GUIDELINE – CHRONIC PAIN & OPIOD DEPENDANT PATIENT + ORAL EQUIPOTENT CONVERSION GUIDE

Objectives

- To provide safe and effective perioperative analgesia for the opioid tolerant patient, including avoidance of opioid withdrawal and aberrant opioid behaviours.
- To use the peri-operative period as an opportunity for patient education aiming to:
  - improve patient and/or carer knowledge of post-surgical and chronic pain.
  - guide patient expectations regarding post operative analgesic strategies and treatment duration.
  - encourage a broad approach to pain management including opioid reduction/cessation where appropriate.

Guidelines

1. For a planned procedure in **less than two months** the standard recommendation is to continue the existing opioid regimen. Where doses are greater than 120 mg/day of morphine (80 mg/day of oxycodone) recognize that this is likely inappropriate therapy for non-cancer pain, and will require the use of specific strategies (see below). Consideration should be given to opioid rotation/reduction/cessation in the postoperative period either during hospital stay or via patient's GP. there are concerns about lack of efficacy or adverse effects then consider discussion with the usual prescriber. Very rarely there may be a need to delay surgery to optimise pain management strategies.

2. For a planned procedure in **greater than 2 months**, consider using the waiting time to optimise pain management strategies. This may include opioid reduction or rotation, the development of a broader approach incorporating physical activity, improved nutrition and community psychological support. Local outpatient clinic referral can be considered.

3. **Specific Medications.**

- ***Buprenorphine***. Buprenorphine is a partial Mu receptor agonist. However at the relatively low doses used clinically with the transdermal route there is no significant Mu antagonist effect and the drug can be continued throughout the perioperative period. In contrast high dose (sublingual) buprenorphine has a significant Mu receptor partial agonist effect and will impact on perioperative analgesic management. Additional pure Mu receptor agonists can be used but will be less effective in the presence of high dose sublingual buprenorphine. There is a need to optimise non-opioid analgesic strategies. Any proposed change in the sublingual buprenorphine regime should be discussed with the regular prescriber.
- ***Methadone***. May be continued throughout the perioperative period. Consider dividing the daily dose in two and administering twice daily following discussion with the patient, Drug and Alcohol team and/or Pain Team.
- **Slow release opioids** greater than 120 mg daily oral morphine equivalent can be expected to significantly impact on peri-operative pain management strategies. See opioid conversion chart. Consider perioperative analgesic management strategies for the opioid tolerant patient.

4. **Implanted pain management devices.**

The perioperative management of devices providing Intrathecal drug therapy and spinal cord stimulation should be discussed with the prescriber or implanter of the device. The standard recommendation is to continue intrathecal therapy throughout the perioperative period.

5. **Perioperative Analgesic Management Strategies for the Opioid Tolerant Patient.**

Optimise peri-operative analgesic management as stated above.

Pharmacological strategies.

- Pre-emptive analgesia (gabapentin, parecoxib, dexamethasone).
- Regional anaesthesia/analgesia where appropriate.
- Anticipate opioid withdrawal if regular opioid medications ceased perioperatively.
- Utilise multimodal analgesia. Where preoperative opioid doses are >120 mg morphine equivalents/day and regional analgesia cannot be used, expect to use ketamine by infusion in the immediate perioperative period and consider the parenteral use of other non-opioid analgesics as appropriate.
- Suggest PCA titration of opioid medications. Patient may require 2 to 3 time expected opioid dose.

Consider Acute Pain Team referral (where available).

Non-pharmacological strategies may be useful for selected cases

- Physiotherapy
- Psychological
- Nutritionist
- Social worker
- Music/Play therapist

6. **Education of patient/carer**

- See Hunter Integrated Pain Service website www.hnehealth.nsw.gov.au

7. **Referral to Drug and Alcohol Services**.

For patient under the Drug and Alcohol Team or if patient requires Drug and Alcohol referral please see Drug and Alcohol Referral flow chart. Drug and Alcohol Services (DACS) central intake number is 49232060. DACS will provide rapid response for elective procedural patients to facilitate safe de-toxification. This is a self-referral service that can be initiated at first point of contact.

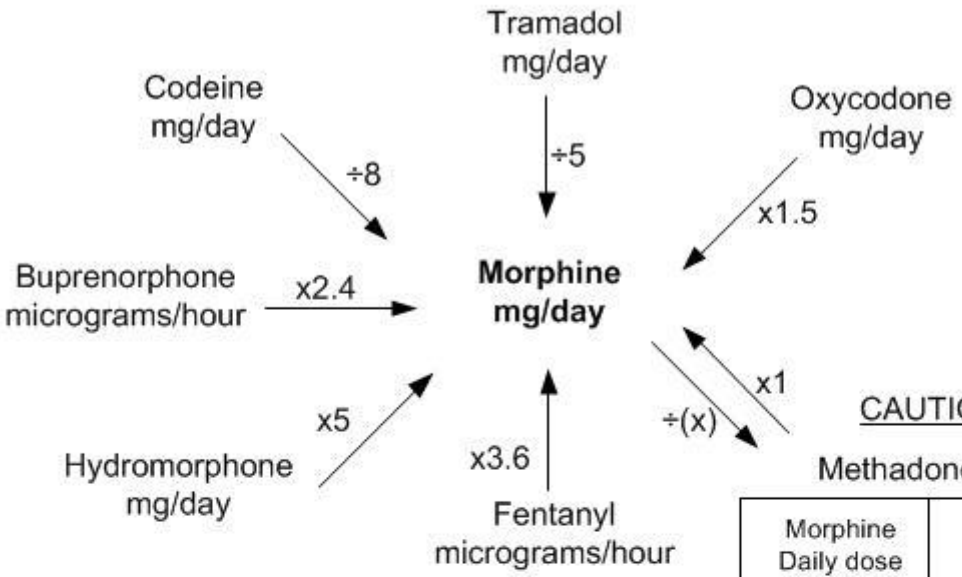
Opioid Equivalence.

This is a controversial subject. Recognise that cross–tolerance is incomplete: see attached tool.

REFER TO Oral Equipotent Conversion Guide

Oral Equipotent Conversion Guide

1. Oral opioid → Morphine oral dose per 24 hour



Morphine Daily dose	(x)
≤100	3
100-300	5
300-600	10
600-800	12
800-1000	15
>1000	20

2. Oral opioid long term patient rotation to 50% equipotent opioid dose ie. ½ morphine daily dose

3. For oral to I.V / S.C. / I.M. →

Hydromorphine	4 : 1
Morphine	3 : 1
Methadone	2 : 1
Oxycodone	2 : 1
Tramadol	1 : 1

References

Macintyre PE, Schug SA, Scott DA, Visser EJ, Walker SM; APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine (2010), Acute Pain Management: Scientific Evidence (3rd edition), ANZCA & FPM, Melbourne.