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NHS Lancashire and South Cumbria Integrated Care Board

MLCSU Clinical

Prescribing Tip For Information

High strength opioid trials in new patients with chronic non-cancer pain

Primary care prescribers should only consider a trial of strong opioid use in **new** patients with chronic non-cancer pain when other therapies have been insufficient e.g. exercise therapy, manual therapy (e.g. physiotherapy, TENS), self-management techniques and non-opioid analgesics (e.g. simple, topical)[1]. The opioid trial establishes whether the patient achieves any reduction in pain with the use of opioids and should only be commenced after completion of a GP-Patient Opioid Agreement Form.

LSCMMG has produced guidance for prescribers to use when assessing a patient's suitability for strong opioid use, which includes advice on how a trial should work. To complement this guidance, LSCMMG has established a position statement on the maximum doses that could then be prescribed in primary care.

Recommendations for prescribers with newly initiated patients

1. **Aim for the lowest effective dose** that will reduce the pain intensity (a 30-50% reduction in pain is a reasonable goal to agree with patients – more substantial pain reductions are rarely an achievable goal, and this should be explained to the patient before initiating a trial).
2. Following the trial, **the opioid must be** reviewed, and it should be **discontinued if there is no response** (even if there are no other treatment options available).
3. If continuing, **the MAXIMUM morphine equivalent dose (MED) prescribed in primary care for new patients should not exceed 80mg** (this maximum dose has been agreed locally at ICB level with pain specialists and consultants to act as safety net/buffer and encourage prescribers to seek specialist advice before escalating doses further).
4. **80mg MED is not a 'target' to aim for**, most new patients should obtain reasonable reductions in pain at doses far below this maximum recommended level.
5. In instances **where clinicians consider a patient may benefit from a dose > 80 mg MED per day,** or where there are rapidly escalating doses (e.g. 10mg MED increasing up to 40mg MED over a period of 8 weeks) **it is strongly recommended that advice and guidance (A&G) should be sought** from our Pain Clinic specialists.

To help prescribers visualise the **80mg MAXIMUM MED** that should not be exceeded in primary care for **newly initiated patients**, the following table has been adapted using opioid equivalencies from the Faculty of Pain Medicine[2] and the BNF[3].

Medication		Dose	Equivalent oral morphine dose per day* (80mg = maximum oral morphine equivalent dose per day recommended by local Pain consultants)
LOW STRENGTH OPIOIDS (showing max licensed dose per day)	Oral **codeine**	**240mg**	**24mg**
	Oral **dihydrocodeine**	**240mg**	**24mg**
	Oral **tramadol**	**400mg**	**40mg**
HIGH STRENGTH OPIOIDS	Oral **hydromorphone**	**16mg**	**80mg**
	Oral **tapentadol**	**200mg**	**80mg**
	Oral **oxycodone**	**50mg**	**75mg**
	Transdermal **buprenorphine**	**30mcg**	**72mg**
	Transdermal **fentanyl**	**25mcg**	**60mg**

*as per Faculty of Pain Medicine / BNF (equivalencies checked Oct-23)

Whilst the above information relates to patients being newly initiated on high strength opioids, it is recognised that due to historical prescribing, practices will have several existing patients **already** prescribed high strength opioids where doses exceed 80mg morphine equivalent. In these cases the following advice would apply:

1. The Faculty of Pain Medicine advises that harms outweigh the benefits when morphine equivalent doses exceed 120mg daily.
2. Patients **already** receiving a morphine equivalent dose exceeding 120mg daily in primary care should be reviewed and a reduction below this harmful level agreed. Seek A&G if required.
3. Patients **already** receiving a morphine equivalent dose between 80mg and 120mg daily in primary care should be regularly reviewed (every 6m). Where there are requests for higher doses **and/or** ineffective pain relief, **further dose increases should not occur**, and A&G should be sought.

1. high-dose-morphine-prescribing-for-chronic-non-cancer-pain-position-statement.pdf (lancsmmg.nhs.uk)
2. Dose equivalents and changing opioids | Faculty of Pain Medicine (fpm.ac.uk)
3. Prescribing in palliative care | Medicines guidance | BNF | NICE