Clinical update no. 531

17 June 2020

Harm from opioid misuse is well known. Most relates to chronic use and prescribing. The role of ED as a cause of this and its role in prevention is less clear. There can be a difficult balance between treating acute pain and ensuring non-opioid options are safe and effective. There is also the role of ED in reducing harm from chronic use.

Opioid-related deaths prompts urgent need for national prescription monitoring

12 May 2020 | Avant Media

https://www.avant.org.au/news/opioid-related-deaths the full link is too long, but when medical defence gets involved then it is a problem.

In Australia, opioids account for about 3 deaths daily and nearly 150 hospitalisations. The majority are unintentional and involved prescription drugs. The TGA has introduced smaller pack sizes, and updated guidance and safety warnings. Notably, fentanyl patches should only be used for cancer related pain, palliative care and exceptional circumstances. Victoria has mandated a SafeScript database to check before prescribing; there has been a 25% reduction in high risk use – see https://www2.health.vic.gov.au/public-health/drugs-and-poisons/safescript/medicines-monitored a separate PBS data base helps identify "doctor shoppers" seeking drugs from multiple sources

Prescription Shopping Programme

The Prescription Shopping Programme (PSP) helps prescribers check a patient's prescribing history and make more informed prescribing decisions for their patient.

Emergency Department

EDs see patients with chronic pain seeking repeat or new precriptions. However most ED care relates to acute pain. How should acute pain be best managed, and what impact does initiating opioids have on long term use?

TOXICOLOGY/ORIGINAL RESEARCH

Opioid Use During the Six Months After an Emergency Department Visit for Acute Pain: A Prospective Cohort Study

Annals of Emergency Medicine Volume 75, NO. 5 : May 2020

What this study adds to our knowledge

In this prospective analysis of 484 patients followed during 6 months by telephone calls and through statewide prescription database review, 5 (1%) met the study's primary outcome of filling 6 or more opioid prescriptions. In this latter group, the frequency of new prescriptions decreased over time.

How this is relevant to clinical practice

Persistent opioid use is uncommon after the ED prescription of opioids to treat acute pain.

The study evaluated persistent opioid use during the 6 months after an ED visit in New York, defined as filling 6 or more prescriptions. 484 opioid-naive patients with acute pain who were prescribed an opioid at discharge were followed up.

Most patients (66%; 95% CI 61 - 70%) filled only the initial prescription; 21% filled 2. Five patients (1%) met criteria for persistent use with 4 of these 5 reporting ongoing pain.

Of those 5, 1 was for chronic pain after trauma, 2 were for fractures requiring surgery, 1 had Zoster and a subsequent cholecystectomy, and 1 was for arthritis.

Although ongoing opioid use might have been reduced by a different approach, they were clearly significant conditions with chronic pain. The risk for the overall cohort was small.

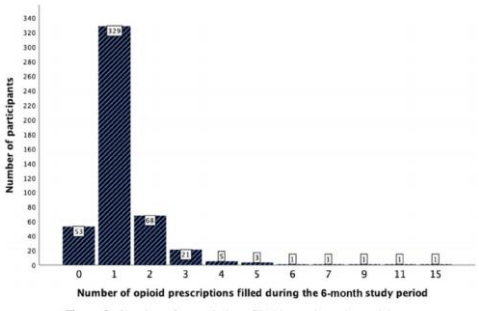
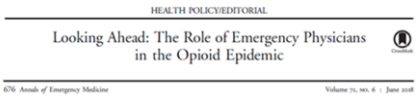


Figure 3. Number of prescriptions filled by each study participant.

Risk scores had limited ability to identify the patients having persistent opioid use. There was suboptimal pain control in 4 of the 5. Opioid related euphoria appears more common with oxycodone and may represent a risk. Risk can also be managed with use of non-opiates which have equivalent analgesic

effect in a range of conditions, and by limiting initial supply. However the overall risk is low.

This concurs with other studies.



HEALTH POLICY/EDITORIAL

Looking Ahead: The Role of Emergency Physicians in the Opioid Epidemic

EDs contribute <5% prescribed opioid use

Use at 1 year from ED prescription <2%

RISK FROM POOR PAIN CONTROL

Academic Emergency Medicine
Official Journal of the Society for Academic Emergency Medicine

ORIGINAL CONTRIBUTION

Relationship between pain, opioid treatment, and delirium in older emergency department patients

22 May 2020 https://doi.org/10.1111/acem.14033

Background

Emergency department (ED) stay and its associated conditions (immobility, inadequate hydration and nutrition, lack of stimulation) increase the risk of delirium in older patients. Poorly controlled pain, and paradoxically opioid pain treatment, have also been identified as triggers for delirium. The aim of this study was to assess the relationship between pain, opioid treatment, and delirium in older ED patients.

A prospective study of patients ≥65yr waiting for admission and non-delirious on ED arrival, with an ED stay >8hr.

Delirium and pain assessments were done in ED and for 24hr on the ward.

12% developed delirium, at 47 ±19hr after ED admission. ***Patients in pain had more than four times the incidence delirium***. There was *no association with opioid administration*.

Conclusions

Severe pain, not opioids, is associated with the development of delirium

Opioid Prescribing Limits for Acute Pain — Striking the Right Balance

N ENGL J MED 379;6 NEJM.ORG AUGUST 9, 2018

In short, pain needs to be managed, and opiates have a role. There is limited evidence for policies aimed at restricting use.

> Although prescribing limits seem like a commonsense approach to reducing exposure, adoption of these policies is outpacing the evidence.

NEJM Resident 360

21 MARCH

Challenges of Managing Chronic Pain with Opioids – Part 1

These isues are discussed in a NEJM podcast on management of chronic pain. For the most part this is managed outside of ED.

There are some insightful comments including a patient perspective on some of the barriers to achieiving adequate pain control.

The evidence base for chronic opiate use in managing chronic pain is limited, with methodological problems and evaluation over a short time frame. There are changes in pain pathways and perception over time which lead to hyperalgesia and adverse effects.

Patients fear loss of pain control which leads to behaviour that might be interpreted perjoritavely. For example they may seek an alternate provider to cover for their primary provider being unavailable; they may keep a supply in excess of need in case a planned dose reduction strategy does not work out and they may have difficulty negotiating an increase in dosing back to previous intake.

Patients with CNCP have a primary provider/prescriber

- No renewals or new Rx – if they show up early at their own clinic they do not get more meds! They are told they have to wait for their normal visit.
- Average time to control CNCP in pain clinic – *3 months*
  - 'Start low and go slow'
  - NO imperative to control the pain quickly – too many adverse effects

Do not hesitate to communicate with the provider/primary prescriber

Management of chronic pain from ED is not about prescribing more opioids in higher doses. It is also not about adding pregabalin or gabapentin which have adverse side effects and poor efficacy for most chronic pain.

Physical activity, improving mobility, setting realistic goals and managing depression and other issues is required.

That cannot be done from ED, and is the role of their usual doctor. It's not an emergency.

It is our responsibility to properly address their pain needs

- Reassurance and giving control to the patient
- Consider which analgesic approach is optimal:

These updates are a review of current literature at the time of writing. They do not replace local treatment protocols and policy. Treating doctors are individually responsible for following standard of care.