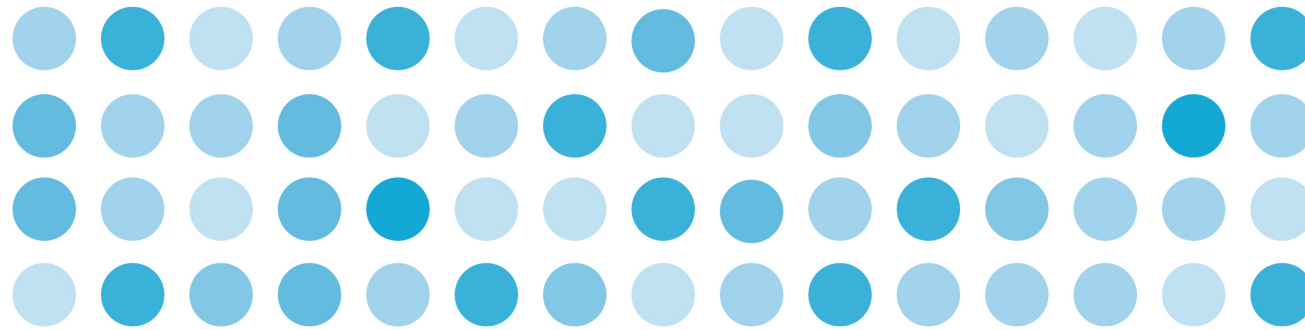


25-26 October 2010  
Melbourne Cricket Ground



Anex 2010

# AUSTRALIAN DRUGS CONFERENCE

Public Health and Harm Reduction

## Dr Benny Monheit



Principal Sponsor



Sponsor



# Guidelines for prescribing highly dependent pharmaceuticals

Benny Monheit

Southcity Clinic & Alfred Hospital

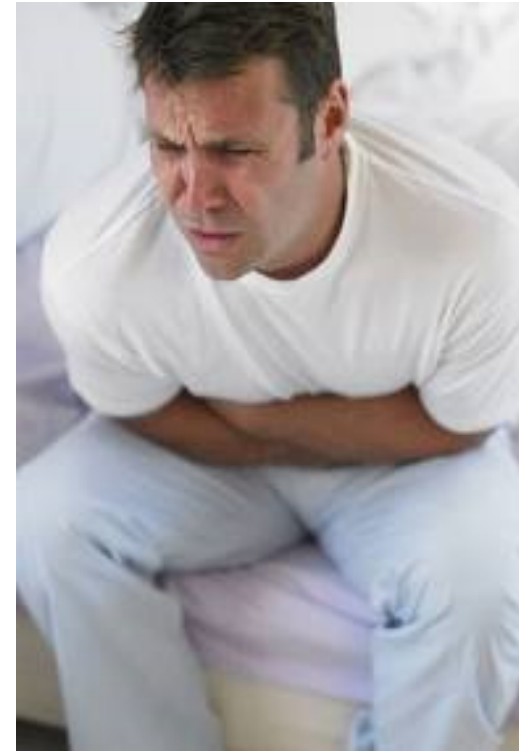
Anex Conference 2010

# Guidelines

- Many guidelines for pain management have been developed by different expert groups
- A small group of chronic pain patients abuse their opioid medications
- Guidelines struggle to strike a balance between good access and no access to opioids (other than methadone) for patients with a history of addiction.

# `Robert`

- Aged 33
- Heroin use in his 20s – was on methadone program for 1 year
- Acute pancreatitis – 2 years ago
- Chronic pancreatitis – 3 hospital admissions for pain control. Overused his MS Contin. Treated with oxycontin, gabapentin, in hospital
- On discharge - ? Pain management plan re opioids



# Pain treatment audit

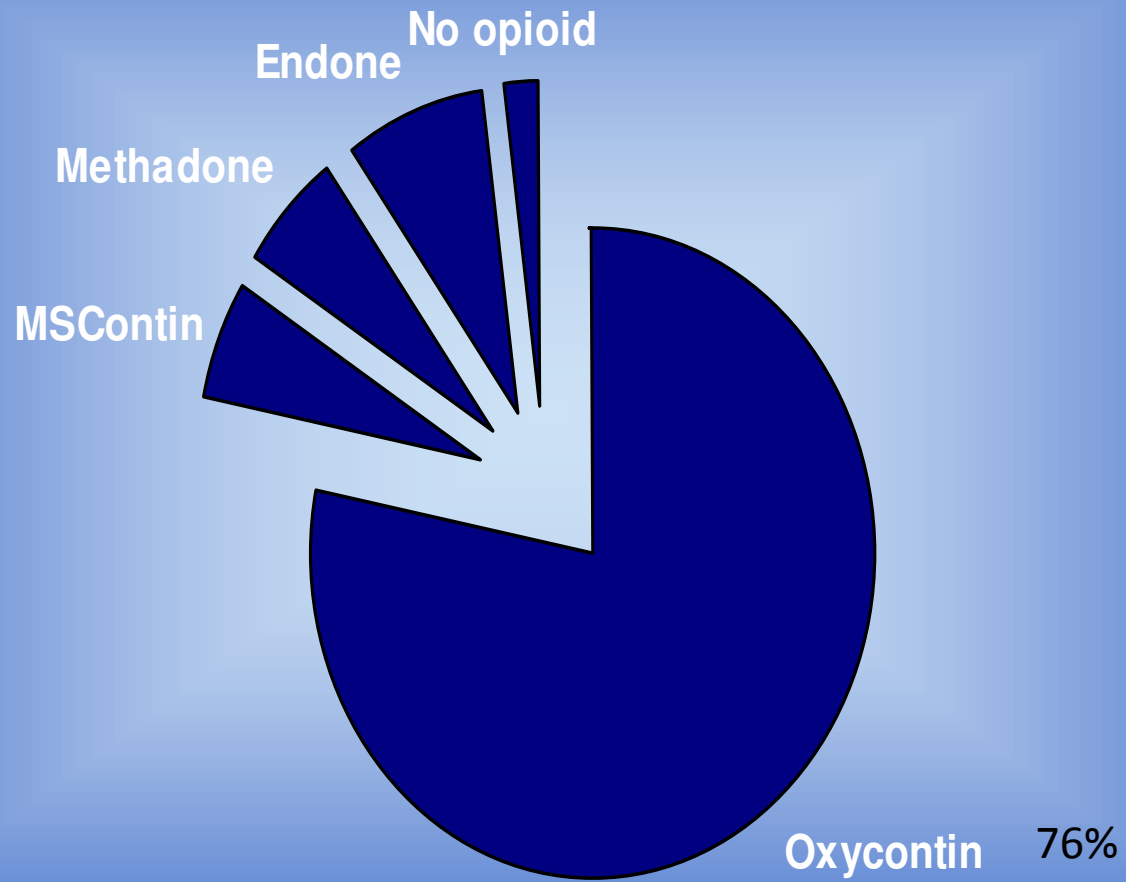
Retrospective audit over 6 months in 2009 at Alfred  
Hospital

58 patients referred to Alfred's Acute Pain Service  
for post operative analgesia

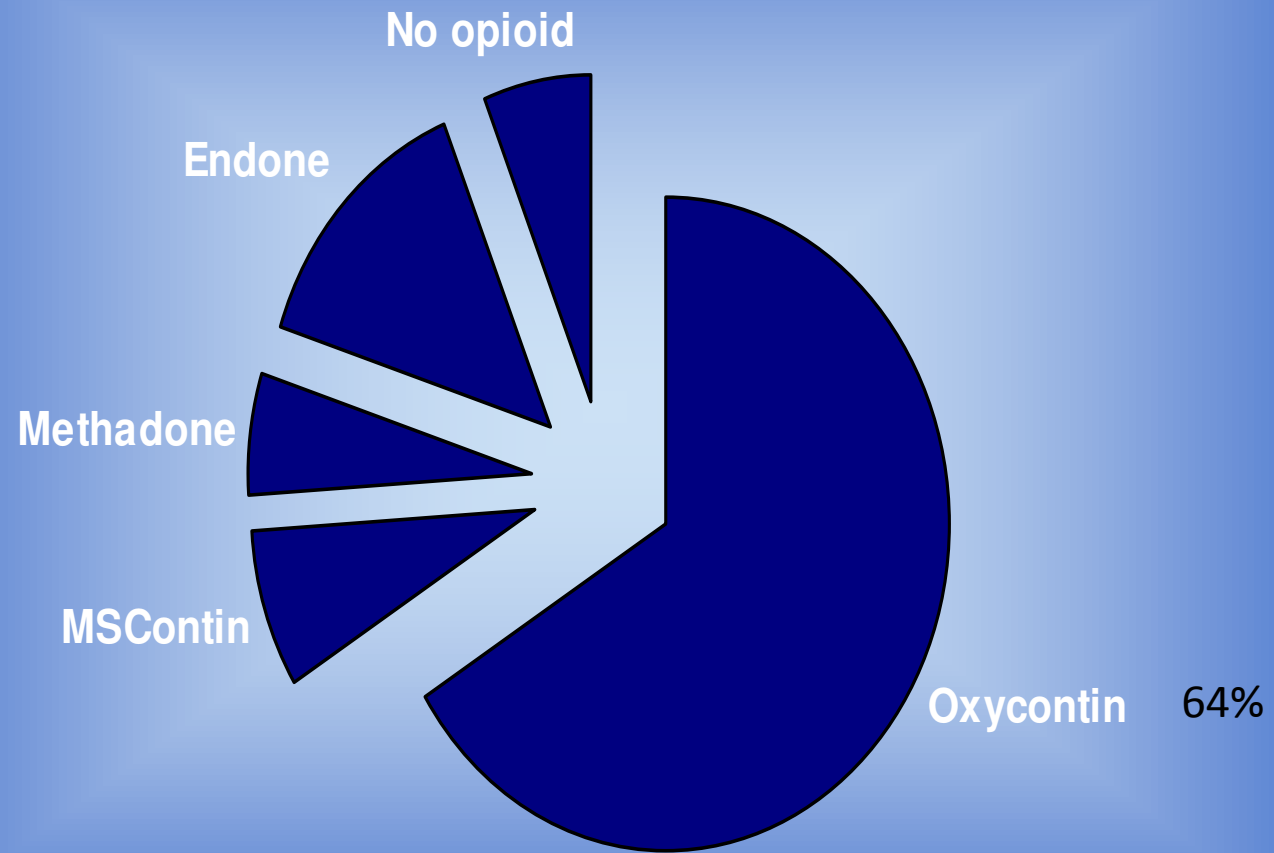
Data from medical files and Pharmacy database

Report by Dr Kerry Thompson , Anaesthetics Dept, Alfred Hospital

# Opioid on discharge from APS



# Opioid on hospital discharge



# Opioid hospital discharge plans

## Aims

Wean opioids prior to discharge if possible

Discharge on opioids of low abuse potential

Daily/weekly pick ups of meds

Clear opioid weaning plan conveyed to GP

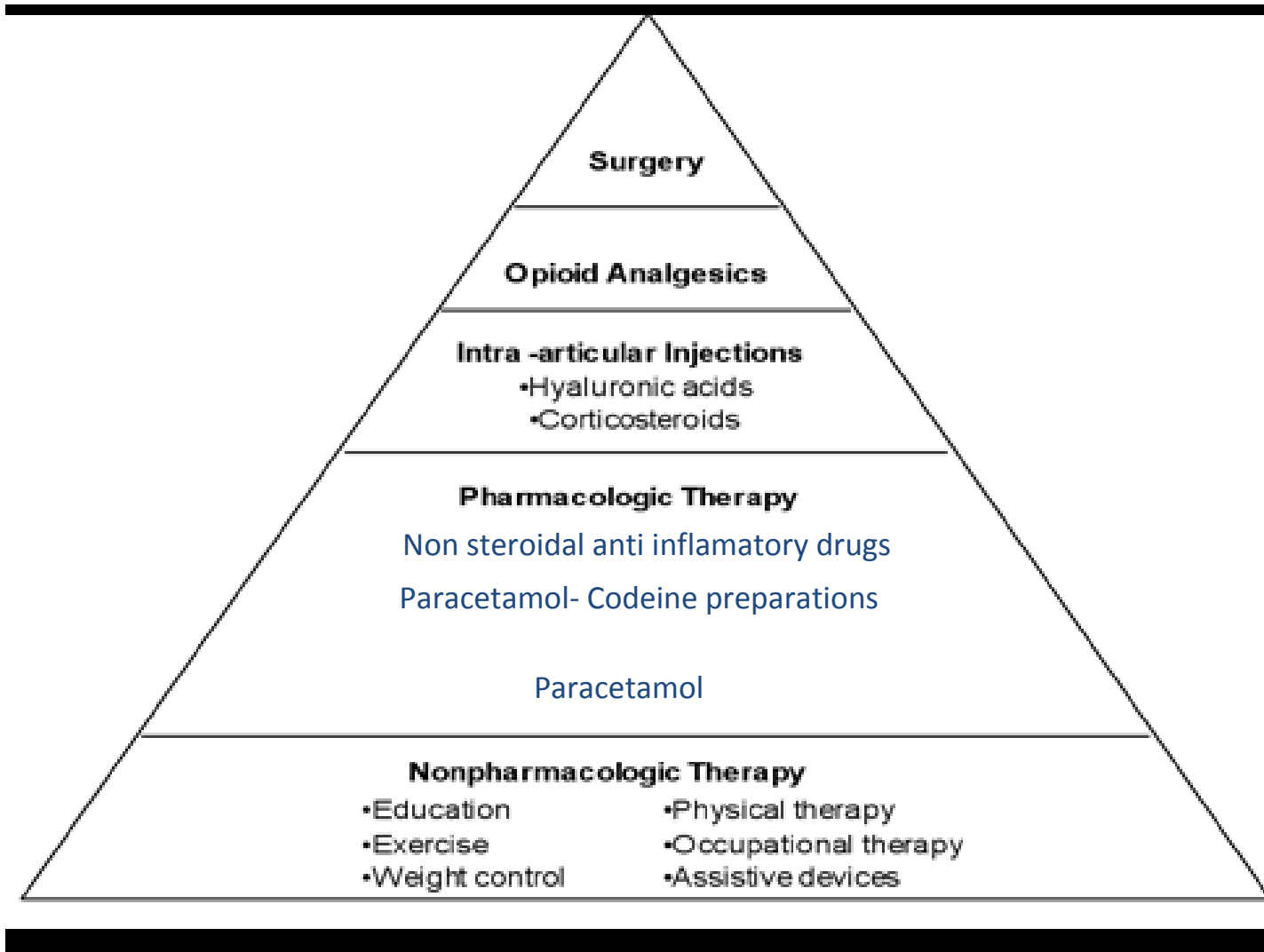
# Why do Drs prescribe opioids longterm?



# Why do Drs prescribe oxycontin?

- Start in hospital – it's a very effective analgesic
  - Biphasic action: quick relief and prolonged analgesia
- Other drugs becoming less popular
- Effective marketing by drug company
- Professional education has not kept up
- Contradictory messages re use of opioids in CNMP.
- Patients becoming more aware and demanding stronger pain relief

# Pain Management Pyramid for osteoarthritis





**Australian Government**  


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 Department of Health and Ageing  
 Therapeutic Goods Administration

**Vioxx (Rofecoxib)**  
**Medicine recall**

<b>Level:</b>	Consumer	<b>Class:</b>	II
<b>Reference:</b>	R2004/1226-9	<b>Date:</b>	1 October 2004
<b>Product:</b>	VIOXX (Rofecoxib) tablets 12.5mg (AUST R 69872) VIOXX (Rofecoxib) tablets 25mg (AUST R 69871) VIOXX (Rofecoxib) oral suspension 12.5mg/5mL (AUST R 69870) VIOXX (Rofecoxib) oral suspension 25mg/5mL (AUST R 69869)		

Australian Dr 8/10/2010

# Codeine should be phased out: experts

CODEINE is more trouble than it's worth as an analgesic and should be phased out and replaced with morphine, experts say.

Codeine had poor analgesic properties and was unpredictable, editorialists reported in the *CMAJ* (4 October), noting it was a pro-drug whose analgesic effects were almost entirely attributed to its metabolite morphine.

"That's the problem — the pharmacokinetics of codeine are unpredictable," they said.

"Because codeine has been in common use for over 200 years, it was never subjected to the regulatory requirement for the rigorous safety studies that are now mandatory for new drugs."

In addition, there was a general

perception that the drug was safe, yet emerging evidence showed it could cause serious clinical consequences as there were many genetic factors that could influence its rate of metabolism, they said.

For example, it could result in toxic levels of morphine in children and cause respiratory depression in adults, they said.

The potential risk associated with codeine must be mitigated, they said, noting that restricted access for infants and young children might be warranted.

"[However], perhaps a more direct approach is now needed: to stop using the prodrug codeine altogether and instead use its active metabolite, morphine," they said.

Dr Bruce Rounsefell, director of the

pain management unit at Royal Adelaide Hospital, agreed with the editorial, saying codeine should be phased out entirely.

"We would be better off without it," he said, noting that tramadol and morphine were other options.

"These are more predictable analgesics [with] fewer adverse events when given in regulated doses," he said.

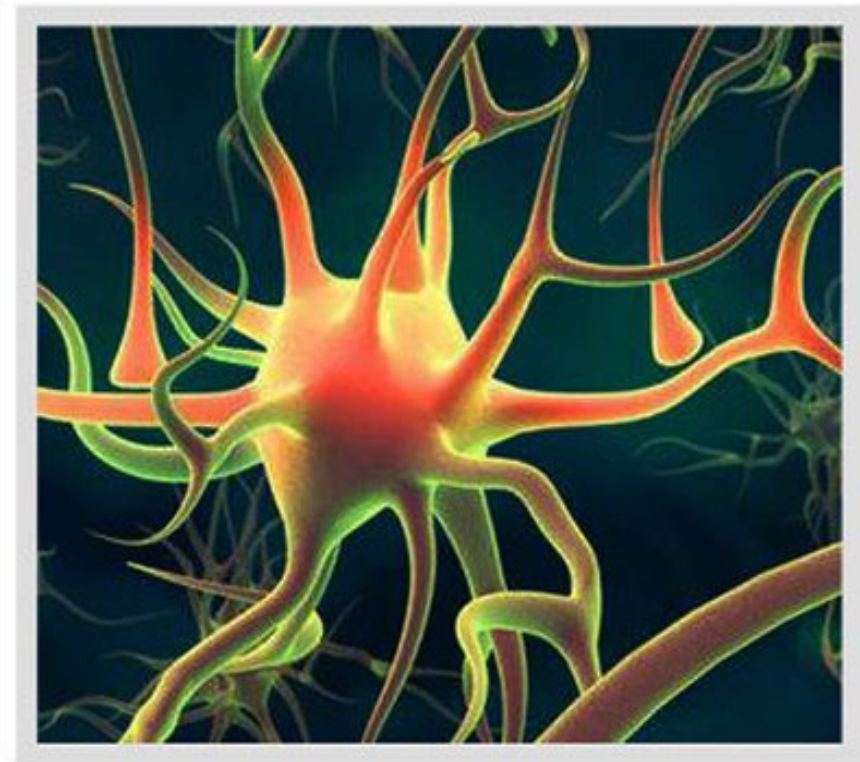
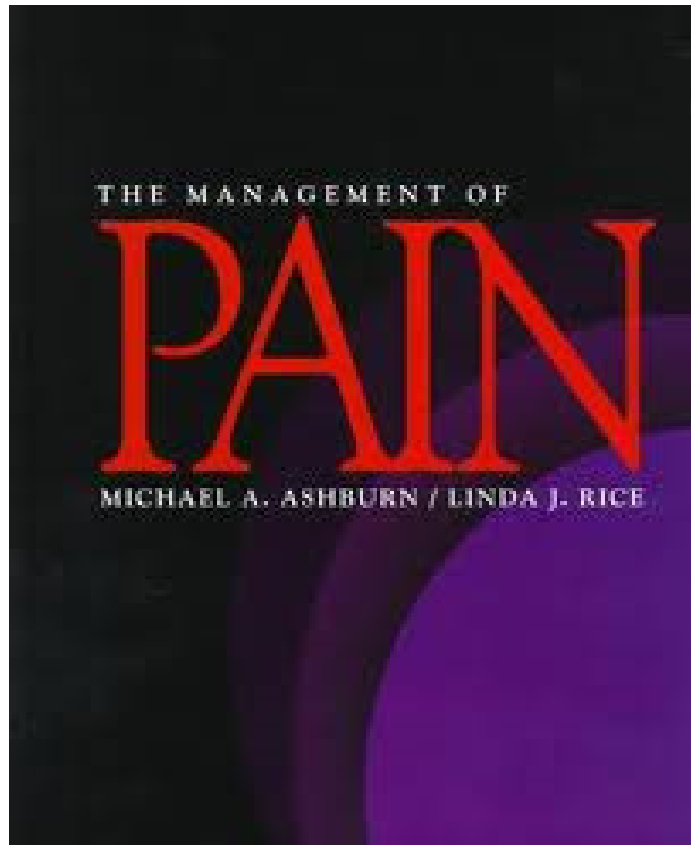
It was more logical to use specific doses of major analgesic metabolites, such as morphine, he said, noting it was a purer analgesic that was easier to control.

However, widespread use of morphine would need to be carefully regulated by the Therapeutic Goods Administration, he said.

**Louise Wallace**

*CMAJ* 2010; online.

# Modern Pain Management



# Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain 2010

- Patients deserve to have their chronic pain treated. Opioids can be a useful and appropriate treatment option. Harms associated with opioid use can be reduced when:
- Drugs are prescribed and monitored with knowledge of the patient's history and risks,
- Patients understand potential benefits and harms and participate in reducing harms, and
- Clinicians assess outcomes for both effectiveness and harms.

# Strategies for preventing prescription drug misuse

- Develop a policy for your clinic on requests from new patients for drugs of addiction
- Share the responsibility of care – use other health workers eg psychologist, physio, chronic pain clinic.
- Be aware of legislation : permits,
  - 2<sup>nd</sup> opinion, consult with a peer or DACAS

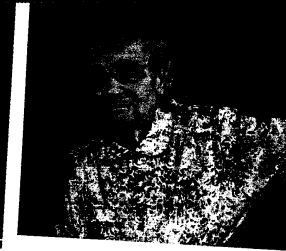
# Universal Precautions in Pain Management

- Regard all chronic pain patients as potentially getting dependent on their opioids
- Screen for past history of drug abuse, aberrant behaviour, mental health problems
- Explain roles of opioids carefully
- Aim to discharge from opioids after acute pain episodes as quickly as possible
- Multi disciplinary team if on maintenance  $\bar{R}$
- Consider long acting opioids, methadone

# Pharmaceutical Company Advertising



# How would you manage Pearl's pain?



Pearl, 74

**History:** • Chronic lumbar back pain  
• Neuropathic leg pain interfering with sleep

**Management:** • Tramadol SR 150mg bd  
• Gabapentin 300mg tds

**Presentation:** • Moderate neuropathic leg pain despite  
maximum tolerated dose of gabapentin

## Considerations:

- The pain is having a significant impact on Pearl's quality of life.
- Conservative methods of analgesia have been tried and have failed.
- A full biopsychosocial assessment has been undertaken and there are no:
  - psychological contraindications
  - drug-seeking behaviour
  - history of drug or alcohol abuse

**Option:** commence treatment with a low-dose opioid

**OXYCONTIN®**  
Controlled-release oxycodone hydrochloride tablets

# Treatment plan

## ➔ **After discussion:**

- ▶ Tramadol ceased, gabapentin maintained at existing dose
- ▶ *OxyContin*<sup>®</sup> tablets initiated at 5mg q12h<sup>2</sup>\*
- ▶ Gentle exercises and relaxation strategies recommended

## ➔ **Follow up 10 days later:**

- ▶ Back and neuropathic leg pain improved
- ▶ Sleep still mildly disturbed by neuropathic leg pain

## ➔ **Management:**

- ▶ Gabapentin maintained at existing dose
- ▶ *OxyContin*<sup>®</sup> tablets titrated to 5mg mane and 10mg nocte<sup>2</sup>

## ➔ **Follow up 10 days later:**

- ▶ Pain settled, improved sleep and activities of daily living

\*As part of a multimodal pain management program that should also include, for example, physiotherapy, exercise, psychosocial assessment, coping strategies, etc.

# Judy

- 36 year old separated woman
- In 2007 acute back pain . CT and MRI changes at S1.
- No PH of drug use except ecstasy
- Commenced on oxycontin – prescription shopper. Depressed
- Arrived from Queensland – In severe pain.
- On MS Contin, oxynorm – overusing it, looks drug affected

