GoldNet Research Network Event

The **GoldNet Research Network** is pleased to welcome you our research networking event. Here we will be discussing the **current evidence & practical strategies** to opioid prescribing in primary care.

Joyce McSwan
Managing Director, PainWISE Pty Ltd
GCPHN Persistent Pain Program Clinical Director, BNPHN Persistent Pain Program Clinical Director, President, Australian Pain Society

Dr Caitlin Jones,
Postdoctoral Research Associate
The Institute for Musculoskeletal Health,
The University of Sydney

Dr Aili Langford,
NHMRC Emerging Leadership Fellow
Centre for Medicine Use and Safety, Faculty of Pharmacy and Pharmaceutical Sciences, Monash University

Prof. Nick Zwar
Executive Dean, Bond University and
Chair of GoldNet Research Steering Committee

Opioid Prescribing in Primary Care

Presentations to commence at 6:30 pm

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GoldNet Research

Welcome

Opioid Prescribing in Primary Care

Professor Nick Zwar

Chair of GoldNet Research Steering Committee
Executive Dean of Faculty of Health Sciences and Medicine,
Bond University

BOND UNIVERSITY

We acknowledge the Kombumerri clan of the Yugambeh language group as the traditional custodians of this land.

We pay respect to their Elders – past and present for their wisdom, teaching and cultural knowledge.

Artwork *by* Narelle Urquhart 2018

GoldNet Research

Opioid Prescribing in Primary Care

6:30 pm	Welcome and Introduction	Professor Nick Zwar – Chair
6:40 pm	Opioids for acute spinal pain: The OPAL trial	Dr Caitlin Jones – University of Sydney
6:50 pm	Deprescribing Opioid Analgesics in Primary Care	Dr Aili Langford – Monash University
7:00pm	A practical approach to translating opioid guidelines into clinical practice	Joyce McSwan
7:20pm	Q&A Panel	Chaired by Professor Zwar
7:50pm	Close	Professor Zwar

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GPGC Healthy General Practice Healthy Gold Coast

Presentation:

Dr Caitlin Jones

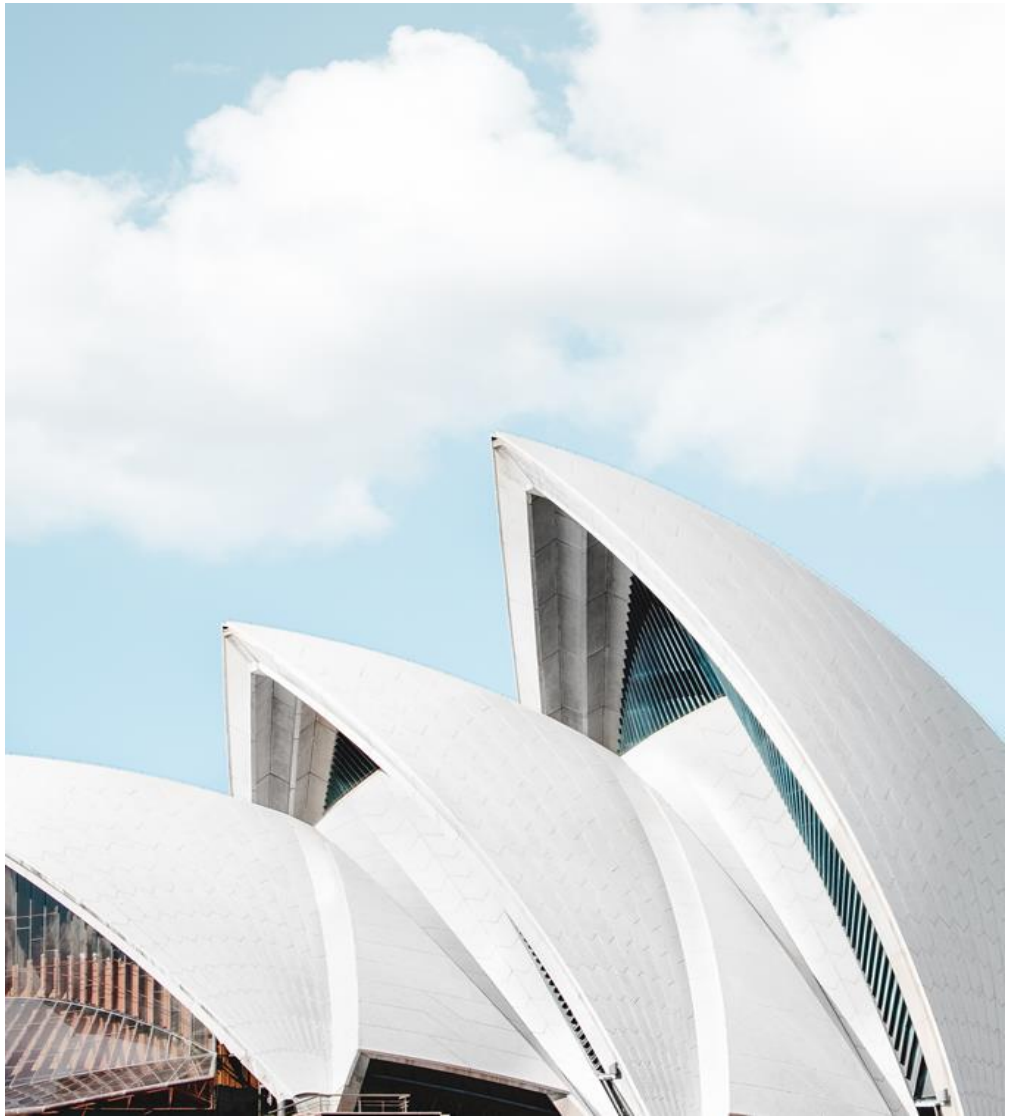
Postdoctoral Research Associate from The Institute for Musculoskeletal Health, The University of Sydney

Opioids for acute spinal pain: The OPAL trial

Institute for Musculoskeletal Health

A research partnership between Sydney Local Health District and the University of Sydney in musculoskeletal health and physical activity

OPAL: a placebo controlled trial of an opioid for acute non-specific low back and neck pain



Presented by Dr Caitlin Jones

NSW GOVERNMENT Health Sydney Local Health District

THE UNIVERSITY OF SYDNEY

Publication

Opioid analgesia for acute low back pain and neck pain (the OPAL trial): a randomised placebo-controlled trial

*Caitlin M P Jones, Richard O Day, Bart W Koes, Jane Latimer, Chris G Maher, Andrew J McLachlan, Laurent Billot, Sana Shan, Chung-Wei Christine Lin, on behalf of the OPAL Investigators and Coordinators**

Summary

Background Opioid analgesics are commonly used for acute low back pain and neck pain, but supporting efficacy data are scarce. We aimed to investigate the efficacy and safety of a judicious short course of an opioid analgesic for acute low back pain and neck pain.

Methods OPAL was a triple-blinded, placebo-controlled randomised trial that recruited adults (aged ≥18 years) presenting to one of 157 primary care or emergency department sites in Sydney, NSW, Australia, with 12 weeks or less of low back or neck pain (or both) of at least moderate pain severity. Participants were randomly assigned (1:1) using statistician-generated randomly permuted blocks to guideline-recommended care plus an opioid (oxycodone–naloxone, up to 20 mg oxycodone per day orally) or guideline-recommended care and an identical placebo, for up to 6 weeks. The primary outcome was pain severity at 6 weeks measured with the pain severity subscale of the Brief Pain Inventory (10-point scale), analysed in all eligible participants who provided at least one post-randomisation pain score, by use of a repeated measures linear mixed model. Safety was analysed in all randomly assigned eligible participants. The trial was registered with the Australian New Zealand Clinical Trials Registry (ACTRN12615000775516).

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See Online/Comment
https://doi.org/10.1016/S0140-6736(23)00671-2

*Members listed in the appendix (pp 2–3)

Sydney Musculoskeletal Health (C M P Jones PhD, Prof J Latimer PhD, Prof C G Maher DMedSc, Prof C-W C Lin PhD) and Sydney Pharmacy School

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)00404-X/fulltext

Institute for Musculoskeletal Health

NSW GOVERNMENT Health Sydney Local Health District

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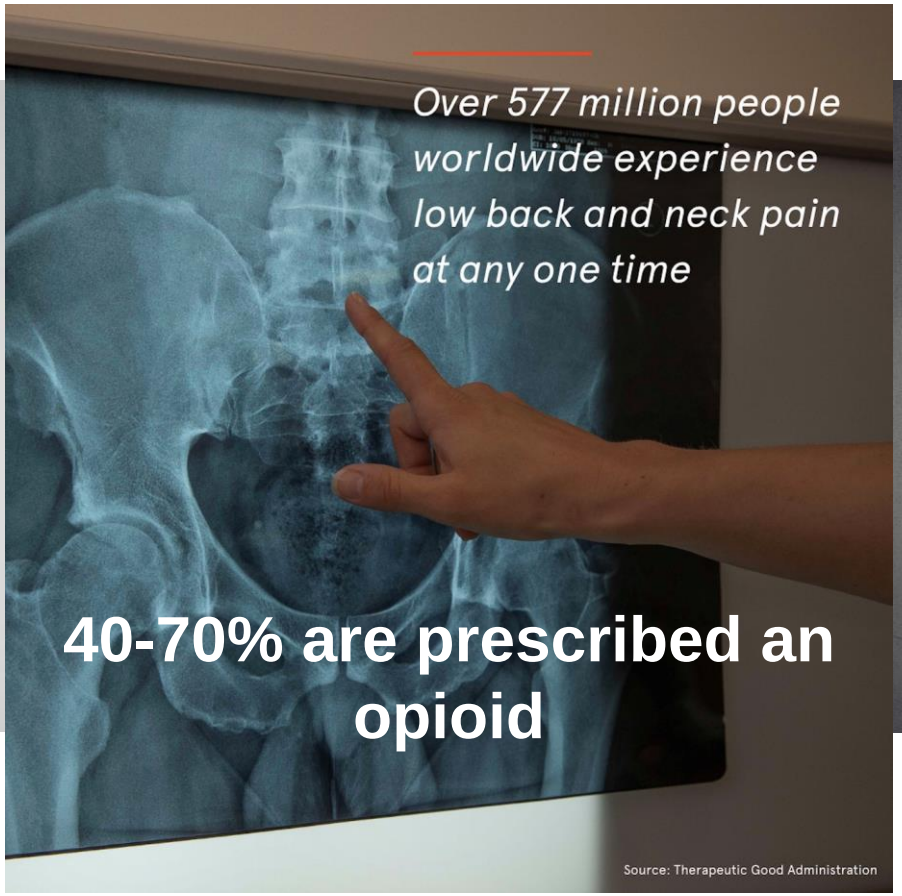
Low back and neck pain

Point prevalence: 8%



Point prevalence: 4%

Clinical guidelines

Clinical guidelines recommend that opioids can be considered for short periods of time when other treatments have failed

European Spine Journal (2018) 27:2791–2803
https://doi.org/10.1007/s00586-018-5673-2

REVIEW

Clinical practice guidelines for the management of non-specific low back pain in primary care: an updated overview

Crystian B. Oliveira[1] · Chris G. Maher[2,3] · Rafael Z. Pinto[4] · Adrian C. Traeger[2,3] · Chung-Wei Christine Lin[2,3] · Jean-François Chenot[5] · Maurits van Tulder[6] · Bart W. Koes[7,8]

Received: 15 March 2018 / Accepted: 17 June 2018 / Published online: 3 July 2018

Abstract

Objective The aim of this study was to provide an overview of the recommendations regarding the diagnosis and treatment contained in current clinical practice guidelines for patients with non-specific low back pain in primary care. We also aimed to examine how recommendations have changed since our last overview in 2010.

Method The searches for clinical practice guidelines were performed for the period from 2008 to 2017 in electronic databases. Guidelines including information regarding either the diagnosis or treatment of non-specific low back pain, and targeted at a multidisciplinary audience in the primary care setting, were considered eligible. We extracted data regarding recommendations for diagnosis and treatment, and methods for development of guidelines.

Results We identified 15 clinical practice guidelines for the management of low back pain in primary care. For diagnosis of patients with non-specific low back pain, the clinical practice guidelines recommend history taking and physical examination to identify red flags, neurological testing to identify radicular syndrome, use of imaging if serious pathology is suspected (but discourage routine use), and assessment of psychosocial factors. For treatment of patients with acute low back pain, the guidelines recommend reassurance on the favourable prognosis and advice on returning to normal activities, avoiding bed rest, the use of nonsteroidal anti-inflammatory drugs (NSAIDs) and weak opioids for short periods. For treatment of

The opioid crisis

THE LANCET

THE LANCET COMMISSIONS | VOLUME 399, ISSUE 10324, P555-604, FEBRUARY 05, 2022

Responding to the opioid crisis in North America and beyond: recommendations of the Stanford–*Lancet* Commission

Prof Keith Humphreys, PhD • Chelsea L Shover, PhD • Christina M Andrews, PhD • Amy S B Bohnert, PhD • Prof Margaret L Brandeau, PhD • Prof Jonathan P Caulkins, PhD • et al. Show all authors

Published: February 02, 2022 • DOI: https://doi.org/10.1016/S0140-6736(21)02252-2 • Check for updates

The OPAL trial

- Recruit people with acute non-specific back and/or neck pain who present to general practice or EDs with moderate to severe pain
- Randomise to up to 6 weeks of either an opioid (oxycodone) or a placebo
- Follow up for 12-months

Trial regimen

N = 347 received guideline care: advice to remain active, reassurance etc

Intervention: n = 174
Oxycodone 5mg / Naloxone 2.5mg (modified release), 1 tablet twice per day, titrating as required

Control: n = 173
Visually identical placebo tablets, same regimen

For up to 6 weeks, or until recovery

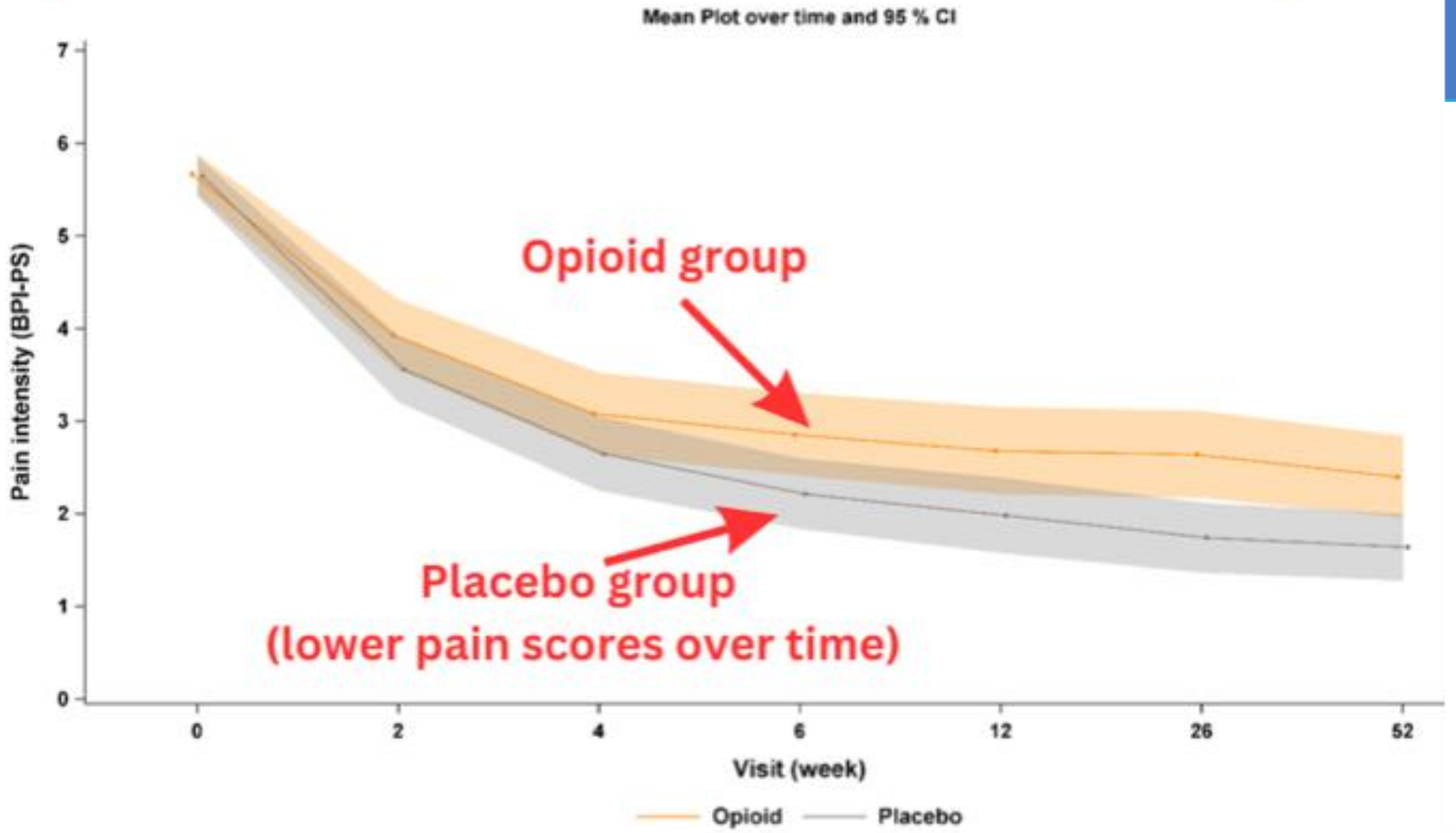
Outcomes

Primary outcome: Pain severity at 6 weeks

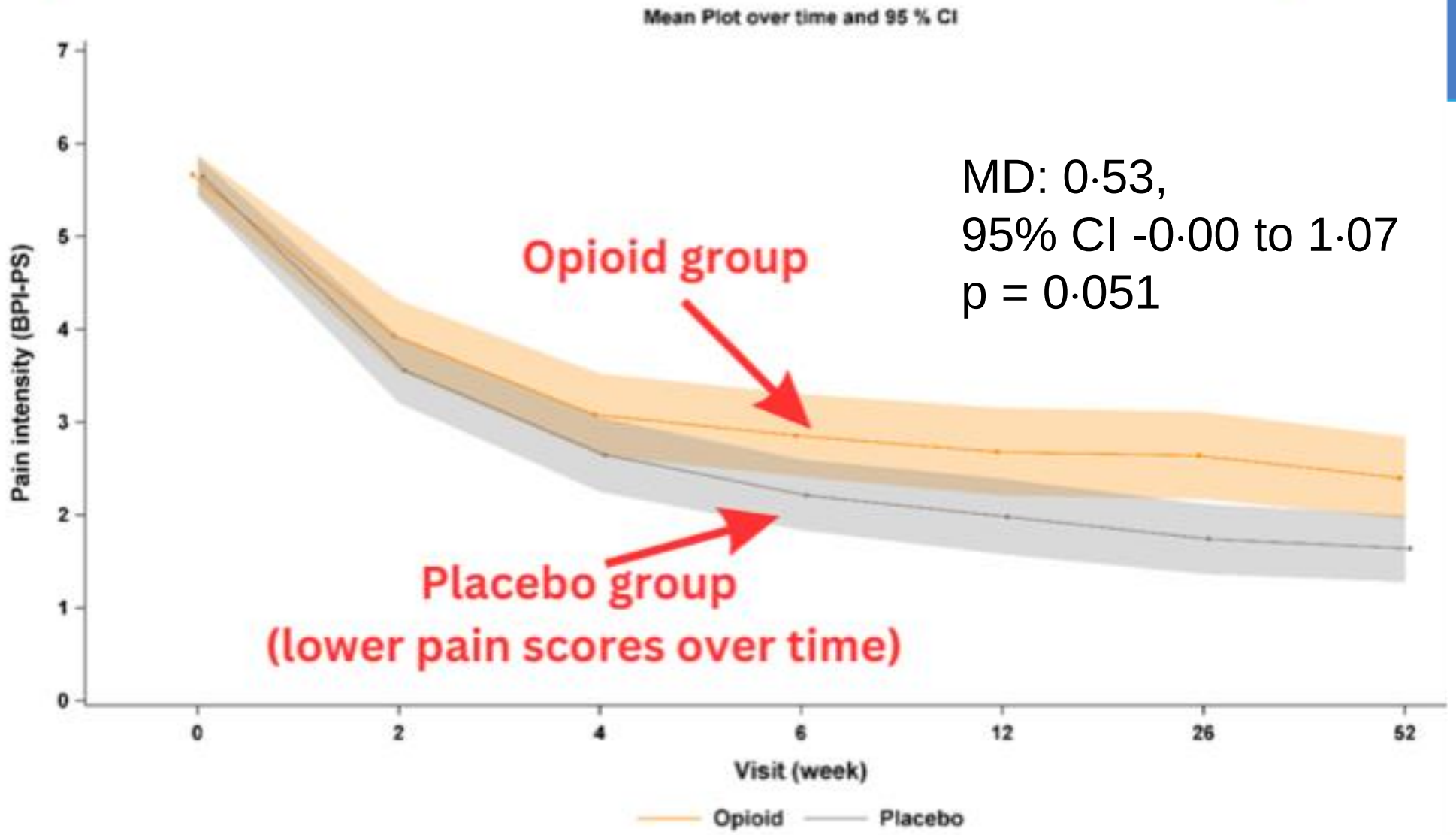
Other pain outcomes: Pain scores daily for 12 weeks
Brief Pain Inventory at weeks 2, 4, 6, 12, 26 and 52

Other outcomes: Time to recovery, function, QoL, adverse events, use of healthcare, concomitant medicines, etc

Opioids not effective for acute back and neck pain

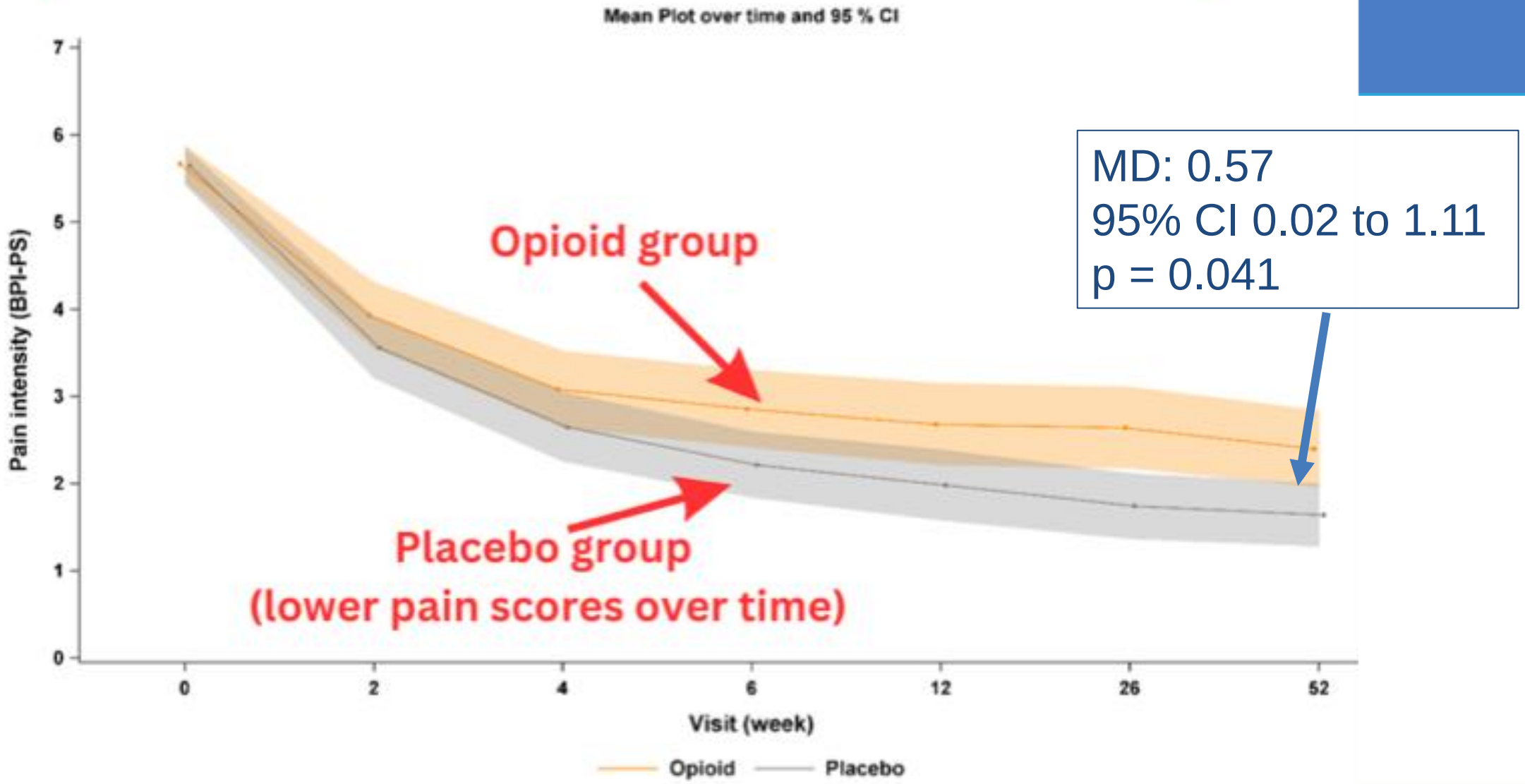


Opioids not effective for acute back and neck pain



MD: 0·53,
95% CI -0·00 to 1·07
p = 0·051

Opioids not effective for acute back and neck pain



Results - Secondary

Secondary outcomes	Finding (MD (95% CI)
Physical functioning	No difference
Quality of life (physical)	No difference
Quality of life (mental)	SFv2: -3·25 (-5·63; -0·87) p=0.003
Global perceived effect	No difference
Risk of opioid misuse at 12 months	20% opioid versus 10% placebo

Results – Adverse events

- No difference between groups
- ~ 1/3 of people in each group reported at least one AE
- Classic opioid AEs were more common in the opioid group

Discussion - Implications

- OPAL first large and long-term study
- Guidelines should be changed to no longer recommend opioids for acute non-specific back and neck pain
- Implement findings into practice – how can we reduce opioid prescribing for this population?

Discussion – Trial methods

- How did the modified release formulation impact results?
    - formulated with naloxone (reduces constipation, increase compliance, and protects blinding)
    - achieved same blood concentration as immediate release after day or so, then around-the-clock effect
    - OPAL can’t answer question about immediate relief (first hours)

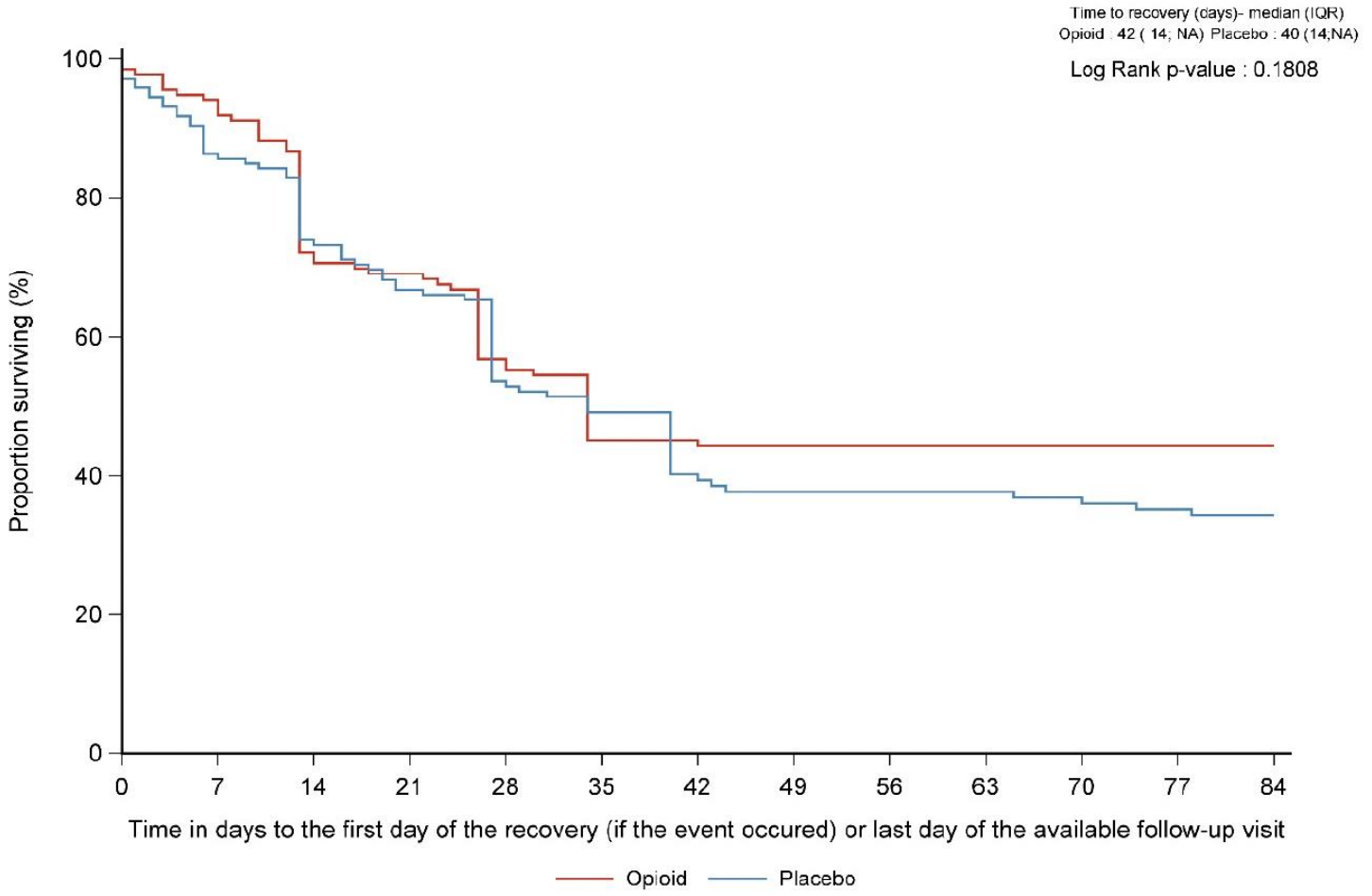
Discussion – Trial methods

May have missed an effect due to primary timepoint being 6 weeks?

Discussion – Trial methods

May have missed an effect due to primary timepoint being 6 weeks?

No difference in time to recovery

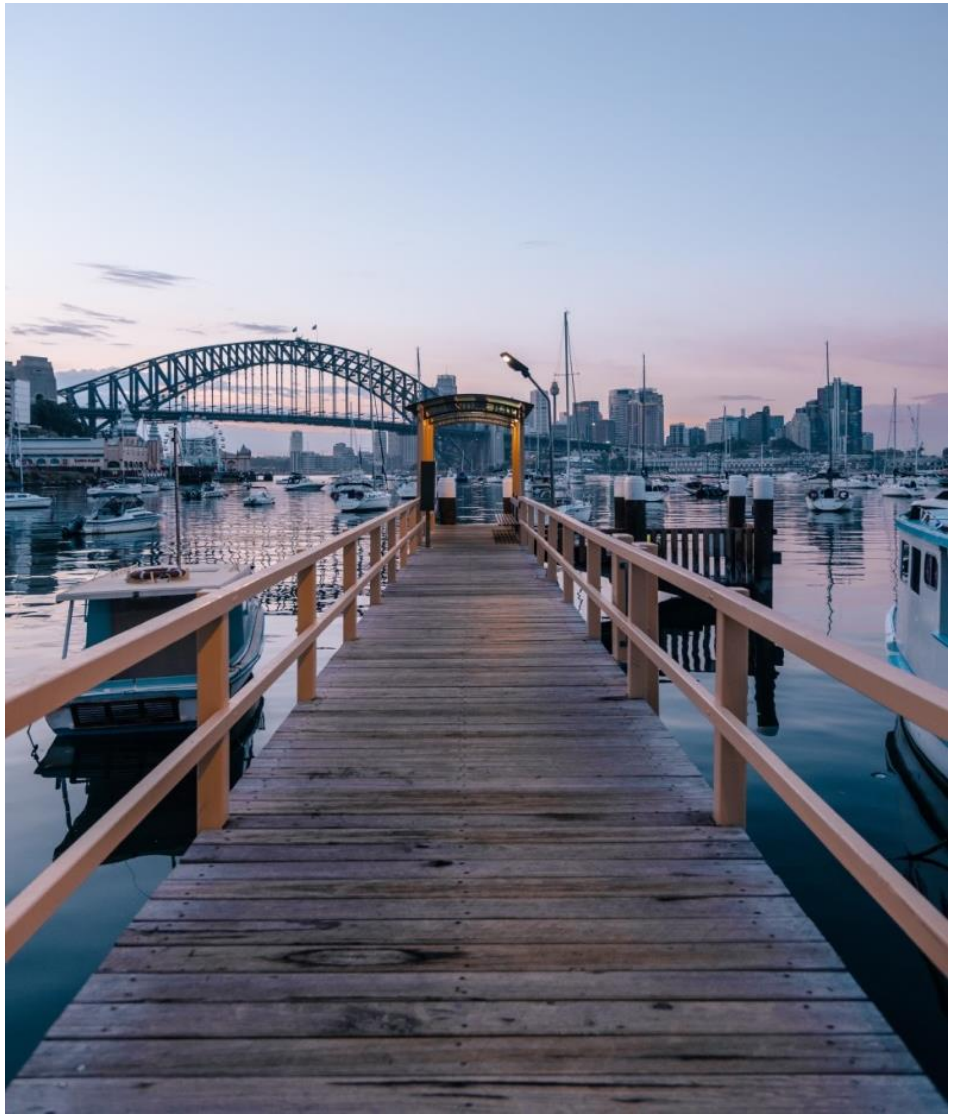


Acknowledgements

- Funders – NHMRC, USYD Medical School, ReturntoWorkSA
- Operations team – Hanan McLachlan, Melanie Hamilton, Melissa Webb
- Investigators – Christine Lin, Laurent Billot, Ric Day, Bart Koes, Jane Latimer, Chris Maher, Andrew McLachlan, Sana Shan
- OPAL collaborators
- And all 157 doctors, 94 pharmacies and 347 participants

Institute for Musculoskeletal Health

A research partnership between Sydney Local Health District and the University of Sydney in musculoskeletal health and physical activity



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Link to paper

NSW GOVERNMENT Health Sydney Local Health District

THE UNIVERSITY OF SYDNEY

Presentation:

Dr Aili Langford

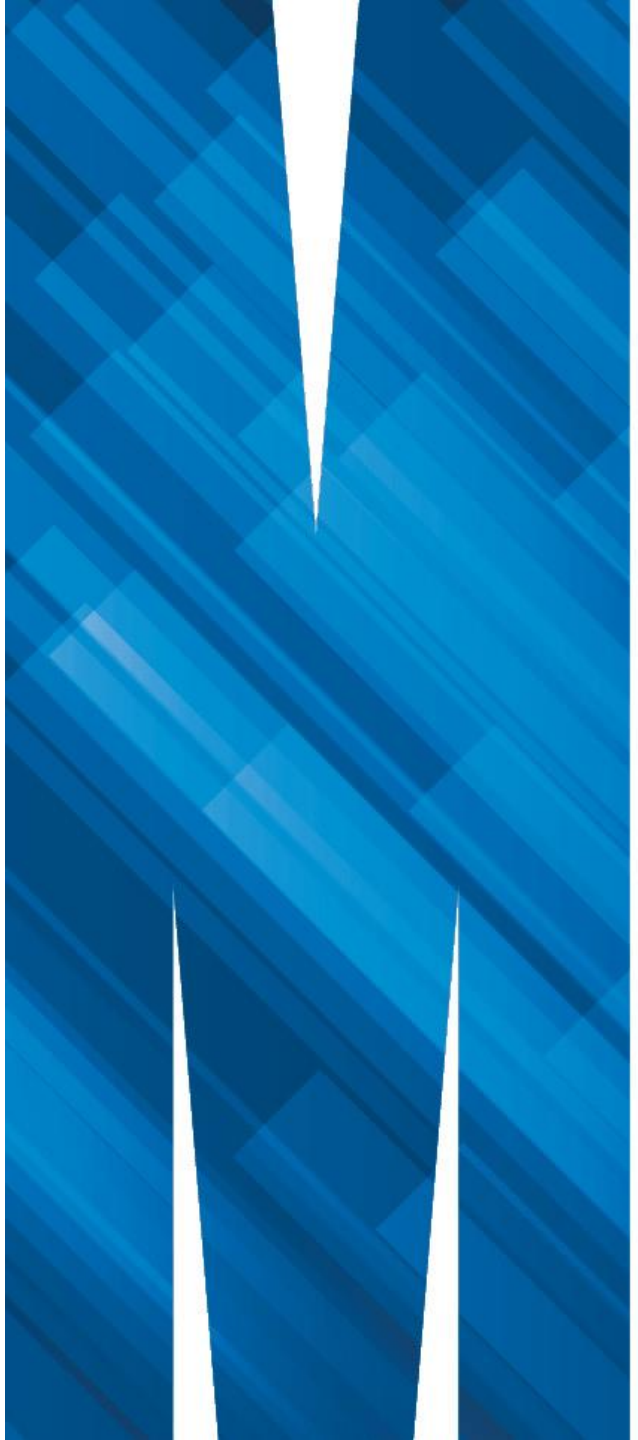
NHMRC Emerging Leadership Fellow from Centre for Medicine Use and Safety, Faculty of Pharmacy and Pharmaceutical Sciences, Monash University

Deprescribing Opioid Analgesics in Primary Care

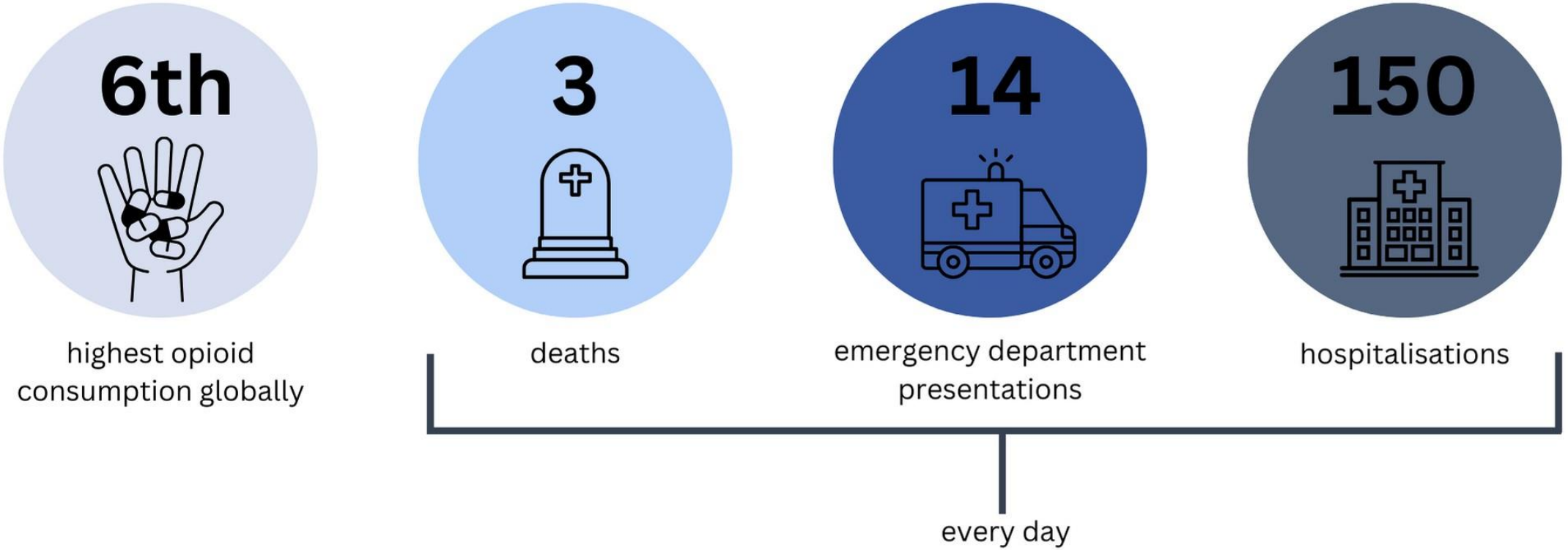
MONASH University

Evidence-Based Opioid Deprescribing Guidelines

Dr Aili Langford
BPharm(Hons), PhD
NHMRC Emerging Leader Research Fellow
Centre for Medicine Use and Safety
Faculty of Pharmacy and Pharmaceutical Sciences
Monash University



Australia's Opioid Landscape



Australian Institute of Health and Welfare, Opioid Harm in Australia, 2018

Response to the ‘Opioid Crisis’

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Recommendations and Reports / November 4, 2022 / 71(3);1–95

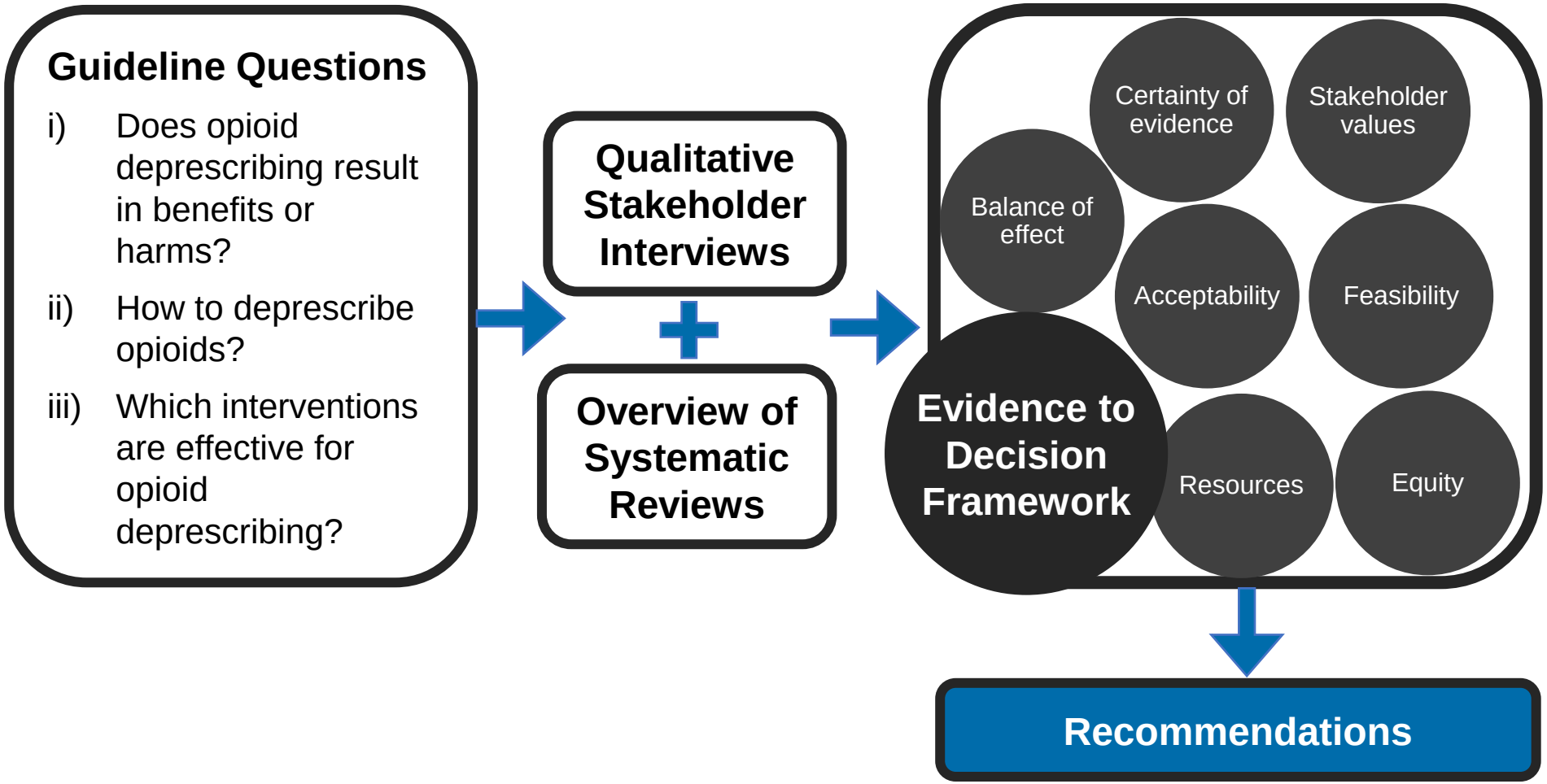
Deborah Dowell, MD[1]; Kathleen R. Ragan, MSPH[1]; Christopher M. Jones, PharmD, DrPH[2]; Grant T. Baldwin, PhD[1]; Roger Chou, MD[3] (VIEW AUTHOR AFFILIATIONS)

View suggested citation

Summary

This guideline provides recommendations for clinicians providing pain care, including those prescribing opioids, for outpatients aged ≥ 18 years. It updates the CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 (MMWR Recomm Rep 2016;65[No. RR-1]:1–49) *and includes recommendations for managing acute (duration of <1 month), subacute (duration of 1–3 months), and chronic (duration of >3 months) pain. The recommendations do not apply to pain related to sickle cell disease or cancer or to patients receiving palliative or end-of-life care. The guideline addresses the following four areas: 1) determining whether or not to initiate opioids for pain, 2) selecting opioids and determining opioid dosages, 3) deciding duration of initial opioid*

Recommendation Generation



Langford, et al., BMJ Qual Saf, 2021
Langford, et al., Pain, 2021
Langford, et al., Basic Clin Pharmacol Toxicol, 2023
Langford, et al., J Clin Epidemiol, 2023
Langford, et al., Med J Aust, 2023

Public Consultation

- Dementia Australia
- Pharmaceutical Society of Australia (PSA)
- Society of Hospital Pharmacists (SHPA)
- The Royal Australian & New Zealand College of Psychiatrists (RANZCP)
- The Royal Australian College of General Practitioners (RACGP)
- The Agency for Clinical Innovation (ACI)
- Royal Australasian College of Physicians (RACP) – AFPHM and AChAM
- Painaustralia
- Palliative Care Australia (PCA)
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- Australian Pain Society (APS)
- Chronic Pain Australia
- Australian Physiotherapy Association (APA) - Pain Special Interest Group
- Australian Commission on Safety and Quality in Health Care - Clinical Pharmacy Unit
- Faculty of Pain Medicine (FPM), Australian and New Zealand College of Anaesthetists (ANZCA)
- Australian Deprescribing Network (ADeN)
- Australian Pain Management Association (AMPA)
- The Australasian Society of Clinical and Experimental Pharmacologist and Toxicologists (ASCEPT)
- Seqirus
- Australian College of Nurse Practitioners (ACNP) & Drug & Alcohol Nurses of Australasia (DANA) (joint response)
- The Australian Psychological Society (APS)
- Northern Territory Department of Health
- Victorian Department of Health
- Western Australian Department of Health
- QScript Management Unit – Queensland Health

Recommendations

1 Classification of recommendations, adapted from the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) handbook[25]

Recommendation for

A "recommendation for" is given when the guideline development group is confident that the desirable effects of an intervention outweigh its undesirable effects. This implies that most or all individuals will be best served by the recommended course of action.

Recommendation against

A "recommendation against" is given when the guideline development group is confident that the undesirable effects of an intervention outweigh its desirable effects. This implies that most or all individuals will be best served by the recommended course of action.

Conditional recommendation for

A "conditional recommendation for" is given when the guideline development group considers that the intervention's desirable effects probably outweigh the undesirable effects but appreciable uncertainty exists. A conditional recommendation implies that not all individuals will be best served by the recommended course of action. There is a need to consider the individual person's circumstances, preferences and values more carefully than usual.

Conditional recommendation against

A "conditional recommendation against" is given when the guideline development group considers that the intervention's undesirable effects outweigh the desirable effects but appreciable uncertainty exists. A conditional recommendation implies that not all individuals will be best served by the recommended course of action. There is a need to consider the individual person's circumstances, preferences and values more carefully than usual.

Consensus recommendation

A consensus recommendation can be given for or against an intervention. This type of recommendation is used when there is not enough evidence to give an evidence-based recommendation but the guideline development group still considers it important to give a recommendation. These recommendations are made based on expert opinion and were formulated by a consensus process.

- **WHEN** to deprescribe
- **WHEN NOT** to deprescribe
- **HOW** to deprescribe

01 Consensus Recommendation

We suggest developing and implementing a deprescribing plan for persons being prescribed opioids at the point of opioid initiation.

02 Conditional Recommendation for (Very low certainty evidence)

We suggest initiating deprescribing for persons taking opioids for chronic non-cancer pain, if (any of the following):

a) there is a lack of overall and clinically meaningful improvement from baseline in function, quality of life or pain,

b) there is a lack of progress towards meeting agreed therapeutic goals, OR

c) the person is experiencing serious or intolerable opioid-related adverse effects in the physical, psychological or social domains.

03 Consensus Recommendation

We suggest initiating deprescribing for persons taking opioids for chronic cancer-survivor pain if, (any of the following):

a) there is a lack of overall and clinically meaningful improvement from baseline in function, quality of life or pain,

b) there is a lack of progress towards meeting agreed therapeutic goals, OR

c) the person is experiencing serious or intolerable opioid-related adverse effects in the physical, psychological or social domains.

04 Consensus Recommendation

We suggest considering deprescribing for persons taking opioids for chronic pain with one or more of the following clinical characteristics:

a) Co-morbidities which may increase risk of opioid related harms e.g. sleep-disordered breathing or sleep apnoea, chronic obstructive pulmonary disease (COPD).

b) Concomitant use of medicines or substances with sedating effects e.g. benzodiazepines, alcohol, gabapentinoids, antipsychotics and sedating antidepressants.

c) High doses of prescribed opioids.

05 Consensus Recommendation

We suggest avoiding deprescribing for persons taking opioids for pain or dyspnoea who are nearing the end-of-life.

06 Conditional Recommendation against (Moderate certainty evidence)

We suggest avoiding opioid deprescribing for persons taking opioids with a severe opioid use disorder and suggest that evidence-based care, such as transition to, or referral for, medication assisted treatment of opioid use disorder is provided.

07 Recommendation for (Low certainty evidence)

We recommend gradual tapering of opioids. Abrupt cessation of opioids without prior dose reduction may increase risks of harm.

08 Recommendation for (Very low certainty evidence)

We recommend tailoring the deprescribing plan based on the person's clinical characteristics, goals and preferences.

09 Consensus Recommendation

We suggest conducting regular monitoring and review of a person taking opioids throughout the opioid deprescribing process. Response against agreed therapeutic goals contained in a deprescribing plan should be regularly assessed.

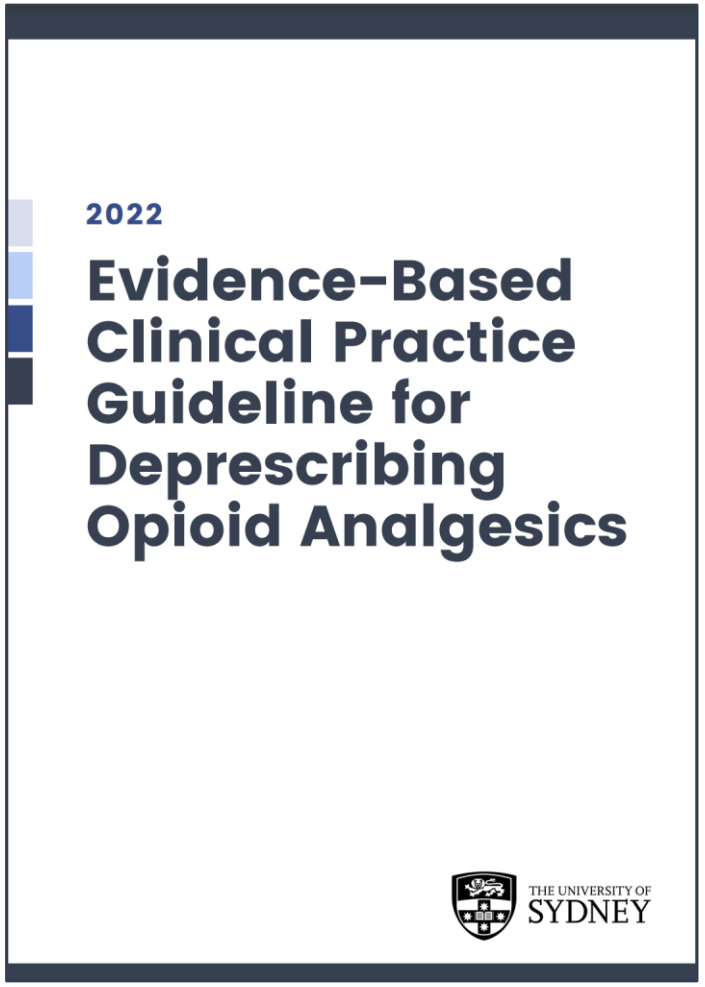
10 Conditional Recommendation for (Low certainty evidence)

When available, we suggest the use of interdisciplinary or multidisciplinary care, or a multimodal approach which emphasises non-pharmacological and self-management strategies to deprescribe opioids.

11 Conditional Recommendation for (Very low certainty evidence)

We suggest the consideration of evidence-based co-interventions to support opioid deprescribing.

NHMRC Approved Guideline



MONASH University

Guideline Summary

Guideline summary

Clinical practice guideline for deprescribing opioid analgesics: summary of recommendations

Aili V Langford[1,2], Christine CW Lin[3], Lisa Bero[4], Fiona M Blyth[2], Jason Doctor[5], Simon Holliday[6], Yun-Hee Jeon[2], Joanna Moullin[7], Bridin Murnion[2,8], Suzanne Nielsen[9], Rawa Osman[10], Jonathan Penm[2,11], Emily Reeve[1,12], Sharon Reid[2], Janet Wale[13], Carl R Schneider[2,*], Danijela Gnjidic[2,*]

Pain and pain-related conditions are a leading cause of disability and disease burden globally,[1] with one in five adults aged 45 years and over reporting persistent, ongoing pain.[2] Opioids are commonly prescribed for the management of pain, and increases in the use of prescription opioids have been observed globally over recent decades, particularly in Organisation for Economic Co-operation and Development (OECD) countries.[3] In Australia, over 1.9 million adults initiate opioid therapies each year,[4] with the majority of prescriptions in primary care issued for maintenance therapy in chronic non-cancer pain.[5,6] Although shown to be an effective component of the management of acute pain, opioids may not provide longer term clinically important improvements in pain or function compared with placebo or non-opioid medications.[7,8] Further, opioid use presents a significant risk of harm, with about 80% of people who take opioids for three months or more experiencing adverse effects.[9]

Escalating opioid use and subsequent harm has been recognised as an international public health concern. The World Health Organization has set a global goal of reducing severe avoidable medication-related harm through its Medication Without Harm Global Patient Safety Challenge.[10] Australia's response

Abstract

Introduction: Long term opioids are commonly prescribed to manage pain. Dose reduction or discontinuation (deprescribing) can be challenging, even when the potential harms of continuation outweigh the perceived benefits. The *Evidence-based clinical practice guideline for deprescribing opioid analgesics* was developed using robust guideline development processes and Grading of Recommendations, Assessment, Development and Evaluation (GRADE) methodology, and contains deprescribing recommendations for adults prescribed opioids for pain.

Main recommendations: Eleven recommendations provide advice about when, how and for whom opioid deprescribing should be considered, while noting the need to consider each person's goals, values and preferences. The recommendations aim to achieve:

- implementation of a deprescribing plan at the point of opioid initiation;
- initiation of opioid deprescribing for persons with chronic non-cancer or chronic cancer-survivor pain if there is a lack of overall and clinically meaningful improvement in function, quality of life or pain, a lack of progress towards meeting agreed therapeutic goals, or the person is experiencing serious or intolerable opioid-related adverse effects;
- gradual and individualised deprescribing, with regular monitoring

Langford, et al., Med J Aust, 2023

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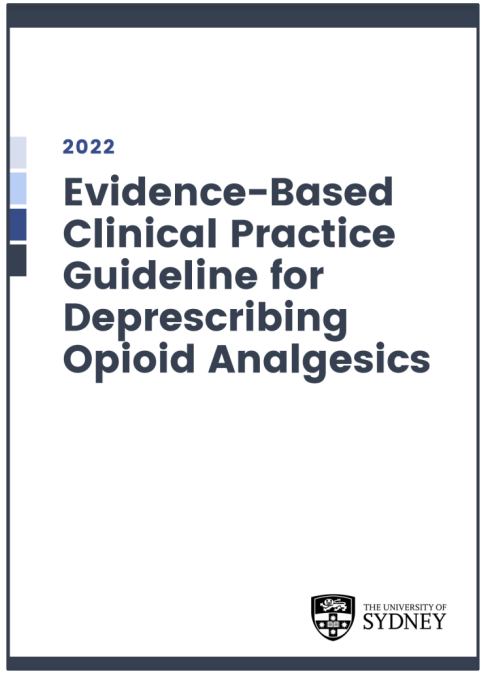
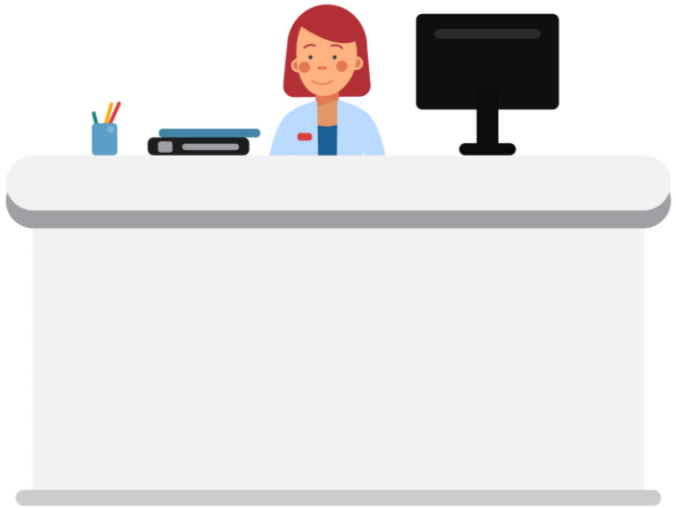
Next Steps





Dr Aili Langford

Monash University

Dr Aili Langford is a pharmacist and postdoctoral research fellow at the Centre for Medicine Use and Safety (CMUS), Monash University. Aili's research focuses on reducing medication-related harm through deprescribing (medication dose reduction or cessation). During her PhD at the University of Sydney, Aili led the development of the Australian Evidence-Based Clinical Practice Guideline for Deprescribing Opioid Analgesics, with recommendations approved by the National Health and Medical Research Council. Aili is passionate about exploring ways to translate evidence into practice to improve medication management and patient care.

Developing evidence-based resources for older adults to support person-centred opioid deprescribing

One in five Australian adults have chronic pain. Opioids are medicines commonly prescribed to manage pain. When taken long-term, opioids do not significantly improve pain or function and can cause many side effects (e.g. constipation, falls, confusion, overdose). Older Australians are more likely to take opioids and experience opioid-related harms. Deprescribing is the process of reducing or discontinuing a medicine when the risk of harm outweighs the benefits. This project aims to develop resources for consumers to educate and empower them to engage in opioid deprescribing. Focus groups and interviews will be conducted to design and refine the content, format, design and language of the resources. By co-designing resources with consumers and healthcare professionals, we will make sure that they are clear and easy to use. They will support conversations between older adults and their healthcare professionals to help older adults take the right pain medicines at the right doses for them, while reducing the chance of harm.

Award: $9,921

Monash Institute of Pharmaceutical Sciences awarded close to $10m in NHMRC funding

19 December 2023

Researchers from the Monash Institute of Pharmaceutical Sciences (MIPS) have collectively generated $9,492,833 in National Health and Medical Research Council (NHMRC) Investigator, Ideas and Development Grant funding across six projects in total.

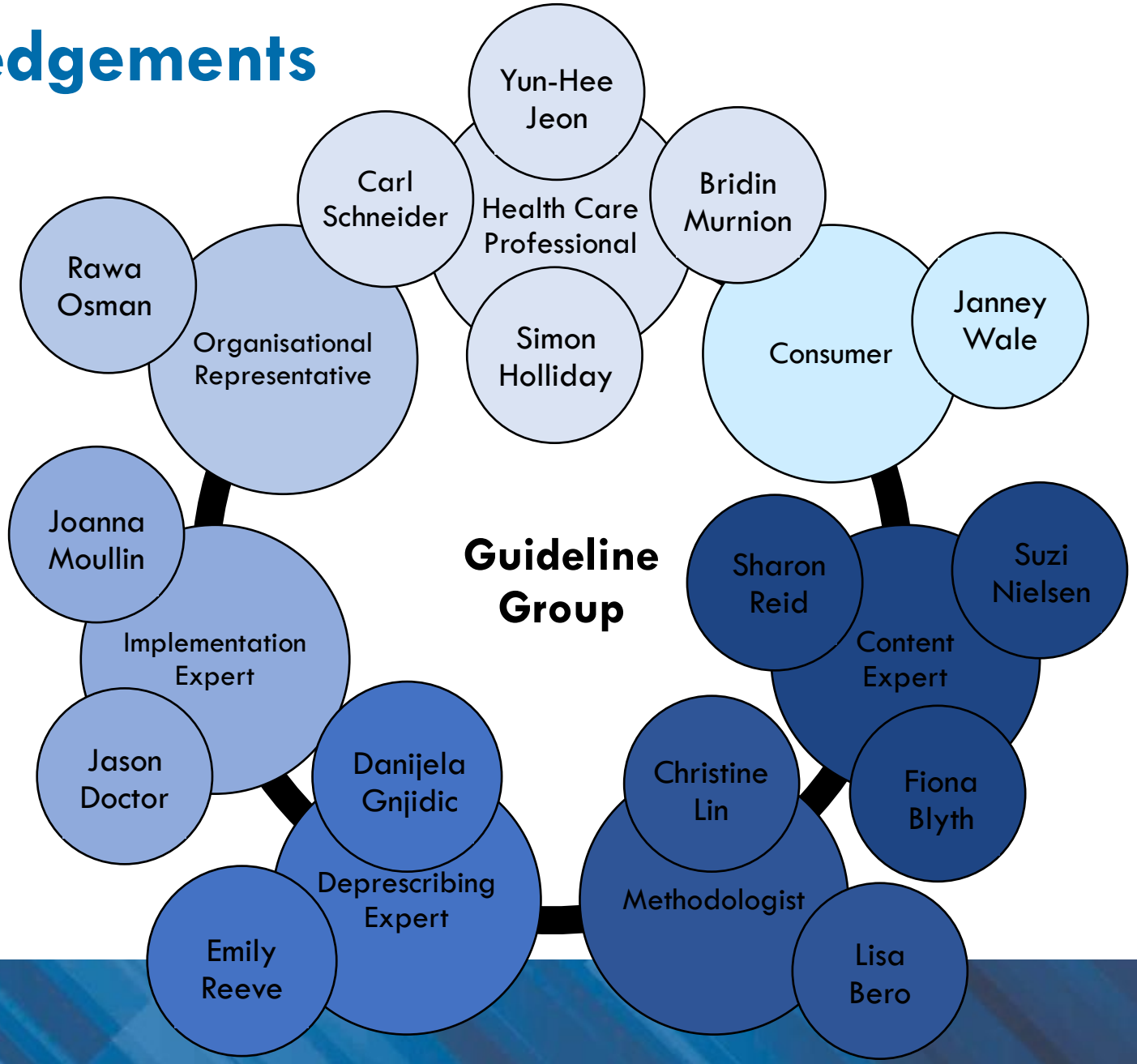
Funded projects, announced by the Minister for Health and Aged Care, the Honourable Mark Butler MP, will address a range of medical needs including metabolic disease, cardiovascular disease, diabetic kidney disease, safer approaches to treating pain, and reducing harm associated with opioids.

Director of MIPS, Professor Chris Porter, welcomed the funding and said the projects all aim to address

2023 NHMRC Investigator Grant Recipients L - R: Professor Patrick Sexton, Professor Rebecca Ritchie, Professor Denise Wootten, Dr Arisbel Gondin, Professor Ray Norton, Dr Aili Langford.

MONASH University

Acknowledgements



A/Prof Carl Schneider
A/Prof Danijela Gnjidic
Prof Christine Lin
The University of Sydney

MONASH University

GoldNet Research

Opioid Prescribing in Primary Care

Presentation:

Joyce McSwan

GCPHN Persistent Pain Program Clinical Director, BNPHN Persistent Pain Program Clinical Director, President, Australian Pain Society

A practical approach to translating opioid guidelines into clinical practice

BOND UNIVERSITY | INSTITUTE FOR Evidence-Based Healthcare

Griffith UNIVERSITY Queensland, Australia

phn GOLD COAST An Australian Government Initiative

GPGC Healthy General Practice Healthy Gold Coast

A Practical Approach to Translating Opioid Guidelines into Clinical Practice

Joyce McSwan
Clinical Program Director, Gold Coast Primary Health Network Persistent Pain Program
Managing Director, PainWISE Pty Ltd
President, Australian Pain Society
B.Pharm.FPS Cert IV TAE

Disclosure of conflicts

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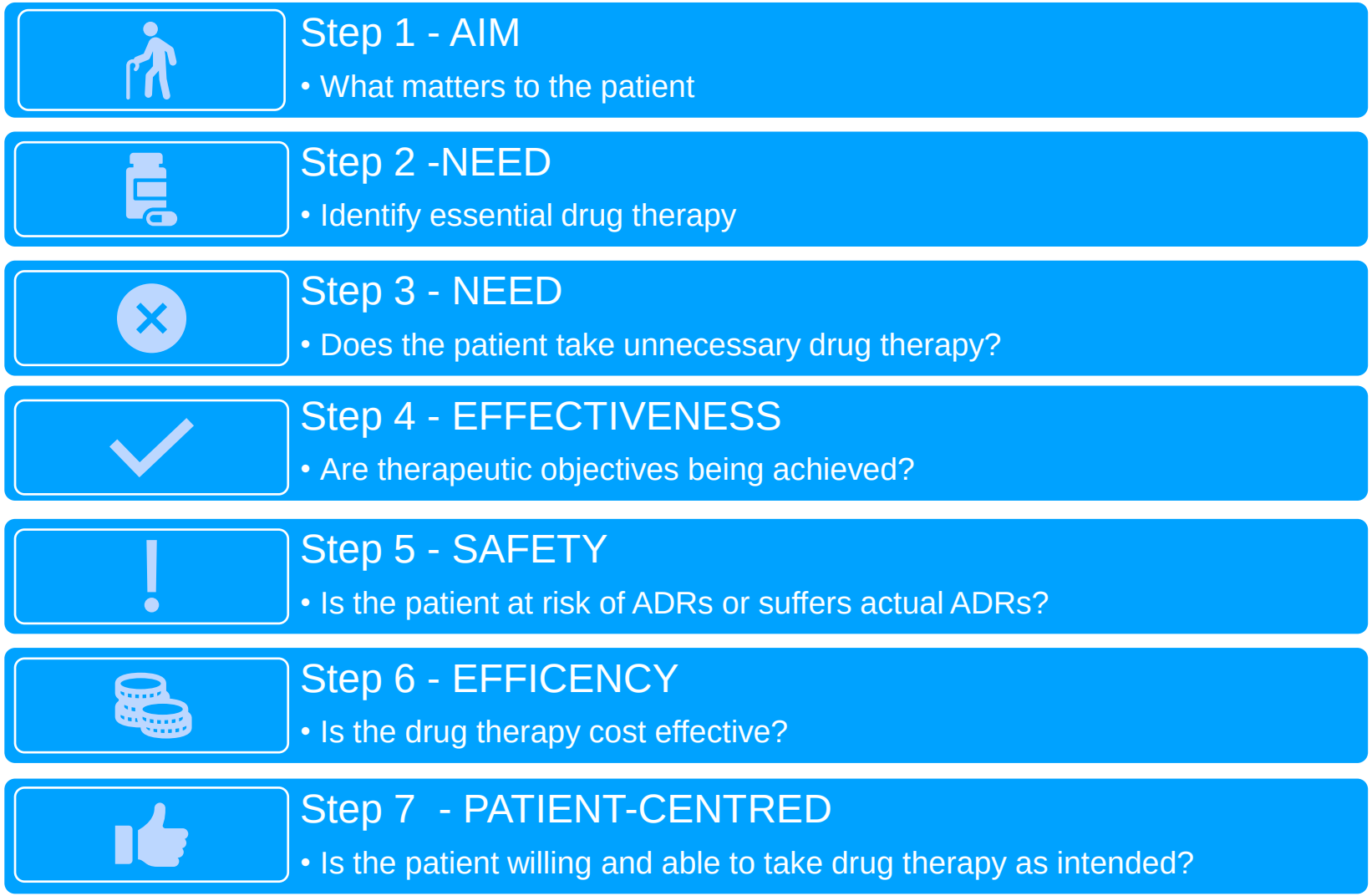
All views in this presentation are my own and not representative of any of the companies listed.


Harm
Benefit
Efficacy
Deprescribing
Quality
Polypharmacy
Rationalising
tapering
Withdrawing
Reducing
Wean
Reconciliation
Safety
Cost
Making sense of

7 Steps to medication rationalisation



https://managemeds.scot.nhs.uk/for-healthcare-professionals/principles/the-7-steps-medication-review/ . Accessed 29th May 2023

Weighing up the risks

The risk of serious harm:
Accidental overdose, death, hospitalisation, unconsciousness, respiratory failure

Compared to OMEDD 1-20mg:

OMEDD	RISK MULTIPLIER
20-50mg	**1.5 x**
50-100mg	**4 x**
> 100mg	**9 x**

Risks are likely to be developed by **80%** of people on long term opioids.

Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med. 2010;152(2):85-92. 2

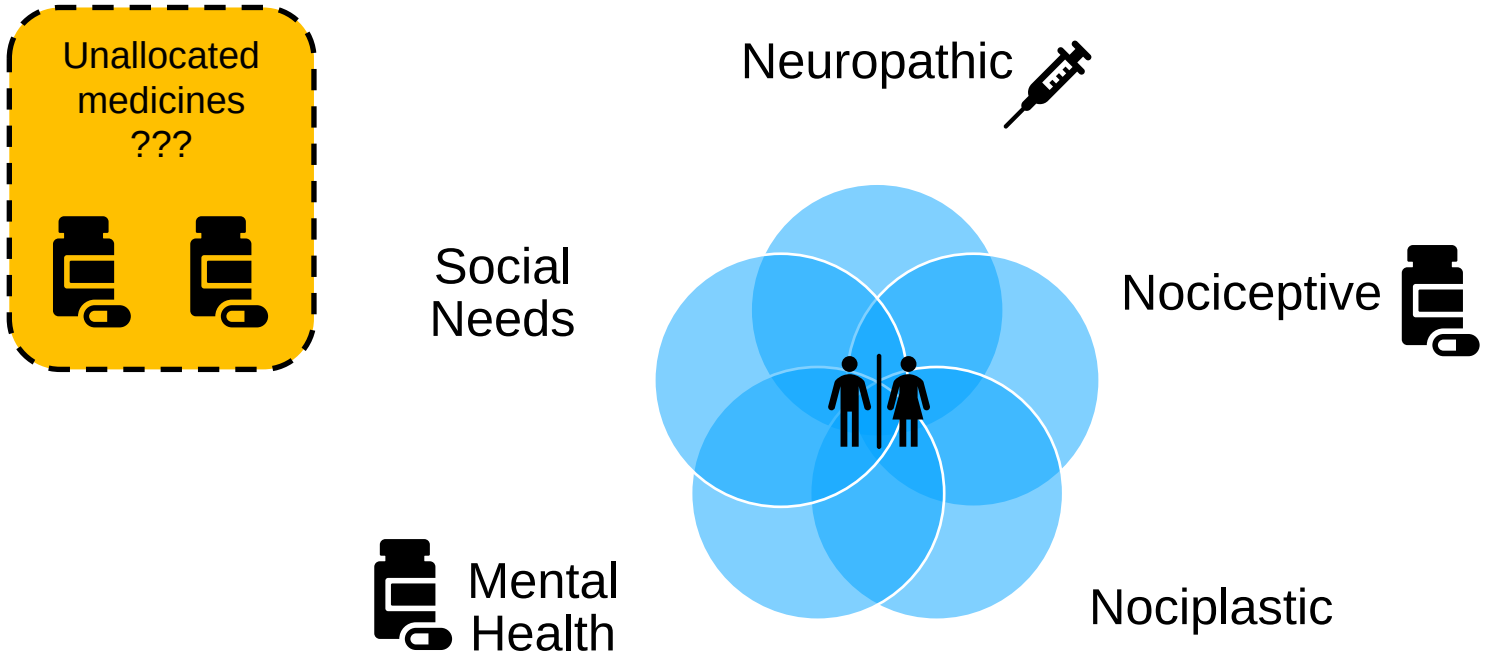
The ART of medication rationalization

- Medication rationalization is a complex process
- Careful judgement is required - Unconscious bias
- Balanced approach
- Risk vs. benefits of withdrawing/tapering medicines

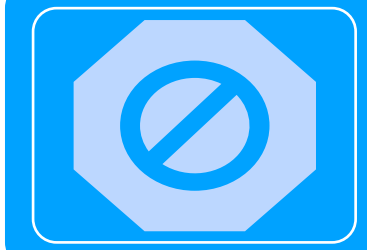
Translating medication rationalization to clinical practice

Step 1 - AIM	• What matters to the patient
Step 2 -NEED	• Identify essential drug therapy
Step 3 - NEED	• Does the patient take unnecessary drug therapy?

Making Sense of Pain

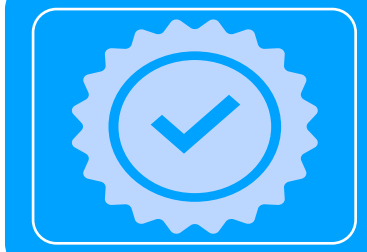


Translating medication rationalization to clinical practice



STOP

- The obvious ones: person does not like them, is not taking them, should not be on repeat or the condition has resolved.



SORTED

- Medicines assessed and monitored within the last 12 months
- E.g. Chronic disease clinics, Specialist review, no outstanding concerns.

SPECIAL

- Focus of discussion
- Person’s priorities, high-risk medicines, prescribing indicators

Avera A et al. Rationalising medications through deprescribing. BMJ 2019;364:l570 doi: 10.1136/bmj.l570

Case Study 1: Meet Sam

Age: 65 year old man
Ht: 163cm; Wt: 70kg

Pain Hx:
2010 – MVA, no fractures, concussion and complained of neck pain at the time
2013 – Depression and anxiety
2015 – LBP from a fall in his house whilst doing gardening
2016- Low back pain – complain of severe tension
2022 – Osteoarthritis – bilateral knee pain

Work history:
- Worked since yearly 20s as a commercial cleaner
- 2016- stopped work due to pain
- 2017- Taxi driving - now stopped

Other medical conditions:
- Depression and anxiety
- Hypertension

Biochemistry:
- FBC – normal
- LFTs and RFTs – normal

Case Study 1: Meet Sam

Reason for referral:
Referred by ED team due to frequent ED presentation, 6 presentations in the last 2 months due to extreme pain

Clinical presentation:
- Sam was nervous and appeared to have a brave face of his pain. Very softly spoken man.
- Observed to have antalgic gait.
- Also complains of low back pain of 8/10 and tension in muscles localised to the L5, S1 region, worsened on exertion. Localised allodynia in the L5,S1 area which limits how long he can sit for.
- Sitting capacity is approximately 10 minutes.
- Walking capacity is approximately 10 minutes on even surface. Hesitant to walk on uneven surfaces or up hills.
- Lying does relieve the pain, but he has to change sides frequently.
- Neurological symptoms are absent.
- Radiculopathy is absent.
- Observed to be apathetic and complains of severe fatigue.
- Insomnia at night even though he is very tired, he can’t sleep.
- Not keen to see allied health, especially physios, as he has had poor experience previously
- Also complains of peripheral oedema

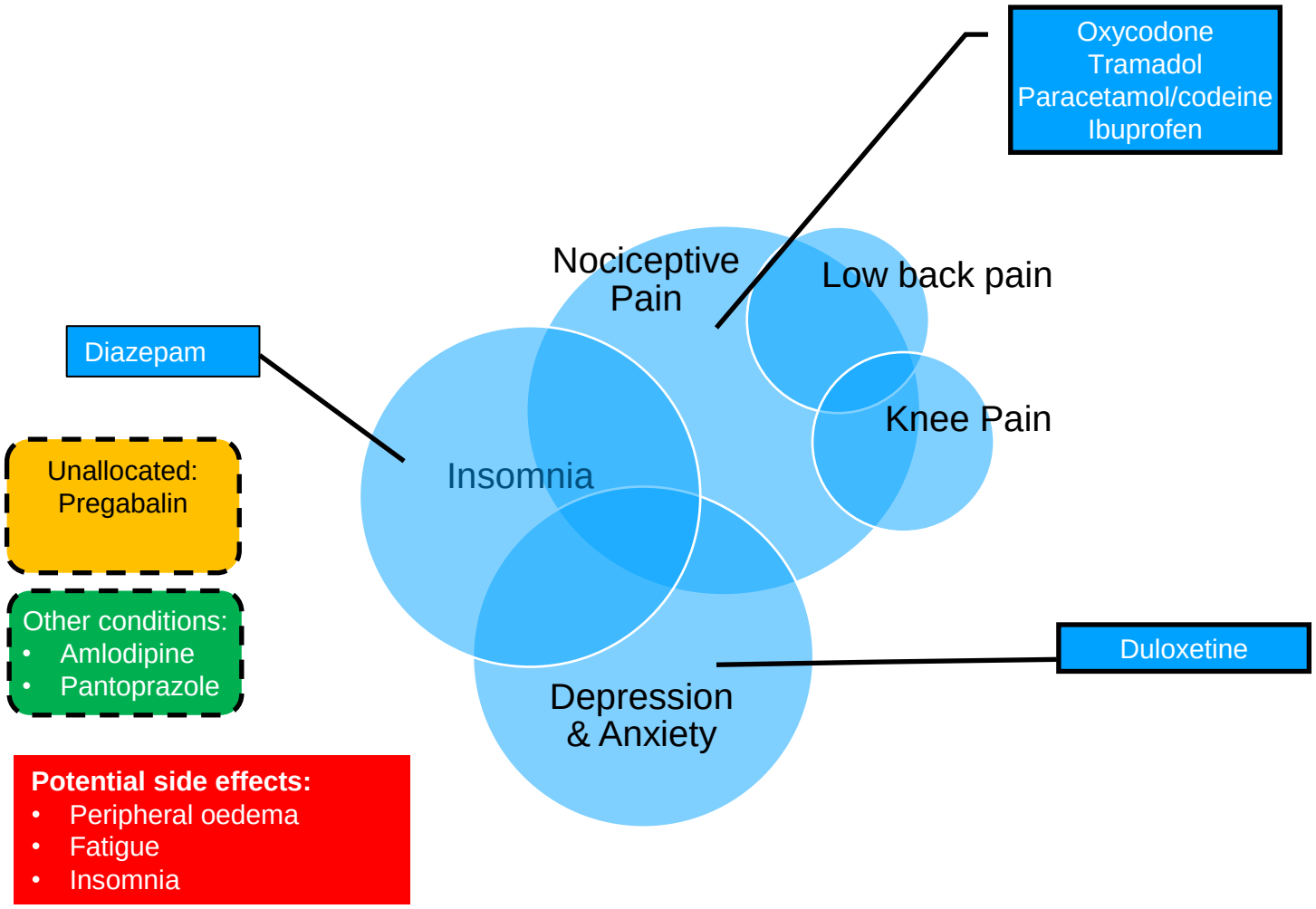
Case Study 1: Meet Sam

Medication:
Amlodipine 5mg daily
Oxycodone SR 20mg BD (Started since 2015 when he fell at home and dose increased over time)
Pantoprazole 20mg daily
Pregabalin 150mg BD (Started since 2016, not sure if it works)
Duloxetine 90mg at night (Started since 2018 after he stopped driving taxis)
Diazepam 5mg 2-3 PRN (Started since 2018 when he could not sleep and back spasms became worse)
Paracetamol 500mg/Codeine 30mg – 2 QID PRN (Take this when he has a flare up, usually post exertion)
Ibuprofen 400mg TDS PRN (Takes this when he has a flare up, usually post exertion)
Tramadol IR 50mg – 1 QID PRN (Alternative to Paracetamol/Codeine)

Previous interventions:
2017- Facet Joint injection, L5/S1 – 1-2 months benefit
2020 – Nerve block – L5/S1 – worsened pain for 1 month and 3 months marginal benefit
Not keen on any other invasive interventions

Patient's Priority:
1. Sleep better
2. Improve fatigue
3. Reduce back tension
4. Be able to sit and walk for longer duration
5. Drive taxi again or do some volunteer work

Rationalising Sam's medications



Rationalising Sam's medications and priorities

Sleep better	• Change duloxetine to morning dose and reduce to 60mg mane
Improve fatigue	• Monitor Testosterone levels • Reduce Pregabalin by 25mg mane with the aim of ceasing depending on symptom control (may also improve peripheral oedema) • Reduce diazepam use if orphenadrine is helpful
Reduce back spasms	• Trial orphenadrine 100mg BD PRN in place of diazepam • Low continuous heat therapy (FlexEze®) • Physio consult for gentle neural glide knowledge and exercise • Celecoxib 400mg STAT for flare ups in place of Ibuprofen, Paracetamol/codeine or tramadol.
Sit, walk for longer duration	• Physio consult for graded movement planning and understanding of pacing vs. movement goals – rapport and reassurance ++ • Gait review • Monitor peripheral oedema and consider changing amlodipine to lecarnidipine (discuss with GP)

Rationalising Sam's medications

1 month later

Testosterone level – 5.5 nmol/L
It reported a reference range of 9.7–34.3 nmol/L with a mean of 18.2 nmol/L (Australian study in 21-35 year olds)
Vitamin D levels – 20 nmol/L (deficient)

Sleep better

- Change duloxetine to morning dose and reduce to 60mg mane – Sleep improved

Improve fatigue

- Low testosterone – discussion about reducing oxycodone SR
- Reduction going well, reduce Pregabalin by 25mg nocte with the aim of ceasing depending on symptom control (no change in peripheral oedema) and no worsening of pain symptoms
- Diazepam dose reduced to 5mg nocte PRN only
- Reduce Oxycontin to 10mg TDS

Reduce back tension

- Orphenadrine well tolerated and has been helpful for back tension
- Low continuous heat therapy (FlexEze®) – going well and finding it helpful
- 2 physio visits so far – going well
- Celecoxib 400mg STAT for flare ups –helping and less overall use of other PRN analgesics

Sit, walk for longer duration

- Has graded walking and sitting plan – now walking for 13 minutes
- GP was keen to change to lecarnidipine
- Commence Vit D 2000IU daily

6 months later ……

Sleep better	• Change duloxetine to morning dose and reduce to 60mg mane – Sleep improved • Less overall diazepam taken – now 5mg PRN (approx. fortnightly for anxiety)
Improve fatigue	•Pregabalin ceased •Oxycodone SR 5mg TDS with paracetamol 665mg 2 TDS •Diazepam dose reduced to 5mg nocte PRN only for anxiety •Fatigue improved •Volunteering at grand kids school for reading time
Reduce back tension	•Orphenadrine well tolerated and has been helpful for back tension •Low continuous heat therapy (FlexEze®) – going well and finding it helpful •Monthly physio visits •Celecoxib 400mg STAT for flare ups •Topical NSAIDs – compounded •Paracetamol/codeine, tramadol and ibuprofen ceased
Sit, walk for longer duration	• Now walking 20 minutes every second day, pacing with movement program as a guide • Peripheral oedema now improved
Vitamin D	• Continue on Vitamin D 2000IU daily and levels improved to 40nmol/L-less fatigue

In review….10 months later

Medication changes:

~~Amlodipine 5mg daily~~ Lecarnidipine 5mg daily
Oxycodone SR ~~20mg BD~~ 2.5mg TDS
Paracetamol MR 665mg – 2 TDS
Pantoprazole 20mg daily
~~Pregabalin 150mg BD~~ Ceased
Duloxetine ~~90mg at night~~ 60mg in the morning
Diazepam 5mg ~~2-3 PRN~~ once daily PRN
~~Paracetamol 500mg/Codeine~~ - Ceased
~~Ibuprofen 400mg TDS PRN~~ - Ceased
~~Tramadol IR 50mg – 1 QID PRN~~ - Ceased
Celebrex 400mg STAT PRN
Vitamin D 2000IU daily

Allied Health:

- Physio – Every 4 weekly visits for gait and exercise review
- Going to floatation therapy – finds this relaxing

Social Activities:

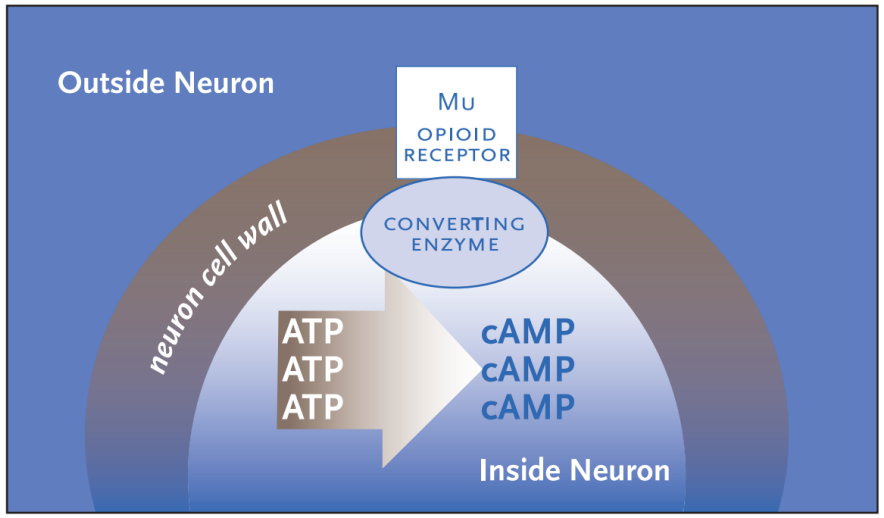
- Volunteering in grandchildren's school for reading time
- One day a week goes for coffee at the beach café (can't walk on beach yet but enjoys being there)
- Going for lunch with a friend once a month

Patient's Priority:

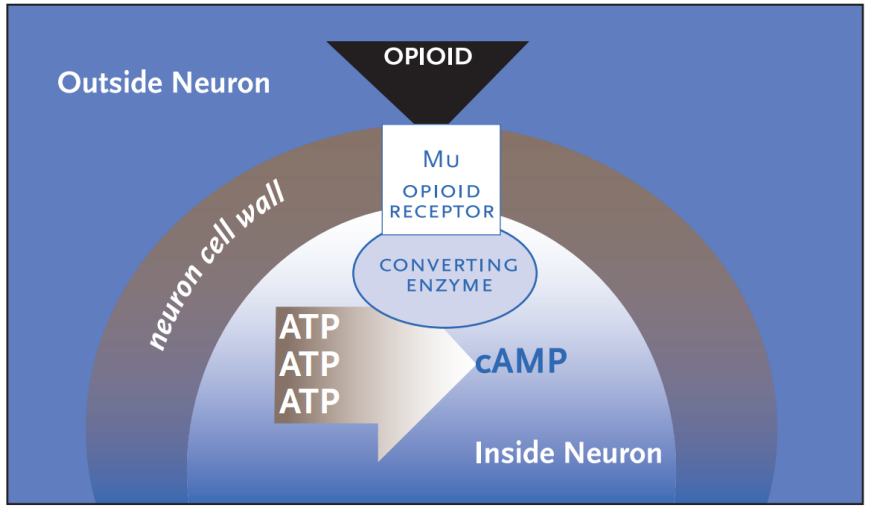
- ✓ Sleep better - sleeping better overnight
- ✓ Improve fatigue – less fatigue in the day and clearer in the mind
- ✓ Reduce back tension – allodynia much improved and low back more relaxed
- ✓ Be able to sit and walk for longer duration – sitting for 30 mins and walking for 20 minutes
- ✓ Drive taxi again or do some volunteer work - volunteering at grandchildren's school for reading time

Explaining opioid withdrawal

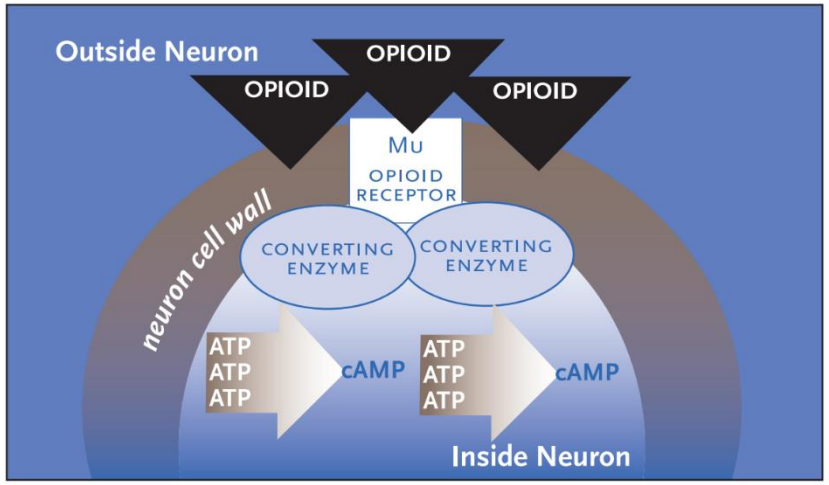
A. Baseline: Normal production of NA



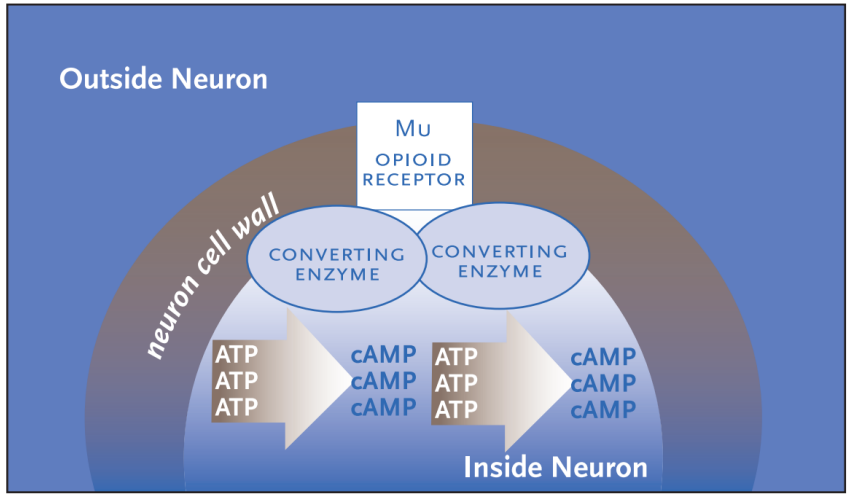
B. Acute opioid inhibition of converting enzyme: Abnormally low production of NA



C. Chronic opioid inhibition leads to increased converting enzyme activity: Normal NA level

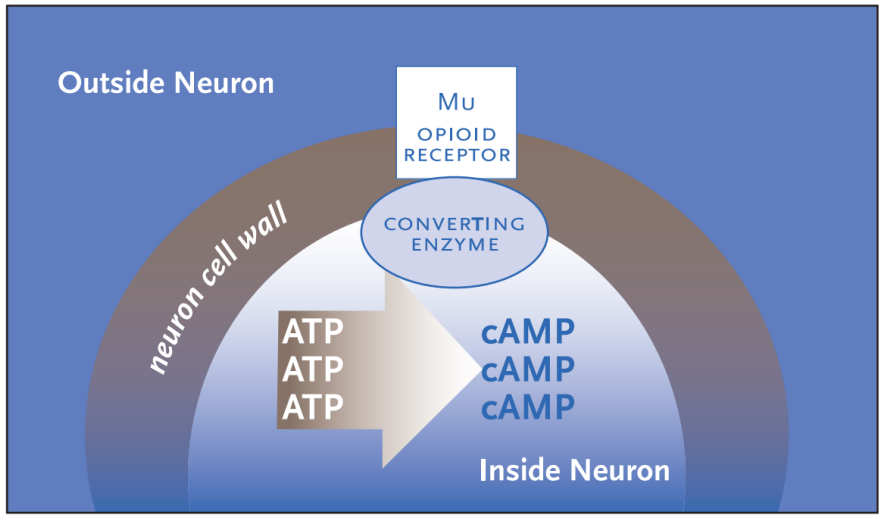


D. Discontinuing opioid leads to increased cyclic AMP due to loss of inhibition: NA excessively high



Ref: Kosten T, George T, The Neurobiology of Opioid Dependence: Implications for Treatment. Sci Pract Perspect. 2002 Jul; 1(1): 13–20.

A. Baseline: Normal production of NA



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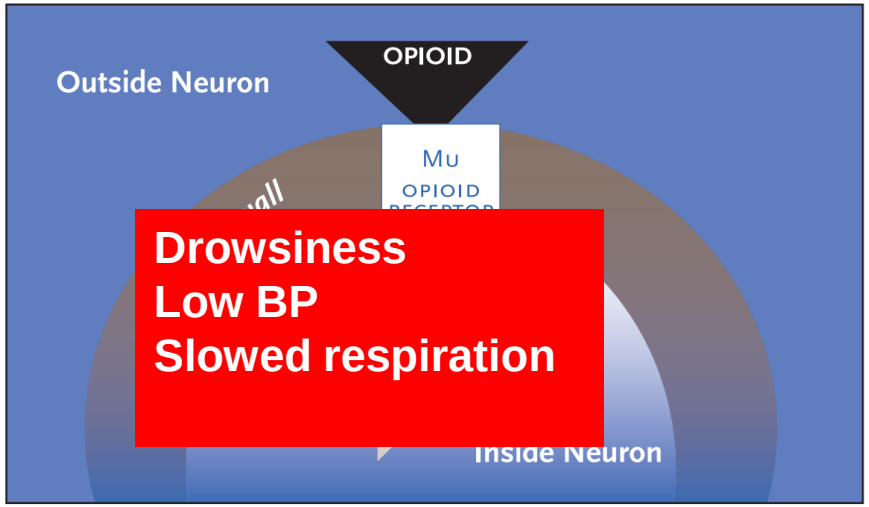

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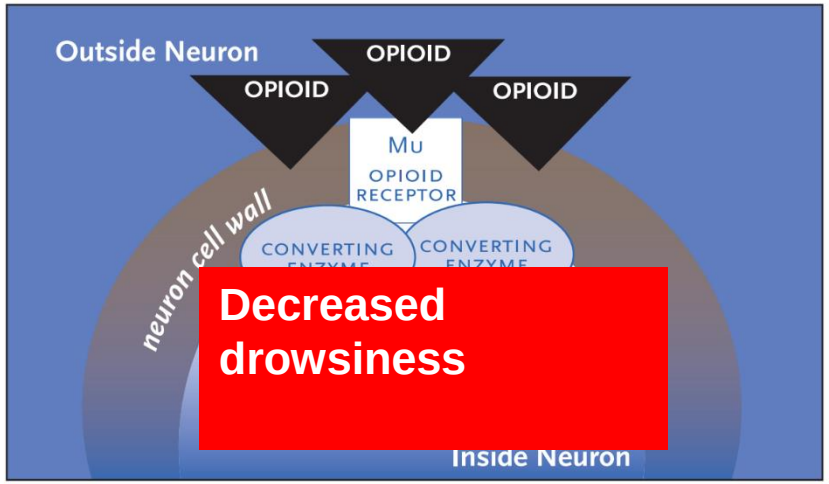

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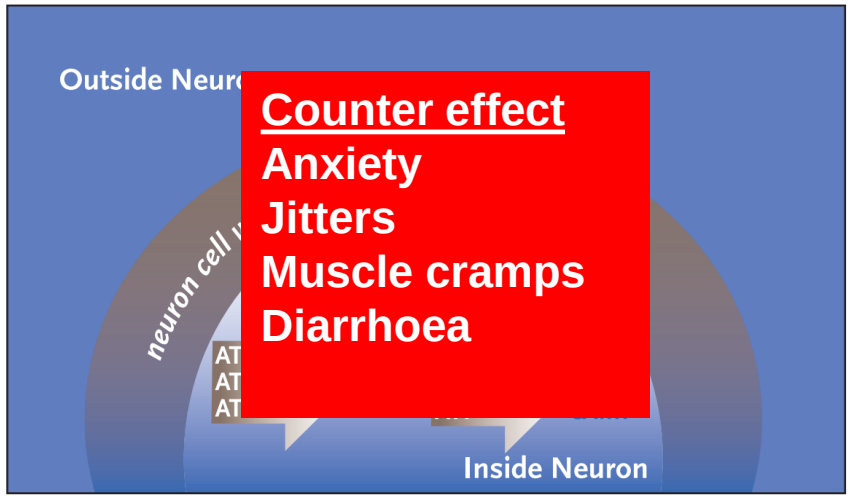
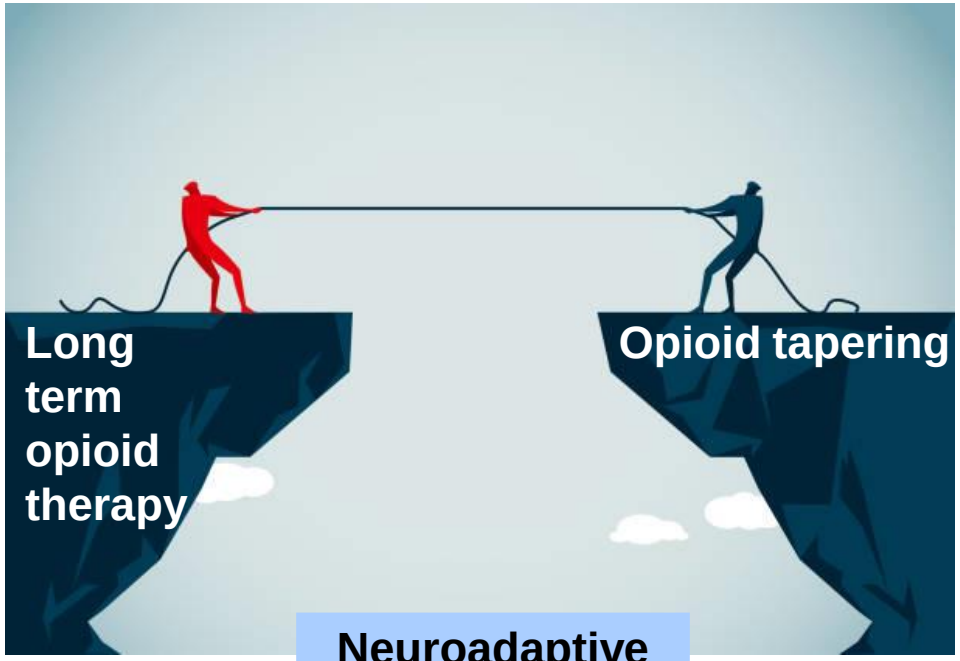


Ref: Kosten T, George T, The Neurobiology of Opioid Dependence: Implications for Treatment. Sci Pract Perspect. 2002 Jul; 1(1): 13–20.

A Gray Area... Complex Persistent Opioid Dependence



Neuroadaptive process

Complex Persistent Opioid Dependence[1]
OR
Opioid Induced Chronic Pain syndrome[2]

1. Manhapra A, Sullivan MD, Ballantyne JC, MacLean RR, Becker WC. Complex Persistent Opioid Dependence with Long-term Opioids: a Gray Area That Needs Definition, Better Understanding, Treatment Guidance, and Policy Changes. J Gen Intern Med. 2020 Dec;35(Suppl 3):964-971. doi: 10.1007/s11606-020-06251-w. Epub 2020 Nov 6. PMID: 33159241; PMCID: PMC7728942.
2. Manhapra, A. Complex Persistent Opioid Dependence—an Opioid-induced Chronic Pain Syndrome. *Curr. Treat. Options in Oncol.* **23**, 921–935 (2022).

Resources

- **GUIDELINE FOR DEPRESCRIBING OPIOID ANALGESICS**
https://www.opioiddeprescribingguideline.com/

- **RACGP aged care clinical guide (Silver Book) 5th edition Part A. Deprescribing**
https://www.racgp.org.au/getattachment/1e7f5be2-910e-44e6-8274-6a8263fcd8dd/Deprescribing.aspx

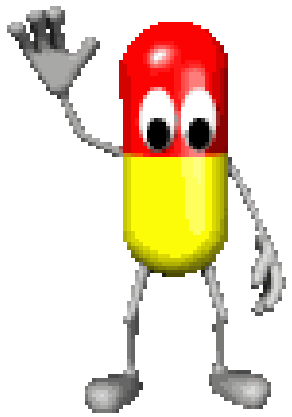
- **Deprescribing.ORG**
https://deprescribing.org/

- **NPS Tapering algorithm**
https://www.nps.org.au/assets/NPS-MedicineWise-opioid-tapering-algorithm.pdf

- **Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard**
https://www.safetyandquality.gov.au/standards/clinical-care-standards/opioid-analgesic-stewardship-acute-pain-clinical-care-standard

Connect with me

Thank you



Panel Discussion

Opioid Prescribing in Primary Care

Our Panel:

Joyce McSwan
Managing Director, PainWISE Pty Ltd
GCPHN Persistent Pain Program Clinical Director, BNPHN Persistent Pain Program Clinical Director, President, Australian Pain Society

Dr Caitlin Jones,
Postdoctoral Research Associate
The Institute for Musculoskeletal Health,
The University of Sydney

Dr Aili Langford,
NHMRC Emerging Leadership Fellow
Centre for Medicine Use and Safety, Faculty of Pharmacy and Pharmaceutical Sciences, Monash University

Chair:

Prof. Nick Zwar
Executive Dean of the Faculty of Health Sciences and Medicine, Bond University.

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Griffith UNIVERSITY Queensland, Australia

phn GOLD COAST An Australian Government Initiative

GPGC Healthy General Practice Healthy Gold Coast

GoldNet Research & UQGP Research - Online Journal Club

The GoldNet Research Network is pleased to invite you to our upcoming online collaborative journal club with UQGP Research – The University of Queensland PBRN.

Date: Tuesday 21st May 2024
Time: 6 pm – 7 pm (AEST)

The benefits and harms of drug treatment for type 2 diabetes

Hosted by:

Prof. Nick Zwar
Executive Dean, Faculty of Health Sciences and Medicine, Bond University & Chair of GoldNet

Professor Katharine Wallis
Mayne Professor and Head, Mayne Academy of General Practice and Head, General Practice Clinical Unit, Medical School, The University of Queensland

Guest Panel:

Dr Geoffrey Spurling
Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care and General Practice Clinical Unit, The University of Queensland

Dr Anish Menon
Endocrinologist,
The University of Queensland

If you are interested in joining this journal club, please register to our PBRN emailing list.

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GPGC Healthy General Practice Healthy Gold Coast

Current Projects - APCOM

Activating **P**rimary Care **CO**PD Patients with **M**ultimorbidity (**APCOM**) Trial

- The APCOM Trial is a randomized controlled clinical trial that aims to test **a personalised self-management support program**, to be delivered by Practice Nurses (PNs) to patients with COPD and other long-term health conditions.
- The trial will evaluate whether this program is **effective in improving quality of life**, increasing **patient knowledge** of COPD and can be effectively **implemented in primary care**.
- **29** practices across Australia, and **221** patients

Current Projects

GP's use of non-drug interventions in primary care

- Institute for Evidence-Based Healthcare researchers invite GPs to participate in a qualitative, semi-structured interview about GP's **barriers** and **facilitators** to using **non-drug interventions** and the RACGP **Handbook of Non-Drug Interventions** (HANDI)
- This study will assist in understanding the enablers and barriers in using NDIs and HANDI in general practice and assist in the development and co-design of a platform to improve the **ease of prescription of NDIs**
- Interviews are from 30-45 minutes and can be conducted face-to-face or virtually.

Scan the QR code for more

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Current Projects

Developing a co-design vaping cessation program for young adults

- Griffith University researchers are currently **co-designing a vaping cessation program for young adults aged 18-24yrs** (GU Ref 2022/925).
- They are currently recruiting **Key Stakeholders** who may be involved in the care of young adults' health, such as a General Practitioner, Psychiatrist, Psychologist, Addiction Specialist, Pharmacist, Counsellor, and/or Practice Nurse.
- The workshops explore vaping cessation, and ideas previously generated by vapers and former vapers of what they think a vaping cessation program should look like. Participants will be offered a **gift voucher $50** as a token of thanks.

Scan the QR code for more

Griffith UNIVERSITY
Queensland, Australia

Current Projects

Evaluating the feasibility of a digital program for secondary prevention of stroke.

CAPS
CARE ASSISTANT PLATFORM FOR STROKE

- Researchers at the **CSIRO** and **Monash University** have developed a digital program for secondary stroke prevention.
- We are conducting research with General Practitioners to better understand the potential barriers and facilitators for its implementation in practice.
- **We are seeking 8-10 GPs across Australia to participate in an online 1-hour focus group**

Scan the QR code for more

MONASH University

CSIRO Australian e-Health Research Centre

GoldNet Research

To get involved in the PBRN, please scan the QR code to register for our email list

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Thank you!

Opioid Prescribing in Primary Care

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