Prescribing Update

NHS Lancashire and South Cumbria Integrated Care Board

Medicines Matters

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Avoiding Concurrent Prescription of Weak and Strong Opioids in Short Term Pain Management

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. A small proportion of people may obtain good pain relief with low dose opioids for short term use. Opioids are classified as weak (e.g. codeine, dihydrocodeine, tramadol) or strong (e.g. buprenorphine, morphine, oxycodone, fentanyl). When a patient's pain is not adequately controlled with a weak opioid, best practice is to switch to a strong opioid for short term, not add one to the other. If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped[1], even if no other treatment is available.

Prescribing both a weak and a strong opioid together offers no therapeutic advantage and poses significant clinical risk. It is therefore advised that weak opioids should be discontinued when initiating a strong opioid for acute pain

Do Not Co-prescribe Weak and Strong Opioids

- The concurrent use of weak and strong opioids is not recommended
- **"If a person is already taking a weak opioid and this is not effective, consider switching to a low dose of a strong opioid rather than adding the two together."** [2]

Risks of Combining Weak and Strong Opioids

- No enhanced analgesic benefit: Weak opioids have a ceiling effect; adding a strong opioid does not increase efficacy.
- Increased risk of harm: Including sedation, nausea, constipation, respiratory depression, and confusion.
- Complex titration: Managing two opioids complicates dose adjustments and monitoring.
- Polypharmacy: Increases risk of interactions and medication errors.

Best Practice Recommendations for any current combination prescribing

Review the Medication History Thoroughly

- Check if both opioids were intentionally prescribed
    - Confirm current doses, duration, and any history of dose escalations.
- If pain control is suboptimal, assess whether:
    - The weak opioid is providing any added benefit.
    - The strong opioid is being used at an effective and safe dose.
- Look for signs of opioid toxicity:
    - Sedation, confusion, constipation, respiratory depression.
- Assess for functional impairment or signs of dependence.

Deprescribing and Optimisation Strategy

- Discontinue the weak opioid unless there is a compelling reason to retain it.
- Optimise Strong Opioid Dosing if needed for the shortest duration and taper down once pain controlled.
- Consider non-opioid options by adding or optimising paracetamol, NSAIDs (if not contraindicated), adjuvants (e.g. antidepressants or anticonvulsants for neuropathic pain).

The Biopsychosocial Model is a holistic approach for clinicians to understand and address the biological, psychological and social dimensions of pain. Clinicians should therefore consider, the role of physiotherapy, exercise therapy, talking therapy and social prescribing support in the non-pharmacological management of their patient's pain

References

1. Opioids Aware, Faculty of Pain Medicine, Royal College of Anaesthetists. https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
2. NICE NG193: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain. National Institute for Health and Care Excellence, April 2021. https://www.nice.org.uk/guidance/ng193