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Polypharmacy and de-prescribing in pain control

Katrine Petersen, Advanced Physiotherapist in Pain Management, MSc, Independent Prescriber

Non-Medical Prescribing CPD Study Day March 2018

London South Bank University
EST 1892

Outline:

My background and role

De-prescribing in pain management, why and how

Case study

Advanced Physiotherapist
First Contact Physiotherapist
Chronic Pain
Abdomino-pelvic pain specialism
Large MDT (70 staff) – excellent governance and supervision/mentoring
Tertiary care/specialist setting so often work beyond guidelines i.e. neuropathic
Recommendations/education
Do not write prescriptions

Types of patients

Have most often been to local pain clinic
Referrals from England (can travel very far)
Multiple co-morbidities
Abdomino-pelvic pain
Neurological conditions
MDT needs

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IFOMPT conference: Study finds that patients of physio independent prescribers have greater satisfaction levels

8 July 2016 - 1:02pm

Independent prescribing has broadened the horizons of physiotherapists in the UK and has benefited patients.

Tweet Share 11 Recommend 0

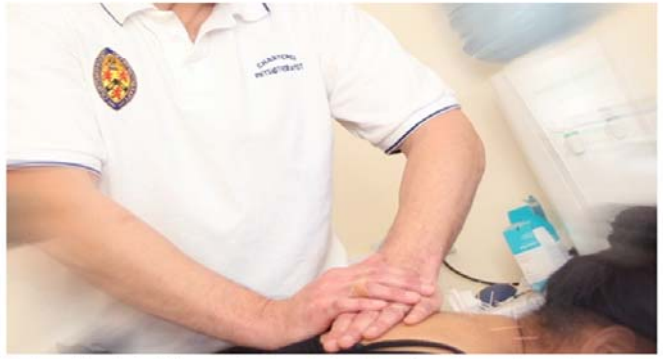
CSP professional adviser Pip White

Physios are vital to 'first contact care', says National Association of Primary Care chief

15 September 2016 - 11:56am

Physiotherapy is 'absolutely vital' as part of 'first contact care', according to Dr James Kingsland, president of the National Association of Primary Care.

Tweet Share 42 0 Comment 0



Dr James Kingsland said the current system of referral from primary to secondary services was no way to integrate services

ADDED BY:
Gill Hitchcock

TAGGED AS

integrated workforce, Integration, Primary care

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NHS gives green light to consultation on drugs physios can prescribe

19 February 2018 - 9:35am

NHS England has confirmed that a public consultation will take place to review the list of controlled drugs that independent prescribing physiotherapists can use.

Tweet 1 Comment 5

Codeine and tramadol are two controlled drugs that will be considered during the consultation

ADDED BY:
Robert Millett

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Consultation, controlled drugs, independant prescribing, NHS England

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A competency Framework for all Prescribers 2016

Physios prescribe differently

Physio front end, not back end of pain service
Hook patient into self-management to improve quality of life
Empower patients/have alternatives

What are we dealing with?

Systematic review found up to 30-50% of the population suffer with a chronic pain condition (Fayaz, 2016)

NICE guidance – Guideline scope
Persistent pain: Assessment and management

£537 million spend on analgesic prescriptions, with a further 50% spent on anti-depressants and anti-epileptics

There are no medical (pharmacological or non-pharmacological) treatments that work for more than a minority of people

https://www.nice.org.uk/guidance/gid-ng10069/documents/draft-scope

The Opioid Epidemic: A Crisis Years in the Making

By Maya Salam Oct. 26, 2017

Examining the body of a woman who died of an overdose in August. Todd Heisler/The New York Times

The current opioid epidemic is the deadliest drug crisis in American history. Overdoses, fueled by opioids, are the leading cause of death for Americans

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Health

Prescription of opioid drugs continues to rise in England

Doctors give patients drugs such as tramadol despite risks of addiction and ineffectiveness when treating chronic pain

Sarah Boseley
Health editor

Tue 13 Feb 2018
06.05 GMT

185

▲ Tramadol was the most commonly prescribed opioid in England from August 2010 to February 2014. Photograph: Jeremy Durkin/Rex Features

The prescription of opioid drugs by GPs in England is steadily rising, especially in

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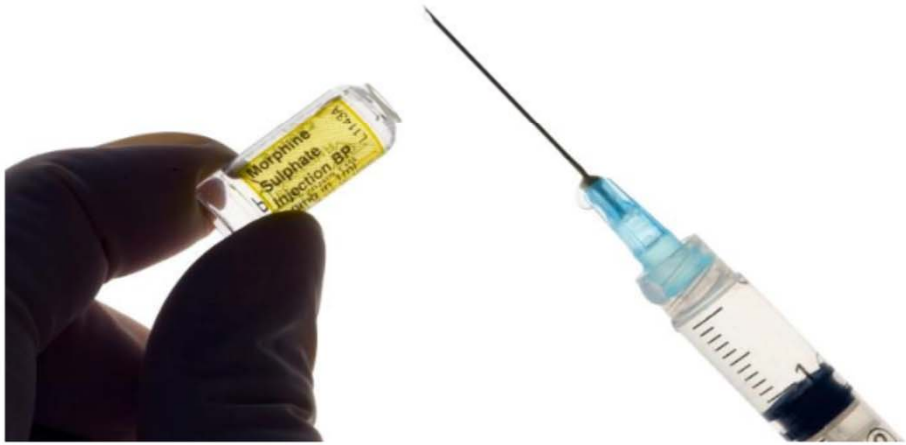
GPs dish out deadly opioids amid lack of chronic pain care



A report has suggested setting up a database of patients on high doses of opioids to ensure they get proper treatment
MEDICIMAGE/REX/SHUTTERSTOCK

GPs are prescribing the equivalent of a kilogram of morphine every month because there are so few services to deal with chronic pain,

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Physiotherapist fact sheet: Talking to people about the changes to codeine access

5 March 2018

On this page: Information for physiotherapists | About the change to codeine access | Providing physiotherapy care as an alternative to opioids | Useful resources for patients and clinicians

Print version

Print version of Talking to people about the changes to codeine access (pdf, 946 KB)

How to access a pdf document

Information for physiotherapists

Codeine became a Prescription Only Medicine on 1 February 2018. As a result, all codeine-containing medicines are no longer available without a prescription. The Royal Australian College of General Practitioners (RACGP) have encouraged general practitioners (GPs) to refer patients to physiotherapists as an alternative to prescribing codeine. Physiotherapists should be prepared to discuss the changes with patients who may desire, but can no longer access, codeine–containing medicines.

About the change to codeine access

There is high-quality evidence from a systematic review (which includes 14 randomised controlled trials) that over-the-counter codeine-containing medicines offer modest pain relief (around 12 points on a 100-point pain scale) in the immediate term (three hours post ingestion) when

The role of a physiotherapist is to thoroughly assess pain and provide effective non–medicinal options for pain relief

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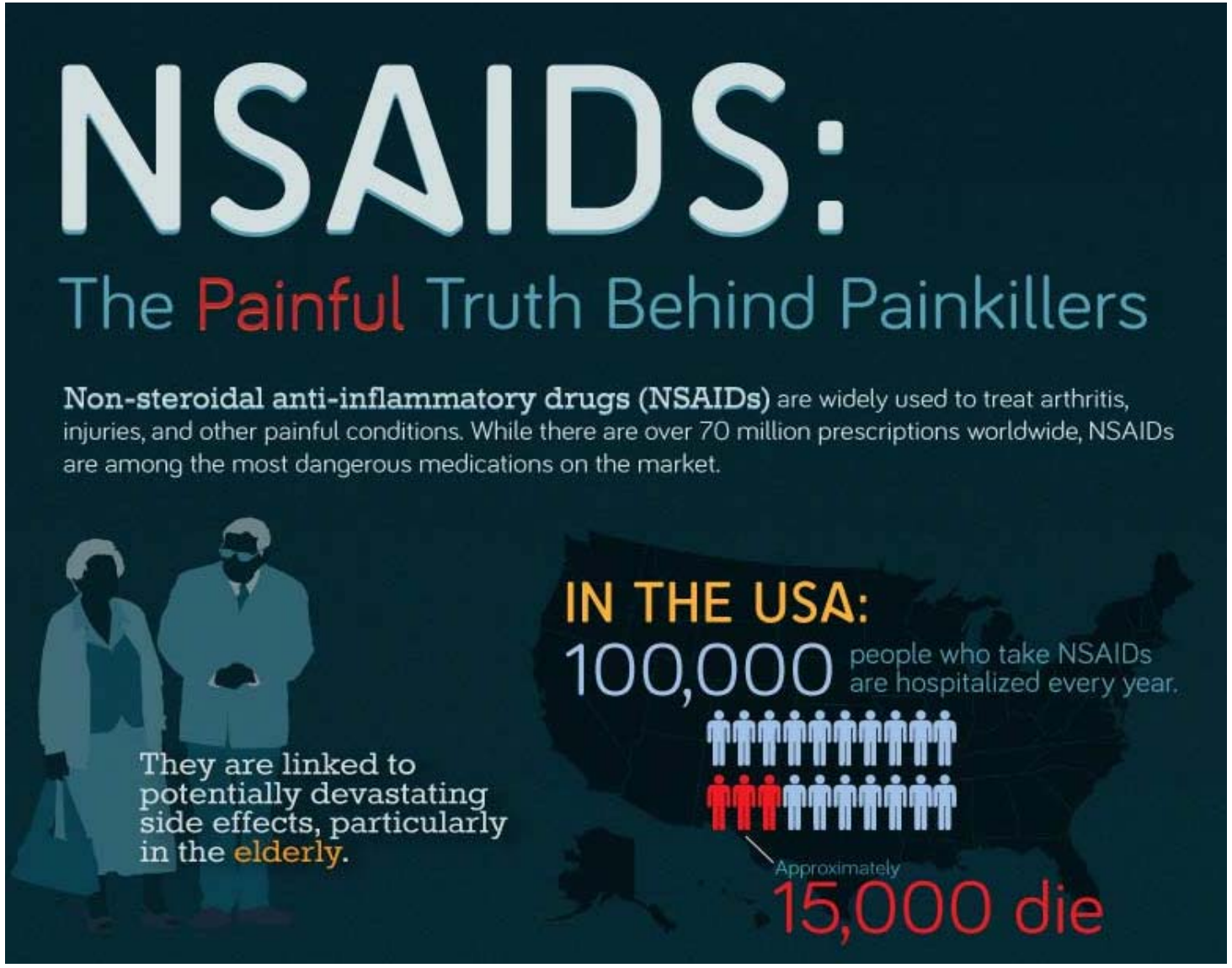
NSAIDS:
The Painful Truth Behind Painkillers
Non-steroidal anti-inflammatory drugs (NSAIDs) are widely used to treat arthritis, injuries, and other painful conditions. While there are over 70 million prescriptions worldwide, NSAIDs are among the most dangerous medications on the market.
They are linked to potentially devastating side effects, particularly in the elderly.
IN THE USA:
100,000 people who take NSAIDs are hospitalized every year.
Approximately
15,000 die

http://blogs.lse.ac.uk/usappblog/2018/02/26/why-has-the-us-opioid-crisis-not-spread-to-the-uk-thank-the-nhs/

What do we have to avoid a US opioid crisis:

NHS pain management

Access (?)

Clinician led with patient involvement (less reliant on pharmaceutical/industry funding)

Guidelines

1. 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.

2. A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).

3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.

4. If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.

5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

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We need to get better at evaluating treatment to minimise iatrogenic harm and utilise resources appropriately

Related NICE guidance

- Endometriosis: diagnosis and management (2017) NICE guideline NG73
- Spondyloarthritis in over 16s: diagnosis and management (2017) NICE guideline NG65
- Neuropathic pain in adults: pharmacological management in non-specialist settings (2017) NICE guideline CG173
- Low back pain and sciatica in over 16s: assessment and management (2016) NICE guideline NG59
- Multimorbidity: clinical assessment and management (2016) NICE guideline NG56
- Palliative care for adults: strong opioids for pain relief (2016) NICE guideline CG140
- Controlled drugs: safe use and management (2016) NICE guideline NG46
- Rheumatoid arthritis in adults: management (2015) NICE guideline CG79
- Headaches in over 12s: diagnosis and management (2015) NICE guideline CG150
- Workplace health: management practices (2015) NICE guideline NG13
- Osteoarthritis: care and management (2014) NICE guideline CG177
- Common mental health problems: identification and pathways to care

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Why de-prescribe?

Medication to relieve chronic pain have poor evidence long term and lots of side-effects

Influencing a complex nervous system:
If things are fluctuating dramatically and the patient has very low mood/has poor support (psychosocial);
medications unlikely to be more than a drop in the ocean

More is not better

Life expectancy for cancer patients is changing so we need to be careful with opioid use in palliative care
- we can still make people worse

Pain medication use in chronic pain (non-cancer):

· Patients report worse compliance with pain medication

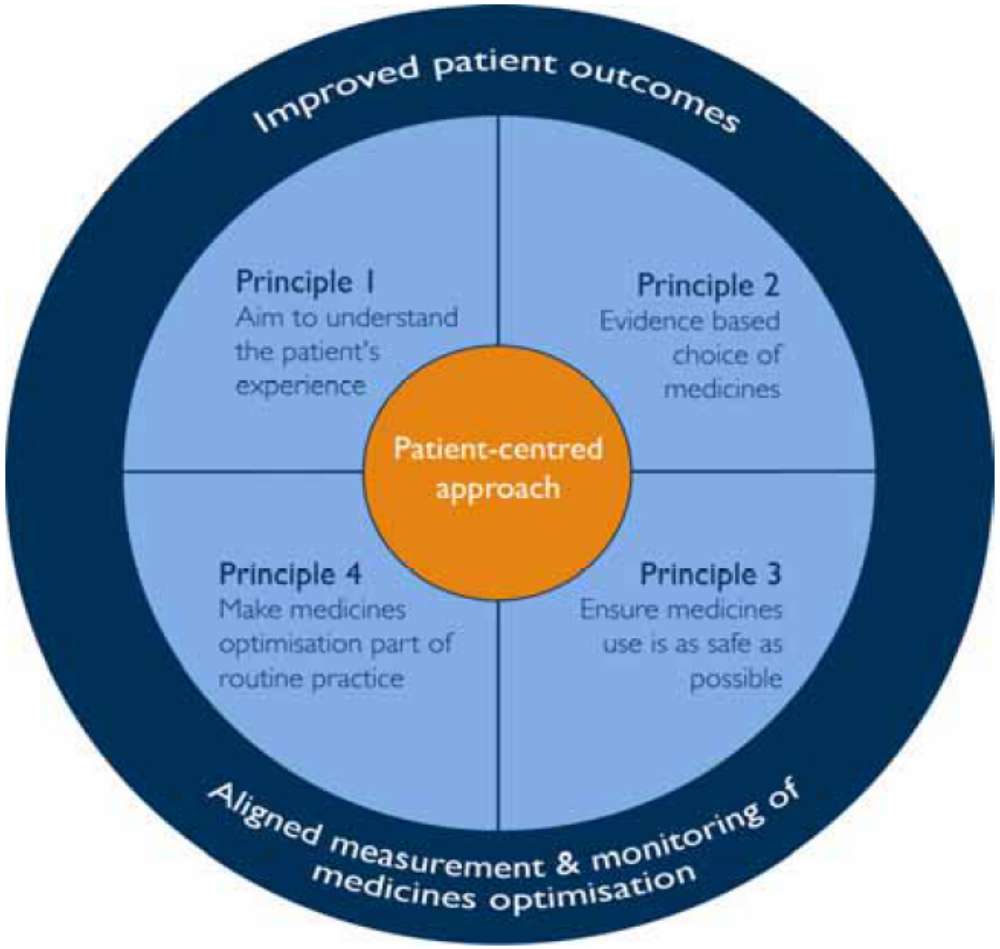
· Strongly linked to perception and attitude to pain

McCracken LM, Hoskins J, Eccleston C. Concerns about medication and medication use in chronic pain. J Pain 2006;7:726-34.

Obstacles for prescribers (David Baker, 2018)

Over focus on pain and medications
Difficulty accepting that there is no cure
Conversation about medications with non-medical prescriber/public perception
Knowing our scope
Not able to answer all questions
Distraction from rehabilitation
Lack of resources and access to support
Inappropriate referrals

Figure 1. Summary of the four principles of medicines optimisation.



https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy

NICE (2017) **Medicines optimisation in long-term pain**

Options for local implementation

Ensure people with long-term pain receive optimal pain treatment with careful consideration of the benefits and risks of treatment options.

Assess risk and address harms of medicines where safety issues are a concern, such as opioids, gabapentin and pregabalin.

Review and, if appropriate, optimise prescribing of opioids, gabapentin or pregabalin to ensure that it is in line with national guidance.

https://www.nice.org.uk/advice/ktt21/chapter/Evidence-context#managi

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Choosing Wisely® Promoting conversations between patients and clinicians

Do I really need this test, treatment or procedure?
What are the risks or downsides?
What are the possible side effects?
Are there simpler, safer options?

What will happen if I do nothing?

http://www.choosingwisely.org/

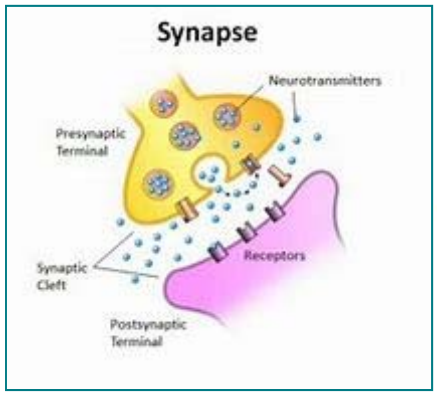
Aim of pain management:

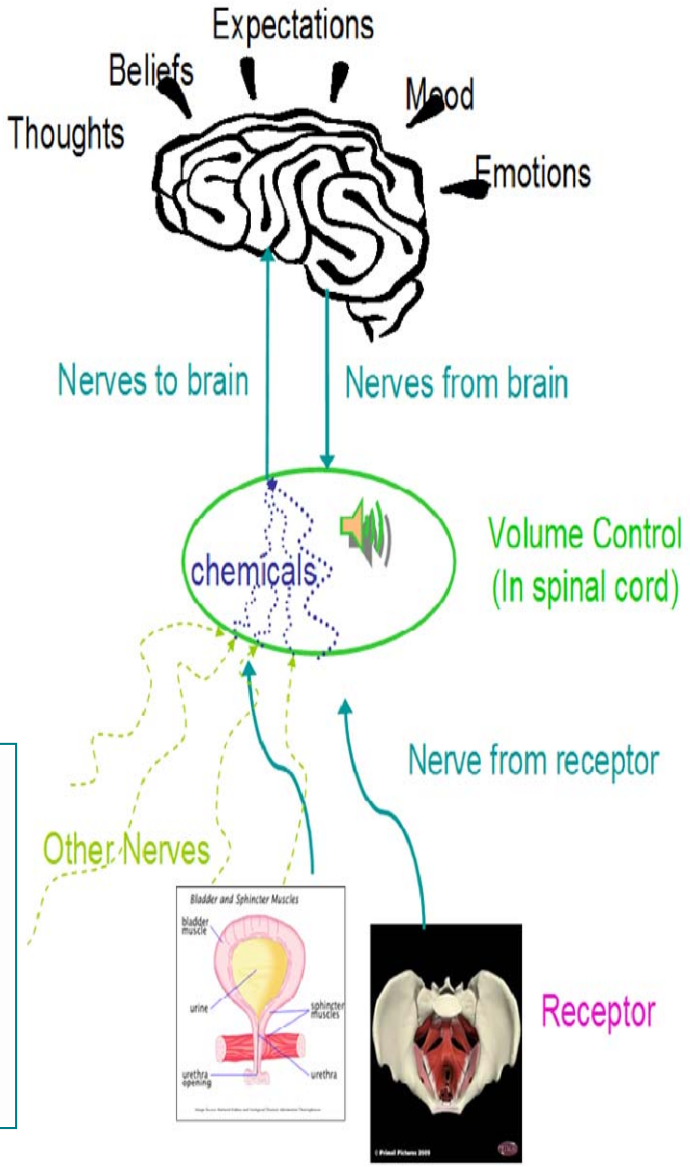
Long-term reorganisation and downregulation:

Modalities:

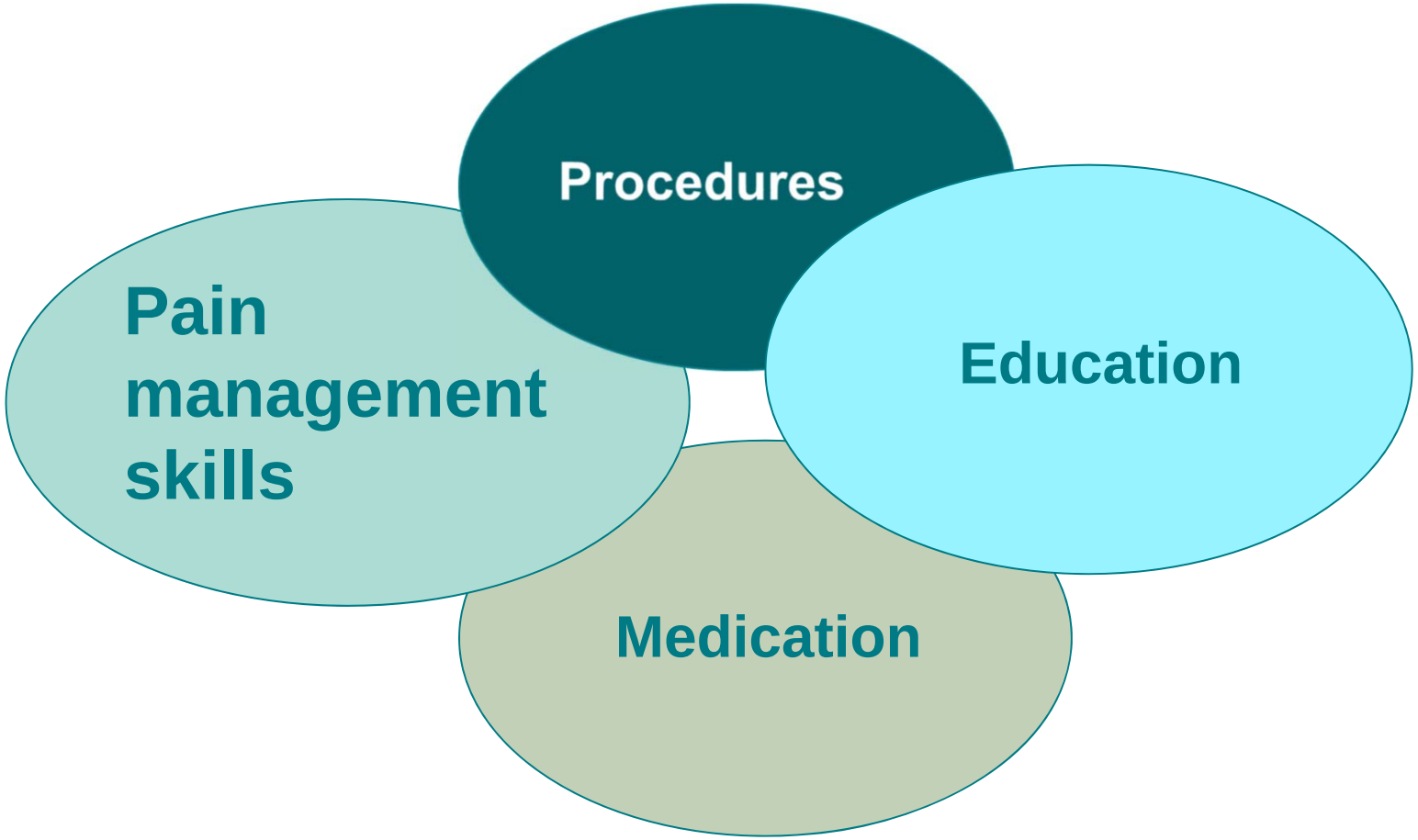
Medication

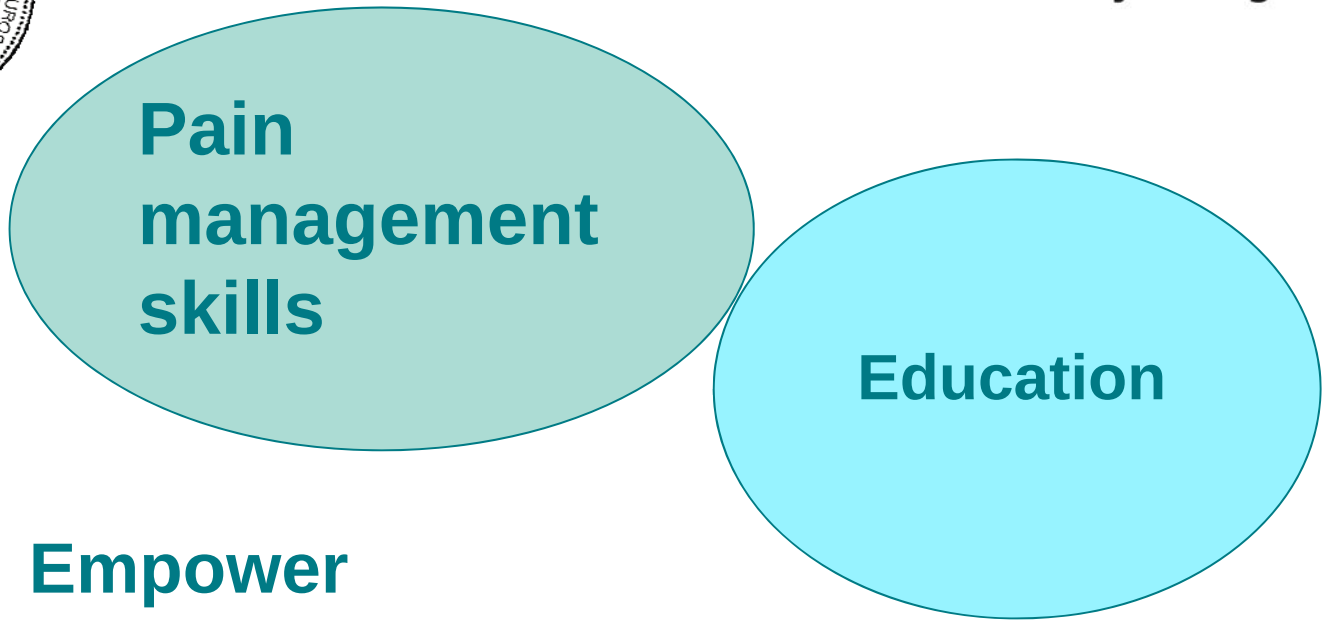
Other factors influencing neurochemical 'soup'?





Pain management:





Empower
Patient goals
Self-management
Group programmes or individual support
Opioid reduction clinic
MDT/phone support

Educate other HCPs

Examples of pain management skills

- Understanding pain mechanisms and key messages:

- pain does not equal harm/safe to move

- pain is complex/individual and changing neurophysiology through the environment, thoughts, sleep, diet, activity etc

- Standard ‘gate theory’ pain relief: Heat, cold, TENS (acupuncture)
- Activity management/pacing/exercise
- Desensitisation
- Mindfulness
- Relaxation
- CBT
- Flare-up management
- Goal setting

Support primary care clinicians and patients with alternative options

Patient-centred care in which the patient's experience, priorities, and views are elicited and respected to foster a collaborative relationship and empower and validate the patient and achieve shared decision making is critical

Butow, Phyllis, and Louise Sharpe. (2013) PAIN@154;S101-107
"The impact of communication on adherence in pain management."

De-prescribing, practical skills to support patients:

Accept that we do not currently have a ‘cure’ for chronic pain

Education:
Choice
Not disease modifying
Risk versus benefits

Normalising the lack of effectiveness of pain medication long-term as well as the reasons why people might continue to take them regardless

Routine support the patient to establish a routine which enables them to develop awareness and monitor the effect the medication and self-management skills

Review impact

Motivation re-evaluate patient ability to change/reduce reliance on medication

Make small changes patients will often be fearful of medication reduction

- however:

Explain neural plasticity

CAN help patients who think they will need medication ‘forever’- might modify some neural connections enabling the nervous system to respond differently

Chronic pain is harmful, poorest quality of life, increases risk of co-morbidities significantly

Case study Mr X:

Initial presentation:

Long standing LBP. Unsuccessful decompression surgery 5 years earlier. Poor mobility, lives with wife who has her own health issues. Drowsy, difficulties making decisions. Very poor sleep. Feeling hopeless.

320 mg MR oxycontin, 3x20 mg immediate release oxycontin (morphine equivalent of 1400 mg per day)
Naproxen 4 x 250 mg, Amitriptyline 70 mg, Gabapentin 3 x300 mg

After 2 years:

40 mg BD MR oxycontin and 4x20 mg oxynorm (daily equivalent of 320 mg morphine).
Amitriptyline 70 mg for sleep.

He has had 3 RNB for back pain. Pain management programme to develop non-medical sills.
Nurse support: phone him every two weeks.

Mrs Y

We agreed to reduce Fentynal patches by 12.5 mcg per three months and reduce by 100 micrograms once every three weeks– patient struggling with this new regime, using more Fentynal, asking GP for more when she runs out
Fentanyl 400 micrograms x 7 per day (morphine equivalent 364 mg)
Fentanyl Patch 75 micrograms (morphine equivalent: 180 mg)

What would you do?

Conclusion:

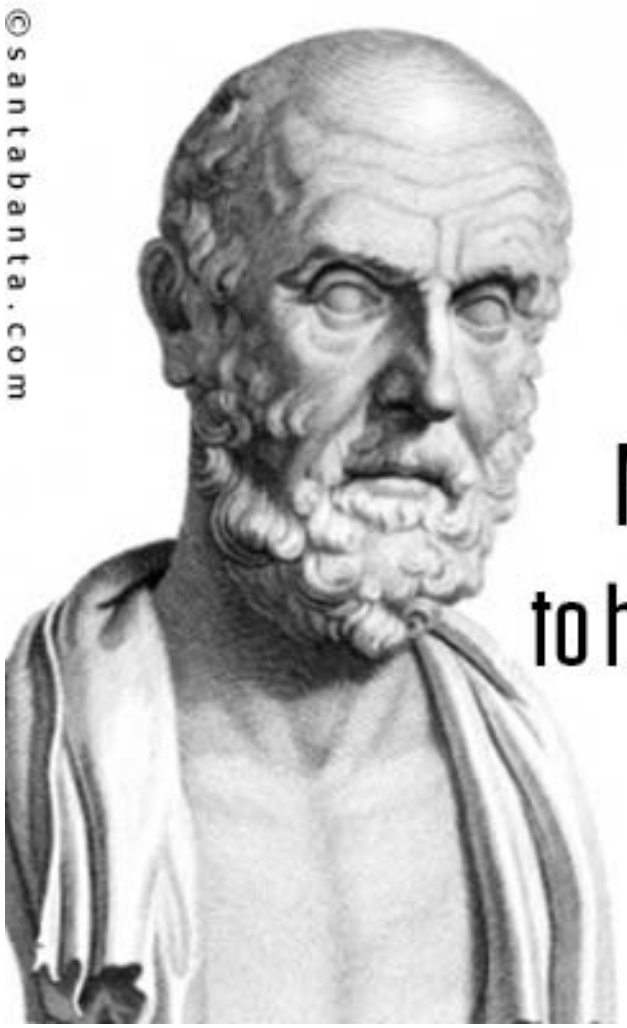
We do not yet have a cure for chronic pain

Pain medication has poor evidence for improving people's quality of life in chronic pain conditions

It is not disease modifying

If you ask the patient to chose, they need information and access to non-medical choices

Having prescribing skills include the ability to de-prescribe where appropriate



Make a habit of two things:
to help; or at least to do no harm.

~ Hippocrates

https://www.surveymonkey.co.uk/r/VMTTGV2

"My colleague is exploring the role for physiotherapy regarding prescribing and the opioid crisis. Although we are not in the same situation as the US, there are signs the problem is growing here (UK). We do however have unique differences here in that the NHS is free and physios can train to prescribe as well as skills in pain management and rehabilitation with patients. It would really help him if you would complete the survey. Thanks"
Diarmuid Denneny

Thank you!

katrine.petersen@uclh.nhs.uk