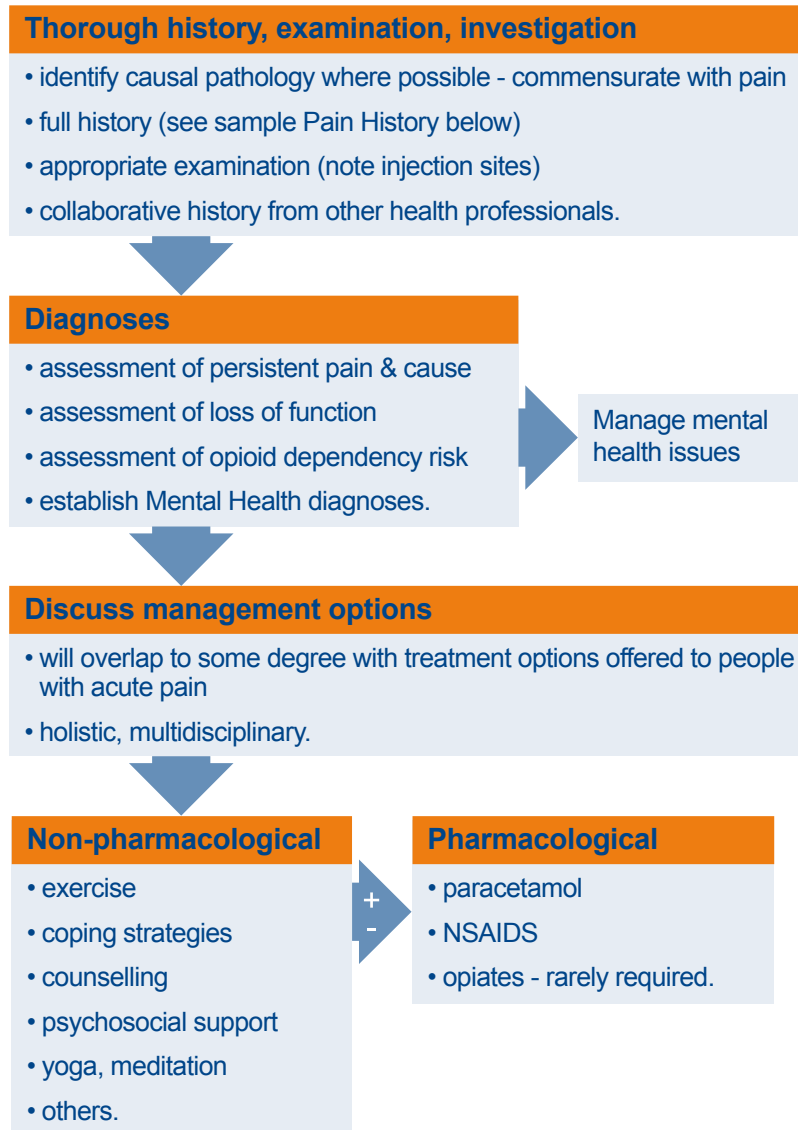


chronic pain management clinical flowchart



Pain History

- **Cause** - mechanism of injury, medical findings, patient beliefs.
- **Description** - location/radiation, intensity, nature, duration/temporal characteristics, aggravating/relieving factors, associated features.
- **Impact** - biological, psychological, social, spiritual.
- **Treatments** - current and past, effectiveness.
- **Medications** - current and past, effectiveness, drawbacks/side effects.
- **Context** - medical history, family experiences including illness, personal development, social supports, education, employment.

Notes

- In the rare instances that opioids are prescribed, they are used in conjunction with other therapeutic modalities, and not as a monotherapy.
- Clients who present requesting specific psychoactive medications (ie. opiates, benzodiazepines) should not be prescribed these unless there are valid medical indications verified by background prescriber checks.
- Opiate dependency is not an indication for the prescription of morphine or any other opiate. Only supervised buprenorphine, suboxone and liquid methadone can be legally prescribed for this purpose.
- Transfer of prescribers for clients with a history of chronic pain managed with opiates should only occur with supporting documentation and collaborative history from previous prescriber.
- Clients with a history of multiple prescribers are at high risk of aberrant behaviour. Clients should receive opiates from one prescriber only and undertake treatment contracts where indicated.
- Important indications for specialist referral (ie. pain clinic, AOD): past history of addiction or abuse; aberrant behaviours (see List B); psychologically unstable patients; young patients with obscure pathology; complex compensable patients.



When opiates are to be trialled:

Opiate Equivalence Table

Opiate equivalence tables are useful when transferring between medications, including the commencement of supervised dosing of methadone or buprenorphine for the management of opiate dependence. The following medications are roughly equivalent over a 24-hour period (based on Therapeutic Guidelines):

- Codeine 240mg
- Morphine 40mg
- Methadone 10-15mg
- Oxycodone 20-30mg
- Buprenorphine 2-4mg

Significant dose escalation above these levels is often only performed after discussion with or review by other medical colleagues.

- Trial of opiates indicated (ie. anticipated functional benefits outweigh adverse effects and risks of dependence)
- Screen for psychological stability
- Mental health issues addressed.

Four - six week trial of opiate analgesia

- One doctor only to prescribe. Short-acting opiates only for short-term use; codeine preferable to morphine; tramadol and buprenorphine may be an alternative to codeine for mild-moderate pain.
- Agree on how to assess outcome of therapy, ie. level of function, goals. (employment)
- Obtain informed consent (see List A).

Goals achieved

Goals not achieved

Client wishes to continue opiates

Client prefers non-opiate treatments

Cease opiates

- Decision to treat with long-term opiates
- Made in conjunction with pain clinic where possible
- One doctor only to prescribe, avoid short-acting and IM preparations
- Informed consent - must address all aspects in List A
- Clearly articulated expectations regarding behaviour and mutual obligations.

Regular review (including screen for aberrant behaviour when opiates are being prescribed. See List B)

**Chronic Pain Management Clinical Flowchart****List A: Essential Features Of Informed Consent**

- Medication side effects, ie. constipation, nausea, sedation, dry mouth/poor dentition, hormonal effects (menstrual irregularities, decreased libido, immunosuppression)
- Establish appropriate treatment goals. Include functional criteria.
- Explain risks of dependence, addiction and withdrawal.
- Acknowledge the lack of proven benefits (pain control, function) of long-term opiate use for non-cancer pain.
- Explain opioid tolerance¹, withdrawal hyperalgesia² and opioid-induced abnormal pain sensitivity³.
- Discuss possible effects on cognition and driving ability. Studies in cancer patients suggest cognitive function may improve with adequate analgesia.
- Risks of overdose, including interaction with other sedatives.
- For women, possibility of physical dependence in newborns (neonatal abstinence syndrome).
- Indications for cessation of treatment with opioids (ie. treatment goals not achieved, behavioural or safety concerns).
- Patient responsibilities regarding security of his or her medication.
- Consequences of aberrant behaviour (see below)

List B: Aberrant Drug-related Behaviour That Is Predictive Of Developing Addiction

Major aberrant behaviour - more predictive	Management options for major aberrant behaviour
<ul style="list-style-type: none">• concurrent abuse of alcohol or illicit drugs• multiple non-sanctioned dose escalations• multiple episodes of prescription loss• injecting oral formulations• repeatedly seeking prescriptions from other physicians or emergency departments without informing the prescriber or after warnings to desist• obtaining prescription drugs from non-medical sources• evidence of deterioration in function at work, in the family, or socially, that appear to be drug-related• repeated resistance to therapy changes despite clear evidence of adverse physical or psychological effects from the drug• selling prescription drugs• prescription forgery• stealing or borrowing drugs from others.	<ul style="list-style-type: none">• wean and cease opioid• notify relevant alcohol and drug authority and consider joint management• consider very frequent (eg. weekly or daily) supply.
Minor aberrant behaviour - less predictive	Management options for minor aberrant behaviour
<ul style="list-style-type: none">• aggressive complaining about the need for more drug• drug hoarding during periods of reduced symptoms• requesting specific drugs• openly acquiring similar drugs from other medical sources• unsanctioned dose escalation• unapproved use of the drug to treat other symptoms.	<ul style="list-style-type: none">• reassess medication, expectations, underlying nociceptive source• consider changing to another drug• reinforce previous discussions concerning restrictions of supply from other sources• consider reducing time interval between supply of medication• consider urine testing.

Reference

This flowchart is intended to be a quick reference for general practitioners and is based on the article:

Graziotti PJ, Goucke CR: *Oral opioids for chronic non cancer pain: management strategies*. Med J Aust 1997; 167: 30-34.

A similar reference, by the same authors, appears on the website of the Australian Pain Society.

1. Opioid tolerance: the need, over time, to increase the opioid dose to maintain the same analgesic effect.

2. Withdrawal hyperalgesia: the experience of rebound pain levels above baseline levels on reduction or cessation of long-term opioids.

3. Opioid-induced abnormal pain sensitivity: includes increased pain from noxious stimuli (hyperalgesia) and pain from previously innocuous stimuli (allodynia), due to upregulation of nociceptors during long-term opioid therapy. Ref: NEJM 349:20(1943-53)



Useful Contacts

Alice Springs

Alcohol and Other Drug Services Central Australia (ADSCA)	
Opiate Pharmacotherapy Program, DHCS	8951 7580
Alice Springs Hospital, DHCS	8951 7777
Central Australian Aboriginal Alcohol Programs Unit	8955 5336
Clinic 34, DHCS (for STI and BBV testing)	8951 7549
Crisis Line.....	1800 019 116

Darwin

Alcohol and Other Drug Services (ADS) Opiate Pharmacotherapy Program, DHCS	8922 8399
Amity Community Services	8981 8030
Banyan House	8947 0832
Clinic 34, DHCS (for STI and BBV testing)	8999 2678
Crisis Line	1800 019 116
Withdrawal Services, DHCS	8948 0087
Medicare Australia	1800 631 181
Northern Rehabilitation Network, DHCS	8922 8866
Northern Territory AIDS and HepC Council	8941 1711
Therapeutic Advice and Information Service (TAIS)	1300 138 677

Alcohol and Drug Information Service (ADIS NT)1800 131 350

ADIS is a 24 hour, 7 days a week telephone counselling, information and referral service for anyone in the Northern Territory wishing to discuss an alcohol or drug related issue. It both supports and complements the network of treatment and support services in the community through the provision of multiple, immediate response to people affected by alcohol and drug issues.

Drug and Alcohol Clinical Advisory Service (DACAS NT)1800 111 092

DACAS is a 24-hour specialist consultancy service designed to assist health and welfare professionals with the clinical management of drug and alcohol problems. The service provides secondary consultation to health professionals by telephone, to enhance the capacity for health professionals to respond in a supported and appropriate way to the variety of clinical scenarios that arise within generalist settings.

Need more information?

Poisons Control
Department of Health and Community Services
Phone: 8922 7341
Fax: 8922 7200

www.health.nt.gov.au