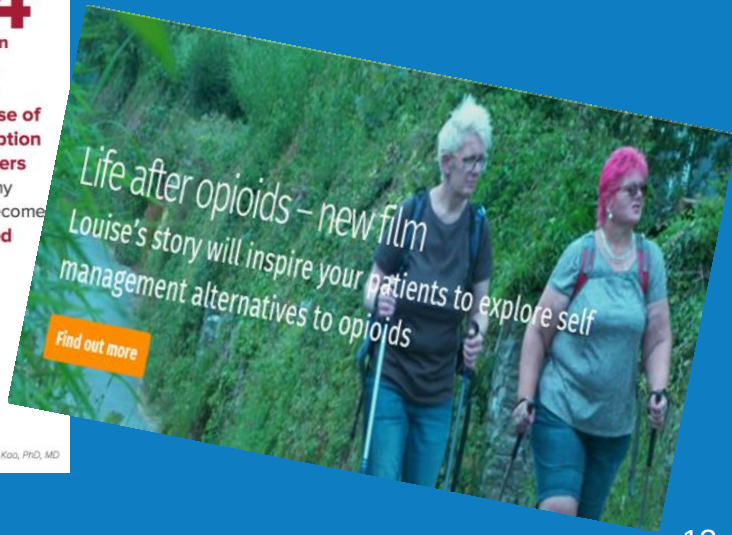
A Public Case Study….

Awareness


Take the temperature
of your opioid painkillers
In persistent pain, using opioid painkillers, such as codeine, tramadol and morphine for more than a few months, has not been shown to be helpful.
As doses increase above the equivalent of 120mg oral morphine per day, there is a much greater risk of harm and little extra pain relief.
Harms can include:
• Muddled thinking
• Dizziness
• Tiredness
• Shaking
• Weight gain
• Mood changes
• Depression
• Headaches
• Vision changes
Opioids can even make pain worse.
So, how much are you taking? Use this thermometer to check your dose.
The higher your dose, the greater your risk of problems. If you take more than one opioid, your total dose will be even further up the thermometer.
Wherever you are on the thermometer, if you have concerns about your medicines or side effects and would like to discuss other ways to manage your pain, talk to your healthcare team.
For more information and ideas on other ways to manage your persistent pain, visit www.mysliveswithpain.co.uk
oral morphine
my Lives Well with Pain


Opioid Drug Side Effects
Stanford HEALTH CARE
STANFORD MEDICINE
Opioid medications are useful and appropriate after injuries and surgeries for brief time periods. When used long-term, they cause many side effects. For this reason, Comprehensive Pain Medicine does not include on-going opioid therapy.
Cognitive Dysfunction
Sleep Disorders
Drowsiness
Physical Dependence & Tolerance
Dry Mouth & Tooth Decay
Opioid Induced Hyperalgesia
Accidental Overdose & Death
Breathing & Heart Problems
Constipation & vel Dysfunction
ex Hormones
Risk of Fracture
every day
44
people in the U.S.
die from
overdose of prescription painkillers
and many more become
addicted
Centers for Disease Control and Prevention
© 2016 Ming-Chih Kao, PhD, MD


Life after opioids – new film
Louise's story will inspire your patients to explore self management alternatives to opioids
Find out more

When to stress the need to deprescribe….

Size of the Problem: Pregabalin

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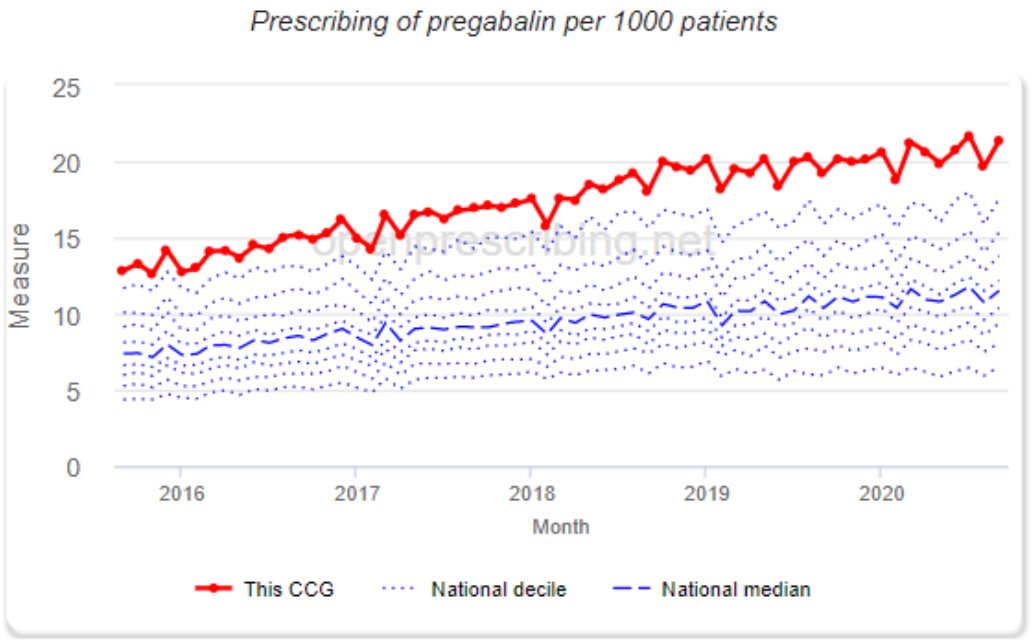
Prescribing of pregabalin



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Prescribing Pregabalin and Gabapentin:

WHY?

Systematic review of the evidence was limited for efficacy in conditions such as lower back and radicular pain (Enke et al 2018)

Around 50% of patients using Gabapentin or other neuropathics for conditions such as Fibromyalgia show no significant reduction in pain (Moore et all, 2014)

SIDE EFFECTS:

Majority of patients taking Gabapentinoids will experience at least one of the following side effects:

Weight gain
Foggy Head (poor concentration, forgetfulness)
Sedation

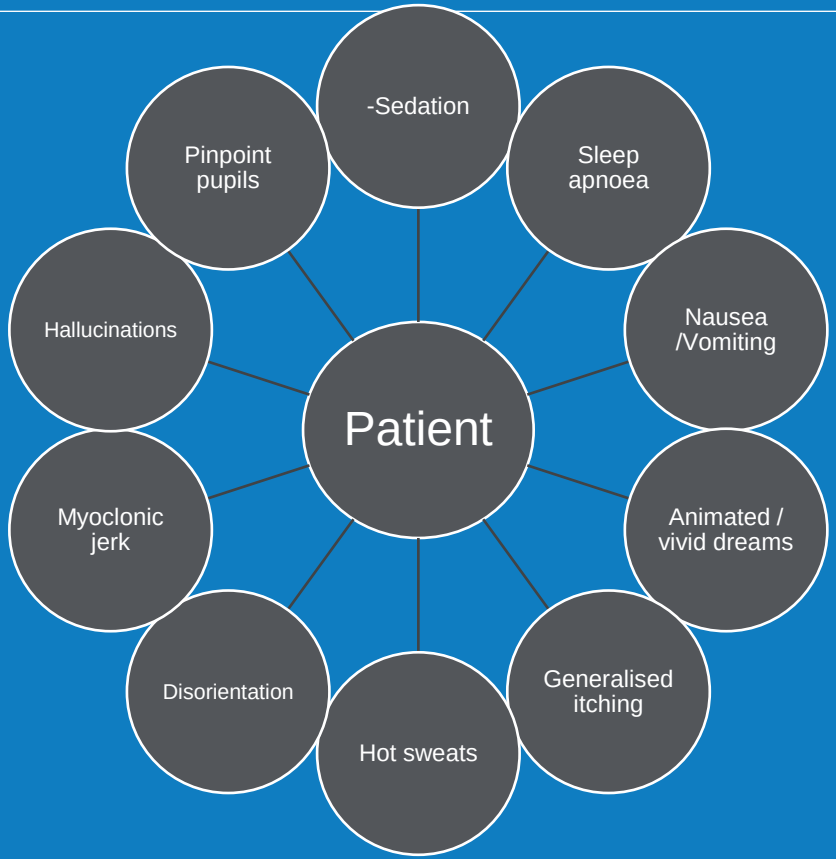
These side effects often outweigh any reduction in pain perceived

Opioid Induced Hyperalgaesia

POLL

Opioid Induced Hyperalgaesia

- High pain score
- Sensitivity to mvt
- Opioid Toxicity



Public Helalth England reports

Public Health England

Research and analysis

Prescribed medicines review: summary

Updated 10 September 2019

Contents

Print this page

1. Introduction

Public Health England

In 2017, the minister for public health and primary care commissioned Public Health England (PHE) to identify the scale, distribution and causes of prescription drug dependence, and what might be done to address it.

The review covered adults (aged 18 and over) and 5 clas

- benzodiazepines (mostly prescribed for anxiety)
- z-drugs (sleeping tablets with effects similar to benzo

Public Health England

Prescription Medicines Review:
Prescribing rates for each medicine class

Medicine class	Numbers receiving prescription for at least 3 years continuously up to March 2018
Antidepressants	930,000
Opioid pain medicines (excluding for cancer pain)	540,000
Gabapentinoids	160,000
Benzodiazepines	120,000
Z-drugs	100,000

Case Study Mr M

39yr old Male

Medication: on assessment

- Pregabalin 50mgs twice a day. The patient has reduced doses
- Tramadol (50mgs), 100mgs for times a day (equivalent of 40-50mgs a day Morphine) - gives most relief
- Zapain 30/500, 4 a day on average 120mgs Codeine, (equivalent of 12-15mgs Morphine)
- Paracetamol 4 tablets a day
- Zomorph 30mgs one twice a day (60mgs a day of Morphine)
- Ibuprofen was stopped a few month
- Fibrogel as needed averages once a day. Bowels open alternate day with hard stool

Case Study Ms T (32yr old female)

Medication - Restarted pain meds 4 weeks ago

- Took Dihydrocodeine During pregnancy - Breast fed for 8 weeks, Bottle feeding now
- Insulin
- Codeine 30mgs averaging 6 a day - used to help but not now 180mgs - 4mgs morphine
- Paracetamol 2 three times
- Tramadol 50mgs average 2 a day - causes drowsiness 10-15mgs morphine -
- Pregabalin 25mgs one at night
- Sumatriptan nasal spray - for migraines at least one a week
- Cyclizine 50mgs two twice - feels sick permanently. No help to wean and stop
- Brufen 10% gel - helps for 10mins knees, wrists and shoulder consider stopping
- Laxatives none - bowels open every 3 days
- Citalopram 40mgs at night
- Naproxen Occasional 250mgs ad hoc with omeprazole
- Multi vitamin
- Vitamin D
- CBD oil - helps
- Zopiclone not started. Advised not to start

Case Study Ms T Follow up Progress

Medication update June

- Tramadol stopped with her last dose 3-4 weeks ago, she continues on Codeine but lower dose and is using dissolvable paracetamol which she feels helps
- Brufen gel stopped as the non-medicated OTC Biofreeze gel better
- Cyclizine stopped 3-4 weeks ago
- Vitamin D continues

Progress

[redacted] feels more awake alert less drowsy

Pain is better, sleeping has significantly improved, using mindfulness, using less codeine

Pain was scoring approx. as 7-8/10, now currently average 5-6/10 this being a 25% drop pain and with the reduction and discontinuation of some pain medications

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Patient Story

FLIPPIN PAIN
Engage | Educate | Empower

Pain: I Get It - Fen's Story

Fen, from Lincoln, explains how understanding her pain helped her become a Pain Survivor.

Gaining an understanding of persistent pain can be a long and difficult journey.
Life with persistent pain for me used to be one of anger and depression. It seemed so unfair. And annoyingly, there wasn't a great big gaping wound for everyone to see how much I was hurting. People would tell me that I looked well, but this only caused me to question my sanity. I felt people didn't believe that I really was in that much pain.

I felt I had to justify everything I did, especially on those rare 'good days' when I had just a little less pain and a bit more energy. I felt guilty if I'd managed to hang the washing out or do some gardening because 'surely I couldn't be that bad if I could do that'.

Being in constant pain was a lonely experience.
Even though I was surrounded by loved ones I still felt alone and helpless. I began to isolate myself because everything was such a massive effort. It was just me and my pain - no one else understood.

I felt I had nothing to say so didn't see the point in going to family occasions, planning a holiday, enjoying my hobbies or even talking to anyone; I was only my pain after all. No one wanted to hear me whingeing about how much I hurt all the time, how many tablets I had to take or the nasty side effects they caused.

It didn't take long before I truly became a victim of my pain, staying in my pyjamas all day, lying on the sofa, staring at the ceiling and feeling sorry for myself.

I became a bystander in my own life; a miserable shadow of my former self. The pain had stolen my identity, my purpose, my enthusiasm, my job and my joy. I existed like this for years and sometimes I slip back into this 'pain victim' mode.

I now consider myself a pain survivor.
I cannot accurately pinpoint when I decided I no longer wanted to be a victim of my pain but I'd decided what I *didn't* want to do:

I didn't want to join in with others in the pain clinic waiting room who appeared to be having a verbal competition as to who was in the most pain and on the strongest opioids.

I didn't want to have another 17 injections of Kenalog across my trapezius muscles every six months because the 'relief' only lasted 3 weeks and didn't really help. I didn't want the Lidocaine infusions that made my legs feel leaden.

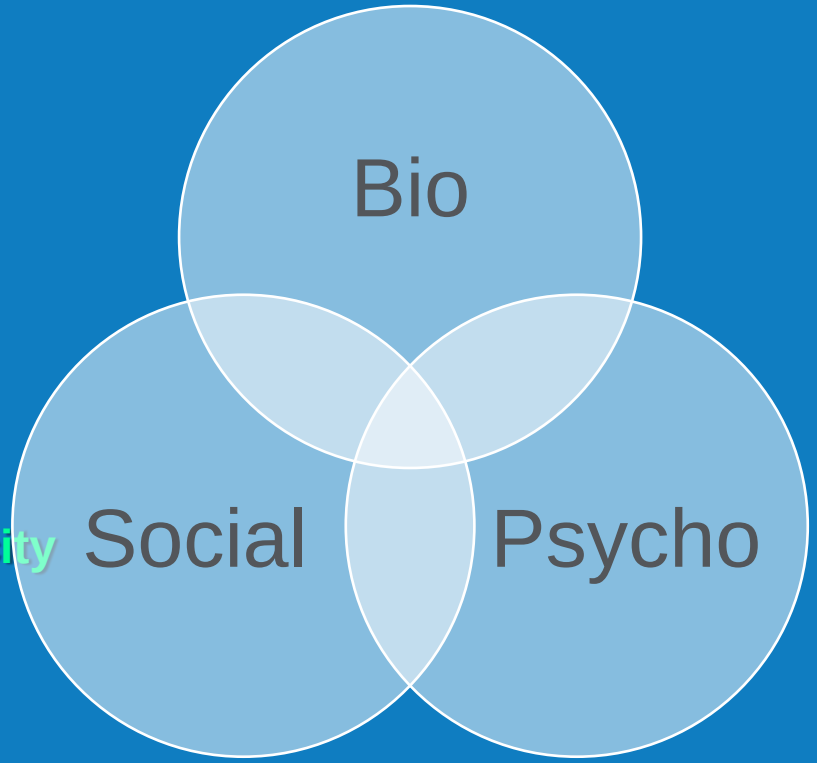
I didn't want to feel like an opioid zombie; permanently in a brain fog and having difficulty articulating even the simplest of sentences. I didn't want to be told by the pain specialist that because I was not responding to their drug/infusion/injection programme I was being discharged. I didn't want to try another course of anti-depressants because they didn't solve the pain.

I didn't want to be pitied by friends or condescended to by clinicians. I didn't want to spend another year on the sofa, looking out at a tree and watching the seasons change.

I didn't want to feel like an opioid zombie; permanently in a brain fog and having difficulty articulating even the simplest of sentences. I didn't want to be told by the pain specialist that because I was not responding to their drug/ infusion/injection programme I was being discharged. I didn't want to try another course of anti-depressants because they didn't solve the pain.

How to address the challenges - fill the opioid gap

- Deconditioning
- Mood:
- Over reliance on meds
- Drugs & Opioid toxicity
- Opioid Induced Hyperalgesia
- No self management strategies
- Constipation / Dehydration / caffeine toxicity
- Diet
- Poor coping
- Acceptance / expectations



Inviting Patients to review their Meds

Dear <PATIENT>

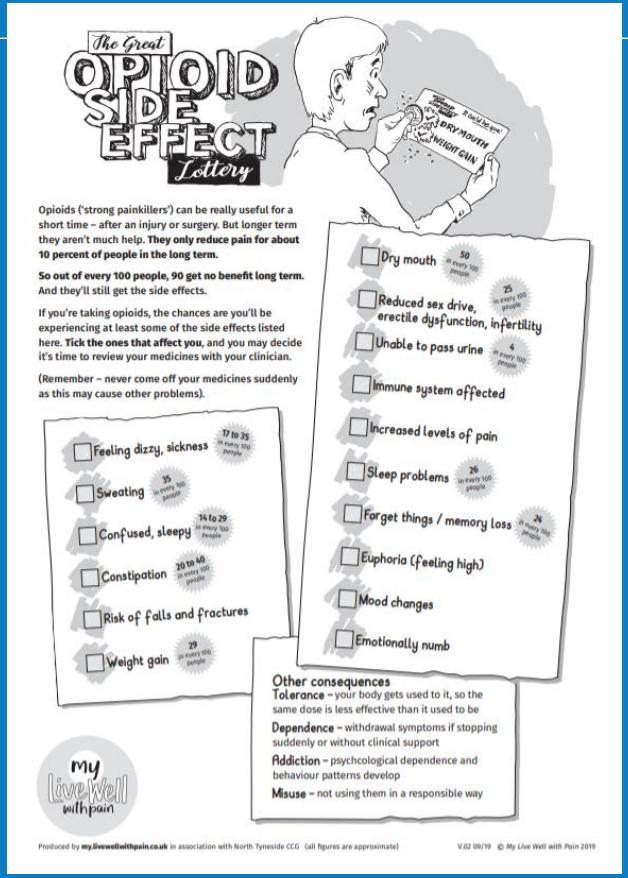
We are currently looking to offer patients with long term pain an opportunity to look at how they are doing at present and to offer extra help and support to manage their pain in a safe and effective way.

We would like to invite you have a dedicated appointment to review your pain, medication and any problems you may be encountering. We have found having done this recently many patients have been having side effects with medicines that have affected their quality of life and some medicines haven't helped their pain so well.

As a starting point we wondered you could complete the enclosed questionnaire which detail some of the current side effects and problems people report with their pain medications. Some problems associated with pain medications have caused problems with nausea, constipation or feeling very sleepy, some people have also reported problems with their breathing too.

We can then discuss this in clinic in more detail including any concerns or queries you may have.

We hope that this appointment will be help and support you.



Initiating the conversation

Reassure

- Best interests
- Safety is a priority
- Shared decision making will be used

Be curious

- Avoid making assumptions
- Ask about side effects
- Explore what the patient is looking for from you

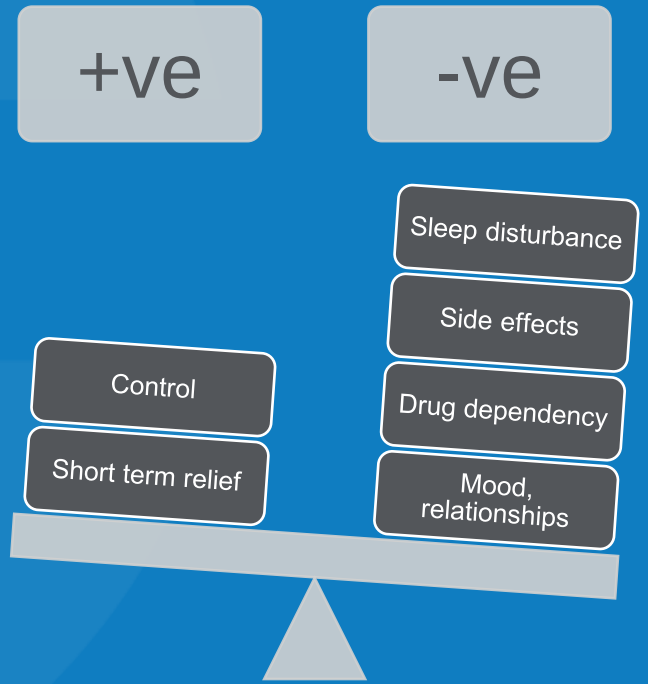
Present options

- Signpost to resources
- Counsel on risks of long-term use
- Encourage patient to consider being open to reducing in future

Tips to support Deprescribing

- Build trust
- Acknowledge this may take time
- Emphasise the long term health benefits
- Signposting

Calculating the individual level of Risk



Key Take Home Messages

1) Prescribe Less
2) Improve Wellbeing

Useful Websites

- https://www.britishpainsociety.org/
- https://fpm.ac.uk/opioids-aware
- https://www.paintoolkit.org/
- https://livewellwithpain.co.uk/
- https://www.gov.uk/drug-driving-law
- http://www.lifehappens-mindfulness.com/book-audio/
- https://britishsnoring.co.uk/sleep_apnoea/epworth_sleepiness_scale.php
- https://www.fl-exercise.com
- https://www.gov.uk/government/publications/prescribed-medicines-review-report
- https://www.youtube.com/watch?v=RWMKucuejIs
- ‘how to manage pain in less than 5 mins’

References / Resources

1. https://livewellwithpain.co.uk/
2. https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
3. https://www.fpm.ac.uk/opioids-aware/structured-approach-opioid-prescribing
4. https://www.ouh.nhs.uk/services/referrals/pain/opioids-chronic-pain.aspx
5. https://www.ouh.nhs.uk/services/referrals/pain/documents/opioid-calculator.xlsx
6. Fayaz A, Croft P, Langford RM, et al. Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies. BMJ Open 2016;6:e010364. doi:10.1136/ https://bmjopen.bmj.com/content/6/6/e010364#
7. https://www.flippinpain.co.uk/
8. https://openprescribing.net/

Thank you for your attention and participation!

Questions?