Fact sheet Health Professional Information

Adverse effects due to long term opioids

This information is intended as a general guide only.

OPIOIDS NOT PROVEN TO HELP CHRONIC PAIN

Evidence indicates that opioids are less effective for persistent pain than acute pain. Opioids may provide up to 30% reduction in persistent pain and are only helpful for opioid sensitive (nociceptive) pain and only some neuropathic pain states. None of the studies reviewed for opioid use in chronic pain ever lasted more than 16 weeks. There are no randomised controlled trials on the long term effectiveness of opioid use in chronic non-cancer pain. In a systematic review of 111 trials with administration of opioids either orally or topically, only 4 studies evaluated effectiveness beyond 6 months. One evaluated tapentadol with weak positive evidence, the second evaluated morphine with negative evidence, the third evaluated oxycodone with negative evidence, and the fourth evaluated fentanyl and morphine with indeterminate results.[1] Many pain medicine specialists now recommend a maximum of 100 mg Morphine for 90 days only.

UNEXPLAINED DEATH

The daily dose of opioid among patients receiving opioids for non-malignant pain is strongly associated with opioid-related mortality. More than 100mg of oral morphine per day results in a two fold increase in the risk of death, more than 200mg results in three fold risk increase.[2] Avoid using opioids with other sedative medication including benzodiazepines, alcohol, cannabis and antihistamines.

Equipotent Value of	Fentanyl patch/ Durogesic	Oxycontin Or Targin	Buprenorphine/ Norspan patch	Kapanol/ MS Contin/ MS Mono	Jurnista/ Hydro-morphone
100mg morphine per day	25mcg/ hr	60mg	40mcg/hr	100mg/ day	20mg
Methadone – variable, speak to pain medicine specialist					

OXYCONTIN “LIKEABLE”

Oxycontin has the highest demand for diversion in Australia. Injecting drug users in Australia indicate more than 1 in 6 had used pharmaceutical drugs illicitly (i.e. using medications not prescribed for them).[3] Safer medication for chronic pain may be Norspan patches or Targin.

HYPOTHALAMIC-PITUITARY AXIS SUPPRESSION

Opioids cause a decrease in various hormones including testosterone. This can result in loss of libido, sexual dysfunction, infertility, muscle weakness, fluid retention, osteoporosis and fractures.

SLEEP APNOEA

Opioids contribute to depressed respiratory effort and exacerbation of sleep apnoea. It is recommended that patients who require greater than 50mg methadone or 150mg morphine equivalent per day should be **referred for formal sleep apnoea evaluation**. It is also recommended to advise patients to decrease their daily opioid doses by at least 30% during respiratory tract infection or asthmatic episodes for safety reasons.[4]

OPIOID-INDUCED HYPERALGESIA

There is a growing body of evidence that opioid use, especially longer term and higher doses can make the pain experienced more severe. Weaning opioids may lead to improved pain levels with less side effects.

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DENTAL CARIES

Patients on long-term opioids therapy are often upset when they discover dental caries and need for dentures were caused by opioid therapy.

IMMUNE SUPPRESSION

Opioids increase risk for infection, and may contribute to malignancies.

IMPAIRED ABILITY TO DRIVE

Opioids cause cognitive slowing, adverse effect on mood, impaired concentration, memory, driving ability and increased risk of falls. The SA Drugs of Dependence Unit suggests formal driving test is needed for drivers using **more than 200mg oral morphine equivalent per day**.[5] They also warn of risks mixing opioids and other sedative drugs.

CONSTIPATION

A side effect that does **not** resolve over time.

PHYSICAL DEPENDENCE AND WITHDRAWAL REACTIONS.

Many patients are reluctant to entertain the idea of weaning opioids simply because "I never took them for a few days and then I really felt it". This is a withdrawal reaction and opioids can be weaned slowly and safely.

EFFECT ON MOOD AND MOTIVATION

Chronic non-malignant pain and depression are closely linked with one-half to two thirds of people being less able or unable to exercise, enjoy normal sleep, perform household chores, attend social activities, drive a car, walk or have sexual intercourse. The risk of death by suicide seems also to be doubled in chronic pain patients compared with controls. The treatment of chronic pain patients should therefore encompass a multi-disciplinary approach addressing co morbid mental health issues and teaching non medication strategies for dealing with pain and the principles of pacing. This would include referral to psychologists and physiotherapists. Opioids in such a group of patients can be counterproductive.[3] Therefore consider weaning opioids by a rate of 10% every 1-2 weeks to minimise side effects if the patient has persisting pain despite being on opioids.

OTHER EFFECTS

Individual drugs have specific risks e.g. Methadone can prolong QT syndrome and patients on Methadone should have an ECG to exclude this.

References:

1. Manchikanti et al. Focussed Review - Effectiveness of Long-Term Opioid Therapy for Chronic Non-Cancer Pain. Pain Physician 2011;14:E133-E156
2. Gomes T et al. Less is More - Opioid Dose and Drug-Related Mortality in Patients With Nonmalignant Pain. Arch Intern Med. 2011;171 (7):686-691.
3. Prescription Opioid Policy. A publication by The Royal Australian College of Physicians, Faculty of Pain Medicine ANZCA, The Royal Australian College of General Practitioners and The Royal Australian and New Zealand College of Psychiatrists.
4. L Webster. President's Message (American Academy of Pain Medicine) – Eight Principals for Safer Opioid Prescribing. Pain Medicine 2013;14: 959-961.
5. DASSA Website. Benzodiazepines , opioids and driving.