Top tips for prescribing opioids in chronic pain in older people living with frailty

The aim of this document is to inform health care professionals who work with older people living with frailty on best practice for the management of chronic pain (excluding palliative care patients). As with all patients, for chronic pain management in older people, clinicians should consider nonpharmacological treatment and nonopioid pharmacological treatment options before initiating opioids. Opioid use should be initiated only when alleviation of pain and improvement of function outweigh the risks to the patient. The British Geriatric Society (BGS) has issued guidance on the management of pain in older people, which suggests opioid therapy may be considered for older people with moderate or severe pain, particularly if the pain is causing functional impairment or is reducing their quality of life. However, the needs and clinical context in this population cohort tends to be varied as such treatment plans must always be individualised and carefully monitored.

Before prescribing opioids in older adults:

- Consider **age related physiological** changes – an estimation of creatinine clearance and hepatic function is always needed to guide clinicians in dosage adjustments.
  - *Creatinine Clearance* - older people may have reduced renal function, even in the absence of renal disease, thereby leading to a reduction in medication clearance from the body and potential increased risk of drug accumulation. There is a narrow therapeutic window between opioid doses that are safe and those that could lead to more side effects such as respiratory depression or overdose.
  - *Hepatic Function* – older people with decreased hepatic function must also be closely monitored. The liver is responsible for the metabolism of opioids to their metabolites. Liver insufficiency can lead to an accumulation of the drug in the body; therefore, it may be necessary to adjust the dose and instruct carers and patients to allow longer administration intervals.
- Assess **polypharmacy** (over-the-counter analgesics, benzodiazepines, antidepressants, antipsychotic drugs) and **drug-drug interactions.** Consider **multimorbidity.**
- Share **realistic treatment goals** and make a **therapeutic plan**. Explain that opioids are poorly effective for long-term pain. For a small proportion of patients, opioids may be successfully used as part of a broader plan including non-medication treatments and self-management.
- It is important that **exercise programmes**, **psychological interventions** and **support from social prescribers** are considered at an **early stage** to ensure the optimum support for the patient, potentially aiding a reduction in the required dose of analgesia and offer other benefits such as increased function, relaxation and stress relief.
- Discuss the circumstances in which opioid therapy will be stopped and arrangement for review.
- Seek advice from the relevant clinical team, where appropriate.

Considerations for prescribing opioids in older people living with frailty:

- Start **low and go slow** - Start at the lowest possible dose and titrate upwards based on tolerability and efficacy. Consider a trial period of about four weeks and monitor for excess sedation or confusion as well as analgesic control.
- Longer dosing intervals and more regular monitoring should be considered.
- Ensure **quantities** of opioids prescribed are appropriate for the patient's pain management.
- Avoid prescribing concentrated preparations (e.g., oral morphine oral solution 20mg/1ml), to prevent confusion errors.

- Patients can be prone to drink liquid preparations straight from the bottle, consider using a rubber bung on the bottle to minimise this risk as appropriate (rubber bungs can be obtained from community pharmacies). Patients should be **counselled** on the dose and frequency and advised to use an accurate measuring spoon or syringe.
- **Switching to another opioid** might be indicated in cases of **unacceptable side effects** or insufficient analgesic control.
- The **oral route** may be appropriate for many older people however any swallowing and compliance issues should be considered, and transdermal preparations may be more appropriate in these situations.
- Consider a patient's dexterity when prescribing oral liquid medication. Also take account their support network and capacity to manage the dosing regimen e.g. don't prescribe four times a day, if only twice daily carer support.
- Clinicians should be aware of the **high sodium content in soluble/effervescent** paracetamol, especially in those with impaired renal function. Paracetamol suspension may be more appropriate in these patients.
- **Controlled-release formulations** and **transdermal formulations** are generally preferred (lower risk of addiction and adverse effects).
- Patients should be **counselled** on the side effects of any opioids prescribed and appropriate **safety netting advice** given including where they should seek advice if needed.
- Opioid side effects including nausea and vomiting should be anticipated and suitable prophylaxis considered. Appropriate **laxative therapy**, such as the combination of a stool softener and a stimulant laxative, should be prescribed throughout treatment for all older people who are prescribed opioid therapy to prevent constipation (see BNSSG Constipation guidelines).
- Other common opioid side effects include falls, sedation, confusion and hallucinations. Note, hallucinations are very common with tramadol and hence is best avoided in this group, low dose codeine may be a preferred *weak opioid.*
- Codeine metabolism varies widely among patients, so conversion to morphine may occur to a greater or lesser extent, with a varying degree of pain relief and side effects and prescribers should be aware of this.
- Low dose strong opioids may be used where pain is severe and likely to diminish rapidly over days however within a chronic pain setting there may still be a role for weak opioids.
- Buprenorphine transdermal patches may be preferred for some older patients for example to support bridging between weak and strong opioids. Its ceiling effect may also be helpful against accidental respiratory suppression in this cohort.
- If a *strong opioid* is required, consider patient needs on an individual basis including renal impairment and seek advice where needed.
- Prescribers should be aware of the dose equivalencies of opioids.
- Risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day (in the general population), but there is no increased benefit. Extra consideration is needed for older people in relation to the dose prescribed as there will likely be increased risk of drug interactions, adverse effects, multimorbidity and pharmacokinetic/pharmacodynamic changes.
- Ensure ongoing **monitoring** of treatment goals and adverse effects. Long term harms from opioids include increased risk of falls which is of particular importance in older people living with frailty, as well as affects on the endocrine and immune system.
- Check opioid drug is still clearly needed and **stop (appropriately) if no longer necessary**. If tapering or stopping/deprescribing high dose opioids, this needs careful planning and collaboration between clinician and patient.

Please note where patients are palliative please refer to local hospice guidance and Remedy.

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References:

Faculty of Pain Medicine, Opioids Aware https://www.fpm.ac.uk/opioids-aware

Abdulla A, Adams N, Bone M, Elliott AM, Gaffin J, Jones D, Knaggs R, Martin D, Sampson L, Schofield P. Guidance on the management of pain in older people. *Age Ageing.* 2013;42 Suppl 1:i1–57. [PubMed]

Guerriero F, Guidance on opioids prescribing for the management of persistent non-cancer pain in older adults World J Clin Cases. 2017 Mar 16; 5(3): 73–81.

Published online 2017 Mar 16. doi: 10.12998/wjcc.v5.i3.73, accessed via Guidance on opioids prescribing for the management of persistent non-cancer pain in older adults - PMC (nih.gov)